

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

SUMMARY

New York State law requires group and blanket school policy insurers covering any health care services to also provide coverage for substance abuse services “on par” with all other health care services covered under the policy.¹ There is mounting evidence that New York State mandated insurers are covering substance abuse services in a manner that violates the spirit of the law. The summary of Greg Heller’s discussion displays efforts in Pennsylvania, in an analogous situation, to cope with the systemic failure of Managed Care Organizations and Health Maintenance Organizations to provide coverage for substance abuse, as well as several possible remedies available in Pennsylvania that could also be available in New York. Because of the similarities between the states, Heller’s suggested legal remedies and the format for the study would be helpful in New York State’s attempts to prevent insurance companies from disregarding mandated coverage requirements. This summary was created in collaboration with and with express permission from the author, Gregory Heller.

Discussion

SUMMARY: “THE COST-SHIFTING CONSEQUENCES OF FAILED MANAGED CARE REGULATIONS: SOME LESSONS FROM PENNSYLVANIA’S EXPERIENCE WITH ADDICTION TREATMENT”

Pennsylvania’s statute, Act 106 of 1989 requires group insurers to provide at least 30 days in patient, 30 visits outpatient, an additional 30 outpatient visits which can be exchanged for 15 days inpatient every year and 28 days of residential detoxification.² The mandate requires coverage so long as “a licensed physician or licensed psychologist certif[ies] the insured is a person

1 Chapter 748 of the Laws of 2006, as amended by Chapter 502 of the Laws of 2007.

2 Article from Gregory B. Heller, Attorney with Young Ricchiuti Caldwell & Heller, The Cost-Shifting Consequences of Failed Managed Care Regulations: Some Lessons from Pennsylvania’s Experiences with Addiction Treatment, 1- 94 (unpublished article, on file with author) *citing* 40 Pa. Stat § 908-4(a) (West 2009).

suffering from alcohol, drug abuse or dependency and refer[s] the insured for appropriate treatment.”³

The National Alliance for Model State Drug Laws, and Drug and Alcohol Service Providers Organization of Pennsylvania commissioned a study, designed by the Parente Randolph, a firm of accountants and consultants with extensive experience in healthcare work. The study involved reviewing data from a Residential Adolescent Addiction Treatment Facility in Pennsylvania. The legal implications of this study were discussed by attorney Gregory B. Heller.⁴ The study demonstrated the systemic disregard of Pennsylvania law by Managed Care Organizations to such extent that only 0.1 percent of treatment was paid for by Managed Care Organizations and Health Maintenance Organizations.⁵ If the findings of a single residential adolescent addiction treatment facility are projected on a straight-line basis across all adolescent treatment beds in the entire state, \$1.6 to \$2.6 million of treatment is being paid for by public sources and \$1.2 to \$1.9 million is being paid for by the facilities themselves every year, instead of private insurers.⁶ These numbers are for adolescent treatment alone. These numbers may not be entirely accurate because it was based on one facility, and the number of patients insured by plans, or mandated by state law, may be too low or too high due to the varying types of coverage.⁷ Heller suggests that the number may actually be too low.⁸ However, the implications of this study, if applicable statewide or nationally, is that cost-shifting by MCO’s have reached epidemic proportions, and must be addressed. If MCO’s are not paying for treatment they are placing the burden on an already

³ HELLER, *supra* note 2, at 15 citing 40 Pa. Stat. § 908-4.

⁴ HELLER, *supra* note 2, at 1; HELLER, *supra* note 1, at 8.

⁵ Hereinafter referred to as MCO; HELLER, *supra* note 2, at 21

⁶ HELLER, *supra* note 2, at 14.

⁷ HELLER, *supra* note 2 at 26.

⁸ HELLER, *supra* note 2, at 26.

strained system, and a population that cannot afford high premiums that are not being used to pay for needed services.

Heller’s study discussed the observations of a Pennsylvania Residential Adolescent Addiction Treatment Facility for approximately 12,000 “treatment days” over two years and tracked the actions of rightful payors, actual payors, and the amount of payments actually made to the facility.⁹ The types of payors included private insurance, public funding, self pay, and free services provided by the facility, often referred to as “charity care”.¹⁰ Payment observations indicated how frequently MCO’s shifted the cost of treatment for their own insured onto another entity, known as out-of-plan cost shifting.¹¹ In this study the other entity was either public funding, or charity care.¹² Approximately thirty percent of those in the study had private health insurance, and twenty percent of the treatment days for each patient should have been paid for by private insurers each year.¹³ Of that twenty percent per year, less than one percent of the treatment was actually paid for by private insurers.¹⁴

The MCO’s shifted the costs primarily through illegal denials of coverage based on medical necessity, even if the patients met Pennsylvania’s coverage requirement through an examination and admittance to the facility by a physician indicating alcohol or substance dependency. Another tactic of MCO’s was citing technical difficulties with computers, office equipment, or phone lines.¹⁵

There are several common reasons why cost shifting occurs in addiction treatment. When a MCO denies coverage for treatment those in treatment don’t pursue the claims because they are

9 HELLER, *supra* note 2, at 6.

10 HELLER, *supra* note 2, at 16.

11 HELLER, *supra* note 2, at 10-11.

12 HELLER, *supra* note 2, at 11.

13 HELLER, *supra* note 2, at 20-21.

14 HELLER, *supra* note 2, at 21.

15 HELLER, *supra* note 2, at 29

physically, or mentally unable to or are shamed by their addiction or need for treatment.¹⁶

Further, the availability of public funding makes it easier for the patient to focus on treatment instead of pursuing the MCO to pay for treatment.¹⁷

Cost-shifting goes unnoticed because there is no system that adequately tracks the changes in insurance from private to public or the frequency of payment by private insurers.¹⁸ In addition, consumer complaint systems focus on single claims, not an aggregate portrayal of the MCO's actions.¹⁹ The insured appeals a plan's determination, not the frequency or difficulty of receiving benefits for treatment at a facility. Also, attempts to curb MCOs' behavior by the Pennsylvania Department of Health are ineffective because the information that is available is not used.²⁰ The Insurance Commissioner has regulatory enforcement power, but its market conduct studies have been limited by incomplete information. Furthermore, violations of Pennsylvania's Unfair Insurance Practices Act cannot be used as independent basis for UTPCPL claims.²¹

One of several legal remedies suggested to recover the public funds lost through cost shifting is the Pennsylvania's Unfair Trade Practices and Consumer Protection Law (UTPCPL). The UTPCPL provides a remedy through damages and injunctive relief for actions where there is "continued, systemic" malfeasance, such as an MCO effectively defrauding the public by not providing services which they contractually agreed to provide.²² Additionally, the disregard for mandated coverage of services, presuming they had actual and constructive knowledge of such malfeasance, is adequate proof of deceptive acts and practices as suggested by the studies showing

16 HELLER, *supra* note 2, at 11.

17 HELLER, *supra* note 2, at 4.

18 HELLER, *supra* note 2, at 12.

19 HELLER, *supra* note 2, at 35.

20 HELLER, *supra* note 2, at 40-41.

21 HELLER, *supra* note 2, at 66.

22 HELLER, *supra* note 2, at 57-60.

that “the pattern of conduct referred to above was not the unintentional act of a few honestly mistaken employees.”²³

Other legal remedies include unjust enrichment, fraud/misrepresentation, bad faith, breach of common law duty, civil conspiracy, and prompt payment violations. A claim for unjust enrichment, if successful, would cause an MCO to reimburse the state for the monies spent on treatment (the benefit conferred), that the MCO should have paid for but didn't (appreciated and retained the benefit), which would be unjust for the MCO to keep.²⁴ It would be difficult to prove that the MCO's actually received and retained a benefit because sometimes monies were paid to the treatment program by public funding or the treatment program provided free care.²⁵ This remedy could be used for single claims by the insured or as a class action, as it is easier to prove that an insured paid a premium for coverage but did not receive the contracted for coverage.²⁶

The remedy of fraud/misrepresentation could be proven by showing that the MCO actually represented to the insured that they would have coverage for treatment services, as mandated by Pennsylvania law, which the insured relied on to their detriment by obtaining treatment services which MCO's did not pay for.²⁷ This remedy could be applied to both state, individual or class action claims.²⁸

Bad faith, in Pennsylvania, is defined by “a refusal to pay [a claim] . . . [when the] conduct imports a dishonest purpose” and the insurer actually owed a duty to the insured.²⁹

²³ HELLER, *supra* note 2, at 72; HELLER, *supra* note 2, at 61. *citing* Cordon v. Pennsylvania Blue Shield, 458 A.2d 600 (Pa. Super, 1988); Horowitz v. Federal Kepmer Life Ins. Co., 57 F 3d 300, 307 (3d Cir. 1995). HELLER, *supra* note 2, at 59.

²⁴ HELLER, *supra* note 2, at 76.

²⁵ H ELLER, *supra* note 2, at 66.

²⁶ HELLER, *supra* note 2, at 76.

²⁷ HELLER, *supra* note 2, at 77.

²⁸ HELLER, *supra* note 2, at 77.

²⁹ HELLER, *supra* note 2, at 78.

Therefore, if an MCO intentionally or recklessly denied a claim without any reason, they have acted in bad faith.³⁰ In order to pursue a bad faith claim it is possible that Pennsylvania would have to get the insured's to assign their rights to pursue such a claim, but the law is unclear as to whether or not it would be required.³¹

A claim for a breach of common law duty rests on Pennsylvania's stance that MCO's do in fact owe a duty to their insured.³² If there is a breach of that duty there is a cause of action. Because of this stance, Pennsylvania could pursue this claim on behalf of the insured.³³

A civil conspiracy claim, which is suggested as a last resort claim, would not be difficult to prove.³⁴ The systemic nature of the MCO's in failing to provide coverage, which is not limited to a single insured, indicates a concerted effort to defraud the state.³⁵

The Pennsylvania Prompt Payment Law requires an insurer to pay "clean claims" within 45 days. Pennsylvania's Insurance Department, as provided by law, is able to enforce this. However, Parente did not assess the language of Pennsylvania's legal definition of a clean claim in relation to the cost-shifted claims in the study.³⁶

Conclusion

The systemic failures of MCO's in Pennsylvania are analogous to those currently occurring in New York. The conclusion to be taken from this document is that Heller's study could be used as a foundation for New York action, providing a roadmap for remedies and possible contacts for the development of a New York based study. The various legal remedies presented indicate how a state could regain the public funds wrongly used to pay for patients

30 HELLER, *supra* note 2, at 79.

31 HELLER, *supra* note 2, at 76.

32 HELLER, *supra* note 2, at 81.

33 HELLER, *supra* note 2, at 81.

34 HELLER, *supra* note 2, at 82.

35 HELLER, *supra* note 2, at 82.

36 HELLER, *supra* note 2, at 84.

with private insurance (MCO's) if their laws mandate addiction coverage or if the insurance company is not providing a service which was contracted for.³⁷

³⁷ HELLER, *supra* note 2, at 66.