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 7
 8 IN THE MATTER OF THE ARBITRATION
 9 BETWEEN

10
 11
 12 PATSY BATES, an individual,

13 Claimant,

14 vs.

15 HEALTH NET, INC., a California Corporation;
 HEALTH NET LIFE INSURANCE COMPANY,
 16 ROBERT TORREZ; and DOES 1-50, Inclusive,

17 Respondent..

Case No.: BC321432

**INTERIM ARBITRATION
 AWARD (BINDING)**

18
 19 The undersigned was designated by the parties to serve as Arbitrator in this case. A binding
 20 arbitration hearing was conducted on November 8, 9, 12, 13, 14, 15 and 16, 2007. In addition to
 21 receiving written closing arguments, Arbitrator allowed oral closing arguments which were heard
 22 on January 11, 2008. All of the proceedings were held at the IVAMS' offices located in Rancho
 23 Cucamonga, California.

24 Claimant Patsy Bates was represented by Attorneys William M. Shernoff, Evangeline Fisher
 25 Grossman and Joel A. Cohen. Respondent Health Net Life Insurance Company was represented by
 26 Attorneys William A. Helvestine, Damian D. Capozzola and J. Susan Graham.

27 Seven witnesses testified at the hearing. The testimony of an additional two witnesses was
 28 received via video deposition. Each witness rendered sworn testimony which was subjected to cross-
 examination. In the order of appearance they were:

- 1 1. Robert Torrez (video deposition)
- 2 2. Chester Morris
- 3 3. Loree Bianchi (video deposition)
- 4 4. Barbara Fowler
- 5 5. Mark D. Ludwig
- 6 6. Patsy M. Bates
- 7 7. Stephen D. Prater
- 8 8. Franklin Tom
- 9 9. Raghu Nandan, M.D.

10 In addition to the testimony of the above-named witnesses, Arbitrator has read and
 11 considered:

- 12 1. Claimant and Respondent arbitration briefs
- 13 2. Claimant and Respondent written closing arguments
- 14 3. Claimant's Exhibits 1-44, inclusive
- 15 4. Respondent's Exhibits 501-546, inclusive
- 16 5. Court Exhibits 1-28, inclusive, which were received at the hearing
- 17 6. Depositions of:
 - 18 a. Rajeev Arhi, M.D.
 - 19 b. Marcel Bates
 - 20 c. Patsy Bates
 - 21 d. Trenise Bates
 - 22 e. Loree Bianchi
 - 23 f. Terrell Daniels
 - 24 g. Barbara Fowler
 - 25 h. Divinia Garcia
 - 26 i. Jody Giordano
 - 27 j. Danilo Jaravata, M.D.
 - 28 k. Tessie Lagasca

- 1 l. Mark D. Ludwig
- 2 m. William L. Madrid, M.D.
- 3 n. Chester Morris
- 4 o. Stephen D. Prater
- 5 p. Mark J. Schein, M.D.
- 6 q. Franklin Torn
- 7 r. Robert Torrez
- 8 s. Petra Wong, M.D.
- 9 t. Tony Wren

10 The claims of Patsy Bates (hereinafter referred to as "Bates") arise out of the rescission of an
11 individual health insurance policy she had with Respondent Health Net Life Insurance Company
12 (hereinafter referred to as "Health Net"). The policy was approved by Health Net effective August
13 1, 2003. In September, 2003, Bates was diagnosed with breast cancer. In December, 2003, Health
14 Net sent Bates a letter asking for a clarification of certain responses she had made on Health Net's
15 enrollment application in July, 2003. In January, 2004, Health Net sent Bates a letter notifying her
16 health insurance policy was rescinded. At the time of the arbitration hearing, Bates had unpaid
17 medical bills of at least \$129,809.00 (Court Exhibit 28).

18 Bates set forth two causes of action in this case. The first was breach of contract; the second
19 cause of action stated a breach of the duty of good faith and fair dealing. Bates has requested
20 damages for her unpaid medical expenses, emotional distress and exemplary damages. As to the
21 latter damages, Bates has contended Health Net violated the provisions of California Civil Code
22 Sections 3294(a) in that in rescinding Bates' policy Health Net was guilty of oppression, fraud or
23 malice.

24 On August 24, 2007, Arbitrator granted Bates' motion for summary adjudication regarding
25 her claim Health Net had breached her contract. The matter was extensively briefed by both parties.
26 Each side was given an opportunity to engage in oral argument. On this date, based on Arbitrator's
27 finding that Health Net failed to comply with the mandatory requirements of California Civil Code
28 Section 10381.5, Bates' motion was granted. As a result, the hearing which commenced on

1 November 8 was limited to the second claim she made regarding Health Net's failure to satisfy its
2 duty of good faith and fair dealing.

3 Patsy Bates is 51 years old, a high school graduate with two children and one grandchild. She
4 has been employed in her own beauty shop as a cosmetologist over 25 years (Reporter's Transcript
5 (hereinafter RT), Pg 10). She obtained health insurance in 2000 or 2001 with Universal Care. She
6 had no problems with this company (RT, Pg 12).

7 Bates was contacted by Robert Torrez, who called regarding health insurance. When advised
8 she already had insurance, Torrez suggested he might be able to give her a better rate (RT, Pg 12).
9 An appointment was made. Torrez arrived at the shop at a time when she had three clients in the
10 shop, including the one she was working on.

