

## **Plaintiff's Strategies in HMO Litigation**

**Litigating managed care cases presents several challenges for plaintiff's lawyers. The following is a discussion of some highlights to keep in mind when prosecuting HMO cases.**

### 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 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. UTILIZATION REVIEW STANDARDS

The governing authority for HMO's 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 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 should be used, and ultimately introduced to the jury.

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 "medial necessity" of treatment recommended by a specialist doctor should also be reviewed by a qualified specialist doctor.

### 3. DISCOVERY IN HMO LITIGATION

The key document in an HMO Bad Faith case is the Evidence of Coverage and Disclosure Booklet issued by the HMO to the plan participants which ordinarily will already be in the possession of the client. Other items that should be in the plaintiff's possession will include the advertising materials received prior to enrollment and the enrollment form. In addition, if it is a group plan, many times there will be an "open enrollment package" provided to employees prior to the time of enrollment. It is very important to evaluate the information provided to the plan members to induce their enrollment compared to what was actually provided to the patient when medical treatment became necessary. In addition to obtaining the documents in the plaintiff's possession, the following are additional areas of discovery to conduct once litigation has commenced:

#### A. The IPA Services Agreement

The HMO will contract with a medical group to act as the "Independent Physicians Association" (IPA), to provide medical care to the plan participants. The evidence of how utilization review responsibilities is divided between the HMO and the IPA is essential to proving the misconduct. If the HMO delegates at least some portion of utilization review responsibility to an IPA, there will typically be an IPA Services Agreement between the HMO and the designated medical group which acts as the IPA. The contract is essential in discovering who is "on the hook" for the costs of the different medical services that may be requested.

Typically, attached to the IPA Services Agreement will be a "payment responsibility matrix". The matrix will show those items, usually out-of-plan treatment and/or hospitalizations, for which the HMO retains financial responsibility, as well as complete control with respect to utilization. Typically, the IPA is delegated the responsibility for utilization review and management relating to in-plan treatment, and is financially responsible for those "standard" medical care costs. However, it is important to note that normally the HMO will retain ultimate authority for approving or denying even the most standard medical care based on its determination of "medical necessity".

In addition to disclosing who is on the hook for the medical treatment requested, the IPA Services Agreement will provide information concerning confidentiality (gag clauses), whether there is financial incentive to limit treatment, particularly in-patient care (frequently entitled "hospital incentive fund"), guidelines for responsibilities of the IPA and HMO, as well as a full disclosure of the capitation amounts received by the IPA for basic health services to be provided to plan members. The IPA Services Agreement will also contain the requirements imposed by the HMO for quality assurance and utilization review. It is important to remember that although the HMO may delegate the responsibility for conducting utilization review and utilization management, as well as quality assurance, it cannot avoid liability for the injuries caused to the plan member by reason of inappropriate delays and/or denials under NCQA guidelines.

#### B. The Primary Care Physician Agreement

After contracting with the HMO to conduct utilization review and utilization management, as well as providing medical care to plan members, the IPA will, in turn, contract with physicians to act as "primary care physicians" (PCPs) for the plan members. The role of the primary care physician is essentially the same in all instances - to supervise all the medical needs of the plan participant, and to bear responsibility for requesting authorizations for medical care. The "Primary Care Physician Agreement" will provide information concerning capitation fees received by the PCP, the services he is expected to perform, and his responsibilities relating to utilization review (UR) and utilization management (UM). It is unusual to find that a PCP has done anything inappropriate. Normally, you will find that the PCP has advocated for the patient, and that the injury was caused by the UR/UM conducted by the IPA and the HMO. It is not, however, unusual to find that by reason of the contracts that exist, the PCP's hands are tied concerning the decisions that are made.

#### C. The Group Services Agreement

If your client has his HMO coverage through employment rather than as an individual plan, there will be a contract between the employer and the HMO, typically entitled "Major Group Medical and Hospital Service Agreement". This document is very important in that it many times will contain exclusions and limitations that are not disclosed to the plan members in the Evidence of Coverage and Disclosure Booklet. Such treatment of exclusions and limitations is in direct violation of the provisions of the Knox-Keene Act, which requires that the Evidence of Coverage and Disclosure Booklet be a complete disclosure to the plan participant.

