

**The Cost-Shifting Consequences of Failed Managed Care Regulation: Some Lessons from Pennsylvania’s Experience with Addiction Treatment**

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This article discusses an empirical study designed by Parente Randolph, which was retained by the author’s law firm to design and carry out the study. Parente Randolph’s report on the results of the study was written by Richard Gering, Ph.D., and James O’Brien, CPA. The Parente Randolph study was jointly funded by NAMSDL and by the Drug and Alcohol Service Providers Organization of Pennsylvania (“DASPOP”), which is a statewide coalition of addiction treatment programs and drug and alcohol abuse prevention programs and associations.

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For years, managed care companies have successfully shifted the costs of addiction treatment from private insurance onto taxpayers and onto treatment programs. Managed care companies have done so by failing to provide benefits that they promised to pay, and by failing to provide benefits that they were required by law to pay.

This article sets forth the results of an effort to define more precisely the scope of the problem. The analysis examined more than 12,000 residential addiction treatment days in Pennsylvania. Only a fraction of one percent were paid for by private insurance – despite the fact that Pennsylvania has a strong, clear law mandating coverage for addiction treatment. The overwhelming majority of the treatment days were paid for by public funders. In other words, the costs of treatment were shifted from private insurers to public funders.

This article sets forth the results of this analysis, places those findings in context, suggests some broader lessons about managed care regulation that can be learned from these findings, and sets forth an approach that would restore to the public fisc the significant sums that were wrongfully shifted to the public.

Addiction treatment is an important component of the health care treatment system in this country. The consequences of untreated and inadequately treated addictions are severe, and have a disproportionate effect on other health care costs. Untreated addicts and members of their families incur health care costs at rates

significantly higher than the general population.<sup>2</sup> Furthermore, the overwhelming majority of those incarcerated in this country are either chemically dependent or serving time for a crime committed while under the influence of drugs or alcohol. In an analysis that takes into account these costs and other factors, the Substance Abuse and Mental Health Services Administration has estimated that the total economic costs of alcohol abuse are over \$184.6 billion per year and the total economic costs of drug abuse are over \$143.4 billion, which adds up to over \$320 billion per year.<sup>3</sup> These economic costs are, of course, dwarfed by the incalculable human toll exacted by substance abuse and addiction.

The amounts spent treating substance abuse -- roughly \$21 billion annually as of 2003<sup>4</sup> -- are far smaller than the economic burdens imposed by substance abuse. In a sense, the health care system is trying to fix a \$320 billion dollar problem with a \$21 billion solution. It is essential that these scarce dollars be spent wisely.

The importance of treatment funding is underscored by the relationship between treatment and the market for illegal drugs. There is considerable evidence that addiction

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<sup>2</sup> Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States: 1992-1998* (2001), [http://www.whitehousedrugpolicy.gov/publications/pdf/economic\\_costs98.pdf](http://www.whitehousedrugpolicy.gov/publications/pdf/economic_costs98.pdf).

<sup>3</sup> Katherine R. Levit et al., *Future Funding for Mental Health Treatment and Substance Abuse: Increasing Burdens for the Public Sector*, *Health Affairs*, w513-33, Oct. 7, 2008, <http://content.healthaffairs.org/cgi/content/full/27/6/w513>; *see also* Tami L. Mark et al., U.S. Dep't of Health and Human Servs., Substance Abuse and Mental Health Servs. Admin., *National Expenditures for Mental Health Services and Substance Abuse Treatment 1993-2003* 38 (2007), *available at* <http://www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf>.

<sup>4</sup> Levit *et al.*, at 38, and sources cited therein.

treatment is one of the most cost-effective tools in the nation's continuing struggle to reduce and eliminate the market for illegal drugs and the enormous costs and burdens imposed by illegal drug trafficking.<sup>5</sup>

The majority of the \$21 billion spent treating substance abuse is public money. Public funding accounted for more than three quarters of addiction treatment funding in 2003. This disproportionate reliance on public funding is expected to increase in the years ahead. A recent article projected that public sources will account for 83 percent of all addiction treatment funding by 2014.<sup>6</sup>

There is some evidence that this disproportionate reliance on public funding is in part a result of the application of managed care techniques – most prominently, but not exclusively, medical necessity utilization review – by private managed care companies. In other words, private insurers are shifting the costs of care to public funding sources. This accelerating shift to public funding is taking place notwithstanding the fact that at least 38 states have laws that require private insurers to cover treatment for addiction to alcohol or other drugs.<sup>7</sup>

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<sup>5</sup> See generally, C. PETER RYDELL & SUSAN C. EVERINGHAM, CONTROLLING COCAINE: SUPPLY VERSUS DEMAND PROGRAMS (Rand 1994), available at [http://www.rand.org/pubs/monograph\\_reports/2006/RAND\\_MR331.pdf](http://www.rand.org/pubs/monograph_reports/2006/RAND_MR331.pdf).

<sup>6</sup> Levit et al., *supra* note 3, at w519.

<sup>7</sup> NAT'L CONF. OF STATE LEGISLATURES, STATE LAWS MANDATING OR REGULATING MENTAL HEALTH BENEFITS, Dec. 18, 2008, <http://www.ncsl.org/programs/health/Mentalben.htm>. I have not independently verified this figure and there is reason to be skeptical of NCSL's precise number, if only because NCSL's nationwide mandate and limited resources, when combined with the remarkable diversity in state approaches to regulating managed care, sometimes make impossible the careful attention required for

The incentives for insurers and managed care companies to shift the costs of treatment onto public funding sources are obvious. Equally important, addiction treatment presents a unique set of opportunities for insurers and managed care companies to shift the costs of care onto the public, for several reasons. First, because there is (and should be) a great deal of public funding for addiction treatment there is frequently a funding source onto which patients can be shifted.<sup>8</sup> Second, the shame and denial that accompany addiction make it unlikely that individuals and families desperately in need of treatment will enforce their rights against private insurers. Third, the stresses placed on families by diseases of addiction often make it difficult or impossible for individuals and families to successfully pursue their rights even if they are otherwise inclined to do so.<sup>9</sup>

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accurate analysis. A somewhat larger number of states – over 40 – has often been cited by experts involved in nationwide lobbying and advocacy efforts. Whatever the precise number, it is clearly a large majority of the states.

<sup>8</sup> *See generally* Schlesinger, Some Distinctive Features of the Impact of Managed Care on Psychiatry, Harvard Review of Psychiatry 8(5):216-29 (2000).

<sup>9</sup> MCOs also take advantage of the strong, informed, and sensible determination to treat addicts that is so often found in the stewards of public treatment dollars, and in personnel who work at facilities that treat these patients. As explained in more detail below, in general a patient does not receive publicly funded treatment unless (a) a public steward concludes, after an assessment, that the patient needs the treatment, and (b) a treatment facility, which conducts its own assessment, concurs. Often these decisions are made after a private MCO has already successfully maneuvered the patient onto a public funding track, or at the same time that the patient is shifted onto a public funding track. Either way it is the MCO, and not the treatment facility or the public steward, that has caused the shift.

Because treatment funding is so scarce and so important, and because a clear and accelerating shift toward public funding is underway, it is important that states develop strategies and plans to ensure that private insurers and managed care companies pay their fair share, and to ensure that laws regulating the conduct of private insurers are enforced.

Over two decades ago Pennsylvania enacted a strong private insurance law mandating coverage for treatment of drug and alcohol addiction, Act 106 of 1989.<sup>10</sup> Act 106 requires that group health plans include detoxification, non-hospital residential, and outpatient benefits, and prescribes the method by which individuals can access the benefit in a way that leaves no room for managed care interference.<sup>11</sup>

Notwithstanding these explicit statutory requirements, in the 1990's an avalanche of anecdotal reports of MCO non-compliance began to accumulate. This trend accelerated in the years after 2000. It was clear to those in the addiction treatment field that private insurers and managed care companies were paying for virtually no residential addiction treatment at all, and instead were shifting the costs of residential addiction treatment to public funding sources. These claims were so strong and consistent that they seemed to merit rigorous attention.

Parente Randolph was asked to design a study that would allow an accurate assessment to be made of payment behavior from all sources (including all public

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<sup>10</sup> 40 Pa. Stat. § 908-1 to 908-8 (West 2009). This 1989 statute essentially re-enacted and expanded a prior law, 64 of 1986, P.L. 226. The prior law covered only alcohol addiction, and contained a sunset provision. Act 106 of 1989 extended the statute to cover drug addiction, and also eliminated the sunset provision. *See* 1989 Pa. Legis. Serv. 1989-106 (West).

<sup>11</sup> *See infra* at n. [\_\_].

funding sources, all private funding sources including insurance and self-pay, and charity care) at a single residential addiction treatment facility for adolescent males in central Pennsylvania (the “Rehabilitation Facility”), across a period of two fiscal years, spanning the time period from July 1, 2002 to June 31, 2004.

Parente Randolph’s analysis found that (a) private insurers were paying for virtually no residential addiction treatment, even though they were required by law to pay for a great deal of such care, (b) public funders were paying for a great deal of care that should have been paid for by private insurers, and (c) the Residential Facility was providing a great deal of scholarship care, for care that could have been paid for by private insurance. Parente Randolph also projected the total number and cost of adolescent non-hospital residential addiction treatment days that should have been paid for by private insurance, but were not, for Pennsylvania as a whole during the two studied fiscal years.

When projected across the Commonwealth these cost shifts amounted to \$1.6 million to \$2.6 million annually transferred to public funding, and \$1.2 million to \$1.9 million annually transferred to facility scholarship care. These costs shifts represented \$2.7 million to \$4.1 million annually in financial benefit to private MCOs. These figures are of course for a limited population: for the adolescent population alone, and for Pennsylvania alone.

Part One of this article defines cost shifting, and briefly surveys a taxonomy of cost shifting that helps place the Rehabilitation Facility results in context. Part One then sets forth the results of Parente Randolph’s analysis, both at the Rehabilitation Facility and as projected across the Commonwealth of Pennsylvania.

The extent of the cost shift, and the sheer brazen magnitude of private MCOs' failure to fund residential addiction treatment, was not adequately understood or timely addressed by the entities charged with regulating managed care companies and insurance companies in Pennsylvania. Part Two explores some lessons that can be learned from these regulatory failures.

Part Three suggests a straightforward approach that would permit the Commonwealth of Pennsylvania to recover, from private managed care companies, amounts that have been wrongfully shifted to the public. This would restore to the public treasury the millions upon millions of public dollars spent for treatment that should have been, but were not, paid for by private companies.

This article discusses managed care, a term that covers an extremely wide range of strategies, techniques, and contractual arrangements that govern the financing, organization, and delivery of health care. Preauthorization and concurrent utilization review are two prominent features of managed care that are highly visible and rightly receive a great deal of attention. They are, however, only a small subset of the tools through which managed care companies control and influence treatment services and payment for treatment services. Managed care companies control and influence treatment services by carefully selecting networks; by using a variety of direct or indirect financial incentives; through benefit design; through cost-sharing arrangements; through normative information influences; through interactions with colleagues, provider organizations, and policymakers; by creating, supporting and enabling guidelines, critical pathways, and criteria; and through a "sentinel effect," in which the very existence of

utilization management systems may itself deter care.<sup>12</sup> This article uses managed care in an intentionally broad sense. Most of the discussion below is concerned more with the actual result (namely, the shifting of treatment costs onto the public fisc) than the precise details of how a particular managed care organization managed to achieve that result. Where a specific subset of these tools, such as preauthorization, is being discussed I will use the specifically applicable term.

This article will use the term Managed Care Organization, or MCO, to refer to all entities that carry out managed care activities. The term covers a wide range of entities and arrangements. Sometimes a traditional health insurer sets up provider networks, carries out utilization review activities, etc. The majority of addiction treatment benefits, however, are not managed by traditional health insurers, but rather by specialty managed care contractors -- often called carve-out contractors -- that specialize in behavioral health. Carve-out contractors can themselves be insurers and at risk, or they can be act simply as administrators. Many parts of this article are concerned with the result (cost shifting) and not with the particular arrangement involved, and as a result the term MCO will be used in an intentionally broad sense, meant to include all entities that carry out

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<sup>12</sup> See generally Elizabeth Levy Merrick *et al.*, *Managed Care Organizations' Use of Treatment Management Strategies for Outpatient Mental Health Care*, 33 ADMIN. & POL'Y IN MENTAL HEALTH SERV. RESEARCH 104 (2006); see also Robert Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation & Policymaking*, 16 STAN. L. & POL'Y REV. 234, 236-37 (2005)(containing a useful and sufficiently broad definition of managed care.).

managed care activities. Where it is necessary to refer with more precision to a particular type of managed care entity, a more precise and narrow term will be used.

## **Part One: Cost Shifting at a Residential Addiction Treatment Facility**

### **A. What Cost Shifting Is, and Why It Can Be Hard to Measure**

The possibility that private MCOs will shift the costs of care to the public sector has long been recognized. The problem has become more important in recent years, as the reliance on specialized behavioral health carve-out companies has increased.<sup>13</sup> This concern is driven by a recognition that managed care companies have strong incentives to shift the costs of care to others – which, in the case of behavioral health, often means public funding sources.<sup>14</sup> The trend toward managed behavioral health, and therefore the need to monitor the effects of these incentives, will in all likelihood accelerate in the near future, as recently enacted legislation mandating parity between physical health benefits and behavioral health benefits comes into effect.<sup>15</sup> As insurers and health plans adjust to

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<sup>13</sup> See, e.g., Zuvekas et al., *Cost Shifting Under Managed Behavioral Health Care*, 58 PSYCHIATRIC SERV. 100, 107 (2007) (“[t]he rapid growth of carveouts to MBHOs in the past two decades heightened long-standing concerns about cost shifting in mental health treatment.”).

<sup>14</sup> See, e.g., Norton et al., *Cost Shifting in a Mental Health Carve-Out for the AFDC Population*, 18 HEALTH CARE FINANCING REV. 95 (1997) (discussing incentives in contract); see also Frank & McGuire, *Savings From a Carve-Out Program for Mental Health and Substance Abuse in Massachusetts Medicaid* (Harvard University working paper, 1996); Stoner et al., *Expenditures for Mental Health Services in the Utah Prepaid Mental Health Plan*, 18 Health Care Financing Rev. 73 (1997).

<sup>15</sup> See The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, 122 Stat. 3765-3931 (2008), codified at, *inter alia*, 29 U.S.C. §1185A.

the new federal parity law, they will in all likelihood come to rely even more on MCOs that are specialty managed behavioral health contractors.

Cost shifting takes many different forms, and the term cost shift has different meanings in different subsets of the literature. In the helpful taxonomy set forth by Professor Domino, “[o]ut-of-plan cost shifting” is cost shifting that occurs when the cost of medical treatment provided to a patient is shifted from a managed care plan to some other entity or funding source.<sup>16</sup> “Within-plan cost shifting” occurs when costs are shifted from a more expensive treatment to a less expensive one paid for by the same managed care company – for example, by shifting a patient from residential treatment to outpatient treatment.<sup>17</sup>

Within-plan cost shifting has received a great deal of attention in the literature. We know, from this work, that many managed care plans shift patients from more expensive to less expensive forms of treatment.<sup>18</sup>

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<sup>16</sup> Domino *et al.*, *Cost Shifting to Jails after a Change to Managed Mental Health Care*, 39 HEALTH SERV. RESEARCH 1379 (2004), available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1361075&blobtype=pdf>.

<sup>17</sup> I note, for the sake of completeness, that another form of cost shifting occurs when private insurers (or health plans) pay a higher price for medical care, as a result of lower prices paid by medicare, medicaid, and other public funding sources. *See generally* Dobson, et al., *The Cost-Shift Payment Hydraulic: Foundation, History and Implications*, 25 Health Affairs 22 (2006). This form of systemic pricing pressure is not addressed in this article.

<sup>18</sup> *Id.* at 1382.

Out-of-plan cost shifting, by contrast, has received less attention.<sup>19</sup> On the face of it this knowledge gap seems counterintuitive. Policymakers and regulators must understand out-of-plan cost shifting because public money should not be spent doing someone else's job. Furthermore, public funders of addiction treatment tend to be sophisticated purchasers of health care who are, or should be, well aware that managed behavioral health care presents unique incentives and opportunities for cost shifting. One of the significant opportunities for cost shifting is found in the nature of addiction itself. Diseases of addiction are accompanied by shame and defined by denial, and leave addicts and their families ill-equipped to fight managed care companies. In addition, the very nature of a behavioral health carve-out creates incentives to underutilize care, because behavioral health carve-outs are not responsible for the physical health implications of untreated or inadequately treated mental health disorders. Nor are they responsible for the costs of untreated addiction borne by the criminal justice system.

