

## **Litigating an HMO Bad Faith Case From the Plaintiff: Perspective and the Lessons of**

### **Goodrich v. Aetna**

**Litigating HMO bad faith cases presents several challenges for trial lawyers. The following is a discussion of some highlights to keep in mind when prosecuting HMO bad faith cases as well as a discussion of the case Goodrich v. Aetna as an example.**

#### 1. THE HMO MODEL

The starting point in litigating against HMO's is to understand how the system works. Specifically, it is important to understand the distinction between traditional "fee for service" medical insurance and how an HMO operates. The basic difference starts with the promise made to an insured under a major medical insurance policy as compared with a managed care plan. Under a fee for service medical policy, the insurance company promises to reimburse you for the covered medical bills that you incur. So, if you get sick, you can go to your own doctor and the insurance company pays the bill. In contrast, under a "managed care" plan, an HMO promises to provide the care that you need. Thus, the managed health care system is a hybrid. On the one hand, an HMO assumes the role of an insurance company by defining and determining the parameters of the level and extent of health care that will be provided in exchange for premiums. To that end, the HMO must make coverage decisions through a process known as "utilization review". On the other hand, the HMO establishes the A network or system of medical care providers to actually render the medical care covered under the established parameters. The bottom line is that managed care is both insurance and medicine.

And how do HMO's go about fulfilling their dual role of performing utilization review and providing the medical care to their members? As to utilization review, in some instances, the HMO will conduct reviews itself. In other cases, the HMO will hire an Independent Physicians Association or "IPA" to conduct utilization review on behalf of the HMO. Usually, the HMO will reserve utilization review decisions for itself on more expensive procedures such as surgery or hospitalization, while the IPA may be authorized to conduct review on more routine procedures such as ordering diagnostic tests.

As to its role in providing care, the HMO will typically enter into a risk sharing contract with medical providers known as "capitation". Under a capitation agreement, the HMO will pay provider groups a flat fee based on the number of patients that are assigned to that provider group for care. Inherent within such an arrangement is a financial disincentive for the medical provider to suggest or recommend care. After all, the more care that is rendered to patients, the less money that is left over for the provider. Thus, if a provider refers a patient to a specialist or orders expensive testing, the providers share of the premium is cut down.

#### 2. BACKGROUND OF INSURANCE BAD FAITH ACTIONS

The seminal case establishing insurance bad faith in California was *Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 328 P.2d 198. In *Comunale*, the insured, Sloan, hit Mr. and Mrs. Comunale while they were in a cross-walk. When the Comunales sued Sloan, he tendered the claim to his insurer for defense. The insurer refused to defend, claiming there was no coverage for Sloan while he was driving another vehicle. The insurer also refused to fund the Comunales' settlement demand which was well within the \$10,000 policy limits -- again on the assertion that the claim was not covered.

After a \$25,000 verdict was entered against Sloan, the Comunales sued the insurer under Insurance Code

§11580 which allows a direct action by a claimant against the insurance company to enforce a judgment obtained against the insured. But such an action is subject to the policy limits. In that proceeding, the Comunales prevailed on the coverage issue and collected the \$10,000 policy limit. Thus, the Comunales had to sue twice to get what they reasonably should have been provided early on in the claim. And even after two suits, they were still left with a \$15,000 shortfall on the total judgment. The insured assigned to the Comunales any right of action he had against his insurer to collect the amount of the judgment in excess of the policy limit.

The Comunale court held that the insurer had a duty under the contract to give the insured's interests as much consideration as it did its own. If the insurer wrongfully denies the existence of coverage, declines a settlement offer within the policy limits, and a judgment in excess of the policy limits is rendered, the insured has the right to claim, as damages for the insurer's breach of its duty of good faith, the amount of the excess judgment. Thus, through the assignment, and after a third lawsuit, the Comunales were able to collect their full damages.

