

Pleading into a Bad Faith Case: Whom to Sue, What to Allege and How to Survive
It's finally happened. After all these years of fender-bender and collection cases, someone has walked in your door with what appears to be an ironclad bad faith suit.

He's told you all about how his disability carrier or HMO denied a claim that clearly should have been covered, and he wants you to take on the insurer.

The prospective client hasn't even finished telling you his story, and your head is already dizzy with visions of a seven-figure judgment against a deep-pocket defendant that a jury is sure to despise. But before you spend your share of the recovery, you may want to ask some hard questions about your potential client's case. For example, does the law currently support lawsuits against HMOs? What theories of recovery can be pursued against a disability carrier? Are there any other defendants that should be named in the suit?

This syllabus is designed to help you answer these questions and others like them, and to increase the likelihood that your dreams of a substantial jury verdict for your client will become a reality.

Pleading Against a Disability Carrier

In recent years, there has been a proliferation of takeovers and mergers in the disability insurance industry. The resulting mega-insurers have been closing their local claim offices and centralizing all operations at national home offices. In certain instances, this has led to claims personnel having only a limited knowledge of individual states' statutes, regulations and case law concerning disability insurers' obligations to their policyholders.

Thus, it is more important than ever that an insured's attorney have a solid understanding of his state's law regarding a disability carrier's duties before writing a complaint. It is especially essential that the drafting attorney have a firm grasp on the implied covenant of good faith and fair dealing, and that he weave the insurer's breaches of that covenant into his complaint. The implied covenant of good faith and fair dealing includes the duty to:

thoroughly investigate the insured's claim, and to "fully inquire into all possible bases that might support the insured's claim";¹

objectively evaluate the insured's claim;²

promptly investigate the insured's claim;³

timely respond to the insured's inquiries and otherwise communicate with the insured;⁴

contact and speak with the insured's treating physicians;⁵

truthfully represent to the insured what is covered under the policy;⁶

pay benefits due and owing under the policy;⁷

timely pay benefits due under the policy;⁸

fully pay benefits owed under the policy;⁹

reserve rights only when it has a good faith belief in the existence of the rights asserted;¹⁰

institute declaratory relief or other litigation against its insured only where it has a reasonable basis for doing so;¹¹

refrain from construing a disability policy term in a more restrictive manner than the accepted legal definition;¹² and

refrain from imposing additional preconditions to coverage beyond those set forth in the policy.¹³

Of course, your complaint will need to include enough factual details to withstand any demurrer or motion to dismiss by the disability carrier. Toward that end, you will need to obtain and review all pertinent documents in the insured's possession. These would include:

Advertising and marketing materials (newspaper or magazine ads, trade journals, flyers, brochures, etc.); these will help you understand what the "bait" was, what the insured's reasonable expectations regarding coverage were, and whether the insurer ultimately delivered what it promised

The policy, including the application and all declarations pages, riders, endorsements and amendments

Payment information - canceled premium checks, receipts, premium lapse notices

Claim notices and proofs of loss

Pertinent photographs, videos and newspaper reports

Previous written or recorded statements by the insured

Medical records

Correspondence between the insured and the insurer, insurance agents, and any other key players

Diaries, logs or journals maintained by the insured.¹⁴

Additionally, you should keep in mind that it is the complaint will give your trial judge (assuming that the case has been assigned to one judge for all purposes) his first impression of your client's case. Thus, it is at the complaint stage that you should start to think about your theme of the case, and begin to imbed that theme into the mindset of your judge.

Here are some possible themes for you to consider:

A deal is a deal. An insurer, like any person, should keep the promises it made. Here, instead of accepting responsibility and owning up to its commitments, the insurer welched on its word.

This is a story of betrayal. The insured paid hard-earned money for what he trusted would be protection, peace of mind and security. The insurance company betrayed that trust by delaying, then denying, the insured's claim.

The insurance company went trolling, and the plaintiff took the bait. Through newspapers, radio, television, mailings, and agents' presentations, the insurer touted its age-old experience ("been around since the midnight ride of Paul Revere") and dependability, extolled the features, advantages and benefits of its policy, and promised that it would be there if the plaintiff ever needed help - and the plaintiff was hooked. But when the plaintiff became injured or sick, the insurer tossed him back into the ocean and let him fall to the very

bottom of his life - and, in the process, wholly disregarded its sales promises. It was advertising and marketing fraud, plain and simple.

