No. SCWC-15-0000393

IN THE SUPREME COURT OF THE STATE OF HAWAII

PATRICIA E. G. ADAMS, IN HER CAPACITY AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BRENT ADAMS, AND IN HER PERSONAL CAPACITY, Petitioner/Plaintiff-Appellant, vs. HAWAII MEDICAL SERVICE ASSOCIATION, Respondent/Defendant-Appellee.	ON APPLICATION FOR A WRIT OF CERTIORARI TO THE INTERMEDIATE COURT OF APPEALS ICA Summary Disposition Order: June 8, 2018 ICA Judgment: July 6, 2018 Circuit Court: Civil No. 07-1-1388 Circuit Court of the First Circuit Hon. Virginia L. Crandall Judgment: January 6, 2015

APPLICATION FOR A WRIT OF CERTIORARI

APPENDIX 1

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IN THE SUPREME COURT OF THE STATE OF HAWAII

PATRICIA E. G. ADAMS, IN HER CAPACITY AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BRENT ADAMS, AND IN HER PERSONAL CAPACITY, Petitioner/Plaintiff-Appellant, vs. HAWAII MEDICAL SERVICE ASSOCIATION, Respondent/Defendant-Appellee.	ON APPLICATION FOR A WRIT OF CERTIORARI TO THE INTERMEDIATE COURT OF APPEALS ICA Summary Disposition Order: June 8, 2018 ICA Judgment: July 6, 2018 Circuit Court: Civil No. 07-1-1388 Circuit Court of the First Circuit Hon. Virginia L. Crandall Judgment: January 6, 2015

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Brent Adams was diagnosed with Stage III multiple myeloma, a rare and aggressive bone marrow cancer. Time was critical. A tandem auto-allogenic transplant—a series of treatments that would first transplant Brent's own stem cells, and then stem cells from one of his five siblings (if any matched)—was his best chance for survival.[1] HMSA knew Brent urgently needed this final procedure in a multi-stage treatment plan—Brent and Patricia told HMSA he needed this treatment, and HMSA was well aware of the procedure, because a bone marrow transplant involves dozens and dozens of claims for services associated with the transplant, all of which HMSA was processing. For months, HMSA knew it would not cover auto-allo transplants, but did not tell Brent. Eventually, Brent's doctor submitted a written request for coverage after having orally requested approval in the previous month. Two business days later, HMSA denied coverage, as it knew it would. But it did not deny coverage until it was too late for Brent to seek other alternatives.

This is a bad faith action by Brent's widow Patricia which presents the opportunity to clarify the scope of an insurer's duty to treat its insureds fairly: was HMSA required to give Brent complete and accurate information about HMSA's coverage and policy requirements *before* he submitted a formal claim? The ICA held no, concluding that HMSA's duty of good faith only arose when Brent's doctor submitted his written claim. Thus, HMSA's only duty was to respond to the claim in good faith in accordance with the insurance contract and inform Brent the treatment he needed was not covered, a fact which HMSA knew long before.

In response to HMSA's motion for summary judgment, Patricia submitted undisputed evidence that HMSA understood that Brent believed this procedure was his best hope; that Brent was actively exploring how and where to get it done; that he was testing his siblings at his own expense to determine whether they could serve as donors; that HMSA knew about the treatment Brent was in the process of seeking; and that he would be requesting coverage. And, most critically, that HMSA knew it did not cover this procedure. The circuit court and the ICA, however, concluded HMSA did not have a duty to tell him immediately, and that it could never be bad faith for an insurance company to wait for an insured to submit a formal written request before

[1] In a tandem auto-*allogenic* transplant, Brent would receive two stem cell transplants. The first, an autologous transplant using stem cells harvested from Brent himself. Dkt. 30 at 259-60, 262. The second, an allogeneic transplant, which would use stem cells from a matched sibling donor. Dkt. 30 at 260, 262. A tandem auto-*auto* transplant, by comparison, is two transplants a few months apart, both using Brent's own stem cells. Dkt. 30 at 260, 262.

disclosing its coverage position. The circuit court concluded the evidence Patricia submitted (which raised a factual dispute about what HMSA knew about the procedure and coverage under its own policy) was not relevant to bad faith, instead focusing solely on the terms of the insurance contract, concluding that HMSA's only duty was to respond to Brent in accordance with the contract, in effect carving out a safe harbor from bad faith tort claims if there's no breach of contract. The ICA affirmed. *See* App. 1. To the courts below, evidence of what an insurer did before submission of a written claim, what it might have known, and what information it withheld is irrelevant to bad faith, even if that evidence would support a jury finding the insurer misled the insured, affirmatively or by its silence.

But an insurer's duty of good faith and "broad obligation of fair dealing and a responsibility to give equal consideration to the insured's interests,"[2] encompasses more than simply responding to claims in accordance with the policy. It applies to their entire relationship, as this Court concluded when it held that even if an insurer does not breach its contract, it still has a duty of good faith.[3] This includes a duty to inform the insured as to coverage and policy requirements. The ICA, however, intermixed HMSA's good faith tort duty with the separate issue of whether it breached the contract,[4] and affirmed judgment as a matter of law even though key facts about HMSA's pre-claim actions were disputed. This Court should accept certiorari, vacate entry of summary judgment, and remand to the circuit court for a trial on the merits.

QUESTION PRESENTED

Can summary judgment be granted on an insurance bad faith claim when HMSA timely denied the claim in compliance with the policy, but there is evidence that HMSA was aware the insured would be submitting a request to approve a procedure that HMSA knew it did not cover, but failed to inform the insured of his lack of coverage until the claim was actually submitted?

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[2] *Bryant v. Country Life Ins. Co.*, 414 F. Supp. 2d 981, 997 (W.D. Wash. 2006).

