IN THE SUPERIOR COURT OF PENNSYLVANIA

No. 1843 EDA 2001

MARK P. SOLOMON, M.D., and REGIONAL NEUROSURGICAL ASSOCIATES, PC

v.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. and AETNA, INC.

APPEAL OF MARK P. SOLOMON, M.D. and REGIONAL NEUROSURGICAL ASSOCIATES, PC

Appeal from the Orders Entered June 19, 2001 in the Court of Common Pleas of Philadelphia County, at March Term 1999 No. 1288

# BRIEF OF THE PENNSYLVANIA MEDICAL SOCIETY AND THE AMERICAN MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS MARK P. SOLOMON, M.D. AND REGIONAL NEUROSURGICAL ASSOCIATES, PC

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## INTEREST OF *AMICI CURIAE* THE PENNSYLVANIA MEDICAL SOCIETY AND THE AMERICAN MEDICAL ASSOCIATION

*Amicus Curiae* the Pennsylvania Medical Society ("the Medical Society") is a Pennsylvania non-profit corporation that likewise represents physicians of all specialties and is the largest physician organization in the Commonwealth. *Amicus Curiae* the American Medical Association ("the AMA"), an Illinois not-for-profit corporation, is a private, voluntary organization of approximately 300,000 physicians throughout the country whose members practice in all fields of medical specialization. The Medical Society is a state component of the AMA.

The Medical Society regularly participates as *amicus curiae* in Pennsylvania appellate courts in cases raising important health care issues. In the Pennsylvania Supreme Court, the Medical Society has participated in recent years in:

- Duttry v. Patterson, 771 A.2d 1255 (Pa. 2001) (informed consent does not include claims of alleged misrepresentations of physician's experience);
- Witthoeft v. Kiskaddon, 733 A.2d 623 (Pa. 1999) (ophthalmologist not liable to accident victim for failure to warn patient with vision problems not to drive);
- Eighty-Four Mining Company v. Three Rivers Rehabilitation, Inc., 721 A.2d 1061 (Pa. 1998) (referral provisions of Worker's Compensation Act);
- Emerich v. Phila. Center for Human Development, Inc., 720 A.2d 1032 (Pa. 1998) (psychiatrist's duty to protect and/or warn);
- Rudolph v. Pennsylvania Blue Shield, 717 A.2d 508 (Pa. 1998) (scope of judicial review of Blue Shield utilization review determination);
- Morgan v. MacPhail, 704 A.2d 617 (Pa. 1997) (applicability of informed consent requirements to injection of medication);
- In Re: Fiori, 673 A.2d 905 (Pa. 1996) (right to die); and
- Cafazzo v. Central Medical Health Services, Inc., 668 A.2d 521 (Pa. 1995) (products liability re surgical implants).

The Medical Society has also participated in numerous cases in this Court, including West Penn Specialty MSO v. Nolan, supra (physician restrictive covenants); Nationwide Mutual Insurance Company v. Nelson, No. 00924 PHL 1998 (Dec. 2, 1998) (physician's authority to delegate services); Tominello v. Janeway, 573 A.2d 218 (Pa. Super. 1990) (Health Care Services Malpractice Act); Sanderson v. Bryan, 522 A.2d 1138 (Pa. Super.

1987) (Peer Review Protection Act) and a series of cases raising issues under the Pennsylvania Insurance Guaranty Fund (Bell v. Slezak, Panea v. Isdaner, and Baker v. Myers, 773 A.2d 782 (Pa. Super. 2001) (en banc); McCarthy v. Bainbridge, No. 3261 PHL 1998; and Storms v. O'Malley, Nos. 1509-1510, 2001 WL 688477 (Pa. Super. June 20, 2001).

The AMA files this Brief as a representative of the American Medical Association/State Medical Society Litigation Center. The Litigation Center is a coalition of the AMA and state medical societies that seeks to represent the views of organized medicine in the courts. Fifty state medical societies, including the Pennsylvania Medical Society, join the AMA as members of the Litigation Center.

The AMA participates as *amicus curiae*, nationwide, in cases of importance to physicians, including two recent cases in Pennsylvania appellate courts (Southard v. Temple University Hospital, No. 22 EAP 2000 (pending decision); and West Penn Specialty MSO, Inc., et al. v. Theresa A. Nolan, M.D., 737 A.2d 295 (Pa. Super. 1999)). Because of the importance of the issue in this case to its physician members throughout Pennsylvania, the Pennsylvania Medical Society and the American Medical Association respectfully submit this *amici* Brief on behalf of its members and in support of appellants Mark P. Solomon, M.D. and Regional Neurosurgical Associates, PC.

## STATEMENT OF JURISDICTION

This Court has jurisdiction over this appeal under 42 Pa.C.S.A. §§702(a), 742.

