

Trial
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Discover the Key to HMO Bad-Faith Cases:

Plaintiff lawyers must have a sound approach to discovery in order to effectively litigate bad-faith cases against health-maintenance organizations (HMOs).

Discovery will establish whether there was a critical delay in authorization, an improper basis for denial, or a lack of proper investigation, all of which demonstrate bad-faith conduct by the HMO.

As always, begin by obtaining all of the relevant documents. Several will be critical in every HMO case.

Utilization-review file. This is the equivalent of an insurance claim file in a traditional bad-faith case. Although the information in the file is complex and may be difficult to sort through and digest, doing so is worth the time and effort.

The term utilization review refers to the review process the HMO or its agents engage in when deciding whether to approve or deny care to a plan member. The utilization-review file serves as a record of every person who was involved in handling the requests for treatment--it shows what decisions were made, who made them, and why. This will be the most telling evidence you obtain in discovery.

As a whole, the utilization-review file reflects the attitude the insurer took towards its insured. It may show an insurer who gave the claimant the benefit of the doubt and an adjuster who looked for ways to find coverage. On the other hand, it may reveal an insurer who looked for any reason to avoid responsibility for the insured's medical care. You can use such a file to prove that the insurer acted in bad faith and that punitive damages should be awarded.

In discovery, ask that the file include, but not be limited to, every request for medical-treatment authorization submitted on behalf of the plan member and every authorization or denial of those requests. HMOs may use different systems to log and track requests, but usually each is assigned a number, which you can use to trace related decisions. For instance, you can determine how long it took to obtain an authorization or denial and the grounds for the denial. This information is critical in proving misconduct.

Underwriting file. You should also seek production of the underwriting file, which shows what coverage the insured requested when applying to be a plan member. Whereas the utilization-review file will reveal the decision-making involved in authorizing or denying care for the insured, the underwriting file will demonstrate the type of coverage that the insured sought in entering into the HMO plan. You can then determine whether the denied care was contemplated by the HMO in agreeing to underwrite the health plan and thus whether the HMO denied coverage that it had promised to provide.

Also request any advertising materials that the insured relied on when purchasing the policy. Compare statements made in the advertisements with the medical treatment and coverage that the plan member actually received. It is especially important to obtain this information in cases where the advertising materials were disseminated during open enrollment periods. During these periods, the HMO is aggressively targeting potential plan members to convince them to join the HMO's plan. Therefore, any promises of coverage made in the advertising material that the HMO subsequently denies is significant in demonstrating bad faith.

Policy and procedure manuals. Because you are questioning the HMO's claims-handling practices, it is important that you request the utilization-review policy-and-procedure manuals and underwriting manuals. Compare the guidelines these manuals set forth for handling claims with the facts of the case to see if the HMO complied with its own policies and procedures. The manuals typically specify turnaround times for treatment-authorization requests, procedures for denying medical treatment, and appropriate steps for notifying the primary-care physician (PCP) and the patient as to whether a request for authorization has been approved or denied.

Managed-care contracts. Obtain any contracts between the HMO and the medical groups assigned to act as independent physicians associations (IPAs), which provide medical care to plan members. These IPA-services agreements detail how utilization-review responsibilities are divided between the HMO and the IPA, disclose who is responsible for covering the costs of medical services, and include the HMO's requirements for quality assurance. Remember that although the HMO may delegate the responsibility for conducting utilization review, utilization management, and quality assurance, it cannot avoid liability for injuries to plan members caused by inappropriate delays or denials.

The agreements also provide information concerning confidentiality and whether the HMO has provided financial incentives for the IPA to limit the treatment provided to the insured--particularly in-patient (hospital) care, which can be costly and therefore subject to denial, even if medically necessary to the insured. And they include a full disclosure of capitation amounts--set fees an HMO agrees to pay a physician per patient, regardless of the frequency or cost of the medical care provided.

Also examine any contracts between the IPA and the individual doctors whom plan members select as PCPs.

The PCP's role is standard--to provide for the medical needs of the plan member and to request authorizations for medical care. The PCP agreement discloses the PCP's capitation fees, the services that the PCP is expected to perform, and the PCP's responsibilities relating to utilization review and management.

If your client has HMO coverage through his or her employer rather than through an individual plan, there will be a contract between the employer and the HMO, typically called a Major Group Medical and Hospital Service Agreement. Examine this document carefully. For example, if it contains exclusions and limitations that are not disclosed to plan members in an Evidence of Coverage and Disclosure booklet, in California, the HMO has violated the Knox-Keene Act, California Health & Safety Code section 1340 et seq., which regulates HMO plans. Other states may have similar regulations.

Depositions. Once you have obtained and reviewed all of the relevant documents discussed above, the next step involves deposing the appropriate people. When preparing for depositions, ask yourself this question: What do I want to establish through this witness? Whether you are trying to show a critical delay in authorization, an improper basis for denial, or a lack of proper investigation, set your specific goals before taking each deposition. Doing so will force you to establish and refine the theme of your case.

In most cases, you should depose the PCP, all other treating physicians, and any physicians who signed denials or authorizations for treatment. On issues related to the medical necessity of a requested treatment, the utilization-review file should contain a report by a qualified medical specialist, often the HMO or IPA's medical director. Depose this medical specialist, as well as the company's specialists on utilization review, utilization management, quality assurance, and advertising--both in general and with respect to your client's case.

In addition to the witnesses reflected in the utilization-review file, you should also depose the HMO's executives and supervisory personnel. These individuals may be listed in the file, or their names may be disclosed during the depositions of lower-level employees. Ultimately, to prove punitive damages, you must demonstrate that the people acting on behalf of the HMO did so in a managerial capacity. In other words,

you must show that the HMO ratified its employees' conduct.

One way to establish this is to ask questions that demonstrate upper-management support for the conduct at issue. For example:

- " Based on your review of the file, you think the company did nothing wrong in handling this member's claim. Is that true?
- " Nothing was done that you thought was inconsistent with the company's claims-handling guidelines, true?
- " No one was reprimanded for the work they did on this file. Is that true?
- " Was anyone commended for their work on this file?
- " This claim was handled according to the company's guidelines for handling claims, correct?
- " No changes were made to the company's claims-handling guidelines as a result of this claim. Is that true?

Your goal with this line of questioning is to establish that the manner in which the HMO handled this particular claim is representative of how the company handles all claims.

Proper litigation of an HMO bad-faith action requires a methodical and thorough approach to discovery. The right tactics will expose bad-faith practices that deprive plan members of medically-necessary care.