#### D. The Utilization Review File

Utilization Review files will be maintained by both the IPA and the HMO. This will be the most telling evidence you will obtain in discovery. Requests for these items of discovery should include, but not be limited to, each and every request for authorization for medical treatment submitted on behalf of the client, and each and every authorization and/or denial concerning the requests that were submitted. Each HMO and IPA may use a different system for the logging and tracking of requests, but normally each request is assigned a number and you will be able to track decisions relating to that request by the number assigned to it. You will be able to determine how long it took to obtain either an authorization or denial of the request and the grounds for the denial if it was denied. This information is critical in proving any misconduct. The Utilization Review files can be very confusing to sort through, but it is well worth the time and effort to carefully digest everything

produced.

#### E. UR/UM Quality Assurance Policy and Procedure Manuals

Seek the policies and procedures of both the IPA and the HMO. Those manuals should contain turn around times for requests for authorization of treatment, specific procedures to be followed in the event of a denial of medical treatment, and appropriate notification procedures to both the Primary Care Physician as well as the patient.

#### F. The Primary Care Physician's File

Naturally, the chart maintained by the Primary Care Physician must be obtained, but in addition, his or her correspondence file containing any requests for authorizations for treatment and responses to the same should also be obtained. Many times notations in the Primary Care Physician's file will give detail of communications with the IPA or HMO in seeking authorization for treatment.

#### G. Certificates of Accreditation

Many HMOs become accredited through governing agencies as discussed above. Accreditation serves well as a marketing tool and boosts enrollment numbers. It is important to determine whether an HMO has subjected itself to the standards imposed by the governing agencies in an effort to be accredited. It is also interesting to determine if an HMO sought accreditation, but was denied the same because it could not demonstrate appropriate UR/UM or Quality Assurance procedures in order to meet accreditation standards.

#### H. Depositions

Other than the obvious depositions to be taken, the Primary Care Physician, all treating physicians and anyone signing any denials or authorizations for treatment, it is important to depose the Medical Director of the IPA and the HMO. With respect to issues of medical necessity, there should always be a review by a qualified, medical specialist, and normally the IPA and/or HMO will maintain that the Medical Director is the individual who fulfills that requirement. You will also want to depose the Person(s) Most Knowledgeable (PMKs) with respect to utilization review, utilization management, quality assurance in general, and the PMKs with respect to your client's individual case in those areas as well. In addition, if you have advertising issues, you will want to depose the PMKs regarding that material.

### 4. ERISA PREEMPTION AND EXCEPTIONS

ERISA is a federal regulatory scheme enacted in 1974 in an effort to control fiduciary looting of company or union pension plans which left thousands of retired Americans stripped of the pension benefits they had accumulated after decades of work. (*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 8590 (1983); *Marshall v. Bankers Life & Casualty Co.*, 2 Cal.4th 1045, 1051 (1992); 29 U.S.C. §1001(b). Determination of whether an HMO action is preempted by ERISA is critically important because of the limited nature of the remedies available under ERISA. The courts generally conclude that remedies for recovery of benefits under an ERISA-preempted insurance policy, healthcare plan or self-insured benefit plan, are limited to recovery of the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages, or punitive damages are recoverable in such a case. And, a jury trial is not available in an ERISA preempted action.

As discussed in greater detail below, under ERISA's "preemption clause" all state laws that relate to an employee benefit plan are preempted (29 U.S.C. section 1144(a)), except those state laws regulating insurance under the "savings clause," (29 U.S.C. section 1144(b)(2)(A)). Because most people obtain

healthcare coverage through their employee benefit plan, determining whether a case is preempted by ERISA is a common question that arises. The first step in the analysis is to determine if the claimant is simply statutorily exempt from ERISA's expansive preemption provision. For example:

\*An independent contractor is not an "employee" for ERISA purposes and is therefore not subject to ERISA preemption. (*Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 319, 327, 112 S.Ct. 1344, 1350 (1992).) However, if the independent contractor obtains insurance benefits through the same group plan that covers employees of the company, the court may determine that the independent contractor's claims are also subject to ERISA preemption as a "participant." (See, e.g., *Harper v. American Chambers Life Ins. Co.*, 89 F.2d 1432, 1434 (9th Cir. 1990).)

\*A government employee or the employee of a public agency is exempted. (29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32).) However, most federal government employees are covered under the Federal Employee Health Benefits Act (5 U.S.C. section 8902), which has remedy limitations similar to ERISA's. But ERISA's government plan exemption does exclude other public employees, including judges, teachers, district attorneys, and the like, from ERISA preemption and their normal state-law based causes of action remain actionable.