## ORDERS IN QUESTION

The Orders of June 19, 2001 state as follows in pertinent part:

AND NOW, this 19th day of June, 2001, upon consideration of Defendants' Preliminary Objections to Count VII (Violation of the Pennsylvania Health Care Act) of Plaintiffs' Second Amended Complaint, and all submissions related thereto, it is hereby ORDERED that Defendants' Preliminary Objections are SUSTAINED, and Count VII of Plaintiffs' Second Amended Complaint is DISMISSED with prejudice.

BY THE COURT:

/s/_____
STEPHEN E. LEVIN, S.J.

AND NOW, this 19th day of June, 2001, upon consideration of Defendants' Motion for Summary Judgment to Count I (Breach of Contract) of Plaintiffs' Second Amended Complaint, and all submissions related thereto, it is hereby ORDERED that Defendants' Motion for Summary Judgment is GRANTED, and Plaintiffs' Count I is DISMISSED with prejudice. It is further ORDERED that Plaintiffs' Cross-Motion for Summary Judgment is DENIED.

BY THE COURT:

/s/_____
STEPHEN E. LEVIN, S.J.

## STATEMENT OF QUESTIONS PRESENTED

1. Did the trial court err in concluding that Aetna did not have a duty of good faith and fair dealing under the HMO contract when those duties are implied into every contract in Pennsylvania and Aetna's compliance with those duties is particularly important here because the HMO contract is a contract of adhesion in which Aetna has substantially more market power than do the individual physicians and practices with which it contracts and has used that market power to dictate the terms of the contract.

2. Did the trial court err in concluding that the HMO contract permitted Aetna to reimburse physicians whenever it wanted to when that conclusion:

- violates the "hornbook law" under the Restatement (Second) of Contracts, §204, and numerous Pennsylvania appellate decisions that when a contract specifies no time within which a contract obligation must be performed, that obligation must be performed in a "reasonable" time; and
- produces the ridiculous result that Aetna would have no enforceable payment obligations and could never be in breach, even by never making payment, since its payments would have no due date and could, therefore, never be overdue.

3. Did the trial court err in concluding that §2166 of the Quality Health Care Accountability and Protection Act, 40 P.S. §991.2166, did not provide physicians with an implied private cause of action to enforce its prompt payment and enhanced interest provisions when all of the standards of Witthoeft v. Kiskaddon, 733 A.2d 623 (Pa. 1999) were satisfied in that:

- §2166 provides a particularized and targeted benefit for an HMO's medical providers, thus satisfying the "especial benefit" prong of the Witthoeft test;
- An implied private right of action is "consistent with the underlying purposes of the legislative scheme" because, absent a private right of action, the rights created by §2166 are virtually unenforceable; and
- The legislative history neither supports nor negates the implied right of action.

The Medical Society and the AMA seek affirmative answers to all of these questions.

## STATEMENT OF THE CASE

### A. Procedural History

Plaintiffs, an individual physician and a physician practice specializing in plastic surgery and neurosurgery, respectively, provide those specialized medical services to individual patients who are subscribers to Aetna-U.S. Healthcare ("Aetna"), a health maintenance organization. See Second Amended Complaint, ¶¶18-20. Dissatisfied with the manner and timing in which Aetna reimbursed them for providing those services, plaintiffs filed this action.

Chief among plaintiffs' complaints was that Aetna failed to pay claims that it had previously certified and which were "clean claims", i.e., those which had "no defect or impropriety" (see 40 P.S. §991.2102) -- "in a reasonably timely manner." Id. at ¶4. Plaintiffs sought class action certification on behalf of all physicians as to whom Aetna had acted in this manner. Plaintiffs sought past damages, and declaratory and equitable relief specifying and enforcing Aetna's timely payment obligations.

As bases for that relief, the Second Amended Complaint presented claims of, *inter alia*:

- Breach of Contract (Count I);
- Breach of the Covenant of Good Faith and Fair Dealing (Count II); and
- Violation of the Pennsylvania Quality Health Care Accountability and Protection Act (referred to commonly and in this Brief as "Act 68") (Count VII).