[3] *See Enoka v. AIG Hawaii Ins. Co.*, 108 Haw. 537, 549, 128 P.3d 850, 862 (2006) ("[T]he tort of bad faith allows an insured to recover even if the insurer performs the express covenant to pay claims.").

[4] *See Deese v. State Farm Mut. Auto. Ins. Co.*, 838 P.2d 1265, 1266 (Ariz. 1992) ("We hold that breach of an express covenant of an insurance policy is not a necessary prerequisite to a tort claim based on bad faith."); *Hatch v. State Farm Fire & Casualty Ins.*, 842 P.2d 1089, 1099 (Wyo. 1992) (Plaintiff "need not prevail on the contract claim in order to prevail on the bad faith claim").

STATEMENT OF THE CASE AND PRIOR PROCEEDINGS

I. BRENT'S DOCTORS ALL RECOMMENDED HE UNDERGO A TANDEM AUTO-ALLO TRANSPLANT

In August 2005, after a visit to the emergency room for a roller blading accident, Brent's doctors discovered he had Stage III multiple myeloma, a rare form of bone marrow cancer. Dkt. 30 at 41-42, 259. The doctor who diagnosed Brent, Dr. Rajdev, recommended that he seek a tandem auto-allo transplant at a mainland transplant center that was conducting clinical trials. *Id.* As noted above, this procedure is in two major stages. In the first (the "auto" phase), Brent would receive an autologous transplant using his own stem cells. Dkt. 30 at 259-60, 262. In the second (the "allo" phase, a few months later), he would be transplanted with stem cells from a matched sibling donor. Dkt. 30 at 260. Thereafter, Brent saw Dr. Coutre at the Stanford Cancer Center, who also recommended an aggressive treatment including the allo transplant. *Id.*; Dkt. 30 at 143.

Wade Makizuru—and later Greg Keast—were Brent's HMSA case managers. Their purpose, Keast informed Brent and Patricia, was to "help members work with their doctors and the rest of their health care team to manage their health care and make the most of their HMSA health plan." *Id.* at 43, 241. The case manager also works with the member's doctor "to assist in the coordination of the plan of care and ensure maximum use of plan benefits." Dkt. 30 at 244. After informing HMSA that upon his doctors' recommendations, Brent would be seeking a tandem auto-allo transplant, HMSA recommended that Brent seek coverage at a Blue Quality Center for Transplants (BQCT). *Id.* at 44. Based upon HMSA's recommendation, Brent and Patricia believed that if he chose a BQCT, he would receive the best care and recommended treatment. *Id.* Brent decided to seek treatment at the City of Hope in Duarte, California because it was a BQCT. *Id.* at 44. BQCTs are contracted with HMSA to provide bone marrow transplants. *Id.* at 160-170, 162.

II. HMSA KNEW BRENT NEEDED AND WOULD BE REQUESTING COVERAGE FOR THE ALLO TRANSPLANT

On December 6, 2005, Patricia informed Makizuru that Brent was pursuing the tandem auto-allo transplant at City of Hope, and asked Makizuru if there was anything else they needed to do. *Id.* Makizuru did not provide any other instructions or advice (such as having Brent's doctor submit a request for the procedure in writing), nor did he indicate that the allo portion of the transplant would *not* be covered by Brent's HMSA plan. *Id.* at 44. After meeting with Dr. Stein at City of Hope, Brent and Patricia were given clinical trial agreements, including one for a tandem auto-allo transplant. On December 29, 2005, Brent signed an Informed Consent for participation

in a trial for a tandem auto-auto transplant *or*, if he had a sibling match, for a tandem auto-*allo* transplant. Dr. Stein initially requested approval from HMSA for a tandem auto-auto transplant, so he could begin treatment prior to knowing whether one of Brent's siblings was a donor match. HMSA approved coverage for the auto-auto transplant. Dkt. 30 at 186.

Thereafter, City of Hope faxed a request for sibling testing to HMSA on December 23, 2005. Dkt. 30 at 250-55. In the Transcription Report attached to the request, Dr. Stein stated, among other things, "We will also go ahead and HLA-type the patient and get blood from his five siblings in New Zealand to see if an allogeneic stem cell transplant is an option," again putting HMSA on notice that Dr. Stein wanted an allo transplant for Brent. Dkt. 30 at 253. HMSA ultimately denied the request to pay for donor testing on January 11, 2006 but did not indicate it would deny coverage of the allo transplant itself.[5] In continued preparation for the allo transplant, Brent's siblings were tested (at Brent and Patricia's expense), to determine if any of them matched. Dkt. 30 at 319. One sibling, Cindy, was a perfect match. *Id.* at 45. As HMSA knew, or should have known, the only reason to have Brent's siblings tested was to go forward with the allo transplant.

Although Patricia remembers mentioning the allo transplant to HMSA as early as December 5, 2005, Keast's notes confirm that no later than January 17, 2006, he was aware that Brent desired the allo transplant, and that Keast had previously been informed by Dr. Stein that they were pursuing the allo transplant. Dkt. 30 at 154. Keast also noted that Patricia "stated they would appreciate any assistance [HMSA] could provide, [especially] facilitating any internal HMSA processes." Dkt. 30 at 154. According to Keast's notes, Patricia and Brent requested an update from Keast regarding whether the allo transplant was approved on February 22 and 27, 2006, with Keast merely responding that he had not received the written request from Dr. Stein, even though he had previously acknowledged that Dr. Stein had requested over the phone to have the allo transplant approved. Dkt. 30 at 155-56. Keast never informed Brent or Patricia they could have submitted the written request themselves, which HMSA later stated was possible even though

[5] S*ee* Dkt. 30 at 246 (emails between HMSA employees, copying Dr. Stein, stating that testing of siblings would only be approved if auto transplant failed, but giving no indication that allo transplant would not be covered); *see also* Dkt. 30 at 257 (HMSA notes indicating a representative called Dr. Stein to inform him that HMSA would only pay for the testing of the donor sibling, but giving no indication that the allo transplant would not be covered); Dkt. 30 at 154 (Keast's notes stating that an HMSA analyst informed him that because Brent was only approved for a tandem auto-auto transplant, Dr. Stein needs to submit a request for the allo transplant, and if approved, HMSA will only pay for testing of the person who is ultimately identified as the donor).