11 Torrez asked Bates if she had any major illnesses then proceeded to complete the Health Net
12 enrollment application. The application was filled out by Torrez, then signed by Bates (RT, Pg 22).
13 Bates never reviewed the application. She didn't feel there was any problem because she was just
14 changing insurance. Torrez was the insurance man and knew she was just "changing over" (RT, Pg
15 23). When asked about her weight, she told him the weight on her driver's license was 185 lbs. (RT,
16 Pg 24). She never told Torrez to change the weight, nor was she aware the weight had been changed
17 (RT, Pgs 24 and 25).

18 Bates advised Torrez Dr. Petra Wong was her doctor with Universal. She wanted to remain
19 her patient. Bates didn't recall giving Health Net an authorization to obtain her medical records but
20 she had no objection if they obtained the records (RT, Pg 26). Torrez was in her shop approximately
21 thirty minutes. She saw him once again when he left the policy with her (RT, Pg 29).

22 As indicated above, the testimony of Robert Torrez was received via video deposition held
23 on April 26, 2007, approximately four years after his interview with Bates.

24 Torrez was never a big seller of health insurance. He recalled approximately 20 applications
25 with Health Net over two or three years (Depo: Pg 25, Lines 20-25; Pg 26, Lines 1-5.) He preferred
26 selling life insurance (Pg 26, Lines 21-22). Torrez stopped selling health insurance because he didn't
27 want to specialize (Pg 31, Lines 11-16). Torrez asked an applicant about medications, in general.

28

1 He followed up by asking if the person was in good health. Everybody always says yes (Pg 32, Lines
2 13-18).

3 Torrez would generally go through each health question on the application by reading them
4 off (Pg 34, Lines 14-17). He read the question to the applicant or he could have the applicant read
5 them although he felt the applicants didn't read the question (Pg 34, Lines 20-21). Torrez guessed
6 he had one or two conversations with Bates before meeting with her. He couldn't recall because of
7 the time difference. He just assumed so because that would normally be the case (Pg 36, Lines 16-
8 25).

9 Torrez acknowledged filling out the Health Net enrollment application because he recognized
10 his handwriting (Pg 40, Lines 15-22). Bates signed the application; Torrez saw her sign (Pg 41, Lines
11 13-18).

12 Bates was working on a client when Torrez asked her questions. She took breaks to sign stuff
13 (Pg 44, Lines 23-25; Pg 45, Lines 1-4). When personal questions on the application were asked; i.e.,
14 pelvic exams and things like that, Bates would stop working and come over to the front waiting room
15 where Torrez was located (Pg 45, Lines 16-25; Pg 46, Lines 1-7). Torrez couldn't recall if Bates had
16 time to go through the application (Pg 48, Lines 11-17).

17 Torrez recalled calling Bates after leaving her shop and advising her she would be rated at 185
18 lbs.; i.e., Bates would have to pay a higher premium (Pg 51, Lines 17-25; Pg 52, Lines 1-4). Bates
19 told him the weight was different; Torrez made the change and initialed it. He knew it may not look
20 good but that's what happened (Pg 53, Lines 10-22).

21 Torrez wanted people to know he had made the change and they would be able to identify him if there
22 were any questions regarding the change (Pg 54, Lines 8-15). Torrez filled out the application (Pg
23 56, Lines 15-19). Except for his general practice, Torrez did not recall the manner in which questions
24 on the application were asked (Pg 61, Lines 1-6). Torrez didn't recall any of the specifics regarding
25 his conversation with Bates on the date of the application (Pg 63, Lines 8-11).

26 Torrez knew Bates had coverage with another health care company. He wrote it down on the
27 application. Bates and he planned on stopping it on August 1 when the Health Net policy would start
28 (Pg 63, Lines 18-25; Pg 64, Lines 1-2). Before signing the application, Torrez normally didn't say

1 anything. He told applicants where to sign. If the applicant wanted to read the application, they did.
2 If not, applicants didn't read it. He did not recall if Bates read the application (Pg 65, Lines 3-17).
3 Torrez could not recall if he gave Bates a copy of the application (Pg 72, Lines 24-25; Pg 73, Line
4 1).

5 Torrez believed he had asked Bates all of the questions on the application. That was his
6 general business practice and he knew of no reason why he would deviate from that general practice
7 (Pg 88, Lines 1-25).

8 The testimony of Loree Bianchi (hereinafter Bianchi) was received via a video deposition
9 which took place on September 7, 2007. Bianchi is employed by Health Net of California (hereinafter
10 referred to as HNC) as a senior medical underwriter (Depo: Pg 8, Lines 10-18). Her paycheck,
11 including any benefits, are received from HNC (Pg 14, Lines 25; Pg 15, Lines 106). Bianchi took
12 classes at Cal Western in medical terminology. She was not trained on the California Insurance Code
13 (Pg 17, Lines 1-14). The HNC underwriting manual was reviewed and a senior medical underwriter
14 (Vicky Mata'afa) reviewed applications with her, answered questions and guided Bianchi in making
15 a decision (Pg 30, Lines 19-23).

