Marshall

THE INSURANCE FEDERATION OF PENNSYLVANIA, INC.

Public Testimony

prepared for

HOUSE JUDICARY COMMITTEE

on

House Bill 2849

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The Insurance Federation of Pennsylvania, Inc.
1600 Market Street, Suite 1520
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GOOD AFTERNOON, AND THANK YOU FOR THE OPPORTUNITY TO BE HERE TODAY. MY NAME IS SAM MARSHALL, AND I AM THE VICE PRESIDENT OF THE INSURANCE FEDERATION. THE FEDERATION IS A NON-PROFIT TRADE ASSOCIATION REPRESENTING ALL SIZES AND SHAPES OF INSURERS DOING BUSINESS IN THIS COMMONWEALTH. OUR MEMBERS INCLUDE ALL THE TYPES OF INSURERS COVERED IN THIS BILL WITH THE EXCEPTION OF THE BLUES - MEANING THAT WE REPRESENT MANAGED CARE INSURERS, INDEMNITY GROUP AND INDIVIDUAL HEALTH INSURERS, AUTO INSURERS AND WORKERS COMPENSATION INSURERS.

PROBABLY TO NOBODY'S SURPRISE, THE FEDERATION OPPOSES THIS BILL. WHAT IS SURPRISING - AT LEAST TO ME - IS THE STRONG SUPPORT THE BILL HAS WITHIN THE PROVIDER COMMUNITY.

THE FEDERATION, ALONG WITH PROVIDERS, HAS LONG BEEN A SUPPORTER OF TORT REFORM, AND SPECIFICALLY MEDICAL MALPRACTICE REFORM. TO THAT END, WE HAVE SUPPORTED THE MALPRACTICE REFORMS PASSED BY THE HOUSE EARLIER THIS YEAR IN SENATE BILL 790. YES, WE OPPOSE THE BILL'S ARBITRARY 10% RATE ROLLBACK ON MALPRACTICE INSURANCE RATES, AND WE WOULD OPPOSE SUCH AN ARBITRARY ROLLBACK ON PROVIDERS' RATES, TOO. BUT WE HAVE BEEN STRONG SUPPORTERS OF THE TRUE TORT REFORMS IN THAT BILL.

AMONG THOSE REFORMS IS A LIMIT ON PUNITIVE DAMAGES. FIRST, THE BILL IMPOSES A SIGNIFICANTLY HIGHER THRESHOLD OF PROOF THAN NOW EXISTS; SECOND, IT LIMITS THOSE DAMAGES TO 200% OF THE COMPENSATORY DAMAGES; AND THIRD, IT IMPOSES SANCTIONS ON THOSE WHO FAIL IN

CLAIMING SUCH DAMAGES. WE BELIEVE, AS DOES THE PROVIDER COMMUNITY, THESE ARE REASONABLE LIMITS IN THE EFFORT TO BRING MEDICAL MALPRACTICE, AND THE RELATED COSTS IT PLACES ON THE HEALTH CARE SYSTEM AND ON THOSE WHO USE AND PAY FOR IT, UNDER CONTROL.

NOW LET'S TAKE A LOOK AT THIS BILL, SPECIFICALLY SECTION (B) ON DAMAGES. WHENEVER AN INSURER IS FOUND TO BE WRONG IN A QUESTION OF MEDICAL NECESSITY, SECTION (B) IMPOSES TREBLE DAMAGES PLUS 12% INTEREST PLUS THE COSTS OF ANY CHALLENGE PLUS ALL ATTORNEY FEES.

MAKE NO MISTAKE, THESE ARE PUNITIVE DAMAGES. THEY ARE CONSIDERABLY MORE GENEROUS THAN THE PUNITIVE DAMAGES ALLOWED IN SENATE BILL 790: THERE, THE CAP IS 200%; HERE IT IS 300% PLUS INTEREST PLUS COSTS PLUS ATTORNEY FEES. THE PUNITIVE DAMAGES HERE ARE ALSO MORE EASILY AWARDED THAN THOSE IN SENATE BILL 790: THERE, YOU NEED "CLEAR AND CONVINCING EVIDENCE" OF "OUTRAGEOUS CONDUCT," WITH THE SPECIFIC RESTRICTION THAT GROSS NEGLIGENCE ALONE WILL NOT BE ENOUGH. HERE, YOU NEED ONLY SHOW THAT THE CARE WAS MEDICALLY NECESSARY, AS MEASURED BY A SUBJECTIVE RATHER THAN OBJECTIVE STANDARD, AND THAT PAYMENT WAS DENIED.

