Individual Health Insurance Lawsuits and Bad Faith

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I. The Importance of the Governing’s State’s Bad-Faith Standard

Whether an insurer may be held liable for bad faith stemming from an individual health insurance policy often turns on the jurisdiction’s standard for determining bad faith. For example, in Oulds v. Principal Mut. Life Ins. Co., 6 F.3d 1431 (10th Cir. 1993), the Tenth Circuit explained that, under Oklahoma law, bad faith occurs “only where there is a clear showing that the insurer unreasonably, and in bad faith, withholds payment of the claim of its insured.” Id. at 1436. In other words, the “insured must present evidence from which a reasonable jury could conclude that the insurer did not have a reasonable good faith belief for withholding payment of the insured’s claim.” Id.

Similarly, other jurisdictions apply the reasonable basis test to bad faith claims and hold that an insurer breaches its duty of good faith and fair dealing if it “has no reasonable basis for denying or delaying payment of a claim.” Henry v. Mut. of Omaha Ins. Co., 503 F.3d 425, 429 (5th Cir. 2007)(applying Texas law). Thus, if the insurer has any reasonable basis for the coverage denial, it will not be liable for bad faith. Id.

In order to state a bad faith cause of action under Pennsylvania law, the insured must prove, by clear and convincing evidence, “that the insurer: (1) did not have a reasonable basis for denying benefits under the policy; and (2) knew or recklessly disregarded its lack of a reasonable basis in denying the claim.” Muckelman v. Companion Life Ins. Co., 4:13-CV-00663, 2014 WL 957425, at *3 (M.D. Pa. Mar. 12, 2014). Negligence or bad judgment does not constitute bad faith under Pennsylvania law, and the insurer’s conduct must “import a dishonest purpose.” Id. at *4.

In California, however, it is not necessary to prove that the insurer’s conduct was dishonest. Carma Developers (Cal.), Inc. v. Marathon Dev. California, Inc., 2 Cal. 4th 342, 373, 826 P.2d 710, 727 (1992); see also Bosetti v. U.S. Life Ins. Co. in City of New York, 96 Cal. Rptr. 3d 744, 769 (Ct. App. 2009) (“[t]he ultimate test of [bad faith] liability in ... first party [insurance] cases is whether the refusal to pay policy benefits was unreasonable ... In other words, an insured plaintiff need only show, for example, that the insurer unreasonably refused to pay benefits or failed to accept a reasonable settlement offer; there is no requirement to establish subjective bad faith.”) (internal citations omitted; emphasis in original).

Under Florida law, the standard for evaluating a bad faith claim is whether, under the totality of the circumstances, the insurer acted fairly and honestly toward its insured with due regard for the insured’s interest. State Farm Mut. Auto. Ins. Co. v. Laforet, 658 So.2d 55 (Fla. 1995); see also Hogan v. Provident Life & Acc. Ins. Co., 665 F. Supp. 2d 1273, 1281 (M.D. Fla. 2009).

Accordingly, conduct that constitutes bad faith in one jurisdiction may not constitute bad faith in a different jurisdiction. However, health insurance bad faith cases from across the country reflect similar claims handling issues that give rise to bad faith lawsuits. Insurers should evaluate their internal policies and training to avoid these recurring issues, and defense counsel should be aware of these potential issues – particularly when preparing the insurer’s employees for deposition.

A health insurance bad faith claim often stems from the insurer’s alleged failure to conduct a proper claim investigation before denying the claim. Although what constitutes “proper” claim handling often depends on the specifics of the claim, the cases discussed below reflect typical ways that bad faith claims may arise.
II. Delays in Claim and Appeal Decisions, Failing to Keep the Insured Advised, and Failing to Conduct a Thorough Investigation

The Ohio Supreme Court’s opinion in Dardinger v. Anthem Blue Cross & Blue Shield, 781 NE2d 121 (Ohio 2002) underscores the importance of expeditious claims handling and the need to conduct a thorough investigation. The Ohio Supreme Court’s opinion reads like a tragic novel and reflects the jury appeal that health insurance bad faith cases may present. In Dardinger, the jury awarded the estate $1,350 for breach of contract, $2.5 million on the bad faith claim, and $49 million in punitive damages. In October 1996, Esther Dardinger was diagnosed with brain cancer that had spread from her breast. Esther underwent chemotherapy, which stabilized, but did not shrink the tumors. In March 1997, Esther’s neuro-oncologist, who was the director of neuro-oncology at the James Cancer Hospital and Solove Research Institute at the Ohio State University (“OSU”), recommended that Esther begin intra-arterial chemotherapy1 in order to shrink the brain tumors. The neuro-oncology tumor board at OSU agreed with this treatment recommendation.

