SUING HEALTH CARE PROVIDERS AND INSURERS – BAD FAITH AND OTHER CLAIMS

By Frank N. Darras and Lissa A. Martinez

I. TAKING ON AN HMO – CIRCUMVENTING THE INSURER'S ROADBLOCKS

A. **Avoiding Medicare Preemption:** A growing number of senior citizens who qualify for Medicare benefits are opting for coverage under HMO senior care plans. If you decide to represent a senior who has been denied benefits by his HMO or other insurer, you likely will be faced with an argument that tort claims arising from wrongful refusal to provide benefits under a senior care plan are preempted by the Medicare Act. (42 U.S.C. §§ 1395 *et seq*.)

1. U.S. Department of Health and Human Services, the federal agency that administers Medicare, has confirmed, in a published analysis, that "**tort claims or contract claims under State law are not preempted" by Medicare**. (Health and Human Services, 63 Fed. Reg. 34968, 35013 (1998).)

2. Numerous courts have flatly ***rejected*** Medicare preemption of bad faith suits and other tort actions:

   a. *McCall v. Pacificare of Cal., Inc.*, 25 Cal. 4th 412, 21 P.3d 1189, 106 Cal. Rptr. 2d 271 (2001) [An enrollee can sue his Medicare HMO and physician provider group for damages in state court because state-law based tort claims that do not seek Medicare benefits, or seek reimbursement for benefits that Medicare should have paid, do **not** arise under the Medicare Act, and are **not** "inextricably intertwined" with the Act, even if the claim, as pleaded, "incidentally refers to a denial of benefits under the Medicare Act." *Id.* at 425.]

   b. *Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1999) [State law tort claims for wrongful death against a private Medicare provider, even when predicated on the wrongful denial of Medicare benefits, are **not** preempted by the Medicare Act. Thus, Medicare's administrative remedies need ***not*** be exhausted before those claims can be pursued in state court. Court noted that plaintiffs' injuries could not be "remedied" by the retrospective authorization or payment of benefits, even if plaintiffs had exhausted the administrative remedies contained in the Medicare Act. *Id.* at 500.]

   c. *Solorzano v. Superior Court (FHP, Inc.)*, 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d (1992) [Medicare beneficiaries allowed to pursue claim for damages and injunctive relief to stop HMO's alleged unfair competition, deceptive trade practices and deceptive advertising because federal statute and regulations do not displace state regulation of HMO's

marketing practices.]

d. *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998) [State law causes of action which are not based on a claim for payment of benefits or for reimbursement, but rather on the tortious acts of a medicare benefit administrator, do not arise under, nor are they preempted by Medicare.]

e. *Albright v. Kaiser Permanente Med. Group*, 1999 WL 605828 (N.D. Cal. 1999) [Tort claims against HMO for breach of the covenant of good faith and fair dealing, unfair business practices, and fraud are **not** preempted by Medicare because the claims do not "seek reimbursement of Medicare benefits and therefore are not 'inextricably intertwined' with a claim for benefits under the Medicare Act." *Id.* at *4.]

f. *Plocica v. NYLCare of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999) [State law claims for wrongful death based on HMO's tortious conduct in the inadequate quality of care and treatment of insured are **not** preempted by the Medicare Act because plaintiffs are not seeking to recover for denied coverage or refusal to pay benefits. And pursuing the administrative Medicare appeal process would be futile since the insured is dead.]

3. Other favorable cases concerning Medicare preemption include:

a. *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997) [Nursing home resident not required to exhaust state administrative remedies before suing nursing home for violation of resident rights provisions of the Medicare Act.]

b. *Berman v. Abington Radiology Assoc., Inc.*, 1997 WL 534804 (E.D. Pa. 1997) [State law negligence claim against HMO for failure to exercise reasonable care in hiring medical personnel and in monitoring the standards and capabilities of medical personnel did not "arise under" the Medicare Act because (1) state common law, not the Medicare Act, provides the standing and substantive basis for the presentation of the claim, and (2) claim is not "inextricably intertwined" with a claim for Medicare benefits because plaintiff is not seeking to recover such benefits. *Id.* at *4.]

c. *Zamora-Quezada v. HealthTexas Medical Group of San Antonio*, 34 F. Supp. 2d 433 (W.D. Tex. 1998) [Enrollees are not required to exhaust administrative remedies under the Medicare Act before suing their HMOs and Physician Provider Groups for discrimination relief under the ADA and Rehabilitation Act. Court applied the reasoning in *Ardary*, finding that federal law claims did not "arise under" the Medicare Act. *Id.* at 440.]

d. *Winkler v. Interim Services, Inc.*, 36 F. Supp. 2d 1026 (M.D. Tenn. 1999)

[Disabled Medicare beneficiaries claims against HMO for breach of contract, violation of the Rehabilitation Act, common law abandonment, breach of duty of care, and violations of Tennessee Consumer Protection Act are not preempted by Medicare Act.]

e. *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. 1999) [Enrollee's claim for state law tort damages inflicted by HMO as a result of its delay in granting the requested benefits were collateral to a claim for Medicare benefits, and therefore not preempted by Medicare.]

f. *Caputo v. Unites States Health Care Systems of Pa.*, 1998 WL 808611 (E.D. Pa. 1998) [Plaintiff's tort claims against HMO do not "arise under" and are not preempted by the Medicare Act because neither standing nor the substantive basis for the presentation of a negligence claim is the Medicare Act and plaintiff is not seeking to recover Medicare benefits.]