16 Bianchi understood that as a senior medical underwriter she was to review applications and
17 any accompanying materials thoroughly, make sure all questions are answered, that sufficient details
18 are provided then make a decision to approve or not based on the application (Pg 31, Lines 17-22).
19 If there was a medical history then an additional questionnaire or medical records would be requested
20 (Pg 31, lines 22-25).

21 In 2003, Bianchi processed approximately 1,000 to 1,200 applications a month (Pg 43, Lines
22 13-17). Applications were processed in two to three days (Pg 44, Lines 2-8). The application was
23 supposed to be completed by the applicant (Pg 46, Lines 1-7). If it was determined the application
24 was not filled out by the applicant, it was to be returned with an explanation the application was not
25 completed by the applicant. The applicant was to review the application, make sure all information
26 is accurate, update all medical information, then sign and date each page of the application (Pg 46,
27 Lines 19-25; Pg 47, Lines 1-3). The underwriter did make an analysis of the handwriting on the
28 application by comparing the broker's and the applicant's (Pg 47, Lines 17-21). The signature on

1 Page 7 of the application is an indication to HNC the applicant completed the application (Pg 49,
2 Lines 6-9).

3 Bianchi had never seen Insurance Code Section 10384 (Post claims underwriting prohibited)
4 (Pg 49, Lines 23-25; Pg 50, Lines 7-24). HNC had never trained her concerning this section (Pg 51,
5 Lines 1-9). HNC has guidelines regarding an applicant's medical history. The underwriter
6 determines if the application has triggered the guidelines so that medical records are requested (Pg
7 52, Lines 18-25; Pg 53, Lines 1-5).

8 The Bates' application received a Code 1 designation meaning it could be approved with no
9 additional information. The application is reviewed twice. It takes two to five minutes to review the
10 application once or twice (Pg 56, Lines 2-24).

11 Bianchi did notice the weight on the Bates' application had been changed. However, all
12 questions were answered "no"; she had a check-up a month or two before and said everything is okay;
13 the broker personally saw the application signed. The application was a clean application. There was
14 no need for additional information (Pg 60, Lines 2-26). If the applicant weighs above 198 it is a
15 decline; however, the underwriter always has discretion to rate the application by giving it a plus 50.
16 The whole application is examined (Pg 63, Lines 17-25; Pg 64, Lines 1-10). It was Bianchi's decision
17 to approve the Bates' application (Pg 64, Lines 20-25).

18 Bianchi knew Bates was covered with Universal from approximately 1998 to August 1, 2003. Since
19 she had continuous coverage, a pre-existing exclusion would not be applicable to her (Pg 66, Lines
20 3-14). In using the term "ever" in the application in relation to post medical history HNC is asking
21 "since birth" (Pg 69, Lines 6-15). By looking at the Bates' application, Bianchi knew she could
22 obtain Bates's medical records from Dr. Wong (Pg 70, Lines 2-6; Pg 71, Lines 15-25; Pg 72, Lines
23 1-15). In 2003, per HNC's guidelines, if all the questions on the application were answered "no", and
24 if the applicant had not been to a doctor per the application in the past two years and the applicant was
25 50 years or older, the applicant would be sent a questionnaire asking for a detail of doctor visits, the
26 reason for tests done and the results, including dates for the past two years (Pg 76, Lines 2-13).

27 HNC does not have a protocol requiring the broker or agent to weigh and measure the
28 applicant (Pg 94, Lines 12-15). If there was a question regarding the change in weight or the Bates'

1 application, Bianchi could have gone back to Bates and gotten a questionnaire. She looked at the
2 whole thing (application) and decided to approve it (Pg 96, Lines 2-10).

3 At the time of the Bates' application, HNC did not have a protocol or custom and practice
4 wherein the person doing the rescission investigation spoke with the initial underwriter before
5 rescinding (Pg 98, Lines 6-13).

6 Bianchi does receive an annual bonus. One of the components is the claims ratio, i.e., are the
7 right decisions being made on assessing the risk so that claims fall within a predicted amount and
8 HNC can meet its obligations to its members (Pg 103, Lines 16-25; Pg 104, Lines 1-11).

9 Barbara Fowler and Mark Ludwig (hereinafter referred to as Fowler and Ludwig) were both
10 examined initially by Claimant's counsel pursuant to Evidence Code Section 776. Fowler and
11 Ludwig are both employees of HNC (RT, Pg 115). Fowler started with HNC in 1998; her position
12 on the date of the hearing was Senior Risk Selection Analyst. In that position, she is responsible for
13 the investigation and possible rescission of HNC policies (RT, Pgs 9 and 10).

14 Ludwig was responsible for formulating certain diagnostic codes which are used to trigger a
15 rescission investigation. At the time of the hearing, they numbered three or four hundred, although
16 there could be more (RT, Pg 11).

17 In addition to her rescission responsibility, Fowler also reviews pharmacy claims (RT, Pg 12),
18 although her rescission activity in 2003 and 2004 was her only responsibility (RT, Pg 13).

19 Fowler was aware the duty of good faith extended to investigating rescission evenly and fairly;
20 that she should be looking for ways to support the policyholder's position as well as ways to rescind
21 the contract (RT, Pg 17). Information in an application which was omitted by mistake could be
22 grounds for rescission (RT, Pg 21). The criteria Fowler understands for rescission is the criteria
23 superiors gave her; she hasn't been given any other criteria that comes from legal cases or statutes in
24 California (RT, Pg 21). The criteria used for rescission as stated in the contract, in the application
25 and in the rescission letter came from Fowler's superiors (RT, Pg 32).