On June 19, 2001, the trial court issued a Memorandum Opinion and Orders resulting in the dismissal of the action. The Court granted defendant's Preliminary Objections to the Act 68 count (Count VII) on the basis that the statute provided no private cause of action to physicians to enforce its timely payment requirements. Id. at 5-7. The Court also granted defendant's Motion for Summary Judgment as to the breach of contract count (Count I). It did so on the basis that the contract "contains no explicit requirement" regarding timely payment or for payment of interest on late-paid claims and that Aetna had over its years of dealing with the plaintiffs "habitually" failed to make timely payment. This "course of dealing," the Court found,

prevented the Court from finding a timely payment obligation in the contract. Id. at 9-12. Previously, by Order of November 30, 1999, the Court had sustained Preliminary Objections to all of the "tort counts" (Counts III-VI asserting claims of unjust enrichment, fraud, conversion, and negligent misrepresentation) in the then-pending Amended Complaint. The Court did so on its view that because the "gist of the action" was contractual in nature, the tort claims were not viable. Memorandum Opinion at 2. Finally, that earlier Order also dismissed the claim of Breach of the Covenant of Good Faith and Fair Dealing (Count II) on the basis that "there is no evidence in the parties' agreement, or in their conduct, which suggest the existence of an implied covenant between the parties." Id. at 3, n.1.

Plaintiffs timely appealed both of the June 19, 2001, Orders.

**B. Plaintiffs' Contracts With Aetna**

All plaintiffs had contracts with Aetna and/or its predecessors relating to the medical services they were to provide to Aetna subscribers. The contracts, in Aetna's words below, are "substantively identical . . . in all relevant aspects, containing essentially the same terms with respect to the provision of services, reimbursement and termination." Defendants' Memorandum in Support of Motion for Summary Judgment, at 8. Indeed, most HMO contracts contain common features. See Pegram v. Herdrich, 530 U.S. 211, 218-19 (2000).

Plaintiff Mark P. Solomon, M.D. entered into his "Aetna Contract" (Second Amended Complaint, Exh. A) in June of 1985. The Contract was actually with the Individual Practice Association ("IPA") of the Health Maintenance Organization of Pennsylvania, a fictitious name used by Aetna's predecessor US HealthCare. The Contract recites that the IPA had contracted to provide physician services to the HMO, including in Dr. Solomon's field of plastic and reconstructive surgery and hand surgery, and that the IPA wished to utilize his services "from time to time in connection with its provision of [those] physician services." The Contract provided that Dr. Solomon would provide services to the HMO's subscribers "only upon referral of such patients by [a] Primary Physician of IPA"; that the IPA would "have final authority to determine whether [Dr. Solomon's] services [were medically] necessary and to adjust payments for services

rendered by [Dr. Solomon] in accordance with the results of such determinations; and that Dr. Solomon would use "only those in-patient extended care and ancillary service organizations which have been approved in advance by IPA." Contract, ¶1(B-C).

Regarding compensation, Dr. Solomon's Contract stated simply that "compensation for services hereunder shall be at the rates set forth in the Fee Policy annexed hereto as Attachment A." Id., ¶2. The referenced Attachment A, entitled "Maximal Reimbursement Policy participating Specialist Physicians," did not, however, "set forth" rates in any commonly understood manner. Instead, it stated in pertinent part that "Participating Specialist Physicians will be reimbursed according to our [the HMO's] Maximal Reimbursement Policy, excerpts of which will be distributed to all Participating Physicians upon application."

The 1989 Agreement with plaintiff Steven J. Barrer, M.D. (Second Amended Complaint, Exh. B) is virtually identical as to compensation: "Specialist Physician's compensation for services hereunder shall be in accordance with HMO's Maximum Reimbursement Schedule." Id., ¶2. The only change is that Dr. Barrer's 1989 Contract abandons the pretense in Dr. Solomon's 1985 Contract that the rates were "set forth" within the Contract or in an attachment.

None of the contracts had any further provisions regarding compensation, including provisions relating to the time of payment or Aetna's payment of interest in the event payment was not timely made.

## SUMMARY OF ARGUMENT

The HMO contracts at issue here are adhesion contracts. Aetna, based on its market power, has dictated the terms. To properly decide this appeal, this Court must do what the trial court did not: (1) imply the necessary terms that the contract, because of Aetna's market power, does not expressly contain; and (2) apply the necessary construction principles so that Aetna implements its obligations fairly and in good faith. When that is done, and Pennsylvania's HMO statute is also properly applied, Aetna's position that it can reimburse physicians who provided care to Aetna's subscribers whenever it wanted to cannot stand.

First, Aetna's actions violate its duty of good faith and fair dealing, which are implied into every Pennsylvania contract. Donahue v. Federal Express Corp., 753 A.2d 238 (Pa. Super. 2000). Imposing those duties into an adhesion contract is particularly important. Many standard HMO contract provisions can harm the quality of health care if the HMO does not exercise its contract authority fairly and in good faith, on the basis of professional standards, rather than unduly influenced by financial concerns. The duty of good faith/fair dealing provides a basis to require HMOs to do so.

Second, "Hornbook law" establishes that when a contract specifies no time within which a contract obligation must be performed, that obligation must be performed in a "reasonable" time. The trial court's contrary conclusion produces the ridiculous result that Aetna would have no enforceable payment obligations and could never be in breach, even by never making payment, since its payments would have no due date and could, therefore, never be overdue.

