

Bottom Line

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Big Bad Bothersome HMO Traps: How to Fight Back and Win

As an attorney who represents consumers who are trying to force health insurance companies to pay their claims, I have recently noticed several disturbing trends.

In an effort to keep costs down, a growing number of managed-care providers and HMOs are denying or limiting payment in a number of situations.

Here's what is worrying me most and how to fight back.

WORRISOME TRENDS

Increase of bonus incentives. A growing number of HMOs and managed-care systems provide doctors, administrators and claims adjusters with financial incentives to deny or cut back coverage to customers. Insurance companies seldom disclose these financial arrangements to customers, except when disputes turn into lawsuits.

Hidden arbitration clauses in plan documents. Most people don't realize it, but when they sign up for coverage through some plans, they abandon their constitutional rights to a jury trial in the event of a health care policy dispute or fraudulent business practice. Instead, they have agreed to file an arbitration suit, which is typically decided by administrative panels with strong ties to the medical community. In many states, these panels cannot award consumers more than the cost of contested medical services.

THE IMPACT ON YOU

Insurers may discourage doctors from referring patients to specialists. I've encountered this problem often in cases when consumers require treatments that are expensive or somewhat new or unusual.

Typical problem areas: High-risk pregnancies, cancers, multiple sclerosis and other serious diseases. Some HMOs and managed-care systems deny full reimbursement to primary care physicians who refer patients to specialists, no matter how severe the patients' illnesses. That means primary care physicians lose money when they recommend specialists, leading to an ethical conflict that their patients only learn about if they sue the health care provider.

Solution: The best thing you can do under these circumstances is complain. Start by making an argument in writing to your primary care physician about why you believe you need a specialist's care. The next step is to complain to your HMO's board of directors. If the board isn't sympathetic, consider consulting a specialist and filing your claim, and hope for the best. Your health always comes first.

Insurers may discourage doctors from recommending acute rehabilitation care. Based upon my experience, this problem typically occurs among patients over age 65 following a serious stroke, a serious injury that results in paraplegia or quadriplegia or hip surgery. Although the problem is widespread, it's most pronounced when Medicare patients receive their care from HMOs.

Solution: Don't succumb to the marketing pitches you hear from HMOs. There's absolutely no reason to assign your Medicare coverage to an HMO -you'll only wind up limiting your freedom of medical choice.

Insurers may refuse to pay for certain emergency treatments. This usually happens when an HMO patient has a medical emergency while traveling and must be treated at a hospital that doesn't belong to the HMO. It's also common in states where people often work more than one hour from their homes and must seek treatment at nonmember hospitals.

Trap: Providers often deny claims on the grounds that the patient should have been treated at his/her own hospital or could have been transferred to a member hospital.

Solution: Always request a letter from the emergency room facility documenting that you experienced a medical emergency and were unable to be transferred to another facility without endangering your health.

WHEN INSURERS WONT PAY CLAIMS

At both HMOs and traditional insurers, more and more medical claims are being challenged by insurers on the grounds of being "not medically necessary." In these cases, it's the insurance plan doctor's judgment against any other physician's judgment. Regardless of what your doctor tells you, the decision may be influenced by bonus incentives. Some HMOs and insurers are even disallowing claims as unnecessary-after they have been recommended by physicians and preapproved.

Example: I've seen cases in which a woman stayed in the hospital for five days after a cesarean section-under doctor's orders. Then the HMO or insurance company refused to pay for more than two days' bills, despite the fact that the patient could not have discharged herself early from the hospital.

If your HMO or insurance company tries one of these ploys to deny you or a family member medical coverage, here's what you can do:

Start by following the insurer's complaint procedure. Most health care policies require you to report your grievance to a specified person or department. Don't forget to put your complaint in writing and include all relevant documentation. Retain a copy for your records, then send the complaint by registered mail.

If this fails, turn to state regulators. If your complaint is with an insurer - even one with a managed-care policy -complain to your state insurance department. Be sure to include a copy of your original complaint, plus all of the relevant correspondence. If your complaint is with an HMO, turn to your state department of corporations. You may want to report cases of severe bad faith or fraudulent behavior to your state attorney general and/or local Better Business Bureau.

Make as much noise as possible. Since state regulatory oversight in these areas is often weak, you may improve your chances by also reporting your problem to the local consumer hotlines and consumer affairs reporters at television stations and newspapers.

Seek legal redress if necessary.

If the sum in dispute is small, you may be wiser to sue in small-claims court. Check your state limits to see if this solution will work for you. Otherwise, you may want to consult an attorney.

Important: If a lawsuit seems likely, you are better off hiring a contingency fee attorney so that you'll only be charged if you win your case. If your policy includes an arbitration clause, you'll still be better off with a contingency lawyer -but finding one to represent you may be difficult since the financial payoff is limited.

Strategy: Interview several contingency fee attorneys who specialize in HMO lawsuits. The initial consultation

should be free. Also find out whether your state permits arbitration awards larger than your contested medical claims. That should increase your chances of finding a lawyer to represent you.

Protect your interests before signing up for coverage and long before potential problems can arise. Steps to take:

Question potential insurers or HMOs about arbitration clauses and hidden financial incentives for denied claims. If any exist, don't sign up.

Check with state agencies and consumer groups to see if your HMO or insurer has a record of complaints. If so, that's another reason to avoid signing up.

If you've got no choice because your employer offers only one type of coverage, I advise you to:

Put your objections in writing.

Save a copy for your records.

Send your letter to your plan representative by registered mail as proof that the insurer or HMO has been informed of your objections. Also give a copy to your employer's plan administrator.

This may help protect your legal interests in the event that you ever face a policy dispute.