This is a classic example of the two faces of Eve. On the sales side, the insurer is all warm, fuzzy and reassuring, promising peace of mind and security. But when an insured, after faithfully paying premiums for years, has the audacity to actually make a claim, the dark side of Eve rears her ugly head. In the claim zone, it's cold, the insured is swimming upstream, and the water is plenty deep. The insured has moved from the asset side of the insurer's ledger to the liability side, and that's where the promise made becomes the promise broken.

You can't change an agreement after it's been made (unless both sides want to change it). So, for example, if a policy doesn't specifically say that the insured is entitled to benefits only if he can "objectify" his disability, the carrier can't rewrite the contract to say that he has to do so. And if the policy doesn't expressly state that the insurance company can require the insured to undergo surgery to alleviate his disability, the insurer cannot condition the continued payment of benefits on such surgery. The insurance company has to live with the policy as it was written, because it's the insurer and its lawyers who created the product, designed it, selected the language, chose the definitions, decided what to charge, and happily banked the premiums. Instead of paying benefits when due, the insurance company made the insured jump through a series of unnecessary and duplicative hoops - and then, after the insured did so, the insurer still refused to pay.

Instead of looking at the insured's claim with a keen, vigilant eye toward objectively evaluating and paying the claim, the insurance company viewed the claim with a closed - or, at best, patched - eye.

The insurance company put its corporate economic interests before the interests of its insured and his family. It chose profit over people.

An insured shouldn't need a map - or a lawyer - to navigate his way around his insurance policy. But the policy cobbled together by this insurer was, for all practical purposes, unreadable - coverage here, exclusions there, limitations here, preconditions there. And although the exclusion is cited by the insurer in bold capital letters in its moving papers in court, in the actual policy it was buried in fine print in the middle of the policy under a misleading section heading. It is virtually impossible to find that exclusion, much less decipher its legalese.

And it is important to consider the possibility of naming defendants other than the insurance company, especially if you are trying to defeat federal diversity jurisdiction. Potential defendants include the agent who procured the policy for the insured,¹⁵ the insurer's claim investigator,¹⁶ the physician retained by the insurer to perform an "independent" medical examination of the insured,¹⁷ and the insurer's claim adjusting agency.¹⁸ The theories of recovery against those defendants may include conspiracy to defraud,¹⁹ intentional infliction of emotional distress,²⁰ misrepresentation of coverage,²¹ and/or professional negligence.²²

Pleading Against an HMO

Effective January 1, 2001, California Civil Code section 3428 imposes liability against an HMO that fails to furnish covered benefits. Under the statute, an HMO owes its members a duty of ordinary care to arrange for the provision of "medically necessary" health care services as provided under the HMO plan [Civil Code § 3428(a)]. And an HMO is liable for "any and all harm" caused by its breach of that duty where (1) the breach results in the denial, delay or modification of care recommended for, or furnished to, a member²³ and (2) the member suffers "substantial harm"²⁴ [Civil Code § 3428(a)]. Moreover, recoverable damages include, but are not limited to, the tort damages set forth in Civil Code § 3333 ("all detriment proximately caused" by the breach of duty), such that emotional distress damages and, presumably, punitive damages may be recovered

[see Civil Code § 3428(j)].

But even without Civil Code section 3428, HMOs - like other insurers - have been found liable for insurance bad faith. For example, in *McEvoy v. Group Health Co-Op* (1997) 213 Wis.2d 507, 570 N.W.2d 397, the Wisconsin Supreme Court concluded that HMOs are subject to the same duties and liabilities under a bad faith analysis as are traditional insurers. Similarly, the California Supreme Court has confirmed that any distinction between traditional insurance companies and health care service plans is "immaterial" [*Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 4, 233 Cal.Rptr. 76, n. 1], and thus that a health care organization can be held liable for breach of the covenant of good faith and fair dealing.²⁵ Recent appellate decisions concur that courts should "construe the [HMO health care service] plan as [they] would an insurance policy" [*Warren-Guthrie v. Health Net* (2000) 84 Cal.App.4th 804, 101 Cal.Rptr.2d 260, 267].