26 Fowler did discuss the Bates' case with Ludwig for approximately 10 or 15 minutes (RT, Pg
27 32). Fowler did notice the change in weight on the Bates' application and the initials near the change
28 (RT, Pg 34). Her concern for the alteration on the application triggered the talk with Ludwig (RT,

1 Pg 35). If Fowler found out the applicant didn't fill out the application it could possibly make a
2 difference (RT, Pg 37). There was no discussion with Ludwig regarding contacting the agent to find
3 out about the alteration and whose handwriting was on the application (RT, Pg 38). HNC's policy
4 is they will rely on an application for purposes of rescission which has been totally filled out by the
5 agent (RT, Pg 47).

6 All of the information used for rescission came from the medical records of Dr.(s) Wong and
7 Nandan (RT, Pg 75). Fowler did have rescission goals but regardless of the goals they have never
8 affected how she performs her job duties (RT, Pg 89). It was important to her to make sure every
9 decision regarding the rescission of someone's policy was done thoroughly and accurately (RT, Pg
10 89). Fowler believed she was aware of the fact that a failure to achieve her personal goal, if she were
11 off by 50%, would impact her bonus at the end of the year (RT, Pg 91). Fowler's goals and their
12 achievement are tied to her work on rescission investigations because her job is to investigate medical
13 history and performance (RT, Pg 102). She estimates approximately 1,000 rescissions total for 2003,
14 2004 and 2005 (RT, Pg 102). All of the rescissions are done by Fowler and Ludwig who are
15 employees of HNC (RT, Pg 115).

16 When the underwriting file came into Fowler's possession, she knew Bates had continuous
17 coverage with Universal since 1988 and would have been past the contestability period with Universal
18 (RT, Pgs 116-117).

19 Ludwig has expressed satisfaction at the way Fowler was doing her job. She has never been
20 disciplined for anything at HNC (RT, Pg 130). Fowler feels she is following company procedure in
21 the way she has handled rescissions (RT, Pg 131).

22 Fowler's bonus is based on a fraction of a fraction. Twenty percent (20%) of her bonus was
23 based on personal goals combined (RT, Pg 132). No portion of her bonus in 2000, 2001 and 2002
24 related to personal goals (RT, Pg 133). No body has put pressure on her to do more rescissions (RT,
25 Pg 144). In reviewing rescission cases, Fowler gives no consideration to whether or not claims have
26 come in for the member involved. She doesn't look at claims, only the application, medical history
27 and the underwriting guidelines (RT, Pg 151). The decision to send a clarification letter doesn't
28 depend on claims in the system, only the medical history (RT, Pg 152). The inquiry is triggered when

1 a provider submits a bill with a diagnostic code number that falls within the misrepresentation
2 diagnostic code (RT, Pg 159). When reviewing a case for rescission, Fowler looks carefully at the
3 application as well as the entire file; she definitely looks to see if the initial underwriting was done
4 appropriately (RT, Pg 160). If the underwriting wasn't done appropriately, Fowler would not proceed
5 with rescission; she would close the file (RT, Pgs 160-161) whether the broker has filled out the
6 application causing a disapproval is not a hard and fast guideline, if the application is complete, all
7 questions are answered and the applicant has signed and dated the application (RT, Pg 167).

8 The testimony of Barbara Fowler was followed by the testimony of her supervisor, Mark D.
9 Ludwig. Like Fowler, Ludwig is an employee of HNC and is the director of individual underwriting.
10 He indicated that he has no formal medical or legal training (RT 264 and 265). HNC does all of the
11 underwriting services for Health Net Life Insurance Company (RT 266). The criteria used in
12 rescissions was formulated by Ludwig. In so doing, Ludwig worked with the HNC's law department
13 (RT, Pg 269).

14 The criteria HNC uses for rescission includes; determining if the underwriting decision would
15 have been different if HNC knew the true facts; did the applicant answer questions truthfully; is it
16 reasonable to conclude the applicant was aware of the omitted medical information; and, was the
17 application underwritten according to department (HNC) standards (RT, Pgs 271, 272 and 273).
18 Applicants are expected to know and remember all their medical history going back 20, 30 or 40 years
19 (RT, Pg 279). During the course of Ludwig's experience, applicants have remembered medical
20 history 30 or 40 years old (RT, Pg 286). An unintentional omission can still be a potential ground
21 for rescission (RT, Pg 294).

22 Ludwig assumes the applicant, by signing the application, has reviewed the application before
23 signing (RT 295). The home office underwriting manual does not require the application to be filled
24 out by the applicant (RT 297). When Fowler saw Ludwig regarding the Bates' application, Ludwig
25 did not think about calling Torrez to find out about the alteration or whose handwriting was on the
26 application (RT, Pg 309 and 310). Ludwig felt he protected Bates' rights in the rescission
27 investigation; he felt the way it was handled was very reasonable and did not violate her rights (RT
28 313).

1 An oral explanation to the clarification letter sent by HNC is not an acceptable way to respond
2 (RT, Pg 316). As far as Ludwig knows no applicant has ever called in with a detailed oral
3 explanation (RT, Pg 318). When the clarification letter was sent, Ludwig was aware Bates had been
4 diagnosed with breast cancer (RT, Pg 322).