Finally, the statute, 40 P.S. §991.2166, establishes minimum requirements for timely payment and enhanced interest for late payment. Physicians satisfy all three prongs of the test established in Witthoeft v. Kiskaddon, 733 A.2d 623 (Pa. 1999) and can therefore enforce those provisions. Of particular note, that statute provides a particularized and targeted benefit for an HMO's medical providers but those rights are virtually unenforceable absent a private right of action.

## ARGUMENT

### I. INTRODUCTION TO ARGUMENT: THE HEALTH CARE INSURANCE MARKET IN SOUTHEASTERN PENNSYLVANIA, ADHESION CONTRACTS, THEIR IMPACT ON HEALTH CARE, AND THE IMPORTANT ISSUES RAISED BY THIS APPEAL

According to figures maintained by the State Department of Health, two HMOs accounted for nearly 90% of the HMO enrollment in Southeastern Pennsylvania in 2000. Aetna alone insured nearly 1.3 million persons or nearly 50% of the region's HMO enrollment. According to 2001 data compiled by InterStudy and Atlantic Information Service, Aetna's HMO market share translates into approximately 21% of the entire health insurance market in the region, i.e., including non-HMO forms of health insurance. It is likewise the case that a few HMOs control substantial market share in most other regions of the Commonwealth.

There are various HMO models, and the terms and conditions of individual HMO contracts will, of course, vary somewhat. But one important constant is that substantial financial incentives and penalties lead an HMO's insureds to seek and receive medical care only from providers with which the HMO has contracted. This, in turn, means that unless a physician contracts with an HMO, the physician, as a practical matter, cannot treat patients whose care the HMO insures.[1] When an HMO insures only a small portion of a physician's patients, the physician can determine, with relative financial impunity, not to participate with that HMO. But as an HMO's market share increases and the HMO's insureds represent a substantial portion of the physician's patients, the physician's freedom not to contract lessens until it almost disappears. The adverse consequences to the physician's practice of exercising a choice become too great.

The fact that a physician has little choice but to contract with an HMO that has significant market share necessarily also means that the physician has little ability to negotiate the terms of the agreement. The facts of this case and Aetna's defense to those facts demonstrate

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[1] Absent unusual circumstances, insureds themselves pay the costs when they are treated by physicians who have not contracted with the HMO.

this point. Aetna's defense is substantially that it has habitually paid claims on a late basis, and that the plaintiff physicians have accepted that course of conduct. That "acquiescence" in the face of Aetna's commercially unreasonable conduct reflects the physician's inability to do otherwise in light of Aetna's market share. If those physicians had a meaningful choice not to do business with Aetna, or a meaningful ability to negotiate with Aetna the terms on which they would do business, Aetna could not successfully continue that "course of dealing."

An HMO's market power reflects itself in contractual provisions other than Aetna's late payment practices. Among the common clauses in HMO contracts are the following:

- *Medical necessity definition* - Medical necessity may be defined in a manner that incorporates non-medical considerations and allows the health insurer to surreptitiously limit care.
- *Medical care requirements* - The physician is required to deliver care in accordance with the HMO's protocols, regardless of the medical appropriateness of those protocols or the patient's individualized medical needs.
- *Referral restrictions* - The physician is only permitted to refer patients within the health insurers network, regardless of the adequacy of the network or the patient's individualized medical needs.
- *Unilateral amendment provisions* - The health insurer is authorized to unilaterally amend key terms such as the amount of payment.
- *Final say clauses* - The health insurer is granted unfettered discretion to make the final decision over matters such as whether a service is medically necessary or otherwise a covered service.
- *Incorporated open-ended documents* - The physician is bound by the provisions of incorporated documents that can be unilaterally adopted and amended by the health insurer. These documents typically cover important matters such as utilization/quality review and reimbursements.
- *Retroactive denials* - The health insurer is permitted to retroactively deny coverage after a service was rendered, even when it pre-authorized the service.
- *Termination without cause or due process* - The health insurer can terminate a physician's participation in the health insurers network without cause or due process, a right that can be used to intimidate and leverage physicians from advocating on behalf of their patients.

Evidence at trial would demonstrate that these (and other) provisions are not bargained for but rather, reflecting the parties' disparate market power, are dictated by the HMO. They are part and parcel of the HMO's standard form provider agreement. The contracts themselves are paradigm contracts of adhesion. See Rudolph v. Pennsylvania Blue Shield, 717 A.2d 508, 511-12 (Pa. 1998) (Nigro, J. concurring) (standard contract between Pennsylvania Blue Shield and physicians is a contract of adhesion); Bishop v. Washington, 480 A.2d 1088, 1094 (Pa. Super. 1984).

