An Introduction to HMO

This article provides an overview of the major issues involved in bringing an action for insurance bad faith action against a Health Maintenance Organization ("HMO") in California, arising out of the improper denial of medical care.

HMOs are licensed and regulated by the California Department of Managed Healthcare under the Knox-Keene Act. They are called "health care service plans" in the Act. Although they are somewhat different than traditional insurance companies, and are not governed by the Insurance Code, it is settled that, with respect to the promises made to their insureds (called subscribers or enrollees), HMOs are in the *business of insurance* and subject to tort remedies for their bad-faith denial of medical care. *See Smith v. PacifiCare Behavioral Health of California*, 93 Cal.App.4th 139, 113 Cal.Rptr.2d 140 (2001); *Sarchett v. Blue Shield of California*, 43 Cal.3d 1, 233 Cal.Rptr. 76 (1987); *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039, 1045-1046 (9th Cir. 1998); Health & Safety Code § 1341 and Insurance Code § 740(g).

The Delegated Model and Financial Incentives to Deny Care

In California, HMOs operate primarily through a *delegated model*. Under this model, the HMOs do not directly employ health-care providers to treat their subscribers. Instead, the HMOs enter contracts with groups of physicians called Primary Medical Groups or Independent Practice Associations ("IPAs") to provide medical services to their subscribers. The contracts essentially transform the IPAs into small insurance companies and provide the IPAs with financial incentives to deny care. In exchange for payments from the HMOs, the IPAs usually agree to determine what medical care a subscriber requires and whether that care is covered under the HMO's contract with its subscribers (called an Evidence of Coverage). Most importantly, the IPAs agree to
provide or pay for most of the medical care.

The contracts often provide the 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 $200 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 $200 for the subscriber without having to INSURANCE BAD FAITH 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 $200 for the subscriber. Capitation is legal and authorized by *Health & Safety Code* § 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 in-patient hospital stays. 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, many IPAs in California are in financial trouble and several have filed bankruptcy. In sum, the IPAs have strong financial motives to deny medical care to increase their profits.

The financial incentives also trickle down to the treating physicians. Many IPAs enter capitation contracts with primary care physicians and specialists. As a result, physicians have financial incentives to maintain large patient populations under their care. In addition, physicians often have ownership interests in IPAs or receive bonuses based on the IPA's profitability.

Evaluating a Potential HMO Bad-Faith Case

An HMO bad-faith case should be evaluated much like any other insurance bad-faith case, but there are a few key issues to consider.

First, determine whether the Employee Retirement Income Security Act ("ERISA") preempts the case. Although the reach of ERISA pre-emption is worthy of a separate article, in general, if the client is a subscriber in an HMO through an employer, and is not self-employed or employed by the government or a church organization, ERISA probably preempts the claims. *See* 29 U.S.C. 1003(b) and 29 C.F.R. § 2510.3-3(b). If ERISA preempts the claims, the client cannot recover any consequential or punitive damages and the client's potential remedies are limited to contract benefits and reasonable attorneys' fees. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985); *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 113 S.Ct. 2063 (1993).

If the case appears to be ERISA preempted, review Civil Code section 3428. The California legislature enacted section 3428 in an effort to avoid ERISA preemption. Under this section, HMOs have a duty to arrange for the provision of medically necessary services and are liable for any harm caused by a breach of their duty where it results in the denial, delay, or modification of the recommended care and the subscriber suffers "substantial harm." Substantial harm includes loss of life, significant impairment of a limb or bodily function, significant disfigurement, severe and chronic physical pain or significant financial loss. But before filing suit, a subscriber must first exhaust the applicable independent review procedures, unless substantial harm occurred, or will imminently occur before the completion of the independent review process.

Second, if the client is enrolled in a Medicare HMO, evaluate whether the Medicare Act preempts the client's claims. Generally, the Medicare Act preempts claims seeking medical care or the payment for medical care. *See* 42 U.S.C. §§ 1395 et. seq. These claims are subject to the Medicare appeals process. 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 pre-empted. *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).

Third, review the clients' Evidence of Coverage to determine if it includes an enforceable arbitration provision. Almost all Evidences of Coverage in California include mandatory, pre-dispute arbitration provisions. HMOs that utilize mandatory arbitration provisions must comply with the requirements of Health & Safety Code section 1363.1. This statute requires HMOs to disclose in clear and understandable language that they use binding arbitration to settle disputes. The disclosure must be prominently displayed on the plan enrollment form and appear immediately before the enrollee's signature line. The disclosure must also appear as a separate article in the Evidence of Coverage and be expressed substantially in the wording provided in Code of Civil Procedure section 1295(a).

Smith v. PacifiCare Behavioral Health of California, supra, 93 Cal.App.4th 139, 113 Cal.Rptr.2d 140, held that the Federal Arbitration Act did not preempt section 1363.1, and affirmed a trial court's denial of the HMO's petition to compel arbitration because the plan documents did not meet the statutory requirements.

HMOs waive their right to enforce arbitration provisions when they engage in litigation conduct inconsistent with an intent to arbitrate, such as engaging in discovery. *See Berman v. Health Net*, 80 Cal.App.4th 1359, 1373 96 Cal.Rptr.2d 295 (2000)); *Guess?, Inc. v. Superior Court*, 79 Cal.App.4th 553, 94 Cal.Rptr.2d 201 (2000). Courts have also held arbitration provisions to be unconscionable where they improperly limit potential remedies, fail to provide for adequate discovery, or require a claimant to pay unreasonable costs as a condition of arbitration. *See Armendariz v. Foundation Health Psychare Services, Inc.*, 24 Cal.4th 83, 103-104, 99 Cal.Rptr.2d 745, 759- 60 (2000).

The Proper Defendants and Causes of Action

The potential defendants include the HMO, the IPA, and the individuals that denied authorization for the medical care at issue (often the IPA Medical Director). 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 strongest potential causes of action to allege against the IPA and its decision makers include breach of fiduciary duty (for failing to disclose financial incentives that may affect coverage decisions.) *See Moore v. Regents of the Univ. of California*, 51 Cal.3d 120, 128-32, 148 Cal.Rptr.146, 149-52 (1990); and tortious interference with the contract between the HMO and the subscriber (based upon a theory that the IPA interfered with the Evidence of Coverage by improperly denying covered medical care for its own financial gain). *Wilson v. Blue Cross of Southern California*, 222 Cal.App.3rd 660, 673 (1990).

Discovery

The utilization review process is the process through which HMOs and IPAs evaluate requests for care. It is crucial to obtain all of the HMO's and IPA's policies, procedures and guidelines related to their utilization review processes and all documents related to their utilization review related to the client. In order to discover the specific financial incentives at issue, request the contract between the HMO and IPA and the contract between the IPA and the treating physicians. The HMOs' advertising documents and promotional materials frequently contain promises that the HMOs fail to keep.

The National Committee for Quality Assurance ("NCQA") is an accrediting body that accredits managed care organizations. In order to obtain NCQA accreditation, which is analogous to the Good Housekeeping "Seal Of Approval" and helpful for an HMO's marketing, an HMO must agree to comply with the NCQA's standards. Because HMOs often fail to comply with the NCQA's standards, obtain all documents relating to the HMO's NCQA accreditation status during the relevant time period.

Defenses

The HMOs and IPAs often assert defenses based on causation. They will inevitably retain medical experts to testify that the client was not damaged by the denial of medical care. It is crucial to retain your own medical experts early to ensure that you will be able to prove that the denial of care damaged the client. Interview the client's treating physicians to determine whether they believe that the denial damaged the client.

Finally, the HMOs often argue that they are not liable for denials of medical care because they delegated the responsibility for utilization review to the IPA. The contracts between the HMOs and the IPAs specify that the IPA is an independent contractor. In California, however, HMOs have a non-delegable duty to "process claims fairly and in good faith." See Hughes v. Blue Cross of No. California, 215 Cal.App.3d 832, 848, 263 Cal.Rptr.850, 859 (1989) and the NCQA's Standards for the Accreditation of Managed Care Organizations, effective July 1, 2001. Thus, the HMOs are fully liable for the IPA's denials of medical care just as if the HMO itself had denied the care.