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Joanne B. Stern Whittier College School of Law

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BAD FAITH SUITS: ARE THEY APPLICABLE TO HEALTH MAINTENANCE ORGANIZATIONS?*

JOANNE B. STERN**

I. INTRODUCTION

Over the past several years, a new tort¹ has emerged, one which has been used primarily against insurance companies and which has resulted in claims for an enormous amount of damages—the tort of bad faith breach of contract. At this point, the tort of bad faith breach of contract has not been extended much beyond the insurance industry. It is very likely, however, that in the near future, this tort will also be extended to other industries in the public interest, and particularly to Health Maintenance Organizations (hereinafter referred to as HMOs).²

In every contract there is implied by law a covenant of good faith and fair dealing, a covenant that neither party will do anything to injure the right of the other party to receive the benefits of the contract.³ To the extent that this

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** Professor of Law, Whittier College School of Law; A.B., Brown University, Summa Cum Laude; J.D., Yale Law School.

¹ Case law has held that bad faith breach of contract sounds both in contract and in tort. See Crisci v. Security Ins. Co., 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967). For the purposes of this article, the cause of action will be referred to as a tort due to the potential tort damages which may be recovered. See infra note 3.

² A Health Maintenance Organization (HMO) is an organization which “assumes a contractual responsibility to provide or assure the delivery of health services to a voluntarily enrolled population that pays a fixed premium that is the HMO’s major source of revenue.” Wolinsky, The Performance of Health Maintenance Organizations: An Analytic Review, 58 Milbank Memorial Fund Q. 537, 546 (1980).

covenant is breached, either party can maintain a breach of contract suit against the other, even though there has been no violation of the explicit terms of the contract. Moreover, in the insurance context, many jurisdictions have extended the rights of the aggrieved party and have permitted recovery in tort, as well as in contract. Most significantly, in a tort action for a bad faith breach, the amount of damages potentially available to the plaintiff is far greater than that in a contract action; such damages would include, in addition to foreseeable economic loss, unforeseeable economic loss, emotional distress, and where applicable, the possibility of extensive punitive damages. Thus far, this tort of bad faith breach of contract has been applied primarily to the insurance industry. However, there are several indications that such restriction is not likely to endure.

Although California is in the forefront of jurisdictions defining and permitting this action, many other states have considered and accepted tort claims in bad faith, either through application of statutory (insurance) law or through judicial decisions. For the most part, courts have been willing to intervene and apply this tort in the insurance context in order to encourage bet-


ter treatment of the insured, to penalize unfair insurance practices and to give the insured the benefit of his contractual bargain. To the extent that unfair insurance practices were previously condoned or ignored, the judicial acceptance of this extraneous remedy is designed to produce a heightened consciousness and enlightened interest on the part of insurance companies and consumers, which can be expected to lead, in turn, to a greater concern for the rights and interests of the insured.

II. ANALOGY TO INSURANCE INDUSTRY

The emergence of the tort of bad faith breach of contract is particularly relevant to the HMO situation. Where reimbursement for care obtained outside of the HMO is sought, the HMO acts exactly as an insurer does and would be hard pressed to deny potential liability. Where HMO services are

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* Since the HMO acts in such situations as an insurer, it would likely come within the statutory guidelines with which insurers must conform. For example, section 790.03 of the Insurance Code of California, which outlines the standards by which an insurer's claims activity will be judged, has formed the basis of many claims against HMOs which fail to compensate enrollees on a timely basis. Such provisions include the following:

1. Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

2. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

3. Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

4. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

5. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

6. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

7. Attempting to settle a claim by an insured for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

8. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent, or broker.

9. Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

10. Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

11. Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

12. Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.
unavailable or inadequate, pursuit of a bad faith claim can be used by the enrollee to supplement and expand a traditional malpractice claim.\textsuperscript{10} In the insurance context, a bad faith action generally arises from a failure to pay for health care services; in the HMO context, a bad faith claim can arise as well from the failure to render adequate care. The potential consequences in the latter context are far more extensive and dangerous than the mere failure to reimburse and could lead to substantial additional damage awards against the HMO.\textsuperscript{11}

Although there are no HMO bad faith decisions presently reported in ap-

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\textsuperscript{10} Various situations relating to bad faith refusal of care will not necessarily translate to liability in a malpractice action since many potential claimants have either been diverted to other providers, have discovered and treated their ailments outside the system, or could not have been cured despite early treatment. Thus, while breach of duty or actual causation of injury cannot be proved for the malpractice claim, it is possible that bad faith can be proved. Therefore, a claim for substantial emotional distress may be much more viable as the damage will be perceived to flow from the failure to provide necessary medical care rather than the failure to pay money damages.

\textsuperscript{11} In purchasing insurance, the consumer is essentially entering into a contract by which the insurer assumes particular risks for the insured and promises to pay the insured a specified or ascertainable sum based on the occurrence of a designated contingency. In such cases, the event insured against is the incurring of contractual indebtedness to a provider of medical care for a covered service. Generally, the discretion of the insurer is limited to the determination of whether a claim falls within the scope of coverage under the contract. Other than a very narrow test (i.e., whether reimbursable health care was medically necessary), there is no judgment under the contract as to what health care the insured needs or ought to receive. In the insurance context, the insured can, for the most part, rely on protection from catastrophic financial loss largely as a result of the ability of the insurance company to spread the burden of financing health care among a broad number of people.

