BLUE CROSS HEALTH CARE, INC., Petitioner, vs. NEOMI and DANILO OLIVARES, Respondents.

G.R. No. 169737. February 12, 2008

Ponente: CORONA, J.

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CORONA, J.:

This is a petition for review on certiorari[1] of a decision[2] and resolution[3] of the Court of Appeals (CA) dated July 29, 2005 and September 21, 2005, respectively, in CA-G.R. SP No. 84163 which affirmed the decision of the Regional Trial Court (RTC), Makati City, Branch 61 dated February 2, 2004 in Civil Case No. 03-1153,[4] which in turn reversed the decision of the Metropolitan Trial Court (MeTC), Makati City, Branch 66 dated August 5, 2003 in Civil Case No. 80867.[5]

Respondent Neomi T. Olivares applied for a health care program with petitioner Blue Cross Health Care, Inc., a health maintenance firm. For the period October 16, 2002 to October 15, 2003,[6] she paid the amount of P11,117. For the same period, she also availed of the additional service of limitless consultations for an additional amount of P1,000. She paid these amounts in full on October 17, 2002. The application was approved on October 22, 2002. In the health care agreement, ailments due to "pre-existing conditions" were excluded from the coverage.[7]

On November 30, 2002, or barely 38 days from the effectivity of her health insurance, respondent Neomi suffered a stroke and was admitted at the Medical City which was one of the hospitals accredited by petitioner. During her confinement, she underwent several laboratory tests. On December 2, 2002, her attending physician, Dr. Edmundo Saniel,[8] informed her that she could be discharged from the hospital. She incurred hospital expenses amounting to P34,217.20. Consequently, she requested from the representative of petitioner at Medical City a letter of authorization in order to settle her medical bills. But petitioner refused to issue the letter and suspended payment pending the submission of a certification from her attending physician that the stroke she suffered was not caused by a pre-existing condition.[9]

She was discharged from the hospital on December 3, 2002. On December 5, 2002, she demanded that petitioner pay her medical bill. When petitioner still refused, she and her husband, respondent Danilo Olivares, were constrained to settle the bill.[10] They thereafter filed a complaint for collection of sum of money against petitioner in the MeTC on January 8, 2003.[11] In its answer dated January 24, 2003, petitioner maintained that it had not yet denied respondents' claim as it was still awaiting Dr. Saniel's report.

In a letter to petitioner dated February 14, 2003, Dr. Saniel stated that:

> This is in response to your letter dated February 13, 2003. [Respondent] Neomi T. Olivares called by phone on January 29, 2003. She stated that she is invoking patient-physician confidentiality. That she no longer has any relationship with [petitioner]. And that I should not release any medical information concerning her neurologic status to anyone without her approval. Hence, the same day I instructed my secretary to inform your office thru Ms. Bernie regarding [respondent's] wishes.

> xxx xxx xxx[12]

In a decision dated August 5, 2003, the MeTC dismissed the complaint for lack of cause of action. It held:

> xxx the best person to determine whether or not the stroke she suffered was not caused by "pre-existing conditions" is her attending physician Dr. Saniel who treated her and conducted the test during her confinement. xxx But since the evidence on record reveals that it was no less than [respondent Neomi] herself who prevented her attending physician from issuing the required certification, petitioner cannot be faulted from suspending payment of her claim, for until and unless it can be shown from the findings made by her attending physician that the stroke she suffered was not due to pre-existing conditions could she demand entitlement to the benefits of her policy.[13]

On appeal, the RTC, in a decision dated February 2, 2004, reversed the ruling of the MeTC and ordered petitioner to pay respondents the following amounts: (1) P34,217.20 representing the medical bill in Medical City and P1,000 as reimbursement for consultation fees, with legal interest from the filing of the complaint until fully paid; (2) P20,000 as moral damages; (3) P20,000 as exemplary damages; (4) P20,000 as attorney's fees and (5) costs of suit.[14] The RTC held that it was the burden of petitioner to prove that the stroke of respondent Neomi was excluded from the coverage of the health care program for being caused by a pre-existing condition. It was not able to discharge that burden.[15]

Aggrieved, petitioner filed a petition for review under Rule 42 of the Rules of Court in the CA. In a decision promulgated on July 29, 2005, the CA affirmed the decision of the RTC. It denied reconsideration in a resolution promulgated on September 21, 2005. Hence this petition which raises the following issues: (1) whether petitioner was able to prove that respondent Neomi's stroke was caused by a pre-existing condition and therefore was excluded from the coverage of the health care agreement and (2) whether it was liable for moral and exemplary damages and attorney's fees.

The health care agreement defined a "pre-existing condition" as:

> x x x a disability which existed before the commencement date of membership whose natural history can be clinically determined, whether or not the Member was aware of such illness or condition. Such conditions also include disabilities existing prior to reinstatement date in the case of lapse of an Agreement. Notwithstanding, the following disabilities but not to the exclusion of others are considered pre-existing conditions including their complications when occurring during the first year of a Member's coverage:
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> I. Tumor of Internal Organs
>
> II. Hemorrhoids/Anal Fistula
>
> III. Diseased tonsils and sinus conditions requiring surgery
>
> IV. Cataract/Glaucoma
>
> V. Pathological Abnormalities of nasal septum or turbinates
>
> VI. Goiter and other thyroid disorders
>
> VII. Hernia/Benign prostatic hypertrophy
>
> VIII. Endometriosis
>
> IX. Asthma/Chronic Obstructive Lung disease
>
> X. Epilepsy

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> XI. Scholiosis/Herniated disc and other Spinal column abnormalities
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> XII. Tuberculosis
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> XIII. Cholecysitis
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> XIV. Gastric or Duodenal ulcer
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> XV. Hallux valgus
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> XVI. Hypertension and other Cardiovascular diseases
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> XVII. Calculi
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> XVIII. Tumors of skin, muscular tissue, bone or any form of blood dyscracias
>
> XIX. Diabetes Mellitus
>
> XX. Collagen/Auto-Immune disease
>
> After the Member has been continuously covered for 12 months, this pre-existing provision shall no longer be applicable except for illnesses specifically excluded by an endorsement and made part of this Agreement.[16]

Under this provision, disabilities which existed before the commencement of the agreement are excluded from its coverage if they become manifest within one year from its effectivity. Stated otherwise, petitioner is not liable for pre-existing conditions if they occur within one year from the time the agreement takes effect.

Petitioner argues that respondents prevented Dr. Saniel from submitting his report regarding the medical condition of Neomi. Hence, it contends that the presumption that evidence willfully suppressed would be adverse if produced should apply in its favor.[17]

Respondents counter that the burden was on petitioner to prove that Neomi's stroke was excluded from the coverage of their agreement because it was due to a pre-existing condition. It failed to prove this.[18]

We agree with respondents.

In Philamcare Health Systems, Inc. v. CA,[19] we ruled that a health care agreement is in the nature of a non-life insurance.[20] It is an established rule in insurance contracts that when their terms contain limitations on liability, they should be construed strictly against the insurer. These are contracts of adhesion the terms of which must be interpreted and enforced stringently against the insurer which prepared the contract. This doctrine is equally applicable to health care agreements.[21]

Petitioner never presented any evidence to prove that respondent Neomi's stroke was due to a pre-existing condition. It merely speculated that Dr. Saniel's report would be adverse to Neomi, based on her invocation of the doctor-patient privilege. This was a disputable presumption at best.

Section 3 (e), Rule 131 of the Rules of Court states:

> Sec. 3. Disputable presumptions. â€- The following presumptions are satisfactory if uncontradicted, but may be contradicted and overcome by other evidence:
>
> xxx xxx xxx
>
> (e) That evidence willfully suppressed would be adverse if produced.

Suffice it to say that this presumption does not apply if (a) the evidence is at the disposal of both parties; (b) the suppression was not willful; (c) it is merely corroborative or cumulative and (d) the suppression is an exercise of a

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privilege.[22] Here, respondents' refusal to present or allow the presentation of Dr. Saniel's report was justified. It was privileged communication between physician and patient.

Furthermore, as already stated, limitations of liability on the part of the insurer or health care provider must be construed in such a way as to preclude it from evading its obligations. Accordingly, they should be scrutinized by the courts with "extreme jealousy"[23] and "care" and with a "jaundiced eye."[24] Since petitioner had the burden of proving exception to liability, it should have made its own assessment of whether respondent Neomi had a pre-existing condition when it failed to obtain the attending physician's report. It could not just passively wait for Dr. Saniel's report to bail it out. The mere reliance on a disputable presumption does not meet the strict standard required under our jurisprudence.

Next, petitioner argues that it should not be held liable for moral and exemplary damages, and attorney's fees since it did not act in bad faith in denying respondent Neomi's claim. It insists that it waited in good faith for Dr. Saniel's report and that, based on general medical findings, it had reasonable ground to believe that her stroke was due to a pre-existing condition, considering it occurred only 38 days after the coverage took effect.[25]

We disagree.

The RTC and CA found that there was a factual basis for the damages adjudged against petitioner. They found that it was guilty of bad faith in denying a claim based merely on its own perception that there was a pre-existing condition:

> [Respondents] have sufficiently shown that [they] were forced to engage in a dispute with [petitioner] over a legitimate claim while [respondent Neomi was] still experiencing the effects of a stroke and forced to pay for her medical bills during and after her hospitalization despite being covered by [petitioner's] health care program, thereby suffering in the process extreme mental anguish, shock, serious anxiety and great stress. [They] have shown that because of the refusal of [petitioner] to issue a letter of authorization and to pay [respondent Neomi's] hospital bills, [they had] to engage the services of counsel for a fee of P20,000.00. Finally, the refusal of petitioner to pay respondent Neomi's bills smacks of bad faith, as its refusal [was] merely based on its own perception that a stroke is a pre-existing condition. (emphasis supplied)

This is a factual matter binding and conclusive on this Court.[26] We see no reason to disturb these findings.

WHEREFORE, the petition is hereby DENIED. The July 29, 2005 decision and September 21, 2005 resolution of the Court of Appeals in CA-G.R. SP No. 84163 are AFFIRMED.

Treble costs against petitioner.

SO ORDERED.

Puno, C.J., (Chairperson), Sandoval-Gutierrez, Azcuna, and Leonardo-De Castro, JJ., concur.

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* The petition spelled the name of respondent as Noemi Olivares but in the decision of the Court of Appeals, Neomi was used since she signed as such in the verification and certificate of non-forum shopping attached to her complaint.

[1] Under Rule 45 of the Rules of Court.

[2] Penned by Associate Justice Japar B. Dimaampao and concurred in by Associate Justices Martin S. Villarama, Jr. and Edgardo F. Sundiam of the Former Fifteenth Division of the Court of Appeals; rollo, pp. 17-25.

[3] Id., pp. 27-28.

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[4] Penned by Judge Romeo F. Barza; id., pp. 38-43.

[5] Penned by Judge Perpetua Atal-Paño; id., pp. 44-47.

[6] Id., p. 178.

[7] Id., p. 39.

[8] Id., p. 18.

[9] Id., p. 39.

[10] Id., p. 109.

[11] Id., p. 38.

[12] Id., p. 29.

[13] Id., p. 47.

[14] Id., p. 43.

[15] Id., p. 42.

[16] Id., p. 114.

[17] Id., p. 195.

[18] Id., p. 214.

[19] 429 Phil. 82 (2002).

[20] Id., p. 90.

[21] Id., pp. 93-94, citations omitted.

[22] People v. Andal, 344 Phil. 889, 912 (1997), citing People v. Ducay, G.R. No. 86939, 2 August 1993, 225 SCRA 1 and People v. Navaja, G.R. No. 104044, 30 March 1993, 220 SCRA 624, 633.

[23] DBP Pool of Accredited Insurance Companies v. Radio Mindanao Network, Inc., G.R. No. 147039, 27 January 2006, 480 SCRA 314, 322, citing Malayan Insurance Corporation v. Court of Appeals, 336 Phil. 977, 989 (1997).

[24] Western Guaranty Corporation v. Court of Appeals, G.R. No. 91666, 20 July 1990, 187 SCRA 652, 659-660, citing Taurus Taxi Co., Inc. v. The Capital Ins. & Surety Co., Inc., G.R. No. L-23491, 31 July 1968, 24 SCRA 454 and Eagle Star Insurance, Ltd. v. Chia Yu, 96 Phil. 696 (1955).

[25] Rollo, pp. 196-198.

[26] PAL, Inc. v. CA, 326 Phil. 824, 835 (1996), citations omitted.

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