Provisions in an adhesion contract are not necessarily improper, let alone invalid. Instead, a court must examine the content of the contracts and the manner in which the dominant party applies its provisions to determine if they are "unreasonably favorable" to the dominant party. Rudolph v. Pennsylvania Blue Shield, 717 A.2d at 512 (Nigro, J. concurring); Witmer v. Exxon Corporation, 434 A.2d 1222, 1228 (Pa. 1981) (adopting definition of unconscionability from Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965). Here, virtually all of the provisions listed above (and others not listed) favor the HMO over the medical provider.

*Amici* recognize that some of the HMO provisions noted above can, in some circumstances, serve useful purposes, such as controlling excess or unnecessary costs. See Pegram v. Herdrich, 530 U.S. 211, 219 (2000). But equally, most of these provisions are subject to abuse -- they can harm physicians and the health care they deliver to their patients -- if the HMO does not exercise the authority the provisions convey fairly and in good faith. For example, definitions of medical necessity, medical care requirements, and limitations on referrals can directly and obviously harm patients if not made on the basis of professional standards and if they are instead unduly influenced by financial concerns. Similarly, when Aetna delays payments to health care providers to financially benefit itself from the "float," it depletes the resources available for quality patient care. See Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377 (3d Cir. 2000) (intensifying the degree of scrutiny in review of ERISA benefit decisions to match the degree of the conflict between the funder and recipient of those benefits).

This appeal is thus about two related goals: (1) recognizing the necessary contract terms that the HMO contract, because of Aetna's market power, does not expressly contain but which the Pennsylvania legislature has nevertheless imposed; and (2) applying the necessary contract construction principles so that Aetna implements its contract obligations fairly and in good faith. Securing those results is what motivates *amici's* participation in this appeal.

## II. AETNA'S ACTIONS VIOLATE ITS DUTY TO PERFORM ITS CONTRACT OBLIGATIONS IN GOOD FAITH AND TO DEAL FAIRLY WITH THE PHYSICIANS WITH WHOM IT HAS CONTRACTED

Aetna's argument that the HMO contract allows it to reimburse physicians whenever it wants to violates the contract requirement that it deal fairly and in good faith with the medical providers with whom it has contracted. An implied provision imposing these duties is part of every contract in Pennsylvania. See Donahue v. Federal Express Corp., 753 A.2d 238, 242 (Pa. Super. 2000); Baker v. Lafayette College, 504 A.2d 247, 255 (Pa. Super. 1986).[2] Those duties are recognized and defined in the Restatement (Second) of Contract, §205, which was adopted by this Court in Creeger Brick & Bldg. Supply, Inc. v. Mid-State Bank & Trust Co., 560 A.2d 151 (Pa. Super. 1989). Section 205 states the governing principle in the simplest possible terms: "Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." The underlying principle can be found in Pennsylvania case law as far back as 1933. See Jacobs v. Kraft Cheese Co., 164 A. 774 (Pa. 1933). These duties

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[2] The Third Circuit has viewed those duties as present only in a more limited set of contracts. See Northview Motors, Inc. v. Chrysler Motors Corp., 227 F.3d 78, 91 (3d Cir. 2000) (citing this Court's pre-Donahue decision in Creeger Brick & Bldg. Supply, Inc. v. Mid-State Bank & Trust Co., 560 A.2d 151 (Pa. Super. 1989) and its own decision in Parkway Garage, Inc. v. City of Philadelphia, 5 F.3d 685 (3d Cir 1993). Northview was issued several months after Donahue and does not reference it or Baker.

arise as a matter of contract, not tort, law. Creeger Brick & Bldg. Supply, Inc., 560 A.2d at 153; Woody v. State Farm Fire Ins. Co., 965 F.Supp. 691 (E.D. Pa. 1997).[3]

The general obligation imposed on parties to a contract is a "sincere and substantial performance of [a party's] contractual undertakings, complying with the spirit as well as the letter of the contract." Baker v. Lafayette College, 504 A.2d at 255. Although a "complete catalogue of types of bad faith is impossible," Somers v. Somers, 613 A.2d 1211, 1213 (Pa. Super. 1992) and "its meaning varies somewhat with the context," Baker v. Lafayette College, 504 A.2d at 255, there are several recognized "strains of bad faith" conduct:

> Evasion of the spirit of the bargain, lack of diligence and slacking off, willful rendering of imperfect performance, [and] abuse of a power to specify terms ....

Somers v. Somers, 613 A.2d at 1213.