These dynamics are widely acknowledged and should not be a surprise to any public funder of addiction treatment.

One reason why out-of-plan cost shifting has received less attention may be simply because it is hard to measure. Patients, and information about the care they receive and who paid for the care, can be tracked within a particular insurer or MCO or within a particular public payment system (or even set of systems).<sup>20</sup> Where cost is

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<sup>19</sup> *Id.*

<sup>20</sup> *See, e.g., Zuvekas et al., supra* note 14; *Domino, supra* note 18 (measuring out-of-plan cost shifting for mental health services, from Medicaid managed care plans to jails, based on data allowing patients to be tracked between jail system, county mental health agency and Medicaid).

shifted from private insurance to a wholly separate funding source (say, from private insurance to public treatment dollars), however, it is rarely possible to track the patient across individual patient funding streams without examining individual patient funding records, including records from the criminal justice system. As one careful student of data sources has observed, “[i]t is rarely possible to link administrative information on the same patients in both public and private reimbursement systems to determine the extent to which this [public] safety net is being used.”<sup>21</sup>

A great deal of information can come from tracking patient care and payment information across the various components of a public reimbursement system. For example, Professor Domino’s study was designed to evaluate the hypothesis that when County mental health services for the Medicaid population were turned over to a capitated managed care plan, the costs of outpatient mental health care (which would be borne by the capitated managed care plan) would decrease and jail costs (which are free to the capitated plan) would increase. Patients were tracked across the King County, Washington jail system, the Medicaid system, and the King County mental health system. Each of these is funded with public dollars. Domino found “a strong increase in the probability of jail use for persons on Medicaid after the introduction of managed care,”<sup>22</sup> and estimated a total annual shift of \$1.13 million to the jail sector.<sup>23</sup> The effects of this

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<sup>21</sup> Garnick *et al.*, *Selecting Date for Substance Abuse Services Research*, 22 J. OF SUBSTANCE ABUSE TREATMENT 11, 11-12 (2002).

<sup>22</sup> Domino, *et al.*, *supra* n. 18, at 1392.

<sup>23</sup> *Id.*

shift were “concentrated in the severely mentally ill population.”<sup>24</sup> Because the Domino study was limited to public funding sources, however, the study could not have detected or measured any shifting from private insurers to public funding sources. In other words, private insurers enjoy a *de facto* immunity from this kind of examination.

The sole example that I am aware of in the published literature that directly measures shifts from private to public funders is a 2001 study by Carole Siegel, Judith Samuels, and Joseph Wanderling. This study used a mental health data set that covered two counties in the Rochester, New York area.<sup>25</sup> The study classified patients by payor category – private, combined public/private, and wholly public – and measured the number of, and certain characteristics of, patients who changed categories from one year to the next. The study found fairly small shifts between categories. For the first pair of years studied, 1991 and 1992, the study found that 1.7 percent of patients who initially received privately funded services shifted to private/public or wholly public funding. For the second pair of years, 1991 and 1992, the study found that 3.2 percent experienced such a shift.<sup>26</sup>

While the approach taken in Professor Siegel’s study is obviously helpful, it relies upon a dataset covering all payers and a range of providers. This type of dataset is rare, and creating more of them would be hard, time-consuming, and expensive and may raise significant confidentiality issues. The approach taken by Siegel also has a more

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<sup>24</sup> *Id.*

<sup>25</sup> Siegel *et al.*, *Cost-Shifting from Private to Public Payers:*

*The Scene Before Parity Legislation*, 4 J. MENTAL HEALTH POL’Y & ECON. 17, 21 (2001).

<sup>26</sup> *Id.* at 22.

fundamental limitation, in that it can only record shifts for patients whose care was funded by private payers in the first place (that is, in the first of the two years studied). If the capitated managed care plan simply refused outright to pay for the care in year 1, there would be no cost shift detected or recorded. This approach measures changes over time, but does not ask and cannot measure whether there is compliance with or disregard of applicable laws.

**B. Cost Shifting at a Residential Adolescent Addiction Treatment Facility**

Identifying and quantifying out-of-plan cost shifting becomes straightforward if detailed information about who paid for care is accompanied by information that identifies who *should* have paid for the care. It then becomes possible to assess whether the actual behavior of MCOs is consistent with (or inconsistent with) a pattern of reimbursement behavior prescribed by a particular set of legal rules.

When this type of analysis – comparing who paid for the care to who *should* have paid for the care – was carried out at the Rehabilitation Facility, a significant cost shift from private MCOs to public funding sources was identified. When projected on a straight-line basis across the Commonwealth, these cost shifts amounted to \$1.6 million to \$2.6 million annually transferred to public funding; \$1.2 million to \$1.9 million annually transferred to facility scholarship care; and \$2.7 million to \$4.1 million annually in financial benefit to private MCOs. These figures are for the adolescent population alone; figures for the adult population are certain to be an order of magnitude larger.

Much of this analysis turned on a particular feature of Pennsylvania insurance law. Pennsylvania has a very strong mandated benefit law that requires all group health

plans to include the following addiction treatment benefits. (a) Non-hospital residential alcohol treatment services must be included as a covered benefit for a minimum of 30 days per year. This minimum of 30 days may not be exchanged for outpatient addiction treatment services. (b) In addition, outpatient alcohol treatment services must be included as a covered benefit for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The baseline 30 visits per year may not be exchanged for non-hospital residential addiction treatment services. (c) In addition, a further 30 outpatient visits must be included. This second set of 30 outpatient visits may be exchanged on a two-for-one basis for up to 15 non-hospital residential addiction treatment days, above and beyond the initial 30 days referred to in (a) above. These benefits may be subject to a lifetime cap of 90 days for non-hospital residential treatment services and 120 outpatient, full-session visits or equivalent partial visits. Pennsylvania law also mandates detoxification benefits. The law applies to group health plans, and to insurance provided through the Children's Health Insurance Program.

Pennsylvania law also spells out, and therefore limits, the prerequisites to a private insurer's obligation to pay for this treatment. In order for this coverage to apply, "a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment."<sup>27</sup> This is the only lawful prerequisite to treatment.<sup>28</sup>

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<sup>27</sup> 40 Pa. Stat. § 908-4(a); *see also* Pennsylvania Insurance Department Bulletin Notice 2003-06, "Drug and Alcohol Use and Dependency Coverage," 33 Pa. Bulletin 4041 (Aug. 9, 2003); *see also* Insurance Federation of Pennsylvania, Inc. v. Commonwealth, Ins. Dept., 929 A.2d 1243 (Pa. Commw. Jul 26, 2007) (NO. 10 M.D. 2004) (affirming the Insurance Department's interpretation of Act 106), *probable*

The Rehabilitation Facility's procedures required physical examination of patients on admission, and physician approval of a treatment plan for the patient. This is consistent with the applicable accreditation standards required by the Joint Commission on Accreditation of Healthcare Facilities.<sup>29</sup> Thus, we know that if the patient received treatment, all lawful prerequisites to coverage were satisfied. If the patient received treatment and had coverage subject to Act 106, we know that treatment, up to the limits of the available Act 106 benefit, should have been reimbursed by private insurance.

Parente Randolph, a firm of accountants and consultants with extensive experience in health care work, was asked to help design an analytic approach that would compare actual reimbursement behavior at the Rehabilitation Facility to the reimbursement behavior that one would have expected, had MCOs complied with Act 106.

During the time period covered in the analysis, the Rehabilitation Facility treated privately insured patients, publicly funded patients, and self-pay patients. It also

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*jurisdiction noted*, September 17, 2007. This case is currently pending in the Pennsylvania Supreme Court at Docket No. 89 MAP 2007.

<sup>28</sup> *Id.*

<sup>29</sup> *See* 2003 Comprehensive Accreditation Manual for Behavioral Health Care Standard LD 1.8.2.

Furthermore, Pennsylvania Department of Health regulations that govern residential treatment facilities and programs require extensive documentation for each patient including a physical examination with a detailed history and a treatment plan reviewed and approved by a physician. *See* 28 Pa. Code §§ 709.51 (freestanding drug and alcohol treatment facilities), 711.51 (drug and alcohol treatment programs that are part of a health care facility). It is fair to assume that similar physician approvals are found in patient charts at all nonhospital residential addiction treatment facilities.

provided a considerable amount of care that was never paid for. This uncompensated care can fairly be characterized as charity care.

An adolescent treatment facility was selected for study because children suffering from diseases of addiction are more likely than adults suffering from addiction to have kept – and not lost – their health insurance coverage. Parents get fired, kids do not. Adolescents are therefore presumably more likely to have insurance at the time they seek treatment.

The empirical study conducted by Parente Randolph proceeded as follows.

Facility personnel reviewed every patient file at the Rehabilitation Facility covering two fiscal years: FY03, which ran from July 1, 2002 through June 30, 2003; and FY04, which ran from July 1, 2003 through June 30, 2004. The actual file reviews were performed by facility personnel, an approach that removed any confidentiality concerns.<sup>30</sup> Data were entered into spreadsheets, and patients were identified by unique facility tracking identification numbers. For each individual who was a patient during FY03 or FY04, the patient's clinical/administrative file and medical record file were reviewed. Financial files, monthly billing/funding reports, and daily population reports were also reviewed. Information was also obtained from queries against ledgers in the facility's financial database.

From these sources, and for every patient who received residential treatment at the facility during FY03 or FY04, the following information was obtained: dates of

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<sup>30</sup> Addiction treatment records are subject to an array of strict confidentiality requirements, under both state and federal law. *See, e.g.*, 42 U.S.C. §§ 1320d-1329d-8; 45 C.F.R. §§ 164.102-534; 71 Pa. Stat. §§ 1690.101 - 1690.112; 4 Pa. Code § 255.5; and 28 Pa. Code § 709.28(c).

admission and discharge; the first and last day billed for each month the patient was at the facility; the discharge date; the discharge status (complete or incomplete); total length of stay; home county of residence; the payor (or payors); the number of days billed to each payor; payment status for each payor; whether or not the treatment was Court-Ordered; the parent's private insurance plan or medical assistance plan; and whether or not the parent's insurance was privately purchased or provided through CHIP (that is, if the insurance was privately purchased or CHIP the field was marked "yes"; if the insurance was neither privately purchased nor CHIP, the field was left blank). For some patients, if a private insurance card was not found in the patient's file, an inquiry was made to the entity that had referred the patient for treatment.

Using this approach, it was determined that in 2003, 25 of 81 patients (31 percent) had private insurance or CHIP coverage, and in 2004, 38 of 103 patients (37 percent) had private insurance or CHIP coverage.

This may significantly understate the number of patients who had private insurance or CHIP. A 2004 study commissioned by the Pennsylvania Insurance Department found that 92 percent of Pennsylvania residents had some form of health insurance coverage. For the age group between 0 and 17, 70 percent of children had private health insurance; for the age group between 18 and 64, 77 percent had private health insurance.<sup>31</sup> These more general numbers probably apply, because the Rehabilitation Facility is located in the middle of Pennsylvania, in a region that is home

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<sup>31</sup> HC4 "FYI" Report, Issue No. 29, April 21, 2005; *see also*

[http://www.ins.state.pa.us/ins/lib/ins/chip\\_ab/uninsured\\_study\\_web2.pdf](http://www.ins.state.pa.us/ins/lib/ins/chip_ab/uninsured_study_web2.pdf);

[http://www.ins.state.pa.us/ins/lib/ins/chip\\_ab/Exec\\_Summary.pdf](http://www.ins.state.pa.us/ins/lib/ins/chip_ab/Exec_Summary.pdf).

to state government and to a large number of skilled workers likely to have insurance. The Rehabilitation Facility treats patients from across the socioeconomic spectrum and it is unlikely that this patient population had significantly less private insurance than the population in Pennsylvania as a whole.

The above-cited figures from the Insurance Department (70% of children) do not precisely establish the general percentage of Pennsylvania children with coverage subject to the requirements of Act 106. In 2004, many children were covered under CHIP; this coverage complied or should have complied with Act 106, and these children would need to be added to the Insurance Department's figures for private health insurance. Of course the Insurance Department figures also include self-insured plans that are exempt from Act 106 pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA").<sup>32</sup> The Insurance Department's figures apparently count as insured those individuals who receive benefits through self-insured ERISA plans, and therefore the number of individuals who receive health benefits through self-insured ERISA plans would need to be subtracted from the Insurance Department's figures.

However the adjustments referred to in the previous paragraph work out, it does seem clear that the percentage documented as having an Act 106 benefit in the Rehabilitation Facility analysis – 31 percent in 2003 and 37 percent in 2004 – is a conservative figure.<sup>33</sup>

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<sup>32</sup> 29 U.S.C. §§ 1001 *et seq.*; *see also, e.g.*, *FMC Corp. v. Holliday*, 111 S.Ct. 403, 411 (1990) and its many progeny.

<sup>33</sup> It is worth repeating that Parente Randolph was not asked to, and did not, undertake to analyze or evaluate the percentage of Pennsylvania children who have private health insurance or private health

Because over thirty percent of the patients had private insurance, and because the vast majority of private insurance in Pennsylvania is provided through group health plans that are subject to Act 106, one would have expected a significant percentage of the treatment days to be paid for by private insurance.

That was not the case. In fact, the hard numbers show that virtually no treatment days were paid for by private insurance. The overwhelming majority of treatment days that should have been paid for by private insurance were in fact paid for by the public or by the Rehabilitation Facility in the form of unreimbursed charity care.

More precisely, if the addiction treatment benefits required under Act 106 had been provided to all patients at the Rehabilitation Facility identified as having private insurance or CHIP, there were (assuming 30 days of coverage under Act 106) 644 treatment days in 2003 that should have been covered by private insurance. There were 911 treatment days in 2004 that should have been covered by private insurance. Assuming 45 days of coverage, there were 898 treatment days in 2003 that should have been covered by private insurance, and 1195 days in 2004.<sup>34</sup> Again, these are treatment days that were actually provided to patients, treatment days for care that was appropriate in the eyes of treating clinicians, and treatment days for which all lawful prerequisites to insurance coverage had been satisfied.

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insurance with Act 106 benefits. Parente Randolph's analysis was based on documented insurance information in the patient's file, as reported by the Rehabilitation Facility.

<sup>34</sup> These figures are the total treatment days provided to patients identified as having private insurance or CHIP coverage, limited to the lesser of (a) the actual number of treatment days received, or (b) 30 or 45 days.

These treatment days are a significant percentage of the total treatment days at the Rehabilitation Facility. There were 6,021 total treatment days in 2003, and 6,727 treatment days in 2004. Assuming a 30-day benefit period, 10.6 percent of the treatment days (644/6,021) should have been covered in 2003, and 13.5 percent of the treatment days (911/6,727) should have been covered in 2004. If a benefit period of 45 days is used, 15 percent of the treatment days (898/6,021) should have been covered by private insurance in 2003, and 17.8 percent of the treatment days (1195/6,727) should have been covered in 2004.

In fact, only a fraction of one percent of the treatment days were paid by private insurance. In 2003, 23 treatment days out of 6,021 treatment days were covered by private insurance. That works out to .4 percent. In FY04, 54 treatment days out of 6,727 were covered by private insurance. That works out to .8 percent. In other words, in a state that has one of the nation's strongest laws mandating private insurance coverage for residential addiction treatment, MCOs paid for essentially no residential addiction treatment.

For some of these treatment days, the Rehabilitation Facility never received any reimbursement and the care was provided as scholarship care. Assuming a 30-day benefit period, there were 110 treatment days in FY03, and 256 treatment days in FY04, that should have been paid for by private insurance but were in fact provided as scholarship care. Assuming a 45-day benefit period, there were 162 treatment days in FY03, and 363 treatment days in FY04, that should have been paid for by private insurance but were in fact provided as scholarship care.

The overwhelming majority of the treatment days eligible for private insurance, however, were paid for by public funding sources. Assuming a 30-day benefit period, there were 450 treatment days in FY03 that should have been paid by private insurance but in fact were paid by public funding sources, and 302 such treatment days in FY04. Assuming a 45-day benefit period, there were 665 treatment days in FY03 that should have been paid by private insurance but in fact were paid by public funding sources, and 498 such treatment days in FY04.

Some of the treatment days that should have been paid for by private insurance were paid for by patients and their families. Assuming a 30-day benefit period, these figures are 30 days in FY03 and 63 days in FY04. Assuming a 45-day benefit period, these figures are 37 days in FY03 and 76 days in FY04.