B. **Avoiding Arbitration:** The HMO will likely assert that your client's claim must be arbitrated. But even if your client's policy has an arbitration clause, there are numerous arguments you can make to try to circumvent arbitration and get the case to court. For example:

1. Insured did not knowingly **agree** to arbitration.

   a. Arbitration is inappropriate unless the parties agreed to arbitrate. (*United Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574, 582 (1960).)

   b. 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 (1998).)

2. 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).)

3. Insurer **waived** its right to arbitration.

   a. *Delay* in pursuing arbitration.

      i. 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).)

      ii. Insurer delayed in *filing a petition to compel arbitration* after the insured had filed a civil action.

         (a) *Sobremonte v. Superior Court*, 61 Cal. App. 4th 980, 72 Cal. Rptr. 2d 43 (1998) [10-month delay; waiver even though arbitration

raised in answer]

(b) *Davis v. Continental Airlines*, 59 Cal. App. 4th 205, 69 Cal. Rptr. 2d 79 (1997) [6-month delay; waiver even though arbitration raised in answer]

b. Insurer engaged in *litigation conduct inconsistent with an intent to arbitrate* (filing demurrers and/or motions, attending court hearings, propounding discovery, etc.).

i. *Berman v. Health Net*, 80 Cal. App. 4th 1359, 1373, 96 Cal. Rptr. 2d 295, 305 [Defendants 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.]

ii. *Davis v. Continental Airlines*, 59 Cal. App. 4th 205, 212-13, 69 Cal. Rptr. 2d 79, 83-84 (1997) [Courts won't 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."]

iii. *Hayworth v. City of Oakland*, 129 Cal. App. 3d 723, 729-30, 181 Cal. Rptr. 214, 218 (1982) [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.'"]

4. Arbitration clause is **unconscionable**.

a. 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).)

b. 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.)

c. 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).)

d. Arbitration clause provides for only minimal discovery. (*Armendariz*, 24

Cal. 4th at 104-05, 171 Cal. Rptr. 2d at 760.)

e. 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).)

f. 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).)

5. Claims alleged are beyond the **scope** of the arbitration provision.

a. 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).)

b. "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).)

c. 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).)

d. 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).)

C. **Avoiding ERISA Preemption:** If your client's health plan was provided by his employer, the insurer will argue that his civil suit is preempted by the Employee Retirement Income Security Act (ERISA). 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. (*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).)

1. **Remedies** in connection with an ERISA-preempted healthcare plan, insurance policy, 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. (*Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142-44 (1985); *Mertens v. Hewitt Assoc*., 508 U.S. 248, 255-59, 262-63 (1993).)

a. However, one line of cases has held that damages are properly recoverable under ERISA based on language in the U.S. Supreme Court's opinion in *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133 (1990). In that case, an employee sought **compensatory and punitive damages** for his employer's tortious termination of his employment just before his plan benefits would have vested. (*Id.* at 136.) The Supreme Court stated that "it is clear that the relief requested here is well within the power of federal courts to provide." (*Id.* at 145.) This language was authored by Justice O'Connor, the same Justice who only three years earlier penned the landmark decision in *Pilot Life*. Based on *Ingersoll-Rand*, some courts have concluded that consequential and punitive damages ***are*** meant to be recoverable under ERISA. (*See, e.g.*, *Weems v. Jefferson-Pilot Life Ins. Co., Inc*., 663 So. 2d 905, 911 (Ala. 1995); *Haywood v. Russell Corp.*, 584 So. 2d 1291, 1295 (Ala. 1991); *East v. Long*, 785 F. Supp. 941, 944 (N.D. Ala. 1992); *International Union, United Auto., Aerospace & Agric. Implement Workers v. Midland Steel Prods. Co*., 771 F. Supp. 860, 863-64 (N.D. Ohio 1991).) At present, however, that is far from the majority view.

2. **Circumventing ERISA**: 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. For example:

a. For California insureds, one of the best ways to sidestep ERISA is to bring suit under **California's new HMO liability statute**. 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.

i. 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." (Cal. Civ. Code § 3428(a).) "Substantial harm" means loss of life, loss of significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss. (Cal. Civ. Code § 3428(b)(1).)

ii. Recoverable damages include, but are not limited to, the tort damages set forth in California Civil Code section 3333 ("all detriment proximately caused" by the breach of duty), such that emotional distress damages and, presumably, punitive damages may be recovered.

iii. If the California Legislature has its way, ERISA will ***not*** bar persons whose HMO plans are provided by their employers from suing their HMOs under the new law or limit the damages they can recover in such a suit.

(a) The California Legislature has declared that, at least for purposes of statutory liability under Civil Code § 3428, *HMOs "are engaged in the business of insurance* . . . as that term is defined for purposes of the McCarron-Ferguson Act." (Statutory notes to Civil Code § 3428 (emphasis added).)