Nine years later, the Supreme Court extended the available relief under a cause of action for breach of the duty of good faith to encompass recovery of other consequential damages, including economic losses and emotional distress. (*Crisci v. Security Ins. Co. of New Haven, Conn.* (1967) 66 Cal.2d 425, 58 Cal.Rptr. 13.) In *Crisci*, the insured was a 70 year old immigrant widow who owned an apartment building. A tenant was injured when a step collapsed. The tenant fell through the opening up to her waist and dangled there, 15 feet above ground. Although the insurer defended Mrs. Crisci, it refused to settle the case for the \$10,000 policy limit. After entry of the \$100,000 verdict after trial, Mrs. Crisci was left indigent. She was forced to work as a babysitter and her grandchildren paid her rent. Because of her financial problems, her health declined and she became suicidal.

The *Crisci* court concluded that in refusing to settle within the policy limits, the insurer failed to give its insured's interests as much consideration as it did its own and, having thereby breached the duty of good faith, the insurer was properly liable for not only the judgment amount in excess of the policy limits, but for the other economic and emotional distress damages which resulted to the insured.

The next major evolution in California's bad faith law occurred in 1973 when the Supreme Court confirmed that an insurer not only owes its policyholders a duty of good faith and fair dealing in handling third party claims against the policyholder under liability policies, but also owes the same duty of good faith in handling "first-party" claims as well, i.e., where the insured is making a direct claim under an insurance policy for benefits owed to the insured. (*Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566, 108 Cal.Rptr. 480.) As noted by the court in *Gruenberg* after reviewing its prior decisions in *Comunale* and *Crisci* and intermediate appellate decisions subsequent to those cases:

"It is manifest that a common legal principle underlies all of the foregoing decisions; namely, that in every insurance contract there is an implied covenant of good faith and fair dealing. The duty to so act is imminent [sic] in the contract whether the company is attending to the claims of third persons against the insured or the claims of the insured itself. Accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort."

As the *Gruenberg* court explained, implied in every insurance contract is the promise that the insurer will handle claims under the policy reasonably and in good faith. When it fails to do so, it breaches that promise and tort liability will lie. The usual predicate for recovering tort damages for breach of the duty of good faith and fair dealing is a showing that the insurer withheld benefits "unreasonably" or "without proper cause." (*Neal v. Farmers Ins. Exch.* (1978) 21 Cal.3d 910, 920, 148 Cal.Rptr. 389, 394; *Austero v. National Cas. Co.* (1978) 84 Cal.App.3d 1, 32, 148 Cal.Rptr. 653, 673; *Kardly v. State Farm Mut. Auto. Ins. Co.* (1995) 31 Cal.App.4th 1746, 1752, 37 Cal.Rptr.2d 612, 615.)

As part of its obligation to act in good faith, an insurer has a duty to fully, fairly and thoroughly investigate the insured's claim. (*Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 169 Cal.Rptr. 691.) And in so doing, the insurer must give at least as much consideration to its insured's interests as it does to its own. (*id.*) And "[a]n insurance company may not ignore evidence which supports coverage. If it does so, it acts unreasonably towards its insured and breaches the covenant of good faith and fair dealing." (*Mariscal v. Old Republic Life Ins. Co.* (1996) 42 Cal.App.4th 1617, 1624, 50 Cal.Rptr.2d 224, 227-228.).

Moreover, not only must the insurer investigate thoroughly, it must also evaluate the information it garners fairly, reasonably and objectively. (*Hughes v. Blue Cross of No. Calif.* (1989) 215 Cal.App.3d 832, 845-846, 263 Cal.Rptr. 850, 857; *Delgado v. Heritage Life Ins. Co.* (1984) 157 Cal.App.3d 262, 277, 203 Cal.Rptr. 672, 681.) Indeed, where an insurer knowingly applies an improper standard to the determination of a claim, it can be subject to not only bad faith but punitive damage liability. (*Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 621, 197 Cal.Rptr. 878, 884.)

Importantly, bad faith liability may lie not only where the insurer failed to pay the benefits at all, but also where the insurer failed to pay the full amount of the benefits due or even where the full benefits were eventually paid, but where the insurer unreasonably delayed in doing so. (*Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 169 Cal.Rptr. 691; *Waller v. Truck Ins. Exch.* (1995) 11 Cal.4th 1, 36, 44 Cal.Rptr.2d 370, 390.) As stated by the court in *Waller*:

"Delayed payment based on inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable and numerous other tactics may breach the implied covenant because they frustrate the insured's right to receive the benefits of the contract in prompt compensation for losses. (*Waller v. Truck Ins. Exch.* (1995) 11 Cal.4th 1, 36, 44 Cal.Rptr.2d 370, 390).