During April through June 1997, Esther underwent three intra-arterial chemotherapy treatments, which significantly shrunk her brain tumors and alleviated her pain and symptoms. The health insurer approved the first three treatments of a 12-treatment program, and Esther was scheduled for a fourth treatment on June 30 and July 1, 1997. However, despite its approval of the first three treatments, the insurer refused to approve additional treatments. As described in the opinion, the following occurred during the insurer’s claim investigation:

- The insurer blamed its local medical director for mistakenly approving the first three treatments. Before approving the treatments, the medical director sought an opinion from a board-certified oncologist, but the consultant oncologist was out of town at the time. The medical director exercised his own authority to approve the medical treatments pending the consultant oncologist’s review. However, throughout the claim and the appeal, the insurer did not consult with a neuro-oncologist, which was the medical specialty at issue. This undermined the insurer’s argument that the intra-arterial chemotherapy treatment was experimental.
- The consultant oncologist spent only ten minutes reviewing Esther’s claim before denying it as an experimental treatment. However, this same consultant oncologist had approved intra-arterial chemotherapy for other patients treating at OSU “just before” his denial of Esther’s treatment.
- During the course of the claim and litigation, the insurer changed its reasoning for denying the intra-arterial chemotherapy.
- Several weeks after denying the claim, the insurer’s representative informed Esther and her doctor that intra-arterial chemotherapy was re-approved. Then, two weeks later, the insurer recanted this approval claiming that this re-approval was made in error.
- Esther and her doctor requested that Anthem reconsider its denial on approximately July 2, 1997, and a formal appeal was submitted to the insurer on August 5, 1997. However, Anthem did not deny the appeal until after Esther’s death. The OSU doctor that treated Esther opined that intra-arterial chemotherapy could have prolonged Esther’s life by eight months to two years. The court faulted the insurer’s appeal process, noting:
- Anthem mistakenly closed the appeal on August 28 due to lack of records, but the Anthem representative did not request the records. This significantly delayed the appeal.
• During the litigation, Anthem claimed that Esther’s appeal paperwork requesting approval for brain cancer treatment “said nothing about urgency,” and that Anthem had 120 days under the contract to resolve appeals.

• Certain Anthem employees circulated internal emails requesting that the appeal be expedited due to the nature of the claim, but these “[w]ell-meaning individuals could do nothing to overcome the bureaucracy.” One employee wrote: “I am darn near speechless on how this appeal has been handled by the other area (and we all know it is hard to get me to be speechless) … the urgency of the appeal has been lost in Anthem’s red tape and that is a sad and embarrassing situation for Anthem.”

• Anthem did not supply its reviewing doctor with complete medical records or the treatment protocols from Esther’s doctor. The doctor reviewing the appeal spent less than 30 minutes reviewing the appeal before denying it.

While the Ohio Supreme Court reduced the punitive damages award from $49 million to $30 million, the court determined that “the jury could easily find that a pervasive corporate attitude existed with the defendant to place profit over patients and that the defendants disregarded the right of their insured[s] in an effort to obtain higher profits.”

The need for an insurer’s prompt claim decision also is reflected in the court’s denial of an insurer’s motion to dismiss the insured’s bad faith claim in *Muckelman v. Companion Life Ins. Co.*, 4:13-CV-00663, 2014 WL 957425 (M.D. Pa. Mar. 12, 2014). The insured requested approval for two bone marrow transplants. While the insured awaited approval, he underwent chemotherapy treatments and he was assured by the health insurer that it would pay for these treatments. After ten months of waiting for the approval, the insurer denied coverage and rescinded the policy due to the insured’s response to an application question. The court found that the insured stated a claim for bad faith based on the ten-month delay in the insurer’s decision to deny the insured’s claim, during which the insurer “allegedly misled the plaintiffs into believing that their claims would be covered under the insurance policy.” Additionally, the court found “suspect” the insurer’s delay in “denying coverage for [the insured’s] cancer treatments and rescinding the policy; a reason apparently unconnected to [the insured’s] condition for which he sought insurance coverage, and a reason that should have and could have been easily established once the insurance application was first submitted.”

