DANIEL F. CLARK, MEMBER
HOUSE P.O. BOX 202020
ROOM 401 SOUTH OFFICE
HARRISBURG, PA 17120-2020
PHONE: (717) 783-7830
FAX: (717) 783-3899

TUSCARORA MOTOR INN OFFICES
P.O. BOX 225
MIFFLINTOWN, PA 17059
PHONE: (717) 436-6002

31 WEST THIRD STREET
LEWISTOWN, PA 17044
PHONE: (717) 242-2141

9 SOUTH MAIN STREET
P.O. BOX 292
MIDDLEBURG, PA 17842
PHONE: (570) 837-1414

House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

COMMITTEES

JUDICIARY
MAJORITY SUB-COMMITTEE
CHAIRMAN ON COURTS
COMMERCE AND ECONOMIC DEVELOPMENT
ENVIRONMENTAL RESOURCES AND ENERGY

THE PENNSYLVANIA HOUSE OF REPRESENTATIVES
JUDICIARY COMMITTEE
SUBCOMMITTEE ON COURTS HEARING
ON HOUSE BILL 710
THURSDAY, JANUARY 20, 2000
DOBBIN HOUSE
89 STEINWEHR AVENUE
GETTYSBURG, PA 17325

AGENDA

10:00 A.M.	The Honorable Albert Masland 199th Legislative District
10:10 A.M.	The Honorable Mike Fisher Attorney General - Commonwealth of Pennsylvania
10:30 A.M.	John C. Eline Vice President - Gettysburg Hospital
11:00 A.M.	Samuel R. Marshall President & CEO - Insurance Federation of Pennsylvania, Inc.
11:30 A.M.	Ross F. Schriftman Legislative Chair - Pennsylvania Association of Health Underwriters
12:00 NOON	David Masur State Director - Pennsylvania Public Interest Research Group
12:30 P.M.	Kenneth P. Smith President - Independent Insurance Agents of Pennsylvania

SUBCOMMITTEE ON COURTS HEARING

January 20, 2000

1:00 P.M.	Gregory B. Heller, Esquire Litvin, Blaumberg, Matusow, & Young
	Lauren Townsend, Executive Director Citizens for Consumer Justice
1:30 P.M.	Deb Beck President - Drug and Alcohol Service Providers of Pennsylvania

PRINTER'S NO. 748

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 710 Session of 1999

INTRODUCED BY MASLAND, L. I. COHEN, YOUNGBLOOD, THOMAS, ARMSTRONG, BELARDI, STURLA, PESCI, CURRY, CLARK, BARD, BARRAR, CLYMER, M. COHEN, DeWEESE, FREEMAN, GANNON, GORDNER, HARHAI, HENNESSEY, HORSEY, JOSEPHS, LAUGHLIN, MAHER, MANDERINO, MICHLOVIC, ORIE, PLATTS, SAINATO, SEMMEL, SERAFINI, S. H. SMITH, SOLOBAY, STEELMAN, STERN, SURRA, E. Z. TAYLOR, TRELLO, VAN HORNE, WALKO AND WILT, MARCH 2, 1999

REFERRED TO COMMITTEE ON JUDICIARY, MARCH 2, 1999

AN ACT

Amending Title 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, providing for health insurer liability.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Title 42 of the Pennsylvania Consolidated Statutes is amended by adding a section to read:

§ 8313. Health insurer liability.

(a) General rule.--Whenever a health insurer fails to conform with accepted standards of medical practice in supervising, managing, approving or providing, in a timely manner or otherwise, any health care service to the extent the health insurer is legally required to do so, the health insurer shall be liable for any personal injury, death or other damages caused by that failure.

(b) Causation.--The failure of an enrollee entitled to a health care service, or any other person responsible for acting on the enrollee's behalf, to seek an alternative health care provider for, to pay for or to otherwise obtain the service irrespective of a health insurer's failure under subsection (a) shall not diminish the health insurer's liability for any reason, including, but not limited to, lack of causation, contributory negligence and assumption of the risk.

(c) Patient advocacy.--No health insurer may remove a health care provider from its health care plan or refuse to renew a health care provider with its plan because the health care provider advocates a health care service for an enrollee that conforms with accepted standards of medical practice.

(d) Indemnification.--No contract between a health insurer and a health care provider may contain any language that purports to transfer to the health care provider, through an indemnification requirement or otherwise:

(1) any liability of the health insurer or an employee, agent or independent contractor of the health insurer; or

(2) any responsibility to defend or pay for the costs of defending a claim that asserts such a liability.

