

# Avoiding Arbitration in Health Insurance Bad Faith Cases

By Rob Gianelli and Alexandra Gianelli

## I. WHY IT MATTERS

A health insurance bad faith case—one that is not subject to ERISA or some other exception to California common law claims—can provide a compelling story for a significant jury verdict. (See, e.g., *Sierra Health and Life Insurance Company, Inc. v. Eskew* (Nev. 2024) 553 P.3d 441 where the Nevada Supreme Court upheld an extremely large, multi-million verdict against a UnitedHealthcare affiliate for its bad faith denial of a claim for proton therapy to treat the insured's esophageal cancer.) Jurors understand the frustration and suffering that can result when needed medical care is unjustly delayed or denied and they are not afraid to render a big verdict.

Arbitration is a different story. The same case would likely result in a much smaller award, *if any*. Studies have shown the disparate results between arbitration and jury

trials for securities and employment cases.<sup>1</sup> Arbitrators rarely award large compensatory damage awards, much less the punitive damage awards that are typically the centerpiece of an insurance bad faith case.

It is not surprising then that health plans doing business in California (with the exception of Blue Shield of California) place binding arbitration agreements in their contracts and, when sued, readily file motions (or petitions) to compel arbitration. Needless to say, beating that motion will make a significant difference in the value of a client's health insurance bad faith case. Care must be taken to address all the arguments that can be advanced to defeat the motion and avoid arbitration.

## II. THE DISCLOSURE STATUTES

Both the Insurance Code and the Health & Safety Code contain statutes that authorize the use of binding arbitration provisions in

health care contracts covering California residents. If a health plan utilizes such a provision, however, it must make certain disclosures in both the contract's binding arbitration provision and the insured's enrollment form. Insurance Code section 110123.9; Health & Safety Code section 1363.1 ("section 1363.1"). For reasons likely related to the market share of contracts subject to the Health & Safety Code, the reported decisions on the application of these laws all concern section 1363.1. Accordingly, the following comments are confined to that law.

A health plan's compliance with section 1363.1 is the first line of attack in opposing its motion to compel arbitration.

### A. The basics

"Section 1363.1 establishes mandatory disclosure requirements for health services plans that require binding arbitration.'" (*Baglione v. Health Net of California, Inc.* (2023) 97 Cal.App.5th 882, 887 (*Baglione*), quoting *Rodriguez v. Blue Cross of California* (2008) 162 Cal.App.4th 330, 335 (*Rodriguez*).)

The disclosures required by section 1363.1 must appear in both the agreement issued to the subscriber and the enrollment form. (Section 1363.1, subd. (b); *Rodriguez*, 162 Cal.App.4th at 341.)

A failure to comply with section 1363.1 renders any arbitration agreement unenforceable. (*Baglione*, 97 Cal.App.5th at 890; *Rodriguez*, 162 Cal.App.4th at 340.) "Even '[t]echnical violations' of the statute ... render [the] arbitration provision unenforceable' regardless of whether the



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person enrolling in the health plan received some notice of the arbitration clause by reviewing the noncomplying provision. [Citations].” (*Baglione*, 97 Cal.App.5th at 889.)

And because section 1363.1 is a law that regulates the business of insurance within the meaning of the McCarran-Ferguson Act, it is not preempted by the Federal Arbitration Act. (*Baglione*, 97 Cal.App.5th at 894; *Smith v. PacifiCare Behavioral Health of Cal., Inc.* (2001) 93 Cal.App.4th 139, 162.)

## B. Enrollment form disclosures

A health plan’s non-compliance with section 1363.1 typically occurs in the insured’s enrollment form when a disclosure is not “prominently displayed” in violation of subdivision (b) and/or is not “displayed immediately before the signature line” as required by subdivision (d).

### 1. Prominence

Prominence of the disclosure was found lacking in *Imbler v. PacifiCare of Cal., Inc.* (2002) 103 Cal.App.4th 567, where the court found that a disclosure in the middle of other information on the enrollment form and “in the same font as the rest of the paragraph, and was not bolded, underlined or italicized” did not stand out and was not “readily noticeable.” (*Id.* at 579. See also *Burks v. Kaiser Foundation Health Plan, Inc.* (2008) 160 Cal. App.4th 1021, 1029 [“Given the plain, small typeface Kaiser used for its arbitration disclosure without any heading, and

given that most of the rest of the form ... contains larger typeface, some of which is bold and some of which is highlighted by a different colored background, we agree with the trial court that the disclosure is not ‘prominently displayed’ on the enrollment form”]; *Zembsch v. Superior Court* (2005) 146 Cal.App.4th 153, 165-167 [arbitration provision that was in the same typeface as the majority of the enrollment form was not prominently displayed].)

