IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CIVIL TRIAL DIVISION

PENNSYLVANIA CHIROPRACTIC ASSOCIATION, et al.,	:	AUGUST TERM, 2000
Plaintiffs	:	No. 2705
v.	:	COMMERCE CASE PROGRAM
INDEPENDENCE BLUE CROSS, et al.,	:	
Defendants	:	Control No. 111113

ORDER

AND NOW, this 16th day of July, 2001, upon consideration of defendants' Preliminary Objections to plaintiffs' First Amended Complaint, plaintiffs' opposition thereto, all respective memoranda, all other matters of record, having heard oral argument on this matter, and in accord with the contemporaneously-filed Opinion, it is hereby **ORDERED** as follows:

1. The demurrers to Counts I (as to Provider Plaintiffs) and to Count II (as to Subscriber Plaintiffs) are **Sustained**.
2. The demurrer to Count III is **Overruled**.
3. The Preliminary Objection regarding the lack of standing of the Pennsylvania Chiropractic Association and the Southern New Jersey Chiropractic Society is **Sustained**.
4. The motion to strike the demand for punitive damages as to Count I is **Granted**.
5. Defendants shall file an Answer to the First Amended Complaint within twenty (20) days of entry of this court's Order.

BY THE COURT,

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JOHN W. HERRON, J.

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v.	:	COMMERCE CASE PROGRAM
INDEPENDENCE BLUE CROSS, et al.,	:	
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MEMORANDUM OPINION

Presently before this court are the Preliminary Objections of defendants, Independence Blue Cross, Amerihealth, Inc., Keystone Health Plan East, Inc., Healthcare Delaware, Inc., American Health Alternatives, Inc., Amerihealth Insurance Company, QCC Insurance Company, Vista Health Plan and Amerihealth Administrators (hereinafter "Independence Blue Cross" or "defendants") to the First Amended Class Action Complaint of plaintiffs, Pennsylvania Chiropractic Association ("PCA"), Southern New Jersey Chiropractic Society ("SNJCS"), Steven C. Eisen, D.C. ("Eisen"), Alice E. Wright, D.C. ("Wright"), Douglas G. Pfeiffer, D.C. ("Pfeiffer"), John Cecchini, D.C.("Cecchini"), Deborah A. Carl ("Carl") and Sally Ann Spall ("Spall") .

For the reasons set forth in this Opinion, the court overrules the Preliminary Objections in part and sustains them in part.

BACKGROUND[1]

A. The Parties

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[1]The facts set forth in this background were gleaned from the Amended Complaint, and are accepted as true for the purpose of ruling on the Preliminary Objections. See Tucker v. Philadelphia Daily News, 757 A.2d 938, 941-42 (Pa.Super.Ct. 2000).

Plaintiffs are two associations representing chiropractors in Pennsylvania and southern New Jersey (PCA and SNJCS), four doctors of chiropractic medicine who are members of those associations (Eisen, Wright, Pfeiffer, and Cecchini) and two patients who have required chiropractic care (Carl and Spall). Am.Compl. at ¶¶ 1, 9-18.

The named individual doctors are referred to as the "Provider Plaintiffs" who seek to represent a class of all similarly situated Independence Blue Cross ("IBC") network providers. Id. at ¶ 3. PCA has approximately 750 members, of which 250 are IBC network providers, including Eisen, Wright and Pfeiffer. Id. SNJCS has 350 members, of which approximately 250 are IBC network providers, including Cecchini. Id. The Provider Plaintiffs entered into IBC Provider Contracts, pursuant to which they have agreed to accept discounted fees for providing chiropractic services in exchange for being granted full access to IBC subscribers. Id. at ¶ 14. The providers who have entered into the IBC provider contracts provide services to IBC subscribers and are known as "in-network" or "participating" providers, while those offering services without a contract with IBC are known as "out-of-network" or "nonparticipating" providers. Id. at ¶ 2.

The named patients are described as the "Subscriber Plaintiffs" who are former subscribers to health care plans operated or administered by IBC, and who seek to represent a class of all similarly situated IBC subscribers. Id. at ¶ 3. Specifically, Carl's health care plan was provided through her employer, Montgomery County, and Spall's health care plan was offered through her husband's employer, the Upper Perkiomen, Pennsylvania School District.[2] Id. at ¶¶ 15-16. The Subscriber Plaintiffs allegedly

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[2]Both health care plans are alleged to be government-sponsored health care plans which are exempt from the Employee Retirement Security Income Act of 1974 ("ERISA"). Am.Compl. at ¶¶

suffered from physical ailments for which chiropractic services were medically necessary and were appropriately covered under the terms of their health care plans. Id. at ¶ 17. Each of the Subscriber Plaintiffs appealed the allegedly improper denial of coverage for their chiropractic treatment and were unsuccessful in these appeals. Id. at ¶ 18. Additionally, IBC allegedly provided inadequate information concerning the procedure by which the Subscriber Plaintiffs could appeal the denials of care, including what guidelines were relied upon in denying care in the first instance. Id.

Defendant IBC provides and administers health insurance plans to millions of subscribers and has contracts with numerous health care providers including plaintiffs. Id. at ¶ 2. IBC enjoys special, statutorily bestowed benefits and exemptions under the Health Plan Corporation Act. Id. at ¶ 19. The remaining defendants are IBC subsidiaries, related to IBC and offer health care products and services by and through policies and practices developed by IBC, which were created to assist in the administration of health care plans designed by IBC. Id. at ¶ 20(a)-(i). These defendants include holding companies, HMOs, third-party administrators of health care plans, and insurance agencies. Id.

B. The Nature of the Action

The gravamen of the action is that plaintiffs seek relief from IBC's alleged policy and practice of improperly denying medically necessary chiropractic care in direct contravention of its contractual obligations with both its in-network health care providers and its subscribers in order that IBC may reduce its medical expenses and maximize its profitability. Id. at ¶ 1. As such, members of the Provider Class have allegedly been denied reimbursement for providing such services and members of the Subscriber

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15-16.

Class have allegedly been denied coverage for medically necessary chiropractic care despite having paid for quality health insurance which they were not provided. Id. at ¶ 8. With regard to the Provider Plaintiffs, IBC has allegedly breached the express and implied terms of the IBC provider contract(s) by applying undisclosed and improper medical guidelines to deny pre-certification for medically necessary chiropractic care and refusing to reimburse them for providing services that fall within the scope of their chiropractic licenses. Id. at ¶ 14. As to the Subscriber Plaintiffs, IBC allegedly refused to cover them for medically necessary chiropractic treatment and forced them to pay for such services out-of-pocket. Id. at ¶ 17.

1. Provider Class Claims

Each individual Provider Plaintiff entered into a provider contract with the defendants, under which they have agreed to serve as in-network providers of chiropractic care to IBC subscribers. Id. at ¶ 39. Pursuant to the terms of the provider contracts, the Provider Plaintiffs must agree to provide Covered Services, defined as "the Medically Necessary[3] health care services and supplies that are provided pursuant

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[3]The provider agreement defines "Medically Necessary" as follows:

1.13 Medically Necessary or Medical Necessity. The requirement that Covered Services or medical supplies are needed, in the opinion of (a) the Primary Care Physician or the referred specialist, as applicable, consistent with [IBC] policies, coverage requirements and utilization guidelines; and (b) [IBC], in order to diagnose and/or treat a Member's illness or injury, as applicable, and:

A. are provided in accordance with accepted standards of American medical practice;

B. are essential to improve the Beneficiary's net health outcome and may be as beneficial as any established alternatives;

C. are as cost-effective as any established alternative; and

D. are not solely for the Beneficiary's convenience, or the convenience of the

to a Benefit Program," to IBC subscribers in "the same manner, and with the same availability, as services are rendered to other patients without regard to reimbursement"; and "the clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by [IBC]." Id. at ¶ 40. See Am.Compl., Exhibit A at § 2.2.[4] The provider agreements also establish that the providers will receive compensation, in accordance with §§ 3.1-3.11, when Covered Services are provided. Id. at ¶ 44.[5]

Beneficiary's family or health care Provider.

Am.Compl., Exhibit A at § 1.13.

[4]The provider agreement includes this clause in relation to the provider's duties, which states in relevant part:

2.2 Provision of Services.

(a) Provider agrees to render Covered Services to Beneficiaries . . . in accordance with: (1) the terms and conditions of this Agreement; (2) all laws, rules and regulations applicable to Provider, or [IBC]; 93) the Utilization Management Program, Quality Management Program, Benefit Program Requirements, grievance, appeals and other policies and procedures of the particular Benefit Program under which the Covered Medical Services, as detailed in the Provider Manual published by and revised from time to time by [IBC] ("Provider Manual"), are rendered; (4) the same manner, and with the same availability, as services are rendered to other patients without regard to reimbursement; and (5) the clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by [IBC].

Am.Compl., Exhibit A at § 2.2(a).

[5]With respect to compensation, the provider agreement states in relevant part:

3.1 Compensation Rates. Provider shall accept as payment in full for Covered Services rendered under this Agreement to Beneficiaries the amounts payable by [IBC] as set forth in the applicable reimbursement schedule, less Copayment amounts payable by Beneficiaries in accordance with the applicable Benefit Program . . . .

3.7 Conditions for Reimbursement for Excluded Services. Provider may bill a

Doctors of Chiropractic, seeking reimbursement for spinal manipulation or mobilization, use a set of five "W-Codes" established by the Pennsylvania Insurance Department in 1996, which delineate the level of therapy needed depending on the complexity of the spinal problem and include a proposed reimbursement schedule. Id. at ¶ 46. These codes include the following: W0801 ("minimal"), W0802 ("minor"), W0803 ("low to moderate complexity"), W0804 ("moderate to high severity and "decision making of moderate complexity"), and W0805 ("moderate to high complexity"). Id. IBC refers to these codes as "S-Codes": S8901 (for W0801), S8902 (for W0802), S8903 (for W0803), S8904 (for W0804), and S8905 (for W0805). Id. at ¶ 47. As alleged, IBC has unilaterally re-written the provider contracts to limit compensation to the first three S-Codes and refuse to provide compensation for symptoms of the other two code levels, even where medically necessary or IBC denies pre-certification for more complex problems. Id. at ¶ 49. In addition, IBC and its agents have allegedly refused to pre-certify and provide compensation for other medical services like evaluation, diagnostic services or rehabilitation; have improperly restricted reimbursements for multiple and secondary treatments, have

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Beneficiary for other Excluded Services rendered by Provider to such Beneficiary only if the Provider satisfies the requirements set forth in Section 2.9 prior to Provider's rendition of such services or if the individual was not eligible to receive Covered Services on the date Excluded Services were provided. Neither a Beneficiary, nor [IBC] shall be liable to pay Provider for any contracted service rendered by Provider to a Beneficiary which is determined under a Utilization

(footnote 5 cont'd)

Management Program not to be Medically Necessary.

Am.Compl., Exhibit A at §§ 3.1, 3.7.

denied reimbursement for chronic conditions, and engaged in various other arbitrary conduct in violation of the provider contracts. Id. at ¶¶ 50-94.

2. Subscriber Class Claims

Members of the Subscriber Class have either contracted directly with IBC or subscribed to IBC plans through their employers. Id. at ¶ 95. The terms and conditions of the health care benefits offered by defendants to the Subscriber Plaintiff are set forth in the subscriber agreements, which are substantially identical to each other. Id. at ¶ 96. These agreements state that only treatment which is "medically necessary" will be covered. Am.Compl., Exhibit B.[6] The Subscriber Agreements also provide that "Benefits" will be provided for "Restorative Services"[7] (which include chiropractic services), in

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[6]The subscriber agreement defines "medically necessary" as follows:

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) - services or supplies provided by a Facility Provider that the Carrier determines are:

A. ordered by a Professional Provider or other appropriately licensed health care professional; and
B. required for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury; and
C. appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and
D. in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and
E. not primarily for the convenience of your Immediate Family, or of the Facility Provider or Professional Provider; and
F. the most efficient and economical supply or level of service that can be safely provided to you . . . .

Am.Compl., Exhibit B at 7.

[7]The Subscriber Agreement defines "Restorative Services" as "courses of treatments prescribed or provided by Professional Providers to restore loss of function of a body part.

accordance with the schedule of benefits.[8] Am.Compl. at ¶ 98. See Am.Compl., Exhibit B at 10, 24-25. The subscriber agreements do not identify the restrictions or limits on chiropractic care which IBC has purportedly imposed unilaterally through its policies, including denying coverage for (a) moderate to high complexity problems; (b) non-manipulation services; (c) multiple or secondary treatments provided during a particular visit; (d) chronic, as opposed to acute, care; (e) more than an undisclosed number of sessions predetermined by IBC according to its undisclosed guidelines; and (f) services when the patient has not fallen within IBC's undisclosed range of percentages of improvement. Am.Compl. at ¶ 99. IBC has thus restricted or limited the access of its subscribers to chiropractic care. Id.

Restorative services generally involve neuromuscular training as a course of treatments over weeks or months. Examples of restorative services include, but are not limited to:

- Manipulative treatment of functional loss from back disorder
- Therapy treatment of functional loss following foot surgery
- Treatment of oculomotor dysfunction.

Am.Compl., Exhibit B at 10.

[8]With respect to benefits for restorative services, the Subscriber Agreement states, in pertinent part, that:

Benefits shall be provided, up to the limits specified in the Schedule of Benefits, for Restorative Services when performed by a Professional Provider in order to restore loss of function of a body part. Restorative Services are any service, other than those specifically detailed above under THERAPY SERVICES, provided in accordance with a specific plan of treatment related to the Covered Person's condition which generally involve neuromuscular training as a course of treatments over weeks or months. . . .

Following a determination by a Professional Provider that restorative services are required, a specific plan of treatment must be precertified by the Carrier. Failure to pre-certify Non-Preferred Services will result in a 50% reduction in the benefits payable for these services.

Am.Compl., Exhibit B at 24-25.

Under this background, plaintiffs have brought their complaint, asserting counts for breach of contract and/or implied covenant of good faith and fair dealing on behalf of all plaintiffs, breach of fiduciary duty on behalf of the subscriber class, and violation of the Pennsylvania Unfair Trade Practices and Consumer Protection Law ("UTP/CPL")[9] on behalf of the subscriber class. Defendants filed Preliminary Objections, setting forth a demurrer to each count of the Amended Complaint, as well as challenging the standing of PCA and SNJCS, the two associations who purport to bring claims on behalf of their members.

LEGAL STANDARD

Rule 1028(a)(4) of the Pennsylvania Rules of Civil Procedure [Pa.R.C.P.] allows for preliminary objections based on legal insufficiency of a pleading or a demurrer. When reviewing preliminary objections in the form of a demurrer, "all well-pleaded material, factual averments and all inferences fairly deducible therefrom" are presumed to be true. Tucker v. Philadelphia Daily News, 757 A.2d 938, 941-42 (Pa.Super.Ct. 2000). Preliminary objections, whose end result would be the dismissal of a cause of action, should be sustained only where "it is clear and free from doubt from all the facts pleaded that the pleader will be unable to prove facts legally sufficient to establish [its] right to relief." Bourke v. Kazara, 746 A.2d 642, 643 (Pa.Super.Ct. 2000)(citation omitted). Moreover,

> [I]t is essential that the face of the complaint indicate that its claims may not be sustained and that the law will not permit recovery. If there is any doubt, it should be resolved by the overruling of the demurrer. Put simply, the question presented by demurrer is whether, on the facts averred, the law says with certainty that no recovery is possible.

[9]The UTP/CPL is codified at 73 P.S. §§ 201-1 et seq.

Bailey v. Storlazzi, 729 A.2d 1206, 1211 (Pa.Super.Ct. 1999). However, the pleaders' conclusions of law, unwarranted inferences from the facts, argumentative allegations, or expressions of opinions are not considered to be admitted as true. Giordano v. Ridge, 737 A.2d 350, 352 (Pa.Commw.Ct. 1999), aff'd. 559 Pa. 283, 739 A.2d 1052 (1999), cert. denied, 121 S.Ct. 307 (U.S. 2000).

DISCUSSION

I. PROVIDER PLAINTIFFS IN COUNT I[10] FAIL TO STATE A CAUSE OF ACTION FOR BREACH OF THE IMPLIED DUTY OF GOOD FAITH IN THE ALTERNATIVE SINCE THE EXPRESS CONTRACT PROVISIONS GOVERN DEFENDANTS' ALLEGED MISCONDUCT, RESULTING IN THE DENIAL OF COVERAGE AND COMPENSATION FOR ALLEGEDLY MEDICALLY NECESSARY TREATMENT.

Defendants argue that the Provider Plaintiffs[11] have failed to state a cause of action for breach of the implied duty of good faith and fair dealing on the following grounds: (1) the Provider Plaintiffs failed to allege a confidential or special relationship that might give rise to such a duty and the parties' relationship is that of independent entities; (2) there can be no breach of the implied duty since the express terms of the Provider Agreements govern the alleged misconduct and the implied duty cannot act to displace the express terms; (3) there can be no remedy for breach of the implied duty since the Pennsylvania Insurance Department provides an adequate forum to address the Provider Plaintiffs' claims; (4) no implied duty

[10]Count I of the Amended Complaint is entitled "First Cause of Action." For purposes of clarity, this count and the other two counts shall be designated as Count I, Count II and Count III.

[11]Defendants requested that this count be dismissed in its entirety in their Preliminary Objections, but they expressly admitted at oral argument that the Subscriber Plaintiffs have a claim for breach of the implied duty of good faith and fair dealing and defendants only addressed the purported defects to this claim as to the Provider Plaintiffs in their memorandum of law. 4/24/01 N.T. 10. This court will thus only address the demurrer with respect to the Provider Plaintiffs.

arises for conduct which pre-dates the contract(s) at issue; and (5) punitive damages may not be allowed under this count which sounds in contract. Defs. Mem. of Law, at 6-15.

In response, the Provider Plaintiffs argue (1) that the relationship between the providers and defendants is analogous to a franchisor/franchisee relationship since defendants impose their own requirements on the Provider Plaintiffs and exert some dominance over them which allows for application of the implied duty of good faith; (2) plaintiffs are not seeking to imply a contradictory contract by implying the duty of good faith but are seeking to compel defendants to comply with the express terms of the contract(s), which do not expressly relate to the specific instances of the conduct alleged here, but obligate defendants to provide coverage and compensation for services which are medically necessary; and (3) that the Pennsylvania Insurance Department is not an adequate forum to present such claims, as demonstrated by the Pennsylvania Legislature's enacting 42 Pa.C.S.A. § 8371 to provide a statutory private right of action for insurance bad faith. Pls. Mem. of Law, at 13-21.

In addressing defendants' objections to Count I, this court notes certain principles. First, the implied duty of good faith arises under the law of contracts, not under the law of torts. Creeger Brick and Building Supply v. Mid-State Bank and Trust Co., 385 Pa.Super. 30, 35, 560 A.2d 151, 153 (1989). As such, conduct which pre-dates the formation of the contract may not be the subject of the duty of good faith and fair dealing. Id. Further, punitive damages are not allowed in this count, which sounds only in contract. Baker v. Pennsylvania Nat'l. Mut. Cas. Ins. Co., 370 Pa.Super. 461, 469-70, 536 A.2d 1357, 1367 (1987), quoted in Brickman v. CGU Ins. Co., July 2000, No. 909, slip op. at 22 (C.P. Phila. Jan. 8, 2001)(Herron, J.) and Rader v. Travelers Indemnity Co. of Illinois, March 2000, No. 1199, slip op. at 4 (C.P. Phila. Sept. 25, 2000)(Herron, J.). Therefore, the part of the *ad damnum* clause, requesting

exemplary and punitive damages for defendants' breach of contract and/or breach of the implied duty of good faith is stricken as to Count I. Further, plaintiffs' claim in Count I may not be based on advertisements or promotions regarding defendants' health care products and/or defendants' alleged non-disclosure of the limitations on the receipt of chiropractic care. See Am.Compl. at ¶¶ 101, 114.[12]

Section 205 of the Restatement (Second) of Contracts (1979) suggests that "[e]very contract imposes each party a duty of good faith and fair dealing in its performance and its enforcement." The Pennsylvania Superior Court expressly adopted this section in Creeger Brick, 385 Pa.Super. at 35, 560 A.2d at 153 and Baker v. Lafayette College, 350 Pa.Super. 68, 84, 504 A.2d 247, 255 (1986). See also, Donahue v. Federal Express Corp., 753 A.2d 238, 242 (2000)(examining duty in employment context); Kaplan v. Cablevision of Pa., Inc., 448 Pa.Super. 3.006, 318, 671 A.2d 716, 721-22 (1996)(addressing duty in class action suit by subscribers against cable companies); Liazis v. Kosta, Inc., 421 Pa.Super. 502, 510, 618 A.2d 450, 454 (1992)(examining duty in context of opening confessed judgment on note); Germantown Manufacturing Co. v. Rawlinson, 341 Pa.Super. 42, 60, 491 A.2d 138, 148 (1985)(same). A similar requirement has been imposed upon contracts within the Uniform Commercial Code by 13 Pa.C.S.A. § 1203. Somers v. Somers, 418 Pa.Super. 131, 136, 613 A.2d 1211, 1213 (1992).

The duty of "good faith" has been defined as "[h]onesty in fact in the conduct or transaction concerned." Id. (citing 13 Pa.C.S.A. § 1201). The obligation to act in good faith in the performance of contractual duties varies somewhat with the context, however, examples of "bad faith" conduct include:

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[12]These allegations may, however, be linked to defendants' alleged breach of its fiduciary obligations as to the Subscriber Plaintiffs in Count II or to the claimed violation of the UTP/CPL in Count III. The court will address the merits of these two counts in the discussion below.

"evasion of the spirit of the bargain, lack of diligence and slacking off, willful rendering of imperfect performance, abuse of a power to specify terms, and interference with or failure to cooperate in the other party's performance." Kaplan, 448 Pa.Super. at 318, 671 A.2d at 722 (quoting Somers, 418 Pa.Super. at 136, 613 A.2d at 1213, citing Restatement (Second) of Contracts, § 205, cmt. d.).

The implied duty of good faith might also arise from the doctrine of necessary implication. This doctrine of contract law allows the court to imply a contract term "where it is clear that an obligation is within the contemplation of the parties at the time of contracting or is necessary to carry out their intentions." Id. at 314, 671 A.2d at 720 (quoting Slater v. Pearle Vision Center, Inc., 376 Pa.Super. 580, 586, 546 A.2d 676, 679 (1988)). The Pennsylvania Supreme Court explains:

> In the absence of an express provision, the law will imply an agreement by the parties to a contract to do and perform those things that according to reason and justice they should do in order to carry out the purpose for which the contract was made and to refrain from doing anything that would destroy or injure the other party's right to receive the fruits of the contract. . . .

Frickert v. Deiter Bros. Fuel Co., Inc., 464 Pa. 596, 603, 347 A.2d 701, 705 (1975)(Pomeroy, J., concurring)(quoted in Slater, 376 Pa.Super. at 586, 546 A.2d at 679). See also, Amerikohl Mining, Inc. v. Mount Pleasant Twp., 727 A.2d 1179, 1183 (Pa.Super.Ct. 1999)(determining that the court may apply a missing term to a contract only when it is necessary to prevent injustice and it is abundantly clear that the parties intended to be bound by such term).

However, the implied duty of good faith cannot act to displace the express terms and there can be no implied duty as to any matter specifically covered by the written agreement. See Hutchison v. Sunbeam Coal Corp., 513 Pa. 192, 198, 519 A.2d 385, 388 (1986); Greek v. Wylie, 266 Pa. 18, 23, 109 A.529, 530 (1920); Reading Terminal Merchants Ass'n v. Samuel Rappaport Assocs., 310 Pa.Super. 165, 176,

456 A.2d 552, 557 (1983). See also, 11 Williston on Contracts § 1295 (3d ed. 1968) (implied term justifiable only when not inconsistent with express terms of contract and absolutely necessary to effectuate intent of parties). It is also true that "[t]he law will not imply a contract different than that which the parties have expressly adopted." Stonehedge Square Limited Partnership v. Movie Merchants, Inc., 454 Pa.Super. 468, 480, 685 A.2d 1019, 1025 (1996)(quoting Hutchison, 513 Pa. at 198, 519 A.2d at 388.). See also, Creeger Brick, 385 Pa.Super. at 36-37, 560 A.2d at 154 ("[t]he duty of good faith imposed upon contracting parties does not compel a lender to surrender rights which it has been given by statute or by the terms of its contract."); Northview Motors, Inc. v. Chrysler Motors Corp., 227 F.3d 78, 91 ("[c]ourts have utilized the good faith duty as an interpretive tool to determine the parties' justifiable expectations in the context of a breach of contract action, but that duty is not divorced from the specific clauses of the contract and cannot be used to override an express contractual term."); Advanced Lifeline Servs., Inc. v. Northern Health Facilities, Inc., 1997 WL 763024, at *4 (E.D.Pa. Dec. 9, 1997).

Moreover, there is no independent cause of action for breach of the implied duty of good faith absent an underlying breach of contract. See, e.g., Donahue, 753 A.2d at 242 (affirming dismissal of at-will employee's claim for breach of implied duty of good faith and fair dealing arising out of employee's termination); Kaplan, 448 Pa.Super. 306, 318, 671 A.2d 716, 721-22 (1996)(concluding that plaintiff did not have a viable claim for breach of contractual duty of good faith and fair dealing since cable companies were not contractually bound to provide continuous service or voluntarily provide credits for interruption of cable service); Commonwealth v. BASF, April 2000, No. 3127, slip op. at 21-22 (C.P. Phila. Mar. 15, 2001)(Herron, J.)(holding that plaintiff failed to allege that pharmaceutical company improperly performed one of the contractual duties imposed by the agreement, even though agreement had express

"integrity" provisions).

In addition, it is not clear that the existence of a special or confidential relationship is a necessary prerequisite for upholding a cause of action based on the implied duty of good faith. One line of cases, both state and federal, adheres to the principle that the duty of good faith only applies in these limited situations. See, e.g., Commonwealth, Dep't. of Transp. v. E-Z Parks, Inc., 153 Pa.Commw. 258, 267-68, 620 A.2d 712, 717 (1993)(stating that "[a] business association may be the basis of a confidential relationship 'only if one party surrenders substantial control over some portion of his affairs to the other'" and holding that there was no confidential relationship between the parties, which merely had a typical landlord-tenant relationship); Creeger Brick, 385 Pa.Super. at 35, 560 A.2d at 153-54 (noting that a duty of good faith has been imposed between franchisors and franchisees, between insurer and insured and in an employer-employee relationship, but not when evaluating obligations between a creditor and a debtor); Parkway Garage, Inc. v. City of Philadelphia, 5 f.3d 685, 701 (3d Cir. 1993)(interpreting Creeger, *supra*, for the proposition that "under Pennsylvania law, every contract does not imply a duty of good faith."); Chrysler Credit Corp. v. B.J.M., Jr., Inc., 834 F.Supp. 813, 841-42 (E.D.Pa. 1993)(finding no duty of good faith where evidence failed to show that a special, confidential or fiduciary relationship existed between the parties that would give rise to a duty of good faith).

On the other hand, a separate line of cases holds that every contract in Pennsylvania imposes on each party a duty of good faith and fair dealing in its performance and its enforcement, even if the duty was not applicable in light of the facts of those cases. See, Donahue, 753 A.2d at 242; Kaplen, 448 Pa.Super. at 318, 671 A.2d at 721-22; Somers, 418 Pa.Super. at 136, 613 A.2d at 1213 (holding that plaintiff/former employee stated a claim for breach of the implied duty of good faith where defendant

allegedly showed lack of good faith in settling claim for less than it was worth and payments to subcontractors were excessive as a result of defendant's failure to exercise diligence); Ross v. Canada Life Assurance Co., 1996 WL 182561 at *7-8 (E.D.Pa. April 16, 1996)(allowing plaintiffs to pursue their claim for breach of an implied duty of good faith as an alternative to their breach of express contract claim).

Here, the providers and IBC are explicitly described as "independent entities" in Section 6.14 of the Provider Agreement(s). Am.Compl., Exhibit A, at § 6.14. This section states the following:

> **6.14 Status as Independent Entities**. None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create, any relationship between Provider and [IBC] other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor [IBC] nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other.

Id. (emphasis added). The inclusion of this provision means to this court that the providers cannot maintain a cause of action for breach of the implied duty of good faith based on a finding of a "special" relationship since the court cannot imply a duty which conflicts with the express terms of the agreement. See Hutchison, 513 Pa. at 198, 519 A.2d at 388.

Further, Count I purports to state a claim based on both an express breach of contract, and, in the alternative, a breach of the implied duty of good faith and fair dealing, by denying coverage for allegedly medically necessary chiropractic care, acting contrary to generally accepted medical standards, failing to apply appropriate standards and procedures for pre-certifying chiropractic care, and acting in a manner inconsistent with its network providers' expectations. See Am.Compl. at ¶¶ 104-107. Specifically, IBC allegedly committed the following contractual breaches:

(1) improperly restricting reimbursements for multiple and secondary treatments by pre-certifying only one S-Code per visit even if two or more separate manipulations are necessary on a given day;

(2) improperly limiting pre-certification and reimbursement to "acute" conditions and denying reimbursement for "chronic" conditions;

(3) imposing artificial limits on the number of sessions it will cover;

(4) improperly denying coverage based on a percentage of improvement;

(5) permitting non-qualified personnel to make medical necessity determinations; and

(6) relying on undisclosed, improper and internally-generated guidelines to determine medical necessity which are not subject to peer review or evaluation by independent practitioners.

Id. at ¶¶ 58-60; 63-68; 74-79; 81-93. All of these alleged breaches are arguably addressed by the compensation provisions in the provider agreement(s), which generally deem that providers would be compensated for rendering "medically necessary" treatment, as well as the manner for obtaining compensation for excluded or emergency services. See Am.Compl., Exhibit A at §§ 3.1-3.11. "Medical Necessity" is determined both by the Primary Care Physician or referred specialist and IBC, according to accepted standards of the medical community, as well as being essential to the Beneficiary's net health outcome, are as cost-effective as any established alternative, and are not solely for the Beneficiary's convenience or the convenience of the health care provider. Id. at § 1.13. "Excluded Services" are those which are determined not to be medically necessary. Id. at § 1.12. Since the gravamen of the provider plaintiffs' allegations is that defendants denied reimbursement or provided insufficient reimbursement for rendering purportedly medically necessary chiropractic care, plaintiffs' proper redress is for an express breach of contract.

For these reasons, the court is sustaining the demurrer to Count I, as to the providers' claim for breach of the implied duty of good faith.[13] However, the provider plaintiffs are allowed to proceed on an express breach of contract claim and the subscriber plaintiffs may proceed on either theory.

II. COUNT II CANNOT SURVIVE DEMURRER SINCE A BREACH OF FIDUCIARY DUTY CLAIM SOUNDS ONLY IN CONTRACT, IT IS REDUNDANT OF THE SUBSCRIBER PLAINTIFFS' CLAIM FOR BREACH OF THE IMPLIED DUTY OF GOOD FAITH AND PRE-CONTRACT CONDUCT CANNOT BE A BASIS FOR A BREACH OF FIDUCIARY DUTY CLAIM AGAINST A HEALTHCARE INSURER

Defendants assert that plaintiffs' allegations of a confidential relationship between themselves and

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[13]This court finds no merit in defendants' argument that the [Provider] Plaintiffs have an adequate forum in the Pennsylvania Insurance Department ("PID") to litigate their claim for breach of the implied duty of good faith and fair dealing. For this proposition, defendants primarily relied on D'Ambrosio v. Pennsylvania Nat'l Cas. Mut. Ins. Co., 494 Pa. 501, 507, 431 A.2d 966, 970 (1981), which held that insured could not recover punitive damages for bad faith conduct in connection with the nonpayment of a claim for damage to his property and held that there is no common law tort remedy in Pennsylvania for a failure by an insurer to act in good faith toward its insured. The D'Ambrosio decision also examined the insured's claim in the context of the Unfair Insurance Practices Act, codified at 40 P.S. §§ 1171.1 et seq. 494 Pa. at 505-06, 431 A.2d at 969. As no such claim is stated here, this court finds this case to be inapplicable on the issue of whether the PID provides an adequate forum to litigate this matter.

In response to the D'Ambrosio decision, the Pennsylvania Legislature created a statutory remedy for bad faith of an insurer to its insured in 42 Pa.C.S.A. § 8371, as explained in O'Donnell v. Allstate Ins. co., 734 A.2d 901, 905 (Pa.Super.Ct. 1999). Defendants' demurrer to Count I merely addresses the Provider Plaintiffs' claim for breach of the implied duty of good faith, since defendants have stipulated that the Subscriber Plaintiffs (the insured) have such a claim. See note 11, *supra*. Therefore, defendants' argument on this point seems misplaced. Moreover, it is unclear that any decision from the PID would bar the Provider Plaintiffs from bringing contract or tort claims in this court, notwithstanding the allegations that the PID approves the use of W-Codes (S-Codes, as implemented by IBC), which determine the level of spinal manipulation and treatment and also set the compensation rates. See Am.Compl. at ¶¶ 46-50. See also, Lafarge Corp. v. Commonwealth, 557 Pa. 544, 551, 735 A.2d 74, 77 (1999)(stating "[PID] approval does not insulate the insurer from liability. Allegations of breach of fiduciary duty or other corporate torts are properly heard in the courts of common pleas.")(citation omitted).

defendants is insufficient to support a fiduciary duty and that no fiduciary duty arises in this context since a fiduciary duty is limited to situations when an insurer assumes the right to handle its insured's claims and control settlement. Alternatively, defendants argue that plaintiffs' claim merely duplicates their allegations for the breach of the duty of good faith. Defs. Mem. of Law, at 15-18. Plaintiffs, in response, contend that defendants' position is too narrow with respect to the fiduciary duty, and that, in the health insurance context, defendants have assumed a fiduciary responsibility by overseeing the health care providers, by determining what is medically necessary and by assisting in determining the most appropriate treatment plans. Plaintiffs also assert that their breach of fiduciary duty claim is not merely redundant of their breach of the implied covenant of good faith because of the alleged misrepresentations by defendants regarding coverage, which were made to entice existing subscribers to remain with defendants. Pls. Mem. of Law, at 24-25.

Initially, this court notes that neither party cited a case which addresses a breach of fiduciary duty in the health insurance context, nor has this court found an applicable Pennsylvania case applying the fiduciary duty to a health insurer's administration of a plan which is exempt from ERISA.[14] Therefore, the

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[14]"ERISA" or the Federal Employee Retirement Income Security Act is codified at 29 U.S.C.A. §§ 1001 et seq.. The statute does impose a fiduciary duty upon plan administrators. See 29 U.S.C.A. §§ 1102(21),1104 (a)(1)(A), (B). See Pegram v. Herdrich, 530 U.S. 211, 228 n.8 (2000)(noting that an HMO is "a fiduciary insofar as it has discretionary authority to administer the plan, and so it is obligated to disclose the characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries' material interests.") (dismissing ERISA fiduciary claim because it is based upon HMO physician's "mixed eligibility" decision concerning how to test patient to diagnose condition.)

Here, Plaintiffs explicitly alleged that the health care plans, at issue, are exempt from ERISA as "government-sponsored" plans. Am.Compl. at ¶¶ 15-16. Therefore, cases addressing fiduciary claims under ERISA and its remedies are inapplicable to the present case.

court finds the issue of whether such a health insurer may be held liable for breach of a fiduciary duty to its subscribers is one of first impression in Pennsylvania and has rarely been addressed by other jurisdictions.[15]

Recently, the Pennsylvania Superior Court repeated the general concepts for finding a confidential relationship and the resulting fiduciary duty in Basile v. H & R Block, Inc., 2001 WL 460913, at *4-5 (Pa.Super.Ct. May 3, 2001). "The essence of [a confidential] relationship is trust and reliance on one side, and a corresponding opportunity to abuse that trust for personal gain on the other." Id. at *4 (quoting *In re* Estate of Scott, 455 Pa. 429, 432, 316 A.2d 883, 885 (1974). A confidential relationship thus exists where the parties do not deal on equal terms, "but, on the one side there is an overmastering influence, or on the other, weakness, dependence or trust, justifiably reposed." Id. (quoting Frowen v. Blank, 293 Pa. 137, 145-46, 425 A.2d 412, 416-17 (1981). "[T]he party in whom the trust and confidence are reposed must act with scrupulous fairness and good faith in his dealings with the other and refrain from using his position to the other's detriment and his own advantage." Id. (quoting Young v. Kaye, 443 Pa. 335, 342, 279 A.2d 759, 763 (1971). "[A] confidential relationship and the resulting fiduciary duty may attach 'wherever one occupies toward, another such a position of advisor or counsellor [*sic*] as reasonably to inspire confidence that he will act in good faith for the other's interest'." Id. at * 5 (citation omitted). Such a relationship may be found as between trustee and cestui que trust, guardian and ward, attorney and client,

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[15]This court did find one Pennsylvania case, involving subscriber claims for breach of subscription agreements and breach of fiduciary duty against their insurer and provider hospitals arising from the refusal to pay for hospital and medical costs incurred by subscribers. Sharkus v. Blue Cross of Greater Philadelphia, 494 Pa. 336, 347, 431 A.2d 883, 888 (1981)(holding that those claims may be resolved through class action mechanism, but noting that "the present case does not seek to litigate the issue of medical necessity for hospitalization."). Notwithstanding the Sharkus decision, the merits of a fiduciary duty claim against a health insurer by its subscribers has not been addressed in Pennsylvania.

or principal and agent, or where the facts and circumstances so indicate and are apparent on the record. Id.

"As a general rule, the relation between the parties to a contract of insurance is that of debtor and creditor; that is, of one contracting party to another contracting party, rather than an equitable one. However, insurance policies are contracts of the utmost good faith and must be administered and performed as such by the insurer. Good faith demands that the insurer deal with laymen as laymen and not as experts in the subtleties of law and underwriting." 3 Couch on Insurance § 40:7 (3d ed. 1995).

The majority of cases, examining whether an insurer owes its insured a fiduciary duty, arise in the context of liability insurance involving the defense, handling or settlement of claims, whether third party or first party claims. See, e.g., Dercoli v. Pennsylvania Nat'l. Mut. Ins. Co., 520 Pa. 471, 477-78, 554 A.2d 906, 909 (1989); Gray v. Nationwide Mut. Ins. Co., 422 Pa. 500, 508, 223 A.2d 8, 11 (1966); Gedeon v. State Farm Mut. Auto. Ins. Co., 410 Pa. 55, 59-60, 188 A.2d 320, 322 (1963); Birth Center v. St. Paul Companies, Inc., 727 A.2d 1144, 1156-58 (Pa.Super.Ct. 1999), app. granted in part, 560 Pa. 633, 747 A.2d 858 (2000); Gilderman v. State Farm Ins. Co., 437 Pa.Super. 217, 226-27, 649 A.2d 941, 945-46 (1994); Strutz v. State Farm Mut. Ins. Co., 415 Pa.Super. 371, 375, 609 A.2d 569, 571 (1992); Hall v. Brown, 363 Pa.Super. 415, 420, 526 A.2d 413, 415 (1987).

This court previously examined a claim for breach of fiduciary duty for failure to renew a liability insurance contract and stated the following:

> In the insurance context, the mere fact that an insurer and an insured enter into an insurance contract does not automatically create a fiduciary relationship. 2A Couch Insurance 2d, § 23.11 (1984); 1A Long, The Law of Liability Insurance, § 5A.07. See also Connecticut Indemnity Co. v. Markman, 1993 WL 304056, at *5 (E.D.Pa. Aug. 6, 1993) (applying Pennsylvania law). An insurer's fiduciary status and duty to act with the "utmost good faith" arise

> by virtue of the policy provisions which give the insurer the right to handle claims and control settlement. Gedeon v. State Farm Mut. Auto. Ins. Co., 410 Pa. 55, 59, 188 A.2d 320, 322 (1963); Birth Center v. St. Paul Companies, Inc., 727 A.2d 1144, 1155 (Pa.Super.Ct. 1999), app. granted in part, 560 Pa. 633, 747 A.2d 858 (2000); Gilderman v. State Farm Ins. Co., 437 Pa.Super. 217, 226, 649 A.2d 941, 945-46 (1994). Therefore, an insurer's voluntarily assumed fiduciary duty is a contractual duty. Under the insurance contract, "the insurer assumes a fiduciary responsibility towards the insured and becomes obligated to act in good faith and with due care in representing the interests of its insured when handling, *inter alia*, all third party claims brought against the insured." Birth Center, 727 A.2d at 1155 (citing Gedeon, 410 Pa. at 59, 1888 A.2d at 322). The insurer's fiduciary duty or duty to act in good faith "is said not to arise under the terms of the contract, but because of the contract, and to flow from the contract." Id. (citing Gray v. Nationwide Mut. Ins. Co.., 422 Pa. 500, 508, 223 A.2d 8, 11 (1966)).

Brickman, slip op. at 13-14 (sustaining demurrer to breach of fiduciary claim for the alleged failure to renew a liability insurance contract where claim did not involve a breach of the insurance policy, itself, or derive directly therefrom).

As Brickman demonstrated, a breach of fiduciary duty in the insurance context is a breach of the contractual duty to act in good faith when the insurer assumes the responsibility to handle claims, control settlement or take over the litigation on the insured's behalf. Id. See also, Ingersoll-Rand Equip. v. Transportation Ins. Co., 963 F.Supp. 452, 453 (M.D.Pa. 1997)(determining that Pennsylvania does not allow a separate cause of action in tort against an insurer for breach of fiduciary duty, but such claim must be brought in contract)(relying in part on D'Ambrosio, 494 Pa. at 507, 431 A.2d at 970; Gedeon, 410 Pa. at 58, 188 A.2d at 321; and Cowden v. Aetna Cas. & Sur. Co., 389 Pa. 459, 468, 134 A.2d 223, 227 (1957)). The breach of fiduciary duty and the breach of the duty of good faith are thus treated synonymously in the insurance context. See Gedeon, 410 Pa. at 59-60, 188 A.2d at 322. See also, Keefe v. Prudential Property & Cas. Ins. Co., 203 F.3d 218, 227-28 (3d Cir. 2000)(stating "[u]nder Pennsylvania law, a fiduciary duty higher than the duty of good faith and fair dealing does not arise out [of]

an insurance contract until an insurer asserts a stated right under the policy to handle all claims asserted against the insured."); Belmont Holdings Corp. v. Unicare Life & Health Ins. Co., 1999 WL 124389, at *4 (E.D.Pa. Feb. 5, 1999)(dismissing breach of fiduciary duty claim as redundant of claim for breach of contract and/or bad faith claim under 42 Pa. C.S.A. § 8371 where insurer allegedly changed the terms of the policy, forced the insured to pay greater premiums and forced insured to agree to a new renewal date); Garvey v. National Grange Mut. Ins. Co., 1995 WL 115416, at *4 (E.D.Pa. Mar. 16, 1995)(same). But see, Guthrie Clinic, Ltd. v. Travelers Indemnity Co. of Illinois, 2000 WL 1853044, at *3-4 (M.D.PA. Dec. 18, 2000)(allowing breach of fiduciary duty or breach of duty of good faith to proceed simultaneously with breach of contract and statutory bad faith claim where insurer's denial of coverage or benefits also involved insurer's alleged bad faith in its conduct during the renewal process).

Since a breach of fiduciary duty arising from an insurance contract is a contractual claim, punitive damages for such a breach would not be available in any event. Baker, 370 Pa.Super. at 469-70, 536 A.2d at 1367. See also, Rader, slip op. at 4. This court sees no reason to deviate from this rationale and provide a tort remedy for the alleged breach of fiduciary duty simply because the present case involves health insurance. The only method for assessing punitive damages for bad faith against an insurer is to bring a claim pursuant to 42 Pa.C.S.A. § 8371.[16] However, Plaintiffs conceded that their claim for breach of

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[16]The bad faith statute provides that:

> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:
> (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
> (2) Award punitive damages against the insurer.

fiduciary duty is not based on a duty of good faith and fair dealing, or insurance bad faith, which were at issue in Belmont Holdings and Garvey. Pl. Mem. of Law, at 23 n.17.[17] Therefore, this court cannot now treat the Subscriber Plaintiffs' claim for breach of fiduciary duty as a a cause of action under § 8371.

Additionally, one recent case, which this court finds persuasive, is Batas v. Prudential Ins. Co. of America, 2001 WL 286902 (N.Y.A.D., 1 Dept. Mar. 20, 2001). In Batas, subscribers filed a class action against their health care insurer including claims for breach of contract, breach of fiduciary duty and fraud arising out of the denial of benefits which allegedly prevented plaintiffs from receiving timely and necessary treatment, as well as failure to disclose reliance on certain utilization guidlines to determine what is medically necessary. 2001 WL 286902, at *1-2. The appellate court affirmed the dismissal of the breach of fiduciary duty claim, reasoning that the allegations were insufficient to show that defendants sought to gain the plaintiffs' trust and confidence or that the relationship differed from that of a typical contractual insurance relationship. Id. at *3-4. The majority in Batas also noted the following:

> [w]hile we agree that an insured should have an adequate remedy to redress

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(3) Assess court costs and attorney fees against the insurer.

(footnote 16 cont'd)

42 Pa.C.S.A. § 8371. Courts have since held that § 8371 is the only basis for a private action for bad faith against the insurer. See, e.g., Adamski v. Allstate Ins. Co, 738 A.2d 1033, 1039 n.5 (Pa.Super.Ct. 1999), app. denied sub nom. Goodman v. Durham, 759 A.2d 387 (2000)(noting "[a] bad faith action under section 8371 is neither related to nor dependent on the underlying contract claim against the insurer."); Terletsky v. Prudential Property and Cas. Ins. Co., 437 Pa.Super. 108, 124, 649 A.2d 680, 688 (1994).

[17] As noted above, both those cases dismissed counts for breach of fiduciary duty where those claims were redundant of the bad faith claims under 42 Pa.C.S.A. § 8371. Belmont Holdings, 1999 WL 124389, at *4; Garvey, 1995 WL 115416, at *4.

> an insurer's bad faith refusal of benefits under its policy, the dissent's proposed new cause of action for tortious breach of the implied covenant of good faith has no basis in the record or briefs.

Id. at *4. The dissent in that case proposed that the "fiduciary duty" claim should be substituted by the words "duty of good faith" and provide a remedy in tort since an insurer's breach of a health insurance contract may result in further physical injury or emotional distress from the delay in obtaining treatment. Id. at *7-9. The dissent also relied on other states' laws, including 42 Pa.C.S.A. § 8371, which allowed for a tort remedy in the insurance context for a "bad faith" claim in an insurer's denial of a claim without a reasonable basis. Id. at *8.

As noted above, this court cannot treat plaintiffs' claim for breach of fiduciary duty as a "bad faith" claim under § 8371. It does not appear that Pennsylvania law would find a fiduciary duty or breach of said duty in this context; rather, Pennsylvania law seems to limit this duty to instances when the insurer has assumed the role of counselor or advisor in the handling of claims under a liability insurance policy. This court also finds that plaintiffs' allegations for breach of fiduciary duty by IBC in Count II are subsumed by the breach of the implied duty of good faith in Count I, notwithstanding the allegations that IBC misrepresented the terms and conditions of its health care plans in its advertising and promoting its health care products. See Am.Compl. at ¶¶ 101, 114. A breach of fiduciary duty claim in the insurance context cannot be applied to these alleged misrepresentations, which represent conduct occurring prior to the contract's formation. Moreover, this court finds that plaintiffs failed to establish the existence of a confidential relationship between IBC and themselves, but they merely alleged, in conclusory fashion, that such a relationship existed, since IBC assumed the responsibility for overseeing the subscribers' health care and determining whether such care is medically necessary, and, hence, covered under the health care plans.

Id. at ¶¶ 100, 113. This court need not accept mere conclusions or expressions of opinion when ruling on a demurrer. See Giordano, 737 A.2d at 352.

For these reasons, the demurrer to Count II is sustained.

III. PLAINTIFFS' ALLEGATIONS THAT DEFENDANTS IMPROPERLY LIMITED COVERAGE FOR CHIROPRACTIC SERVICES BY ALLOWING NON-QUALIFIED PERSONNEL TO MAKE TREATMENT DECISIONS, RELYING ON IMPROPER GUIDELINES TO MAKE MEDICAL NECESSITY DETERMINATIONS, FAILING TO DISCLOSE THOSE GUIDELINES AND MISREPRESENTING THE TERMS AND CONDITIONS OF THEIR HEALTH CARE PLANS ARE SUFFICIENT TO ALLEGE MISFEASANCE AND MAKE OUT A CAUSE OF ACTION UNDER THE UTP/CPL

Defendants also demur to plaintiffs' third cause of action on the grounds that the claim is based on IBC's policy of improperly denying necessary chiropractic care and that such a claim may not be allowed for mere nonfeasance but only misfeasance under the UTP/CPL. Defs. Mem. of Law, at 18-20. In response, Subscriber Plaintiffs contend the misfeasance/nonfeasance dichotomy was expressly rejected in Phico Ins. Co. v. Presbyterian Med. Servs. Corp., 444 Pa.Super. 221, 228, 663 A.2d 753, 757 (1995), and that, even if the test had merit, they clearly alleged misfeasance on the part of the defendants. Pls. Mem. of Law, at 25-28.

The purpose of the UTP/CPL is to protect the public from fraud and unfair or deceptive business practices. Keller v. Volkswagen of America, Inc., 733 A.2d 642, 646 (Pa.Super.Ct. 1999)(citation omitted). It is to be liberally construed in order to effectuate its purpose. Id. See also, Wallace v. Pastore, 742 A.2d 1090, 1092 (Pa.Super.Ct. 1999)(citing Commonwealth v. Monumental Properties, Inc., 459 Pa. 450, 459, 329 A.2d 812, 816 (1974)). The remedies provided by the UTP/CPL are not exclusive, but are in addition to other causes of action and remedies. Wallace, 742 A.2d at 1092 (citations omitted).

Section 3 of the UTP/CPL declares that "[u]nfair methods of competition" and "unfair or deceptive acts in the conduct of any trade or commerce" are unlawful. 73 P.S. § 201-3. The relevant sections of the UTP/CPL which define "unfair methods of competition" or "unfair or deceptive acts" include the following:

> (v) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have . . .;
>
> * * *
>
> (vii) Representing that goods or services are of a particular standard, quality or grade, or that goods are of a particular style or model, if they are of another;
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> * * *
>
> (ix) Advertising goods or services with intent not to sell them as advertised; or
>
> * * *
>
> (xiv) Failing to comply with the terms of any written guarantee or warranty given to the buyer, at, prior to or after a contract for services is made . . . .

73 P.S. § 201-2(4). <u>See</u> Am.Compl. at ¶ 117. A private cause of action may be asserted under the UTP/CPL for "[a]ny person who purchases or leases goods or services primarily for personal, family or household purposes and thereby suffers any ascertainable loss of money or property . . . as a result" of an unfair or deceptive practice. 73 P.S. § 201-9.2.

Additionally, the Pennsylvania Superior Court has stated that "[n]onfeasance alone is not sufficient to raise a claim pursuant to the [UTP/CPL]." <u>Gordon v. Pennsylvania Blue Shield</u>, 378 Pa.Super. 256, 265, 548 A.2d 600, 604 (1988)(affirming dismissal of UTP/CPL claim where it was based on negligent breach of contract by health insurer for refusal to pay benefits to which insured felt entitled). The court in <u>Gordon</u> stated the following:

> The test used to determine is there exists a cause of action in tort growing out of a breach of contract is whether there was an improper performance of a contractual

obligation (misfeasance) rather than the mere failure to perform (nonfeasance).

* * *

> Plaintiffs allege that defendant's negligence is grounded in their 'failure' to take certain actions in the handling of plaintiff's claim. Our examinination of this alleged conduct indicates that it is in the nature of 'nonfeasance' inasmuch as it is the 'omitting to do, or not doing something which ought to be done.'

Id. at 264, 542 A.2d at 604 (quoting Raab v. Keystone Ins. Co., 271 Pa.Super. 185, 188, 412 A.2d 638, 639 (1979)). The misfeasance/nonfeasance distinction appears to remain a valid test for claims under the UTP/CPL, notwithstanding plaintiffs' reliance on Phico Ins. Co. v. Presbyterian Med. Servs. Corp., 444 Pa.Super. 221, 228, 663 A.2d 753, 757 (1995). In Phico, the court expressly rejected Raab's misfeasance/nonfeasance distinction to determine when claims in tort may be brought alongside claims in contract. Id. at 228, 663 A.2d at 757. Instead, the Phico court upheld the "gist of the action" test allowing tort claims where the contract is merely collateral to the conduct in question. Id. at 229, 663 A.2d at 757. The Phico decision is not dispositive for assessing a claim under the UTP/CPL which involves a statutory remedy and does not merely arise out of common law tort claims. Additionally, in Tenos v. State Farm Ins. Co., 716 A.2d 626, 631 (Pa.Super.Ct. 1998), a post-Phico case, the court upheld the Gordon test requiring allegations of misfeasance rather than mere nonfeasance to state a cause of action under the UTP/CPL.

Moreover, the federal courts, which are persuasive when applying Pennsylvania law, continue to require misfeasance to allow a claim under the UTP/CPL, but they differ on what constitutes misfeasance based on the individual facts of those cases. See, e.g., Horowitz v. Federal Kemper Life Assurance Co., 57 F.2d 300,307 (3d Cir. 1995)(affirming summary judgment on UTP/CPL claim in favor of insurer where

insurer's letter notifiying insured of refusal to pay claim and its reasons for denying payment did not constitute misfeasance); Lites v. Great American Ins. Co., 2000 WL 875698, at *3-4 (E.D.Pa. June 23, 2000)(finding sufficient allegations of defendant's misfeasance to state UTP/CPL claim where complaint alleged that defendant/insurer had no reasonable basis to deny the claim and included allegations of bad faith conduct in forcing plaintiffs to enter into unnecessary litigation, improperly investigating claims and engaging in efforts to delay processing plaintiffs' justifiable claims); Carlucci v. Maryland Cas. Co., 1999 WL 179750, at *1 (E.D.Pa. Mar. 15, 1999)(finding allegations of failure to investigate, evaluate, negotiate and otherwise handle claim properly to sufficiently set forth alleged misfeasance to make out claim under the UTP/CPL beyond mere nonfeasance in the alleged failure to process a claim in a timely manner); Guesnt v. Western Pacific Mut. Ins. Co., 1998 WL 150985, at *6-7 (E.D.Pa. Mar. 30, 1998)(finding that insured's evidence sufficiently showed malfeaseance to survive motion for summary judgment where insurer allegedly tried to force repair solution on insured in contravention of the terms of warranty); Leo v. State Farm Mut. Auto. Ins. Co., 939 F.Supp. 1186, 1193 (E.D.Pa. 1996)(granting summary judgment in favor of insurer on UTP/CPL claim where plaintiff's allegations of failure to pay insurance benefits in a timely manner do not amount to misfeasance, notwithstanding allegation that insurer misrepresented contract provisions relating to parties' obligations); Lombardo v. State Farm Mut. Auto. Ins. Co., 800 F.Supp. 208, 213 (E.D.Pa. 1992)("refusal to pay benefits to which plaintiff is entitled is a 'nonfeasance' and therefore not actionable under the CPL.").

Here, contrary to defendants' argument, the Subscriber Plaintiffs allege more that just a failure to reimburse the Subscriber Plaintiffs or provide them with the benefits to which they believe they are entitled pursuant to the terms of the Subscriber Agreements. Defendants, rather, mischaracterize the tenor of

plaintiff's allegations. In Count III, plaintiffs allege the following in relevant part:

> IBC has failed and continues to fail to provide the level of health insurance it has promised to its subscribers, by improperly limiting coverage for chiropractic services. Moreover, IBC has misled the members of the Subscriber Class into becoming and remaining IBC subscribers by misrepresenting the terms and conditions of its health care plans and the circumstances under which subscribers will be entitled to coverage for chiropractic care. . . .

Am.Compl. at ¶ 117. As such, plaintiffs allege that IBC violated subsections (v), (viii), (ix) and (xiv) of § 201-2 of the UTP/CPL. Id. Specifically, in the preceding paragraphs, plaintiffs allege that defendants improperly limit chiropractic care by relying on undisclosed and improper medical guidelines which limit subscribers' access to care, improperly deny care for certain "medically necessary" treatments, impose arbitrary limits and designations on "chronic" versus "acute" conditions, allow non-qualified personnel to make treatment decisions, misrepresent the terms and conditions of the health care plans and place their financial needs over the health care needs of their subscribers. Id. at ¶¶ 46-74, 80-93, 101, and 114. These allegations, in their entirety and taken as true, could rise to the level of misfeasance in order to state a claim under the UTP/CPL.

Therefore, the demurrer to Count III is overruled.

IV. THE PCA AND THE SNJCS DO NOT HAVE ASSOCIATIONAL STANDING TO SUE FOR INJUNCTIVE RELIEF TO COMPEL DEFENDANTS TO COMPLY WITH THE PROVIDER CONTRACTS SINCE THE PCA AND THE SNJCS ARE NOT PARTIES TO THE CONTRACTS AND RESOLVING THE BREACH OF CONTRACT CLAIM REQUIRES THE PARTICIPATION OF THE INDIVIDUAL PROVIDERS

Defendants, pursuant to Pa.R.C.P. 1028(a)(5), lastly assert that the PCA and the SNJCS do not have standing as associations to bring this action on behalf of its members because both associations are strangers to the contracts and the nature of the claim and requested relief requires participation of its

members. Defs. Mem. of Law, at 20-25; Defs. Reply Mem., at 16-19. The Association Plaintiffs, in response, argue that the relief sought by them is for injunctive relief from the defendants' alleged contractual misconduct, which does not require the participation of the individual providers. Pls. Mem. of Law, at 29-30

Generally, an association, as a representative of its members may have standing to bring a cause of action even in the absence of injury to itself. Pennsylvania School Boards Ass'n., Inc. v. Commonwealth Ass'n. of School Administrators, 696 A.2d 859, 868 (Pa.Commw.Ct. 1997)(citation omitted). In order to establish standing, the association must allege that at least one of its members is suffering immediate or threatened injury as a result of the challenged action. Id. Further, the member of the association who is threatened with injury must have an interest in the litigation that is substantial, direct and immediate. Id. As explained by the Pennsylvania Supreme Court in William Penn Parking Garage, Inc. v. City of Pittsburgh, 464 Pa. 168, 195-96, 346 A.2d 269, 282-83 (1975), an interest is "substantial" when there is a discernable adverse effect to an interest of the aggrieved individual which differs from the abstract interest of the general citizenry in having others comply with the law. Id. at 195, 346 A.2d at 282. An interest is "direct" when an aggrieved person can show a causal connection between the alleged harm to his or her interest and the matter of which he or she complains. Id. Lastly, an interest is "immediate" when the causal connection between the injury and the matter complained of is not too remote. Id. at 196, 346 A.2d at 283. Accord Pennsylvania School Boards Ass'n., 696 A.2d at 868.

In determining issues of standing, the Pennsylvania Supreme Court has traditionally relied on federal decisions. Housing Auth. of the County of Chester v. Pennsylvania State Civil Service Comm'n., 556 Pa. 621, 629, 730 A.2d 935, 939 (1999). The United States Supreme Court sets forth the following three-

part test for an association to bring suit on behalf of its members: (1) when its members would otherwise have standing to sue in their own right; (2) when the interests it seeks to protect are germane to the organization's purpose; and (3) when neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit. Hunt v. Washington State Apple Advertising Comm'n., 432 U.S. 333, 343 (1977). Accord, Friends of the Earth, Inc. v. Laidlaw Environmental Services, Inc., 528 U.S. 167, 181 (2000); International Union, United Auto., Aerospace & Agricultural Implement Workers of America v. Brock, 477 U.S. 274, 282 (1986); American Booksellers Ass'n., Inc. v. Rendell, 332 Pa.Super. 537, 554, 481 A.2d 919, 927 (1984).

Here, the PCA and the SNJCS purport to represent chiropractors in Pennsylvania and Southern New Jersey, respectively, and allegedly spend substantial resources in representing their members in disputes with IBC over the problems alleged in this action. Am.Compl. at ¶ 9. As analyzed above, the named provider plaintiffs, Eisen, Wright, Pfeiffer and Cecchini, are able to go forward on their express breach of contract claim. In light of these circumstances, the first two prongs of the Hunt test have seemingly been met.

Defendants, here, focus primarily on the third prong of the Hunt test in arguing that the nature of the claim and the proof to be obtained requires a finding that the individual members are indispensable since proof of a breach of one contract is not necessarily proof of the breach of another contract, even though the contracts are purportedly uniform. This court agrees. There are two aspects to this third prong, i.e., the nature of the claim and the relief requested, both of which must be met before an association can have standing to raise claims on behalf of its members. It is true that when an "association seeks a declaration, injunction, or some other form of prospective relief, it can reasonably be supposed that the remedy, if

granted, will inure to the benefit of those members of the association actually injured." Hunt, 432 U.S. at 343 (quoting Warth v. Seldin, 422 U.S. 490, 515 (1975)). Therefore, at first glance, the injunctive relief sought by the PCA and the SNJCS to compel IBC to comply with the express terms and conditions of the provider contracts would be an appropriate type of relief to confer standing on these associations. See Am.Compl. at ¶ 111.

Nonetheless, the nature of the breach of contract claim appears to require the participation of the individual members or the named providers. "[I]t is fundamental contract law that one cannot be liable for a breach of contract unless one is a party to that contract." Electron Energy Corp. v. Short, 408 Pa.Super. 563, 571, 597 A.2d 175, 178 (1991)(holding that corporate president cannot be liable for breach of contract where he is not a party to the contract). See also, Fleetway Leasing Co. v. Wright, 697 A.2d 1000, 1003 (Pa.Super.Ct. 1997)("a person who is not a party to a contract cannot be held liable for breach by one of the parties to a contract"); Commonwealth v. Noble C. Quandel Company, 137 Pa.Commw. 252, 260, 585 A.2d 1136, 1140 (1991)(same). Here, it is undisputed that the PCA and the SNJCS are not parties to any provider contract with IBC. At oral argument, plaintiffs referred this court to Tower South Property Owners Ass'n. v. Summey Building Systems, Inc., 47 F.3d 1165, 1995 WL 60765, at *4 n. 4 (4th Cir. Feb. 15, 1995), which held that property owners' association has standing to sue for breach of implied warranty and breach of contract for alleged construction defects even where no contractual privity exists between the association and the defendant. The Tower South holding was influenced by the property association's stated purpose to maintain common elements of construction. Id. at * 4 n. 4. The holding was also influenced by the fact that the defendant did not raise lack of standing until after the jury's verdict. Id. at *4. This court does not find this case to be persuasive but finds that the

PCA and SNJCS do not have contractual privity with IBC or its affiliates and cannot pursue either breach of contract claim on behalf of their members, even though these associations only seek injunctive relief.

Moreover, the cases relied on by plaintiffs, which found the associations had standing, were based on legislation conferring such standing and/or challenges to government actions, but they do not support that associations have standing to enforce their members' private agreements through injunctive relief. See, e.g., Thompson v. Metropolitan Multi-List, Inc., 34 F.2d 1566, 1571 (11th Cir. 1991)(examining antitrust standing); New York State Nat'l. Organization for Women v. City of New York, 886 F.2d 1339, 1349 (2d Cir. 1989)(challenging the constitutionality of Operation Rescue and seeking injunctive relief to ensure unobstructed access to family planning facilities); Nat'l. Ass'n. of Pharmaceutical Manufacturers v. Ayerst Laboratories, 850 F.2d 904, 912-14 (2d Cir. 1988)(examining standing under the Clayton Act and the Lanham Act); Nat'l. Ass'n. of College Bookstores, Inc. v. Cambridge University Press, 990 F.Supp. 245, 249-51 (S.D.N.Y. 1997)(examining alleged violations of the Robinson-Patman Act); Eastern Paralyzed Veterans Ass'n. v. Veterans' Administration, 762 F.Supp. 539, 546 (S.D.N.Y. 1991)(examining equal protection and due process claims on a motion for class certification); American College of Obstetricians and Gynecologists v. Thornburgh, 552 F.Supp. 791, 795 (E.D.Pa. 1982)(challenging the constitutionality of the Pennsylvania Abortion Control Act).

Finally, defendants rely on Pennsylvania Psychiatric Society v. Green Spring Health Services, Inc., Civ. A. No. 99-937, 2000 U.S. Dist. LEXIS 8017 (W.D. Pa. Feb. 15, 2000)(Magistrate's Recommendation), adopted as opinion, 2000 U.S. Dist. LEXIS 7953 (W.D.Pa. Mar. 24, 2000), a substantially similar case which held that the plaintiff association did not have standing to sue on behalf of its members on claims for breach of its provider agreements for monetary, injunctive or declaratory relief

since proof of the claims will entail the involvement of the individual members. 2000 U.S. Dist. LEXIS 8017, at *10-12. In that case, the Pennsylvania Psychiatric Society alleged, *inter alia*, that the defendant HMO had refused to credential physician applicants; created obstacles to physician credentialing; imposed overly-burdensome administrative requirements; failed to timely pay members for services rendered; interfered with physican-patient relations; gave overly-restrictive treatment authorizations; and made determinations concerning the level and quality of care received by patient-subscribers based on criteria other than medical necessity. Id. at *11-12. The court acknowledged that though the society seeks "broad based" changes in the defendant's procedures, the plaintiff would have to establish that the specific instances and alleged abuses occurred which would require the members' individual involvement. Id. at *12.

The breach of contract claim and type of relief sought in the present case are similar to those in Pennsylvania Psychiatric Society. Like that case, this court finds that the PCA and SNJCS do not have standing to sue on behalf of their members because resolution of the breach of contract claims requires participation from the individual members, even though the associations only seek injunctive relief on behalf of the other unnamed chiropractic providers.

Therefore, defendants' objection raising lack of standing on the part of the PCA and the SNJCS, pursuant to Pa.R.C.P. 1028(a)(5), is sustained.

CONCLUSION

For the reasons set forth, the demurrers to Count I, as to the provider plaintiffs, and to Count II, as to the subscriber plaintiffs, is sustained. The objection of lack of standing of the PCA and the SNJCS

is also sustained. However, the demurrer to Count III is overruled. Additionally, the motion to strike the demand for punitive damages as to Count I is granted. Defendants shall file an Answer to the Amended Complaint within twenty (20) days from the date of entry of this Opinion. An Order will be entered this date in accord with this Opinion.

BY THE COURT,

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JOHN W. HERRON, J.

Dated: July 16, 2001