5 In 2002, one of Fowler's goals was to achieve a monthly average of 15 IPP (individual and
6 family plan) contract rescissions; Fowler exceeded the goal (RT, Pg 326 and 327); she did 275
7 rescissions (RT, Pg 328). The estimated savings to HNC over the life time of the applicant, was 5.5
8 million dollars (RT, Pg 329).

9 In 2003, Fowler's goal was 300 (RT, Pg 352). Ludwig noted on Fowler's performance
10 evaluation that 2003 was a banner year for Barbara in several respects (RT, Pg 334). Ludwig noted
11 6 million in unnecessary health expenses were avoided (RT, Pg 334).

12 Fowler's goal in 2004 was stated in cost savings of 6.5 million rather than stating the number
13 of rescissions (RT, Pg 335). In addition to her goal regarding rescissions, Fowler also had the goal
14 of achieving PHQ processing in three days or less PHQs are provider health questionnaires (RT, Pg
15 343). The most important part of her job was to review cases to determine if there was adequate
16 evidence of misrepresentation (RT, Pg 346).

17 There are three ways a rescission investigation can be initiated. The largest group are claims
18 from a provider with a diagnostic code; another way is a review of paid pharmacy claims data; and,
19 from calls made by providers for prior authorization (RT, Pg 362). A person gets investigated only
20 if they have a health problem. HNC has no other way of knowing (RT, Pg 366). Only claims with
21 dates of service within ten months of the effective date of the policy are investigated. After this
22 period, HNC no longer examines claims. With pharmacy claims only claims that were incurred
23 within six months of the effective date of the policy are looked at (RT, Pg 367). The policy provider
24 HNC can go back for two years. After two years, HNC is locked into whatever is on the application
25 (RT, Pg 368).

26 When Ludwig worked on developing the application and initial underwriting process he
27 worked with HNC's law department (RT, Pg 392). The rescission letter's standard language was
28 written by an attorney in the law department (RT, Pg 393). Ludwig has had the opportunity to have

1 general discussions with the law department regarding the criteria for rescission (RT, Pg 394). The
2 clarification letter was recommended by someone in the law department. It's mailed in every case
3 of proposed rescission (RT, Pg 395-396).

4 HNC keeps track of applicants accepted and those declined. Approximately 70-72% of the
5 applicants will be approved; 18 to 20% will be declined and there is a percentage of applications
6 cancelled or withdrawn (RT, Pg 405-406). Approximately one rescission will result from
7 approximately 15 to 20 investigations (RT, Pg 406).

8 Ludwig discussed the weight change on the application with Fowler. The broker wasn't called
9 first before writing the clarification letter to Bates because the applicant would tell us if there was
10 some claim of broker misconduct (RT, Pg 416).

11 The initials by Torrez actually give strength to the process because he is telling HNC he is the one
12 who made the change. Ludwig didn't feel it would be improper if the applicant consented to the
13 change (RT, Pg 417-418).

14 At the hearing and in closing argument, Claimant has asserted Respondent breached the
15 covenant of good faith and fair dealing implied in law in every contract. Claimant maintained Health
16 Net did not have the right to rescind the Bates' policy. Claimant has argued that Health Net failed
17 to comply with the provisions of California Insurance Code Section 10381.5. Therefore, it is
18 contended, Health Net is acting in bad faith when the rescission rests upon information given by Bates
19 to Health Net in the enrollment application.

20 In addition to violating the provision of Section 10381.5, Claimant also contended Health net
21 acted in bad faith by violating the provisions of California Insurance Code Section 10384. Claimant
22 argues the process by which the application was completed and submitted by Torrez raised reasonable
23 questions which should have been resolved by a pre-insurance medical investigation. Had Health net
24 done so, it was argued, it would have gained the exact information which was the basis for the
25 subsequent rescission. Assuming, then, Health Net chose to decline Bates' application, she would
26 have been able to continue her policy with Universal and have avoided the disastrous consequences
27 which flowed from the later rescission. In failing to complete medical underwriting, Health Net was
28 guilty of postclaims underwriting which Section 10384 prohibits.

1 Claimant has advanced the further argument in support of her bad faith claim that if Health
 2 Net had conducted a full and fair investigation of the circumstances surrounding the completion of
 3 the application it would have realized rescission was not justified because of the requirement set forth
 4 by the California Supreme Court in Thompson v Occidental Life Insurance Company (1973) 9 Cal
 5 3d 909, at page 916, that "... if the applicant for insurance had no present knowledge of the facts
 6 sought, or failed to appreciate the significance of information related to him, his incorrect or
 7 incomplete response would not constitute grounds for rescission."

8 As discussed in Claimant's closing reply brief, Health Net's further bad faith is reflected in
 9 the fact:

- 10 1. Health Net set annual rescission targets, expressed in terms of numbers of rescissions
 11 or anticipated savings;
- 12 2. A portion of the bonus paid to employees engaged in rescission work was tied to
 13 achieving rescission goals;
- 14 3. The clarification letter policy was disingenuous; and
- 15 4. Health Net documents; i.e., the enrollment application, clarification letter, rescission
 16 letter and guidelines mistake California rescission law. (See: Bates' Closing
 17 Argument Reply Brief, Page 2.)