I DON'T THINK IT IS RIGHT FOR A PROFESSION TO CALL FOR TORT REFORM TO REDUCE ITS OWN LIABILITIES WHILE AT THE SAME TIME CALL FOR THE EXPANSION OF THE TORT SYSTEM TO EXPAND THE LIABILITIES OF THOSE WHO PAY IT. IT MAY BE NATURAL, BUT IT ISN'T RIGHT.

I HOPE THE PROVIDERS WHO ARE ATTEMPTING TO STRADDLE BOTH SIDES OF THIS FENCE COME DOWN ON THE SIDE WHERE WE, THEY AND MANY OTHERS CONCERNED WITH THE EXISTING TORT SYSTEM ARE - FOUR-SQUARE IN FAVOR OF REFORMS THAT WILL LIMIT, NOT EXPAND, TORT EXPOSURE AND THE DRAIN IT PUTS ON OUR ECONOMY.

I SUPPOSE SOMEBODY COULD ARGUE THAT FAVORING THE TORT RESTRICTIONS IN SENATE BILL 790 IS NOT INCONSISTENT WITH FAVORING THE TORT EXPANSION IN THIS BILL. THEY COULD CONTEND THAT MEDICAL MALPRACTICE IS A RUN-AWAY TRAIN THAT IS HURTING EFFORTS TO PROPERLY AND ECONOMICALLY TREAT PATIENTS, AND THAT IS WHY TORT RESTRICTIONS ARE NEEDED. ON THE OTHER HAND, THE ARGUMENT COULD GO, CLAIM DENIALS BECAUSE OF INCORRECT DETERMINATIONS OF MEDICAL NECESSITY ARE A RUN-AWAY TRAIN IN THE OPPOSITE DIRECTION, WITH EXPANDED TORT LIABILITY NEEDED TO BRING THEM UNDER CONTROL.

THE PROBLEM WITH THIS ARGUMENT IS THAT THERE IS NO RUN-AWAY TRAIN WITH RESPECT TO CLAIM DENIALS BECAUSE OF QUESTIONS OF MEDICAL NECESSITY. TO THE CONTRARY, MANY STUDIES SHOW THAT THERE IS A REAL PROBLEM WITH EXCESSIVE CARE IN THIS COMMONWEALTH AND THIS COUNTRY, AND THERE IS A REAL NEED FOR INSURERS AND OTHERS WHO PAY FOR HEALTH CARE TO BE VIGILANT IN FERRETING OUT EXCESSIVE AND UNNECESSARY CARE. THAT IS ONE REASON WHY MANAGED CARE HAS WORKED AT HOLDING DOWN COSTS; IT IS ONE REASON THE AUTO AND WORKERS COMPENSATION REFORMS HAVE WORKED IN HOLDING DOWN THE COSTS OF THOSE COVERAGES.

THE RECORD IS ALSO CLEAR THAT THE DENIALS OF MEDICALLY UNNECESSARY CARE HAVE NOT HURT THE WELL-BEING OF PATIENTS OR THE AVAILABILITY OF CARE TO THEM - WHICH SHOULD, I THINK, BE THE CORNERSTONE OF YOUR DELIBERATIONS.

THAT IS NOT TO SAY THAT IF AN INSURER DENIES A CLAIM ON THE BASIS OF MEDICAL NECESSITY, AND IF THAT DENIAL IS OUTRAGEOUSLY, DELIBERATELY WRONG, IT SHOULD NOT BE SUBJECT TO HEIGHTENED DAMAGES. I THINK THOSE DAMAGES ALREADY EXIST IN THE FORM OF THE UNFAIR INSURANCE PRACTICES ACT, WHERE THE INSURANCE DEPARTMENT HAS THE POWER TO SIMPLY PUT A COMPANY OUT OF BUSINESS IF ITS CLAIMS HANDLING FALLS INTO THIS CATEGORY.