In contrast, the HMO arrangement involves a contract for health care services. In exchange for monthly dues, which the subscriber pays or an employer pays on his behalf, the member has peace of mind that he will receive all necessary care within the specified parameters of the contract between the subscriber and the plan. In exchange for such guarantee, the member forfeits his right to go to providers outside the HMO's system. Therefore, in a practical sense the HMO member is contracting to allow the HMO to be his monopoly health care provider.

Unlike insurance benefits, which must be paid on the occurrence of an extrinsic event, HMO benefits can be conferred on a member only when a professional agent of the plan (usually a physician) determines which, if any, health care services are vital to the interest of the member at that time. It is expected by the member that in the exercise of such judgment by the physician, the interest of the patient rather than the costs to the HMO will be the paramount concern of the decision-maker. The plan, on the other hand, has a concurrent duty to its overall membership, and possibly to its investors, to preserve its resources by avoiding the provision of unnecessary and inappropriate services.

Thus, a crucial distinction between insurers and HMOs relates to the consequences that may ensue when either insurance company or the HMO defaults on its obligation. Commonly, the insurer, when defaulting, is refusing to pay for care after it has been rendered, although in given instances, failure to acknowledge coverage may result in withholding of or discontinuance of service. With the HMO, on the other hand, except when it is acting as an indemnifier, a breach or default usually involves the failure to provide the care itself.
pellate cases, the clear applicability of this tort to the HMO industry is difficult to deny. Indeed, HMOs would seem to be peculiarly vulnerable to bad faith claims in that they are the providers as well as the insurers of health care services, and thus their potential for abuse is significantly greater than that of insurance companies.  

A. Rationale for Application of Bad Faith Tort

In the insurance cases, a substantial justification for the application of the bad faith tort derives from the public interest aspect of the industry. The rationale enunciated by the courts for the application of such tort actions to insurance companies are particularly compelling when applied to HMOs. In both industries, the availability of a bad faith tort action is necessary to insure that the consumer, who has very little power vis-a-vis the company, is afforded the benefit of the bargain. For elucidation of the “benefit of the bargain” concept in insurance cases, see Egan v. Mutual of Omaha Ins. Co., 24 Cal. 3d 809, 598 P.2d 452, 157 Cal. Rptr. 482 (1979), cert. denied, 445 U.S. 912 (1980); Delos v. Farmers Ins. Group, Inc., 33 Cal. App. 3d 642, 155 Cal. Rptr. 843 (1979); see generally Summers, “Good Faith” in General Contract Law in the Sales Provisions of the Uniform Commercial Code, 54 Va. L. Rev. 195 (1968).


Moreover, HMOs, like insurance companies, are of quasi-public concern and are imbued with the public interest. They offer a vital service, which is quasi-public in nature, and are subject to substantial government regulation. Indeed, in this regard, HMOs, as providers as well as insurers, are even more highly regulated than insurance companies. Like insurance companies, HMOs are in a fiduciary relationship with the subscriber, a relationship which implies certain expectations of decency and humanity. In both cases, the consumer is purchasing more than financial se-
curity—he is purchasing peace of mind.\textsuperscript{18} In both instances, the bad faith breach of contract would be considered socially repugnant, thus increasing the court's willingness to allow the plaintiff a tort as well as a contract remedy.

Moreover, there are other aspects of the HMO structure which make it especially susceptible to bad faith suits. One in particular is the common arrangement with HMO physicians whereby such providers are offered economic incentives to limit costs and control the utilization of health care services. This may take several forms; in some staff model HMOs, salaried physicians are offered bonuses which are based on their ability to limit costly referrals to specialists and hospitals; at other HMOs, contracting physicians receive a sliding scale percentage of their fee-for-services rates, which is adjusted according to their ability to control costs and utilization. In both instances—and there are many other variations—the primary care providers, who make initial decisions about enrollees' need for additional health care services, receive a direct and tangible benefit from making a negative decision regarding the availability of services. In so doing, they act as agents of the HMO. Such decisions, if they are not made in good faith and if they are tinged with economic motives, could further implicate the HMO in a bad faith situation.

Furthermore, quite a few HMOs have been set up by the physicians themselves and are directed and controlled by such providers. In such instances, the health care providers, who are also managers or investors, have a significant and substantial interest in the economic well-being and survival of the HMO. They do not merely get a bonus for helping to control costs. Instead, they have committed a significant portion of their time, energies and resources to the HMO venture and may have a significant financial stake in its ultimate success. They frequently comprise a majority of the board of directors of the HMO, and in addition to their role as medical providers, they supervise and control the administration of the HMO. It is obvious in such instances that conflicts may often arise with respect to the best interests of the HMO and its economic health, vis-a-vis the best interests of the subscribers and their medical needs. How can an interested doctor, who is also a provider, adequately fulfill his dual obligation to both the company itself and its investors, and to the HMO enrollees he treats? Under such circumstances, every decision which limits the medical care provided to the enrollee is fraught with potential bad faith implications.\textsuperscript{19}

B. Principles and Standards Expressed in Case Law

There are a number of cases in which insurance companies have been held liable which provide, by analogy, examples of potential bad faith claims against


\textsuperscript{19} For a complete discussion of the provider's potential conflicts as a board member, see Stern, \textit{Potential Liability of the Board of Directors of a Health Maintenance Organization}, 3 Whittier L. Rev. 1 (1981).
HMOs. Many factual situations and legal implications in the insurance context replicate situations in the HMO context. The following, then, is a partial list of the conduct and actions of insurance companies which have, in the past, led to bad faith liability against such companies:

1. Unwarranted offset of worker's compensation benefits under an insurance policy;  

2. Refusal to cover an alleged pre-existing condition;  

3. Attempt to escape liability by rescinding the contract due to alleged nondisclosure of information on the insurance application;  

4. Failure to pay a hospital bill in a situation where the treating physician and Hospital Utilization Review Committee had agreed hospitalization was necessary;  

5. Lack of a thorough investigation of the factual basis of action;  

6. Unfair termination or cancellation of policy;  

7. Compelling the insured to resort to litigation to recover policy benefits;  

8. Arbitrary delays in the payment of claims;  

9. Attempting to compel the insured to accept a settlement which is less than the amount of the claim;  

10. Intentionally misconstruing important definitions found within the policy (such as "total disability," "custodial care," "medically necessary");  

11. False or misleading advertisements.

Most of these examples arising in the insurance context are equally relevant in the HMO setting. Moreover, as noted previously, HMOs provide mem-


23 Sarchett v. Blue Shield, Doc. No. EAC-24405 (June, 1982). (This case is currently on appeal from a trial court decision in favor of plaintiffs.)  

24 Egan, 24 Cal. 3d at 819, 598 P.2d at 456, 157 Cal. Rptr. at 490. Such a claim could arise if the HMO refuses reimbursement for emergency care received outside of the HMO setting.  


29 Terms which are undefined or have no clear meaning are particularly suspect. Ambiguous language will be strictly construed against the plan. See Holz Rubber Co. v. American Star Ins., 14 Cal. 3d 45, 533 P.2d 1055, 120 Cal. Rptr. 415 (1975).  

bers with additional services and functions over and above those which are offered by insurance companies. Thus, potential bad faith liability of an HMO is likely to be considerably greater than that of an insurance company. The more extensive the contract with the subscriber, the more extensive the potential grounds for a bad faith claim.

Despite the dearth of appellate decisions, numerous bad faith suits are currently being pursued against HMOs at the trial level. Furthermore, since a substantial number of HMOs have binding arbitration clauses in their subscriber contracts, it is likely that additional claims are being pursued through the arbitration process. In reviewing a number of such cases and discussing bad faith actions with plaintiffs' attorneys, it is apparent that the majority of present claims arise out of the HMO's refusal to reimburse the enrollee for services rendered outside the system. Such suits do not differ significantly from insurance suits wherein requested reimbursement is not forthcoming.

It is important to note that a bad faith action is independent of the specific terms of the contract; thus, the plaintiff's lack of conformity to contractual terms is not theoretically relevant to the pursuit and success of the bad faith claim. Breach of contract by the subscriber does not justify a bad faith

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31 After her speech on this issue, several HMO attorneys specifically approached the author to emphasize that there are "hundreds" of bad faith suits currently pending against HMOs in California alone. See supra note 12, where six attorneys involved in HMO litigation were interviewed for the purposes of this article and all such attorneys noted the proliferation of HMO bad faith suits. Moreover, a review of recent court filings against HMOs in Los Angeles has also confirmed the quantity and extent of potential bad faith suits against HMOs.

32 A typical HMO arbitration clause in a subscriber contract reads as follows:

BINDING ARBITRATION

In the event of any controversy or dispute between interested parties (which term includes the Subscriber Group, a Member, a Dependent, or the heirs-at-law or personal representatives of a Member or Dependent, and Plan, its agents, Plan Providers, or Employees), whether involving a claim in tort, contract, or otherwise, and including disputes which are not adequately resolved by the Plan's grievance procedures shall be submitted to binding arbitration. Such arbitration may be initiated by any interested party, but if the matter in dispute is one which is subject to review under the Plan's grievance procedures, arbitration may not be initiated until the completion of such procedures. All such claims, controversies and disputes shall be submitted to arbitration in accordance with the applicable rules of the American Arbitration Association.

It should be noted, however, that many arbitration provisions have been deemed invalid and have been successfully challenged due to the decision in Davis v. Blue Cross of Northern California, 25 Cal. 3d 418, 600 P.2d 1080, 158 Cal. Rptr. 828 (1979), which held that Blue Cross, by failing to advise its insureds of the availability of, and the procedures for initiating, arbitration, and, as a consequence, waived any right to subsequently compel its insured to resort to arbitration. However, arbitration clauses similar to this have been generally upheld in California, particularly with respect to HMOs. See, e.g., Beynon v. Garden Grove Medical Group, 100 Cal. App. 3d 669, 161 Cal. Rptr. 146 (1980); Madden v. Kaiser Foundation Hospitals, 17 Cal. 3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976); Doyle v. Giuliani, 62 Cal. 2d 606, 401 P.2d 1, 43 Cal. Rptr. 697 (1965).

33 A prominent Los Angeles area plaintiff's attorney has said that "[m]ost of the [bad faith] claims [against HMOs] have been regarding indemnification where the plan... refused to pay the claim because the member did not go to one of their facilities.” (Interview with plaintiff's attorney, June 30, 1982, at Los Angeles, California.)