Delay issues are amplified in HMO bad faith cases. In many instances, insureds have a "window of opportunity" to obtain medically necessary treatment, particularly when dealing with fast spreading diseases like cancer. In those cases, it is not uncommon that delays in obtaining pre-authorization from an HMO for medical services results in irreparable deterioration of the insured health, such as metastasis. In many such cases, once authorization is given, it is too late for the insured to receive treatment and the "window of opportunity" has been lost for the insured.

In an insurance bad faith action, all tort remedies caused by the insurer's bad faith conduct are recoverable. Naturally, this would first include the contractual damages under the policy. In addition, consequential economic damages and emotional distress damages arising from an insurer's denial or unreasonable handling a claim may also be sought. And, an insured may also recover the attorney fees expended to recover the contractual benefits. The case establishing this principle is the California Supreme Court decision in *Brandt v. Superior Court*, (1985) 37 Cal.3d 813, 210 Cal.Rptr. 211. The *Brandt* decision departed from the general rule that each party must bear their own attorney fees. The rationale for doing so was stated by the Supreme Court as follows:

[W]hen the insurer's conduct is unreasonable, a plaintiff is allowed to recover for all detriment proximately resulting from the insurer's bad faith, which detriment . . . includes those attorney fees that were incurred to obtain the policy benefits and that would not have been incurred but for the insurer's tortious conduct. (*Brandt*, 37 Cal.3d at 819).

Punitive damages may also be available in an action for breach of the implied covenant of good faith & fair dealing. The purpose of punitive damages is to punish a defendant, to set an example, and, thereby, deter others from similar conduct. (See *Neal v. Farmers Ins. Exchange* (1978) 21 Cal.3d 910, 928.) Punitive damages are recoverable whenever an insurer's conduct in handling a claim exhibits "malice", "oppression", or "fraud" as defined in Civil Code §3294. "Malice" means despicable conduct that is carried on by the insurer

with a willful and conscious disregard for the rights of its own insured. A carrier acts with conscious disregard for the rights or safety of its insured when it is aware of the probable dangerous consequences of its conduct, yet willfully and deliberately fails to avoid those consequences. "Oppression" means despicable conduct that subjects an insured to cruel and unjust hardship in conscious disregard of that person's rights. "Despicable conduct", in turn, is conduct which is so vile, base, contemptible, miserable, wretched or loathsome that it would be looked down upon and despised by ordinary decent people. Finally, "Fraud" means an intentional misrepresentation, deceit, or concealment of a material fact known to the insurer with the intent on the part of the insurer to deprive the insured of property or legal rights or otherwise cause injury. As noted in one leading treatise, the factors to be included in the evaluation of punitive damages claim:

The bottom line factor [in evaluating a punitive damages claim] is whether the insurer was attempting to evade its responsibilities under the contract: i.e., does the claim file show the carrier was attempting to service its policyholder and live up to its obligations? Or, had it adopted the attitude, "even if the claim may be valid, let's do everything we can to get out of paying it!" (Crosky, Kaufman, et al, California Practice Guide, Insurance Litigation (1998 TRG) ¶13:451, p. 13-96).

Upon a showing, by "clear & convincing" evidence, that an insurer acted with the requisite "malice", "oppression" or "fraud", punitive damages may be recoverable as further tort damages for the breach of the implied covenant of good faith and fair dealing.

### 3. BAD FAITH LIABILITY IN THE HMO SETTING

In *Sarchett v. Blue Shield of California*, 43 Cal.3d 1, 3, fn. 1, 233 Cal.Rptr. 76 (1987), the California Supreme Court determined that the duty of good faith and fair dealing owed by Blue Shield, as a health care service plan, i.e., HMO, required Blue Shield to adequately notify and inform its members of their arbitration rights and the bad faith failure to do so constituted a waiver of the right to enforce arbitration. Simply put, the Supreme Court based its decision and determination that a duty of good faith was owed on the implicit conclusion that an HMO is the same as and equivalent to an insurance company.

