THE NATIONAL LAW JOURNAL
OCTOBER 10, 2005
An ALM Publication

UP CLOSE | **HMO SETTLEMENT**

A fairer deal for doctors

By June D. Bell
SPECIAL TO THE NATIONAL LAW JOURNAL

HAMMERING OUT a multimillion-dollar class action settlement is a challenge even for veteran negotiators. That process takes on an extra layer of complexity when the plaintiffs insist on changing the way the defendants run their business.

No wonder that attorneys representing about 700,000 doctors and 18 medical societies spent more than a year settling their case with insurer WellPoint Health Networks of Indianapolis.

Doctors not only wanted to be compensated for patient claims they alleged the insurer wrongly denied; they also wanted assurance that they wouldn't get shortchanged again. Their insistence on safeguards helped push the insurer to spend $250 million to redesign its payment-systems software.

"In an ordinary case, it's just about dollars. In ordinary cases, the plaintiff wants X amount of money and the defendant wants to pay X minus Y," said Harley Tropin, co-lead counsel for the plaintiffs and a partner at Kozyak Tropin & Throckmorton of Coral Gables, Fla. "In this case, the defendants had legitimate business problems and the doctors had specific needs."

THE PLAINTIFFS' HOT LIST

The assorted state and county medical associations that were plaintiffs in the case had to sign off on the proposed settlement as well. The back-and-forth process, Tropin said, was similar to negotiating a collective bargaining agreement.

Announced in July, the WellPoint settlement is the latest in a series of class actions brought by doctors alleging racketeering and fraud on the part of some of the country's largest health insurance companies. The plaintiffs claimed that the insurance companies defrauded them by using claims-processing software that routinely underpaid doctors' claims. Their motivation, the plaintiffs said, was financial: Trimming payments to doctors helped the insurance companies hold down escalating health care costs.

Most recent agreement

WellPoint became the seventh of 10 defendants to settle the 2000 lawsuit, bringing the total amount of the settlement to more than $1.5 billion. The company agreed to pay about $200 million: $135 million to the doctors, $5 million to establish a nonprofit company to improve health care and about $58 million in legal fees.

Doctors were willing to accept a smaller monetary settlement in exchange for more changes in the way the defendants handled payments, Tropin said.

WellPoint is the country's largest publicly traded health company, with about 28 million subscribers.

ELIZABETH LIPPMAN

BOTTOM LINE: *Edith M. Kallas said that the plaintiffs insisted that the insurers agree to be bound by generally accepted standards of care when reviewing claims.*

The WellPoint settlement provides three important forms of relief to the plaintiffs.

—Edith M. Kallas

The 10 defendants represent about 80% of the managed-care business in the United States. The companies that settled are Health Net Inc., Prudential Insurance Co. of America, Aetna Inc. and Cigna Corp. Anthem Inc., a defendant that had merged with WellPoint, was part of the WellPoint settlement.

The defendants that have settled have denied any wrongdoing. WellPoint's attorney, Craig A. Hoover of Hogan & Hartson in Washington, referred questions about the case to WellPoint's corporate office in Indianapolis.

WellPoint spokesman Jim Kappel said the company opted to settle because "we felt it was very important to put this litigation behind us so we can focus on what's most important to us: serving customers."

Three forms of relief

WellPoint expects to invest about $250 million in software and equipment to "enhance the claims payment process," which includes enabling doctors to locate fee schedules more easily, Kappel said. Those improvements were tied to the litigation, he said, but also are part of the company's ongoing efforts to improve efficiency and customer service.

The WellPoint settlement, like others that preceded it, provides three important forms of relief to the plaintiffs, said Edith M. Kallas, one of the lead negotiators and an attorney for medical society plaintiffs. She is a partner at Milberg Weiss Bershad & Schulman in New York.

First, the settlement requires insurance companies to define what treatments constitute "medical necessity," based on standard medical practice. With this knowledge, doctors can be confident that they will be paid for their treatment plan when it is based on generally accepted medical standards. "We would not settle these cases without this," Kallas said.

Second, the settlement requires insurance companies to make their payment processes more transparent, enabling doctors to understand how claims and reimbursements are adjudicated. And finally, the settlement establishes compliance and appeals processes.

Kallas and the plaintiffs' team of attorneys also negotiated an external claims-review process. Doctors pay $50—refunded if they prevail—for a binding resolution handed down by an independent party.

The absence of such a simple vehicle for doctors to resolve insurance disputes was one catalyst for the lawsuits. Though the managed-care contracts allowed doctors to arbitrate claims issues, few bothered. The effort involved in recovering $50 or $100 that the insurer refused to pay was hardly worth the busy doctors' time.

"Typically, none of the procedures would justify an arbitration, but cumulatively, it was hurting" the doctors financially, and they wanted relief, Tropin said.

The door to class actions against health care companies swung open with a 1999 U.S. Supreme Court decision. Humana v. Forsyth, 525 U.S. 299, paved the way for Racketeer Influenced Corrupt Organizations Act (RICO) claims against health care companies, according to Kallas.

Doctors and medical groups were eager to take action. They had watched as patients sued managed-care companies over payment practices, litigation that was generally unsuccessful. There were a few settlements, but judges rejected class certification or dismissed most cases, saying the patients failed to show a connection between the quality of their medical care and the insurance companies' payment systems.

Doctors' efforts to involve lawmakers also tanked. "They were just so desperate," Kallas said. "There was nothing left to do."

10 million pages

Archie Lamb of The Law Offices of Archie Lamb in Birmingham, Ala., launched the litigation and eventually added Joe R. Whatley of Whatley Drake, also based in Birmingham. Hundreds of lawyers and paralegals reviewed more than 10 million pages of documents—more documents than have ever been obtained in any case, Whatley said. There were more documents in the case, he said, than in the entire digitized Library of Congress.

The plaintiffs persuaded the Miami judge to certify the case as a class action because the doctors' insurance claims were processed automatically by the defendants' software, which meant that all plaintiffs were treated identically. In re Managed Care Litigation, MDL No. 1334 (S.D. Fla.). Class status was affirmed by the 11th U.S. Circuit Court of Appeals.

The four remaining defendants are scheduled for trial in April in Miami before U.S. District Judge Federico Moreno. They are Coventry Health Care of Maryland; Kentucky-based Humana and United Health Group of Minnesota, which has merged with California-based PacifiCare, the fourth defendant. Whatley expects some defendants to settle but is preparing for a trial that would last about six weeks.

A similar suit against the Blue Cross companies is pending before Moreno. Arguments on class status in that case are scheduled for November. Thomas v. Blue Cross & Blue Shield Association, No. 03-21296-CIV (S.D. Fla.).

More information about the settlements is available at www.hmosettlements.com. NLJ