Brent's policy states that Member's "provider *will contact* HMSA" for the Member. Dkt. 24 at 51 (emphasis added); Dkt. 34 at 57. Keast, being aware of the terms of Brent's policy and whose purpose was to manage Brent's healthcare and make the most of his plan, also never informed Brent or Patricia that the allo transplant was not going to be covered.

III. HMSA DENIED ALLO COVERAGE

Brent's first auto transplant was in January of 2006. On February 6, 2006, after the successful operation, Brent returned home to Honolulu to rest before undergoing the second stage, the allo transplant. Dkt. 30 at 46. On March 2, 2006, Grace Pruett from City of Hope, on behalf of Dr. Stein, submitted a handwritten note requesting approval for the second cycle—the allo phase—of the transplant procedure. Dkt. 30 at 119. Two business days later, on March 8, 2006, HMSA faxed a letter entitled "Notice of Medical Denial" stating "we have denied coverage" because the auto-allo transplant is "considered investigational to treat multiple myeloma." Dkt. 30 at 123. Patricia and Brent were shocked at the denial because, as HMSA was fully aware, they had been preparing for the allo phase for months, including testing Brent's siblings in New Zealand, to see if they were a match for the allo-transplant. *Id.* at 46. Once HMSA sent the denial letter, Keast was no longer available for consultation, or explanation. *Id.*

When they received HMSA's denial for the allo transplant, Brent and Patricia were told by Brent's medical team that he had a limited window to undergo a second transplant, and they feared he would miss this window if he further delayed and awaited the results of HMSA's internal appeals process. Dkt. 30 at 46. Because Brent had responded well to the auto-transplant, instead of appealing HMSA's denial or making alternative arrangements, Brent underwent the second stage of the tandem transplant as *auto* rather than as *allo*. Dkt. 30 at 83. The second transplant took place, but Brent's cancer eventually relapsed. Dr. Stein again requested the allo transplant. HMSA denied it again. This denial was the subject of a separate agency action. Brent died on June 26, 2008.

IV. THE COURTS BELOW CONCLUDED AN INSURER'S DUTY ONLY BEGINS UPON SUBMISSION OF A CLAIM

A. Circuit Court: Summary Judgment For HMSA

Patricia filed a complaint against HMSA as Brent's survivor and on her own behalf in 2007 asserting five claims: a breach of contract claim, and four tort claims (bad faith, intentional and negligent infliction of emotional distress, and punitive damages). The case was stayed until the

Insurance Division (and eventually the ICA) resolved a concurrent administrative proceeding. [6] Dkt. 28 at 27, 178. After the circuit court lifted the stay, it granted summary judgment in favor of HMSA on all counts of the complaint because it held that the ICA had concluded that the allo transplant was not covered under Brent's plan. Dkt. 28 at 562. Patricia appealed to the ICA, which affirmed summary judgment on breach of contract claim, but, critically, vacated the tort claims judgment, and remanded, because "[g]enerally questions of bad faith are questions of fact and allegations of bad faith regarding fair dealing by the insurer with its insured are the kind of issue best decided by a jury and not the court." Dkt. 28 at 617; *Adams v. Haw. Med. Serv. Ass'n*, No. 30314, 2013 Haw. App. LEXIS 569 (App. Sept. 30, 2013) (*Adams II*). The ICA also noted, "HMSA presented no evidence that the [Adams'] 2006 request for an allo-transplant was handled in a timely manner and we cannot say that, as a matter of law, the time HMSA took to issue its denial was, under all the circumstances, reasonable." Dkt. 28 at 617-18. "Similarly, based on the evidence presented below, we cannot say that, as a matter of law, the Adams did not present a *prima facie*, case for their NIED [negligent infliction of emotional distress] and IIED [intentional infliction of emotional distress] claims in opposition to HMSA's motion for summary judgment." Dkt. 28 at 618. Thus, the ICA concluded the circuit court should not have granted HMSA summary judgment on Patricia's tort claims. Dkt. 28 at 618-19. On remand, Patricia amended the complaint to eliminate the breach of contract claim, leaving the tort claims. Dkt. 28 at 1020. Despite the ICA's holding that bad faith claims should usually be resolved by a jury, the circuit court again entered summary judgment for HMSA.

B. The ICA Affirmed: No Duty To Provide Accurate Information Prior To Submission Of A Claim

Patricia appealed, and the ICA affirmed. Contrary to its prior ruling, the ICA looked exclusively at the terms of HMSA's contract, which required a written request for preauthorization of a procedure, and concluded that HMSA's duty of good faith only arose after Brent's doctor's submitted a written request for preauthorization on March 2, 2006. App. 1 at 4-5. The ICA concluded that evidence presented by Patricia which showed that HMSA did not inform either her

[6] The administrative action was eventually appealed to the ICA by HMSA and the ICA reversed the circuit court and the Insurance Division review panel, concluding "the Plan language 'specifically excluded' an allo-transplant as a treatment for multiple myeloma." *Haw. Med. Serv. Ass'n v. Adams*, 120 Haw. 446, 454, 209 P.3d 1260, 1268 (App. 2009) (*Adams I*).

or Brent of his coverage, or HMSA's policy requirements, was immaterial. App. 1 at 4. Further, the ICA concluded that HMSA could not have provided them with complete and current information about Brent's coverage because "the dispute regarding this very coverage issue was not resolved until 2009, in *Adams I.*"[7]

REASONS FOR ACCEPTING THE APPLICATION

Patricia submitted evidence that HMSA understood Brent would be submitting a request to approve a treatment he desperately needed, but which HMSA knew his plan didn't cover, and that in the face of this, HMSA remained silent, waiting until he formally submitted a claim. This should have defeated HMSA's summary judgment, as it was up to a jury, not the court as a matter of law, to determine whether this was bad faith by HMSA. Instead, the ICA held that HMSA's only duty was to process Brent's claim once it was received in writing—a claim it already determined it would not cover.