The takeaway here is that the disclosure must be set off from other language in the enrollment form such that it is “readily noticeable”: a heading, distinctive typeface, or bolding.

### 2. Immediately before the signature line

This requirement means exactly what it says. A statutorily compliant disclosure must be directly before the insured’s signature line “without any intervening language.” (*Robertson v. Health Net of California, Inc.* (2005) 132 Cal.App.4th 1419, 1426, emphasis in original.) It does not matter that the enrollment form elsewhere may have contained the required disclosures. The intervening matter ruptures the procedural requirement of immediacy, which is “mandated” under the statute. (*Id.* at 1428.)

In *Baglione*, the enrollment form contained broad language regarding the types of disputes subject to arbitration. But before the signature line, “the disclosure qualifies this broad language by mentioning that ‘a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance.

Mandatory arbitration may not apply to certain disputes if the Employer’s plan is subject to ERISA[.]” (*Id.*, 97 Cal.App.5th at 888-889.) This reference to “additional documents and inapplicable laws between the bulk of the disclosure and the signature line” violated subdivision (d). (*Id.*)

## 3. Affordable Care Act cases

There is an open issue regarding whether section 1363.1’s enrollment form disclosure requirements apply to online and telephonic applications through Covered California.<sup>2</sup>

Health plans contend the enrollment form requirements are “conflict preempted” by California’s implementation of the Patient Protection and Affordable Care Act, specifically, the requirement in Cal. Code Regs., tit. 10, § 6470 that Covered California use a “single, streamlined application” containing generic arbitration language. For this proposition, health plans cite *Hunter v. Kaiser Foundation Health Plan, Inc.* (N.D. Cal. 2020) 434 F.Supp.3d 764 and the unpublished case *Hunter* relies on, *Simon v. Blue Cross of California* (Cal. Ct. App., Nov. 1, 2019, No. B292118) 2019 WL 5677552.

But *Hunter* and *Simon* do not address the conflict preemption test or dare to explain how the allegedly conflicting law meets that test. Effective counter arguments can be made.

A party asserting conflict preemption has the burden to prove that it is impossible to comply with both the federal and state requirements. (*Viva! Internat. Voice for Animals v. Adidas Promotional*

*Retail Operations, Inc.* (2007) 41 Cal.4th 929, 936, “[C]onflict preemption will be found when simultaneous compliance with both state and federal directives is impossible.”)]

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To begin with, Cal. Code Regs., tit. 10, § 6470 is directed to Covered California, not a specific health plan, so it does not prevent health plans from doing anything. The “single, streamlined application” requirement is addressing the Covered California application process, not health plan’s duties. And the regulation’s generic reference to arbitration explicitly advises the applicant that the details of the arbitration agreement, if any, are in the “full arbitration provision” in the health plan’s contract. This supports the argument that the specific disclosures required by section 1363.1 are left to the health plan and, therefore, do not interfere with the Covered California online enrollment process.

Next, because the health plan must ultimately enroll the insured, the argument can be made that it had the opportunity and means to provide the required disclosures after Covered California determined the applicant’s eligibility. This should refute any argument that it was impossible to comply with section 1363.1.

Finally, the question of whether a third party’s control of the enrollment process precludes application of section 1363.1 was addressed in *Medeiros v. Superior Court* (2007) 146 Cal.App.4th 1008. There the health plan entered into a group contract with Medeiros’s employer, the County of San Bernardino, to provide health coverage to the County’s employees. (*Id.* at 1011.) Like Covered California, the

County was not regulated by the Department of Managed Health Care or the Knox-Keene Act. The health plan argued that, because the County enrolled employees with its own form, it was not required to comply with section 1363.1. The court rejected this argument finding that “[i]f an employer prepared form does not provide the health plan with an appropriate ‘vehicle’ to make the required disclosures then the health plan must provide its own form for this purpose.” (*Id.* at 1018.)