III. The Danger in Denying Claims Based on Limited Evidence and the Need for Flexibility

While a single medical record can be determinative, insurers must exercise caution when basing a denial on limited evidence, as reflected in *White v. Blue Cross & Blue Shield of Greater New York*, 549 N.Y.S.2d 598 (N.Y. Sup. Ct. 1989). Additionally, an insurer should always evaluate how its internal procedures may appear to a jury and determine whether an exception to that procedure is appropriate. In *White*, the court denied the insurer’s partial summary judgment motion as to the plaintiff’s punitive damages claim because the insurer’s “conduct in this case is not only morally reprehensible, but shows an indifference to the human condition.” The plaintiff, a self-employed mother of two, was diagnosed with cancer and underwent surgery and chemotherapy. Shortly after submitting her claim to the insurer, the insurer denied the claim and cancelled the plaintiff’s health insurance policy due to a single medical record that later, during the claim investigation process, turned out to be incorrect. The insurer reinstated coverage retroactively, but refused to pay the plaintiff’s medical bills until the plaintiff paid the past premiums on the policy. The plaintiff claimed that, because she was forced to pay her own medical bills due to the insurer’s mistaken policy cancellation, she
could only make partial premium payments. The insurer refused to accept partial payment and demanded payment in full. The plaintiff alleged that in order to pay for her cancer treatment she had to sell her car, home, and personal belongings, and return to France to obtain medical treatment under the country’s socialized medical program. In addition to the claims issues discussed above, the court noted that the insurer lacked claims review procedures, and that the insurer’s employees’ testimony reflected that there were “different standards of review” used to evaluate claims.

A claim denial based on an insurer’s reliance on a single erroneous medical record also occurred in *Eichenseer v. Reserve Life Ins. Co.*, 934 F.2d 1377, 1379–80 (5th Cir. 1991) (applying Mississippi law). In *Eichenseer*, the insurer denied a claim as a preexisting illness due to a doctor’s mistake in a medical record that noted that the plaintiff had experienced abdominal pain for the “last 2-3 *years*” instead of “2-3 *days*.” During the claim process the plaintiff submitted an affidavit from the doctor who created the mistaken medical record, but the insurer claimed to have lost the affidavit. In upholding a $500,000 punitive damages award based on a $1,000 compensatory damages award, the Fifth Circuit found that the insurer had acted “with reckless disregard – if not intentional disregard – for the rights of its insured” by:

- Refusing “to initiate even the most cursory investigation of [the insured’s] claim”;
- Failing to submit the claim to its in-house medical personnel for review;
- Refusing to interview the insured or her doctor; and
- Refusing to obtain the insured’s medical records and relying on the insured to submit documentation supporting her claim, which the insurer lost “often under suspicious circumstances.”

**IV. The Importance of Obtaining and Reviewing All Relevant Medical Records Before Denying a Claim**

The Alabama Supreme Court’s decision in *Aetna Life Ins. Co. v. Lavoie*, 505 So. 2d 1050 (Ala. 1987), underscores the importance of obtaining all relevant medical records before denying a claim. *Lavoie* involved a dispute over whether approximately $1,500 in hospital treatment was “necessary,” and the case resulted in a $3 million punitive damages award (after remittitur). The court found that the insurer failed to obtain “critical” medical records before denying the insured’s claim, which supported the jury’s conclusion that the insurer had not “properly investigated” the claim, and that the insurer showed a “reckless indifference to facts or to proof.”

**V. Obtaining Summary Judgment on Bad Faith Claims**

At base, a health insurance policy, like all insurance policies, is a contract between two parties. Although health insurance bad faith claims often involve tragic situations, obtaining summary judgment is more likely when the insurer (a) explains the policy’s coverages to the insured accurately and in a timely manner; and (b) quickly obtains all relevant medical records and any necessary physician opinions (such as whether a treatment is experimental, or in determining whether treatments are medically necessary).

In contrast to the above cited cases, the Fifth Circuit’s opinion in *Henry v. Mut. of Omaha Ins. Co.*, 503 F.3d 425, 426–27 (5th Cir. 2007), applying Texas law, provides an example of an insurer obtaining summary judgment on bad faith claims based on the insurer’s excellent claim handling and communication with the insured. The health insurance policy at issue provided coverage for “medically necessary”2 injuries and sickness. The insured was diagnosed with hypogammaglobulinemia immunological deficiency and his physician recommended that the insured undergo intravenous immunoglobulin replacement therapy (“IVIG”). The
insured's physicians sought approval for IVIG treatment, and the insurer sought the opinion of its in-house physician and an independent immunologist as to the medical necessity of IVIG treatment. Both of these doctors recommended that the insurer deny the insured's claim for IVIG treatment. After receiving this denial, the insured’s physician wrote to the insurer urging the insurer to approve the IVIG treatment because it was medically necessary.