\*Employees of churches or church-operated businesses. (29 U.S.C. section 1003(b).) A plan qualifies as a "church plan" if:

1. It is exempt from tax under 26 U.S.C. section 501; and,
2. Is "controlled by or associated with a church or a convention or association of churches." An entity is "associated with" a church, etc., if "it shares common religious bonds and convictions with that church . . . ."

\*A self-employed person is exempt from ERISA, so long as the business does not provide benefits under the policy to a common-law employee.

In *Kennedy v. Allied Mutual Ins. Co.*, 952 F.2d 262 (9th Cir. 1991), two owners of the company set up a pension plan. They actually intended that the plan comply with ERISA requirements, and that it be subject to ERISA regulation. When the financial advisor to the plan caused losses of approximately \$1.8 million, the plan sought recovery under a fidelity bond issued to the plan.

That bond was effective only if the plan qualified as an ERISA plan. The insurer therefore moved for a summary judgment to establish that the plan was not an ERISA plan. The District Court granted the motion on the grounds that the only participants vested in the plan were the owners of the business. When the owners later claimed that one other employee was vested, the Ninth Circuit remanded the action for further findings by the District Court on that other employee and when she was indeed vested.

In so ruling, the Ninth Circuit made clear that where the only plan participants are the owners of the business, ERISA does not regulate the plan. The Kennedy court based its holding on Department of Labor regulations, promulgated under 29 U.S.C. §1135. Pursuant to 29 C.F.R. §2510.3-3(b):

"For purposes of Title I of the Act and this chapter, the term 'employee benefit plan' shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan . . . . For example, a so-called 'Keogh' or 'H.R. 10' plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under Title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under Title I. Similarly partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to Title I."

Similarly, 29 CFR section 2510.3-3(c) defines employees as follows:

"(2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership." (Emphasis added.)

However, if the partnership or business has a common law employee covered under the same policy, the owner/partner will be considered a "participant" under the plan and subject to ERISA preemption. (*Peterson v. American Life & Health Insurance*, 48 F.3d 404 (9th Cir. 1995).)

Finally, the Department of Labor's "safe harbor" provisions (29 C.F.R. 2510.3-1(j)) permit exemption of a "plan" where:

(1) The employer does not "endorse" the program;

(2) Employee participation is completely voluntary;

(3) Premiums are paid entirely by the employee;

(4) The employer's sole function is to collect the premiums through payroll deductions and to remit the premiums to the insurer; and,

(5) The employer receives no consideration. However, reasonable compensation for administrative services provided by the employer in connection with collecting and remitting the premiums is permitted.

In order to fall within these "safe harbor" provisions, however, case law requires that all the criteria be present. (*Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988); *Qualls v. Blue Cross of Calif.*, 22 F.3d 839, 843 (9th Cir. 1994).)

## 5. THE EROSION OF ERISA PREEMPTION

Even if a case does not fall within one of the statutory exceptions to ERISA, there are other escapes from preemption. The "preemption clause" under ERISA provides that:

"except as provided in the [savings clause] the provision of this title . . . shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan . . ." (29 U.S.C. §1144(a)).

The "savings clause", in turn, provides that:

". . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." (29 U.S.C. §1144(b)(2)(A) (emphasis added)).

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549 (1987), the insured brought an action against his disability insurer for "tortious breach of contract" under Mississippi State law. First, the United States Supreme Court noted that "there is no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan and therefore fall under ERISA's express pre-emption clause." However, the question was whether the common law bad faith action against the insurer "regulated insurance" such that it fell within the "savings clause", and therefore not preempted by ERISA.

Ultimately, the Supreme Court in *Pilot Life* found that Mississippi's law of "bad faith" did not "regulate insurance" and was therefore not "saved" from ERISA preemption. In arriving at its conclusion, the Supreme Court noted that the "bad faith" doctrine in Mississippi was not specifically directed to the insurance industry

such that it "regulated insurance" under Mississippi law. Specifically, the Supreme Court stated: "Certainly, a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the savings clause. A common sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law." (Pilot Life, 481 U.S. at 50) (emphasis added).