### **C. The Statewide Implications of the Rehabilitation Facility Data**

The Parente Randolph analysis was used as a benchmark to project the total number and cost of treatment days that should have been paid for by private insurance, but were not, for adolescent addiction treatment at Pennsylvania nonhospital, residential addiction treatment facilities for FY03 and FY04 based on the following further assumptions:

- There are 792 adolescent residential addiction treatment beds in Pennsylvania.<sup>35</sup>

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<sup>35</sup> This number was provided to Parente Randolph and was not independently established by them. The figure was obtained through a survey of Pennsylvania licensing records.

- Pennsylvania adolescent residential addiction treatment facilities operate at 83 percent program capacity.<sup>36</sup>
- The Rehabilitation Facility is fairly representative of adolescent residential addiction treatment facilities in Pennsylvania.
- The Rehabilitation Facility's utilization rates (number of treatment days divided by maximum annual bed days available), which were 66 percent in 2003 and 74 percent in 2004, are consistent with utilization rates at other residential addiction treatment facilities in Pennsylvania.
- Public funds pay for adolescent residential addiction treatment at a rate of \$170 per day.
- Private insurance companies pay for adolescent residential addiction treatment at a rate of \$270 per day.

Based on these assumptions, there were 158,271 adolescent residential addiction treatment days provided in FY03 and 177,455 adolescent residential addiction treatment days provided in FY04. This figure is arrived at by taking the total number of available bed days (792 available addiction treatment beds times 365 days), then multiplying it by 83% (because it is assumed that programs operate at 83% of capacity), and then

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<sup>36</sup> The Rehabilitation Facility has 30 beds, and a normal program capacity of 25 beds. These two numbers differ because The Rehabilitation Facility can only exceed 25 patients at a time if they deploy additional staff. Thus, its normal program capacity is 83% (25/30) of available beds. The Rehabilitation Facility does, at times, have more than 25 patients, but these departures from standard capacity are not factored into the projections.

multiplying it by 66% for FY03 (the utilization rate for that year) and by 74% for FY04 (the utilization rate for that year).

These are straight-line projections. Parente Randolph only reviewed data at one facility which represented a small percentage of the adolescent treatment beds in Pennsylvania -- 25 out of 792 available beds, or 3.1 percent. The study did not evaluate the extent to which reimbursement behavior at the Rehabilitation Facility, program capacity, or utilization rates were fairly representative of other residential addiction treatment facilities in Pennsylvania during the time period studied. It is fair to say that there is no direct evidence that the Rehabilitation Facility data present an accurate picture of statewide behavior. It is equally fair to say, however, that there is no evidence that the Rehabilitation Facility data are *not* fairly representative. Perhaps additional research will uncover a facility or even a set of facilities where private insurers paid for significant nonhospital residential addiction treatment stays during the studied years. But no such facility is known to the author, to treatment advocacy organizations in Pennsylvania, or to legislative personnel actively engaged in substance abuse and addiction treatment issues. Until such a facility or set of facilities is found, it seems reasonable to explore the projected statewide implications of the data that we do have.

Data from the Rehabilitation Facility established that a significant percentage of treatment days should have been funded by private MCOs but in fact were funded by public funding sources. Assuming a 30-day addiction treatment benefit, these days were 7.5% of the total treatment days in FY03 (450 out of 6,021) and 4.5% of the total treatment days in FY04 (302 out of 6,727). Assuming a 45-day addiction treatment

benefit, these figures were 11.0% of the total treatment days in FY03 (665 out of 6,021) and 7.4% of the total treatment days in FY04 (498 out of 6,727).

Parente Randolph applied these percentages to the number of treatment days to establish the number of treatment days that should have been paid for by private insurance, but in fact were paid for by public funding sources, in FY03 and FY04.

	FY03	FY04
30-day benefit	11,870	7,985
45-day benefit	17,409	13,131

Parente Randolph also projected the number of treatment days that should have been covered by insurance but were provided as uncompensated facility scholarship care, in the same way. Using a 30-day benefit, facility scholarship days that should have been funded by private insurance were 1.8% of the total treatment days at the Rehabilitation Facility in FY03 and 3.8% of such treatment days in FY04. Using a 45-day benefit, those figures are 2.7% for FY03 and 5.7% for FY04. Applying these percentages to the statewide figures yields the following:

	FY03	FY04
30-day benefit	2,849	6,743
45-day benefit	4,273	10,115

These projections were also expressed in economic terms. The public reimbursement rates for residential adolescent addiction treatment in Pennsylvania in 2003 and 2004 were at least \$170 per day. Using this figure, the total direct cost to the public of care that was paid for by public funding sources but should have been paid for by private insurance is as follows.

	FY03	FY04	Average
30-day benefit	\$2,017,900	\$1,357,450	\$1,687,675
45-day benefit	\$2,959,530	\$2,232,270	\$2,595,900

The benefit to private insurers was far greater, because the private reimbursement rates that they avoided paying is higher than the public reimbursement rate. If a figure of \$270 per day is used, the benefit to private insurers is as follows.

	FY03	FY04	Average
30-day benefit	\$3,204,900	\$2,155,950	\$2,680,425
45-day benefit	\$4,700,430	\$3,545,370	\$4,122,900

The economic burdens of facility scholarship care are on the same order of magnitude – and are borne by institutions that are often non-profits constantly struggling with limited resources. If this care is valued at the same \$270 per day figure assumed to be paid by private insurers, the costs of this care are as follows.

	FY03	FY04	Average
30-day benefit	\$769,230	\$1,820,610	\$1,294,920
45-day benefit	\$1,153,710	\$2,731,050	\$1,942,380

While Parente Randolph’s analysis was based on hard data and on assumptions grounded upon solid evidence, the empirical study had a limited scope and there are many areas that would obviously benefit from additional inquiry. One obvious issue is the possibility that the percentage of patients identified as having an Act 106 benefit is not accurate and is either an undercount (a distinct possibility, because private insurance figures appears to be roughly half of generally accepted figures regarding insurance in the population at large) or an overcount (because some of the patients identified as having

private insurance did not have group coverage, or had coverage through a self-insured plan that was not required to comply with Act 106).

Furthermore, while the overwhelming majority of patients at the Rehabilitation Facility reside in Pennsylvania, a small number of patients documented as having private health insurance had policies issued in other states. It should be noted, however, that removing out of state insureds from the study group would likely have made the MCOs' reimbursement behavior more dramatic, not less so. The majority of treatment days reimbursed by private insurers in 2003 and 2004 came from out-of-state insurers (20 of the 23 days in 2003, and 30 of the 54 days in 2004). The Rehabilitation Facility was in all likelihood an out-of-network facility for these patients, and out-of-network benefits are often not subject to managed care utilization review. In all likelihood these treatment days were paid for only because they slipped through this particular chink in the MCOs' utilization review armor. If these treatment days are removed from the Rehabilitation Facility data, then the number of treatment days reimbursed by private insurance is even closer to zero.

It is also important to note that the stark abrogation of a mandated benefit identified at the Rehabilitation Facility is useful information irrespective of whether or not any particular patient's claim would, if considered individually, have met all the requirements for reimbursement. In Pennsylvania, Act 106 makes MCO review for medical necessity review inapplicable, but even if an MCO's judgment on medical necessity were somehow relevant to coverage, that would not disturb the central lesson of the Rehabilitation Facility analysis.

The utter failure to fund residential addiction treatment cannot be defended based on a claimed lack of medical necessity because the Rehabilitation Facility and the public funders of addiction treatment involved were satisfied that the care was medically necessary and appropriate. Even in the absence of this existing evidence of medical necessity, a defense based on medical necessity would not and could not justify the near-complete failure of private MCOs to fund residential treatment unless the asserted medical necessity standard were a standard impossible to meet. The medical necessity defense only works for the MCOs involved if essentially every patient treated at a duly licensed, well-regarded facility over a two-year period failed to meet the asserted standard. The only standard that could justify the MCOs' failure is a "medical necessity" standard that that is not bounded by common sense or accepted standards of practice.

Of course, medical necessity is only a small part of the problem. Even if an MCO could come up with some plausible-sounding excuse for nonpayment for every single patient, that in itself should be considered strong evidence something is seriously amiss. On this point, a brief recitation of some of the excuses that have been advanced by a single managed care organization, Magellan, over the years will help illustrate this point. Each of the following has appeared, over the years, as a purported justification for not paying claims:

- a. The claim is not showing on the Magellan computer;
- b. Magellan has not received the bill and the treatment facility needs to re-mail or re-fax the bill (this has often happened several times with the same bill, sometimes after the bill was originally been sent certified mail, with a signed return receipt both requested and obtained; at times

Magellan has denied employing the employee who signed the return receipt);

- d. The claim is not on file with Magellan;
- e. There is no authorization on file (facilities generally do not submit bills unless they have an authorization);
- f. The authorization was “accidentally voided”;
- g. The claims system is down;
- h. The claim has not been entered yet;
- i. Medical records are needed;<sup>37</sup>
- j. The claim is “in a random audit”;
- k. The Magellan computer is showing “a large backlog”;
- l. All service representatives are busy;
- m. The claim was sent to the wrong Magellan post office box; and
- n. The copier at Magellan is not working.

When these hurdles are raised, there has often been no way for the facility to address them efficiently. Magellan has on occasion told facilities, when they call to pursue inquiries regarding a large number of claims, that they cannot check more than one or two claims during one telephone call, making it necessary for facility personnel to hang up and reinitiate the call. Where hundreds of late claims are involved, any practical resolution of the massive backlog of late unpaid claims is impossible.

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<sup>37</sup> These demands for information often include demands for records that the treatment facilities are barred by law from releasing. *See supra* n. [ ].

Focusing on aggregate payment behavior makes it easy to see beyond this impressively diverse list of excuses, in a way that is much more difficult if each case is viewed in isolation, or one at a time. I return to this observation below, and suggest that the difference between the clarity of the Rehabilitation Facility analysis and the confusion sown by a collection of individual excuses holds some important lessons for health insurance regulation more generally.

**D. A note on Criteria**

A great deal of attention is paid to the development of criteria and other formal guidelines that govern the provision of, and MCO reimbursement for, addiction treatment. The American Society of Addiction Medicine (“ASAM”) has developed and promulgated criteria. In Pennsylvania, care for the medical assistance population and certain other publicly funded populations is guided by ASAM criteria and, for the adult population, specific guidelines developed by the Department of Health’s Bureau of Drug and Alcohol Programs, known as the Pennsylvania Client Placement Criteria.<sup>38</sup>

Parente Randolph did not independently determine whether the patient days satisfied any particular criteria because the study was designed to evaluate compliance with Act 106. In Pennsylvania, reimbursement under Act 106 is driven by the judgment of clinicians directly involved in caring for the patient. It appears that MCOs have broken the law and failed to comply with legal requirements established by lawmakers.

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<sup>38</sup> See, e.g., Commonwealth of Pennsylvania Department of Public Welfare, Healthchoices Behavioral Health Program, Program Standards and Requirements – Primary Contractor – County (2003), at Appendix T.

Should regulators and enforcement personnel really care that the MCOs' conduct would have escaped the disapprobation of the American Society of Addiction Medicine?

Also, the only criteria or guidelines that could possibly justify the private MCO reimbursement behavior identified at the Rehabilitation Facility are criteria or guidelines that would essentially never support any nonhospital residential addiction treatment. Neither ASAM criteria nor the PCPC criteria achieve this result when properly applied. As a result their application would never change the stark central lesson of the Rehabilitation Facility analysis. The Rehabilitation Facility analysis did not identify a marginal dropoff in residential treatment, but instead a complete and wholesale abandonment of residential rehabilitation.<sup>39</sup>

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<sup>39</sup> Furthermore, applying criteria to a particular set of patients would pose enormous, possibly insurmountable, logistical hurdles. See *Garnick et al.*, National Institute on Alcohol Abuse and Alcoholism, *Performance Measures for Alcohol and Other Drugs* (2006), <http://pubs.niaaa.nih.gov/publications/arh291/19-26.htm> (“medical records are not commonly used for performance measures because of the cost and complexity of compiling the necessary data from a wide range of medical record formats”). This suggests that any set of legal rules based solely on criteria might be impossible to enforce, and therefore possibly unwise for that reason alone.

**Part Two: Why Regulators Did Not Identify The Failure of Private MCOs to Pay For Addiction Treatment and Did Not Identify the Shift to Public Funding**

The cost shift identified in the Rehabilitation Facility analysis – and the clear, utter abandonment of an express statutory mandate -- took place at a time when managed care conduct in this area was receiving a significant amount of attention, both within and outside of state government. Despite this attention, no regulatory authority defined the scope of the problem, and no actor within government took steps to restore, to taxpayers and to the public fisc, amounts that had wrongfully been shifted to the public. In those failures lie some important lessons.

To fully understand the depth of these failings, it is worth briefly describing the intensity and clarity of the public attention that was focused on the issue. Much of this attention came about as a result of a strong leadership role taken by the Pennsylvania General Assembly.

In October, 2001, the Pennsylvania House of Representatives' Health and Human Services Committee Subcommittee on Drugs and Alcohol held a hearing on access to addiction treatment. The Subcommittee heard testimony critical of managed care barriers to addiction treatment from numerous witnesses, including Pennsylvania's then-Attorney General (and now Third Circuit Judge) the Honorable Mike Fisher, from treatment programs located in different regions of the state, and from employer representatives.<sup>40</sup>

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<sup>40</sup> Materials on this hearing are on file with the author.

In September, 2002 another hearing was held by the Health and Human Services Committee of the House of Representatives. This hearing focused on the effects that managed care barriers to addiction treatment had on adolescents, and included testimony critical of managed care from judges, juvenile probation officers, a district attorney, and treatment program personnel.<sup>41</sup> In February, 2003, The Legislative Budget and Finance Committee, which is the auditing arm of the Pennsylvania General Assembly, released a report that discussed difficulties that patients and families had accessing addiction treatment benefits under health plans subject to Act 106.<sup>42</sup>

In April, 2003 the Pennsylvania House of Representatives Health and Human Services Committee and Children and Youth Committee hosted a joint hearing on juvenile access to mental health/drug and alcohol treatment services. At this hearing, a District Attorney, consumers, addiction treatment programs, and county government officials discussed the need to enforce Act 106 to ensure addiction treatment for juveniles.

In November, 2005 the Pennsylvania House of Representatives Health and Human Services Committee held a hearing on the impact of denial of addiction treatment under Act 106. The Committee received testimony from a former prosecutor who testified about how managed care barriers to access to addiction treatment drive up crime,

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<sup>41</sup> Materials on this hearing are on file with the author.

<sup>42</sup> Legislative Budget and Finance Committee, Pennsylvania General Assembly, Drug and Alcohol Treatment Services in a Managed Care Environment (2003).

from employers who had difficulties accessing residential addiction treatment for employees, and others.<sup>43</sup>

Despite all this focused attention from the General Assembly, none of the regulatory authorities whose job it is to regulate managed care in Pennsylvania identified or documented, in any coordinated, systematic, or rigorous way, the wholesale abandonment of residential addiction treatment so clearly demonstrated at the Rehabilitation Facility. This Part explores how and why those charged with regulating managed care failed to identify this pattern with sufficient clarity, and failed to follow up on evidence of wholesale abandonment of a mandated benefit and the consequent cost shift to public funds, and otherwise failed to promptly address and correct this pattern. Or to put it a slightly different way, the Rehabilitation Facility analysis provides a useful yardstick, against which the adequacy and effectiveness of enforcement tools and enforcement efforts can be measured.

In Pennsylvania, front-line authority to regulate managed care health insurance companies resides primarily in the Department of Health and the Department of Insurance. Both Departments have the authority to impose a range of sanctions, up to and including revocation of the entity's license to do business in Pennsylvania.<sup>44</sup>

**A. Individual Complaints: The Difficulty Of Detecting Systemic Problems Reviewing One Case at a Time.**

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<sup>43</sup> Materials from this hearing are on file with the author.

<sup>44</sup> See *infra* at [ ].

For consumers, the most accessible face of managed care regulation is found in consumer complaint systems. In Pennsylvania, HMO members and members of a particular type of Preferred Provider Organization (“PPO”) known as a risk-assuming PPO can appeal adverse decision to the Department of Health’s Bureau of Managed Care. Insureds who are members of a non-risk-assuming PPO can pursue complaints with the Pennsylvania Insurance Department. Insureds can also seek relief through the Pennsylvania Attorney General’s Health Care Unit.

By their very nature, these tools only provide regulators and law enforcement with a view of one case at a time.

This approach inevitably underreports problems, for a number of reasons.

First, these procedures will be invoked only by a small percentage of individuals and facilities having an issue or a problem with a managed care organization. This point is particularly easy to see in the area of addiction treatment (although it is hardly limited to addiction treatment). Addiction is defined by denial and often accompanied by shame. Some suffering from addiction break the law. A person sick enough to require residential addiction treatment is likely in no position to initiate and carry through a regulatory appeal process. And not every insured with a grievance or a complaint will be eager to call up the government to talk about their drug addiction or repeat arrests for drunk driving.