Moreover, the California Supreme Court's decision in *Foley v. Interactive Data Corp.*, 47 Cal.3d 654, 684, 254 Cal.Rptr. 211, 228 (1988) further demonstrates why imposition of the duty of good faith on an HMO is appropriate. In *Foley*, the Supreme Court acknowledged with approval the analysis contained in the decision in *Wallis v. Superior Court*, 160 Cal.App.3d 1109, 207 Cal.Rptr. 123 (1984) regarding the circumstances under which a duty of good faith and fair dealing sounding in tort could properly be imposed. (*Foley v. Interactive Date Corp.*, 47 Cal.3d at 691, 254 Cal.Rptr. at 233, fn. 29.)

The *Wallis* court, analyzing the insurer/insured relationship, concluded that where the following factors are present, a duty of good faith and fair dealing exists, the breach of which is actionable in tort: (1) The parties are in inherently unequal bargaining positions; (2) The plaintiff entered into the contract to secure financial stability and peace of mind; (3) Ordinary contract damages offered no incentive for the defendant not to breach; (4) The plaintiff is in an extremely vulnerable position; and, (5) The defendant is aware of the plaintiff's position. (See *Wallis*, supra, 160 Cal.App.3d at 1117-1119, 207 Cal.Rptr. at 128-129.)

Indeed, those are the very factors which exist in the HMO situation. As a practical matter, the typical HMO "Evidence of Coverage" or plan description reads like a medical insurance policy, makes the same promises as a medical insurance policy and promises to provide exactly the same security and peace of mind as a medical insurance policy. In fact, the only difference between most HMO plans and a standard medical insurance plan is that the HMO provides the payments to the doctors and hospitals under capitation agreements before services are rendered rather than through indemnity agreements after the services are rendered. That difference, however, does not, in any way, affect the purchasers' status or entitlement. Thus, if an HMO refuses to authorize referrals, tests or treatment based on the assertion that it is not covered by the

plan, it assumes the role of an insurance company and, like an insurer, can be subject to liability for breach of the covenant of good faith and fair dealing. (*Sarchett v. Blue Shield of Calif.*, 43 Cal.3d 1, 2, 233 Cal.Rptr. 76, fn 1 (1987).) To pretend that an HMO's Evidence of Coverage is anything less than an insurance policy makes a mockery of the entire system.

Having assumed the same type of relationship with the consumer as an insurance company does, an HMO should bear the same duties, responsibilities and liabilities as an insurer, including the duty of good faith and fair dealing. Furthermore, the same public policy justifications for holding insurers liable in tort for breach of that duty apply to the HMO setting. For example, the California Supreme Court in *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal.3d 809, 169 Cal.Rptr. 691 (1979) quoted:

" The insurers' obligations are . . . rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements. . . . [A]s a supplier of a public service rather than a manufactured product, the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with the public's trust must go private responsibility consonant with that trust.' (*Goodman & Seaton Foreword: Ripe for Decision, Internal Workings and Current Concerns of the California Supreme Court* (1974) 62 Cal.L.Rev. 309, 346-347.)"

Since that public policy analysis regarding an insurer's obligations applies with equal force to the role undertaken by an HMO, the same bases for liability should apply as well. (See, generally, *Stern, Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, 85 W.V.Law Rev. 910 (1983).)

#### 4. UTILIZATION REVIEW STANDARDS FOR HMOs

The governing authority for HMOs varies from state to state. In California, HMOs are governed by the Department of Corporations. The specific regulations governing HMOs are found in the Knox-Keene Act, pursuant to which patients are entitled to "continuity of care" and "ready referral" to other providers [Knox-Keene, Section 1367(d)].