The United States Supreme Court followed its Pilot Life decision in the case of UNUM v. Ward, 526 U.S. 358, 119 S.Ct 1380 (1999). In the Ward case, the plaintiff brought an action pursuant to the ERISA civil enforcement provision, 29 U.S.C. §1132(a), to recover disability benefits from his insurer, UNUM. Essentially, the policy at issue required that the insured bring a claim for disability benefits within one year of the onset of disability. There was no dispute that the plaintiff became permanently disabled on May 5, 1992. While the plaintiff notified his employer, the administrator of the plan, of his disability in February or early March 1993, UNUM did not receive notice of the claim until April 11, 1994, beyond the one year period. UNUM contended that the claim was time-barred under the contract, while plaintiff contended, among other things, that under California's "notice-prejudice" rule, the claim to UNUM was timely.

The parties in Ward agreed that California's "notice-prejudice" rule "related to" an employee benefit plan and thus fell within ERISA's preemption clause (29 U.S.C. §1144(a)). However, the dispute hinged on whether California's "notice-prejudice" rule "regulated insurance" such that it fell within the savings clause (29 U.S.C. §1144(b)(2)(A)). To that end, the Supreme Court set forth the framework for the analysis as follows:

"First, we ask whether, from a 'common-sense view of the matter', the contested prescription regulates insurance [citations]. Second, we consider three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act [citations]: first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." (Ward, 119 S.Ct. at 1386) (emphasis added). In going through the first prong of this analysis, the Supreme Court found that in California, the 'notice-prejudice' rule was specifically directed to the insurance industry and only applicable to insurance contracts. Thus, the Supreme Court found that the "notice-prejudice" rule "regulated insurance" under a "common sense" analysis. Specifically, the Supreme Court stated:

". . .notice-prejudice is a rule of law governing the insurance relationship distinctively. We reject UNUM's contention that the rule merely restates a general principle disfavoring forfeitures and conclude instead that notice-prejudice, as a matter of common sense, regulates insurance." (Ward, 119 S.Ct. at 1389) (emphasis added).

The Supreme Court then turned to the second prong of the analysis and went through the three factors used to determine whether California's "notice prejudice" rule regulated the business of insurance within the meaning of the McCarran-Ferguson Act. Importantly, the Ward decision made clear that the plaintiff did not need to show that all three factors were met in order to find that a law "regulated insurance" under the ERISA savings clause. In going through the three factors, the Court found that the second factor (whether the notice-prejudice rule formed an integral part of the relationship between the insurer and the insured) existed stating:

"The [notice prejudice] rule dictates the terms of the relationship between the insurer and the insured, and

consequently, is integral to that relationship." (Ward, 119 S.Ct. at 1389).

The Court also found that the third factor (whether the notice-prejudice rule was limited to entities within the insurance industry) also existed, and referred back to its earlier finding in the first prong of the analysis:

"As earlier explained, California's notice-prejudice rule focuses on the insurance industry. The rule "does not merely have an impact on the insurance industry; it is aimed at it." (Ward, 119 S.Ct. at 1389) (emphasis added).

Based on these findings, the Supreme Court concluded that California's "notice-prejudice" rule "regulated insurance" and therefore fell within the "savings clause" of ERISA.

Following the Supreme Court's decision in Ward, a Federal District Court decision from the N.D. of Oklahoma, in Lewis v. Aetna U.S. Healthcare, 78 F.Supp.2d 1202, was issued. In Lewis, the core issue was whether the plaintiff's second cause of action for bad faith against her insurer "regulated insurance" and thus fell within the ERISA "savings clause". The Lewis decision then followed the analytical framework provided in Ward and concluded that Oklahoma's bad faith law "regulated insurance" and was thus "saved" from preemption.

As to the first prong of the analysis, the Lewis decision concluded that under a "common sense" view of the matter, Oklahoma's bad faith law "regulated insurance" based on the fact that "[bad faith] law arises out of the special relationship between insured and insurer. Accordingly, the Oklahoma Supreme Court has limited the cause of action at all times exclusively to insurance contracts." (Lewis, 78 F.Supp.2d at 1202) (emphasis added). In arriving at this conclusion, the Lewis Court distinguished the Pilot Life decision as follows:

"the difference between the Oklahoma tort and the Mississippi tort are manifest. First, as discussed above, the [bad faith] tort is 'firmly planted' in Oklahoma statutory 'policy concerns specific to the insurance industry' [citation] not in 'the general principles of [state] tort and contract law.' Furthermore, this tort does not exist outside the insurance industry, and therefore is not available for 'any breach of contract'. Thus, Pilot Life is inapposite." (Lewis, 78 F.Supp.2d at 1202) (emphasis added).