(b) This is critical for purposes of ERISA, since ERISA preempts state laws related to employee benefit plans ***except*** those laws that "regulate insurance" (29 USC § 1144(B)(2)(A)) – and a state law "regulates insurance" if it (1) is specifically directed toward the insurance industry and (2) fits within the *"business of insurance"* as that phrase is used in the McCarron-Ferguson Act. (15 USC §1011 *et seq*.; *see also UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 377 n.7 (1999).)

(c) Thus, the California Legislature's clear goal is to protect the new HMO liability statute from ERISA exemption. And to remove any doubt, the Legislature has declared that its intention is "to ensure that adequate state law remedies exist for *all* persons who are subject to the wrongful acts of those entities that contract to provide insurance for the life, health and disability of California citizens." (Statutory notes to Civil Code § 3428 (emphasis added).)

b. An **independent contractor** is not an "employee" and is therefore not subject to ERISA preemption. (*Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 319, 327 (1992); *Barnhart v. New York Life*, 141 F.3d 1310, 1313-14 (9th Cir. 1998).) However, if the independent contractor obtains insurance benefits through the same group plan that covers employees of the company, the court may determine that he is a "participant" and that his claims are preempted. (*Harper v. American Chambers Life Ins. Co.*, 89 F.2d 1432, 1434 (9th Cir. 1990).

c. A **government employee** or the employee of a public agency is exempt from ERISA. (29 U.S.C. § 1003(b)(1).)

d. **Employees of churches** or church-operated businesses are exempt from ERISA. (29 U.S.C. § 1003(b)(2).)

e. **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. § 2510.3-3(b), (c)(1), (c)(2).)

i. In *Robertson v. Alexander Grant & Co.*, 798 F.2d 868, 872 (5th Cir. 1986), the court relied on those regulation in "[f]inding ERISA *inapplicable to plans covering only partners*."

ii. In *Meredith v. Time Insurance Co.*, 980 F.2d 352, 353, 357 (5th Cir. 1993), the court held that "an insurance plan purchases by a sole proprietor, covering only herself and her spouse, [does not] constitute . . . an 'employee welfare benefit plan' as that term is defined in ERISA."

iii. In *Slamen v. Paul Revere Life Insurance Co.*, 166 F.3d 1102, 1104 (11th Cir. 1999), the court stated that "in order to establish an ERISA employee welfare benefit plan, the plan *must provide benefits to at least one employee*, not including an employee who is also the owner of the business in question," and thus that ERISA does not apply where the "insurance policies at issue were for the *sole interest and benefit of the plaintiff*, and not his employees." And this result does not change simply because the owner is *incorporated* and pays the premiums through his professional corporation. (*Id.* at 1105, 1106 n.4.)

iv. In *Fugarino v. Hartford Life & Accident Insurance Co.*, 969 F.2d 178, 185 (6th Cir. 1992), the court held that a business owner is exempt from ERISA, stating that "*a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA*."

f. Plans that are not "**established or maintained**" by an employer are exempt from ERISA. (29 U.S.C. § 1002(1).)

i. Plan is not "established or maintained" unless the employer **intended** to create an ERISA plan. (*See Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 493 (9th Cir. 1988); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991); *Stanton v. Paul Revere Life Ins. Co.*, 37 F. Supp. 2d 1159, 1163 (S.D. Cal. 1999).)

ii. Plan is not "established or maintained" unless the employer 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. (*See Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991); *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1134 (1st Cir. 1995); *Elco Mechanical Contractors. Inc. v. Builders Supply Assoc.*, 832 F. Supp. 1054, 1057-58 (S.D. W. Va. 1993); *Taggart Corp. v. Life and Health Benefits Admin., Inc.*, 617 F.2d 1208, 1210 (5th Cir. 1980); *Sindelar v. Canada Transp., Inc.*, 520 N.W.2d 203, 207 (Neb. 1994).)

iii. Plan is not "established or maintained" even if the employer was

significantly involved in the administration of the plan. (*See Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118, 1121 (9th Cir. 1998); *du Mortier v. Massachusetts Gen. Life Ins. Co.*, 805 F. Supp. 816, 821 (C.D. Cal. 1992); *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1130 (1st Cir. 1995).)

iv. Plan is not "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. (*See du Mortier v. Massachusetts Gen. Life Ins. Co.*, 805 F. Supp. 816, 820 (C.D. Cal. 1992); *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1132-33 (1st Cir. 1995).)

v. Plan is not "maintained" unless the plan is in **current operation** (*Stanton v. Paul Revere Life Ins. Co.*, 37 F. Supp. 2d 1159, 1166 (S.D. Cal. 1999)), and thus that ERISA does not apply where the former employer has **sold his business** and stopped contributing to the plan (*Loudermilch v. The New England Mut. Life Ins. Co.*, 942 F. Supp. 1434, 1437 (S.D. Ala. 1996)) or has gone **bankrupt** and ceased any involvement in the plan. (*Mizrahi v. Provident Life and Accident Ins. Co.*, 994 F. Supp. 1452, 1453-54 (S.D. Fla. 1998).)

g. Plans that fall under the Department of Labor's "**safe harbor**" regulations (29 C.F.R. § 2510.3-1(j)) are exempt from ERISA. The regulations generally state that ERISA is inapplicable where:

i. The employer does not "endorse" the program, where "[e]ndorsement of a program requires more than merely recommending it." (*Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1136 (1st Cir. 1995).)