In addition, there are national organizations which publish standards relating to utilization review and utilization management and have specific requirements for accreditation for HMOs. Accreditation is the result of a formal review process in which a managed care organization is certified to have the necessary structures and processes to provide quality health care and preserve the rights of patients and providers. The National Committee for Quality Assurance ("NCQA") is widely recognized, as well as the American Accreditation HealthCare Commission/URAC ("URAC"). The NCQA's standards were revised in 1998 to coincide with scheduled reporting of Health Plan Employer Data and Information Sets ("HEDIS"), which is a set of standardized performance measures designed to allow for the reliable comparison of the performance of managed health care plans covering a broad range of areas. These areas include effectiveness of care, accessibility and availability of care, satisfaction with the experience of care, cost of care, stability of the health plan, informed health care choices, use of services, and plan descriptive information. The 1998 NCQA revisions incorporated HEDIS measures into the NCQA accreditation process.

The NCQA and URAC standards can be useful when analyzing an HMO's bad faith liability because they include specific guidelines for "turnaround time" for precertification or authorization of requests for medical care. For example, the guidelines require a two working day turnaround time for standard requests, and a 24 hour turnaround time for urgent requests. The standards also set forth specific requirements for turnaround time on appeals, including expedited appeal procedures. In many instances, decisions on preauthorization are delayed so long that a patient is forced to proceed with treatment without it, which then leads to the

inevitable denial for lack of preauthorization. To attack this "delay and deny" system, evidence of NCQA and URAC violations may be used.

HMOs also establish their own internal guidelines for utilization management to meet the qualifications for NCQA or URAC accreditation. And, when an HMO contracts with an IPA to conduct utilization review and management on behalf of the HMO, the IPA usually maintains its own utilization management plan which should coincide with the utilization management plan of the HMO. Thus, it is helpful to obtain the internal utilization management guidelines of both the HMO and the IPA to then compare whether they were followed. Notably, under the provisions of NCQA, while an HMO may delegate the responsibility for utilization management and review to an IPA, the liability for delays in utilization review is a non-delegable duty. Thus, if an IPA violates NCQA, URAC, or internal guidelines in delaying utilization review decisions, the HMO cannot wipe its hands clean because it is equally responsible for the IPA's delay.

Finally, attention should be given to the qualifications of the personnel conducting utilization review of a treatment request. Normally, a nurse reviewer has authority to make a determination whether a request is "covered" under the health plan. However, determinations of "medical necessity" of treatment recommended by a specialist doctor should also be reviewed by a qualified specialist doctor.

## 5. ARGUING PUNITIVE DAMAGES AGAINST AN HMO:

The punitive damage exposure of any HMO bad faith case will naturally depend on the individual facts of the case. If the ingredients of the case ultimately allow for a punitive damage phase, then there are certain key points to raise with the jury to obtain an appropriate award. The starting point is to explain the purpose of punitive damages.

It is important that the jury understand that the purpose of punitive damages is to protect the public, which includes the members of the jury. To accomplish this task, refer the jury back to the law through special jury instruction such as the following:

"The purpose of punitive damages is purely a public one. The public's goal is to punish wrongdoing, and thereby protect itself from future misconduct, either by the same defendant or other potential wrongdoers. In determining the amount of punitive damages to be awarded, you are not to give any consideration as to how the punitive damages will be distributed." (Adams v. Murakami (1991) 54 Cal.3d 105, 110; Neal v. Farmers Ins. Group (1978) 21 Cal.3d 910, 928, fn 13) (emphasis added).

In the punitive phase, the plaintiff is acting as a public servant, advancing the "public's goal" to punish the HMO's misconduct. Ultimately, the jury should understand that their punitive verdict will protect not just an individual or some special interest group, but rather, will protect everyone from future HMO abuses. The jury must understand the significance of their role to protect the public in the area of health care delivery.

Undoubtedly, the jury will have read countless newspaper articles or television shows discussing HMO horror stories and the efforts for HMO reform. It is important that the jury understand that they have the power to send a warning to the HMO industry as a whole that misconduct will not be tolerated by the public. The jury can do this by setting an example of the defendant. Again, one way to accomplish this is to refer back to the jury instructions, such as the following:

"In addition to actual or compensatory damages which you have already awarded, the law authorizes the jury to make an award of punitive damages in order to punish the wrongdoer for its misconduct or to serve as an example or warning to others not to engage in such conduct." (TXO Production Corp. v. Alliance Resources Corp. (1993) 509 U.S. 443, 459, 463, 113 S.Ct. 2711, 2721 -- 2722, 125 L.Ed.2d 366) (emphasis added).