18 Health net has raised a number of arguments in support of its contention the Bates' claim of
 19 bad faith is meritless. Initially, Health Net has noted the central question is whether Health Net acted
 20 unreasonably and without substantial justification (Closing Argument Opposition Brief, Page 1). In
 21 that regard, Arbitrator has been requested to consider: 1) Claimant's misrepresentations regarding her
 22 heart and weight; 2) Claimant's failure to provide a substantive response to Health Net's letter
 23 requesting clarification; and, 3) Health Net's efforts to comply with California Insurance Code
 24 Section 10381.5 was consistent with existing law.

25 Health Net continued its argument that Bates failed to demonstrate Health Net's bad faith with
 26 the assertion the enrollment application it used in 2003 was not intended to be a trap. The application
 27 used was consistent with those used by other insurers in the industry. In completing the application
 28 nothing Torrez did suggests any bad faith on Health Net's part. Once Health Net discovered the

1 omissions and/or misrepresentations regarding Bates' heart and weight, Health Net had reasonable
2 grounds to believe rescission was appropriate.

3 It is Health net's additional contention that Ludwig and Fowler acted entirely proper
4 throughout the rescission process. To the extent Fowler may have received bonus money related in
5 some way to rescissions, the amount of money received was so small it was irrelevant (Ibid, Pg 32).

6 Arbitrator has considered all of the contentions of the parties and the evidence which was
7 submitted in support thereof.

8 Arbitrator has considered these contentions in the context of the applicable laws as set forth in the
9 Judicial Council of California Civil Jury Instructions (CACI) Section 2330 (Implied Obligation of
10 Good Faith and Fair Dealing Explained) which provides:

11 "In every insurance policy there is an implied obligation of
12 good faith and fair dealing that neither the insurance company nor the
13 insured will do anything to injure the right of the other party to receive
14 the benefits of the agreement.

15 To fulfill its implied obligation of good faith and fair dealing,
16 an insurance company must give at least as much consideration to the
17 interests of the insured as it gives to its own interests.

18 To breach the implied obligation of good faith and fair dealing,
19 an insurance company must, unreasonably or without proper cause, act
20 or fail to act in a manner that deprives the insured of the benefits of the
21 policy. It is not a mere failure to exercise reasonable care. However,
22 it is not necessary for the insurer to intend to deprive the insured of the
23 benefits of the policy."

24 After consideration of all evidence submitted and the law as set forth in CACI Section 2330,
25 Arbitrator finds Health Net failed to satisfy the obligation of good faith and fair dealing it owed to
26 Patsy Bates. Specifically, Arbitrator finds Health Net was primarily concerned with and considered
27 its own financial interests and gave little, if any, consideration and concern for the interests of the
28 insured.

1 In its written closing argument, Health Net quoted BAJI 201:

2 "... The testimony of one witness worthy of belief is sufficient
3 to prove any fact ... "

4 To find Health Net breached its obligation of good faith and fair dealings Arbitrator need go
5 no further than the testimony of Bates' expert, Stephen Prater.

6 Prater has been teaching insurance law and practice at the university level for 25 years. His
7 teaching includes substantial discussion of the issues involved in the Bates' case; i.e., underwriting
8 and claims handling, rescissions, Thompson issues, misrepresentations, point of sale issues and
9 agent/broker issues. This experience alone would qualify Prater as an expert in this case. However,
10 in addition, Prater noted his numerous appearances as an expert testifying on insurance issues in trials
11 (60) and depositions (hundreds) in approximately 20 states in the United States. Prater testified he
12 has been hired to do consulting work with at least 25 insurance companies, including Blue Cross,
13 Blue Shield and State Farm Insurance Company (RT, Pgs 11 and 12). Blue Shield used him as a
14 mediator (RT, Pg 17).

15 Health Net's suggestion Prater lacked the necessary qualifications to testify as an expert is not
16 supported by the evidence. Not only was Prater qualified, Arbitrator found him to be well-qualified.
17 Additionally, Arbitrator found him to be a credible witness.

18 Health Net has used some harsh language to describe Prater's testimony. He was described
19 as "a hired mouthpiece" whose testimony was not only "biased and pre-determined" but it was
20 "fifteen years dated." This attack on Prater's credibility is somewhat understandable considering
21 Health Net offered no expert testimony whatsoever at the hearing. If his testimony was "so far off
22 the wall" as suggested, it would appear Health Net would have had little difficulty in producing at
23 least one expert of its own.

24 Arbitrator finds the evidence in this case does support the opinions and conclusions expressed
25 by Prater. Without consideration of his testimony, it would still be Arbitrator's finding Health Net
26 was guilty of bad faith in its dealings with Bates. Starting with the circumstances by which the
27 enrollment application was completed, Health Net's reliance thereon, without any pre-acceptance
28 investigation, was particularly egregious.

1 Torrez completed the entire enrollment application. He made no effort to explain the
2 significance of the application. Bates thought the form was used merely to transfer her health
3 insurance from one company to another.