ii. Employee participation is completely voluntary.

iii. Premiums are paid entirely by the employee, and the mere fact that the employer gave employees the option of using a portion of their pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. (*Hrabe v. Paul Revere Life Ins. Co.*, 951 F. Supp. 997, 1001 (M.D. Ala. 1996).)

iv. The employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; **and**

v. 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. (*See Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1135-38 (1st Cir. 1995).)

h. State-law claims under a **converted policy** are ***not*** preempted by ERISA.

   i. In *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872 (9th Cir. 2001), the court held that ERISA preemption does ***not*** extend to state-law claims (including breach of the covenant of good faith and fair dealing) arising under an individual health insurance policy – even though the policy was converted from a group health policy that was subject to ERISA. (*Id.* at 877.)

   ii. In *Demars v. CIGNA Corp.*, 173 F.3d 443, 449-50 (1st Cir. 1999), the court explained that ERISA preemption does not apply to converted policies generally, or to specific types of converted policies.

   iii. But see *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 440-41 (8th Cir. 1997), in which the court held that state-law claims were preempted by ERISA because the conversion policy at issue "came into being as a result of [the plaintiff] exercising her right under the group policy to obtain [the conversion policy]."

i. **Impact of *UNUM v. Ward* on ERISA Preemption**: In *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 377 n.7 (1999), the United States Supreme Court noted that the Solicitor General of the United States – on whose brief the Court had based its ruing in *Pilot Life* 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*.

   i. Several federal district courts concur – relying on *Ward* in ruling that ERISA does ***not*** preempt a bad faith cause of action by an insured under a group insurance policy – thereby distinguishing *Pilot Life*, wherein the United States 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" so as to avoid preemption).

      (a) *Hill v. Blue Cross Blue Shield*, 117 F. Supp. 2d 1209 (N.D. Ala. 2000) [concluding that footnote 7 in *Ward* meant that Alabama's bad faith insurance tort was saved from ERISA preemption] (*See also Gilbert v. Alta Health & Life Ins. Co.*, 122 F. Supp. 2d 1267 (N.D. Ala. 2000) [holding that ERISA did not preempt Alabama's bad faith tort].)

      (b) *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F. Supp. 2d 1202 (N.D.

Okla. 1999) [holding that Oklahoma's bad faith remedy was saved]

(c) *Hall v. UNUM Life Ins. Co.*, Case No 97-M-1828 (D. Colo. 1999) [Unpublished order by Chief Judge Richard S. Matsch granting plaintiff's motion to amend her complaint to add a cause of action for bad faith under Colorado law.]

II. PLEADING AGAINST AN HMO

A. **Insurance Bad Faith:** HMOs – like other insurers – have been found liable for insurance bad faith. For example:

1. In *Sarchett v. Blue Shield of Calif.*, 43 Cal. 3d 1, 729 P.2d 267, 233 Cal. Rptr. 76 (1987), the California Supreme Court analyzed the obligations of a health care service plan under the same rules applicable to insurers, and specifically held that the plan could be held liable, just as a traditional insurer could, for breach of the implied covenant of good faith and fair dealing. (*Id.* at 14-16.) The Court emphasized that any distinction between traditional insurance companies and health care service plans is "immaterial." (*Id.* at 4, n.1.) And in *Warren-Guthrie v. Health Net*, 84 Cal. App. 4th 804, 814, 101 Cal. Rptr. 2d 260, 267 (2000), the court relied on the decision in *Sarchett* in "constru[ing] the [HMO health care service] plan as [it] would an insurance policy."

2. In *McEvoy v. Group Health Co-Op*, 213 Wis. 2d 507, 570 N.W.2d 397 (1997), the Wisconsin Supreme Court concluded that HMOs are subject to the same duties and liabilities under a bad faith analysis as are traditional insurers.

3. In *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039, 1045-46 (9th Cir. 1998), the Ninth Circuit found that "[i]n the end, HMOs function the same way as a traditional health insurer" and "are engaged in the business of health insurance," and thus that any nominal variance between HMOs and traditional insurers is "a distinction without a difference."

4. Moreover, both the Fifth Circuit and the Sixth Circuit have expressly adopted the Ninth Circuit's reasoning in *Washington Physicians* that HMOs function the same as traditional health insurers. (*See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 536, 538 (5th Cir. 2000); *Kentucky Assoc. of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364 (6th Cir. 2000).) And two other circuit courts – the First and Seventh – concluded even before *Washington Physicians* was decided that managed care entities are engaged in the business of insurance. (*See Ocean State Physicians Health Plan v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1107-08 (1st Cir. 1989); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994).)

B. **HMO Liability Statute – California Civil Code § 3428:** Effective January 1, 2001, California Civil Code section 3428 imposes liability against HMOs that fail to furnish covered benefits.

1. 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. (Cal. Civ. Code § 3428(a).)

2. 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." (Cal. Civ. Code § 3428(a).) "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. (Cal. Civ. Code § 3428(b)(1).)

3. Recoverable damages include, but are not limited to, the tort damages set forth in California Civil Code section 3333 ("all detriment proximately caused" by the breach of duty), such that *emotional distress* damages and, presumably, *punitive* damages may be recovered. (*See* Cal. Civ. Code § 3428(j).) However, a member must first exhaust applicable independent review procedures, unless substantial harm occurred or will imminently occur before the completion of the applicable review.