Other theories available against an HMO include:

Third-party beneficiary of contract between HMO and physician provider group [see *Croskey, Kaufman, et al.*, *Cal. Prac. Guide: Insurance Litigation* (The Rutter Group 1999), §§ 12:64 and 12.65, *Bass v. John Hancock Mutual Life Insurance Company* (1974) 10 Cal.3d 792, 796, 112 Cal.Rptr. 195 and *Harper v. Wausau Ins. Co.* (1997) 56 Cal.App.4th 1079, 66 Cal.Rptr.2d 64];²⁶

Tortious breach of contract [see *Wilson v. Blue Cross of So. Calif.* (1990) 222 Cal.App.3d 66027];

Interference with doctor-patient relationship [see *Heller v. Norcal Mutual Ins. Co.* (1994) 8 Cal.4th 30, 45, 32 Cal.Rptr.2d 200];²⁸

Intentional misrepresentation [see *Sanchez v. Lindsey Morden Claims Services, Inc.* (1999) 72 Cal.App.4th 249, 254, 84 Cal.Rptr.2d 799, 802 and *Orient Handel v. United States Fidelity & Guaranty* (1987) 192 Cal.App.3d 684, 692-693; 237 Cal.Rptr. 667, 671];

Negligent misrepresentation [see *Davis v. Blue Cross of No. Calif.* (1979) 25 Cal.3d 418, 428-429, 158 Cal.Rptr. 828, 834 and *Westrick v. State Farm Ins. Co.* (1982) 137 Cal.App.3d 685, 692, 187 Cal.Rptr. 214, 219];

Breach of fiduciary duty [see *Moore v. Regents of the University of California* (1990) 51 Cal.3d 120, 128-132];²⁹

Vicarious liability for medical negligence of HMO physicians [see *Dukes v. U.S. Healthcare* (3rd Cir. 1995) 57 F.3d 350; *Chaghervand v. Carefirst* (D. MD 1995) 909 F.Supp. 304; *Dykema v. King* (D. S.C. 1997) 959 F.Supp. 736 and *Elsesser v. Hospital of the Philadelphia College, etc., et al.* (E.D. Pa 1992) 802 F.Supp 1286];³⁰

Intentional infliction of emotional distress [see *Fletcher v. Western National Life Ins. Co.* (1970) 10 Cal.App.3d 376, 394, 89 Cal.Rptr. 78, 88 and *Little v. Stuyvesant Life Ins. Co.* (1977) 67 Cal.App.3d 451, 461-462, 136 Cal.Rptr. 653, 659];

RICO [see *Dana Corp. v. Blue Cross & Blue Shield* (6th Cir. 1990) 900 F.2d 882, 884-885]; and

Unfair business practices [see *State Farm Fire & Casualty Company v. Superior Court (Allegro)* (1996) 45 Cal.App.4th 1093, 1103, 53 Cal.Rptr.2d 229, 234 and *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1299, 22 Cal.Rptr.2d 20 (cause of action under California Business & Professions Code section 17200)].

Further, it is imperative that you analyze whether defendants other than the HMO should be named. Obviously, if the doctor selected by the HMO was negligent in some manner, a medical malpractice claim against the doctor should be considered. The other likely defendant is the HMO's physician provider group. In

that regard, where the provider group conducted the utilization review and made the decision to delay³¹ or withhold care and benefits from the insured, it can be held liable for interference with contractual relationship - specifically, the insured's contractual relationship with the HMO.³² Additionally, if the HMO assigned or otherwise delegated its authority to construe the plan's terms and determine the appropriate level of plan benefits to the provider group, that assignee entity becomes directly responsible to provide the contracted-for performance.³³

Other potential theories of recovery against the provider group include breach of fiduciary duty,³⁴ bad faith (on a third-party beneficiary theory), fraud (e.g., if the physician group made representations on which the insured relied in enrolling with the HMO), conspiracy to defraud, interference with doctor-patient relationship, Intentional infliction of emotional distress and unfair business practices.

Conclusion

Obviously, it is not easy to decide whom to sue, develop the appropriate theories of liability, select an inspiring theme, and survive the pleading stage of a hard-fought bad faith case. We hope that this syllabus and the presentation that accompanies it will prove helpful in your efforts to do so.