4 In the November 2000 agreement Torrez signed, he agreed "he will fully inform each applicant that
5 the Company will rely solely upon these representations in rejecting, conditionally accepting or
6 contracting with applicant, that the subsequent discovery of company of material facts known by
7 applicant and either not disclosed or misrepresented on the application can result in rescission ..."
8 Torrez acknowledged he did just the opposite. He asked Bates to sign the application, nothing else.
9 (Depo: Pg 65, Lines 5-14.)

10 On the first page of the application, it appears Bates' weight was changed. Torrez initialed
11 the change. He has acknowledged he made the change. This change should have been a red flag to
12 Health Net there was a problem with compliance with California Insurance Code Section 10382. This
13 section requires that no alterations on the application shall be made without the applicant's written
14 consent. Nowhere on the form, or elsewhere, did Bates approve the alteration in writing. If Bates'
15 signature is being received as some form of ratification of the change, why didn't she initial the
16 change? It had to be obvious Torrez made the alterations at a later time. In so doing, he failed to
17 comply with Section 10382 because he lacked her written consent.

18 For purposes of completing the application, Arbitrator does agree with the Bates' assertions
19 on this issue (Bates' Closing Argument, Pages 6, 7 and 8) and finds Torrez acted as Health Net's
20 agent. Torrez violated the Health Net guidelines in several ways, not the least of which is the
21 possibility of engaging in criminal conduct by violating Section 10382. Health Net's claim the Bates'
22 application was "clean" and required no investigation lacks credibility.

23 Section 10384 of the Insurance Code defines postclaims underwriting as:

24 "... rescinding, canceling, or limiting of a policy or certificate
25 due to the insurer's failure to complete medical underwriting and
26 resolve all reasonable questions arising from written information
27 submitted on or with an application before issuing the policy or
28 certificate."

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3 Considering the manner in which Torrez violated Health Net's guidelines, to include the possibility
 4 of engaging in criminal conduct Heath Net's failure to conduct an investigation before the policy was
 5 issued is difficult to understand. As described by Prater, Health Net's failure is particularly troubling
 6 since they were dealing with an applicant who already had a policy with significant coverage which
 7 it knew was going to be cancelled if the application was approved. All of the information Health Net
 8 used to rescind was located in the medical records it later obtained from Dr.(s) Petra Wong and Raghu
 9 Nandan. Compliance with Section 10384 would have made them available to Health Net.

10 Bates was diagnosed with breast cancer in September 2003. The treatment which was
 11 necessary involved the submission of claims or approval thereof under diagnostic codes used by
 12 Health Net to trigger a rescission investigation. Medical records were obtained and entries therein
 13 were compared to various responses on the Bates' enrollment application. Health Net gave no
 14 consideration to the provisions of Insurance Code Section 10381.5. This section provides (in part):

15 "the insured shall not be bound by any statement made in an
 16 application for a policy unless a copy of such application is attached
 17 to or endorsed on the policy when issued as a part thereof..."

18 Arbitrator finds Health Net's practice in 2003 of mailing the application to an applicant in a
 19 separate mailing than the mailing used for the policy, even if the two mailings were made within a
 20 day or two of each other, constitutes a violation of Section 10381.5. Health Net should not have
 21 proceeded with a rescission based on any statements Bates made in her application.

22 Health Net has argued its practice in 2003 can't be considered bad faith even if Section
 23 10381.5 was technically violated because a similar practice by Standard Insurance Company was
 24 involved in the case of Standard Insurance Company v. Carls and approved by a northern district
 25 federal court in 2000. Arbitrator finds this argument disingenuous in that no evidence was introduced
 26 in this hearing suggesting Health Net followed its procedure in reliance on the Carls opinion.

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1 In addition to the violations of guidelines and statutes noted above, further evidence of Health
2 Net's bad faith is the bonus practice it put in place, whether large or small which, was tied in some
3 respect to whether an employee met certain recission goals.
4 It's difficult to imagine a policy more reprehensible than tying bonuses to encourage the recission of
5 health insurance that helps keep the public well and alive. Arbitrator finds the question of the timing
6 as to when the goals were set; i.e., before or after the fact of rescission, not particularly significant.
7 It is clear to Fowler and any other member of the rescission team the rescission goals were important
8 because they came down the pike regularly on an annual basis. Health Net's claim they didn't amount
9 to much lacks credibility.

10 In consideration of the discussion above, Arbitrator finds Bates is entitled to: 1) recover the
11 amount of her unpaid medical bills; 2) emotional distress and punitive damages; and, lastly, 3)
12 attorney fees pursuant to Brandt v. Superior Court (1985) 7 Cal 3d 813.

13 Arbitrator agrees with Health Net's position the medical expense claim is essentially a
14 contract claim and the collateral source rule is not applicable. Arbitrator agrees, also, that pursuant
15 to BAJI 10.90 and 14.60 speculative damages may not be awarded. Arbitrator finds the claim for
16 future medical expenses falls into this category. Arbitrator has reviewed Egan v. Mutual of Omaha
17 Insurance Company (1979) 24 Cal 3d 809 and does not feel it supports the claim the entire balance
18 of the contract amount of the Health Net policy should be awarded.