34 See Gruenberg v. Aetna Ins. Co., 9 Cal. 3d 566, 579, 510 P.2d 1032, 1040, 108 Cal. Rptr. 480, 488 (1973). Also, as stated by an HMO attorney: "Bad faith law tends to treat a bad faith action in tort as independent of the specific terms of the HMO contract.” (Interview with attorney for Plan
breach by the insurer or HMO. Thus, for example, if an enrollee fails to give timely notice to the HMO of an emergency hospitalization, as is required by the contract, this breach on the part of the subscriber may not justify an HMO’s bad faith refusal to pay for such claim. The bad faith tort claim, based as it is on extra-contractual considerations, is not related to the enrollee’s adherence to the specific terms of the contract.

The standard of care to be used by the HMO in evaluating claims can be inferred from those set forth by the courts in the various insurance cases. In general, the HMO, in its role as “fiduciary,” must act in “utmost good faith” and must afford the interests of the subscriber “at least as much consideration” as it gives its own interests. The HMO is required to investigate all claims in an “appropriate, thorough and careful manner,” to bring all relevant information to the attention of the insured, and to refrain from unreasonably delaying, upholding or evading payment. The HMO is precluded from doing anything which would “deprive the insured of the benefits of the policy.”

C. Potential Damages.

Failure to adhere to the foregoing principles could expose the HMO to substantial liability. Indeed, in the insurance industry, where the requisite state of mind has been shown, there have been awards of several million dollars in a single case. Since this action sounds in tort, three types of damages are generally allowed:

1. Foreseeable and unforeseeable economic loss, including bankruptcy;
2. Emotional distress and mental suffering, including the trauma of litigation; and
3. Punitive damages, based on proof of oppression, fraud or malice, including ill will as well as conscious disregard.

B, July 13, 1982, at Los Angeles, California.)

The covenant of good faith and fair dealing has been described as bilateral and independent. See Egan, 24 Cal. 3d at 817-18, 598 P.2d at 455-56, 157 Cal. Rptr. at 485-86.

This is especially true if the notification requirement can be shown to be perfunctory or pro forma. If, upon receipt of notice, the HMO would have authorized the emergency services, then the HMO will be hard pressed to show prejudice or damage caused by the lack of notice.


In assessing the amount of punitive damages to be awarded, juries are usually instructed that
It is clear that the total sum of such damages is likely to exceed substantially the overall damages generally available in a traditional breach of contract action as well as in a traditional malpractice action.45

Although bad faith claims can clearly arise in the reimbursement context, i.e., where the HMO acts as insurer, the HMO is particularly vulnerable to such actions when it fails in its role as a provider. In many instances, the subscriber who has received inadequate care will not have suffered the damages necessary to support a malpractice action against the HMO. When the HMO system does not work for an enrollee, the primary harm suffered may be emotional distress. Moreover, to the extent that a plaintiff can show concerted, purposeful actions or policies contributing to his delays, frustrations, and inability to receive adequate care from within the system, punitive damages may also be available.44 Thus, a bad faith action may supplement or supplant a malpractice claim against the HMO.45

III. APPLICATION OF BAD FAITH CLAIMS TO HMO CONTEXT

A. Types of Claims

Potential bad faith claims against HMOs may arise in a wide variety of contexts. Whenever an HMO’s decision in a given case is influenced by internal economic considerations, the “utmost good faith” standard applicable to the insurance industry will be called into question.46 In such a case, a question will

the wealth of the defendant is one significant factor to be considered. See Egan, 24 Cal. 3d at 824, 598 P.2d at 460, 157 Cal. Rptr. at 490. Federally qualified HMOs have traditionally been incorporated as not-for-profit entities. Therefore, one might expect the amount of a punitive damages award to be significantly less than those awarded against a for-profit entity. However, as some HMOs have recently converted to a for-profit status, they can expect to lose any “not-for-profit protection” against a sizable punitive damages award. See Stern, The Conversion of Health Maintenance Organizations From Nonprofit To For Profit Status, 26 St. Louis U.L.J. 711 (1982).

44 Punitive damages, when assessed, have generally been required to bear some reasonable relation to the amount of actual and general damages awarded. However, the parameters of this requirement have not been defined by the courts.

45 It should also be noted that a suit in intentional infliction of emotional distress (IIED) may be successfully maintained under these circumstances. Even without physical injuries, an enrollee may sue in this tort if the HMO acts recklessly, its conduct is sufficiently “extreme and outrageous,” and the resultant distress is “severe.” See RESTATEMENT (SECOND) OF TORTS § 46 (1965). Moreover, the “severe” and “outrageous” elements may be found much more easily in such cases given the vulnerable condition of the “sick” patient and the fiduciary nature of the relationship between the HMO and enrollee. See, e.g., Rockhill v. Pollard, 259 Or. 54, 485 P.2d 28 (1971). Since this is an intentional tort and the specific elements of a negligence case do not apply, expert testimony may not be necessary; causation may be inferred more readily, the statute of limitations is likely to be longer, and punitive damages may be awarded. Indeed, many bad faith suits would also include allegations of intentional infliction of emotional distress. See also, DeCicco v. Trinidad Area Health Ass’n, 40 Colo. App. 63, 573 P.2d 559 (1977); Johnson v. Womans Hospital, 527 S.W.2d 133 (Tenn. 1975); Grimsby v. Sampson, 85 Wash. 2d 52, 530 P.2d 291 (1975).