The insurer then requested a second in-house physician to review the insured's request for IVIG treatment, and this physician also concluded that it was not medically necessary. The insurer informed the insured and his physician of its denial and of the insured's right to request review of the insurer's denial by an independent organization. Neither the insured nor his physician requested an independent review.

Subsequently, the insured obtained an opinion from a new physician that also recommended that the insured undergo IVIG treatment, and the insured sent this physician's report to the insurer requesting reconsideration of the claim denial. The insurer then sent this physician's report to yet another independent physician for review of the claim (the fourth insurer-related doctor to review the medical necessity of the treatment). While the independent physician was reviewing the claim, the insured committed suicide. The insured's parents sued the insurer and asserted several causes of action, including bad faith claims based on the insurer's alleged breach of the duty of good faith and fair dealing.

Under the controlling bad faith law, the insurer could only be liable for bad faith if there was no reasonable basis for the denial of coverage. In other words, “[o]nly if [insurer] did not have any reasonable basis for denying [the insured's] prescribed IVIG treatment on the asserted ground of no medical necessity could [the insurer] have breached its duty of good faith and fair dealing to [the insured].” The court granted the insurer's summary judgment motion as to the bad faith claim based on the “proffered opinions of several board-certified doctors who reviewed [the insured's] claim,” and these reviews demonstrated good faith. Accordingly, the court held that the process of sending the claim to several doctors “was sufficiently thorough and objective to satisfy the reasonable-basis standard.”

VI. Claims of an Insurer’s “General Practice”

Insurers issuing individual health policies must be cautious that claims decisions made in an individual case do not form the basis for a “general practices” claim, which could expose the insurer to punitive damages, additional lawsuits, and permit the insured to introduce evidence of the insurer's handling of unrelated claims. An example of this occurred in *Lorang v. Fortis Ins. Co.*, 192 P.3d 186, 191 (Mont. 2008), which involved a health insurer's approval of a prosthetic leg socket. The insured obtained a prosthetic leg device after her leg was amputated due to bone cancer. The prosthetic leg required the insured to replace the socket on a periodic basis.

While the insurer provided coverage for the prosthetic limb and the first socket in 1993, the insurer denied coverage for the insured's claims for medically necessary replacement sockets in 1994, 1996, 1998, 2002, and 2003. However, the insurer eventually paid for the replacement sockets after either intervention by the Montana Insurance Commissioner or after the insured filed suit against the insurer.

The insured alleged various causes of action, including breach of contract and violations of the Unfair Trade Practices Act (“UTPA”), which provided for punitive damages. In connection with each of the insured's claims for replacement sockets, the insurer asserted that sockets were not covered by the insurance policy, but the court held that “it is undisputed that the … policy provides coverage for the cost of medically-necessary replacement sockets.” Accordingly, the court granted the insured’s partial summary judgment as to the insurer’s violation of UTPA by misrepresenting the coverage provisions of an insurance policy.
Additionally, the court granted the insured’s partial summary judgment motion on a separate violation of UTPA based on the insurer’s denial of claims without first “conducting a reasonable investigation based upon all available information.” The court held that “[s]imply accessing the pertinent information is not enough to satisfy the statutory mandate; rather, that information must be examined in a reasonable manner.”

Likely due to the multiple denials and subsequent approvals of the socket over a period of years, the insured conducted “general practice” discovery in support of her claim that the insurer had an “institutionalized scheme of attempting to avoid its contractual obligations with respect to prosthetics coverage.” The insured obtained testimony from the insurer’s claims adjusters who stated “that the company regularly denies claims for replacement sockets and even trains its adjusters to do so.” The court held that this evidence supported the insured’s claim that the insurer violated a Montana statute that provides that an insurer may not “neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.” Thus, this ruling greatly expanded the evidence of alleged wrongdoing beyond the insured’s specific facts, which could substantially increase a punitive damages award.

This case illustrates the importance of not only conducting a thorough review of an insured’s claim history before deciding a claim, but also ensuring that the insured’s adjusters have a clear understanding of policy provisions.

VII. Best Practices to Avoid Health Insurance Bad Claims and Potential Bad Faith Issues

Listed below are claims handling issues that reoccur in health insurance bad faith cases, and defense counsel should be aware that plaintiffs may raise these issues in support of a bad faith claim:

• Unlike in other types of bad faith cases, such as those involving property damage, casualty, or life insurance, there are often very pressing time constraints on the insurer to make its decision to approve or deny a treatment. An insured waiting for the approval of a cancer treatment or organ transplant may have only weeks to live without the treatment and the insurer’s claim process – including any delays – will be carefully scrutinized by the plaintiff’s counsel, a court, and possibly a jury. This requires, where appropriate, an expedited claims investigations and appeals process, even if the policy technically permits a lengthier decision process.

