[J-94-2008] [M.O. - McCaffery, J.]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

THE INSURANCE FEDERATION OF PENNSYLVANIA, INC.; THE MANAGED CARE ASSOCIATION OF PENNSYLVANIA; AETNA HEALTH, INC.; HEALTHASSURANCE PENNSYLVANIA, INC.; INDEPENDENCE BLUE CROSS; MAGELLAN BEHAVIORAL HEALTH, INC.; AND VALUEOPTIONS, INC.	:	No. 89 MAP 2007
	:	Appeal from the Order of Commonwealth Court entered on 7/26/07 at No. 10 MD 2004 which denied the motion for judgment on pleadings filed by Insurance Federation of PA and granted the pleadings filed by the Pennsylvania Insurance Department
v.	:	
COMMONWEALTH OF PENNSYLVANIA, INSURANCE DEPARTMENT	:	
APPEAL OF: THE INSURANCE FEDERATION OF PENNSYLVANIA	:	
	:	ARGUED: May 14, 2008

DISSENTING OPINION

MR. JUSTICE SAYLOR **Decided: May 27, 2009**

I respectfully dissent. Initially, I agree with the Insurance Federation's core position that Act 106, on its face, does not foreclose utilization review. In this regard, I do not believe that the Legislature's decision to mandate coverage in the abstract, see 40 P.S. §908-2 (requiring that certain insurance policies "include within the coverage [certain] benefits for alcohol or other drug abuse and dependence"), equates to an express prohibition against implementing the required benefits within the terms of the insurer's pre-existing business model. Indeed, having enacted legislation to encourage

managed care practices as a method by which quality health care can be provided on a cost-effective basis,[1] it does not seem likely that the General Assembly would have acted to foreclose such review relative to particular benefits without some form of express indication. Moreover, when the General Assembly expressly accepted utilization review within consumer-protection legislation as a staple of the cost-containment objective of managed care in Act 68,[2] it specifically barred Act 68 from applying within the framework of an enumerated list of existing enactments and programs, but omitted Act 106 from that list. See 40 P.S. §991.2192. Indeed, Act 68 contemplates that under some circumstances "a licensed psychologist may perform a utilization review for behavioral health care services," 40 P.S. §991.2152(d), including treatment for drug and alcohol abuse. See Opinion Announcing the Judgment of the Court, slip op. at 11 (observing that the Department does not challenge the Federation's contention that, in the health care industry, behavioral health subsumes drug and alcohol dependency).

Although the lead opinion purports to rely on the plain terms of the statute in discerning an express indication to foreclose utilization review within the framework of Act 106 benefits, see Opinion Announcing the Judgment of the Court, slip op. at 21, I believe that its rationale, in fact, is more substantially premised on inference from the statutory language. In this regard, I differ with the lead opinion's position that because Act 106 imposes certification and referral prerequisites to obtaining care, it necessarily prohibits any other prerequisites -- or, for that matter, any concurrent or retrospective review process. More centrally, I differ with the lead opinion's position that Act 106's

[1] Act of December 29, 1972, P.L. 1701, No. 364 (as amended, 40 P.S. §§1551-1568).

[2] Act of June 17, 1998, P.L. 464, No. 68 (as amended 40 P.S. §§991.2101-991.2194).

terms imposing a requirement of certification and referral upon an insured ("Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or drug abuse dependency and refer the insured for appropriate treatment," 40 P.S. §§908-4, 908-5), amounts to an express prohibition against utilization review of medical necessity and appropriateness on behalf of the insurer. See Opinion Announcing the Judgment of the Court, slip op. at 12-13. Rather, facially, the statute indicates only that a patient cannot self-refer for such services. Furthermore, as the Insurance Federation stresses, the above-quoted provision does not contain terms in any way similar to the Department's 2003 notice declaring that "the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage [and inpatient detoxification] for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist," and "[t]he certification and referral in all instances controls both the nature and duration of the treatment." I also disagree with the suggestion that, merely because the definition of detoxification indicates that the process is to be administered by a licensed physician, the Legislature intended managed care organizations to abandon their business model and accept the unconstrained determination of any physician. See Opinion Announcing the Judgment of the Court, slip op. at 14.[3]