The punitive damages that the jury awards will not only send a message to the HMO defendant on how it

should do business in the future, but it will also serve as an example or a warning to other competing HMO's that the public will not tolerate such misconduct. The jury should be given examples of warnings they see everyday: if a swimming pool is too shallow, it should have a warning; if a product is dangerous, it should have a warning, etc. Just as the warning in these examples must be prominently displayed to have any impact, so too should the jury's punitive verdict be substantial enough to be prominently displayed to the HMO industry.

The jury must also realize that punitive damages should act as a deterrent against future misconduct. Again, the jury's verdict should not only deter future wrongdoing by the defendant, but also by the HMO industry as a whole. Another important jury instruction to establish this point is the following:

"The object of [punitive] damages is to deter the health care service plan and others from committing like offenses in the future. Therefore, the law recognizes that to in fact deter such conduct, may require a larger fine upon one of larger means than it would upon one of ordinary means under the same or similar circumstances." (TXO Production Corp. v. Alliance Resources Corp. (1993) 509 U.S. 443, 459, 463, 113 S.Ct. 2711, 2721 -- 2722, 125 L.Ed.2d 366) (emphasis added).

The jury should be made aware that the objective of their punitive verdict is to deter the defendant, and the HMO industry, from putting profit interests through delays and denials ahead of members' healthcare. In this regard, the deterrent effect is no different than a lengthy prison term serves as a deterrent to the public against committing crime.

Once the jury understands the "purely public" purpose of punitive damages, it is then time to turn to the amount of punitive damages to assess. The well established guidelines for the assessment of punitive damages in California, and many other jurisdictions, are 1.) the reprehensibility of the defendant's conduct, 2.) the amount of punitive damages which will have a deterrent effect on the defendant in light of the defendant's financial condition; and 3.) the punitive damages must bear a reasonable relation to the injury, harm, or damage actually suffered by the plaintiff. (BAJI 14.72.2).

Naturally, the evidence under each of these guidelines will largely depend on the facts of a given case as to the reprehensibility of the conduct, the defendant's financial condition, and the plaintiff's actual injury. But in addition to these general guidelines, there are other authorities that speak more specifically to the amount of punitive damages. Take the following jury instruction:

"In determining the amount of punitive damages to be assessed against a defendant, you may consider the following factors: One factor is the particular nature of the defendant's conduct. Different acts may be of varying degrees of reprehensibility, and the more reprehensible the act, the greater the appropriate punishment. Another factor to be considered is the wealth of the defendant. The function of deterrence and punishment will have little effect if the wealth of the defendant allows it to absorb the award with little or no discomfort." (Neal v. Farmers Ins. Exchange (1978) 21 Cal.3d 910, 928) (emphasis added).

These jury instructions convey credibility when arguing the amount of punitive damages the jury should award. The jury should be told that the law requires a greater punitive award where the conduct is particularly reprehensible, and the law requires that the punitive award cause some financial "discomfort", in order to serve the public purpose of deterrence. Naturally, determining what amount will cause the appropriate "discomfort" will depend on the financial condition of the HMO. This concept is further set forth in another jury instruction:

"The wealthier the wrongdoing defendant, the larger the award of punitive damages needs to be in order to accomplish the objectives of punishment and deterrence of such conduct in the future" (Adams v. Murakami, (1991) 54 Cal.3d 105, 110) (emphasis added).

Comparisons between a wrongdoing individual and a wrongdoing HMO should be made to assist the jury in arriving at an appropriate punitive award. For example, a punitive award of five percent of an individual's net worth of \$50,000 amounts to \$2,500. In contrast, the same five percent award of an HMO's net worth of \$10 billion amounts to \$500 million.