I. THE TORT OF INSURANCE BAD FAITH

"[T]here is a legal duty, implied in a first-party insurance contract, that the insurer must act in good faith in dealing with its insured, and breach of that duty of good faith gives rise to an independent tort cause of action." *Miller v. Hartford Life Ins. Co.*, 126 Haw. 165, 174, 268 P.3d 418, 427 (2011). The "duty of good faith and fair dealing is based on the reasonable expectations of the insured and the unequal bargaining positions of the contractants[.]" *Best Place, Inc. v. Penn Am. Ins. Co.*, 82 Haw. 120, 130, 920 P.2d 334, 344 (1996). Further, "the insurance contract and the relationship it creates contain more than the company's bare promise to pay certain claims when forced to do so; implicit in the contract and the relationship is the insurer's obligation to play fairly with its insured." *Id.* (citation omitted). The insurer "must refrain from engaging in any action" which puts the insurer's interest above that of the insured. *Finley v. Home Ins. Co.*, 90

[7] This conclusion further highlights the ICA's erroneous analysis. HMSA had to make a timely and current determination on coverage, without waiting years for a court to offer an opinion on what was covered under its own policy. Although Brent's coverage was disputed in the agency appeal, this did not lessen HMSA's duty to inform and convey complete and accurate coverage information applicable to its present interpretation of the policy, particularly when the determination at issue had to be made more than a year prior to the administrative proceeding. Moreover, under the ICA's reasoning, the insurer could deny coverage under any provision in a policy until, potentially years later, a court issued a ruling on the scope and meaning of the policy provision. That would always be utterly extraordinary and inappropriate when a patient was waiting a coverage determination in a life-or-death situation.

Haw. 25, 36-37, 975 P.2d 1145, 1156-57 (1998). "The implied covenant is breached, whether the carrier pays the claim or not, when its conduct damages the very protection or security which the insured sought to gain by buying insurance." *Best Place*, 82 Haw. at 132, 920 P.2d at 346. Some courts describe the relationship of the insurer to its insured as a "fiduciary."[8]

II. HMSA HAD TO TREAT BRENT IN GOOD FAITH THROUGHOUT THEIR RELATIONSHIP, INCLUDING THE DUTY TO INFORM HIM ABOUT HMSA's COVERAGE AND POLICY REQUIREMENTS

The ICA said it best the first time it considered this case: "[g]enerally questions of bad faith are questions of fact and allegations of bad faith regarding fair dealing by the insurer with its insured are the kind of issue best decided by a jury and not the court." Dkt. 28 at 617. The second time around, by contrast, the ICA failed to recognize HMSA's entire relationship with Brent and Patricia, including consequential inquiries from each of them about their options under the HMSA plan, and less than forthright responses from HMSA. Instead, the ICA concluded that HMSA's duty of good faith was only triggered by Brent's doctor submitting a request for coverage of an allo transplant. In short, the ICA concluded HMSA did not breach its duty of good faith because it complied with the terms of the contract once the doctor's written request was faxed: "Chapter 5 of Adams's policy directed that preauthorization requests be made in writing or by fax." App. 1 at 5.[9] The ICA held that HMSA was powerless to act on what it knew was going to be Brent's request for coverage for the allo transplant until HMSA received the request in writing. *Id.*

[8] *See Bryant v. Country Life Ins. Co.*, 414 F. Supp. 2d 981 (W.D. Wash. 2006) ("The source [of the duty] is the fiduciary relationship existing between the insurer and insured. . . . This fiduciary relationship, as the basis of an insurer's duty of good faith . . . implies a broad obligation of fair dealing and a responsibility to give equal consideration to the insured's interests. Thus, an insurance company's duty of good faith rises to an even higher level than that of honesty and lawfulness of purpose toward its policyholders: an insurer must deal fairly with an insured, giving equal consideration *in all matters* to the insured's interests.") (emphasis added).

[9] Chapter 5 of Brent's plan is entitled "Precertification." Dkt. 34 at 54. "Precertification is a special process to ensure that certain medical treatments, procedures, or devices meet payment determination criteria prior to the service being rendered." *Id.* Next to "How to Request Precertification," it states: "Request precertification by writing or faxing us at . . . ." *Id.* Notably, nothing in Chapter 5 suggests that HMSA could not have or should not have informed Brent of his lack of coverage under the policy as soon as HMSA knew of a desired procedure, whether or not it was informed in writing. The ICA should have concluded that these instructions did not apply because the plan expressly states that HMSA would be contacted by the provider for a transplant.