### C. Jury trial waiver and the type of dispute

Section 1363.1, subd. (c) states:

The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.

This disclosure is specific to the waiver of the right to a jury trial and applies to both the enrollment form and the arbitration provision in the contract. It requires the health plan to clearly state if it is requiring such a waiver for medical malpractice disputes and/or other types of disputes and must be expressed in language substantially similar to that in Code of Civ. Proc. section 1295, subd. (a).<sup>3</sup>

Subdivision (c) violations were found in both *Rodriguez* and *Baglione*. In *Rodriguez*, the disclosure began with broad language stating that “Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice.” (*Rodriguez*, 162 Cal.App.4th at 333.) But the jury trial waiver language was limited to a recitation of the language in Code of Civ. Proc. section 1295, subd. (a) without modification for disputes other than medical malpractice. (*Id.* at 338-339.) The court found this violated subdivision (c) because “[t]he discrepancy between the first sentence, which is expansive, and the remainder of the disclosure, which is limited to medical malpractice, creates confusion.” (*Id.*)

In *Baglione*, the disclosure also began with broad language relating to all disputes but qualified that language with an inapplicable reference to ERISA. The court found

this violated subdivision (c) because “the enrollee can only know which disputes he will have to submit to arbitration by determining whether his plan is covered by ERISA and then by determining what disputes ‘may’ be exempted by ERISA.” (*Baglione*, 97 Cal.App.5th at 888-889.)

Given these decisions, any arbitration language in the contract or the enrollment form should be scrutinized for a disconnect between the waiver of the right to a jury trial and other types of disputes, applicable or not. It is also essential to keep in mind that the interpretation standard under section 1363.1 is “clear and understandable,” not the plain meaning standard typically applied to construing contracts or statutes. This means that any ambiguity or uncertainty in a disclosure creates a violation. (*Haynes v. Farmers Ins. Exchange* (2004) 32 Cal.4th 1198, 1211 [holding that an ambiguous policy provision does not satisfy the analogous “plain and clear” standard for interpreting policy exclusions].)

## III. UNCONSCIONABILITY

If no violation of the disclosure statutes can be shown, an arbitration agreement may be unenforceable if it is “unconscionable.” “A written agreement to submit a controversy to arbitration is valid, enforceable, and irrevocable, ‘save upon such grounds as exist for the revocation of any contract.’ (Code Civ. Proc., § 1281.) Unconscionability provides such grounds. [Citation].” (*Ramirez v. Charter Communications, Inc.* (2024) 16 Cal.5th 478, 492.)

Unconscionability has a substantive and a procedural component. Both elements must appear to invalidate a contract, but they need not be present to the same degree. (*Armendariz v. Foundation Health Psychcare Services, Inc.* (2000) 24 Cal.4th 83, 114.) Procedural and substantive unconscionability are considered on a sliding scale. (*Id.*)

### A. Procedural unconscionability

Procedural unconscionability focuses on oppression or surprise due to unequal bargaining power. (*Baltazar v. Forever 21, Inc.* (2016) 62 Cal.4th 1237, 1243.) “Oppression” arises from an inequality of bargaining power which results in no real negotiation and an absence of meaningful choice. (*Davis v. TWC Dealer Group*,

*Inc.* (2019) 41 Cal.App.5th 662, 671.) Surprise occurs when “the supposedly agreed-upon terms of the bargain are hidden,” contrary to the reasonable expectations of the weaker party. (*Heckman v. Live Nation Entertainment, Inc.* (9th Cir. 2024) 120 F.4th 670, 682 [interpreting California law].)

Procedural unconscionability should always be present when assessing a binding arbitration provision in a health care contract. Requiring consumers to agree to arbitration as a condition of entering into a contract for “life’s necessities”—such as contracts for employment or medical care—is inherently oppressive. (*Lhotka v. Geographic Expeditions, Inc.* (2010) 181 Cal.App.4th 816, 823.) No further showing should be required. (*Carbajal v. CWPSC, Inc.* (2016) 245 Cal.App.4th 227, 244.)

Additionally, procedural unconscionability is established by the fact that a health care contract is a contract of adhesion, i.e., a “standardized contract” that was “imposed upon [the insured] without an opportunity to negotiate the terms.” (*Flores v. Transamerica Homefirst, Inc.* (2001) 93 Cal.App.4th 846, 853.) An insured lacks “the ability to modify, negotiate, or refuse any part of the” arbitration agreement as part of the enrollment process. (*Dougherty v. Roseville Heritage Partners* (2020) 47 Cal.App.5th 93, 104; *Haydon v. Elegance at Dublin* (2023) 97 Cal.App.5th 1280, 1288-1289.)

Procedural unconscionability may be enhanced where the health plan fails to make an adequate disclosure of the arbitration rules that will apply to the dispute. This can occur by the simple omission of details or the reference to rules of a dispute resolution organization without providing a copy of its rules. “Numerous cases have held that the failure to provide a copy of the arbitration rules to which the employee would be bound, supported a finding of procedural unconscionability.” (*Carbajal v. CWPSC, Inc.*, *supra*, 245 Cal.App.4th at 244-245 [collecting cases].)

## B. Substantive unconscionability

“Substantive unconscionability examines the fairness of a contract’s terms.” (*OTO, L.L.C. v. Kho* (2019) 8 Cal.5th 111, 129.) In assessing substantive unconscionability, the “paramount consideration” is *mutuality* of the obligation to arbitrate. (*Nyulassy*

*v. Lockheed Martin Corp.* (2004) 120 Cal.App.4th 1267, 1287; *Pinela v. Neiman Marcus Group, Inc.* (2015) 238 Cal.App.4th 227, 241.)

## If no violation of the disclosure statutes can be shown, an arbitration agreement may be unenforceable if it is “unconscionable.”

The primary issue is whether the weaker party is giving up its right to a jury trial on all or certain claims and the stronger party is not. (*Ramirez v. Charter Communications, Inc.*, *supra*, 16 Cal.5th at 497 [finding the arbitration provision substantively unconscionable because it compelled arbitration of claims likely to be brought by the weaker party and exempted from arbitration claims more likely to be brought by the stronger party].) It is important, therefore, to review the sentences of the arbitration provision to determine who is bound to it and for what types of claims. Any disparity between the health plan’s jury trial rights and the insured’s rights will support a claim for substantive unconscionability.

Lack of mutuality can also be shown by the arbitration agreement’s use of one-sided discovery rules. In *Haydon v. Elegance at Dublin*, *supra*, the court found that certain JAMS “Rules and Procedures” were substantively unconscionable, including: (1) limitations on discovery which provide for only a single deposition (absent a determination by the arbitrator that additional depositions are necessary) and do not provide for interrogatories or requests for admission; and (2) a confidentiality provision barring the parties from disclosing the existence, content, or results of the arbitration. (*Haydon*, *supra*, 97 Cal.App.5th at 1291.)

Limitations on discovery are particularly onerous for an insured in a health insurance bad faith case because the bulk of the discovery needed to prove bad faith and entitlement to punitive damages will be in the health plan’s possession. (*Kinney v. United HealthCare Services, Inc.* (1999) 70 Cal.App.4th 1322, 1332 [“Given that United is presumably in possession of the vast majority of evidence that would

be relevant to employment-related claims against it, the limitations on discovery, although equally applicable to both parties, work to curtail the employee’s ability to substantiate any claim against United.”])

There is also the issue of the “repeat player” effect. When a health plan’s arbitration provision designates a particular dispute resolution company to arbitrate the dispute, such as JAMS, the argument can be made that the health plan’s repeated appearance before the same group of arbitrators gives it an unfair advantage. The health plan would know the arbitrators’ temperaments, procedural preferences, styles and the like. Also, the arbitrators may seek to cultivate further business with that health plan by taking a “split the difference” approach to damages. (*Mercurio v. Sup.Ct. (Countrywide Secur. Corp.)* (2002) 96 Cal.App.4th 167, 178; *Sanchez v. Western Pizza Enterprises, Inc.* (2009) 172 Cal.App.4th 154, 177-178 [employer as “repeat player” before single arbitrator has opportunity to gain advantage through its knowledge and experience with arbitrator], abrogated on other grounds as recognized in *Iskanian v. CLS Transp. Los Angeles, LLC* (2014) 59 Cal.4th 348, 366.)