(e) Assignment or delegation.--A health insurer shall remain liable under this section regardless of whether the health insurer assigns or delegates the supervision, management, approval or provision of a health care service to a third party administrator, a utilization review organization, an integrated delivery system or any other person or organization.

(f) Health care services covered.--Nothing in this section shall be construed as requiring a health care insurer to approve, supervise, manage or provide any health care service

that is not covered by the health care plan applicable to the enrollee.

(g) Litigation rights.--No health care insurer shall limit the right of an enrollee to enforce a right or responsibility arising under this section in a court of competent jurisdiction. Nothing in this section shall impair the right of an enrollee, health insurer or health care provider to a trial by jury.

(h) Other remedies.--Nothing in this section shall limit any other right, remedy or cause of action that an enrollee may otherwise have under the laws of this Commonwealth.

(i) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Enrollee." An individual who is enrolled in a health care plan of a health care insurer. The term also includes any dependents of that individual who are covered by the plan.

"Health care provider." An individual or entity who is licensed, certified or otherwise regulated to provide health services under the laws of this Commonwealth, including, but not limited to, a physician, dentist, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, chiropractor and hospital or other health facility. The term also includes an entity that legally contracts to deliver health care services, including, but not limited to, a professional corporation or partnership, an independent practice association and an integrated delivery system of health care providers.

"Health insurer." An entity that provides medical insurance coverage on an expense-incurred, service or prepaid basis. The term includes, but is not limited to, the following:

(1) A stock or mutual insurance company subject to the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) A risk-bearing preferred provider organization subject to section 630 of The Insurance Company Law of 1921.

(3) A health maintenance organization subject to the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(4) A hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(5) A professional health service plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(6) A fraternal benefit society subject to the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(7) A worker's compensation insurer subject to the act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

(8) A motor vehicle insurer subject to 75 Pa.C.S. Ch. 17 (relating to financial responsibility).

(9) Any person subject to a successor act of any of the foregoing.

Section 2. This act shall take effect in 60 days.

HOUSE OF REPRESENTATIVES
REPUBLICAN CAUCUS

BILL SUMMARY

DATE: 4/7/99

COMMITTEE: Judiciary

BILL NO.: HB 710

PRIME SPONSOR: Masland

PRINTER'S NO.: 748

PREPARED BY: Karen L. Dalton

PHONE NO.: 7-8989

A. PRELIMINARY SUMMARY:

HB 710 would add a section called Health Insurer Liability to the Judicial Code (Title 42 of the Pennsylvania Consolidated Statutes). Specifically, this section creates a cause of action against a health insurer which fails to conform to accepted standards of medical practice in supervising, managing, approving, or providing health care services, to the extent legally required to do so, where that failure results in personal injury, death, or other harm.

The bill also specifies that the failure of a patient entitled to a health care service to seek an alternative method of receiving or paying for health care when his own insurer has failed to provide or pay for the service will not diminish the health insurer's liability. Further, no health insurer may remove a health care provider from its plan or service because the health care provider advocates a course of treatment which conforms to accepted standards of medical practice.

Moreover, this legislation prohibits a health insurer from transferring its liability to a health care provider through an indemnification agreement. The health insurer will remain liable for its failures regardless of whether the health insurer delegates the supervision, management, approval or provision of a health care service to a third party administrator, a utilization review organization, an integrated delivery system, or any other person or organization. Similarly, no health insurer may limit the right of an enrollee to enforce a right provided under this legislation.

Finally, HB 2546 provides that its language is not to be construed as requiring a health care insurer to approve, supervise, manage or provide any health care service that is not covered by the health care plan applicable to the enrollee.

The bill defines "enrollee," "health care provider," and "health insurer" as follows:

"Enrollee." An individual who is enrolled in a health care plan of a health care insurer. The term also includes any dependents of that individual who are covered by the plan.

"Health care provider." An individual or entity who is licensed, certified or otherwise regulated to provide health services under the laws of this Commonwealth, including, but not limited to, a physician, dentist, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, chiropractor and hospital or other health facility. The term also includes an entity that legally contracts to deliver health care services, including, but not limited to, a professional corporation or partnership, an independent practice association and an integrated delivery system of health care providers.

"Health insurer." An entity that provides medical insurance coverage on an expense-incurred, service or prepaid basis. The term includes, but is not limited to, the following:

(1) A stock or mutual insurance company subject to the act of May 17, 1921 (P.L.682, No. 284), known as The Insurance Company Law of 1921.

(2) A risk-bearing preferred provider organization subject to section 630 of The Insurance Company Law of 1921.