To bolster its position that Act 106 expressly forecloses the application of the core managed-care practice of utilization review, the lead opinion references a series of other mandatory-benefits statutes. See Opinion Announcing the Judgment of the Court,

[3] Indeed, the Department concedes that Act 106 allows for the employment of at least some managed care practices, including the requirement to use in-network providers. See Brief for the Department at 14.

slip op. at 15-20. Each of these, however, is materially distinct from Act 106. As to the requirements to provide benefits associated with annual gynecological examinations and mammograms, these preventative measures generally apply with respect to an entire class of individuals (women) and on a specific time table (i.e., annually). 40 P.S. §§764c, 1574.[4] Childhood immunizations are also class-wide, preventative measures following a typical regimen, unlike drug and alcohol treatment, which is specific to individual patients and has aspects that are substantially remedial. The operation of the statute requiring coverage for inpatient care for new mothers is, again, a class-wide measure based upon an indisputable event, the delivery of a child. See 40 P.S. §1583(a). Finally, the statute requiring the provision of insurance coverage for inpatient care related to mastectomies and breast cancer reconstruction specifically designates that length of stay is determined by the "treating physician," 40 P.S. §764d(a)(2, 3), thus expressly foreclosing utilization review. I agree with the Insurance Federation that the language contained in this statute demonstrates that the Legislature knows how to place the judgment as to medical necessity and duration of treatment expressly and

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[4] With regard to mammograms for women under the age of forty, the mandate for coverage is specifically based on "a physician's recommendation," 40 P.S. §764c, also clearly foreclosing utilization review upon such a recommendation.

Responsively, the lead opinion stresses its finding of a parallel between Section 764c's requirement of mammogram coverage for women under forty "based on a physician's recommendation," 40 P.S. §764c, and Section 908-4's prescription that "[b]efore an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependence and refer the insured for the appropriate treatment." 40 P.S. §908-4. See Opinion Announcing the Judgment of the Court Opinion, slip op. at 18 n.11. The lead opinion's reasoning, however, fails to account for the very different phrasing of the two statutes, with the former specifying mandatory coverage "based on" a specific condition, and the latter being phrased as a condition precedent, without any particular indication of exclusivity.

exclusively within the hands of a treating physician. Therefore, I believe the General Assembly's failure to do so across the provisions of Act 106 supports the Federation's position that it did not manifest an intention to displace utilization review.

While I differ with the lead opinion's position that the plain language of Act 106 is conclusive, it does seem to me that there is sufficient uncertainty to warrant reference to principles of statutory construction, permitting consideration of, inter alia, the occasion and necessity of the statute; the object to be attained; the consequences of a particular interpretation; the contemporaneous legislative history; and administrative interpretations of the statute. See 1 Pa.C.S. §1921(c). The legislative history of Act 106 reflects the concern of legislators with the treatment of those suffering from alcohol- and drug-related addictions, as well as the alleviation of attendant social problems. However, it also reflects regard for cost control and the burden imposed on insurance companies. See, e.g., Pa. Leg. Journal - House 1945-50 (November 29, 1989). Notably, there is no indication in the statute or in the legislative history that the Legislature designed for insurance companies to fund treatment that is not medically necessary or appropriate. Accordingly, to the degree that managed care organizations maintain appropriate criteria for medical necessity and appropriateness, I do not regard the application of utilization review as fundamentally inconsistent with Act 106. Furthermore, as the Insurance Federation develops in its reply brief, the Legislature has otherwise imposed checks on utilization review designed to facilitate fairness, accuracy, and accountability in the utilization review process.[5]

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[5] The Quality Health Care Accountability and Protection Act requires managed care plans to "[a]dopt and maintain a definition of medical necessity used by the plan in determining health care services," 40 P.S. §991.2111(3), and provide to each enrollee a written "summary of the plan's utilization review policies and procedures," id., §991.2136(a)(7). Further, the statute provides for the certification of utilization review organizations and operational guidelines for those organizations, id., §§991.2151-2152, (continued . . .)