The defense will undoubtedly attempt to avoid or minimize the punitive damage award by arguing that a large punitive damage award will result in higher health care costs for everyone. To prevent this argument in the first place, the following jury instruction should be given:

"The [HMO defendant] must pay any punitive damage award from its assets or profits and cannot pass any punitive damage award on to its members in the form of increased premiums or charges" (Evidence Code §352; Accounting Statement 84-1, November 26, 1984, State of California Department of Insurance; Health and Safety Code §1342.5).

This instruction should preclude, or at least diffuse, any argument by the defense that the punitive award will result in higher premiums for all. It will also alleviate any concerns the jury may have about the impact their award will have on future premiums.

## 6. THE CASE OF GOODRICH v. AETNA

David Goodrich was a career Deputy District Attorney for San Bernardino County, who headed up the gang prosecution unit, who had health insurance through his employment with Aetna Health Plans of Southern California, Inc., which later became Aetna U.S. Healthcare of California, Inc.

On June 5, 1992, David collapsed while in court. After exploratory surgery and testing, David was diagnosed with a rare form of stomach cancer, leiomyosarcoma. He was informed by an Aetna in-plan surgical oncologist that he should be seen at City of Hope since, admittedly, none of the doctors in-plan had "vast experience" with the disease.

David's care and treatment between June 1992 and his death in March 1995 can be divided into three distinct segments. First, was a possible bone marrow transplant in conjunction with high dose chemotherapy to be performed at City of Hope in 1992. Second, a cryosurgery of the liver with follow-up chemotherapy which was performed at St. John's Medical Center in Santa Monica in 1993. And third, a debulking surgery which was performed at St. John's Medical Center as well in early 1995.

In accordance with plan procedure, David sought his primary care physician's referral for medical treatment. At the outset, his primary care physician issued an Authorization for David to be seen at City of Hope for consultation. Doctors at City of Hope had determined that David was a "perfect candidate" for high dose chemotherapy supported with a bone marrow transplant.

Although the in-plan oncologist's indication that David needed to go to City of Hope came on July 21, 1992, a response from Aetna was not forthcoming until November 18, 1992, four months later. The Utilization Review Department of Redlands Medical Group, in accordance with Aetna procedure under a "Terminal Illness Policy", that was not disclosed to treating physicians or plan members, forwarded the request for treatment at City of Hope to Aetna's local Medical Director, who then sent the request on to Aetna's Home Office in Hartford, Connecticut. After delaying its decision, Aetna finally issued a denial letter on the basis that proposed treatment at City of Hope was "experimental" was not a "covered benefit".

Notably, the Evidence of Coverage and Disclosure Form issued by Aetna to David in 1992 did not contain any exclusions or limitations for experimental or investigational procedures! While Aetna had contracted with Redlands Medical Group, later known as Primecare Medical Group of Redlands, for the utilization review and

medical care to be provided to plan members, Aetna maintained final authority to approve or deny out-of-plan hospitalizations.

Unfortunately for David and Teresa Goodrich, by the time Aetna had made its decision to deny the high dose chemotherapy, based on a non-existing exclusion, David's cancer had metastasized to his liver, thereby disqualifying him as a candidate for the procedure. Due to the delay, David lost his window of opportunity for the treatment.

The second major treatment request was on August 26, 1993, when David's primary care physician requested authorization for David to be seen for consultation and possible cryosurgery at St. John's Medical Center. Once again, the UR Department of Primecare Medical Group of Redlands forwarded the request to the local Medical Director of Aetna, who in turn sent the request to the Home Office in Hartford, Conn. It was not until November 3, 1993, two and one half months later, when David received a letter from an R.N. at Aetna, indicating that "out-of-plan" services would not be covered. Aetna later paid for a majority of the medical bills related to the cryosurgery, but not the follow-up chemotherapy. David's treating surgical oncologist testified at trial that had he seen David in February of 1993, and performed the cryosurgery at that time, he could have extended David's life by approximately 15 to 20 months, and that David would have enjoyed a better quality of life.