Second, even those claims that are raised and pursued will not necessarily provide an accurate or complete picture of managed care behavior. MCOs often have contractual defenses to coverage. For example, an insured might, out of desperation, have obtained care from an out-of-network facility, even though their policy that does not have an out-

of-network benefit. Even if this were true of every single denial, however, regulators should still want to know that a mandated benefit was not being provided. This discordance between a state of affairs prescribed by the legislature (that is, private insurers paying for residential addiction treatment) and reality (private insurers not paying for residential addiction treatment) is an important behavior that is wholly separate from the merits of any individual appeal.

These problems are compounded by the particular administrative structure through which managed care complaints are handled in Pennsylvania. As noted above, a complaint against an HMO and a risk-assuming Preferred Provider Organization will be handled by the Department of Health's Bureau of Managed Care. A complaint against a Preferred Provider Organization will be handled by the Insurance Department. The Pennsylvania Attorney General operates a Health Care Unit that independently evaluates complaints and, if consumers go there first, the Attorney General might hear, decide, or otherwise resolve complaints that would otherwise fall within the jurisdiction of the Department of Health or the Insurance Department. This fractured approach inevitably means that there is no single actor with a view of all the problems experienced by consumers in this area.

Third, another set of blinders that is even more fundamental than the limitations set forth above makes it virtually impossible for individual consumer complaints and grievances standing alone to ever provide a comprehensive, coordinated view of managed care behavior. Individuals can complain about and appeal denials, but those challenges can only reach one of the many tools that MCOs use to control and influence treatment. MCOs control and influence treatment, and the extent of their reimbursement obligations,

not only through denials but also by carefully selecting networks; through direct and indirect financial incentives; through benefit design; through cost-sharing arrangements; through normative information influences; through interactions with colleagues, provider organizations, and policymakers; by creating, supporting and enabling guidelines, critical pathways, and criteria; and through a “sentinel effect,” in which the very existence of utilization management systems may itself deter care.<sup>45</sup> By focusing only on denials, the vast majority of managed care behavior and its effect on reimbursement behavior, medical care, public health, and the criminal justice system is simply missed.

**B. Market Conduct Evaluations by the Insurance Department Have Failed To Detect the Cost Shift and Failed to Identify the Scope of the Problem.**

The Insurance Department has broad authority to examine the behavior of licensed insurance companies in Pennsylvania.<sup>46</sup> In recent years, a number of managed care companies have been the subject of investigations undertaken to assess insurer compliance with Act 106. While these studies did identify significant failures to comply with that law, they do not provide an accurate picture of the scope of the problem, or the unfair burden imposed on the public fisc by insurers’ failures to comply with the law.

Two enforcement actions from 2006 make the point.

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<sup>45</sup> See *supra* n. [\_\_].

<sup>46</sup> 40 Pa. Stat. §§ 323.3, 323.4.

In 2006 the Pennsylvania Department of Insurance investigated Cigna Healthcare's compliance with Act 106.<sup>47</sup> The investigation covered the time period between September, 2003 and April, 2006, and concluded that CIGNA had "failed to provide prompt payment of clean claims related to drug and alcohol treatment for two insureds."<sup>48</sup> CIGNA asserted that "these are the only two claims involving drug and alcohol that were denied in whole or in part" during this time period.<sup>49</sup> The investigation resulted in the entry of a Consent Order, in which CIGNA was ordered to comply with Act 106, make restitution to the drug and alcohol treatment providers for the denied days, and pay a civil penalty of ten thousand dollars.<sup>50</sup>

This investigation detected and addressed some serious problems, but there is more work to be done. A lot of important behavior was missed. The Rehabilitation Facility analysis proves that more than two CIGNA-insured patients received medically necessary residential addiction treatment that fell within the Act 106 benefit, but was not paid for by CIGNA. The Rehabilitation Facility analysis identified two patients who had private insurance with CIGNA, and who received treatment that was not reimbursed by CIGNA. One of these patients received 148 days of residential treatment funded entirely by a County Department of Human Services; another patient received 24 days of

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<sup>47</sup> Consent Order, Findings of Fact, Conclusions of Law, and Order, In re: CIGNA Healthcare of Pennsylvania, Docket No. CO06-08-018, *available at* [http://www.ins.state.pa.us/ins/lib/ins/enforcement/consentorders/Cigna\\_Healthcare\\_092906.pdf](http://www.ins.state.pa.us/ins/lib/ins/enforcement/consentorders/Cigna_Healthcare_092906.pdf).

<sup>48</sup> *Id.*, Findings of Fact ¶ 3(d).

<sup>49</sup> *Id.* at ¶ 3(f).

<sup>50</sup> *Id.*, Order ¶ 5.

residential treatment that was never paid for by anyone and was essentially provided by the facility as charity care. The chance that these are the only two patients with valid claims for Act 106 benefits (that is, that these were the two patients identified in the Insurance Department's investigation as having been wrongfully denied an Act 106 treatment benefit) is vanishingly small,<sup>51</sup> and it is virtually certain that there were in fact many more than two CIGNA patients who were effectively denied Act 106 benefits.

Obviously, it is worth devoting more attention to the significant disparity between (a) CIGNA's sworn assertion that the two denials acknowledged in the Consent Decree were the "only two claims involving drugs and alcohol that were denied in whole or in part" and (b) the private insurance behavior observed in the Rehabilitation Facility analysis. Any such inquiry is beyond the scope of this article. For present purposes, the more important observation is that even if the figure were entirely accurate, it could not possibly provide a complete picture of MCO compliance with the law. Focusing on individual denials, or on denials alone, will always provide a limited understanding of MCO behavior, for the reasons set forth above.<sup>52</sup>

Broader information about CIGNA's handling of residential addiction treatment was readily available in the Pennsylvania Department of Health. An annual report that

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<sup>51</sup> The Rehabilitation Facility was only 3.1 percent of the *adolescent* treatment beds in Pennsylvania in 2003 and 2004, and the number of adolescent treatment beds is dwarfed by the number of adult residential treatment beds.

<sup>52</sup> See *supra* at [\_\_].

CIGNA filed with the Pennsylvania Department of Health's Bureau of Managed Care candidly reported that there were no nonhospital residential addiction treatment days reimbursed during the entire year.<sup>53</sup> There is no indication in the publicly available record that this information (which was filed with the Department of Health) was considered and reviewed by the Insurance Department, let alone considered as an integrated piece of a broader picture.

Clearly, market conduct investigations as currently conceived and understood provide a very incomplete picture.

**C. The Pennsylvania Department of Health Failed to Detect the Cost Shift and Failed to Appreciate the Significance of Available Data.**

The Pennsylvania Department of Health has two different bureaus that deal with the regulation of managed care. The Department's Bureau of Managed Care receives and reviews aggregate data bearing on the performance of HMOs and other managed care companies that are regulated by the Department of Health. In addition, the Department's Bureau of Drug and Alcohol Programs has a mandate and an enabling statute that appears, on its face, to permit the kind of broad vision that could detect cost shifting. There is no evidence that either the Bureau of Managed Care or the Bureau of Drug and

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<sup>53</sup> Annual Status Report for CIGNA Healthcare of Pennsylvania, Inc., for year ending December 31, 2005 (relevant portions on file with the author). These annual reports are discussed in more detail in the following section.

Alcohol Programs detected, or took timely, effective measures to address, the cost shift identified at the Rehabilitation Facility.

**1. The Department of Health’s Bureau of Managed Care**

HMOs, other health care plans that use a gatekeeper, and are required to file with the Bureau of Managed Care annual and quarterly reports containing utilization information.<sup>54</sup> The following table reflects the utilization data that MCOs are required to submit to the Bureau of Managed Care every year. The example set forth here is taken from the annual report of Aetna Health, Inc., for 2005.<sup>55</sup>

	<i># of Members Months</i>	<i>Visits Per 1,000</i>	<i>Admissions Per 1,000</i>	<i>Days Per 1,000</i>	<i>Average Length of Stay</i>	<i>Average Cost Per Member Per Month</i>
<b>Inpatient Detox</b>	6,895,389		1.38322	5.95116	4.30	0.12
<b>Non-Hospital Residential</b>	6,895,389		0.00521	0.02083	4.00	0.00
<b>Partial Hospitalization</b>	6,895,389		0.09893	0.58488	5.91	0.04
<b>Intensive Out Patient Program</b>	6,895,389	17.40745	1.83446		9.49	0.04
<b>Outpatient</b>	6,895,389	23.27357				0.16
<b>TOTALS</b>	6,895,389					0.36

<sup>54</sup> 28 Pa. Code § 9.604; *see also* 28 Pa. Code § 9.602 (defining types of managed care plans that are required to submit these reports).

<sup>55</sup> The relevant portions of this report are on file with the author.

There is a stark disparity between the reported average length of stay for nonhospital residential (4 days) and the requirements of Act 106 (30 days).

Aetna is a Health Maintenance Organization, and is required to provide “benefits as may be mandated by State and Federal law.”<sup>56</sup> The Bureau of Managed Care is charged with enforcing this standard. The Bureau of Managed Care’s failure to follow up on the data reported by Aetna is puzzling.

Aetna is also required to have in place, and submit to the Bureau of Managed Care for review, a quality assurance plan.<sup>57</sup> Under the standards that govern quality assurance plans, Aetna’s quality assurance plan is to include “consideration of clinical aspects of care, access, availability and continuity of care.”<sup>58</sup> The plan is also to include provisions that require Aetna to “conduct annual studies of access and availability.”<sup>59</sup> Furthermore, Pennsylvania’s regulatory regime incorporates standards set by national accrediting bodies. For HMO’s, this includes standards set by the National Committee for Quality Assurance (“NCQA”) “or other department-approved quality review organizations”.<sup>60</sup> These standards, in turn, include a general requirement that the MCO

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<sup>56</sup> 28 Pa. Code § 9.651(d).

<sup>57</sup> 28 Pa. Code § 9.674 (components of quality assurance plan), 9.604(9) (requiring submission of quality assurance plan).

<sup>58</sup> 28 Pa. Code § 9.674(b)(7).

<sup>59</sup> 28 Pa. Code § 9.674(c)(1)(v).

<sup>60</sup> 40 Pa. Stat. § 991.2191.

“monitor the impact of its utilization management program to detect and correct potential under- and overutilization of services.”<sup>61</sup>

For 2005, Aetna provided behavioral health benefits through Magellan, which is known as an Integrated Delivery System, or IDS.<sup>62</sup> This essentially made another layer of regulatory review available to the Bureau of Managed Care. Contracts between HMOs and IDSs such as Magellan are subject to the review and approval of the Department of Health’s Bureau of Managed Care,<sup>63</sup> and those contracts must “safeguard patient access to care.”<sup>64</sup> Furthermore, IDSs must independently comply with the performance requirements referred to in the preceding paragraph.<sup>65</sup>

The Department has broad authority to investigate all managed care plans,<sup>66</sup> including HMOs,<sup>67</sup> and the Department is granted “free access to all books, records, papers and documents that relate to the business of the [managed care] plan, other than financial business.”<sup>68</sup> The Department may also “request submission by the plan of a special report detailing any aspect of its operations relating to the provision of health care

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<sup>61</sup> National Committee on Quality Assurance Standard UM-14 (2003).

<sup>62</sup> See 28 Pa. Code § 9.602.

<sup>63</sup> 28 Pa. Code § 9.724(b).

<sup>64</sup> 28 Pa. Code § 9.724(d)(12).

<sup>65</sup> 28 Pa. Code § 9.601(b) (enumerating the HMO laws that IDSs subcontracting with managed care plans are required to comply with)..

<sup>66</sup> With respect to the definition of “managed care plan,” *see supra* n. [ ]. The term includes HMOs and at-risk preferred provider organizations, but does not include every MCO as that term is used in this article.

<sup>67</sup> 28 Pa. Code § 9.605(d).

<sup>68</sup> 28 Pa. Code § 9.605(c).

services to enrollees . . . .”<sup>69</sup> The Department has the same authority over, and right to investigate, IDSs.<sup>70</sup>

If an HMO fails to meet these standards, the Department of Health may impose a range of sanctions, up to and including a revocation of the HMO’s authority to do business.<sup>71</sup> As all contracts between IDSs and HMOs must be approved by the Department of Health,<sup>72</sup> the Department of Health can also effectively prevent a non-compliant IDS from doing business in the Commonwealth of Pennsylvania.

Above, I refer to specific evidence regarding CIGNA and Aetna; reports on file with the Bureau of Managed Care from other managed care companies almost certainly show a similar pattern. Indeed, the Rehabilitation Facility analysis and the extensive record developed as part of the legislative hearings remove any doubt that the failure of MCOs to fund addiction treatment was widespread.

Research has not uncovered any evidence that the Department of Health’s Bureau of Managed Care used any of the tools described above to follow up on the available evidence indicating private MCOs were not paying for residential addiction treatment at the levels mandated by Act 106. There is no indication that the Bureau of Managed Care considered what this abandonment of a mandated benefit meant for Pennsylvania

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<sup>69</sup> 28 Pa. Code § 9.605(e).

<sup>70</sup> 28 Pa. Code § 9.724(d)(7)-(d)(9).

<sup>71</sup> 28 Pa. Code § 9.606.

<sup>72</sup> 28 Pa. Code § 9.724(d).

citizens' access to and availability of care,<sup>73</sup> no indication that the Bureau of Managed Care considered this as evidence of systematic underutilization, and no indication that the Bureau of Managed Care considered the more general implications of these findings for the health of Pennsylvania insureds.

## **2. The Department of Health's Bureau of Drug and Alcohol Programs**

The Department of Health has other broad powers that, if applied with vigor, could have identified the managed care industry's wholesale abandonment of residential addiction treatment. In a law commonly referred to as Act 63 of 1972,<sup>74</sup> the Department of Health is specifically directed to "develop and adopt a State plan for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems."<sup>75</sup> This Plan is required to include provision for "[c]oordination of the efforts of all State agencies in the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems . . . ."<sup>76</sup> The Department of Health is also required to gather "all available published and unpublished data and information on the problems of drug and alcohol abuse and dependence,"<sup>77</sup> and

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<sup>73</sup> 28 Pa. Code § 9.675(b)(7).

<sup>74</sup> 1972, P.L. No. 221, No. 63.

<sup>75</sup> 71 Pa. Stat. § 1690.104(a).

<sup>76</sup> 71 Pa. Stat. § 1690.104(a)(1).

<sup>77</sup> 71 Pa. Stat. § 1690.104(f).

an obligation to “submit an annual report to the General Assembly which shall specify the actions taken and services provided and funds expended under each provision of this act and an evaluation of their effectiveness.”<sup>78</sup> The Department of Health is also granted the power to “promulgate rules and regulations necessary to carry out the provisions of this act.”<sup>79</sup>

The language of Act 63 seems broad enough to permit the Department of Health to gather “all available published and unpublished data” regarding addiction treatment; this would presumably demonstrate that private payers were funding no nonhospital residential addiction treatment – this is clear from the public filings referred to above – and that public funding sources were paying for a great deal of such treatment.<sup>80</sup> This language also appears to permit the Department of Health to either take or recommend steps to fix the problem. As of this writing, however, none of this has happened.

These responsibilities described above are currently handled by the Bureau of Drug and Alcohol Problems, which is a bureau internal to the Department of Health.<sup>81</sup> Gathering and coordinating information takes work, and as a practical matter a bureau

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<sup>78</sup> 71 Pa. Stat. § 1690.104(h).

<sup>79</sup> 71 Pa. Stat. § 1690.104(j).

<sup>80</sup> *See, e.g.*, the legislative hearings referred to above. Of course, this also applies to other levels of care.

This point presumes – one would hope reasonably – that public funders of addiction treatment know, or can easily learn, what treatment they are paying for.

<sup>81</sup> *See* Pennsylvania Department of Health Bureau of Drug and Alcohol Programs Drug and Alcohol Program Reports 2008-2009, available at <http://www.dsf.health.state.pa.us/health/lib/health/bdap/2008-09BDAPStatePlan.pdf>

within the Department of Health cannot make personnel in other Departments devote resources to a particular task. This is a practical reality, not a legal proposition, but it is a proposition that accurately reflects experience to date.

A truly comprehensive view would require a significant coordinated effort involving the Insurance Department, the Department of Public Welfare, and the Department of Health. Experience shows that a bureau within the Department of Health has been unable to make this happen, and has been unable to pursue the vision so clearly spelled out in the enabling statute cited above.