This, however, overlooks the duty which an insurer has to its insured prior to the submission of a claim. That duty arose from Brent's illness and HSMA's status as his insurer, and required HMSA to monitor his condition and numerous claims typically associated with that illness which HMSA routinely approved. The ICA's conclusion also discounted as irrelevant the evidence which Patricia submitted to oppose summary judgment: the request for the allo transplant was not an isolated incident, but followed months of verbal communications between Brent, Patricia, and their medical team, during which HMSA never simply told them that informed the insured that the procedure recommended by the insured's doctor would ultimately be denied if and when it was requested in writing. Indeed, the burden on HMSA in this circumstance was minimal. All it needed to do was say something like, "we know Brent is considering an auto-allo treatment. Brent's plan does not cover that treatment." And the consequences for Brent and Patricia of HMSA's silence for months were catastrophic. If HMSA had only told them that auto-allo transplant was not covered, Brent may have looked elsewhere or attempted to raise the money to pay for the procedure HMSA ultimately disclosed it would not cover. A simple telephone call or email may have avoided this tragedy.

To support its conclusion, the ICA relied on *Safeco Ins. Co. of Am. v. Parks*, 88 Cal. Rptr. 3d 730 (Cal. Ct. App. 2009). App. 1 at 5. That case held that "the duties of good faith and fair dealing implied in every insurance contract, arise after the insured complies with the claims procedure described in the insurance policy." *Safeco*, 88 Cal Rptr. 3d at 740. That quote, however, is taken out of that case's context, and it is difficult to see how that case relates to ours. *Safeco* involved an action for bad faith because the insurer failed to discover a policy it had issued that afforded additional coverage to the insured. *Id.* at 738. The passage quoted by the ICA only relates to whether Safeco had notice of the claim *under the additional policy*, not whether Safeco understood that the insured would be submitting a claim under the known policy. *Id.* at 740. *Safeco* is thus plainly distinguishable from this case because Brent only had a single policy with HMSA, and HMSA was aware of the terms of its own policy throughout the time it had Brent in its hands. Thus, HMSA was required to play fairly with Brent and Patricia throughout their relationship, not just if and when "the insured complies with the claims procedure." The ICA prevented a jury from determining whether it could reasonably accept the evidence that Patricia submitted which showed that HMSA remained silent even though it knew Brent's intention well before his doctor's submission of the formal claim, and HMSA also knew it would not cover the auto-allo treatment.

The ICA also relied upon *Globe Indemnity Co. v. Superior Court*, 8 Cal. Rptr. 2d 251, 255 (Cal. Ct. App. 1992) to support its sole focus on whether HMSA unreasonably delayed its denial of coverage after submission of the written claim. In *Globe*, the court noted, "[t]here can be no 'unreasonable delay' until the insurer receives adequate information to process the claim[.]" App. 1 at 5. Reliance on this quote only highlights the ICA's narrow focus on the timing of the *written* request, when instead it should have focused on HMSA's conduct and claims handling as a whole, which began several months prior to the written request on March 2.

By relying on the terms of the contract to define HMSA's duty and concluding that it did not act in bad faith as a matter of law (and by focusing on the timing of when the written request was submitted and when HMSA responded), the ICA did not consider HMSA's overall conduct and claims handling, including its failure to accurately inform Brent of his coverage and policy requirements.[10] The tort of bad faith reaches beyond the strict terms of the insured's policy and applies to the insurer's entire relationship with the insured. *Enoka v. AIG Hawaii Ins. Co.*, 108 Haw. 537, 549, 128 P.3d 850, 862 (2006) ("[T]he tort of bad faith allows an insured to recover even if the insurer performs the express covenant to pay claims.").[11] Here, the bad faith claim was based on HMSA's conduct leading up to its 2006 denial. A jury, considering the evidence which Patricia submitted, could reasonably have concluded that HMSA breached its duty of good faith by not informing Brent and Patricia from the beginning that HMSA would not cover the allo transplant.

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[10] In *Morgan v. Guaranty Nat'l Ins. Co*, 98-CV-1014-B, 1999 U.S. Dist. LEXIS 1714 (D. Wyo. Feb. 9, 1999), the court noted two ways an insurer could commit the tort of bad faith: (1) unreasonably delaying payment; or (2) "the insurer with knowledge or reckless disregard ignores its responsibility to inform the insured as to coverage and policy requirements." *Morgan*, 1999 U.S. Dist. 1714, at *15. The Court concluded, "there is no requirement that Plaintiff assert a 'claim' before the law will trigger the [insurer's] obligation to inform Morgan of her coverage and policy requirements. While it is apparent that one must submit a 'claim' to trigger the unreasonably delay analysis, the same is not true for an allegation of failure to inform." *Id.*

[11] *See also Marathon Ashland Pipe Line LLC v. Maryland Cas. Co.*, 243 F.3d 1232, 1246 (10th Cir. 2001) ("[T]he duty of good faith and fair dealing emanates from the special relationship of the parties to the insurance contract, not from the express or implied provisions contained in the contract."); *Deese v. State Farm Mut. Auto. Ins. Co.*, 838 P.2d 1265, 1266 (Ariz. 1992) ("We hold that breach of an express covenant of an insurance policy is not a necessary prerequisite to a tort claim based on bad faith."); *Hatch v. State Farm Fire & Casualty Ins.*, 842 P.2d 1089, 1099 (Wyo. 1992) (Plaintiff "need not prevail on the contract claim in order to prevail on the bad faith claim").

III. PATRICIA SUBMITTED EVIDENCE THAT HMSA BREACHED ITS DUTY OF GOOD FAITH WHEN IT DID NOT TIMELY INFORM BRENT THAT THE AUTO-ALLO TRANSPLANT WAS NOT COVERED

Because the ICA relied on the timing of the written request and HMSA's response to the written request to conclude HMSA did not breach its duty of good faith, the court refused to consider as material any of the evidence that Patricia submitted to show HMSA's pre-claim conduct was unreasonable. By doing so, the ICA overlooked the general principle articulated by this Court that "whether an insurer has acted in bad faith is a question of fact." *Willis v. Swain*, 129 Haw. 478, 496, 304 P.3d 619, 637 (2013); *see Bryant*, 414 F. Supp. 2d at 997 ("Whether an insurer acted in bad faith is a question of fact."); *Barry v. Ohio Cas. Gr.*, No. 03:04-188, 2001 U.S. Dist. LEXIS 2684 at *42 (W.D. Pa. January 12, 2007) (summary judgment improper because the case "involves an allegation of bad faith throughout the claims handling process, which necessarily entails an examination of the entire series of events").