46 In the HMO context, the HMO and its member physicians have an economic interest in the rendition of care. The more care that is rendered, the more money is spent (measured in time, supplies or actual dollars). It may be that undue influence or economic considerations will always be inferred if the plaintiff claims that the HMO refused to render care. Therefore, the burden of disproving that economics was an overriding or improper concern may always fall upon the HMO.
arise as to whether the subscriber's interests have been given "at least as much
c consideration" as the interests of the HMO. This issue may well come up in
situations where there is a refusal to refer to a specialist, a reluctance to hospi-
talize, a refusal to order "expensive" tests, the unavailability of specific equip-
ment, lengthy delays in getting appointments, or limitations on tests and ex-
aminations.47 If any of the foregoing conduct is primarily motivated by
financial considerations, and proof of such motive is available to the plaintiff,48
such plaintiff would be foolish not to allege bad faith breach of contract. The
HMO contract provides for the delivery, as well as for the reimbursement of
health care services, and whenever that delivery is thwarted by explicit policies
and improper motives, the good faith covenant implied by law would seem to
be violated.

A few examples might be instructive at this point. Let us say that a pa-
tient goes to an HMO with a complaint that she is suffering from continual
gastric disturbances. She is examined on a perfunctory basis and no evidence
of any obvious problem is found and she is sent home. The same problem and
situation occur again, and she is told that she is probably "swallowing too
much air" due to psychological problems, but there is nothing organically
wrong. Finally, after several months and several more visits, additional internal
tests are given, tests that were not previously given due to their considerable
expense and an inoperable tumor is found.

If the HMO failed to administer the tests initially due to the considerable
expense involved, a case of bad faith may well arise. Even though many pa-
tients with gastric disturbances do not have severe, organic problems (on a
cost-benefit basis obviating the advisability of regularly administering such
costly internal tests), would not this patient have, in fact, benefited from the
early administration of such tests? And, if there is a general "economic" policy
by the HMO not to provide internal tests on initial visits for gastric com-
plaints, would not an HMO enrollee injured by such policy have a legitimate
bad faith claim? Although "all medical care" may be provided by the HMO,
does not the HMO decide, on the basis of its economic situation, what "all
medical care" means?

47 Indeed, these are the "typical complaints" consumers have against HMOs, particularly
those consumers who are accustomed to get whatever services they have requested from their pro-
viders. For example, one new enrollee in Plan A was particularly enraged when after a fall on her
knee and a request made to her HMO primary care physician to see an orthopedist, such referral
was categorically refused as being "unnecessary and uneconomical." It should be noted that many
HMO providers are "at risk" and thus have a significant economic stake in the limited referral
system.

48 Proof of motive may be available from several sources, including disillusioned providers and
disgruntled employees. Indeed, the latter have, in the past, been the source of some very damaging
evidence against insurance companies.

The corporate attorney for Plan B has stated:

There is always a lot of clout behind a lawsuit alleging a concerted effort not to treat
and it probably occurs more than you would think. Of course, there is always an eco-
nomic advantage to the HMO to withhold treatment but it may be difficult to prove to
the court that this has been a primary motivation of the HMO.

(Interview with Plan B attorney on July 13, 1982, at Los Angeles, California).
Another potential problem in this regard could result from a refusal to maintain life-support systems or provide life-sustaining services for an enrollee who has only a minimal chance of survival. Continuous operation of certain life-support equipment, such as respirators and resuscitators, is extremely costly and, on a risk-utility basis, is probably not economically justifiable in the case of any enrollees who have only a small chance of survival. But who is to make this judgment? And on what basis? And what if survival is likely, but due to the enrollee's injuries or condition, the quality of life would be severely jeopardized? Does an HMO, which is duly concerned by the economic consequences of the continuing utilization of life-support equipment, have the right to make a decision to "pull the plug" or withhold nutritional sustenance on behalf of the comatose patient? And even if the enrollee's family is consulted for such decision, how much pressure to terminate life-sustaining services will and can be ethically applied? How much will the HMO's pessimism, induced by its undisclosed economic outlook as well as by its disclosed medical outlook, unduly influence the advisory opinions given to such relatives and the ultimate decisions made by them?

An alarming variation of the foregoing situation has recently occurred in California, and charges of murder have been alleged against the treating physicians. Again, a disgruntled HMO employee, a nurse, has provided the basis for these charges. Clearly, in all but the most hopeless cases, the withholding of extraordinary, life-sustaining services may be economically supportable for the system as a whole, but will frequently be at variance with the best interests of the individual patient.

Many other aspects of the HMO contract could also lead to bad faith actions. The interpretation of ambiguous terms and definitions, lack of clarity in limitations and exclusions, coverage and eligibility misconceptions, misapplication of coordination of benefits clauses—all such contractual provisions, when applied against the subscriber's interest, may give rise to bad faith claims. Thus, disputes as to whether a particular condition was "pre-existing," and therefore not covered, may ultimately lead to bad faith allegations. Ambiguous provisions relating to such matters as the dates of eligibility and the coverage of dependents may lead to bad faith suits, especially if the HMO's adverse determination on these matters is coupled with its concomitant awareness of significant additional expenses if a decision is made in the enrollee's favor.

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49 See Kirsch, A Death At Kaiser Hospital: Mercy or Murder, California Mag. 78 (Nov. 1982); Prosecutors Sketch Case Against 2 MDs, L.A. Times (Jan. 27, 1983). Did the Patient Die—Or Was He Murdered? Newsweek, 76 (Feb. 14, 1983).