**D. The Dangers of Excessive Reliance on Quasi-Private HEDIS Standards**

Above, I have explored some of the possible reasons why the entities directly charged with regulating MCOs and insurance companies did not detect, understand, or timely address the wholesale abandonment of a mandated benefit. This discussion is incomplete without additional consideration of quasi-private performance measures that have become an integral part of managed care regulation in Pennsylvania and in other states.

Pennsylvania's regulatory regime expressly incorporates standards set by national accrediting bodies. For HMOs, this includes standards set by the National Committee for Quality Assurance ("NCQA") "or other department-approved quality review organizations".<sup>82</sup> It has been argued that one set of standards promulgated by NCQA, the Health Healthcare Effectiveness Data and Information Set ("HEDIS"), is a useful

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<sup>82</sup> 40 Pa. Stat. § 991.2191.

accountability tool: “[C]ommercial health plans are being held accountable for improving their baseline [alcohol and other drug] addiction services because performance measures have been included in the HEDIS national reporting system.”<sup>83</sup> This sentiment is part of a more general obeisance to HEDIS found in other places in the health policy literature.

HEDIS has significant limitations as a tool for measuring compliance with statutory mandates in the behavioral health area. HEDIS tells us very little about addiction treatment, does nothing to safeguard public funds, and cannot replace meaningful regulation and enforcement of managed care laws. A careful examination of HEDIS explains why this is so.

HEDIS works through a series of defined measures. There are two that would arguably capture at least some addiction treatment reimbursement behavior.

One category of HEDIS measures purports to assess “Access/Availability of Care,” and one of the measures within that category is “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.” While that measure provides information about the fact of treatment, it provides basically no information at all about what that treatment is. More precisely, that measure is defined as:

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

- Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

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<sup>83</sup> Garnick, *supra* n. [ ], at 6.

- Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.<sup>84</sup>

Another category of HEDIS measures purports to measure “Use of Services”; one of the measures within that category is “Identification of Alcohol and Other Drug Service.” That measure provides only minimal information about the fact that a service has been provided. More precisely, the Identification of Alcohol and Other Drug Services measure is defined as

the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year.

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED.<sup>85</sup>

These measures tell us something about the number of patients who received inpatient treatment (a category that presumably includes residential addiction treatment), but provides no information at all about the duration of that treatment.

For those interested in details of treatment -- such as, for example, regulators and law enforcement personnel in a state with a strong, clear mandate designed to ensure non-trivial, meaningful residential addiction treatment stays -- the HEDIS measures are essentially worthless. For many aspects of managed care behavior that should be of

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<sup>84</sup> HEDIS 2009 Access – Availability of Care at 212 (2009).

<sup>85</sup> *Id.* at 286.

central concern to regulators, “[i]nitiation”, “engagement”, and “identification” tell us nothing or next to nothing.

Some fairly minor changes to the HEDIS measures could address particular shortcomings, but could not correct more fundamental problems with excessive reliance on HEDIS.

One can imagine HEDIS measures that carefully track, and provide detailed reporting on, average lengths of stay at each of the various levels of care specified in Act 106, and measures that track, and provide detailed reporting on, how many patients received what lengths of stay at each level (outpatient, detoxification, nonhospital residential, and outpatient). But this is not a realistic option, because NCQA is by definition (or at least by name) a *national* organization and HEDIS measures are *national* standards. The problem arises because every one of the 40 or so states that have some form of mandated addiction treatment benefit has its own law,<sup>86</sup> and every one of the fifty states in the union has an absolute right to create its own laws. For this reason any set of measures that fairly captured every data element necessary to measure compliance with every state law would inevitably be unworkably complex. Trying to create a uniform national standard that fully tracks compliance with differing state mandates is a project doomed to failure.

As long as states remain an important source of health insurance regulation, managed care regulation, and health regulation, HEDIS cannot fairly be asked to substitute for meaningful regulation at the state level.

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<sup>86</sup> See *supra* n. [\_\_].

Even if it were logistically possible to create a uniform national standard that measured what needed to be measured in every state, abdicating regulatory authority to HEDIS would be unwise because NCQA is a private organization. To make the same point in a slightly different way, state governments should not have to petition NCQA every time they want to obtain additional information about reimbursement behavior or investigate compliance with state law.

The Rehabilitation Facility analysis provides a clear example of the hazards posed by this approach. Regulators, like anyone else, manage what they can measure. Allowing NCQA and HEDIS to define what gets measured effectively allows NCQA and HEDIS to define what gets managed and what gets regulated. It is unwise for Pennsylvania, or any other state, to constrain its ability to enforce the laws in this fashion.

#### **E. Some Lessons From These Regulatory Failings**

The administrative actors charged with primary front-line responsibility for regulating managed care companies in Pennsylvania failed to detect, and did not take timely steps to address or prevent, the wholesale abandonment of a mandated benefit. As a consequence, enormous amounts of money were shifted from private MCOs to the public.

It is easy enough to ascribe regulatory shortcomings to a failure of will. If that were the only problem, then oversight failures could be fixed through the political process. Legislators and legislative committees could provide oversight and focus attention; public interest organizations and the media could keep attention focused on the issue; and others both inside and outside of government could keep the pressure on.

Simply defining the problem as one of political will on the part of regulators, however, oversimplifies the problem and misses some important opportunities. The failure of regulators to address in a timely fashion the problems identified above might be the result of the way that managed care regulation is structured. Two bureaus within the Department of Health, the Department of Insurance, and the Office of the Attorney General all have a hand in regulating and enforcing managed care laws as they relate to addiction treatment. As currently constituted, not one of these actors has both the responsibility and the clear authority to gather all available data and ensure that private insurance laws are being complied with. Furthermore, none of them have the clear legal authority and practical ability to look across both private managed companies and the public funders that bear the fiscal brunt of the cost shift referred to above. The clarity of the Parente Randolph analysis is a direct consequence of the study's ability to broadly survey across all funding streams, not just private insurance.

Act 63 of 1972 accurately describes the kind of coordinated vision and effort necessary to obtain an accurate, complete picture of funding in the area of addiction treatment. This obviously includes private MCO behavior; equally obviously, it also includes public funding sources (including public MCOs). The discharge of these duties by the Bureau of Drug and Alcohol programs has fallen short of the statutory language's promise. This is in significant part a result of the simple – and easily remedied – fact that the responsibilities have been handed to a Bureau internal to the Department of Health. Moving these responsibilities into the hands of a stand-alone Department would ensure that there will always be an organization within government with adequate vision and authority, capable of a sustained effort to understand the behavior of private insurers and

other funders of addiction treatment. Given adequate resources, it is hard to imagine that the kind of wholesale violations detected at the Rehabilitation Facility would have escaped the notice, and therefore timely attention, of regulators and enforcement personnel.

This also holds some lessons for health care regulation more generally. MCOs play an active role in controlling health care and access to health care, and an active role in determining who pays for that care. The tools that are used to regulate their behavior and enforce applicable laws, however, are fractured and inevitably lead to an approach that is both episodic and incomplete. The Parente Randolph analysis makes these failures easy to see in the area of addiction treatment because the power of MCOs in this area is so great and because patients and their families are so vulnerable. But there is every reason to believe that the same dynamics – and the same regulatory lacunae – apply to other areas of health care. A more unified approach to regulation and enforcement would go a long way toward ensuring that government efforts to take a proactive, constructive role in health policy can reach both MCOs and the patients whose health care they control.

### **Part Three: An Approach Using Existing Laws That Would Permit Pennsylvania to Recover Amounts Wrongfully Shifted To The Public Fisc**

Above, I explained that the tools traditionally used to regulate and control managed care companies have failed to prevent, detect, or correct the significant cost shift identified at the Rehabilitation Facility. Individual complaints will not provide, and can never provide, a sufficiently detailed view of managed care behavior. Market conduct evaluations are limited, and miss a great deal. The Department of Health's Bureau of Managed Care has failed to use available enforcement and measurement tools. The Department of Health's Bureau of Drug and Alcohol Programs is unable to fulfill the promise of Act 63 and, as long as it remains a bureau within the Department of Health, cannot fairly be expected to do so. While these regulatory shortcomings can be fixed (on either a temporary basis through extraordinary political pressure, or on a more permanent basis through structural changes), the solutions referred to in the preceding Part are by definition solutions that have to await some action in the future.

This Part discusses another approach to addressing cost shifts does not rely on any of these regulatory mechanisms. This approach need not await any statutory or regulatory changes. Simply put, the Commonwealth of Pennsylvania can require managed care companies to pay for the care that they should have paid for, and can recover amounts wrongfully shifted onto the public. These efforts would inevitably and efficiently provide an opportunity to explore in great detail the extent of the cost shift and how and why it occurred. This Part discusses that approach in detail.

This Part focuses on Pennsylvania law, but it is important to bear in mind that the general approach is hardly limited to Pennsylvania. The problems posed by managed

care barriers to addiction treatment are national in scope. The overwhelming majority of states have laws that require private insurers to cover addiction treatment. All states have consumer protection laws of one form or another, and all states recognize, in one form or another, that private companies should not be permitted to unjustly enrich themselves through unlawful conduct.

This analysis focuses on the Commonwealth of Pennsylvania as a whole, and not any particular Department or Entity within the Commonwealth, because the Commonwealth is in a unique position to seek redress on behalf of all its departments, bureaus, and authorities, including the Pennsylvania Department of Health and its various bureaus; the Department of Welfare and its various bureaus; and the county-based authorities – known as Single County Authorities, or “SCAs” – that allocate the overwhelming majority of public addiction treatment dollars in Pennsylvania.<sup>87</sup> Even though other entities within the Commonwealth almost certainly have their own claims and causes of action available, there are obvious and overwhelming efficiencies to the Commonwealth pursuing claims.

As a general proposition, the Commonwealth has standing to sue in two different capacities: in its sovereign capacity – that is, asserting those rights and remedies available to it by virtue of its status as sovereign – and in its proprietary capacity as a purchaser of

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<sup>87</sup> See 4 Pa. Code § 254.2 (authorizing County Commissioners to establish Single County Authorities);

PENNSYLVANIA DEPARTMENT OF HEALTH, BUREAU OF DRUG AND ALCOHOL PROGRAMS - DRUG AND ALCOHOL PROGRAM REPORTS (2007) (providing general overview of organization and structure of SCAs).

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addiction treatment services.<sup>88</sup> The Commonwealth has the authority to assert these claims on behalf of departments, bureaus, and agencies that have suffered economic harm as a result of misconduct, and can therefore assert claims that arise out of expenditures of funds through the Department of Health; the Department of Public Welfare; through Pennsylvania's 49 SCAs; and through other departments, bureaus, and agencies. While many departments, bureaus, counties, and other entities have standing in their own right to assert claims, only the Commonwealth has the direct ability to pursue claims on behalf of all such entities in a single action.

The claims discussed in this Part are aggregated individual claims. Each instance of an actionable cost shift from private insurance to a public funder of addiction treatment is an individual claim that could (in theory) be pursued alone, but the claims could be aggregated in one action for reasons of practical efficiency and judicial economy. The Pennsylvania Rules of Civil Procedure clearly permit multiple claims by one plaintiff to be joined in a single case.<sup>89</sup>

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<sup>88</sup> Commonwealth v. TAP Pharmaceutical Products, 885 A.2d 1127, 1132 n.4 (Pa. Commw. 2005) (hereinafter "TAP II") (an earlier decision in the same case is recorded at 868 A.2d 624 (Pa. Commw. 2005) ("TAP I").

<sup>89</sup> See Pa. R. Civ. P. 1020(a) (providing that a plaintiff may "state in the complaint more than one cause of action cognizable in a civil action against the same defendant"); Pa. R. Civ. P. 2229(b) (permitting joinder of claims against different defendants "in respect of or arising out of the same transaction, occurrence, or series of transactions or occurrences if any question of law or fact affecting the liabilities of all such persons will arise in the action").

In cases in which the Commonwealth is a plaintiff, the Commonwealth and the Courts of Common Pleas have concurrent jurisdiction. 42 Pa. Cons. Stat. Ann. § 761(a). In the event a case is filed

**F. Unfair Trade Practices and Consumer Protection Law**

Pennsylvania’s Unfair Trade Practices and Consumer Protection Law (hereinafter “UTPCPL”) provides statutory remedies for certain kinds of misconduct.<sup>90</sup> In general, the statute addresses “unfair methods of competition” and “unfair or deceptive acts or practices”; those terms are defined in a way that extends to (and therefore prohibits) much if not all of the managed care misconduct referred to above.

**1. What Conduct Is Covered By The Unfair Trade Practices and Consumer Protection Law?**

The UTPCPL defines “unfair methods of competition” and “unfair or deceptive acts or practices” to include:

- (ii) causing likelihood of confusion or of misunderstanding as to the source, sponsorship, approval or certification of goods or services;  
.....
- (v) representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation or connection that he does not have;  
.....
- (vii) representing that goods or services are of a particular standard, quality or grade, or that goods are of a particular style or model, if they are of another;  
.....

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in the Commonwealth Court, that Court generally follows the Pennsylvania Rules of Civil Procedure. *See* Pa. R. App. P. 106.

<sup>90</sup> 73 Pa. Stat. §§ 201-1 *et seq.*

- (x) advertising goods or services with intent not to supply reasonably expectable public demand, unless the advertisement discloses a limitation of quantity;
- (xi) making false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions;
- .....
- (xiv) failing to comply with the terms of any written guarantee or warranty given to the buyer at, prior to, or after a contract for the purchase of goods or services is made;
- .....
- (xxi) Engaging in any other fraudulent or deceptive conduct which creates a likelihood of confusion or misunderstanding.<sup>91</sup>

In general, the UTPCPL – and the provisions quoted above – are to be liberally construed.<sup>92</sup>

## 2. The Misfeasance/Nonfeasance Distinction

Before turning to particular subsections, it is important to note that there is a great deal of decisional law addressing when, whether and how the UTPCPL can be applied to actions arising out of insurance policies. Recognizing that insurance is subject to heavy regulation (at least on paper) and to its own body of laws and remedies, courts have been reluctant to allow boilerplate invocation of the UTPCPL every time an insurer refuses to pay a claim. On the other hand, courts have also recognized that the UTPCPL says what it says, and there is no evidence that the Pennsylvania legislature intended to grant wholesale immunity to the insurance industry from the important protections embodied in this law.

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<sup>91</sup> 73 Pa. Stat. § 201-2(4).

<sup>92</sup> See generally *Commonwealth v. Monumental Properties*, 459 Pa. 450, 329 A.2d 812 (1974).

Courts have resolved this tension by drawing a distinction between failing to perform an act – often referred to as nonfeasance – and doing something affirmative that is wrong and improper – often referred to as misfeasance or malfeasance. Misfeasance is actionable under the UTPCPL; nonfeasance is not.<sup>93</sup>

The line between nonfeasance and misfeasance can be difficult to draw. An insurer's mere refusal to pay a claim constitutes nonfeasance, and is not actionable under the UTPCPL.<sup>94</sup> There are many reported decisions finding that insureds' claims against their insurers, arising out of failures to provide benefits, are not actionable misconduct under the UTPCPL. On the other hand, performing an improper or inadequate investigation, performing an investigation "in an unfair and nonobjective manner," and misrepresenting the nature of the insurer's contractual obligations have all been held to constitute misfeasance actionable under Pennsylvania law.<sup>95</sup> Furthermore, an insurer's "promise to pay benefits it has no intention of paying" is actionable under the UTPCPL.<sup>96</sup>

The misconduct that is addressed in this article goes far beyond a typical refusal to pay a benefit. The considerable factual record of affirmative misconduct; the systematic, continued refusal to provide addiction treatment benefits; and the persistence

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<sup>93</sup> See, e.g., *Gordon v. Pennsylvania Blue Shield*, 548 A.2d 600 (Pa. Super. 1988); *Horowitz v. Federal Kemper Life Ins. Co.*, 57 F.3d 300, 307 (3d Cir. 1995).

<sup>94</sup> *Gordon*, 548 A.2d at 264-65; *Horowitz*, 57 F.3d at 307.

<sup>95</sup> See *Clugston v. Nationwide Mut. Ins. Co.*, slip op. No. 3:05-CV-2680, 2006 WL 1290450 (M.D. Pa. May 10, 2006); *Carlucci v. Maryland Cas. Co.*, No. CIV. A. 98-CV-3294, 1999 WL 179750 (E.D. Pa. March 15, 1999); *Smith v. Nationwide Ins. Co.*, 935 F. Supp. 616, 621 (W.D. Pa. 1996).

<sup>96</sup> *Krisa v. Equitable Life Assur. Soc'y*, 113 F. Supp. 2d 694, 706 (M.D. Pa. 2000).

of that pattern of conduct even after attention was drawn to the problem,<sup>97</sup> all suggest that a finder of fact would have more than sufficient evidence to find actionable misfeasance, and not merely nonfeasance.

### **3. The Insurance Misconduct Referred To Above Violates The UTPCPL**

All group health plans subject to Act 106 include the addiction treatment benefits specified in Act 106. Even if this statutory benefit were, for some reason, not explicitly included in the policy, it would nevertheless be part of the policy by operation of law. In Pennsylvania, “stipulations in a contract of insurance in conflict with, or repugnant to, statutory provisions which are applicable to, and consequently form a part of, the contract, must yield to the statute, and are invalid, since contracts cannot change existing statutory law.”<sup>98</sup>

Selling an insurance policy that purports to provide coverage for addiction treatment and that essentially fails to provide that coverage violates these subsections. Managed care companies have long known – or should have known – that they were not supplying addiction treatment benefits – an “advertis[ed] . . . good[] or service” in accordance with the “reasonably expectable demand for the service.”<sup>99</sup> This is clear from

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<sup>97</sup> See *infra* at n. [\_\_].

<sup>98</sup> Prudential Prop. & Cas. Ins. Co. v. Colbert, 813 A.2d 747, 750 (Pa. 2002)(quoting GREGORY J. COUCH, COUCH ON INSURANCE § 13.7 (2d ed., rev. ed. 1984)).

<sup>99</sup> COUCH ON INSURANCE, *supra* note 52, at § 201-2(4)(x).

the Rehabilitation Facility analysis, because managed care insurers provide virtually no residential addiction treatment coverage. One reference point, and a well-defined floor, for “reasonably expectable” demand is the set of patients identified in the Rehabilitation Facility analysis who needed, and got, treatment. Another reference point is found in the models used by the Commonwealth to assess treatment needs.

MCOs also violate the UTPCPL when they tell insureds that the insurance policy does not include an Act 106 benefit when in fact it does, and when MCOs tell insureds, explicitly or implicitly, that addiction treatment covered by Act 106 must be precertified when there is in fact no such requirement.

MCOs have, over the years, made many assertions regarding the cost savings and financial benefits of the managed care model. Wholesale abandonment of a state-mandated treatment benefit was never mentioned. It would, in all likelihood, not be difficult to identify specific statements from managed care organizations and their agents that constitute “false or misleading statements of fact concerning the reasons for [and] existence of” price reductions.<sup>100</sup>

When an insurance company issues an insurance policy, it promises to comply with the law, and often promises to provide medically necessary care not subject to a (lawful) exclusion. Managed care insurers have long known, or should have known, that they were not in fact providing any residential addiction treatment benefits to speak of. This violates sections 201-2(4)(vii) and (xiv).

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<sup>100</sup> § 201-2(4)(xi).

Subparagraph (v) has generally been applied to assertions, by a seller, that amount to false advertising.<sup>101</sup> Establishing the applicability of section (v) might require that marketing materials and benefit booklets be gathered and analyzed. This would take some work, but doing so should not prove particularly difficult. Such an examination might well provide a basis for section (v) claims.

Subparagraph (xxi), which is sometimes referred to as the “catch-all” provision, has received considerable attention over the years. The Commonwealth Court has ruled that this section should be liberally construed, and that this section encompasses deceptive conduct that does not rise to the level of intentional fraud.<sup>102</sup> The Pennsylvania Superior Court has reached a contrary result, and has ruled that more stringent standards required for common law fraud must be met, in order for a plaintiff to prevail under this section.<sup>103</sup> The Commonwealth Court, in *Percudani*, explicitly considered and rejected the Superior Court’s position, and as any case filed by the Commonwealth would be either heard in or appealed to the Commonwealth Court, the Commonwealth Court’s

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<sup>101</sup> Commonwealth v. Percudani, 844 A.2d 35, 47-48 (Pa. Commw. 2004), amended in part on reconsideration (but not in relevant part), 851 A.2d 987 (Pa. Commw. 2004); *see also* Commonwealth v. Peoples Benefit Services, Inc., 895 A.2d 683, 694 (Pa. Commw. 2006) (overruling preliminary objections, in an action filed by the Attorney General, to allegations that defendant’s conduct was “false, unfair, deceptive, and misleading”, and therefore violated §§ 201-2(4)(ii), (iii), (v) and (xxi)); *TAP II*, 885 A.2d at 1140 (permitting Commonwealth plaintiff to proceed with claims that “generally encompass false advertising elements”).

<sup>102</sup> *Percudani*, 825 A.2d at 747.

<sup>103</sup> *Booze v. Allstate Ins. Co.*, 750 A.2d 877 (Pa. Super. 2000), *app. denied*, 766 A.2d 1242 (Pa. 2000).

approach will control, unless it overrules its own decision or the Pennsylvania Supreme Court rules otherwise.

Pennsylvania courts have also held that in a private cause of action under section 201-9.2 of the UTPCPL (discussed below), a plaintiff must establish that he relied upon particular fraudulent statements of a defendant.<sup>104</sup> The Commonwealth Court has held, however, that this does not apply to claims brought by the Commonwealth, and the Commonwealth is entitled to proceed “when it has reason to believe that the Law is being or was violated.”<sup>105</sup>

These violations of the UTPCPL do not stand or fall on the question of whether or not Act 106 permits managed care companies to conduct utilization review. A future ruling by the Pennsylvania Supreme Court that permitted utilization review might make any damages analysis derived from the Rehabilitation Facility analysis slightly less probative – because it could no longer be crisply asserted that each private insurer should have covered thirty or forty-five days, regardless of circumstance, if the law had been complied with – but this would not erase in any way either the managed care misconduct involved or the fundamental deception inherent in the insurers’ failure to provide the addiction treatment benefit they had promised to provide.

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<sup>104</sup> *E.g.*, *Weinberg v. Sun Co., Inc.*, 565 Pa. 612, 777 A.2d 442 (2001).

<sup>105</sup> *Percudani*, 844 A.2d at 48; *but see TAP I*, 868 A.2d at 637 n.9 (observing, in an offhand comment in dicta, that “[r]eliance is also an element under the UTPCPL”).

#### 4. The Unfair Insurance Practices Act and the UTPCPL

The insurance industry misconduct that is the subject of this Memorandum violates Pennsylvania's Unfair Insurance Practices Act ("UIPA") in many ways.

The UIPA prohibits "any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act."<sup>106</sup> "Unfair methods of competition" and "unfair or deceptive acts" are defined to mean:

(1) Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which:

(i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

....

(2) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

....

(4) Entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) Knowingly filing with any supervisory or other public official, or knowingly making, issuing, publishing or circulating any false material statement of fact as to the financial condition of a person, or knowingly making any false entry of a material fact in any book, report or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

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<sup>106</sup> 40 Pa. Stat. Ann. § 1171.4.

- (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.
- (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
  - (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.
  - (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
  - (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
  - (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.
  - (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.
  - (vii) Compelling persons to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due and ultimately recovered in actions brought by such persons.
  - (viii) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

....

(xii) Delaying the investigation or payment of claims by requiring the insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance.

(xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

....

(11) Failure of any person to maintain a complete record of all the complaints which it has received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.<sup>107</sup>

Much of the behavior referred to above violates these provisions.

The UIPA permits regulatory enforcement by the Insurance Commissioner, but does not establish or provide for a direct cause of action. Furthermore, the Pennsylvania Superior Court has held that violations of the UIPA cannot be used as independent bases

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<sup>107</sup> 40 Pa. Cons. Stat. Ann. § 1171.5(a); *see also* 31 Pa. Code §§146.1 - 146.10 (Unfair Claims Settlement Practices).

for UTPCPL claims.<sup>108</sup> On the other hand, there is authority supporting the use of the UIPA as a tool in resolving ambiguities in the UTPCPL.<sup>109</sup>

There are many ambiguities in the UTPCPL that might be resolved by reference to the UIPA. One example is found in section 201-2(4)(vii) of the UTPCPL, which refers to representations that goods “are of a particular standard, quality, or grade”. The UIPA makes clear, in section 1171.5(10)(i), that this includes “[m]isrepresenting pertinent facts

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<sup>108</sup> See *Gordon v. Pennsylvania Blue Shield*, 548 A.2d 600 (Pa. Super. 1988); *Prusky v. Aetna Life Ins. & Annuity Co.*, No. 03-6264, 2004 WL 2384967, \*8 n.8 (E.D. Pa. Oct. 25, 2004) (“a violation of the UIPA may not be asserted as a ground for recovery under UTPCPL”), *aff’d in part, rev’d in part*, *Prusky v. Aetna Life Ins. & Annuity Co.*, slip op., Nos. 04-4466, 04-4547, 2006 WL 952320 (3d Cir. April 13, 2006) (citing *Lombardo v. State Farm Mut. Auto. Ins. Co.*, 80 F. Supp. 208, 212 (E.D. Pa. 1992)); *Cantor v. Equitable Life Assur. Soc’y of U.S.*, No. CIV. A. 97-CV-5711, 1999 WL 219786, \*4 (E.D. Pa. April 12, 1999) (“violations of the UIPA cannot be used to prove a defendant violated the UTPCPL”) (citations omitted).

<sup>109</sup> *Leo v. State Farm Mut. Auto Ins. Co.*, 908 F. Supp. 254, 257 (E.D. Pa. 1995) (Pollak, J.) (“Leo I”) ((denying motion to dismiss: “[f]or the present . . . the citation to the UIPA in [Plaintiff’s] complaint will be allowed to stand to the extent that it invokes the UIPA as an aid to the interpretation of the Consumer Protection Act”), *different result reached on summary judgment*, *Leo v. State Farm Mut. Auto Ins. Co.*, 939 F. Supp. 1186 (E.D. Pa. 1996) (“Leo II”) (Opinion of Welsh, M.J., adopted by the district court), *aff’d*, 116 F.3d 468 (3d Cir. 1997) (table) The grant of summary judgment in Leo II was based on the facts developed through discovery. That result does not constitute an abandonment or abrogation of the legal principles covered in Judge Pollak’s earlier decision, in Leo I, on the defendant’s motion to dismiss. See also *Cooper v. Nationwide Mut. Ins. Co.*, 2002 WL 31478874 (E.D. Pa. Nov. 7, 2002) (“We also reject Nationwide’s contention that [the plaintiff] cannot state a claim under the UTPCPL for violations of the UIPA.”)

or policy or contract provisions relating to coverage at issue.” Another example is the “catch-all” provision of UTPCPL section 201-2(4)(xxi), which refers to “any other fraudulent or deceptive conduct which creates a likelihood of confusion or misunderstanding.”<sup>110</sup> It seems clear that the UIPA can and does provide significant useful guidance, regarding what constitutes “fraudulent or deceptive conduct” in the insurance area.

## **5. The Commonwealth’s Direct Remedies Under The UTPCPL**

The remedies available under the UTPCPL fall into two different categories: money damages and injunctive relief.

This relief is obtainable against both insurance companies and their agents, for actions and statements of agents.<sup>111</sup> For this reason, they are available not only against behavioral health carve-out contractors, but against the insurers and plans that hire them and allow them to control their members’ care.

### **a) Injunctive Relief Under Section 201-4**

Section 201-4 provides that “the Attorney General or a District Attorney” may “bring an action in the name of the Commonwealth against such person to restrain by

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<sup>110</sup> 73 Pa. Stat. § 201-2(4)(xxi).

<sup>111</sup> *E.g.*, *Pekular v. Eich*, 513 A.2d 427, 432 (Pa. Super. 1986) (upholding viability of claims under UTPCPL against agent and insurer); *see also Fenkner v. Nationwide Mut. Ins. Co.*, 2005 WL 1172642 (M.D. Pa. May 18, 2005).

temporary or permanent injunction the use of such method, act or practice.”<sup>112</sup> An injunction against future conduct can properly be based on past acts.<sup>113</sup>

Section 201-5 authorizes the Attorney General to accept an assurance of voluntary compliance (“AVC”) from a violator. An AVC can include “a stipulation for voluntary payment by the alleged violator to consumers, of money, property or other things received from them in connection with a violation of this act . . . .” While an AVC may not have the legal force of an injunction, an AVC does have the same effect as an injunction with respect to future penalties for violations of the AVC.<sup>114</sup>

**b) Monetary Relief Under Section 201-4.1**

Section 201-4.1 provides for a fairly broad restitutionary money remedy:

Whenever any court issues a permanent injunction to restrain and prevent violations of this act as authorized in section 4 above, the court may in its discretion direct that the defendant or defendants restore to any person in interest any moneys or property, real or personal, which may have been acquired by means of any violation of this act, under terms and conditions to be established by the court.<sup>115</sup>

The MCOs identified in the Rehabilitation Facility analysis have “acquired” those premium dollars that were not spent, and should have been spent, on addiction treatment.

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<sup>112</sup> 73 Pa. Stat. § 201-4.

<sup>113</sup> Commonwealth v. Percudani, 844 A.2d 35, 45-46 (Pa. Commw. 2004) (“To allow a party to avoid liability for its actions by merely discontinuing its conduct would render the penalty provisions of the Law meaningless in their application.”), *amended* (not in relevant part), 851 A.2d 987 (Pa. Commw. 2004).

<sup>114</sup> *See infra*.

<sup>115</sup> 73 Pa. Stat. § 201-4.1 (emphasis added).

Thus, it appears that the most direct measure of damages under section 201-4.1 is the amount that the managed care companies should have paid, but did not pay, for addiction treatment. Under the analysis set forth above, for the 45-day benefit period, this figure is – for adolescents – over \$4.7 million for Fiscal Year 2003 and over \$3.5 million for Fiscal Year 2004. This measure of damages appears to fit squarely within the statutory language.

Another possible measure of damages is found in the funds that the Commonwealth spent for addiction treatment that should have been covered, but was not. Using the analysis set forth above, this figure is – for adolescents – approximately \$2.9 million for Fiscal Year 2003 and approximately \$2.2 million for Fiscal Year 2004.

While these damages are an obviously significant starting point, they are not necessarily the only category of damages available. The UTPCPL permits recovery of money damages but “does not specifically require that the damages sought arise from payments made directly to a defendant.”<sup>116</sup> Thus, in *TAP II*, the Commonwealth Court ruled that “if the Court were to conclude that the Defendants’ conduct constitutes a violation of the Law, and the Commonwealth establishes the loss of money as a result of the conduct, the Commonwealth may prevail in its claims.”<sup>117</sup>

The defendants in any action would almost certainly claim that there is nothing for insurers to “restore” to the Commonwealth because the Commonwealth never directly paid insurance premiums to the majority of private insurers identified in the

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<sup>116</sup> *Tap II*, 885 A.2d at 1139.

<sup>117</sup> *Id.* at 1140.

Rehabilitation Facility analysis.<sup>118</sup> This argument should not be persuasive, however, because “the UTPCPL, while providing for recovery of damages, does not specifically require that the damages sought arise from payments made directly to a defendant.”<sup>119</sup> Rather, “[s]ection 201-4.1 provides that a court may order a defendant to restore any money lost as a result of a violation.”<sup>120</sup>

Obviously the money lost by the Commonwealth extends far beyond, and is exponentially larger than, the damages captured in the analysis set forth above. This measure includes, for example, the cost of treating more deteriorated addicts within the juvenile criminal justice system, and later in life in the adult criminal justice system. Conceptually, it also includes the more general (but direct and clear) costs associated with untreated and inadequately treated addiction, to the extent that those costs are attributable to managed care misconduct in this area.

It is also important to note that while the majority of reported decisions involve restitution to consumers there is nothing in the statute that limits this remedy to restitution to consumers. Quite to the contrary, section 4.1 explicitly provides that the court may restore “to any person in interest any moneys or property . . .” Because the Commonwealth was harmed by the misconduct described in this article, the

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<sup>118</sup> There are several notable exceptions to this. The Commonwealth is a purchaser (or subsidizer) of insurance coverage through the Children’s Health Insurance Program and through the Pennsylvania Employees Benefit Trust Fund.

<sup>119</sup> *TAP II*, 885 A.2d at 1139.

<sup>120</sup> *Id.* at 1139-40.

Commonwealth should be also be entitled to recover under this broad measure of damages.

**c) Civil Penalties Under Section 201-8**

The UTPCPL also provides for civil penalties. In the absence of a prior injunction or AVC, the UTPCPL provides that if a person or company has willfully used “a method, act or practice declared unlawful” by the UTPCPL, the Attorney General or the District Attorney, acting in the name of the Commonwealth, may recover a fine in an amount “not exceeding one thousand dollars (\$1,000) per violation, which civil penalty shall be in addition to other relief which may be granted under sections 4 and 4.1 of this act.”<sup>121</sup> The pattern of conduct referred to above was not the unintentional act of a few honestly mistaken employees. In all likelihood, a judge or jury would have more than sufficient evidence to support a finding that this conduct was willful and that this section applies.

If a previous injunction or an Assurance of Voluntary Compliance is violated, the Attorney General or a District Attorney can seek to recover a larger statutory fine, in an amount “of not more than [\$5,000] for each violation” of an injunction obtained pursuant to the Act, or an assurance of voluntary compliance obtained pursuant to the Act.<sup>122</sup> This section is an essential backstop to any injunction or AVC , but obviously does not supply

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<sup>121</sup> 73 Pa. Stat. § 201-8(b).

<sup>122</sup> 73 Pa. Stat. § 201-8(a).

a monetary remedy with respect to the Fiscal Year 2003 and Fiscal Year 2004 cost shifts identified above.

**d) Other Equitable Relief**

If an injunction or AVC is violated, the Attorney General or a District Attorney is authorized to seek, and a Court is empowered to grant, in addition to the civil fine referred to above, “any other equitable relief deemed needed or proper”. Equitable relief can include restitution,<sup>123</sup> and traditionally can also include an accounting.

**6. The Commonwealth’s Pursuit of Private Actions Under Section 201-9.2**

The fines and damages set forth above are remedies that are specifically identified, in the text of the UTPCPL, as remedies available directly to the Commonwealth. The UTPCPL also includes a section establishing that consumers are entitled to recover the “actual damages” they have suffered as a result of violations of the UTPCPL:

Any person who purchases or leases goods or services primarily for personal, family or household purposes and thereby suffers any ascertainable loss of money or property, real or personal, as a result of the use or employment by any person of a method, act or practice declared unlawful by section 3 of this act, may bring a private action to recover actual damages or one hundred dollars (\$100), whichever is greater. The court may, in its discretion, award up to three times the actual damages

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<sup>123</sup> *E.g.*, Commonwealth v. Ted Sopko Auto Sales, 719 A.2d 1111, 1114 (Pa. Commw. 1998).

sustained, but not less than one hundred dollars (\$100), and may provide such additional relief as it deems necessary or proper.<sup>124</sup>

Furthermore, the Court may award costs and reasonable attorney fees.<sup>125</sup>

Pennsylvania courts have taken a generally expansive approach to the measure of damages available under this section. In *Agliori v. Metropolitan Life Insurance Co.*, the Superior Court held that “the UTPCPL was meant to supplement – not to replace – common law remedies.”<sup>126</sup>

While this section does not explicitly mention claims by the Commonwealth, the Attorney General has the authority to pursue claims of individual consumers under this section, under its *parens patriae* capacity.<sup>127</sup> The Commonwealth can pursue claims in this capacity, as long as the Commonwealth is asserting and protecting not only the merely private interests of its citizens but also, at least in part, its interest in “the health

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<sup>124</sup> 73 Pa. Stat. § 201-9.2(a).

<sup>125</sup> 73 Pa. Stat. § 201-9.2.

<sup>126</sup> *Agliori v. Metropolitan Life Ins. Co.*, 879 A.2d 315, 319 (Pa. Super. 2005) (citing *Wallace v. Pastore*, 742 A.2d 1090, 1093 (Pa. Super. 1999), further citations omitted).

<sup>127</sup> *TAP II*, 885 A.2d at 1143-44; *see also* *Commonwealth v. BASF Corp.*, 2001 WL 467864 (Phila. Cty. C.C.P. 2001) (overruling preliminary objections challenging, inter alia, Commonwealth’s *parens patriae* standing under the UTPCPL); *Valley Forge Tower South Condominium Ass’n v. Ron-Ike Foam Insulators, Inc.*, 574 A.2d 641, 646 (Pa. Super. 1990), *aff’d*, 605 A.2d 798 (Pa. 1992) (holding that there is no requirement of strict privity between the plaintiff and defendant).

and well-being of its populace.”<sup>128</sup> Claims involving drug and alcohol addiction treatment obviously meet this standard.

There is a strong argument that the purchase of insurance, either directly or through employment, is a purchase for a quintessentially “personal, family or household purpose,” and therefore a purchase within the scope of section 201-9.2.<sup>129</sup> On the other hand, there is a decision from the Philadelphia County Court of Common Pleas, *Shulick v. DeGroat*, that finds the purchase of life insurance as part of a complicated tax-avoidance plan was not a purchase for “personal, family or household use.”<sup>130</sup> The tax planning (or more precisely, tax-avoiding) purpose of the transaction in *Shulick* is simply not the same as the purpose of health insurance, and the case is clearly distinguishable on those grounds.

In order for a private litigant to bring a claim under this section, “a plaintiff must show that he justifiably relied on the defendant’s wrongful conduct or representation and that he suffered harm as a result of that reliance.”<sup>131</sup> It is fair to ask whether or not this requirement would also apply to claims pursued by the Commonwealth in its *parens patriae* capacity, and research to date has not uncovered a clear answer to this question.

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<sup>128</sup> *TAP II*, 885 A.2d at 1127 (Pa. Commw. 2005) (quoting *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 102 S. Ct. 3260 (1982)).

<sup>129</sup> *See, e.g., Valley Forge Tower South Condominium Ass’n, supra* (condominium association’s purchase of a roof membrane, on behalf of individual members, is a “personal, family or household purpose” under the UTPCPL).

<sup>130</sup> *Shulick v. DeGroat*, 2005 WL 1384574 (Phila. Cty. C.C.P. June 7, 2005).

<sup>131</sup> *Yocca v. Pittsburgh Steelers Sports, Inc.*, 854 A.2d 425, 438 (Pa. 2004) (citations omitted).

In any event, it is not difficult to envision scenarios, and arguments, in which individual reliance could be established. For example, if an insurer told an insured (either directly, or indirectly through communications between the insurer and a treatment facility) that the insured was required to abide by the insurer's utilization review decision, and the insured relied upon this incorrect statement assertion (by, for example, not pursuing coverage for treatment from the insurer), then the justifiable reliance required of private plaintiffs would be established.<sup>132</sup>

### **G. Unjust Enrichment**

Unjust enrichment is an equitable doctrine, under which a defendant can be required to pay a plaintiff the value of a benefit that the plaintiff has conferred on the defendant.<sup>133</sup> In order to prevail on this claim a plaintiff must establish:

- (1) plaintiff conferred a benefit on the defendant; (2) the defendant appreciated the benefit; and (3) acceptance and retention by the defendant of the benefits, under the circumstances, would make it inequitable for the defendant to retain the benefit without paying for the value of the benefit.<sup>134</sup>

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<sup>132</sup> By contrast, the damages suffered by individual consumers are not evident on the face of the Rehabilitation Facility analysis – the insured children got treatment, and did not directly pay for it. This is an area that would benefit from further research and consideration.

<sup>133</sup> *Mitchell v. Moore*, 729 A.2d 1200 (Pa. Super. 1999), *app. denied*, 561 Pa. 698, 751 A.2d 192 (2000).

<sup>134</sup> *TAP II*, 885 A.2d 1127, 1137 (Pa. Commw. 2005).

Furthermore, the plaintiff must establish “either that the defendant wrongfully secured the benefit or passively received a benefit that it would be unconscionable to retain.”<sup>135</sup>

A threshold challenge with this theory would be establishing that the Commonwealth has conferred on managed care companies some benefit that they are required to disgorge. While the insurers undoubtedly retained to keep their premium dollars as a result of not paying for addiction treatment, this was not a straightforward monetary payment “conferred” by government payors on the insurers. In the narrowest sense, monetary benefit was more directly “conferred” by the individual insureds who paid premiums for a benefit that they did not receive. These damages are real and quantifiable, but they are not damages explicitly captured in the Parente Randolph analysis.

#### **H. Misrepresentation / Fraud**

The elements of a claim for misrepresentation or fraud are: “(1) a misrepresentation; (2) that is made knowingly, or, if innocently made relates to a matter material to the transaction; (3) where the maker of the misrepresentation intended that the recipient will be induced to act by virtue of the misrepresentation; (4) the recipient justifiably relied upon the misrepresentation; and (5) damage to the recipient is the proximate result.”<sup>136</sup>

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<sup>135</sup> *Id.*, 885 A.2d at 1127 (quoting *Torchia v. Torchia*, 346 Pa. Super. 229, 399 A.2d 581 (Pa. Super. 1985)).

<sup>136</sup> *TAP II*, 885 A.2d at 1138 (citing *Gibbs v. Ernst*, 538 Pa. 193, 207-08, 647 A.2d 882, 889 (1994)).

Pennsylvania law also recognizes the essentially identical tort of intentional non-disclosure, which “has the same elements as intentional misrepresentation ‘except in the case of intentional non-disclosure, the party intentionally conceals a material fact rather than making an affirmative misrepresentation’.”<sup>137</sup> These principles are applicable to insurance policies.<sup>138</sup>

The available facts would appear to strongly support claims by the Commonwealth in its *parens patriae* capacity on behalf of Pennsylvania insureds for misrepresentation and fraud. Insurance policies sold to Pennsylvania insureds during the relevant time period purported to include the Act 106 addiction treatment benefit, and no such benefit was in fact provided.

It is this cause of action that frames most concisely various managed care insurers’ responses to the public and regulatory attention that has been focused on funding for addiction treatment. While the work would have to be done, with the cooperation of the applicable regulatory entities it should not be that difficult to compile responses and submissions made by various managed care insurers directly to the Commonwealth, with respect to the addiction treatment benefits they were purporting to provide to Pennsylvania insureds. It should be an equally straightforward task to relate

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<sup>137</sup> *GMH Associates, Inc. v. The Prudential Realty Group*, 752 A.2d 889, 901 (Pa. Super. 2000) (quoting *Boortz v. Noon*, 556 Pa. 489, 499, 729 A.2d 555, 560 (1999), which was in turn quoting *Gibbs v. Ernst*, 647 A.2d at 889).

<sup>138</sup> *See, e.g., Tran v. Metropolitan Life Ins. Co.*, 408 F.3d 130 (3d Cir. 2005) (holding that Pennsylvania law recognizes a fraud cause of action, for claims arising out of alleged fraud by insurance brokers or agents at the time a policy is issued or sold); *Tonkovic v. State Farm*, 513 Pa. 445, 521 A.2d 920 (1987).

these statements to justifiable reliance by the Commonwealth. The damages flowing from this would include the cost shift identified at the Rehabilitation Facility, because the evidence may establish that if the Commonwealth had known the true extent of the insurers' misconduct, it would have insisted on compliance with the law.

## I. Bad Faith

Pennsylvania has an insurance bad faith statute which grants significant remedies for insurance bad faith:

In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:

- (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
- (2) Award punitive damages against the insurer.
- (3) Assess court costs and attorney fees against the insurer.<sup>139</sup>

Damages recoverable under the statute include punitive damages and attorneys' fees, and also include compensatory damages.<sup>140</sup>

Bad faith has been defined as

any frivolous or unfounded refusal to pay proceeds of a policy; it is not necessary that such refusal be fraudulent. For purposes of an action against an insurer for failure to pay a claim, such conduct imports a dishonest purpose and means a breach of a known duty (i.e., good faith and fair dealing), through some motive of self-interest or ill will; mere negligence or bad judgment is not bad faith.<sup>141</sup>

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<sup>139</sup> 42 Pa. Stat. Ann. § 8371.

<sup>140</sup> *Birth Center v. St. Paul Ins. Cos.*, 787 A.2d 376, 385 (Pa. 2001).

<sup>141</sup> *Terletsky v. Prudential Property and Cas. Ins. Co.*, 437 Pa.Super. 108, 649 A.2d 680, 688 (Pa.Super. 1994) (quoting from Black's Law Dictionary; further citations omitted).

To recover for bad faith, a plaintiff must demonstrate, by clear and convincing evidence, “that the defendant did not have a reasonable basis for denying benefits under the policy and that defendant knew or recklessly disregarded its lack of reasonable basis in denying the claim.”<sup>142</sup> The conduct described above meets this standard.

Furthermore, the Unfair Insurance Practices Act can be used to define what constitutes bad faith.<sup>143</sup> This further underscores the applicability of bad faith, to the insurance conduct referred to above.

The archetypal bad faith claim is a claim pursued by an insured, and the application of this statute to potential claims by the Commonwealth is problematic. Pennsylvania courts have generally held that in order for a plaintiff other than insured to bring a bad faith claim, the bad faith plaintiff must have received an assignment of the insured’s claims.<sup>144</sup> Based on the facts currently available, I do not believe that the Commonwealth seeks or obtains any such assignments as a matter of course. This lack of

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<sup>142</sup> Id. at 688 (citations omitted).

<sup>143</sup> *E.g.*, *Creswell v. Pa. Nat’l Mut. Ins. Co.*, 820 A.2d 172, 180 n.4 (Pa. Super. 2003) (citing *O’Donnell v. Allstate Ins. Co.*, 734 A.2d 901 (Pa. Super. 1999) (further citations omitted)); *but see* *Dinner v. USAA*, 29 Fed. Appx. 823, 2002 WL 336959 (3d Cir. 2002) (holding that the Trial Court did not abuse its discretion when it refused to permit, in a bad faith case, expert testimony regarding the UIPA and Unfair Claims Settlement Practices regulations).

<sup>144</sup> *See* *Johnson v. Beane*, 541 Pa. 449, 664 A.2d 96 (1995), *app. denied*, 788 A.2d 381 (Pa. 2001); *Marks v. Nationwide Ins. Co.*, 762 A.2d 1098 (Pa. Super. 2000); *Brown v. Candelora*, 708 A.2d 104 (Pa. Super. 1998), *app. granted*, 725 A.2d 176 (Pa. 1999).

an assignment might prevent the Commonwealth from asserting bad faith claims on behalf of its citizens or in its *parens patriae* capacity.

A broad assignment to a health care provider of a right to seek reimbursement from health insurers is sufficient to assign a statutory bad faith claim, even if the assignment does not specifically mention bad faith.<sup>145</sup> I am not currently aware, however, of any such assignment applicable to the public funders of the addiction treatment captured in the Rehabilitation Facility analysis.

On the other hand, there is nothing in the statutory language that limits recovery to insureds. The provision regarding punitive damages provides only that the Court may “[a]ward punitive damages against the insurer.”<sup>146</sup> This language pointedly does not say who is entitled to those punitive damages, and it is fair to ask whether the Commonwealth would be entitled to recover punitive damages in its own right. Such a result would be consistent with a nascent national trend, in which punitive damages are provided not to the victims of misconduct, but to some other person or entity in a position to benefit the public at large. For example, in a noteworthy HMO liability case in Ohio, the Ohio Supreme Court ruled that a significant percentage of a \$30 million punitive damages award should go to a cancer research fund.<sup>147</sup>

## **J. Breaches of Common Law Duties**

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<sup>145</sup> See *Champlost v. State Farm*, 2002 WL 31424398 (E.D. Pa. Oct. 29, 2002).

<sup>146</sup> 42 Pa. Cons. Stat. Ann. § 8371.

<sup>147</sup> *Dardinger v. Anthem Blue Cross & Blue Shield*, 98 Ohio St.3d 77, 781 N.E.2d 121 (2002).

In Pennsylvania, managed care companies owe common law duties to their insureds. "When a benefits provider, be it an insurer or a managed care organization, interjects itself into the rendering of medical decisions affecting a subscriber's care it must do so in a medically reasonable manner."<sup>148</sup> Furthermore, the Pennsylvania Superior Court has held that section 323 of the Restatement (Second) of Torts applies to managed care organizations. That section provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

- (a) his failure to exercise such care increased the risk of harm, or
- (b) the harm is suffered because of the other's reliance upon the undertaking.<sup>149</sup>

The application of these duties, and claims and causes of action for breaches of these duties, to individual insureds is settled. Furthermore, these appear to be claims and duties that could be pursued by the Commonwealth on behalf of its citizens in its *parens patriae* capacity.

The damages occasioned by these breaches, however, are not the damages captured in the Rehabilitation Facility analysis referred to above. This is because individual children did receive treatment, and (at least as reflected in the Rehabilitation

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<sup>148</sup> Shannon v. McNulty, 718 A.2d 828 (Pa. Super. 1998); *see also* McClellan v. Health Maintenance Org., 604 A.2d 1053, 1059 (Pa. Super. 1992).

<sup>149</sup> Restatement (Second) of Torts section 323; *see also* Heath v. Huth Engineers, Inc., 420 A.2d 758 (Pa. Super. 1980); Restatement (Second) of Torts § 324A (paralleling section 323, but dealing with liability to third persons).

Facility data) for the most part did not have to pay for it. For this reason, these common law duties do not appear directly applicable to an action by the Commonwealth to recover for the cost shift referred to above.

### **K. Civil Conspiracy**

To establish a claim for unlawful conspiracy, a plaintiff must establish an agreement to either commit an unlawful act or do an otherwise lawful act by unlawful means, and: (1) that the persons have combined “with a common purpose to do a lawful act by unlawful means or unlawful purpose, (2) that an overt act in furtherance of the common purpose has occurred, and (3) [that] the plaintiff has incurred actual legal damage.”<sup>150</sup>

It seems implausible that the insurance industry conduct referred to above was the result of independent action by each health insurer and managed care organization involved. This is particularly so when one considers that some managed care companies operate several different corporate managed care companies, each aimed at and operating in different parts of the market, but sometimes (apparently) sharing common practices. Magellan and Value Behavioral Health are two examples of companies that operate through different subsidiaries, but may share similar patterns of not providing treatment.

There is a relative paucity of hard facts currently available that would support a claim that different entities conspired to carry out the misconduct referred to above. However, it is quite likely that such evidence would emerge fairly early in any discovery

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<sup>150</sup> TAP II, 885 A.2d at 1140.

process, and it is also quite likely that such information might become available outside the formal discovery process. As matters now stand, however, a civil conspiracy claim may be premature.

#### **L. Pennsylvania's Prompt Payment Law**

Pennsylvania's Quality Health Care Accountability and Protection Act requires that insurers pay providers for "clean claims" within 45 days.<sup>151</sup>

The Prompt Payment Law can be, and is, enforced by the Insurance Department.<sup>152</sup>

The Pennsylvania Superior Court has held that this statute does not create a private right of action in favor of providers.<sup>153</sup> According to the Superior Court, the requirements of the statute can be enforced "by the Insurance Department, not by a private action in the courts."<sup>154</sup> The United States District Court for the Eastern District of Pennsylvania has reached a contrary result, and found that the Prompt Payment Law does create a private cause of action in favor of providers.<sup>155</sup> The Commonwealth claims discussed in this Memorandum would be filed in or appealed to the Commonwealth Court and not the Superior Court, and whether or not the Commonwealth Court would side with the Superior Court or the Eastern District is an open question.

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<sup>151</sup> See 40 Pa. Stat. Ann. § 991.2166 (hereinafter "Prompt Payment Law").

<sup>152</sup> See, e.g., the Aetna Consent Order discussed above.

<sup>153</sup> Solomon v. U.S. Healthcare, 797 A.2d 346 (Pa. Super. 2002), *app. denied*, 808 A.2d 573 (Pa. 2002).

<sup>154</sup> 797 A.2d at 353.

<sup>155</sup> Grider v. Keystone Health Plan Central, at \*28 - \*31, 2003 WL 22182905 (E.D. Pa. Sept. 18, 2003).

Section 991.2166 requires payment of “clean claims” within forty-five days.

“Clean claim” has a precise statutory definition:

“Clean claim.” A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely treatment being made on the claim.<sup>156</sup>

This definition would appear to exclude much of the cost-shifted treatment analyzed by Parente Randolph, because most of the time the shift to public funding sources occurred outside of the normal claim submission process.<sup>157</sup> On the other hand, further investigation and examination might reveal some claims that do fall within the statutory definition. This is an issue that would benefit from further inquiry.

If the Prompt Payment Law does create an applicable private cause of action, and if shifted claims are also clean claims within the meaning of the statute, there appears to be a strong argument that the Commonwealth should be permitted to pursue such claims in its *parens patriae* capacity. The most straightforward measure of damages would appear to be payment of the claims – in other words, paying now what should have been paid earlier – plus interest at 10% per annum.<sup>158</sup>

**M. The Statute of Limitations Does Not Apply to Claims Made by the Commonwealth**

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<sup>156</sup> 40 Pa. Stat. § 991.2102.

<sup>157</sup> See *supra* at n. [].

<sup>158</sup> 40 Pa. Stat. § 991.2166(b).

As a general matter, the statute of limitations for claims under the UTPCPL is six years.<sup>159</sup> The statute of limitations on a claim for unjust enrichment claim is four years.<sup>160</sup> The statute of limitations on fraud claims is two years.<sup>161</sup>

These statutes of limitations, however, do not apply to claims made by the Commonwealth. Under a doctrine known as “*nullum tempus occurrit reipublicae*,” a statute of limitations does not apply to the Commonwealth unless the statute of limitations specifically provides that it does.<sup>162</sup>

## N. ERISA Preemption

Many claims and causes of action that would otherwise be available to individual citizens are preempted under the Employee Retirement Income Security Act of 1974.<sup>163</sup> ERISA preemption, if it applies, may eliminate state-law claims and causes of action with respect to privately-purchased insurance obtained through employment (in other words, almost all privately-purchased insurance). ERISA preemption is not a barrier to the claims and causes of action discussed in this article.

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<sup>159</sup> *Gabriel v. O’Hara*, 534 A.2d 488, 491 (Pa. Super. 1987).

<sup>160</sup> *See Cole v. Lawrence*, 701 A.2d 987 (Pa. Super. 1997).

<sup>161</sup> 42 Pa. Cons. Stat. Ann. § 5524(7).

<sup>162</sup> *Department of Transportation v. J.W. Bishop & Co., Inc., et al.*, 439 A.2d 101 (Pa. 1981).

<sup>163</sup> , 29 U.S.C. §§ 1001 *et seq.* *See generally* *Aetna Health, Inc., v. Davila*, 124 S. Ct. 2488 (2004); *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000).

There are two different kinds of ERISA preemption: complete preemption, which is generally tethered to Section 502(a) of ERISA,<sup>164</sup> and express preemption under Section 514 of ERISA.<sup>165</sup>

**e) Complete preemption**

Complete preemption establishes federal jurisdiction over, and essentially eliminates, any claim that falls within the scope of ERISA's civil enforcement remedies, as established under Section 502(a) of ERISA.<sup>166</sup> Claims that are subject to complete preemption, and cases raising such claims, can be (and routinely are) removed to federal court, and state-law claims and causes of action can be (and routinely are) dismissed.

Complete preemption does not apply to the claims and causes of action set forth above, because section 502(a) provides that a "participant or beneficiary" may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."<sup>167</sup> Claims brought by the Commonwealth in its own right are not brought by a "participant or beneficiary," do not fall within the scope of section 1132(a), and are therefore not completely preempted. Further support for this proposition is found in the substantial line of authority holding that providers generally do not have independent

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<sup>164</sup> 29 U.S.C. § 1132(a).

<sup>165</sup> 29 U.S.C. § 1144.

<sup>166</sup> *See, e.g.,* Aetna v. Davila, 124 S.Ct. at 2496.

<sup>167</sup> 29 U.S.C. § 1132(a)(1)(B).

standing to pursue claims under ERISA, and that as a result a complete preemption defense is not available to such claims.<sup>168</sup>

Whether claims brought by the Commonwealth in its *parens patriae* capacity are subject to complete preemption is an open question that would benefit from further research. United States Courts of Appeals outside the Third Circuit have held that provider claims against ERISA plans, seeking reimbursement for care provided to patients under assignments provided by the patients/plan members, can be pursued under section 502(a).<sup>169</sup> For present purposes, it is sufficient to note that even if some claims are deemed to be section 502(a) claims and therefore completely preempted, that would simply transform the claims (or a subset of the claims) from state-law claims to federal ERISA claims. This forced recasting as ERISA claims may not be a desirable result for a variety of practical and legal reasons, but it would likely leave the core of the Commonwealth's damages intact.

#### **f) Section 514 Preemption**

Section 514 of ERISA<sup>170</sup> provides that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” Thus,

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<sup>168</sup> See, e.g., *Pascack Valley Hospital v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393 (3d Cir. 2004) (provider claims against ERISA plan not completely preempted), cert. denied, 126 S.Ct. 336 (2005); *Ahmad v. U.S. Healthcare*, 2005 WL 2241042 (E.D. Pa. 2005) (collecting cases).

<sup>169</sup> Cf. *Pascack*, 346 F.3d at 441-42 (refusing to decide whether assignment-based claims were completely preempted, because the ERISA plan in that case, which had the burden of establishing removal jurisdiction, had not established the presence of such assignments).

<sup>170</sup> 29 U.S.C. § 1144.

any claims that “relate to” an employee welfare benefit plan are preempted (and cannot be pursued), even if those claims are not brought by a “participant or beneficiary”.

Reams have been written about the reach of section 514. That section has been used to deprive hundreds, perhaps thousands, of litigants of any meaningful relief for managed care misconduct. It is not the purpose of this article to cover those developments in detail. A helpful overview – and a clear statement of judicial displeasure with the current state of the law in this area – is found in Chief Judge Edward Becker’s concurring opinion in *DiFelice v. Aetna*.<sup>171</sup>

In Pennsylvania clear and controlling guidance is found in the Pennsylvania Supreme Court’s decision in *Pappas v. Asbel*.<sup>172</sup> In that case, the Pennsylvania Supreme Court held that claims arising out of “mixed eligibility and treatment decisions” – decisions that involved both medical decisionmaking and some level of insurance plan administration (a determination of what is covered under the managed care plan) – were not preempted under section 514.<sup>173</sup> There is a strong argument that this mixed category includes the addiction treatment benefit decisions, and the other managed care practices, that are the subject of this article. Under *Pappas v. Asbel*, claims arising out of those decisions and practices should not be preempted.

It is far from certain that a federal court in Pennsylvania would reach the same result. A Pennsylvania state court, however, is bound by *Pappas v. Asbel*, unless and until that decision is overruled or reversed. State-law claims filed in state court would

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<sup>171</sup> 346 F.3d 442, 453 (3d Cir. 2003).

<sup>172</sup> 768 A.2d 1089 (Pa. 2001), *cert. denied*, 122 S.Ct. 2618 (2002).

<sup>173</sup> 768 A.2d at 1095.

remain in state court unless removed to federal court based on complete preemption. As set forth above, the successful removal of all claims to federal court is not a likely outcome.

It is also important to note that ERISA preemption is a tactical issue, but probably not a strategic one. ERISA preemption often effectively ends litigation pursued by individual victims of managed care misconduct, because private litigants typically are seeking compensatory and punitive damages that go above and beyond the benefit that the insurer should have provided. For example, if an HMO refuses to authorize an MRI and a patient suffers a grievous injury as a result, the patient, as a plaintiff, is not really interested in recovering the cost of the ultrasound, or in (too-late) injunctive relief requiring the insurer to cover the ultrasound. The damages discussed in this article, by contrast, are damages based on what the insurer should have covered, but did not. While ERISA preemption raises a host of tactical challenges and might require careful claim selection, it should not be a significant bar to recovery.

#### **O. State Preemption Under the HMO Act**

Pennsylvania's HMO Act includes the following provision:

(a) Except as otherwise provided in this act, a health maintenance organization operating under the provisions of this act shall not be subject to the laws of this State now in force relating to insurance corporations engaged in the business of insurance nor to any law hereafter enacted relating to the business of insurance unless such law specifically and in exact terms applies to such health maintenance organization. For a health maintenance organization established, operated and maintained by a

corporation, this exemption shall apply only to the operations and subscribers of the health maintenance organization.<sup>174</sup>

HMOs – and doubtless other insurers and managed care organizations – will claim that this language cloaks them with broad immunity.<sup>175</sup> The majority of claims and causes of action referred to above, however, are not based on laws that “specifically and in exact terms appl[y] to . . . health maintenance organization[s].” Furthermore, and more fundamentally, the protections of this section, are limited to HMOs, and would not affect claims against defendants that are not HMOs – including, most notably, behavioral health carve-out contractors.

Furthermore, even with respect to HMOs, this section may not foreclose any of the contemplated claims. Section 1560 appears to draw a clear distinction between (a) “operations and subscribers of the health maintenance organization” and (b) operations of everything else; the misconduct that is addressed in this memorandum clearly arises out of the latter, because most behavioral health and addiction treatments are managed by behavioral health carve-out organizations. The fact that an HMO might be vicariously liable for the misconduct of its chosen behavioral health carve-out contractor does not displace the statutory touchstone, which is explicitly tethered to “operations of the health maintenance organization,” and not to “operations of a behavioral health carve-out contractor”.

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<sup>174</sup> 40 Pa. Stat. § 1560(a).

<sup>175</sup> *See generally* Wirth v. Aetna, 588 Pa. 313, 904 A.2d 858 (2006); DiGregorio v. Keystone Health Plan East, 840 A.2d 361 (Pa. Super. 2003) (statutory bad faith claim against HMO preempted by Section 1560).

It also appears that most of the claims and causes of action set forth above are not “laws of this state now in force relating to insurance corporations engaged in the business of insurance . . . .” Rather, they are based on laws of more general applicability, such as the UTPCPL.

There is not a lot of decisional authority interpreting this language, however, and the most that can be said at this point is that the availability of this section to HMOs, as a defense to the claims that are contemplated above, is uncertain.

Magellan Behavioral Health merits special attention here, because Magellan, and all its affiliates, have undergone a reorganization under Chapter 11 of the Bankruptcy Code.<sup>176</sup> This essentially absolves Magellan of civil liability for most, if not all, of the damages covered in this Memorandum. For Magellan patients, the Commonwealth would have to look for recovery to the HMOs, PPOs, and traditional health insurers that contracted with Magellan, which would likely be vicariously liable, and may well be directly liable, for the cost shift attributable to Magellan.<sup>177</sup>

#### **P. A note on RICO**

The approach outlined does not rely upon, and does not require, claims based on the Racketeer Influenced and Corrupt Organizations Act (“RICO”).<sup>178</sup> RICO claims have been a staple of other broad efforts to obtain redress in the courts for industry-wide

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<sup>176</sup> In re Magellan Health Services, Inc., No. 03-40515 (Bkcty. S.D.N.Y.).

<sup>177</sup> 11 U.S.C. § 514(e) (“discharge of a debt of the debtor does not affect the liability of any other entity on, or the property of any other entity for, such debt”).

<sup>178</sup> 18 U.S.C. § 1961 *et seq.*

managed care misconduct.<sup>179</sup> While RICO claims have many powerful and widely-recognized advantages such as fee awards and provisions for treble damages,<sup>180</sup> they also bring with them a number of threshold challenges. A plaintiff needs to identify and allege, and ultimately prove, a pattern of “racketeering activities” – crimes taken from a specific list of federal crimes – and needs to identify, and describe with at least minimal detail, an “enterprise”.<sup>181</sup> These threshold inquiries and the factual and legal disputes that surround them can easily become quagmires, consuming time, money, and attention on threshold issues and diverting attention from substantive discovery.

The approach spelled out above is based on the simple fact that specific, identified treatment days should have been paid for under the applicable law and were not paid for. These are facts currently in hand or readily obtainable from treatment facilities. There is no need to develop evidence of racketeering activities, and no need to define a RICO enterprise. Discovery may well quickly reveal facts that would establish valid RICO claims, but there is no need to wait for the Commonwealth to develop or wait for such evidence before it takes affirmative steps to get its money back.

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<sup>179</sup> See, e.g., *Maio v. Aetna*, 221 F.3d 472 (3d Cir. 2000); *Klay v. Humana, Inc.*, 382 F.3d 1241 (11th Cir. 2004), cert. denied, 125 S.Ct. 877 (2005).

<sup>180</sup> 18 U.S.C. 1964(c).

<sup>181</sup> E.g., *Klay*, 382 F.3d at 1252.

## **Conclusion**

The Pennsylvania Legislature decided, when it enacted Act 106, that certain kinds of addiction treatment – including residential addiction treatment – should be covered and paid for by private insurers. The managed care industry simply ignored this mandate, and ignored it for years. As a result of this wholesale noncompliance, taxpayers ended up paying for treatment that should have been paid for by private insurers.

The extent of the problem, and the size of the cost shift, were not detected by the Department of Health's Bureau of Managed Care, which is the entity with front-line authority for regulating managed care organizations in Pennsylvania. The extent of the problem, and the size of the cost shift, were not adequately measured or fully appreciated by the Pennsylvania Insurance Department in market conduct studies. Changes in the way addiction treatment benefits are monitored and regulated in Pennsylvania might make it more likely that similarly wide-ranging violations would be promptly detected and promptly corrected in the future. These changes, however, do nothing to return funds to the public treasury.

This article has laid out a roadmap under which the Commonwealth of Pennsylvania, and in all likelihood many other jurisdictions, could recover wrongfully shifted funds, and could recover the ill-gotten gains of private MCOs that failed to comply with the law. This approach is not only fiscally responsible; it would also make tremendous strides toward ensuring that MCOs comply with mandated benefits in the future. If MCOs are aware that governments have the initiative, resources, and will to recover funds that have been wrongfully shifted to the public, the incentive to engineer or

permit such cost shifting largely disappears. It is an approach that merits serious consideration.