1. Egan v. Mutual of Omaha Ins. Co. (1979) 24 Cal.3d 809, 819, 169 Cal.Rptr. 691, 696; Mariscal v. Old Republic Ins. Co. (1996) 42 Cal.4th 1617, 1623, 50 Cal.Rptr.2d 224 ["An insurance company may not ignore evidence which supports coverage". Mariscal, 42 Cal.4th at 1624, 50 Cal.Rptr.2d at 227-228].
2. Hughes v. Blue Cross of Northern California (1989) 215 Cal.App.3d 832, 845-846, 263 Cal.Rptr. 850, Blake v. Aetna Life Insurance Co. (1979) 99 Cal.App.3d 901, 924, 160 Cal.Rptr. 528.
3. Murray v. State Farm Fire and Cas. Co. (1990) 219 Cal.App.3d 58, 65, 268 Cal.Rptr. 33, 37 [Insurer's unreasonable delay in investigating the insured's claim constitutes tortious bad faith, regardless of whether the claim was covered].
4. Delgado v. Heritage Life Insurance Co. (1984) 157 Cal.App.3d 262, 278, 203 Cal.Rptr. 672, 681.
5. Egan, supra, 24 Cal.3d 809, 819, 169 Cal.Rptr. 691; Mariscal, supra, 42 Cal.4th 1617, 1624-1625, 50 Cal.Rptr.2d 224.
6. Delos v. Farmers Insurance Group (1979) 93 Cal.App.3d 642, 664, 155 Cal.Rptr. 843, 857.
7. Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566, 574, 108 Cal.Rptr. 480, 485; Neal v. Farmers Ins. Exchange (1978) 21 Cal.3d 910, 920; McLaughlin v. Connecticut Gen. Life Ins. Co. (N.D. Cal. 1983) 565 F.Supp. 434; Christian v. American Home Assur. Co. (Okla. 1977) 577 P.2d 899, 904.
8. McCormick v. Sentinel Life Ins. Co. (1984), 153 Cal.App.3d 1030, 1035, 1050-1051, 200 Cal.Rptr. 732, 733, 744; Richardson v. Employers Liability Assurance Corp. (1972) 25 Cal.App.3d 232, 239, 102 Cal.Rptr. 547, 552; Waller v. Truck Ins. Exchange (1995) 11 Cal.4th 1, 36; 44 Cal.Rptr.2d 370, 390; Fleming v. Safeco Ins. Co. (1984) 160 Cal.App.3d 31, 37, 206 Cal.Rptr. 313; Berry v. United of Omaha (11th Cir. 1983) 719 F.2d 1127, 1129.
9. Egan, supra, 24 Cal.3d 809, 169 Cal.Rptr. 691; Neal, supra, 21 Cal.3d 910, 148 Cal.Rptr. 389.
10. Fletcher v. Western National Life Ins. Co. (1970) 10 Cal.App.3d 376, 395, 89 Cal.Rptr. 78, 89; Sprague v. Equifax, Inc. (1985) 166 Cal.App.3d 1012, 1032, 213 Cal.Rptr. 69, 82.
11. Kelly v. Farmers Ins. Exchange (1987) 194 Cal.App.3d 1, 239 Cal.Rptr. 259; Dalrymple v. USAA (1995)

40 Cal.App.4th 497, 513-515, 46 Cal.Rptr.2d 845, 853-854.

12. Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 626, 197 Cal.Rptr. 878, 887-888.

13. Mission Ins. Group v. Merco Construction Engineers (1983) 147 Cal.App.3d 1059, 1066-1068, 195 Cal.Rptr. 791.

14. If the insured did not keep a journal or similar record, ask him to prepare a detailed summary of his loss, any medical treatment, and all dealings with the insurer.

15. Westrick v. State Farm Ins. (1982) 137 Cal.App.3d 685, 187 Cal.Rptr. 214; Free v. Republic Ins. Co. (1992) 8 Cal.App.4th 1726, 11 Cal.Rptr.2d 296; Clement v. Smith (1993) 16 Cal.App.4th 39, 19 Cal.Rptr.2d 676.

16. Sprague v. Equifax (1985) 166 Cal.App.3d 1012, 213 Cal.Rptr. 69.

17. Sprague, supra; Younan v. Equifax, Inc. (1980) 111 Cal.App.3d 498, 169 Cal.Rptr. 478.

18. Younan, supra; Sprague, supra; see also Hernandez v. General Adjustment Bureau (1988) 199 Cal.App.3d 999, 245 Cal.Rptr. 288.