50 "Pre-existing" conditions are generally defined as conditions which existed prior to enrolling in the HMO and for which treatment has been sought within a certain period of time prior to enrollment. On hindsight, an HMO may easily argue that many, if not most, "conditions" (as opposed to illnesses or injuries) pre-existed the patient's enrollment in the HMO.

A typical clause reads as follows:

"Pre-Existing Condition" means a condition existing at the time a Member begins a period of continuous coverage under the Group Subscriber Agreement. It includes all conditions for which the Member has sought or received medical care, advice, or treatment from any source whatsoever prior to enrolling in the Plan.

Similarly, certain limitations and exclusions are subject to varying interpretations. What, for example, is the meaning of a "self-inflicted" injury, a "nervous disorder," and "experimental procedure?" Many exclusions and limitations are extremely ambiguous. Consider the following list from a California plan:

**EXCLUSIONS**

1. Payment for treatment provided for illness or an injury to the extent of which an employer is required by law to furnish care in whole or including, but not limited to, State or Federal Workmen's Compensation Laws and Occupational Disease Laws and other employer liability laws.
2. Any illness or an injury for which care is furnished without charge by a governmental body or agency.
3. Rest or custodial care; blood and blood plasma; personal comfort or convenience items.
4. Eyeglasses or contact lenses except for one pair of glasses or contact lenses following a cataract operation.
5. Provision or replacement of durable medical equipment, or prosthetic appliances or devices.
6. Services of nurses on private duty assignments except when ordered by a Plan Physician and approved by the Plan.
7. Cosmetic surgery, except when performed to correct a condition resulting from an accident occurring while covered. Surgical procedures for the treatment of obesity or for changing gender identity are not provided.
8. Dental care or dental x-rays, except as specifically defined in the Benefit Schedule.
9. Physical examinations required for obtaining or continuing employment or governmental licenses.
10. Experimental medical, surgical or other experimental health care procedures.
11. Services to reverse voluntary or surgically induced infertility.
12. Podiatric services and services of a podiatrist or chiropodist.
13. Care or treatment for, or any expenses resulting from, intentional self-inflicted injury.
14. Any charges for professional services rendered by a person who ordinarily resides in your household or who is the spouse, parent, child, brother or sister of you or your dependents.

**LIMITATIONS**

1. In the event of any major disaster or epidemic, Plan Providers shall render or attempt to arrange covered services insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but neither Plan nor Plan Providers has any liability or obligation for delay or failure to provide any such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.
2. If due to circumstances not reasonably within the control of the Plan, such as war, riot, complete or partial destruction of facilities, civil insurrection, labor disputes, disability of a significant part of Plan Providers' personnel, or similar causes, the rendition of services covered hereunder is delayed or rendered impractical, neither Plan nor Plan Providers has any liability or obligation on account of such delay or such failure to provide services.
3. In the event that any Member, for personal reasons, refuses to accept treatment or procedures recommended by Plan Providers, Providers may regard such refusal as incompatible with continuing a satisfactory physician-patient relationship and obstructing the provision of satisfactory medical care. Plan Providers will use their best efforts to render necessary and appropriate professional services in a manner compatible with the Member's desires, insofar as it can be done consistently with the Plan Provider's judgment regarding proper medical practice. If the Member refuses to follow a
to be inconsistent and make its decisions based on the economic merits of a particular case without exposing itself to bad faith liability.

Another example of potential bad faith arises with respect to the application and implementation of coordination of benefit clauses. What, for example, is likely to result if a subscriber is covered by two HMOs, or one HMO and one insurance company, but the coordination of benefits clauses in both policies designate the HMO as the secondary carrier under the circumstances that have arisen. If neither entity will provide for or absorb the cost of care, would they not both be subject to bad faith actions? And even if we assume that the two carriers are prepared to negotiate and will eventually work it out, how long must the enrollee wait before excessive delay gives rise to a bad faith action?

4. Organ transplants are limited to kidney transplants, where the Member is the recipient of such a transplant, and coverage is provided only to the extent specified in the Benefit Schedule. Neither Plan nor Plan Providers shall be obligated to furnish or arrange for a kidney donor for any Member. Expenses incurred by donor are not covered.

5. Treatment for alcoholism is limited to three days of inpatient care for detoxification.

6. Treatment for mental conditions is limited to three days of inpatient care.

7. Treatment for drug-induced conditions caused by a drug or drugs is limited to three days of inpatient care for detoxification.

52 Coordination of benefits clauses relate to the payment for and provision of services to enrollees who are entitled to coverage under more than one plan or company. Provisions for coordination of benefits are often statutory. See, e.g., CAL. ADMIN. CODE Tit. 10, § 2232.51. Similar problems may arise where HMOs refuse coverage for services available under workers' compensation, veterans benefits, and government health programs. A typical coordination of benefits clause reads:

COORDINATION OF BENEFITS

If any benefits to which a Member is entitled under this Agreement are also covered under any other health benefit plan or insurance policy, the payable benefits hereunder shall be reduced to the extent that benefits are available to Member under such other plan or policy whether or not a claim is made for the same.

The rules establishing the order of benefit determination between the Agreement and any other plan covering the Member on whose behalf a claim is made are as follows:

a. The benefits of a plan which does not have a coordination of benefits provision with other health plans shall in all cases be determined before the benefits of this Agreement.

b. For those plans which have applicable coordination of benefits clauses, the following rules shall apply:

1) the benefits of the plan which covers such Member other than as a dependent will be determined before the benefits of the plan which covers such Member as a dependent;

2) the benefits of the plan which covers such Member as a dependent of a male person will be determined before the benefits of a plan which covers such Member as a dependent of a female person;

3) when neither of the foregoing establish an order of benefit determination, the benefits of the plan which has covered such Member for the longer period of time will be determined first.