C. **Other theories available against an HMO include:**

1. **Third-Party Beneficiary** of contract between HMO and physician provider group. (*See Bass v. John Hancock Mut. Life Ins. Co.*, 10 Cal. 3d 792, 796, 518 P.2d 1147, 1149, 112 Cal. Rptr. 195, 197 (1974); *Harper v. Wausau Ins. Co.*, 56 Cal. App. 4th 1079, 1091, 66 Cal. Rptr. 2d 64, 71 (1997).)

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

3. **Interference with Doctor-Patient Relationship**. (*See Heller v. Norcal Mut. Ins. Co.*, 8 Cal. 4th 30, 45, 876 P.2d 999, 1007, 32 Cal. Rptr. 2d 200, 208 (1994). *See also Garcia v. Home Depot U.S.A., Inc.*, 1999 WL 362787 (N.D. Tex. 1999); *Hammonds v. Aetna Cas. & Sur. Co.*, 237 F. Supp. 96, 98-99 (N.D. Ohio 1965); *Hager v. Venice Hosp., Inc.,* 944 F. Supp. 1530, 1535 (M.D. Fla. 1996); *Okusami v. Psychiatric Institute of Washington, Inc.*, 959 F.2d 1062, 1066 (D.C. Cir. 1992).)

4. **Intentional Misrepresentation**. (*See Sanchez v. Lindsey Morden Claims Services, Inc.*, 72 Cal. App. 4th 249, 84 Cal. Rptr. 2d 799 (1999); *Orient Handel v. United States Fidelity and Guar.*, 192 Cal. App. 3d. 684, 237 Cal. Rptr. 667 (1987).)

5. **Negligent Misrepresentation**. (*See Davis v. Blue Cross of No. Calif.*, 25 Cal. 3d 418, 426-27, 600 P.2d 1060, 1065, 158 Cal. Rptr. 828, 833 (1979); *Westrick v. State Farm Ins.*, 137 Cal. App. 3d 685, 687, 187 Cal. Rptr. 214, 215 (1982).)

6. **Breach of Fiduciary Duty**. (*See Moore v. Regents of the Univ. of California*, 51 Cal. 3d 120, 128-32, 793 P.2d 479, 482-85, 271 Cal. Rptr. 146, 149-52 (1990); *but see Pegram v. Herdrich*, 530 U.S. 211 (2000) [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 234.) 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).].)

7. **Vicarious Liability** for medical negligence of HMO physicians. (*See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir. 1995); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Dykema v. King*, 959 F. Supp. 736 (D.S.C. 1997); *Elsesser v. Hospital of the Philadelphia College*, 802 F. Supp. 1286 (E.D. Pa. 1992). *See also Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Edelen v. Osterman*, 943 F. Supp. 75 (D.C. 1996); *Santitoro v. Evans*, 935 F. Supp. 733 (E.D.N.C. 1996); *Roessert v. Health Net*, 929 F. Supp. 343 (N.D. Cal. 1996); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Ouellette v. Christ Hosp.*, 942 F. Supp. 1160 (S.D. Ohio 1996); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Il. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Il. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990).)

8. **Intentional Infliction of Emotional Distress**. (*See Fletcher v. Western Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 394, 89 Cal. Rptr. 78, 88 (1970); *Little v. Stuyvesant Life Ins. Co.*, 67 Cal. App. 3d 451, 461-62, 136 Cal. Rptr. 653, 658-59 (1977).)

9. **RICO**. (*Dana Corp. v. Blue Cross & Blue Shield Mut. Of No. Ohio*, 900 F.2d 882, 884-85 (6th Cir. 1990).)

10. **Unfair Business Practices**. (*Samura v. Kaiser Found. Health Plan, Inc.*, 17 Cal. App. 4th 1284, 1299-1300, 22 Cal. Rptr. 2d 20, 29-30 (1993) [cause of action under California Business & Professions Code section 17200].)

III. STANDARDS TO APPLY IN HMO CASES

A. **NCQA Accreditation Standards:** The National Committee for Quality Assurance ("NCQA") is a national organization that accredits managed care organizations – and has done so for the past 10 years. Toward that end, the NCQA promulgates extensive standards for HMOs. The following are pertinent standards from NCQA's "Standards for the Accreditation of Managed Care Organizations, effective July 1, 2001:

1. **Persons Performing Utilization Review:** Appropriately licensed health

professionals supervise all review decisions. A licensed physician reviews any denial based on medical necessity. The HMO has written procedures for using board-certified physicians from appropriate specialty areas to assist in making determinations of medical necessity. (UM 3.1, 3.2 and 3.3.)

2. **Precertification of Nonurgent Care:** The HMO must make its decision within *two working days* of obtaining all necessary information and must notify the practitioner of its decision within *one working day* of the decision. Where the decision is a denial, the HMO must give the member and practitioner written or electronic confirmation of the denial within *two working days* of the decision. (UM 4.1.1, 4.1.2 and 4.1.3.)