19. See Sprague and Younan, supra.

20. Hernandez, supra; see also Younan and Sprague, supra.

21. See Clement, supra.

22. See Westrick and Free, supra.

23. The care need not have been recommended or furnished by one of the HMO's in-plan providers. It may have been recommended by any health care provider, as long as the recommendation was within the scope of the provider's practice [Civil Code § 3428(b)(2)].

24. "Substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss [Civil Code § 3428(b)(1)].

25. See also Washington Physicians Service Assoc. v. Gregoire (9th Cir. 1998) 147 F.3d 1039, 1045-1046, which found that that because "[i]n the end, HMOs function the same way as a traditional health insurer" and "are engaged in the business of health insurance", any nominal variance between HMOs and traditional insurers is "a distinction without a difference".

26. Harris v. Superior Court (1986) 188 Cal.App.3d 475, 233 Cal.Rptr. 186 could also prove helpful in arguing that the insured is the intended beneficiary of the HMO's contract with the provider group. In Harris, the court held that a doctor associated with a provider group was an intended beneficiary of a contract between the patient and the HMO that referenced the provider group, and thus was subject to that contract's arbitration provision. It would be anomalous for the doctor to be an intended third-party beneficiary of the HMO's contract with the insured but the insured to not be the intended beneficiary of the HMO's contract with the provider group (and, through the provider group, the doctor).

27. As discussed below, the Wilson court also held that an HMO enrollee can sue the HMO's physician

provider group for interference with the enrollee's contractual relationship with the HMO. Id. at 672-674.

28. See also *Garcia v. Home Depot U.S.A., Inc.* (N.D. Tex. 1999) 1999 U.S. Dist. LEXIS 9336, *Hammonds v. Aetna Cas. & Surety Co.* (N.D. Ohio 1965) 237 F.Supp. 96, 98 and 101, *Hager v. Venice Hospital, Inc.* (M.D. Fla. 1996) 944 F.Supp. 1530, 1535 and *Okusami v. Psychiatric Institute of Washington, Inc.* (1992) 959 F.2d 1062, 1066, 295 U.S. App. D.C. 58.

29. In *Pegram v. Herdrich* (2000) 120 S.Ct. 2143, 530 U.S. 211, the United States Supreme Court held that HMO enrollees cannot bring ERISA claims for breach of fiduciary duty against their HMOs in federal court, at least where the claims are nothing more than "wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm". 120 S.Ct. at 2153. However, the Court left the door open to state and other federal suits against HMOs (and perhaps even ERISA claims that allege specific harm arising from the breach of fiduciary duty).

30. See also *Haas v. Group Health Plan, Inc.* (S.D. IL 1994) 875 F.Supp. 544; *Independence HMO, Inc. v. Smith* (E.D. Pa 1990) 733 F.Supp. 983; *Jackson v. Roseman* (D. Md 1995) 878 F.Supp. 820; *Kearney v. U.S. Healthcare* (E.D. Pa 1994) 859 F.Supp. 182; *Ouellette v. Christ Hospital* (S.D. Oh 1996) 942 F.Supp. 1160; *Pacificare of Oklahoma, Inc. v. Burrage* (10th Cir. 1995) 59 F.3d 151; *Prihoda v. Shpritz* (D. Md 1996) 914 F.Supp. 113; *Rice v. Panchal* (7th Cir. 1995) 65 F.3d 637; *Roessert v. Health Net* (N.D. Ca 1996) 929 F.Supp. 343; *Sanitoro v. Evans* (E.D.N.C. 1996) 935 F.Supp. 733; and *Smith v. HMO Great Lakes* (N.D. IL 1994) 852 F.Supp. 669; *Edelen v. Osterman* (D.C. 1996) 943 F.Supp. 75.

31. 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 (or its captive provider group) for medical services results in irreparable deterioration of the insured's health, such as metastasis. In many such cases, once authorization is given, it is too late for the insured to receive the treatment - and the insured's "window of opportunity" has been lost forever.

32. See *Wilson v. Blue Cross of So. Calif.* (1990) 222 Cal.App.3d 660, 271 Cal.Rptr. 876.

33. *Baer v. Associated Life Ins. Co.* (1988) 202 Cal.App.3d 117, 124, 248 Cal.Rptr. 236.

34. See *Moore*, supra, 51 Cal.3d at 128-132.