IT MAY ALSO BE THAT A DAMAGE STANDARD SIMILAR TO THAT ESTABLISHED IN SENATE BILL 790 WOULD BE APPROPRIATE HERE. BUT THERE IS NO JUSTIFICATION FOR PROVIDERS TO IMPOSE ON INSURERS THE ENORMOUS SANCTIONS OF THIS BILL WHILE WANTING THE REDUCED STANDARDS OF SENATE BILL 790 ON THEIR OWN CONDUCT.

THERE IS ALSO NO JUSTIFICATION FOR THE ONE-SIDED NATURE OF THE DAMAGES SOUGHT IN THIS BILL. IF THE INSURER AND THE PROVIDER HAVE A GOOD FAITH DISPUTE ON A QUESTION OF MEDICAL NECESSITY AND IT TURNS OUT THE INSURER IS WRONG, ALONG COME THE PUNITIVE DAMAGES. ON THE OTHER HAND, IF THE PROVIDER TURNS OUT TO BE WRONG, THERE IS NOTHING EXCEPT NON-PAYMENT FOR UNNECESSARY TREATMENT - HARDLY A

PENALTY. I DON'T THINK PUNITIVE DAMAGES FOR GOOD FAITH DISPUTES ARE FAIR TO ANY PARTY - BUT IF THE BILL IS GOING TO IMPOSE THEM, IT AT LEAST SHOULD DO SO EVENLY.

I REALIZE THAT THE BILL DOES MORE THAN IMPOSE "BAD FAITH" DAMAGES ON INSURERS RAISING A GOOD FAITH DISPUTE. MOST IMPORTANT, IT SEEKS TO IMPOSE A UNIFORM STANDARD ON WHAT IS MEDICALLY NECESSARY CARE.

WE APPRECIATE THE NEED TO ADDRESS THE PROBLEM OF SETTING UNIFORM, UNDERSTANDABLE PARAMETERS FOR DETERMINING WHETHER A PROVIDER'S SERVICES ARE MEDICALLY NECESSARY. AS INSURERS, OUR COMMITMENT IS TO PAY FOR MEDICALLY NECESSARY CARE - NO MORE, BUT ALSO NO LESS - AND TO DO THIS AS EFFICIENTLY AS POSSIBLE. CERTAINLY, THE CONSTANT DEBATE BETWEEN PROVIDER AND INSURER DOESN'T HELP; NOR DO UNEVEN STANDARDS - WHICH ARE ALWAYS PERCEIVED AS BEING AMONG INSURERS, BUT ALSO EXIST AMONG PROVIDERS.

I DOUBT THIS IS BEST DONE BY STATUTE. AFTER ALL, IF STATUTES SOLVED ALL AMBIGUITIES, THERE WOULDN'T BE THE NEED FOR LAWYERS.

THE PROBLEM IS THAT THE REVIEW OF MEDICAL NECESSITY IS INHERENTLY A CASE-BY-CASE REVIEW. YES, THERE ARE STANDARD PROTOCOLS THAT BOTH INSURERS AND PROVIDERS CAN (AND DO) USE. BUT THERE IS ALSO THE NEED FOR JUDGMENT, BOTH BY THE PROVIDER AND THE INSURER. TO THAT END, WE NEED BETTER DIALOGUE BETWEEN THE TWO PROFESSIONS MORE THAN

WE NEED ANOTHER ACT AND ANOTHER CAUSE OF ACTION. THAT, OF COURSE, IS PRECISELY THE GOAL OF MANAGED CARE PROGRAMS, WHERE NETWORK PROVIDERS PARTICIPATE AS PART OF THE PROGRAM IN ESTABLISHING GENERAL GUIDELINES AND REVIEWING INDIVIDUAL CASES.

I WILL SAY THAT THIS BILL'S STANDARDS FOR DETERMINING "MEDICAL NECESSITY" IN THIS BILL HAVE MERIT. A COUPLE OF CONCERNS, HOWEVER: FIRST, THE BILL EXCLUDES TREATMENT THAT IS SOLELY FOR PURPOSES OF RESEARCH, EXPERIMENT OR EDUCATION. THAT COULD BE UNDULY LIMITING - SINCE IT ARGUABLY WOULD ALLOW FOR TREATMENT THAT IS PRIMARILY (OR EVEN 99%) EXPERIMENTAL AND THE LIKE.