Patricia presented evidence showing HMSA breached its duty of good faith because it mishandled the entire claims process. A jury could reasonably conclude that well before Brent's doctor submitted the claim in writing, HMSA had affirmatively hid the ball—or at the very least remained silent in the face of facts that should have caused it to react—when it knew that Brent desired the auto-allo transplant, that HMSA would not cover this procedure, and that time was of the essence in treating Brent's aggressive cancer. Brent and Patricia relied on their case managers to help them throughout the claims process because Keast informed them that his role was to make the most of their HMSA health plan and he would assist in the coordination of the plan of care and ensure maximum use of plan benefits. Dkt. 30 at 241-44. Both Brent and Patricia contacted Keast and the previous case manager, Makizuru, on several occasions and expressed their goal of undergoing the auto-allo transplant, the procedure which maximized Brent's chances for survival. HMSA knew that Brent paid out of pocket to have his siblings tested so that he could have the tandem auto-allo transplant (Dkt. 30 at 319), but did not inform him that HMSA would not cover the allo transplant. Further, when the Adams inquired about the approval of the allo transplant, Keast merely stated that Dr. Stein had not yet submitted a written request for the allo portion of the treatment. Keast never informed the Adams that they could have submitted the written request themselves nor did Keast assist the Adams in writing the request. As Brent was actively seeking treatment, Keast could have—and should have—undertaken the minimal effort of assisting them in submitting their request.

Had Brent and Patricia known earlier that HMSA did not cover auto-allo transplants, Brent would have had the correct information to either not have pursued the allo transplant or tried to pursue it through another avenue. However, it was critical that Brent undergo the second transplant within a limited time window after the first procedure, so that he would receive the maximum benefit and the cancer would not return prior to the second transplant. What HMSA knew and what it told Brent are "material" facts to the bad faith claim under Rule 56, and Patricia's submission of admissible evidence in response to HMSA's motion revealed genuine issues of material fact for the jury to resolve, making summary judgment improper. The duty here should not have been limited to the timing of the written request and HMSA's response. Patricia submitted evidence that HMSA breached its duty of good faith based on its conduct and claims handling in the months prior to the written request.

CONCLUSION

This Court should accept certiorari, vacate the judgment of the ICA, and remand to the circuit court for a trial on the merits.

DATED: Honolulu, Hawaii, September 4, 2018.

Respectfully submitted.

DAMON KEY LEONG KUPCHAK HASTERT

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PATRICIA E.G ADAMS

APPENDIX 1

SCWC-15-0000393
Adams v. HMSA
Application for a Writ of Certiorari

NO. CAAP-15-0000396

IN THE INTERMEDIATE COURT OF APPEALS

OF THE STATE OF HAWAI'I

PATRICIA E.G. ADAMS, IN HER CAPACITY AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BRENT ADAMS, AND IN HER PERSONAL CAPACITY, Plaintiffs-Appellants, v. HAWAII MEDICAL SERVICE ASSOCIATION, Defendant-Appellee, and JOHN DOES 1-99; JANE DOES 1-99; DOE ENTITIES 1-20; and DOE GOVERNMENTAL UNITS 1-10, Defendants

APPEAL FROM THE CIRCUIT COURT OF THE FIRST CIRCUIT
(CIVIL NO. 07-1-1388)

SUMMARY DISPOSITION ORDER
(By: Ginoza, Chief Judge, Fujise and Reifurth, JJ.)

In this third appeal from a dispute arising out of insurance coverage for treatments for multiple myeloma, Plaintiff-Appellant Patricia E.G. Adams, in her capacity as Personal Representative of the Estate of Brent Adams and in her personal capacity (Adams), appeals from the January 14, 2015 "Order Granting Defendant[-Appellee] Hawaii Medical Service Association's [(HMSA)] Motion for Summary Judgment Filed November 17, 2014;"[1] the January 16, 2015 Final Judgment; and the April 10, 2015 Order Denying Plaintiff's Motion for Clarification and Reconsideration (Order Denying Reconsideration) entered by the Circuit Court of the First Circuit (Circuit Court).[2]

In the second appeal, Adams v. Hawaii Med. Serv. Ass'n, 130 Hawai'i 351, 310 P.3d 1052, No. 30314 2013 WL 5443025 at *1 (App. Sept. 30, 2013) (SDO) (Adams II), this court remanded the

[1] Although file-marked on January 13, 2015, the order appears to have been signed on January 14, 2015.

[2] The Honorable Virginia L. Crandall presided.

case for further proceedings after we determined that a grant of summary judgment in favor of HMSA on Adams's claim of bad faith mishandling of a 2006 request for pre-authorization for an allogeneic stem-cell transplant (allo-transplant) was in error. We noted that due to the suspension of discovery, very little discovery could have been conducted in the case at that point. In Adams II, we also vacated summary judgment on Adams's claims for negligent infliction of emotional distress (NIED) and intentional infliction of emotional distress (IIED).

On remand, after discovery had been conducted, HMSA moved for summary judgment, arguing that its response to the now-documented, March 2, 2006 written request for pre-authorization for an allo-transplant was timely and objectively reasonable; that it did not "keep silent" about the fact that the insurance policy did not cover allo-transplants for multiple myeloma; Adams's failure to appeal HMSA's decision to deny coverage was not due to any delay on HMSA's part, but based on the treating doctor's opinion that there was no medical basis to appeal; and Adams's claims for IIED, NIED, and punitive damages were deficient as a matter of law. Adams responded that there were genuine issues of material fact regarding whether HMSA mishandled the request for pre-authorization. The Circuit Court granted HMSA's motion for summary judgment from which Adams now appeals.

