Testimony of Greg Heller before the Judiciary Committee
of the Pennsylvania House of Representatives

Hearings on House Bill No. 710,
Session of 1999

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First, I would like to thank the Committee for allowing me to testify, and I would like to thank Representative Masland and the other sponsors of the bill for introducing this important legislation. This is a good bill, and I would like to tell you why.

I would like to start with a brief look at where the law stands now. In *Shannon v. McNulty*, the Pennsylvania Superior Court held, in essence, that general principles of responsibility and accountability apply to the managed care industry. The *Shannon* court did not so much create new law, as hold that the managed care insurance industry is not immune from these longstanding principles. If a company is being paid to do something that is necessary for someone's safety, it must exercise reasonable care when it carries out those tasks. Or to put it slightly differently, the law recognizes the central role that managed care organizations play in the delivery of medical care to insureds. With this role comes a corresponding duty, and like all duties in our system of private rights and remedies, a breach of this duty gives rise to a remedy. *Shannon* got it right, and was a considerable step toward ensuring that insurance companies cannot, in their pursuit of medical control and ultimately profits, ignore the health of Pennsylvania citizens. The Pennsylvania Supreme Court's decision in *Pappas v. Asbel*, while

nominally an ERISA preemption case, is another extremely helpful confirmation of these basic principles of responsibility.

But I don't think these decisions are enough to secure the rights and health of Pennsylvania citizens.

For one thing, *Shannon* is a Superior Court opinion, not a Supreme Court decision. The case is currently before the Pennsylvania Supreme Court. While there is every reason to be hopeful that the Supreme Court will once again recognize the right to a remedy in these circumstances, particularly in light of the Court's analysis in *Pappas*, this is by no means assured. I submit that it would not be at all inappropriate, in an issue that so directly affects the lives of so many Pennsylvanians, for the legislature to remove any possible doubt, and confirm that managed care companies, just like anyone else, can and will be held accountable for misconduct that harms people.

H.B. 710 will also clear up a number of areas that are, at least in the eyes of the managed care industry, unsettled.

Perhaps most significantly, this bill will definitively answer the managed care industry's continued contention – even after *Shannon* and *Pappas* – that non-HMO managed care insurers simply provide reimbursement for services, and do not affect patient care. I have never found this argument credible, or even a little

bit persuasive. If the apparatus of utilization review, patient care management – whatever you want to call it – did not affect care and the costs of care, why would these very very smart companies have these systems in place? It seems obvious to me that their entire purpose is to control costs and control care.

For a long time, this position by the managed care industry struck me primarily as an annoyance. Courts have generally not accepted the argument, at least in recent decisions, and the argument was simply an argument that I needed to respond to. Over time, however, the vehemence and persistence of the argument by the managed care industry gave rise to a different view, one that is considerably more troublesome. What I came to realize was that the managed care industry, or at least an important part of it, might believe this argument. Think about this. People in positions of power and authority within managed care organizations might really believe that when they refuse to authorize a particular treatment - for example, refusing to authorize an MRI for a patient with an aneurysm – this will not directly affect patient care. How can we possibly expect the industry to act responsibly, when they do not admit the obvious reality that their actions have real and immediate effects on patient care? H.B. 710 would send an important and unequivocal message that the law, and the courts, will continue to respect the realities of medical care, and will simply not accept the

industry's evasive and formalistic sophistry.

There are a number of other areas in which H.B. 710 provides considerable help and support to Pennsylvania insureds. Each of these is, in a way, like my prior point: I personally believe that the current law is more than adequate to the task, but I am concerned that the managed care industry will take, or will continue to take, a different view. The issue is not so much that the managed care industries makes the arguments I am about to mention, but that the industry might really believe them. The more firmly the industry believes their own arguments, the more important a strong and unequivocal statement from the legislature is in order.

H.B. 710 talks about a managed care standard of care -- in particular, "accepted standards of medical practice in supervising, managing, approving or providing, in a timely manner or otherwise, any health care service . . . ." The language of *Shannon* and *Pappas* and other managed care cases is, to a large extent, the language of medical malpractice. For reasons primarily related to federal preemption, many of the current decisions speak of medical negligence and a medical standard of care. While this terminology is accurate, it is also, in a way, incomplete. The day-to-day difficulties confronted by insureds are sometimes far removed from a real doctor, even a real insurance company doctor,

making a medical decision. Often, administrative hassles and administrative burdens are a considerable part of the reason why a patient does not receive treatment. Phone calls aren't returned. Faxes gets lost. The customer service representative is always out to lunch, or has just left for the day, or is somehow unavailable. There are repeated requests for redundant and irrelevant information. And after a point, people simply get worn down. I have heard that the insurance industry has a word for this – they apparently call it the "hassle factor." I don't think anyone can fairly dispute that experiences like these are not at all uncommon, for both providers and insureds. At some point, a managed care company's indifference to the hassle factor, and its creation and maintenance of an insuperable and inescapable bureaucratic maw, can result in a failure to obtain care that is every bit as effective as an HMO doctor's medical decision. From the managed care industry's standpoint this can be a real windfall: the patient might -- and I believe often does -- simply become exhausted and go away. H.B. 710 will confirm that managed care companies need to recognize, and take proper account of, this reality; and will confirm that managed care companies need to act not just as responsible doctors, but also as responsible insurance companies, treating their insureds with fairness and respect.

Section (b) prevents managed care companies from blaming the patient.

Under current law, an insurance company might argue that even though it did not approve care, the patient could have paid for the care themselves. I don't think this argument is fair or appropriate. The assurance that needed medical care will be provided is the reason people have insurance in the first place. This insurance company view is also, by the way, inconsistent with reality. Some healthcare providers, and for extensive procedures probably most healthcare providers, will simply not accept direct patient payment from average citizens. Section (b) will prevent insurance companies from raising this argument as a defense.

Section (d) will render indemnification agreements invalid. Under such agreements, medical care providers might have to reimburse an insurance company, even if the insurance company was at fault. This kind of side deal would violate the simple and fundamental principle of responsibility expressed in *Shannon v. McNulty*. This part of the bill would remove any doubt on the issue, and provide unequivocal legislative confirmation that such efforts to sidestep responsibility are invalid and inappropriate.

Section (e) reflects and guarantees this same core principle of responsibility, by preventing insurance companies from sidestepping responsibility by contracting away their duties. Managed care companies often delegate decision making responsibility to another corporation or entity, and then attempt to place

the blame elsewhere when a mistake is made. I believe this is particularly common in the area of mental health. This is, by the way, something we have also seen with doctors – the managed care industry will impose all manner of incentives and restrictions to affect doctors' decisions, and then step aside and leave the physicians solely responsible for the consequences of those decisions. H.B. 710 will prevent the managed care industry from believing it can avoid this responsibility through clever contracting.

Finally, I would like to address section (g), which talks about litigation rights. This provision would invalidate arbitration agreements. The right of access to the courts, and the access to fair, impartial, and complete civil justice, is one of our most important civil rights. This right has been protected by the Courts, and I cannot say that this provision is necessary or would add to the law. But it would send a clear and convincing signal to the managed care industry, that they cannot attempt to place themselves beyond the reach of the law.