3. **Precertification of Urgent Care:** The HMO must make its decision and notify the practitioner of its decision within *one calendar day*. If the decision is a denial, the HMO must also notify the member within *one calendar day*. Where the decision is a denial, the HMO must give the member and practitioner written or electronic confirmation of the denial within *two working days* of the decision. (UM 4.1.4 and 4.1.6.)

4. **Concurrent Review of Services:** The HMO must make its decision regarding inpatient, intensive outpatient or residential behavioral care within *one working day* of obtaining all necessary information and must make its decision regarding ongoing ambulatory care within *10 working days* of obtaining all necessary information. The HMO must notify the practitioner of its decisions within *one working day* of the decision. Where the decision is a denial, the HMO also must give the member and practitioner written or electronic confirmation of the denial within *one working day* of the original notification. (UM 4.1.7, 4.1.8 and 4.1.9.)

5. **Retrospective Review:** The HMO must make its decision within *30 working days* of obtaining all necessary information and must notify the practitioner and member of any denials within *five working days* of making the decision. (UM 4.1.11 and 4.1.12.)

6. **Delegation of Utilization Review:** Although an HMO can delegate all or parts of its utilization review, it retains accountability for the decisions made. (UM 15 (rationale).)

7. **Appeals:** First-level appeals must be conducted by a person who was not involved in the initial claim decision. Decisions must be made within *30 working days*. If the HMO cannot make a decision within 30 working days due to circumstances beyond its control, it can have an additional 15 working days for its decision if it notifies the member of the reasons for its delay before the 30th working day. However, a member or practitioner can request an expedited appeal, in which event the decision must be conveyed no later than *three calendar days* after the request is made. If the initial decision was oral, the HMO will provide written confirmation of its decision within *two*

working days after its oral notification. Second-level appeals are also available. In at least one level of appeal, at least one of the decision-makers must be an actively practicing practitioner in the same or a similar specialty who typically treats the medical condition, performs the procedure or provides the treatment and did not participate in any of the HMO's prior decisions on the case. (UM 7.1.4.1, 7.1.4.2, 7.1.6.2, 7.1.6.3, 7.2 and 7.4.)

B. **Implied Covenant of Good Faith and Fair Dealing:** The implied covenant of good faith and fair dealing – which, as discussed above, *applies to HMOs* – includes the duty to:

1. **Thoroughly investigate** the insured's claim, and to "fully inquire into possible bases that might *support* the insured's claim." (*Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 819, 620 P.2d 141, 145-46, 169 Cal. Rptr. 691, 695-96 (1979); *Mariscal v. Old Republic Life Ins. Co.*, 42 Cal. App. 4th 1617, 1623-24, 50 Cal. Rptr. 2d 224, 227 (1996) ["An insurance company may not *ignore evidence which supports coverage*" or "*just focus on those facts which justify denial* of the claim."].)

2. **Objectively evaluate** the insured's claim (*Hughes v. Blue Cross of No. Calif.*, 215 Cal. App. 3d 832, 845-46, 263 Cal. Rptr. 850 (1989); *Blake v. Aetna Life Ins. Co.*, 99 Cal. App. 3d 901, 924, 160 Cal. Rptr. 528, 541-42 (1979)), and to give at least as much consideration to the insured's interests as it does to its own. (*Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 575, 583, 510 P.2d 1032, 1037-38, 1043, 108 Cal. Rptr. 480, 485-86, 491 (1973).)

3. **Promptly investigate** the insured's claim. In fact, an insurer's delay in investigating a claim constitutes bad faith *even if there is no coverage*. (*Murray v. State Farm Fire and Cas. Co.*, 219 Cal. App. 3d 58, 65, 66 n.5, 268 Cal. Rptr. 33, 37 n.5 (1990).)

4. **Timely respond** to the insured's inquiries and otherwise **communicate** with the insured. (*Delos v. Farmers Ins. Group*, *Inc.*, 93 Cal. App. 3d 642, 664-65, 155 Cal. Rptr. 843, 857-58 (1979).)

5. Refrain from **misrepresenting** what is covered under the policy (*Delos v. Farmers Ins. Group, Inc.*, 93 Cal. App. 3d 642, 664, 155 Cal. Rptr. 843, 857 (1979)), or committing other **fraudulent claims practices** (*Moore v. American United Life Ins. Co.*, 150 Cal. App. 3d 610, 636, 197 Cal. Rptr. 878, 895 (1984).) or "**oppressive conduct** . . . seeking to reduce the amounts legitimately payable" under the policy. (*Love v. Fire Ins. Exch.*, 221 Cal. App. 3d 1136, 1153, 271 Cal. Rptr. 246 (1990).)

6. **Pay benefits** due and owing under the policy. (*Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 573-74, 510 P.2d 1032, 1037, 108 Cal. Rptr. 480, 485 (1973); *Neal v. Farmers Ins. Exch.*, 21 Cal. 3d 910, 920, 582 P.2d 980, 985, 148 Cal. Rptr. 389, 394 (1978); *Christian v. American Home Asur. Co.*, 577 P.2d 899,

904 (Okla. 1978).)