SECOND, THE STANDARDS MUST RECOGNIZE THAT SOME TYPES OF INSURERS HAVE TO MAKE DECISIONS OF CAUSALITY IN REVIEWING A CLAIM. FOR INSTANCE, AN AUTO INSURER PAYING FOR A TREATMENT OF A BAD BACK MUST DETERMINE WHETHER AND HOW MUCH OF THE INJURY IS ATTRIBUTABLE TO THE AUTO ACCIDENT. I THINK THIS IS WHAT THE BILL IS DRIVING AT IN ALLOWING INSURERS TO NOT PAY FOR TREATMENT THAT IS PROPERLY EXCLUDED FROM THE POLICY, BUT THIS COULD BE MORE CLEARLY STATED.

THIRD, THE STANDARDS SHOULD BE AS OBJECTIVE AS POSSIBLE. WHO IS THE ONE WHO WOULD "REASONABLY EXPECT" THAT CARE WILL HELP THE PATIENT? IS IT ONLY THE PARTICULAR PROVIDER, THOSE OF HIS SPECIALTY OR THOSE OF THE SPECIALTY THAT TYPICALLY MANAGES THE CONDITION BEING TREATED?

THE BILL ALSO GOES INTO THE UTILIZATION REVIEW PROCESS BY REQUIRING THAT "ALL RELEVANT CLINICAL DATA" OF THE PATIENT "AS A WHOLE" BE REVIEWED, AND BY REQUIRING THAT FINAL DETERMINATIONS BE MADE ONLY BY PROVIDERS IN THE SAME SPECIALTY AS THOSE UNDER REVIEW.

AS A GENERAL COMMENT, I THINK THE ISSUES RELATED TO UTILIZATION REVIEW ARE SUFFICIENTLY COMPLEX TO MERIT THERE OWN BILL. THIS HAS ALREADY BEEN DONE BY REPRESENTATIVE VANCE IN A BILL THAT HAS HAD SEVERAL HEARINGS BEFORE THE HOUSE INSURANCE COMMITTEE.

AS TO THE SPECIFIC REQUISITES HERE: WE SUPPORT A UTILIZATION REVIEW REQUIREMENT THAT DENIALS OF MEDICAL NECESSITY BE MADE BY LICENSED PROVIDERS OF THE SAME OR SIMILAR SPECIALTY AS TYPICALLY MANAGES THE CARE UNDER REVIEW. THIS IS A MORE OBJECTIVE STANDARD THAN HERE, AND WE RECOMMEND IT BE ADOPTED.

I AM NOT SURE WHAT IS MEANT BY ALL RELEVANT DATA OF THE PATIENT'S CONDITION AS A WHOLE. THIS MAY INUNDATE THE REVIEW PROCESS WITH MORE PAPER THAN IS NEEDED, AS IT MAY REQUIRE THE RECORDS FROM A PATIENT'S OTHER PROVIDERS. IN ANY EVENT, GIVEN THE TIME CONSTRAINTS THAT ARE ON INSURERS USING UTILIZATION REVIEW, ESPECIALLY IN AUTO AND WORKERS COMPENSATION, IT MAKES SENSE TO AT LEAST IMPOSE SOME TIME CONSTRAINTS ON PROVIDERS SUBMITTING THIS DATA - AS WELL AS THE REQUIREMENT THAT THEY SUBMIT ALL OF IT WHEN ASKED.

FINALLY, ONE DRAFTING GLITCH: THE BILL DEFINES THE "HEALTH INSURANCE POLICIES" IT INTENDS TO COVER AS GROUP POLICIES. THAT WOULD LEAVE OUT ALL INDIVIDUAL HEALTH POLICIES AND ALL AUTO POLICIES. WHILE I DO NOT WANT THE BILL TO APPLY TO ANY INSURANCE POLICY, I BELIEVE ITS INTENT IS TO COVER INDIVIDUAL AND AUTO POLICIES. FURTHER, THIS DEFINITION SHOULD EXCLUDE SUCH POLICIES AS MEDICARE SUPPLEMENT, HOSPITAL INDEMNITY AND OTHER "FIXED COST" OR PER DIEM COVERAGES - WHERE QUESTIONS OF MEDICAL NECESSITY DO NOT ARISE IN THE FIRST PLACE.

AGAIN, THANK YOU FOR THE OPPORTUNITY TO BE HERE TODAY. I AM HAPPY TO ANSWER ANY QUESTIONS YOU HAVE.