Several of those "strains" -- in particular, those relating to the "[e]vasion of the" and "abuse of a power to specify terms" -- seem applicable here. Aetna's "pay whenever it wants to" policy clearly violates "the spirit of the bargain." No party providing services under a contract contemplates that the purchaser will adopt that construction of its payment obligations or that payment philosophy and practice. The fact that Aetna can and does operate in this fashion arises from its market power. The contract's compensation terms are largely unstated precisely because Aetna viewed that drafting style as supporting its interests and it could, because of its market power, dictate those terms on providers. It is a classic adhesion contract in which Aetna has "abuse[d]" its "power to specify terms." Adhesion contracts, in particular, are precisely the type of contract in which it is most important to impose the duty of good faith and fair dealing because normal market pressures have little or no impact in those circumstances. These duties extend beyond the issue of timely payment to virtually every aspect of the HMO contract. As a matter of public policy, the courts need to impose the available legal doctrines

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[3] Plaintiffs raised the "good faith/fair dealing" as both part of their breach of contract claim (Count I) and as a separate claim (Count II).

that would help to ensure that health care insurers, such as Aetna, with controlling market power over health care providers, do not abuse that power as Aetna has done.

There are limitations on the duty of good faith and fair dealing. It "cannot be used to override an express contract term." Northview Motors, Inc. v. Chrysler Motors Corp., 227 F.3d 78, 91 (3d Cir. 2000); Creeger, 560 A.2d at 560 (duty of good faith "does not compel a lender to surrender rights which it has been given by statue or by the terms of the contract").[4] If the HMO contract had expressly contained a "pay whenever it wants to" provision, although that provision would likely prevail over the duty of good faith/fair dealing, it would likely be invalidated as "unconscionable." See Heller, Inc. v. United Parcel Service, Inc., 754 A.2d 689, 700-701 (Pa. Super. 2000). But, of course, the HMO contract does not so state. Instead, Aetna seeks to reach that result by arguing that the absence of a payment provision has the same effect. The duty of good faith and fair dealing does not let it do so.

The trial court dismissed this claim on the basis that "there is no evidence in the parties' agreement, or in their conduct, which suggests the existence of an implied covenant between the parties." Slip Op. at 3, n.1. But the covenant of good faith and fair dealing exists as an implied covenant in every contract; no evidence is needed to establish it. Nor is Aetna's haphazard conduct relevant. The implied covenants existed at the moment the parties contracted together, and nothing Aetna has done subsequently can cause them to disappear or otherwise invalidate them. *Amici* are aware of no cases holding that past bad faith conduct can negate an implied duty to act in good faith. Such a holding would be inappropriate in almost any context, but it would be particularly inappropriate as applied to adhesion contract situations in which the injured party had no opportunity to bargain the terms of the contract to ensure a fair deal.

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4 Based on this principle, the Third Circuit in Northview Motors, Inc. v. Chrysler Motors Corp., 227 F.3d at 92, "predicted" that the Pennsylvania Supreme Court "would not extend the limited duty to perform a contract in good faith to a situation ... in which the "parties in great detail set forth their mutual rights and obligations." (emphasis supplied). Even assuming the accuracy of that prediction, the HMO contract is the paradigm of a contract that does **not** "in great detail set forth their mutual rights and obligations."

For these reasons, Aetna had an obligation, arising from its duty of good faith and fair dealing, to pay providers on a commercially reasonable basis.

## III. THE HMO CONTRACT INCLUDES AN IMPLIED REQUIREMENT THAT AETNA COMPENSATE PHYSICIANS WITHIN A "REASONABLE" TIME

The Aetna HMO contract is, at root, a contract for the purchase of services. As such, conditions relating to payment -- its amount and timing -- are central; they are virtually the only obligations that Aetna, the purchaser of the services, has. Indeed, absent contractual terms about such matters, Aetna would have no enforceable payment obligations and could never be in breach, even by never making payment, since its payments would have no due date and could, therefore, never be overdue.[5]

That analysis seems -- and is -- ridiculous, yet it flows precisely from the arguments raised by Aetna and the conclusions reached by the court below, and it highlights the flaws in them. In raising that argument and reaching that conclusion, Aetna and the trial court overlooked the established principle of contract interpretation -- described as "hornbook law" by this Court in Hodges v. Pennsylvania Millers Mutual Insurance Company, 673 A.2d 973, 974 (Pa. Super. 1996) -- that where no time is specified for performance of a contractual obligation, the obligation must be performed within a "reasonable" time.

> The Restatement (Second) Contracts, §204, has adopted this principle:
>
> when the parties to a bargain sufficiently defined to be a contract have not agreed with respect to a term which is essential to a determination of their rights and duties, a term which is reasonable in the circumstances will be implied.

Comment "d" to §204 is even more on point: "if no time is specified, a term calling for performance within a reasonable time is supplied."