(3) A health maintenance organization subject to the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(4) A hospital plan corporation subject to 40 Pa.C.S. Ch.61 (relating to hospital plan corporations).

(5) A professional health service plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(6) A fraternal benefit society subject to the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(7) A worker's compensation insurer subject to the act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

(8) A motor vehicle insurer subject to 75 Pa.C.S. Ch. 17 (relating to financial responsibility).

(9) Any person subject to a successor act of any of the foregoing.

B. EXISTING LAW:

Pennsylvania has no such provision in its statutes.

Currently, policy holders may take the following actions with respect to insurers:

(1) bring a common law action for breach of contract,

(2) bring a common law action for fraud and deceit,

(3) bring a declaratory judgement action under the Declaratory Judgement Act,

(4) bring an action under Pennsylvania's "Bad Faith" statute,

(5) seek an administrative remedy under the Unfair Insurance Practices Act, or

(6) bring an action under Pennsylvania's Unfair Trade Practices and Consumer Protection Law.

The remainder of this section will discuss the latter three statutes.

Pennsylvania's "Bad Faith" Statute

The General Assembly added a section to the Judicial Code entitled Actions in Insurance Policies after the Pennsylvania Supreme Court declined to recognize a common law cause of action for bad faith on the part of an insurer. See D'Ambrosio v. Pennsylvania National Mutual Casualty Insurance Company, 494 Pa.501, 431 A.2d 966 (1981).

Although there is a great deal of debate among scholars and jurists regarding whether the statute creates a new cause of action or merely provides a remedy, it is clear that the statute first requires the existence of an insurance contract. Thus, the statute states:

> In an action arising under an insurance policy, if the court finds that the insurer 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.
> 42 Pa.C.S. § 8371.

Thus, facts which actually make out a claim of bad faith are left to the development of case law.

According to one commentater, Lynette Norton, the most reasonable analysis of 42 Pa.C.S. § 8371 is that implied in all insurance contracts is a duty of good faith on the part of the insurer. A failure to deal in good faith results in a court's assessing attorney fees, punitive damages, or interest.

Elements of a claim of bad faith, thus, would be:
-- existence of an insurance contract
-- in which an insured has rights
-- conduct by the insurer in relation to that contract (either expressed or implied)
-- which intentionally or recklessly violates the standard of good faith.

Lynnette Norton, Insurance Coverage in Pennsylvania, 110 (1997).

According to the federal district court in Pennsylvania, in order for a plaintiff to prevail under 42 Pa.C.S. §8371, he must show that the insurer "did not have a reasonable basis for denying benefits under the policy and that the defendant knew or recklessly disregarded its lack of reasonable basis in denying the claim." Younis Brothers and Company. v. Cigna Worldwide Insurance Company, 899 F.Supp. 1385 (E.D.Pa. 1995). Further, in Pennsylvania, bad faith is "any frivolous or unfounded refusal to pay proceeds of a policy." Id.

The Unfair Insurance Practices Act (40 P.S. § 1171.1 et seq.)

This statute makes it unlawful for insurers to engage in unfair methods of competition or unfair or deceptive acts or practices. The list of conduct is quite lengthy, but includes these prohibitions with respect to claims handling:

(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.
(ix) Attempting to settle or compromise claims on the basis of an application which was altered without notice to or knowledge or consent of the insured of such alteration at the time such alteration was made.
(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.
(xi) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants to induce or compel them to accept settlements or compromises less than the amount awarded in arbitration.
(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. 40 P.S. § 1171.5

Under the statute, the Insurance Commissioner is given the authority to investigate the affairs of every person engaged in the business of insurance in order to determine if that person has violated the act. 40 P.S. § 1171.7. If, after a hearing, it is determined that the person has acted unlawfully,the commissioner may issue a cease and desist order or may suspend or revoke the license. 40 P.S. § 717.9. In addition, the commissioner may seek the imposition of fines by a court. 40 P.S. § 1171.11.

The Unfair Trade Practices and Consumer Protection Law (CPL) (73 P.S. § 201-7 et seq.)

There is case law which holds that policy holders may sue an insurance company in violation of the Unfair Trade Practices and Consumer Protection Law, even though the statute does not specifically include insurers. Pekular v. Eich, 355 Pa. Super. 2376, 513 A.2d 427 (1986), stands for the proposition that: (1) insureds, like any other consumer, may proceed under the CPL and, (2) the Unfair Insurance Practices Act is not the sole remedy with respect to the unscrupulous acts of insurance companies and their agents. Id.

KLD:cmw