The third major segment of David's treatment was on January 11, 1995 when his Aetna In-Plan Primary Care Physician requested an out-of-plan hospitalization at St. John's for debulking surgery and chemotherapy. David did not have the luxury of waiting for Aetna's decision, so the surgery was performed on January 17, 1995. Aetna denied the request the next day, on January 18, 1995, via a letter from another R.N. which was delivered to Teresa at the hospital, while David was on a ventilator in I.C.U. Aetna's letter indicated that David would be financially responsible for all charges incurred. David died two months later believing his wife, a kindergarten school teacher, would be left with roughly \$750,000 in medical bills to pay.

During trial, David's treating specialist testified that David was never stable enough following the January 17, 1995 surgery to be transferred to another facility. David Goodrich died on March 15, 1995, without ever leaving St. John's Medical Center.

Following David's death, Teresa sought the help of the primary care physician in appealing Aetna's decision that left her owing approximately \$750,000 in medical bills. The Primary Care Physician sent his letter pleading with Aetna to reconsider its position on May 16, 1995. It was not until November of 1995 that Aetna responded to the appeal, at which time Aetna upheld its previous decision to deny payment.

The case ultimately went to trial in the fall of 1998 and concluded with the jury's verdict in January 1999. Ultimately, in the first phase of the trial the jury found Aetna acted with malice, oppression and fraud in the handling of David Goodrich's treatment requests, and awarded \$747,655.88 for unpaid medical bills, and \$3,790,603.52 on the wrongful death cause of action. Prior to the punitive phase of the trial, the judge ruled that the net worth of the parent company, Aetna Services Inc., could not be considered by the jury in their punitive damage assessment. Rather, only the net worth of the subsidiary company, Aetna U.S. Health Care of California, could be considered. Significantly, the total assets of the subsidiary company was approximately \$255 million, while the net worth of the parent was approximately \$8 billion. Yet, despite this ruling, after two hours of deliberation the jury awarded \$116,026,104.00 in punitive damages, bringing the total verdict to \$120,564,363.40.

Following the jury verdict, it was discovered that the parent company, Aetna Services Inc., had filed a declaratory relief action in Federal District Court in Pennsylvania against its own reinsurance carrier, seeking indemnity for the Goodrich verdicts. In that separate action, Aetna Services Inc., alleged that the policy covered the punitive damage judgment up to a limit of at least \$76 million.

Based on this new information, on March 19, 1999, plaintiff brought a motion to amend the judgment to add the parent company, Aetna Services Inc., as judgment debtors. Also at that time, Aetna U.S. Healthcare of California brought a motion for new trial and a motion for judgment notwithstanding the verdict. Following the hearing, on March 29, 1999, the Court granted plaintiff's motion to amend the judgment, thus including the parent company, Aetna Service Inc., as a judgment debtor. The Court also denied Aetna's motion for new trial and JNOV, and the verdict was left intact, in its entirety. In its decision not to reduce the punitive damage award, the Court noted, among other things, the following:

"In arriving at this determination, and recognizing the purpose of punitive damages to punish and deter, this court also considers the fact that Aetna Services, Inc., and Aetna U.S. Healthcare of California, Inc., are both generally immune from civil suits arising out of the provision of managed health care, based upon the provisions of ERISA. The Goodrich claim is a rare exception. Additionally, managed health care providers have significant contact with the general public, and the general public is more dependent upon the managed health care providers than virtually any other product or service industry in the private sector."

An amended judgment, including the parent company, Aetna Service Inc., as a judgment debtor, was entered on April 13, 1999. The matter is now on appeal.

The Goodrich case was one of the only few HMO bad faith cases to actually reach a jury. Due to ERISA preemption, the large majority of individuals cannot bring their case before a jury to hold the HMO accountable when treated unfairly. Indeed, the only remedy available under ERISA is that the managed care plan must pay what it owed in the first place. However, because David Goodrich was a government employee, the action was statutorily exempt from ERISA.

## 7. CONCLUSION

The starting point to successfully prosecuting HMO bad faith cases is to understand how the system works, both legally and factually. This includes an understanding of how medical care is delivered under the HMO model and the objective published standards governing HMO's. When a pattern of misconduct emerges punitive damages are available to deter future misconduct on behalf of the public.