As to the second prong of the preemption analysis set forth in Ward, the Lewis court found that Oklahoma's bad faith law satisfied the second and third factors and therefore regulated insurance and fell within the ERISA "savings clause". Specifically, as to the second factor, the Court concluded that bad faith was "an integral part of the policy relationship between the insurer and the insured." (Lewis, 78 F.Supp.2d at 1202). As to the third factor, the Lewis Court, just as the Ward court did, referred back to its analysis under the first prong, stating:

"As discussed at length above, the Oklahoma Supreme Court has consistently declined to extend the [bad faith] tort beyond the insured-insurer relationship, recognizing that the tort, as well as its statutory underpinnings, are designed to address the uniqueness of that relationship. Thus, a [bad faith] cause of action 'does not merely have an impact on the insurance industry; it is aimed at it.'" (Lewis, 78 F.Supp.2d at 1202).

Similar to the Oklahoma bad faith law at issue in Lewis, the California Supreme Court has firmly held that the tortious breach of the implied covenant of good faith and fair dealing is a claim limited to the context of insurance. Specifically, in *Foley v. Interactive Data Corp.*, 47 Cal.3d 654 (1988) the California Supreme Court rejected an attempt to allow a tortious bad faith claim in an employment contract. In doing so, the Court noted while every contract imposes upon each party a duty of good faith and fair dealing, tort remedies are only allowed in the unique circumstances surrounding an insurance contract. Specifically, the Supreme Court stated:

"Because the covenant [of good faith and fair dealing] is a contract term, however, compensation for its breach has almost always been limited to contract rather than tort remedies. . . As a contract concept, breach of the duty [of good faith and fair dealing] led to imposition of contract damages determined by the nature of the breach and standard contract principles. An exception to this general rule has developed in the context of insurance contracts where, for a variety of policy reasons, courts have held that breach of the implied covenant will provide the basis for an action in tort. California has a well-developed judicial history addressing this exception." (Foley, 47 Cal.3d at 684) (emphasis added).

California's limitation of a tortious breach of the implied covenant to insurance contracts was reaffirmed in *Cates Construction Inc. v. Talbot Partners*, 21 Cal.4th 28 (1999). In *Cates Construction*, the plaintiff sought to obtain tort remedies for a bad faith claim against a surety. In rejecting the extension of tort remedies for bad faith actions outside of the insurance context, the California Supreme Court noted:

"compensation for [breach of the implied covenant] has almost always been limited to contract rather than tort remedies [citations]. At present, this court recognizes only one exception to that general rule: tort remedies are available for a breach of the covenant in cases involving insurance policies [citations]. In the insurance policy setting, an insured may recover damages not otherwise available in a contract action, such as emotional distress damages resulting from the insurer's bad faith conduct [citations] and punitive damages if there has been oppression, fraud, or malice by the insurer [citations]. As our decisions acknowledge, tort recovery in this particular context is considered appropriate for a variety of policy reasons. Unlike most other contracts for goods or services, an insurance policy is characterized by elements of adhesion, public interest and fiduciary responsibility [citations]. In general, insurance policies are not purchased for profit or advantage; rather, they are obtained for peace of mind and security in the event of an accident or other catastrophe [citations]. Moreover, an insured faces a unique economic dilemma' when its insurer breaches the implied covenant of good faith and fair dealing [citations]. Unlike other parties in contract who typically may seek recourse in the marketplace in the event of a breach, an insured will not be able to find another insurance company willing to pay for a loss already incurred [citations]." (*Cates Construction*, 21 Cal.4th at 43-44) (emphasis added).

Unlike the Mississippi bad faith claim at issue in *Pilot Life*, which applied to all contracts and not just insurance, many jurisdictions like California allow the same tort claim only in an insurance contract. Following the logic of *Ward and Lewis*, in those jurisdictions it can be argued that the tort of bad faith "regulates insurance" within the meaning of ERISA and is therefore "saved" from ERISA preemption.

## 6. ARGUING PUNITIVE DAMAGES AGAINST AN HMO:

When an HMO bad faith case is not preempted by ERISA, then all tort remedies, including punitive damages, are available to the plaintiff. The punitive damage exposure of any 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).

Before discussing the amount of punitive damages that are appropriate in your case, 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 to 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.

Finally, 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.

## 7. EXAMPLE OF AN HMO BAD FAITH CASE: 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: