An Introduction to Bad Faith Litigation Against HMOs

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A Health Maintenance Organization ("HMO") is a type of health care service plan that is licensed and regulated by the California Department of Managed Health Care. Health & Safety Code § 1341. HMOs arrange for the provision of medical services in exchange for periodic premium payments. They issue contracts to their insureds, referred to as subscribers or members, called an Evidence of Coverage ("EOC"). The EOCs 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 traditional health insurers simply pay for medical services. Traditional health insurers are licensed and regulated by the Department of Insurance under the Insurance Code. But HMOs are specifically exempted from the jurisdiction of the Department of Insurance and the Insurance Code. *Williams v. California Physicians' Service*, 72 Ca.App.4th 722, 729, 85 Cal.Rptr.2d 497 (1999).

Financial incentives to delay and deny care

In California, most HMOs operate through a delegated model of delivering health care services. 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 Participating Medical Groups or Independent Practice Associations ("IPAs") to provide medical services to subscribers. The IPAs then enter separate contracts with physicians, including primary-care physicians and specialists, to treat subscribers.

These contracts provide financial incentives to delay and deny care. The HMOs' contracts with IPAs, commonly called IPA Services Agreements, essentially transform the IPAs into small insurance companies with financial incentives to deny care. In exchange for payments from the HMOs, the IPAs normally agree to determine what medical care a subscriber requires and whether that care is covered under the HMO's EOC. Most importantly, the IPAs agree to provide or pay for most of the medical care that a subscriber needs.

Capitation and risk-sharing pools

The IPA Services Agreements often provide the IPAs with two forms of financial incentives to deny care: capitation payments and risk-sharing pools. Capitation payments are fixed monthly payments based solely upon the number of subscribers that the HMO assigns 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 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 per month for the subscriber. Capitation is legal and authorized by statute. 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 develops 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 actual cost is less than the budget, the IPA receives a percentage of the money left in the risk-sharing pool. Because the HMOs have tremendous bargaining power over the IPAs, many IPAs are in financial trouble and several have filed bankruptcy.

The delegated model also provides treating physicians with financial incentives to deny care. 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. To handle the large patient populations, many primary-care physicians employ nurse practitioners to treat subscribers. The capitation contracts often require physicians to directly or indirectly pay for part of the cost of certain expensive services such as diagnostic procedures. The physicians, therefore, have a financial incentive to limit the number of diagnostic procedures that they order for subscribers. Moreover, physicians often have ownership interests in IPAs and have incentives to make the IPAs profitable. Many capitated primary-care physicians and specialists receive bonuses based on an IPA's profitability.

Defendants and causes of action

The most important defendant is the HMO. The potential causes of action to assert against an HMO include breach of contract, bad faith, unfair business practices, 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 tortuous interference with the EOC based upon a theory that the IPA interfered with the EOC 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).

ERISA and Medicare preemption

It is crucial to determine whether the Employee Retirement Income Security Act of 1974 ("ERISA") applies. Although the reach of ERISA pre-emption is a complicated subject, 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 religious organization, ERISA probably preempts the claims. 29 U.S.C. 1003(b) and 29 C.F.R. § 2510.3-3(b). If ERISA preempts the claims, the subscriber cannot recover any consequential or punitive damages and the subscriber's potential remedies are limited to only contract benefits and reasonable attorneys' fees. *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 § 3428. It provides

that 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.

If the subscriber is enrolled in a Medicare HMO, evaluate whether the Medicare Act preempts the subscriber's claims. The Medicare Act generally preempts claims seeking medical care or the payment for medical care. 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. *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).

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 the HMO's promises in the EOC, published bad faith decisions, statutes, regulations, and industry standards.

The National Committee for Quality Assurance ("NCQA") is an accrediting body that accredits managed care organizations. It annually publishes a set of industry standards for HMOs titled Standards for the Accreditation of Managed Care Organizations ("NCQA standards"). HMOs seek accreditation from the NCQA to help sell their products. 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 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 areas: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 Omaha 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 relating to 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. This is a crucial issue for several reasons. First, subscribers often require prompt treatment. For example, cancer patients may have a short window of opportunity within which to receive appropriate care before their cancer metastasizes and causes further damage. But HMOs operating through a delegated model have created a system that encourages delays. Physicians and subscribers must overcome layers of bureaucracy to obtain authorization for services. Normally all requests for treatment must be submitted by a subscriber's primary-care physician. In many states, it is common for HMO patients to have to wait weeks for an appointment with their primary-care physician. Once a subscriber visits their primary-care physician, the physician is required to submit a request for authorization to an IPA for the member to receive additional services, such as diagnostic tests or referrals to specialists. It can take days to weeks for an IPA to decide whether to authorize the requested service, and IPAs often ask primary-care physicians to submit additional information before they will make a decision. If the IPA approves the request, there often is a delay before the service can be scheduled. If the IPA denies the request, the subscriber can appeal to the HMO. Excluding emergencies, it normally takes HMOs one month to decide whether to uphold or reverse the denial.

In contrast to these delays, 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 decision 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 § 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. 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 § 1367.01(h)(4).

HMOs have a duty to provide continuity of care and coordination of care. Health & Safety Code § 1367(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 regarding the patient.

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

Enhancing punitive damages

As outlined in the U.S. Supreme Court's recent decision in State Farm Mut. Auto. Ins. Co. v. Campbell, et. al., 123 S.Ct. 1513 (2003), the degree of reprehensibility of an insurer's conduct is the most crucial factor in evaluating a punitive damages award against an insurer. To consider reprehensibility, a court must consider (1) whether the conduct involved repeated actions or was an isolated incident, (2) whether the harm was the result of intentional malice, trickery, or deceit or simply an accident, (3) whether the harm caused was physical or economic, (4) whether the conduct evidenced an indifference to, or reckless disregard of, the health and safety of others, and (5) whether the target of the conduct had financial vulnerability.

Plaintiffs should utilize these factors in developing their evidence and case themes. Effective trial themes in HMO bad faith cases include promises and lies and corporate greed. Seek to establish that the HMO systemically failed to honor its promises in its marketing materials and EOC and failed to disclose that it uses financial incentives to deny care. Attempt to prove that an HMO's conduct towards the plaintiff is part of a pattern and practice of similar bad faith utilization review activities towards subscribers. This will help establish that the damage involved repeated acts and resulted from the insurer's intentional malice, trickery or deceit and did not result from an accident. Also emphasize that the HMO's conduct caused physical injuries and evidenced an indifference to, and reckless disregard of, the subscribers' health and safety.

In addition, *State Farm v. Campbell* reaffirmed the Supreme Court's holding in *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 116 S.Ct. 1589 (1996), that a court must consider both actual damages and potential damages when evaluating punitive damages. In *TXO Production Corp. v. Alliance Resources Corp.*, 509 U.S. 443 (1993), the Court indicated that in addition to the potential harm to the plaintiff, a court must consider the potential harm to other victims of the defendant's conduct. Develop evidence through experts that the HMO's wrongful conduct has damaged, or will potentially damage, thousands of other subscribers.

HMOs' Defenses

Where HMOs delegate the utilization-review functions to IPAs, IPAs often make the initial decisions to delay or deny the requests for care without any involvement of the HMO. In these situations, HMOs argue that the IPAs are independent contractors and, therefore, the HMO is not liable for the IPA's conduct.

The IPA Services Agreements generally specify that the IPAs are independent contractors. But an HMO may not delegate away its duty to perform its obligations to

its subscriber in a manner consistent with the implied covenant of good faith and fair dealing. 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 v. Blue Cross* affirmed a trial court's instruction to the jury in a bad-faith case that the health plan's duty to process claims fairly and in good faith was non-delegable. *Hughes v. Blue Cross* upheld a punitive damage award against Blue Cross based on its agent's unreasonable utilization review activities. 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 consistent with cases such as *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 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 characterization of HMOs as providers of health care." Also *see 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.

Arbitration provisions

Almost all EOCs in certain states include mandatory, pre-dispute arbitration provisions. Health & Safety Code §1363.1 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 EOC and be expressed substantially in the wording provided in California Code of Civil Procedure § 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 § 1363.1, and affirmed a trial court's denial of the HMO's petition to compel arbitration because the plan documents did not comply with 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. *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 or fail to provide for adequate discovery. *Armendariz v. Foundation Health Psychare Services, Inc.*, 24 Cal.4th 83, 103-104, 99 Cal.Rptr.2d 745, 759-60 (2000).

Finally, many arbitration clauses require subscribers to pay for half of the arbitration costs. Plaintiffs can argue that such arbitration provisions are unconscionable because they discourage claimants from vindicating their rights. *Armendariz v. Foundation Health Psychare Services, Inc.*, 24 Cal.4th 83, 113 (2000); *Little v. Auto Stiegler, Inc.* 29 Cal.4th 1064 (2003); *Ting v. ATT*, 319 F.3d 1126 (2003); *Ferguson v. Countrywide Credit Industries, Inc.*, 298 F.3d 778 (2002) and *Ingle v. Circuit City*, 328 F.3d 1165, 1177 (2003); and *Abramson v. Juniper Networks*, 115 Cal.App.4th 638 (2004).