7. **Timely pay benefits** due under the policy. (*McCormick v. Sentinel Life Ins. Co.*, 153 Cal. App. 3d 1030, 1035, 1050-51, 200 Cal. Rptr. 732, 733, 744 (1984); *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 36, 900 P.2d 619, 639, 44 Cal. Rptr. 2d 370, 390 (1995); *Fleming v. Safeco Ins. Co.*, 160 Cal. App. 3d. 31, 37-38, 206 Cal. Rptr. 313, 315-16 (1984); *Dalrymple v. USAA*, 40 Cal. App. 4th 497, 514-15, 46 Cal. Rptr. 2d 845, 854 (1995); *Berry v. United of Omaha*, 719 F.2d 1127, 1128-29 (11th Cir. 1983).)

8. **Fully pay benefits** owed under the policy (*Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 620 P.2d 141, 169 Cal. Rptr. 691 (1979)), particularly that portion of a claim which is **not disputed** by the insurer. (*Neal v. Farmers Ins. Exch.*, 21 Cal. 3d 910, 920-21, 582 P.2d 980, 985-86, 148 Cal. Rptr. 389, 394-95 (1978); *Mission Ins. Group, Inc. v. Merco Constr. Eng'rs*, 147 Cal. App. 3d 1059, 1066-68, 195 Cal. Rptr. 781, 785 (1983).)

9. **Promptly settle** claims where liability has become reasonably clear. (*Pray v. Foremost Ins. Co.*, 767 F.2d 1329, 1330 (9th Cir. 1985) [An insurer has "the duty actively to . . . attempt to settle a claim by making . . .[a] reasonable settlement offer."].)

10. Refrain from making **lowball settlement offers.** (Cal. Code Regs. tit. 10, § 2695.7(g); Cal. Ins. Code § 790.03(h)(5).)

11. Reserve rights only when it has a **good faith belief** in the existence of the rights asserted. (*Fletcher v. Western Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 395, 89 Cal. Rptr. 78, 89 (1970); *Sprague v. Equifax, Inc.*, 166 Cal. App. 3d 1012, 1032, 213 Cal. Rptr. 69, 81-82 (1985).)

12. Institute declaratory relief or other litigation against its insured only where it has a **reasonable** basis for doing so. (*Kelly v. Farmers Ins. Exch.*, 194 Cal. App. 3d 1, 7-10, 239 Cal. Rptr. 259, 261-64 (1987); *Dalrymple v. USAA*, 40 Cal. App. 4th 497, 512-15, 46 Cal. Rptr. 2d 845, 853-54 (1995).)

13. Refrain from imposing **additional preconditions to coverage** beyond those set forth in the policy. (*Mission Ins. Group, Inc. v. Merco Constr. Eng'rs*, 147 Cal. App. 3d 1059, 1066-68, 195 Cal. Rptr. 781, 785-86 (1983).)

C. **HMO's Duty is Non-Delegable:** An HMO cannot delegate the above duties to a physician provider group or utilization review company and avoid responsibility if those duties are breached. For example, an HMO cannot escape liability for a biased investigation or unreasonable denial of benefits on the theory that the investigation was actually conducted by, or the denial was technically issued by, the provider group or utilization reviewer. It is well settled that an HMO's "duty to process claims fairly and in good faith [is] a *non-delegable duty*." (*Hughes v. Blue Cross of No. Calif.*, 215 Cal. App. 3rd 832, 848, 263 Cal. Rptr. 850, 859 (1989).) Therefore, there is no distinction between coverage determinations

made by the HMO and those made by its provider group or other utilization reviewer. As the member's insurer, the HMO is responsible for every decision the utilization reviewer made, just as if the HMO had made that decision itself.

D. **The Knox-Keene Act and Related Regulations:** HMOs in California are governed by the Knox-Keene Act. (Cal. Health & Safety Code §§ 1340 *et seq*.) The Knox-Keene Act and its implementing regulations are replete with standards that must be met by HMOs. Those standards include the following:

1. **Continuity of care and ready referral to other providers:** A health care service plan "shall furnish services in a manner providing *continuity of care* and *ready referral of patients to other providers* at times as may be appropriate and consistent with good professional practice." (Cal. Health & Safety Code §1367(d); *see also* Cal. Code Regs. tit. 28, §1300.67.1.)

2. **Basic health care services:** A health care service plan must provide members with the following "basic health care services": "(1) physician services, including consultation and referral, (2) hospital inpatient services and ambulatory care services, (3) diagnostic laboratory and diagnostic and therapeutic radiologic services, (4) home health services, (5) preventive health services, (6) emergency health care services, including ambulance and ambulance transport services and out-of-area coverage, and (7) hospice care." (Cal. Health & Safety Code §§ 1345(b), 1367(d); *see also* Cal. Code Regs. tit. 28, § 1300.67.)

3. **Quality of care:** A health care service plan must ensure that "medical decisions are rendered by qualified medical providers." (Cal. Health & Safety Code § 1367(g).) Toward that end, a health care service plan must "establish procedures . . . for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs." (Cal. Health & Safety Code § 1370; *see also* Cal. Code Regs. tit. 28, § 1300.70.)

4. **Ready availability and accessibility of services:** A health care service plan must make "[a]ll services . . . readily available at reasonable times to all enrollees" and "[t]o the extent feasible, . . . shall make all services readily accessible to all enrollees." (Cal. Health & Safety Code § 1367(e).) These services include not only basic health care services, but also "*specialized* health care services." (Cal. Code Regs. tit. 28, § 1300.67.2; *see also* Cal. Code Regs. tit. 28, § 1300.51.)