• An insurer must gather all necessary medical records before denying an insured’s claim and the insurer should follow-up with medical providers for additional records during a lengthy claim process.

• An insurer should contact, or have its physician contact, the insured’s treating physician where appropriate. This is particularly useful when the insurer must determine whether a treatment is medically necessary or experimental. During such calls, the insurer should request information, including documentation, from the treating physician supporting why the treatment at issue is medically necessary or is not experimental.

• In obtaining medical reviews, the insurer should consider obtaining a physician that specializes in the same type of medicine as the doctor treating the insured.

• The insurer should carefully document the file to reflect all requests for medical records and information, all calls to the insured’s physicians (whether or not the physician actually speaks to the insurer’s representative), and all steps taken as part of the claim review. This will assist the insurer in a later bad faith claim in justifying the reasonableness, thoroughness, and speed of its claim investigation. For example, a lengthy delay that may not have been the insurer’s fault will
be portrayed as the insurer’s unreasonable delay or its “waiting out the clock” on an insured if the insurer is unable to explain the reason for the delay years later during litigation. Assume that everything in the claim file will be discoverable – the file documentation should be professional and objective, and not reflect any personal dislike or disbelief towards the insured.

• As in all claims, the insurer should follow its claim procedures and keep the insured informed of the claim process. Evidence that the insurer misled the insured about the claim approval, or that the claim was still being considered when, in fact, the insurer is gathering evidence to rescind a policy, can be very damaging. This is particularly true when time is of the essence for the insured to obtain treatment and other avenues exist for the insured to obtain treatment in question, such as through hospital charity programs.

• Prior to rescinding a health insurance policy – particularly where the insured is obtaining treatment for a potentially life threatening illness – it is important to thoroughly investigate the grounds for the rescission because an incorrect rescission often forms the basis of a bad faith claim. See Lanham v. Blue Cross & Blue Shield of S.C., Inc., 563 S.E.2d 331 (S.C. 2002) (insurer denied summary judgment on its attempt to void a policy because it was not completely clear that the insured “made a false statement in his application with the actual intent to deceive,” which would entitle the insurer to void the policy). Additionally, prior to rescinding the policy it may be prudent to contact the agent who sold the policy to discuss any potential issues. See Romo v. Amedex Ins. Co., 930 So.2d 643 (Fla. 3d DCA 2006) (plaintiff alleged that the agent who sold her a replacement health insurance policy misrepresented the coverage and benefits available under the replacement policy).

• In an unreported arbitration decision, an insured filed an action to obtain coverage for expensive chemotherapy treatments after the health insurer cancelled her policy. Discovery revealed that the insurer’s apparent motivation for the cancellation was due to the expense of the chemotherapy, and the health insurer paid bonuses to its adjusters who met a cancellation quota for the amount of money saved. While this case likely represents an extreme outlier, it is important to ensure that bonuses, performance review criteria, or similar internal guidelines cannot be construed as rewarding or incentivizing an insurer’s employees to deny claims or rescind policies. Additionally, defense counsel should address this potential line of questioning during deposition preparation sessions.

• Lastly, always be cognizant of how health insurance, more than any other type of insurance, carries with it tremendous jury appeal and the potential for large punitive damages awards. Health insurers must make very difficult claims decisions that may involve denying potentially life-saving treatment. Therefore, small delays or mistakes that would otherwise go unnoticed in other types of insurance claims may appear magnified in the context of health insurance bad faith actions.
Endnotes

1 Intra-arterial chemotherapy delivers chemotherapy to brain tumors through an artery feeding an area of the brain and it allows the patient to receive a substantially higher dose of chemotherapy directly to the tumors without subjecting the rest of the body’s organs to the chemotherapy’s toxicity.

2 The policy defined a medically necessary service or supply as one that: “(a) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (b) is not experimental or investigative; (c) could not have been omitted without adversely affecting the insured person’s condition or quality of medical care; and (d) is delivered at the lowest and most appropriate level of care and not primarily for the sake of convenience.”

3 Pleasant v. Regence Blue Shield, 180 Wash. App. 1014 (2014) presents another example of excellent claim handling and communication with the insured, in which the insurer obtained summary judgment on the bad faith claim.