HOW TO PERFECT YOUR INSURANCE CLAIM AND WHAT TO DO IF YOU ARE DENIED

By Frank N. Darras and Lissa A. Martinez

I. INSURANCE INS AND OUTS

You have been smart. You purchased health insurance for you and your family. Your insurer promised quality care, access to treatment, referrals to specialists, and continuity of care. But now, instead of accepting responsibility and owning up to its commitments, the insurer is breaking its promise. It put profit over patient care and, in the process, practiced cash-register medicine. So, what can you do to perfect your claim?

A. Put It In Writing

- "If it's not in writing, it didn't happen."
- Put all requests (notices of claim, requests for policies, etc.) to the insurer in writing.
- If you have a telephone conversation with an insurer representative, confirm it in a letter.
- If an insurer representative sends you a letter that inaccurately describes your conversation with the representative, send him a letter correcting the mistakes.

B. Hold On To Everything, Throw Away Nothing

- If you end up having to sue the insurance company, your lawyer will want to see everything in your possession concerning your insurance policy and your claim under that policy.
- Advertising and marketing materials (newspaper or magazine ads, trade journals, flyers, brochures, etc.); these will help the lawyer understand what the "bait" was, what your 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 prospective client.
- Third party evaluations – investigator reports, witness statements, police reports.
- Medical records
- Correspondence between you and the insurer, insurance agents, and any other key players.

C. Keep A Diary

- Maintain a diary, log or journal of all dealings with the insurance company. It will prove to be an invaluable tool for your lawyer if you end up having to sue the insurance company.
- The journal will also help refresh your memory of key events, and the order in which they took place, when you are working with your lawyer to preparing for testifying at your deposition and at trial.

D. Choose The Right Lawyer

- It is imperative that you hire an insurance specialist who is experienced in dealing with insurance companies.
- Contact the local plaintiffs' lawyers group (usually called "trial lawyers association" or "consumer lawyers association") for a referral.
- Get recommendations from any friends, work colleagues, or neighbors who have had confrontations with an insurance company.
- When you meet with a potential lawyer, you will need to evaluate him to decide whether you are willing to invest your time, trust and financial future with him.
  - Trust your first impression; it will usually be the right one.
  - Does he appear to be honest? Do you trust him? If not, a jury will likely have the same reservations about him – and, in all likelihood, about you.
  - Do you like him? If you don't like him, the odds are that a jury won't either.
  - Does he answer your questions directly, or is he evasive?
  - What kind of demeanor does he have? Does he have a "presence"? Does he inspire attention and respect, or is he too "low-key"?
  - Does he appear to be knowledgeable about insurance and the type of dispute you are having with your insurer?
  - Is he familiar with the type of policy you have?
  - Has he had other cases against your insurance company?
  - Does he know the claims representative you have been dealing with, or perhaps that representative's supervisors?
  - Does he regularly attend continuing education seminars on insurance-related matters? Better yet, does he ever speak at insurance seminars?
  - Does he ever write insurance-related articles for law review, trade publications, consumer groups or other organizations?

- Do not be offended if the lawyer asks what appears to be an inordinate number of questions about you and your case. If he is thorough in his inquiries and selective about the cases he accepts, it should enhance his credibility in your mind.

E. Help The Lawyer Choose You As A Client

- When you meet with a potential lawyer, he will be evaluating you as well. Here are some of the questions a good lawyer will be asking himself during his initial meeting with you:
  - Do I believe the potential client's story?
  - Does the prospective client appear to be forthright?
  - Is the potential client honest or evasive?
    - For example, were the representations on his policy application true, complete and accurate?
    - If his answers to medical, occupational or financial questions on the application do not fully comport with the facts, the carrier will argue that he lied to obtain the policy and thus that his claimed injury or sickness cannot be believed either. And the jury may in fact discredit him if he lied or exaggerated when he first dealt with the insurance company.
  - Is the potential client articulate and likable enough to be an outstanding witness at trial?
  - Does the prospective client have the emotional stamina to pursue protracted litigation and handle a trial?
  - Does the potential client have the financial wherewithal to litigate and the staying power to survive the appeal process, or is he looking for a quick settlement?
  - What is the caliber of the other people who will need to corroborate the prospective client's story and confirm his damages?
    - What kind of third-party witnesses (spouse, children, friends, employees, supervisors, co-workers, neighbors) does he have? Will a jury believe them?
    - Are his treating physicians respected in the medical and legal communities, or are they known for providing unnecessary treatment and telling patients -- and lawyers -- whatever they want to hear?
  - What kind of damages does the potential client have? How has the insurer's failure to pay benefits affected his life?
    - Has he lost his house?
    - Has his car been repossessed?
    - Did his wife have to sell her wedding ring?
    - Have his children been taken out of private school?
    - Did he have to sell anything in a fire sale?
    - Has he had to cash in an IRA or 401k?
    - Has his credit been ruined? Is he getting dunning letters from credit card companies?
    - Is his family living off cash advances?