Finally, this principle has been accepted by many state and federal cases applying Pennsylvania law. In Field v. Golden Triangle Broadcasting, 305 A.2d 689 (Pa. 1973), cert. denied, 414 U.S. 1158 (1974), the Pennsylvania Supreme Court implied a closing date for an agreement when the agreement specified none. It explained the basis on which it did so:

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5 Although this action focuses on Aetna's timely payment obligations, it is worth noting that the contract also fails to spell out the reimbursement amounts. To say the least, the HMO contracts are unusually drafted, reflecting the fact that they are adhesion contracts.

> [W]e have consistently held that 'where no time for performance is provided in the written instrument, the law implies that it be done in a reasonable time ...' depending upon the nature of the business.

Id. at 694. See also Lefkowitz v. Hummel Furniture Co., 122 A.2d 802, 804 (Pa. 1956) (implying time for completion of construction terms and specifications); Hodges v. Millers Mutual, supra, 673 A.2d at 974-75 (implying time limit for requesting appraisal under insurance contract); Barr v. Deiter, 154 A.2d 290, 293 (Pa. Super. 1959) (implying time limitation on exercise of option in lease); Cashdollar v. Mercy Hospital of Pittsburgh, 595 A.2d 70, 76 (Pa. Super. 1991) (length of employment contract); Scullion v. EMECO Industries, Inc., 580 A.2d 1356 (Pa. Super. 1990), appeal denied, 592 A.2d 45 (Pa. 1991) (same); Hutchinson v. Pennsylvania State Employes' Retirement Board, 738 A.2d 7, 16 (Pa. Cmwlth. 1999) (applying "hornbook law" to imply reasonable time requirement for payment requirement of retirement benefits); ContiMortgage Corp. v. Mortgage America, Inc., 47 F.Supp.2d 575, 577 (E.D. Pa. 1999) (implying time limit for exercising contractual right to demand certain remedies). Indeed, it is part of Pennsylvania's and the nation's commercial code. See 13 Pa.C.S. §2-309(1) ("The time for shipment or delivery or any other action under a contract if not provided in this division or agreed upon shall be a reasonable time."). (emphasis supplied).

In Conti, the most recent decision articulating and applying this principle, the contract at issue gave a party the right to demand certain contract remedies and imposed no specific time period within which it must do so. The plaintiff attempted to exercise that right after the passage of considerable time, the defendant argued waiver, and the plaintiff argued that because there was no specifically stated time period in the contract, there could be no waiver. The District Court disagreed:

> Where the [time for] performance of a contractual obligation is unspecified, Pennsylvania courts will require that the obligation be performed within a reasonable time.

47 F.Supp.2d at 577 (citing Hodges and the Restatement (Second) of Contracts), §204. The federal court further noted that "[this Court's decision in] Hodges explicitly rejected the

defendant's argument that the absence of a time frame permitted defendant to make a demand at any time." Ibid.

In Hodges, this Court implied a "reasonable" time limitation into an insurance policy provision allowing, with no stated time limitation, either the insurer or insured to demand an appraisal of loss. The insurer demanded an appraisal 23 months after receiving notice of the loss, arguing that the provision does not place any "time frame in which [an] Appraisal must be demanded" and that there was, therefore, no such limitation. 673 A.2d at 974. This Court rejected that analysis, applying the "hornbook" law elaborated above. Indeed, this Court went so far as to hold that the insurer's request for an appraisal in that case was untimely.

The text of the Restatement §204 clarifies the analysis the trial court should have made in analyzing appellants' challenge to the HMO contract. First, the trial court needed to determine if the HMO agreement was "a bargain sufficiently defined to be a contract." No party argues that it is not. Second, if the Court concluded there was an enforceable contract, it needed to determine if the time of payment was "essential to a determination of [the physicians'] rights and [Aetna's] duties." A*mici* believe that terms and conditions relating to the amount and timing of payment are central to the contract; they are certainly more central to the bargain here than the provisions at issue in Conti and Hodges. Finally, if the court determined the time of payment was an essential term, it was then required to imply a "reasonable time" provision and allow the parties to present evidence on what constituted a reasonable time for payment in this commercial context. See Conti, 47 F.Supp.2d at 578 (what is a reasonable time under the circumstances is question for finder of fact). See also this Court's decision in Vaskie v. West American Ins. Co., 556 A.2d 436 (Pa. Super. 1989). Simply put, unless the time of payment is an unessential term, the contract must either have an implied term requiring payment on a commercially reasonable basis or it is ineffective. The ultimate result of Aetna's arguments and the trial court's analysis is the conclusion that the Aetna contract is not a contract at all, which, *amici* note, no party contends is the case nor seeks.