Running throughout the Department's brief, and to some degree incorporated into the lead opinion, is a suggestion of distrust of managed care organizations and the utilization review process in terms of the willingness to make fair and valid determinations concerning medical necessity and appropriateness, as well as a lack of confidence in the existing checks to ensure such fairness and validity.[6] This apparent mistrust, at least in its present degree, seems to be a relatively recent development, as it appears that the Insurance Department acceded in the provision of Act 106 benefits within the terms of the managed care business model for fourteen years after passage of the act, until the issuance of its 2003 notice. See, e.g., April 5, 1993 Department

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(. . . continued)
and for mandatory internal and external grievance procedures for utilization review determinations of medical necessity and appropriateness, with an ultimate right of review by a court of competent jurisdiction. Id., §§991.2161-2163.

[6] See Brief for the Department at 19 (indicating that utilization review may be used to "override the prescription of a licensed medical professional" made on the basis of medical necessity); id. at 14 ("The Appellant Federation is trying to turn a mandated benefit into a discretionary benefit."); id. at 16 ("Under the Appellant Federation's 'theory' of statutory construction, managed care organizations could override the judgment of the General Assembly and 'manage' Act 106 benefits out of existence."); id. at 17 ("It would be a gross distortion of the meaning of Act 68 to read this statute to grant complete discretion to managed care organizations to override benefits mandated by the General Assembly for the protection of consumers."); id. at 21 ("Managed care plans and utilization review entities do not have the discretion to ignore the General Assembly's public policy choice in the delivery of Act 106 substance abuse benefits under the guise of utilization review for medical necessity."); id. at 22 ("Managed care organizations should not be permitted to abrogate a mandated benefit under the guise of 'medical necessity.'"); id. at 23 ("As the Appellant Federation would have it, the General Assembly granted unbridled discretion to managed care organizations to second-guess the judgment of certifying and referring medical professionals, leaving both access to and delivery of substance abuse benefits in doubt."); cf. Opinion Announcing the Judgment of the Court, slip op. at 13 (reflecting the concern that an interpretation of Act 106 permitting utilization review "would have the potential to weaken if not effectively eliminate the mandatory language of Act 106").

Notification, R.R. at 108a-109a (reflecting a Department notice in the context of Act 106 benefits indicating, inter alia, that "[i]t is now possible for the Department of Insurance to approve products of licensed health insurers that have pre-certification as part of the process for determining appropriateness of treatment," and that the "Department will accept filings which use managed care techniques in the treatment of substance abuse," subject to enumerated standards).[7] Were there similar misgivings manifested on the face of Act 106, I would join the lead opinion in foreclosing utilization review.

It may be that, in practice, the existing checks on utilization review have proven to be insufficient to ensure the conferral of benefits consistent with legislative intent. However, no such record has been presented to this Court. Moreover, if the mandatory benefits are truly being subverted, the Department has an available and appropriate remedy, in that it is authorized to promulgate substantive rules and regulations it deems necessary for the effective implementation of Act 106. See 40 P.S. §908-7. The formal process for the promulgation of such rules and regulations affords notice and an opportunity on the part of those affected to be heard, as well as the assurance of regularity properly attaching to major policy milestones. See 45 P.S. §§1201-1208; 71 P.S. §§745.1-745.14. In this regard, it seems to me that the Department's repeated expression of concerns with inappropriate administration of insurance benefits at the

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[7] The Department does not specifically deny that it previously acceded to the affordance of 106 benefits via the managed care overlay. Rather, it merely indicates that the 1993 memorandum issued by a former Deputy Insurance Commissioner on the agency's behalf "hardly amounts to an official interpretation of Act 106," and explains that its "legal interpretation of Act 106 has continued to develop over time." Brief for the Department at 31 & n.14.

If Act 106 were as clear as the Department now contends, and as the lead opinion now holds, the Department's apparent prior acquiescence would have represented an abdication of its charge to execute the laws of the Commonwealth in relation to insurance. See 40 P.S. §41.

whims of insurance companies are matched by the Insurance Federation's concern with informal, wholesale alterations of policy on the impulse of state agencies. See, e.g., Brief of Appellant at 47 ("So what are insurers to do, knowing that when the mood hits it a state agency can issue a 'notice' and dramatically change the law overnight?").

Lastly, I recognize that the interpretation of an administrative agency warrants the Court's consideration in statutory construction, and certainly a fair degree of deference is due to the interpretation of an agency charged with the enforcement of a statute. Here, however, I might accord more deference to the Department's interpretation if it would provide greater context concerning its prior interpretation of Act 106 and/or support for its repeated implications that managed care organizations abuse utilization review with regard to Act 106 benefits when permitted to apply it.[8] Moreover, the Department's 2003 notice contains several mistakes and inconsistencies, which I believe further diminish the degree of deference due the notice and the associated reversal of policy. For example, the Department now recognizes that the notice's specification for referral to detoxification by a licensed psychologist finds no basis in the statutory text. See Brief for the Department at 12. Moreover, the statutory provisions

[8] Additionally, the United States Supreme Court has explained that the ordinary deference to which an agency is entitled is lessened where, as here, its interpretation is contained in a notice developed without the benefit of public commentary. See Christensen v. Harris County, 529 U.S. 576, 587, 120 S. Ct. 1655, 1662 (2000); see also Reno v. Koray, 515 U.S. 50, 61, 115 S. Ct. 2021, 132 L.Ed.2d 46 (1995) (internal agency guideline, which is not "subject to the rigors of the Administrative Procedur[e] Act, including public notice and comment," entitled only to "some deference" (internal quotation marks omitted)); accord ARIPPA v. Pennsylvania PUC, 792 A.2d 636, 660 (Pa. Cmwlth. 2002); Brief for Appellant at 40 ("State agencies, like federal agencies, can be empowered with the authority to interpret the laws they enforce through two vehicles -- (1) adjudications; and (2) regulations. Both processes involve formal procedures that seek to ensure a fair and impartial interpretation of the statute at issue, as explained by the [Christensen] Court.").

mandating benefits for detoxification contain no requirement for certification or referral at all. Thus, under the act's plain terms, and contrary to the Department's notice, a patient may self-refer to detoxification and retain eligibility for mandatory benefits upon admission.[9] Additionally, the Department presently retreats substantially from the notice's indication that "[t]he certification and referral in all instances controls both the nature and duration of the treatment," explaining that there may be later coordination between the referring professional and treating professionals as to the nature and duration of treatment. See Brief for the Department at 23.[10]

In summary, I believe that Act 106 is ambiguous in terms of the Legislature's intent relative to the implementation of managed care practices, and, applying principles of statutory construction, I support the approach that such practices are not legislatively

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[9] The lead opinion takes issue with the concept of self-referral relative to inpatient procedures. See Opinion Announcing the Judgment of the Court, slip op. at 14 n.6 ("Detoxification under §908-3 is an **inpatient** procedure, which by definition necessitates **admission** for treatment to a hospital or similar facility. No provision in Act 106 suggests that an insured has been granted the authority to self-admit." (emphasis in original)). Unlike the lead opinion, however, I read the statutory references to physician referral, see 40 P.S. §§908-4, 908-5, as distinct from admission to an inpatient treatment program, see id., §908-3(c). Even if they were not distinct in the abstract, the Notice's provision for certification and referral by any licensed psychologist or physician does not appear identical to the lead opinion's conception of admission to treatment by a doctor at the hospital in question.

[10] The lead opinion concludes that a certification and referral prerequisite is implied, because detoxification treatment requires inpatient care, "which by definition requires admission to a hospital or similar facility and thus necessarily involves determinations by a licensed physician." Opinion Announcing the Judgment of the Court, slip op. at 14. As manifested in other portions of Act 106, however, the Legislature clearly knew how to impose a certification and referral requirement in plain terms. See 40 P.S. §§908-4, 908-5. The legislative acknowledgement, within a definitional provision, that the detoxification process is subject to a doctor's oversight in no way approaches such a specification.

foreclosed. Rather, I believe that, particularly at this juncture, further restrictions on the application of managed care practices should derive from the General Assembly or, at a minimum, be tested via the established procedures for promulgation of substantive rules and regulations.

Mr. Chief Justice Castille joins this dissenting opinion.