5. **Utilization review standards:** A health care service plan must have "written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees." (Cal. Health & Safety Code § 1367.01(b), (e).)

6. **Emergency care:** A health care service plan "shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition." (Cal. Health & Safety Code § 1371.4.) Moreover, "[p]rior to stabilization of an enrollee's emergency medical condition, . . . a health care service plan shall pay for all medically necessary health care services rendered to an enrollee." (Cal. Code Regs. tit 28, § 1300.71.4.)

7. **Prompt utilization review:** A health care plan's decision to approve, modify, or deny a request for approval of health care services "shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed *five business days* from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination." (Cal. Health & Safety Code § 1367.01(h)(1).) However, when the enrollee faces an imminent and serious threat to his or her health, such decisions "shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed *72 hours* after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination." (Cal. Health & Safety Code § 1367.01(h)(2), (5).)

8. **Communication of utilization review decision:** A health care service plan must communicate its decision to the requesting provider within *24 hours* of the decision. And the enrollee must be notified in writing within *two business days* of the decision. (Cal. Health & Safety Code § 1367.01(h)(3), (4).)

9. **Grievance procedures and independent review:** The Knox-Keene Act sets forth various procedures for challenging the denial, delay or modification of requested health care services. (*See* Cal. Health & Safety Code §§ 1368, 1370.4, 1374.30, 1374.32, 374.34; Cal. Code Regs. tit. 28, § 1300.68.)

10. **Reimbursement of uncontested claims:** A health care service plan that is not an HMO is required to reimburse an uncontested claim, or any uncontested portion of the claim, "as soon as practical, but no later than *30 working days*" after it receives the claim. If the health care service plan is an HMO, it has up to "*45 working days* after receipt of the claim" to pay the uncontested claim (or the uncontested portion thereof). (Cal. Health & Safety Code § 1371.) A leading California treatise warns members' attorneys to "be careful about falling victim to the 'contested claim' excuse for delaying payment" and, similarly, to "be alert to possible sham claim contests asserted by plans to avoid the 30-day payment requirement." (Flahavan, Rea & Kelly, Cal. Practice Guide: Personal Injury (The Rutter Group 2000) ¶ 1:204.2.)

E. **California's Claims Settlement Statute and Regulation:** California has both an unfair claims settlement practices statute (Cal. Ins. Code § 790.03(h)) and a fair claims settlement practices regulation (Cal. Code Regs. tit 10, § 2695.7). Any attorney contemplating litigation against an HMO should be familiar with those provisions, as violations thereof can establish bad faith on the part of an

insurer. In that regard, it is well settled that "violations of . . . section [790.03(h)] may evidence the insurer's breach of duty to its insured under the implied covenant of good faith and fair dealing with its insured." (*Shade Foods, Inc. v. Innovative Prod. Sales & Mkt., Inc.*, 78 Cal. App. 4th 847, 916, 93 Cal. Rptr. 2d 364, 412 (2000).) The duties imposed by this statute and regulation include the following:

1. **Prompt investigation:** California Insurance Code section 790.03(h)(3) requires "*prompt investigation* and *processing of claims*" on the part of insurers.

2. **Prompt communications:** Pursuant to California Insurance Code section 790.03(h)(2), an insurer must "acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies."

3. **Prompt decisions on claims:** California Insurance Code section 790.03(h)(4) requires an insurer to "affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured." (*See also* Cal. Code Regs. tit. 10, § 2695.7(b).)

4. **Prompt settlements:** California Insurance Code section 790.03(h)(5) requires an insurer to "attempt[ ] in good faith to effectuate *prompt*, fair and equitable settlement of [a] claim[ ] in which liability has become reasonably clear." (*See also* Cal. Code Regs. tit. 10, § 2695.7(e).)

5. **Fair settlement offers:** California Insurance Code section 790.03(h)(5) provides that an insurer must "attempt[ ] in good faith to effectuate . . . *fair* and *equitable* settlement of [a] claim[ ] in which liability has become reasonably clear." In addition, "[n]o insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low." (*Id.)*

6. **Prompt settlement of undisputed portion or amount of claim:** Pursuant to Title 10 of the California Code of Regulations, section 2695.7(h), "[u]pon acceptance of the claim . . . every insurer . . . shall immediately, but in no event more than thirty (30) calendar days later, tender payment of the amount of the claim which has been determined and is not disputed by the insurer." (*See also* Cal. Ins. Code § 790.03(h)(12).)

7. **Prompt explanation of denials:** California Insurance Code section 790.03(h)(13) requires an insurer to "provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement." (*See also* Cal. Code Regs. tit. 10, § 2695.7(b)(1).)

8. **No unnecessary investigation:** Pursuant to Title 10 of the California Code of Regulations, section 2695.7(d), "[n]o insurer shall persist in seeking information not reasonably required for or material to the resolution of a claim dispute." (*See also* Cal. Code Regs. tit. 10, §2695.7(n).)

IV. 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 to a successful HMO action and, in the process, preserve your client's right to receive timely, quality health care.