The trial court reached its contrary result by ignoring the principle described above and embracing instead the seemingly distinct principle that a court, absent unusual circumstances, will not rewrite the contract the parties have agreed to by, for example, inserting new terms the contract does not expressly contain. See Slip Op. at 9 (citing Kaplan v. Cablevision of Pa., Inc., 671 A.2d 716, 720 (Pa. Super. 1996) (*en banc*), appeal denied, 683 A.2d 883 (Pa. 1996). That principle is, of course, an equally accepted rule of contract interpretation. Those two rules must and do co-exist, however, and the trial court's error was in misunderstanding the relationship between them. *Amici* note that to their knowledge no Pennsylvania appellate court has discussed this relationship.

The facts of Kaplan help to distinguish circumstances in which it is necessary and proper to imply terms from those in which it is not. In Kaplan, cable television subscribers sued to receive rebates from their monthly service charges for the period of time when cable service was interrupted. Plaintiffs argued that the cable company contracts misrepresented that they would provide "continuous, uninterrupted programming" and this misrepresentation violated the Unfair Trade Practices and Consumer Protection Law . The problem was that the contracts did not contain the representation at issue. Accordingly, plaintiffs argued that the court should imply that term and impose the corresponding duty to provide rebates in the event of outages. This Court declined to do so because there was no express or implied basis in the contract to conclude that this obligation was part of the bargain between the parties, nor was the implication of such a term "necessary to prevent injustice." 671 A.2d at 720. Simply stated, it was entirely reasonable to conclude that the parties intended the monthly fee to be compensation for whatever amount of cable programming Cablevision was able, acting in good faith, to provide.

The text of the Restatement, §204, helps meld the two seemingly competing construction principles. The Restatement authorizes a court to imply additional terms when the parties to a bargain have not agreed with respect to a term which is "essential to a determination of their rights and duties...." The Restatement authorizes court action when without it the parties' bargain would lack essential terms and/or could not be meaningfully enforceable. That

description closely resembles the recognized exception to the rule that courts will not add terms to the parties' contract:

> the law will imply an agreement by the parties to a contract to do and perform those things that according to reason and justice they should do in order to carry out the purpose for which the contract was made and to refrain from doing anything that would destroy or injure the other party's right to receive the fruits of the contract.

Slater v. Pearle Vision Center, Inc., 546 A.2d 676, 679 (Pa. Super. 1988). See also Kaplan v. Cablevision, 671 A.2d at 720.

The principles of Restatement, §204, and Kaplan v. Cablevision are thus fully compatible, both balancing the interests in freedom of contract with the need to imply terms when the parties have left important gaps. The more central the missing terms are to the parties' obligations, the clearer both the need and the court's authority to imply terms becomes. When the "omitted" terms are more peripheral -- as in Kaplan -- the less willing courts are and should be to imply additional terms to a written contract. With respect to the specific issue of time (relating both to the exercise of rights and the performance of duties), courts routinely imply a time for performance when the contract provides none because, even when time is not "of the essence" for purposes of determining breach, the time when something must be done is almost always central to the parties' performance of a duty or receipt of a right.

Here, the omitted terms on the time of payment are, in the words of Restatement, §204, "essential to a determination of [the physicians'] rights and [Aetna's] duties." In the words of Kaplan and Slater, a timely payment provision is necessary "to carry out the purpose for which [the physician entered into] the contract" -- to receive payment for medical services they provided -- and to prevent Aetna from taking actions "that would destroy or injure the [physician's] right to receive the fruits of the contract." As *amici* noted earlier, absent contractual terms governing the time of performance, Aetna would have **no** enforceable payment obligations and could **never** be in breach, even by never making payment, since its payments would have no due date and could, therefore, never be overdue.

The trial court also gave undue weight to the apparent fact that Aetna had over its years of dealing with the plaintiffs "habitually" failed to make timely payment, a "course of dealing" that the Court found prevented it from finding a timely payment obligation in the contract. Slip Op. at 9-12. There are circumstances in which the parties' voluntary course of dealing can be relevant post-contract evidence in interpreting what their prior agreement meant. But, supporting *amici's* earlier discussion, evidence at trial would likely have demonstrated that the Aetna contract was a classic adhesion contract. In that context, Aetna's conduct reflects an exercise of market power, not the meaning of contractual terms. *Amici* emphasize that Aetna's "timely payment" obligations arose as a matter of law when Aetna drafted the HMO contract without including language expressly addressing that issue.

To the extent physicians acquiesced in Aetna's conduct -- and the evidence suggests that some of the physicians routinely protested -- it was because, as *amici* discussed in Part I of this Brief they had little, if any, choice in light of the economic realities of the medical marketplace in Southeastern Pennsylvania.

Giving weight to that course of dealing raises additional policy concerns. As *amici* explains in Part IV below, the parties' course of dealing predating the effective date of Act 68 (January 1, 1999); can have no significance regarding Aetna's timely payment obligation after that date; clearly Aetna should not be rewarded for law-breaking behavior. As *amici* note in Part II above, