By Scott Glovsky

"HMOs are in the business of insurance and subject to tort liability for their bad faith denial of medical care"

Building a bad faith case against an HMO arising out of the delay or denial of medical care

This article provides a general approach building a bad faith case against a Health Maintenance Organization (HMO) for its delay or denial of medical care.

An HMO is a type of *health care service plan* that is licensed and regulated by the California Department of Managed Health Care under the Knox-Keene Act (the "Act"). Health & Safety Code section 1341. HMOs arrange for the provision of medical services in exchange for periodic premium payments. They issue contracts called Evidences of Coverage to their insureds, referred to as subscribers or members in the Health & Safety Code. The Evidences of Coverage promise to provide covered medical services.

HMOs are slightly different than traditional health insurers in that they arrange for the provision of medical services while health insurers simply pay for medical services. Health insurers are licensed and regulated by the California Department of Insurance under the Insurance Code. But HMOs are specifically exempted from the jurisdiction of the Insurance Code and the Department of Insurance. *Williams v. California Physicians' Service*, 72 Ca.App.4th 722, 729, 85 Cal.Rptr.2d 497 (1999). Notwithstanding the fact that HMOs and health insurers are subject to different regulatory schemes, HMOs are in the business of insurance and subject to tort liability for their bad faith denial of medical care (see below). *Sarchett v. Blue Shield of California*, 43 Cal.3d 1, 233 Cal.Rptr. 76 (1987).

Who and how to sue

HMOs in California operate primarily through a *delegated model*. Under this model, the HMOs do not directly employ health-care providers to treat their members. Instead, the HMOs enter contracts with groups of physicians called Independent Practice Associations (IPAs) or Primary Medical Groups to provide medical services to their members. Often, these contracts are called *IPA Services Agreements*. Subscribers choose one of the HMO's IPAs to provide their medical care.

The main defendant will be the HMO itself. The strongest potential causes of action to assert against an HMO include breach of contract, bad faith, unfair business practices under Business and Professions Code section 17200, fraud, negligent misrepresentation, wrongful death and intentional and negligent infliction of emotional distress.

The IPA is usually also a proper defendant. The strongest potential causes of action to allege against the IPA is tortious interference with the contract between the HMO and the member, based upon a theory that the IPA interfered with the Evidence of Coverage by improperly denying or delaying covered medical care for its own financial gain. *Wilson v. Blue Cross of Southern California* (1990) 222 Cal.App.3rd 660, 673. Additionally, the IPA can be liable for breach of fiduciary duty for failing to disclose financial incentives that may affect coverage decisions. *Moore v. Regents of the Univ. of California*, 51 Cal.3d 120, 128-32, 148 Cal.Rptr.146, 149-52 (1990).

Developing the case in discovery

To prove that an HMO handled the requests for care unreasonably and maliciously, oppressively or fraudulently, establish that the HMO violated its duties to the member based on published bad faith decisions, Health & Safety Code sections, and industry standards. The National Committee for Quality Assurance ("NCQA") is an accrediting body that accredits managed-care organizations. It publishes a set of industry standards for HMOs entitled Standards for the Accreditation of Managed Care Organizations ("NCQA standards"). HMOs seek accreditation from the NCQA to help sell their product. NCQA accreditation, according to one HMO's advertising materials, is like the Good Housekeeping Seal of Approval. In order to obtain NCQA accreditation, an HMO must promise to comply with the NCQA's standards. The NCQA standards

See Glovsky, Next Page

provide fertile ground for establishing that the HMO violated its duties to the member. To develop a case in discovery, pay particular attention to the following issues:

•HMOs have a duty to *thoroughly investigate* requests for care and fully inquire into all possible bases that might support the request for care. *Egan v. Mutual of Ohaha Ins. Co.*, 24 Cal.3d 809, 819, 169 Cal.Rptr.691, 696 (1979). Explore the ways that the HMO could have fully investigated the request, and then contrast that with the investigation that the HMO or IPA actually conducted. The utilization review process is the process through which HMOs and IPAs evaluate requests for care. Obtain all of the defendants' documents regarding utilization review relating to the member. Also obtain their policies and procedures regarding utilization review. Then depose the decision- makers to find out exactly what investigation they conducted. Find out why they decided to delay or deny the request for care and what documents they read, reviewed or relied upon before making the decision. Often, the individual or individuals that made the decision to delay or deny the care never reviewed any of the member's medical records, spoke with the member or talked with the member's treating physicians.

•HMOs have a duty to *promptly respond* to requests for care. NCQA standards include turnaround times for responding to requests for care. NCQA Standard UM 4 provides that HMOs must make decisions regarding request for non-urgent care within two working days of obtaining the necessary information and decisions regarding urgent care within one working day of obtaining the necessary information. Health & Safety Code section 1367.01 requires HMOs to make utilization review decisions when a member faces an imminent and serious threat to his health within 72 hours after the HMO's receipt of the relevant information, and make decisions regarding other requests for care within five business days.

• HMOs have a duty to ensure that *qualified health professionals* make utilization review decisions. NCQA Standard UM 3 provides that "qualified health professionals assess the clinical information used to support [utilization review] decisions." Additionally, an HMO must have procedures for "using board-certified physicians from appropriate specialty areas to assist in making determinations of medical necessity." Health & Safety Code section 1367.01(e) provides that only a licensed physician or health care provider "who is competent to evaluate the specific clinical issues involved in the health care services requested" may deny a request for care based on medical necessity. Use discovery to determine if the committee was properly constituted. HMOs must communicate decisions to delay, deny or modify requests for care in writing and provide a clear and concise explanation of the reasons for the HMO's decision, a description of the criteria or guidelines used, and clinical reasons for decisions regarding medical necessity. Health & Safety Code section 1367.01, subd. (h)(4).

•HMOs have a duty to provide *continuity of care* and *coordination of care*. Health & Safety Code section 1367, subd. (d). An HMO must ensure that the member receives continuous care from the same physicians and is not shuffled from doctor to doctor during the member's treatment. An HMO must also make sure that a physician is coordinating the member's care. Members with a complicated disease process, such as cancer, often require several different specialists. An HMO must have a physician assigned to coordinate the member's care and be sure that the treating physicians are communicating with each other about the patient.

•HMOs have a duty to provide members with *referrals to specialists* that are consistent with good professional practice. Health & Safety Code section 1367subd. (d). Referring members to specialists costs HMOs money. As a result, primary care physicians often fail to refer members to specialists when it is appropriate. Additionally, HMOs require members to treat with their contracted physicians. HMOs are extremely hesitant to refer members to non- contracted physicians because they then lose all control over the costs of the member's care.

Effective trial themes in HMO bad faith cases include *promises and lies* and *corporate greed*. In order to establish that the defendants' conduct is malicious, oppressive or fraudulent, seek to establish that the HMO systemically failed to honor its promises in its marketing materials and Evidence of Coverage and failed to disclose that it uses financial incentives to deny care. In order to discover the specific financial incentives at issue, obtain the contract between the HMO and IPA. The contract essentially transforms the IPA into a small insurance com-

See Glovsky, Next Page

pany and provides the IPA with financial incentives to deny care. In exchange for payments from the HMOs, the IPA usually agrees to perform utilization review to determine what medical care a member requires and whether that care is covered under the HMO's Evidence of Coverage. Most importantly, the IPAs agree to provide or pay for most of the medical care.

The contracts normally provide IPAs with financial incentives to deny care in two forms, capitation payments and risk-sharing pools. Capitation payments are fixed monthly payments based solely upon the number of subscribers assigned to an IPA. For example, an HMO may pay an IPA $35 per month for each subscriber assigned to that IPA. The IPA receives the capitation payment regardless of whether the subscriber is healthy or sick. If the subscriber is healthy, and requires no medical care, the IPA receives $35 for the subscriber without having to pay for any medical care. If the subscriber is extremely sick, and requires substantial care, the IPA must pay for the expensive care although it still only receives $35 for the subscriber. Capitation is legal and authorized by Health & Safety Code section 1348.6.

HMOs also establish risk-sharing pools to limit the utilization of certain medical services. Risk sharing involves transferring the cost of medical services from the HMOs to the IPAs and health-care providers. For example, some HMOs withhold a percentage of an IPA's capitation payments at the beginning of each year and place the money into a risk-sharing pool that is earmarked for certain services, such as inpatient hospital stays and prescription drug costs. The HMO then uses the pool of money as a budget for the anticipated cost of the hospital stays for the members assigned to the IPA. At the end of the year, if the actual cost of the hospital stays for the members exceeds the budget, the IPA will be financially responsible for some of the additional cost. If the cost is less than the budget, the IPA receives a percentage of the money left in the pool. Because the HMOs have tremendous bargaining power over the IPAs, most IPAs in California are in extreme financial trouble and many have filed bankruptcy. The IPAs have strong financial motives to deny medical care simply to stay solvent.

Defenses

Where HMOs delegate the utilization-review functions to IPAs, IPAs often make the decisions to delay or deny the requests for care without any involvement of the HMO. In these cases HMOs argue that the IPAs are independent contractors and, therefore, the HMO is not liable for the IPA's conduct. But an HMO may not delegate away its duty to perform its obligations to its insured in a manner consistent with the implied covenant of good faith and fair dealing. In California HMOs have a non-delegable duty to "process claims fairly and in good faith." *Hughes v. Blue Cross of No. California*, 215 Cal.App.3d 832, 848, 263 Cal.Rptr.850, 859 (1989). *Hughes* affirmed the trial court's instruction to the jury in a bad-faith case that the insurer's duty to process claims fairly and in good faith was non-delegable. Likewise, in *Rattan v. United Services Auto. Ass'n* 84 Cal.App.4th 715, 101 Cal.Rptr.2d 5 (2001), the court explained, "We fully accept that where an insurer has used an agent to determine when to pay benefits, the agent's derelictions might support liability in tort."

Hughes and *Rattan* are, in essence, the "flip side" of cases like *Gruenberg v. Aetna Ins. Co*., 9 Cal.3d 566, 108 Cal.Rptr. 480 (1973), and *Sanchez v. Lindsey Morden Claims Services, Inc.*, 72 Cal.App.4th 249, 84 Cal.Rptr.2d 799 (1999), which hold that when an insurer hires a claims adjuster to resolve a claim, the adjuster cannot be held liable to the insured for breach of the implied covenant because there is no contractual privity between the insured and the adjuster, and the claims adjuster owes the insured no duty of care. Moreover, NCQA Standard UM 12 provides that an HMO "is accountable for all the [utilization review] activities conducted for its members. Although it may delegate all or parts of [utilization review], it retains accountability for the decisions made."

Thus, the HMOs are fully liable for the IPA's denials of medical care just as if the HMO itself had denied the care.

Historically, HMOs have also argued that they are not subject to tort liability for their unreasonable denial of medical care because they are not insurance companies. But recent caselaw has closed the door on this defense. In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002), the United States Supreme Court confirmed that an HMO "provides health care … as an insurer." The Court noted that an HMO cannot "checkmate common sense by trying to submerge HMOs' insurance features beneath an exclusive

See Glovsky, Next Page

characterization of HMOs as providers of health care." *Id*. *Accord Smith v. Pacificare*, 93 Cal.App.4th 139; 157-158; 113 Cal.Rptr.2d 140, 153 (2001)[HMO's are engaged in providing a service that is a substitute for what previously constituted health insurance, and are in the business of insurance].

The HMO's parent company will contend that it is a separate company and had no involvement with the decision to delay or deny the medical care. To combat this defense, establish that the parent company is in a joint venture with its subsidiary to operate the HMO. Because each joint venturer is the agent for the other members of the venture, all members are liable for the torts committed by any venturer while acting in connection with the venture. *Grant v. Weatherholt*, 123 Cal.App.2d 34, 45, 266 P.2d 185, 186 (1954). If the parent company is a publicly traded company, its SEC 10-K filings should provide admissions regarding its involvement in the subsidiary's business.

If the client obtained heath coverage through an employer, the case is likely subject to, and therefore pre-empted by ERISA. Private plans, and employer plans sponsored by a government or a church organization will not be subject to ERISA.

If the member is enrolled in a Medicare HMO, make sure that the claim is not framed as a claim to obtain a Medicare benefit or reimbursement for the failure to provide a benefit. All issues of Medicare coverage must proceed through the Medicare appeals process, which will be described in the members Evidence of Coverage. See 42 U.S.C. §§ 1395 et. seq. But claims seeking tort damages resulting from the denial of medical care, and not seeking medical care or the payment for medical care, are not preempted. See *McCall v. PacifiCare of California, Inc*., 25 Cal.4th 412, 106 Cal.Rptr.2d 271 (2001) and *Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1999).

Almost all Evidences of Coverage in California include mandatory, pre-dispute arbitration provisions. HMOs that utilize mandatory arbitration must comply with the requirements of Health & Safety Code section 1363.1, which requires HMOs to disclose arbitration clauses in a specified manner. The plan's failure to comply will render the clause unenforceable. *Smith v. PacifiCare Behavioral Health of California, supra*, 93 Cal.App.4th 139, 113 Cal.Rptr.2d 140; *Imbler v. PacifiCare of California*, 103 Cal.App.4th 567, 126 Cal.Rptr.2d 715 (2002) and *Pagarian v. Sup. Ct.*, 102 Cal.App.4th 1121, 126 Cal.Rptr.2d 124 (2002).

Scott Glovsky is in solo practice in Claremont, California. His practice emphasizes insurance bad-faith actions, often against HMOs.