19 Health Net feels Bates' emotional distress damages are minimal. Arbitrator could not disagree
20 more. Bates had a viable policy with Universal she was encouraged to cancel. That would have never
21 happened but for the shoddy practice of Health Net's agent, exacerbated by its own institutional
22 concern for its financial interests over those of its insured. Four years after Health Net's failure to
23 pay her medical bills, Bates' appearance at the hearing demonstrated her obvious emotional distress.
24 BAJI 12.72 defines emotional distress as:

25 "The term "emotional distress" means mental distress, mental
26 suffering or mental anguish. It includes all highly unpleasant mental
27 reactions, such as fright, nervousness, grief, anxiety, worry,

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1 mortification, shock, humiliation and indignity, as well as physical
2 pain.”

3 BAJI 12.73 defines “severe” as:

4 “The word “severe”, in the phrase “sever emotional distress,” means
5 substantial or enduring as distinguished from trivial or transitory.
6 Severe emotional distress is emotional distress of such substantial
7 quantity or enduring quality that no reasonable person in a civilized
8 society should be expected to endure it.

9 In determining the severity of “emotional distress you should consider its
10 intensity and duration.”

11 It is hard to imagine a situation more trying than the one Bates has had to endure. She had
12 valid health insurance, thinks simply she’s making a change when the rug was pulled from underneath
13 and that occurred at a time when she is diagnosed with breast cancer, one of the leading causes of
14 death for women. With insurance she was insured she would receive proper care. Her care was
15 changed when doctors found out she had an insurance problem (Nandan’s testimony, RT, Pg 33). At
16 the hearing, Bates expressed her tremendous concern. At least several times during the hearing
17 Arbitrator was required to take breaks so that Bates could regain her composure. Arbitrator felt her
18 distress was genuine. Arbitrator is convinced it will last the rest of her life.

19 Arbitrator has reviewed the provisions of BAJI 14.71 regarding an award of punitive damages
20 in this case. This section provides (in part):

21 “If you find (Bates) suffered actual injury, harm or damage caused by
22 (Health Net) you should then consider whether you should award
23 punitive damages against (Health Net), for the sake of example and by
24 way of punishment. You should in your discretion award punitive
25 damages, if, but only if, you find by clear and convincing evidence that
26 (Health Net) was guilty of (oppression) (fraud) (or) (malice) in the
27 conduct on which you base your finding of liability.

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1 "Oppression" means despicable conduct that subjects a person to cruel
 2 and unjust hardship in conscious disregard of that person's rights.
 3 "Despicable conduct" is conduct which is ... "contemptible" or
 4 "miserable" that it would be looked down upon and despised by
 5 ordinary decent people ..."

6 The evidence, Arbitrator finds, was clear and convincing in establishing Health Net's
 7 oppressive conduct in this case. Health Net paid no attention to its own guidelines when it examined
 8 the Bates' application. It ignored statutory mandates. Obvious errors, one of which amounting to
 9 criminal conduct, were ignored. Bates' disaster could have been totally avoided through very limited
 10 investigation. Health Net showed no concern for its obligation under Insurance Code Section 10384.
 11 Bates' rights under Section 10381.5 were violated. Throughout the hearing, and in its closing
 12 argument, Health Net has attempted to shift the blame in this case to Patsy Bates. However, it was
 13 Health Net's conduct which was reprehensible. From the initial review of the application to the
 14 rescission the evidence supports a finding Health Net's primary concern was its own financial well-
 15 being.

16 Arbitrator has reviewed the cases of Downey Savings and Loan Association v. Ohio Casualty
 17 Co. (1987) 189 Cal App 3d 1072, Tomaselli v. Transamerica Insurance Co. (1994) 25 Cal App 4th
 18 1269 and Delos v. Farmers Insurance Group (1979) 93 Cal App 3d 642. Arbitrator finds the position
 19 asserted by Bates as set forth in the closing Reply Brief (pgs 24,25 and 26) is well taken and
 20 supported by the cited authorities.

21 Based upon the discussion above as against Health Net Life Insurance Company Claimant
 22 Patsy Bates is awarded:

23	Unpaid medical expenses	-	\$129,809.00
24	Interest pursuant to Civil Code Section 3289 from October 1, 2003 to present (1603 days x		
25	35.56 per day)	-	\$ 57,002.68
26	Emotional distress	-	\$ 750,000.00
27	Total special damages	-	\$ 936,811.68
28	Punitive damages per Civil Code Section 3294	-	\$8,431,305.10

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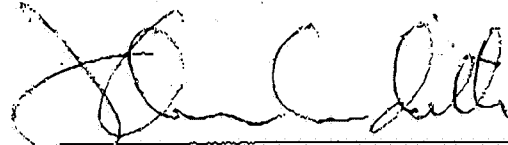
Total Interim Award: \$9,368,116.78

(Note: In computing punitive damages Arbitrator has adopted and incorporated herein the arguments set forth in Claimant's Closing Argument Reply Brief starting on Page 20, Ln 10 through and including Page 22, Ln 16.) Arbitrator used a multiple of 9)

Arbitrator reserves jurisdiction to award attorney fees pursuant to Brandt v. Superior Court (1925) 7 Cal 3d 813 and costs pursuant to CCP 1032, et. seq. Claimant is directed to submit her request within 10 calendar days Respondent shall have 10 calendar days from the date of this interim award thereafter to submit any objections thereto. Arbitrator will submit a final award to the parties within 30 calendar days thereafter.

Dated:

Feb 21, 2008



Sam Cianchetti
Judge, Retired
Arbitrator