- Has the gas or electricity been turned off?

- Do not be offended by if the lawyer's thorough investigation of you and your claim. If you balk at the lawyer's inquiries, he will probably decide that your case isn't as strong as you claim and that he would be better off without investing his reputation, his time, his resources and the emotional penicillin it takes to guide any client through the trial phase.

F. Work With The Lawyer To Develop A Case Theme

- All of your efforts in documenting your claim, picking a good lawyer, and the like will have been for naught if the jury isn't excited about your case. From your deposition early in the case to your lawyer's closing arguments to the jury, you and your lawyer must have a consistent, inspiring theme that will appeal to the judge and resonate in the jurors' minds while they are deliberating -- and hopefully, calculating damages -- in the jury room. Only if your case has a powerful theme will the jury even consider awarding a substantial verdict in your case.
- Although development of a potent theme will be more your lawyer's responsibility than yours, he may seek your help in deciding on one. And once a theme has been selected, your lawyer will likely encourage you to keep that theme in mind when you are testifying at a deposition or at trial.
- Here are some possible themes for you and your lawyer 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 broke its promise.
  - This is a story of *betrayal*. The insured paid his hard-earned money for what he trusted would be protection, peace of mind and security. The insurance company betrayed that trust.
  - The insurance company went fishing, and plaintiff took the bait. Through newspapers, radio, television, mailings, and agents' presentations, the insurer touted its experience 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 he was hooked. But then, when the plaintiff was injured or sick, the insurer tossed him back into the ocean -- 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 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.
  - This insurance company added insult to the insured's injury or sickness. It spat on the insured while he was down and out. Just when the insured

needed a helping hand out of his hole, the carrier kicked dirt down that hole.

- This lawsuit was *unnecessary*. It could have been prevented if the insurance company had just kept its word, honored what it sold and followed the rules of the road: Don't lie, don't cheat, don't chisel, don't lowball, and don't delay. Just *do the right thing*: Be honest, pay what you owe, pay it on time, and do it every time.
- Buying an insurance policy is not like buying a car. You don't get a chance to try it out before you buy it and take it home. So you have to know that it's going to work when you need it. And if it doesn't perform like the seller assured you it would, that seller should be held fully accountable.
- 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 didn't pay anyway.
- The insurance company didn't even bother to investigate before it denied coverage. It knew that if it actually looked at the evidence, it would have to pay money to its insured. So, the insurer kept its head buried in the sand, figuring that what it didn't know couldn't hurt it. *It was wrong*.
- 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.
- Good faith is good business. Bad faith is bad business -- and bad business must come with a price.
- You have the chance to restore to this fine family what the insurance company stole from them: *Their dignity*.
- Plaintiff is not here looking for a windfall. He isn't looking for jackpot justice. He is simply here to fix a debt, and to make the insurer *accountable*.
- The insurance company put its corporate economic interests before the interests of its insured and his family. It chose profit over people.
- This HMO promised quality care, access to treatment, referrals to specialists, and continuity of care. But instead, it put profit over patient care and, in the process, practiced cash-register medicine. Every medical decision was run through a financial filter. The HMO allowed non-

physician utilization reviewers to decide what was, and what was not, medically necessary treatment based on economic considerations. And the HMO's provider groups and participating physicians all made *more* money for treating *less*. Thus, the incentive was always to provide *fewer* specialists, *fewer* out-of network referrals, and *less* care -- which is exactly what this HMO did.

- "HMO" stands for "Heave Mom Out", with drive-through deliveries and drive-through mastectomies. With this HMO, out-patient is "in" and in-patient is definitely "out".
- The benefit payments by this insurance company were not some kind of loan or advance. They were monies that the insurer owed the insured with no strings attached, and the insured is entitled to *keep* those monies. But here, after the carrier paid the insured benefits it obviously owed under the policy, it turned around and sued the insured to get the money back. In so doing, the insurance company acted like a loan shark with an itchy trigger finger, not an insurer that promised peace of mind and security. And it treated the insured like some down-and-out borrower, not a policyholder who had faithfully and timely paid premiums to the insurer for years.
- An insured shouldn't need a map – or a lawyer – to navigate his way around his insurance policy. But the policy pieced 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 here, 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.
- This is nothing more than "denial for dollars". The more the insurance company denies, the more money it gets to keep. It has turned the claim department -- its purported "service center" -- into a profit center. And even the individual adjusters get to make more money (claim "termination" incentive bonuses, raises based on claims denied) if they deny more claims.
- Punitive damages are good "therapy" for insurers who have strayed from what's right, and forgotten that they are in the business of helping people who paid – in advance – for that help if they needed it. Punitive damages are good for the corporate soul, and will remind the insurer that it should treat other policyholders better in the future.

II. HOLDING AN HMO FULLY ACCOUNTABLE

California Civil Code section 3428, which became effective on January 1, 2001, 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.[1] 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 member[2] and (2) the member suffers "substantial harm."[3] 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.[4]

But even without Civil Code section 3428, HMOs – like other insurers – have been found liable for insurance bad faith. Indeed, the California Supreme Court has confirmed that any distinction between traditional insurance companies and health care service plans is "immaterial,"[5,] and thus that a health care organization can be held liable for breach of the covenant of good faith and fair dealing.[6]

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, 12.65];

- Tortious breach of contract [see Wilson v. Blue Cross of So. Calif. (1990) 222 Cal.App.3d 660];[7]

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

---

[1] Civil Code § 3428(a).

[2] 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).

[3] "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).

[4] Civil Code § 3428(j).

[5] Sarchett v. Blue Shield of California (1987) 43 Cal.3d 1,2, 233 Cal.Rptr. 76.

[6] 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*".

[7] 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.

- 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];[8]

- 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

- Business & Professions Code section 17200 [see State Farm Fire & Casualty Company v. Superior Court (Allegro) (1996) 45 Cal.App.4th 1093, 1103, 53 Cal.Rptr.2d 229, 234].

III. ERISA PREEMPTION

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.[9] Although originally designed to prevent pension plan abuses, ERISA also applies to all employee benefit "plans", including health care coverage benefits, even when there is no formal "plan" established and even when the health care benefits are provided through the purchase of a group insurance policy.[10]

A. What Remedies Are Available If ERISA Applies?

---

[8] In Pegram v. Herdrich (June 12, 2000) 120 S.Ct. 2143, 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". Id. 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).

[9] 29 U.S.C. section 1001; Massachusetts v. Morash (1989) 490 U.S. 107, 115, 109 S.Ct. 1668, 1673

[10] Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549

Determination of whether an action is subject to ERISA preemption is critical because of the limited remedies available under ERISA.[11] The courts almost universally conclude that remedies in connection with an ERISA-preempted insurance policy, healthcare plan or self-insured benefit plan are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. No matter how egregiously the insurer treated its insured, that insured cannot recover consequential damages, emotional distress damages or punitive damages if his suit is subject to ERISA.[12]

B. How Can ERISA Be Circumvented?

As a practical matter, most courts will determine that a policy is subject to ERISA preemption if it was provided through employment. That does not mean, however, that there are ***no*** potential ways to elude ERISA when suing an HMO.

One of the best ways to sidestep ERISA is to bring suit under California's new HMO liability statute, or your state's similar statute, if applicable As detailed above, California Civil Code section 3428 imposes upon HMOs a duty of ordinary care to arrange for the provision of "medically necessary" health care services as set forth in the HMO plan. The 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 member and (2) the member suffers "substantial harm."

Other possible ways to avoid ERISA include the following:

- An **independent contractor** is not an "employee" and is therefore not subject to ERISA preemption,[13] unless he obtains insurance benefits through the same group plan that covers employees of the company.[14]

- A **government employee** or the employee of a public agency is exempt from ERISA [29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32)].

- **Employees of churches** or church-operated businesses are exempt from ERISA [29 U.S.C. section 1003(b)].

- **Sole proprietors, partners, and their spouses** are exempt, so long as the business does not provide benefits under the policy to a common-law employee [29 C.F.R. sections 2510.3-3(b) and (c)].[15]

---

[11] 29 U.S.C. § 1132.

[12] Mass. Mut. Life Ins. Co. v. Russell (1985) 473 U.S. 134, 142-144, 105 S.Ct. 3085, 3090; Mertens v. Hewitt Assoc. (1983) 508 U.S. 248, 113 S.Ct. 2063, 2069.

[13] Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 319, 327, 112 S.Ct. 1344, 1350 (1992); Barnhart v. New York Life (9th Cir. 1998) 141 F.3d 1310.

[14] Harper v. American Chambers Life Ins. Co. (9th Cir. 1990) 89 F.2d 1432, 1434.

[15] See also Robertson v. Alexander Grant & Co. (5th Cir. 1986) 798 F.2d 868; Meredith v. Time Insurance Co. (5th Cir. 1993) 980 F.2d 352; Fugarino v. Hartford Life & Acc.

- Some courts have suggested that a plan is not "established or maintained" by an employer [29 U.S.C. section 1002(1)] unless the employer **intended** to create an ERISA plan.[16] Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively **participated** in the design and operation of the plan, directly **controlled** the day-to-day operation of the plan, exercised substantial **discretion** over the plan, and/or established a **separate administrative scheme** to manage the plan.[17] Still others have found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.[18] Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.[19] And a few others have held that the "is maintained" requirement implies that the plan must be in **current operation**,[20] and thus that ERISA does not apply where the former employer has **sold his business** and stopped contributing to the plan[21] or has gone **bankrupt** and ceased any involvement in the plan.[22]

- Plans that fall under the Department of Labor's **"safe harbor"** regulations [29 C.F.R. section 2510.3-1(j)] are exempt from ERISA. The regulations generally state that ERISA is inapplicable where (1) the employer does not "endorse" the program;[23] (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;[24] (4) the employer's sole functions are to permit

---

Ins. Co. (6th Cir. 1992) 969 F.2d 178; Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102, 1104.

[16] See Kanne v. Connecticut General Life Ins. Co. (9th Cir. 1988) 867 F.2d 489, 493; Stanton v. Paul Revere Life Ins. Co. (S.D. Cal. 1999) 37 F.Supp.2d 1159; Hansen v. Continental Ins. Co. (5th Cir. 1991) 940 F.2d 971, 978.

[17] See Hansen, 940 F.2d at 978; Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1134; Elco Mechanical Contractors. Inc. v. Builders Supply Assoc. of West Virginia (S.D. W. Va. 1993) 832 F.Supp. 1054, 1057-1058; Taggart Corp. v. Life and Health Benefits Administration, Inc. (5th Cir. 1980) 617 F.2d 1208, 1210; and Sindelar v. Canada Transport, Inc. (Neb. 1994) 520 N.W.2d 203, 207.

[18] See Zavora v. Paul Revere Life Ins. Co. (9th Cir. 1998) 145 F.3d 1118, 1121; du Mortier v. Massachusetts General Life Ins. Co., supra (C.D. Cal. 1992) 805 F.Supp. 816, 821; Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson, supra, 63 F.3d 1129.

[19] See du Mortier and Johnson, supra.

[20] See Stanton, supra, (S.D. Cal. 1999) 37 F.Supp.2d 1159.

[21] Loudermilch v. The New England Mutual Life Ins. Co. (S.D. Ala. 1996) 942 F.Supp. 1434.

[22] Mizrahi v. Provident Life and Accident Ins. Co. (S.D. Fla. 1998) 994 F.Supp. 1452.

[23] "Endorsement of a program requires more than merely recommending it". Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1136.

[24] The mere fact that the employer gave employees the option of using a portion of their

the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; **and** (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations.[25]

In addition, there is a recent indication by the *United States Supreme Court* that it will be receptive to arguments against ERISA preemption. In UNUM Life Ins. Co. of America v. Ward (1999) 526 U.S. 358, 119 S.Ct. 1380, 1390, n. 7, the Court noted that the Solicitor General of the United States – on whose brief the Court had based its ruling in Pilot Life[26] that ERISA is the exclusive remedy for state law causes of action for bad faith – had *changed its position* on that issue. Although the Court concluded in Ward that it "need not address the Solicitor General's current argument" because Ward was suing under ERISA (for benefits due) rather than trying to circumvent it, the case at least suggests that the Court may be open to reconsidering its decision in Pilot Life.

And the federal district courts concur. During the past year, district court judges in Colorado,[27] Oklahoma[28] and Alabama[29] have relied on Ward in ruling that ERISA does ***not*** preempt a bad faith cause of action by an insured under a group insurance policy. In so holding, those courts distinguished Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549, wherein the U.S. Supreme Court had held that Mississippi's bad faith law was preempted by ERISA because it imposed liability against both insurance and non-insurance entities (and therefore did not "regulate insurance" within the meaning of ERISA's "savings clause" [29 U.S.C § 1144(B)(2)(A)] so as to avoid preemption). Conversely, California, Colorado, Oklahoma and Alabama limit the cause of action to the insurance industry.[30]

---

pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. See Hrabe v. Paul Revere Life Insurance Company (M.D. Ala. 1996) 951 F.Supp. 997, 1001.

[25] Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129.

[26] Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549.

[27] Hall v. UNUM Life Ins. Co. of America, U.S. District Court for the District of Colorado, Case No. 97-M-1828, November 1, 1999 Order by Chief Judge Richard S. Matsch Granting Motion For Leave To File Amended And Supplemental Complaint Adding Third Claim For Relief. Note that although the unpublished order did not expressly reference the Supreme Court's decision in Ward, the order was issued in response to a motion (for leave to file an amended and supplemental complaint) that had been based solely on Ward.

[28] Lewis v. Aetna U.S. Healthcare, Inc. (N.D. Ok. 1999), No. 99-CV-104-H(M).

[29] Hill v. Blue Cross Blue Shield of Alabama (N.D. Ala. 2000) 117 F.Supp.2d 1209.

[30] For example, California courts have repeatedly held that claims for tortious breach of the implied convenat of good faith and fair dealing (i.e., bed faith) can only be brought in cases involving *insurance contracts.* [Foley v. Interactive Data Corp. (1988) 47 Cal.3d

IV. AVOIDING ARBITRATION

The HMO will likely assert that your claim must be arbitrated. But even if your policy has an arbitration clause, there are numerous arguments you can make to try to circumvent arbitration and get your case to a jury. For example:

- Insured did not knowingly **agree** to arbitration.
  - Arbitration is inappropriate unless the parties agreed to arbitrate. [United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582 (1960)].
  - Consent must be viewed as the "starting point" and the "threshold issue," and to do otherwise is to "put the cart before the horse." [Badie v. Bank of America, 67 Cal. App. 4th 779, 790, 79 Cal. Rptr. 2d 273, 280.]
  - HMO's failure to comply with the specific and unambiguous disclosure and notice requirements of California's Health & Safety Code section 1363.1 renders the arbitration clause invalid. [Smith v. Pacificare, 93 Cal. App. 4th 139 (2001).]
- Insured was **fraudulently induced** to enter arbitration agreement. [Engalla v. Permanente Med. Group, Inc., 15 Cal. 4th 951, 938 P.2d 903, 64 Cal. Rptr. 2nd 843 (1997).]
- Insurer **waived** its right to arbitration.
  - Insurer **delayed** in *bringing the arbitration provision to the insured's attention* after it learned that the insured disagreed with the insurer's coverage determination. [Sarchet v. Blue Shield of Calif., 43 Cal. 3d 1, 14-15, 729 P.2d 267, 276-77, 233 Cal. Rptr 76, 85-86 (1987).]
  - Insurer **delayed** in *filing a petition to compel arbitration* after the insured had filed a civil action. [*See* Sobremonte v. Superior Court, 61 Cal. App. 4th 980, 72 Cal. Rptr. 2d 43 (1998), where a 10-month delay was held to be a waiver of right to arbitrate, even though arbitration was raised in answer; Davis v. Continental Airlines, 59 Cal. App. 4th 205, 69 Cal. Rptr. 2d 79 (1997), where a 6-month delay was held to be a waiver of right to arbitrate, even though arbitration was raised in answer.]
- Insurer **engaged** in *litigation conduct inconsistent with an intent to arbitrate* (filing demurrers and/or motions, attending court hearings, propounding discovery, etc.).
  - In Berman v. Health Net, 80 Cal. App. 4th 1359, 1373, 96 Cal. Rptr. 2d 295, 305, insurer engaged in "extensive discovery, including hundreds of interrogatories and requests for production which yielded thousands of pages of responses," thereby prejudicing plaintiffs sufficient to establish waiver.

---

654 684, 254 Cal.Rptr. 211, 228.] In Oklahoma the tort of bad faith is "specific to the insurance industry" [Lewis, 78 F.Supp.2d at 1215], "applie[s] exclusively to contracts between insurance companies and their insureds" [Id. at 1212] and "has never been extended beyond the insurance area" [Id. at 1208]. Similarly, "the only targets for the tort of bad faith in Alabama are insurance companies" [Hill, 117 F.Supp.2d at 1212].

- In Davis v. Continental Airlines, 59 Cal. App. 4th 205, 212-13, 69 Cal. Rptr. 2d 79, 83-84 (1997), court would not allow a party to engage in litigation conduct that is "typically . . . not available in arbitration" and thereby "create his own unique structure combining litigation and arbitration."
- In Hayworth v. City of Oakland, 129 Cal. App. 3d 723, 729-30, 181 Cal. Rptr. 214, 218 (1982), the court held that a defendant who contends that the plaintiff's claim is subject to arbitration "may not . . . participate in litigation in such a manner as to constitute 'testing the water before taking the swim.'"

- Arbitration clause is **unconscionable** for the following reasons:
  - Arbitration clause bars recovery of tort or punitive damages in arbitration or otherwise restricts remedies available in arbitration. [Armendariz v. Foundation Health Psychcare Services, Inc., 24 Cal. 4th 83, 103-04, 6 P.3d 669, 99 Cal. Rptr. 2d 745, 759-60 (2000); Stirlen v. Supercuts, Inc., 51 Cal. App. 4th 1519, 60 Cal. Rptr. 2d 138 (1997); Graham Oil Co. v. Arco Products Co., 43 F.3d 1244 (9th Cir. 1994); Paladino v. Avenet Computer Tech., Inc., 134 F.3d 1054 (11th Cir. 1998).]
  - Arbitration clause requires that insureds, but not insurers, arbitrate their claims. [Armendariz, 24 Cal. 4th at 117-20, 99 Cal. Rptr. 2d at 770-72.]
  - Arbitration clause calls for selection of an arbitrator who is affiliated with one of the parties to the contract or otherwise lacks neutrality. [Armendariz, 24 Cal. 4th at 102-03, 99 Cal. Rptr. 2d at 759; Graham v. Scissor-Tail, Inc., 28 Cal. 3d 807, 623 P.2d 165, 171 Cal. Rptr. 604 (1981).]
  - Arbitration clause provides for only minimal discovery. [Armendariz, 24 Cal. 4th at 104-05, 171 Cal. Rptr. 2d at 760.]
  - Arbitration clause requires insureds to pay unreasonable costs or arbitrator fees as a condition to arbitration. [Armendariz, 24 Cal. 4th at 113, 99 Cal. Rptr. 2d at 766; Paladino v. Avenet Computer Tech., Inc., 134 F.3d 1054 (11th Cir. 1998).]
  - Arbitration clause on non-negotiable pre-printed consumer loan contract required that arbitration take place in another state. [Patterson v. ITT Consumer Financial Corp., 14 Cal. App. 4th 1659, 18 Cal. Rptr. 2d 563 (1993).]
- Claims alleged are beyond the **scope** of the arbitration provision.
  - A "party cannot be required to submit to arbitration any dispute which he has not agreed so to submit." [AT&T Tech. v. Communication Workers of America, 475 U.S. 643, 648 (1986).]
  - "The scope of arbitration . . . is a matter of agreement between the parties." [Ericksen, Arbuthnot, McCarthy, Kearney & Walsh, Inc. v. 100 Oak Street, 35 Cal. 3d 312, 323, 673 P.2d 251, 257, 197 Cal. Rptr. 581, 587 (1983).]
  - A provision calling for arbitration of any "dispute arising from this agreement" only required arbitration of contract issues – **not** tort issues. [Cobler v. Stanley, Barber, Southard, Brown & Assoc., 217 Cal. App. 3d 518, 265 Cal. Rptr. 868 (1990).]

- In an arbitration clause requiring arbitration of any "dispute between the Subscriber and Blue Shield, with respect to any of the terms, conditions, or benefits of this Agreement"; the court held that coverage and breach of contract issues were subject to arbitration, but that the insured's claim for breach of the covenant of good faith and fair dealing was not. [Mansdorf v. California Physicians' Services, Inc., 87 Cal. App. 3d 412, 151 Cal. Rptr. 388 (1978).]

V. CONCLUSION

At the risk of stating the obvious, it's not easy to take on an HMO – but it can be done. We hope that the tips discussed in this outline will help you circumvent the many roadblocks you may encounter in attempting to hold your HMO accountable and, in the process, preserve your right to receive timely, quality health care.