Such a situation would be analogous to the coverage dispute in Silberg v. California Life

https://researchrepository.wvu.edu/wvlr/vol85/iss5/6
The application and interpretation of termination provisions can also present liability problems for the HMO. Among the grounds for subscriber termination, many HMOs include the following: (1) the breakdown in physician-patient relationship; (2) the failure of the patient to furnish adequate information; and (3) the refusal of the subscriber to follow a recommended course of treatment. All of these grounds are subject to potential abuse by the HMO. Consider, for example, an HMO's termination of a problem drinker because he allegedly refuses to give up alcohol and is thus unwilling to follow a prescribed course of treatment. The propriety of such cancellation is highly questionable even though it is technically permissible. If such termination is motivated primarily by concern over the excessive cost of the continuous treatment of an alcoholic, a possibility of bad faith arises. Similarly, who is to say what constitutes a breakdown in a physician-patient relationship or the furnishing of information so inadequate as to justify termination? Any termination which has been immediately preceded by the discovery or diagnosis of a new and expensive condition or disease would seem particularly suspicious.

Another fertile source of potential bad faith suits pertains to the furnishing to subscribers of misleading or deceptive information about the HMO's benefits and coverage. One way this may arise, which is analogous to insurance cases, is through media advertising about the company. Thus, certain insurance cases have pointed to the consumer's misplaced reliance on company slogans and advertisements promising security ("a piece of the rock"), partiality and concern ("we're on your side"), and peace of mind ("you're in good hands"). When the "good hands" drop you arbitrarily or you discover that "your side" consistently is not their side, this may lead to a tort action based on breach of the good faith covenant, as well as on fraud and misrepresentation. Similarly, many HMOs have now begun to utilize mass media advertisements which include catchy slogans and firm assurances about the outstanding

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*Ins. Co.,* 11 Cal. 3d 452, 521 P.2d 1103, 113 Cal. Rptr. 711 (1974), which gave rise to a substantial damages award.

*An in-house HMO attorney specifically indicated to the author that decisions about the alcoholic enrollee is one of the major problems facing the HMO: the expense of treatment is enormous; the physical problems of the alcoholic as well as the need for continuous emergency detoxifications require ongoing medical care. And yet, how can you terminate someone who does not follow medical advice to terminate drinking when the very nature of the disease of alcoholism is the inability to cease ingestion of alcohol?*

*A recent bad faith case arising in Illinois involves the cancellation of an HMO policy of a terminally ill enrollee due to his failure to affirmatively seek conversion to individual membership following cancellation of the group policy. Although the termination was allegedly based on the enrollee's failure to comply with the specific terms of the contract relating to conversion, such breach by the enrollee would not necessarily insulate the HMO from liability based on breach of the good faith covenant.*

In California, such wrongful termination is less likely to occur. By statute, totally disabled members are entitled to a continuation of all benefits of the agreement for up to twelve months following termination of the disabling condition. Therefore, the HMO would be obligated to continue to treat the terminally ill patient without receiving a premium or monthly capitation. *See Cal. Ins. Code § 10128.2(d) (Deering Supp. 1983).*

benefits, simplicity, ease and reliability of their systems. HMOs have promised to “cut out the aggravation of health insurance”; to “bring health care costs back down to earth”; to “provide the maximum care possible”; to “pay 100 percent of all bills”; to “never cut corners on health care”; and to “eliminate all co-insurance and deductibles.” As in insurance, where a fiduciary relationship exists and a vital public service is involved, it is not likely that misleading ads and untrue statements upon which the consumer has relied will be dismissed as mere puffery, but are likely instead to form the basis of contractual actions and, where the facts are sufficiently outrageous, also the basis for tort suits in bad faith.

Misleading representations and false promises may also be made to individual subscribers in order to induce them to enroll in the HMO. Advertising brochures and disclosure forms disseminated to potential subscribers may not always disclose the full picture: benefits may be highlighted while exclusions and limitations are minimized or omitted altogether. The brochure may be confusing and incomprehensible to the lay person, and the definitions of various terms may be purposely unclear. In such cases, where full disclosure is not made to potential enrollees, the HMO cannot subsequently add new terms, consistently interpret ambiguous provisions in its favor, or disavow the marketing materials upon which the enrollee has relied, without risking bad faith suits.

Finally, an HMO involved in the enrollment and servicing of employee groups faces the lingering, hidden problems associated with errors in enrollment and the failure to enroll. Often, various administrative responsibilities are delegated by such HMOs to the employer. These may include distribution of plan literature, completion and submission of enrollment forms, and collection of premiums from employees. Errors may occur in any of these functions: A completed enrollment card may not be forwarded to the HMO; request for addition of a dependent, such as a new spouse, may be ignored; collected premiums may not be transmitted to the HMO; or literature describing proper use

67 These advertisements have been prevalent in California and are generally carried by TV and radio as well as in the print media. The quotes noted herein represent slogans of various HMOs which have been effectively and slickly presented on TV, particularly during “open enrollment” periods and immediately prior to contract expiration dates.