Adams raises four points of error:

> A. The trial court erred when it failed to conclude that, as a matter of law, HMSA violated [Hawaii Revised Statutes (HRS)] § 432:1-101.5 by neglecting on several successive occasions to respond to [Adams's] documented requests for information with current, understandable, and timely responses regarding coverages and benefits, coverage principles, and any exclusions or restrictions on coverage, and even if such violations did not constitute bad faith *per se*, there were genuine issues of material fact whether such violations were violations "under all the circumstances."
>
> B. The trial court erred when it failed to find that it was a genuine issue of material fact whether City of Hope [(COH)] was HMSA's agent for preauthorization requests, upon which finding HMSA could be held liable for [COH's] errors and omissions in handling the preauthorization requests and the donor match results where
>
> --HMSA steered [Adams] away from their preferred provider to [COH] with which HMSA had previously contracted to provide tandem auto-allo transplants

> designating [COH] one of a small number of exclusively contracted transplant centers offered to HMSA members as "Blue Distinction Transplant Centers." and
>
> --HMSA had in its contract with Brent Adams restricted the authority for submitting preauthorization requests to his providers, [COH] and Dr. Stein[.]

C. The trial court erred in assigning dispositive significance to the issue of whether a matched donor was identified prior to [COH's] submission of the request for preauthorization because there was no requirement that a match be identified prior to submitting a request for preauthorization for an allo[-]transplant.

D. The trial court abused its discretion when it excluded as hearsay evidence that a matched donor was identified . . . because it should have held [Adams] to the lower evidentiary standard applicable to non-movants when it was clear that [Adams] could produce [a trial witness], and could have ordered a brief continuance to allow [Adams] time to secure affidavits[.]

After careful consideration of the issues raised and the arguments made by the parties, the applicable authority and the record, we resolve Adams's points on appeal as follows and affirm.

1. Although Adams argues on appeal that the Circuit Court erred when it failed to conclude that, as a matter of law, HMSA violated HRS § 432:1-101.5 (2005), this argument is waived as to the order and entry of summary judgment because it was not properly raised in litigating that motion. See Hawaii Ventures, LLC v. Otaka, Inc., 114 Hawai'i 438, 500, 164 P.3d 696, 758 (2007). Adams did not allege this violation as a basis for her bad faith claim in her Second Amended Complaint. Adams did not rely on this statute in her written opposition to HMSA's motion for summary judgment, nor did she cite to the provision at the hearing on the motion, but merely argued that under a different statute, HRS § 431:10-237, HMSA was obligated to provide Adams with a complete copy of the contract but had not done so. Moreover, Adams's citation to the record for this point in her opening brief does not support preservation by Adams of this claimed error as it does not demonstrate she brought it to the attention of the Circuit Court. See Hawai'i Rules of Appellate Procedure (HRAP) Rule 28(b)(4).

With regard to the Order Denying Reconsideration, Adams also failed to preserve her alleged error as she failed to challenge this decision in this point on appeal. In any event, Adams did not argue until her "[Plaintiff's] Reply to [HMSA's] Memorandum in Opposition to [Plaintiff's] Motion for Clarification and Reconsideration [(Motion for Reconsideration)], Filed March 13, 2015[,]" citing to HRS § 432:1-101.5[3] and Siopes v. Kaiser Found. Health Plan, Inc., 130 Hawai'i 437, 312 P.3d 869 (2013), that HMSA could not rely on the terms of the plan because it did not allege that it gave a copy of the plan to Adams. Adams presented no reason why she could not have raised this argument prior to the Motion for Reconsideration. Ass'n of Apartment Owners of Wailea Elua v. Wailea Resort Co., Ltd., 100 Hawai'i 97, 110, 58 P.3d 608, 621 (2002) ("As this court has often stated, 'the purpose of a motion for reconsideration is to allow the parties to present new evidence and/or arguments that could not have been presented during the earlier adjudicated motion.' Reconsideration is not a device to relitigate old matters or to raise arguments or evidence that could and should have been brought during the earlier proceeding.") (quoting Sousaris v. Miller, 92 Hawai'i 505, 513, 993 P.2d 539, 547 (2000)). The Circuit Court did not err in denying Adams's Motion for Reconsideration on this basis.

Although the Circuit Court found that the March 2, 2006 request was timely acted upon, Adams asks this court to consider the telephone calls, beginning in December 2005, as part of "all the circumstances" leading up to the denial of the March 2, 2006 written request, apparently assuming the telephone calls were the

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[3] HRS § 432:1-101.5, Disclosure of health care coverage and benefits provides:

> In order to ensure that all individuals understand their health care options and are able to make informed decisions, all mutual benefit societies shall provide current and prospective members with written disclosure of coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage.
>
> The information provided shall be current, understandable, and available prior to membership, and upon request after membership. A policy provided to a member which describes coverages and benefits shall be in conformance with part I of article 10 of chapter 431.

equivalent of formal preauthorization requests. While "an action for the tort of 'bad faith' will lie, for example, when an insurance company unreasonably handles or denies payment of a claim," Francis v. Lee Enters., Inc., 89 Hawai'i 234, 238, 971 P.2d 707, 711 (1999), the duties of good faith and fair dealing implied in every insurance contract, arise after the insured complies with the claims procedure described in the insurance policy. Safeco Ins. Co. of Am. v. Parks, 88 Cal. Rptr. 3d 730, 740 (Cal. Ct. App. 2009).