## C. Severability

A finding that an aspect of an arbitration provision is unconscionable does not end the analysis. The health plan will argue that any unconscionable term may be severed, and the arbitration agreement enforced, under Civ. Code § 1670.5(a).

Courts should refuse to enforce an agreement in its entirety, rather than sever an unconscionable provision, “when the agreement is ‘permeated’ by unconscionability.” (*Armendariz*, *supra*, 24 Cal.4th at 122.) “The overarching inquiry is whether the interests of justice ... would be furthered by severance.” (*Carmona v. Lincoln Millennium Car Wash* (2014) 226 Cal.App.4th 74, 90 [quotations omitted].) If the central purpose of a contractual provision, such as an arbitration agreement, is tainted with illegality, then the provision as a whole cannot be enforced. (*Id.*) If the illegality is collateral to the main purpose of the contractual provision, and can be severed or restricted from the rest, then severance is appropriate.

An agreement to arbitrate is considered “permeated” by unconscionability

where, for example, it contains more than one unconscionable provision. (*Magno v. The College Network, Inc.* (2016) 1 Cal. App.5th 277, 292.) This is because such multiple defects indicate a systematic effort to impose arbitration not simply as an alternative to litigation but as an inferior forum that works to the defendant's advantage. (*Carbajal, supra*, 245 Cal. App.4th at 254.)

In *Haydon, supra*, the court found that an arbitration agreement that incorporated multiple substantively unconscionable JAMS Rules was "permeated by unconscionability." (*Haydon, supra*, 97 Cal. App.5th at 1292.)

#### IV. DISCOVERY

Many assume that discovery is unnecessary or not allowed for opposing a motion to compel arbitration. Not so. Discovery is allowed and should be undertaken when there is a relevant factual issue. The hearing on such a motion is an evidentiary one where "the trial court sits as a trier of fact, weighing all the affidavits, declarations, and other documentary evidence, as well as oral testimony received at the court's discretion, to reach a final determination." (*Engalla v. Permanente Medical Group, Inc.* (1997) 15 Cal.4th 951, 972.)

Having said that, there are usually only two relevant arbitration documents for these motions, the health care contract with its arbitration provision and the enrollment form, and both should be attached to the motion. We have seen instances, however, where a health plan has tried to hide a non-compliant enrollment form by simply omitting it and addressing only the arbitration provision in the contract. While this tactic likely causes the health plan to fail in meeting its burden of proving an agreement to arbitrate (*Baglione*, 97 Cal.App.5th at 893), it is best to request the enrollment form and factually prove non-compliance.

A given case may also call for discovery of additional facts. In *Baglione*, the insured was covered under a group health contract (non-ERISA). In moving to compel arbitration, the health plan submitted the insured's individual evidence of coverage and his enrollment form but not the group contract. One of the plaintiff's theories of non-compliance with section 1363.1 was that there was no signature by a representative of the

group immediately below the arbitration disclosure in the group contract. Plaintiff secured the group contract in discovery which showed no signature. The trial court exclusively relied on this fact in finding a violation of subdivision (d). (*Baglione*, 97 Cal.App.5th at 887.)

#### V. CONCLUSION

While losing a motion to compel arbitration in a health insurance bad faith case is not the equivalent of losing the case, it is a close second. To avoid this harsh result and maintain the client's right to a jury trial, time and effort must be given to each of the potential issues that can be raised in opposition to the motion. Make sure all the required statutory disclosures are present in both the arbitration provision and the enrollment form. And always provide a back-up unconscionability analysis given the adhesive nature of the contract and the lack of the insured's ability to opt out of arbitration. Defeating the motion will result in a significantly higher case value. ■

<sup>1</sup> Seru, Tipping the scales: Balancing consumer arbitration cases, Stanford Institute for Economic Policy Research, Feb. 2023; Gough, A Tale of Two Forums: Employment Discrimination Outcomes in Arbitration and Litigation, ILR Review, 74(4), Aug. 2021, pp. 875-897.

<sup>2</sup> Covered California is California's official health insurance marketplace, established under the Patient Protection and Affordable Care Act, where eligible California residents can receive financial assistance to lower the cost of premiums.

<sup>3</sup> Code of Civil Procedure section 1295, subd. (a) provides: "Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language: 'It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.'"