68 Disclosure forms are strictly regulated in California and many other states in order to insure that this does not occur. Nevertheless, the time period between utilization of a misleading (unapproved) form and state enforcement relating thereto is sufficiently lengthy so as to abate the likelihood of meaningful action to eliminate such abusive practices. See transcript of KNXT Channel 2 News, Exposé on Group Health Care Plans, August 30-31, 1982.

Moreover, oral representations by marketing representatives of various plans are particularly difficult to regulate. In California, for example, anyone can sell a plan: no registration or exam is necessary. Thus, in the past, tremendous abuses have occurred, particularly where HMO agents have been paid on a commission based upon the number of individuals enrolled in the plan. In such cases, solicitors are “motivated” to promise far more than what is available from the HMO. Indeed, some have promised everything from free fried chicken dinners every Friday night to a referendum advocating the removal of “Governor Reagan.” See Schneider and Stern, Health Maintenance Organizations and the Poor: Problems and Prospects, 70 NW. L. REV. 90 (1978). See also, CAL. HEALTH & SAFETY CODE 1363 (West 1979); CAL. ADMIN. CODE, tit. 10, R. 1300-89 (1979).
of the plan may not be disseminated by the employer. If any of these occur, the result may be refusal to render care or refusal to reimburse for expenses incurred, and such refusal may give rise to a bad faith claim against the HMO. It is clear in many jurisdictions that, notwithstanding the HMO's lack of actual knowledge of such errors or omissions, the HMO can be held responsible and damages may be awarded against it.\(^{59}\)

**B. Need for Balancing Test**

In all potential cases of bad faith, a central issue will revolve around the extent to which medical decisions have been influenced by economic considerations. Whenever economic motives apparently take precedence over medical values, the HMO exposes itself to bad faith litigation. Nevertheless, the irony of this situation cannot be overlooked. In order to remain viable and solvent, an HMO must have a system of utilization review which stresses fiscal control and provider restraint as well as quality of care. In order to achieve financial health and economic stability, an HMO must have the authority to allocate its resources in a rational manner, to limit the discretion of medical providers, and to consider seriously in its ultimate decision the economic consequences of its policies and actions. Although the HMO may be regarded as a fiduciary, it cannot always place the intangible, subjective interests of the individual consumer above its own sustaining interests (and the interests of the system as a whole) and still survive and flourish.

Thus, it would seem that in guarding against the possibility of bad faith claims, a balancing test must be applied. It should be noted that the concept of a balancing test is not completely unique. The case law specifically recommends balancing in several areas, such as weighing the interests of the member against those of the plan and utilizing reasonableness as a standard for determining when liability becomes clear.\(^{60}\) However, given the unusual nature of an HMO as noted above, balancing becomes more critical. While it is reasonable for an HMO to develop systems and procedures to avoid unnecessary financial expenditures, specific cases should not be decided primarily on this basis. Rather a utilization review system should be based on a consideration of both medical and economic interests and then should be applied in a nondiscriminatory, rational and "good faith" manner. In addition, lines of communication between the HMO and the enrollees should remain open at all times. Policies and decisions should be disclosed on a timely basis to affected subscribers, and such enrollees should be given every opportunity to be heard.\(^{61}\) All decisions

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\(^{59}\) The employer is deemed to be the agent of the plan in undertaking these responsibilities. Therefore, the employer's errors in administering these responsibilities are attributable to the plan. See Norby v. Bankers Life Co., 231 N.W.2d 665 (Minn. 1975); Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 63 Cal. Rptr. 35 (1967). However, in California the insurer can avoid imposition of the agency relationship by clearly stating in the master agreement with the employer that the employer is the agent of the employee. Cal. Ins. Code § 10209 (Deering 1977).

\(^{60}\) See Egan and Silberg.

\(^{61}\) Thus, the development and documentation of enrollee grievance procedures is essential in order to institutionalize a consumer input system and to prove responsiveness to the enrollee point of view.
relating to such matters, as well as the rationale behind them, should be well considered and well documented.

In every case, the HMO must endeavor to preclude and refute any inferences that improper motives have clouded its judgment or unfairly influenced a result which appears contrary to the interests of the enrollee. Whenever financial considerations can be shown to prevail over medical decisions, whether by implication or by explicit policy, the potential for a bad faith suit looms large.

IV. Conclusion

Although the tort of bad faith breach of contract has not yet been applied to the HMO industry, the rationale behind its application to the insurance industry strongly suggests that it is just a matter of time before its application to HMOs is judicially acknowledged. After all, the HMO is a provider as well as an insurer, thus creating the potential for significant abuse. The fewer services provided by the HMO, the more money the HMO retains; from an economic standpoint, the incentive not to provide care is considerably greater than the incentive to provide care. The principal way to ensure that the equation is balanced and that the enrollee gains the “benefit of the bargain” is to expose the HMO to the possibility of expensive bad faith suits.

In a recent article, Dr. Edward Zalta, past president of the Los Angeles County Medical Association, discussed the impact of the million dollar insurance bad faith cases on the health care industry and concluded by stating: “Denial of claims by insurers is measured in dollars. Denial of care by HMOs . . . is measured in lives . . . [If such bad faith suits are successful], the impact on the HMO movement will be more profound than any legislation conceived . . . to prevent the recurring nightmare of the early 1970s.”62 Surely, the realization of this possibility should lead to greater concern and awareness on the part of the HMO industry so as to avoid the spectre of bad faith litigation which has beleaguered the insurance industry, and, at the same time, has contributed to making it considerably more responsive to the needs and interests of the consumer.

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