Chapter 5 of Adams's policy directed that preauthorization requests be made in writing or by fax. HMSA reminded COH by fax correspondence that it was awaiting a modified request for the allo-transplant on February 6, 2006 and February 27, 2006. "There can be no 'unreasonable delay' until the insurer receives adequate information to process the claim[.]" Globe Indem. Co. v. Superior Court, 8 Cal. Rptr. 2d 251, 255 (Cal. Ct. App. 1992). Until HMSA received the pre-authorization request in writing, as required by the policy, there was no claim for it to process, nor would it know what the specific request would be. Once HMSA received the written request on March 2, 2006, it is undisputed that on March 6, 2006, HMSA called COH to inform it that the request was denied, and HMSA sent a formal denial letter which was received by Adams on March 8, 2006.

Although Adams argues that HMSA should have communicated "complete and current information about the coverage and benefits, coverage principles, exclusions and restrictions . . . in writing," she primarily identifies the information that HMSA would deny coverage for an allo-transplant in tandem with an auto-transplant. However, the dispute regarding this very coverage issue was not resolved until 2009, in Adams I. Hawaii Med. Serv. Ass'n v. Adams, 120 Hawai'i 446, 209 P.3d 1260 (App. 2009). Thus, it was an open question at the time HMSA was addressing Adams's request for the allo-transplant in 2006, whether it was covered by Adams's policy. See, Enoka v. AIG, 109 Hawai'i 537, 552-53, 128 P.3d 850, 865-66 (2006).

Thus, the Circuit Court did not err when it held there were no genuine issues of material fact and granted summary judgment in favor of HMSA based on its timely denial of Adams's written request.

2. To the extent that Adams contends that COH mishandled the initial submission of the pre-authorization request and that HMSA should be held liable as its principal, she provides no legal authority for such a result. Other jurisdictions have concluded that even though an insurer required preauthorization in order to pay for treatment by a provider, that did not make the insurer vicariously liable for acts or omissions of the provider. See Basil v. Wolf, 935 A.2d 1154, 1171-72 (N.J. 2007).

3. Adams argues the Circuit Court erred to the extent it based its grant of summary judgment on its view that COH was required to identify a matched donor prior to submitting the pre-authorization request. However it does not appear that the Circuit Court gave this issue dispositive significance when it granted summary judgment. In fact, the Circuit Court stated, "the March 2nd request for the auto-allo was submitted even at that time when they did not have confirmation of a matching donor. But when it was submitted, it was timely acted upon and no appeal from that denial was filed." Rather than affording dispositive weight to whether the request was dependent on securing a donor, the Circuit Court appears to have based its decision on how quickly HMSA acted once the pre-authorization request was formally submitted.

4. Adams argues that if the identification of a matched donor must be considered under all the circumstances in determining whether HMSA's delay was reasonable, then the trial court's exclusion of Adams's declaration as hearsay was reversible error. As discussed *supra*, the identification of a matched donor was not determinative of whether HMSA's delay was reasonable, because the Circuit Court focused on whether the interval between the receipt of the written request and the communication of its denial was reasonable.

Regardless, the Circuit Court properly excluded the testimony as hearsay. "Affidavits in support of a summary judgment motion are scrutinized to determine whether the facts they aver are admissible at trial and are made on the personal knowledge of the affiant." Miller v. Manuel, 9 Haw. App. 56, 66, 828 P.2d 286, 292 (1991). Adams only argues that any doubt concerning the propriety of granting the motion should be resolved in favor of the non-moving party. However, Adams does not argue that the proposed testimony was not hearsay, and the record does not reflect that the Circuit Court erred in ruling that the proposed testimony was inadmissible hearsay.

To the extent Adams argues that the Circuit Court abused its discretion in not granting a continuance to allow her to obtain admissible evidence, such an argument was waived when she failed to request such a continuance and did not state the reasons why she could not present by affidavit the essential facts in support of her position. Hawai'i Rules of Civil Procedure Rule 56(f).

Based on all the foregoing, the January 14, 2015 "Order Granting Defendant Hawaii Medical Service Association's Motion for Summary Judgment Filed November 17, 2014[;]" the January 16, 2015 Final Judgment; and the April 10, 2015 Order Denying Plaintiff's Motion for Clarification and Reconsideration entered in the Circuit Court of the First Circuit are affirmed.

DATED: Honolulu, Hawai'i, June 8, 2018.

Rafael G. Del Castillo,
(Jouxson-Meyers & Del Castillo; James C. McWhinnie and Tred R. Everly, with him on the briefs; Damon Key Leong Kupchak Hastert)
for Plainiffs-Apellants.

Chief Judge

Dianne Winter Brookins,
(John-Anderson L. Meyer, and Morgan Lisa Early with her on the briefs; Alston Hunt Floyd & Ing)
for Defendant-Appellee.

Associate Judge

Associate Judge

No. SCWC-15-0000393

IN THE SUPREME COURT OF THE STATE OF HAWAII

PATRICIA E. G. ADAMS, IN HER CAPACITY AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BRENT ADAMS, AND IN HER PERSONAL CAPACITY, Petitioner/Plaintiff-Appellant, vs. HAWAII MEDICAL SERVICE ASSOCIATION, Respondent/Defendant-Appellee.	ON APPLICATION FOR A WRIT OF CERTIORARI TO THE INTERMEDIATE COURT OF APPEALS ICA Summary Disposition Order: June 8, 2018 ICA Judgment: July 6, 2018 Circuit Court: Civil No. 07-1-1388 Circuit Court of the First Circuit Hon. Virginia L. Crandall Judgment: January 6, 2015

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this date a true and correct copy of the foregoing document, will be duly served on the following parties via JEFS electronically:

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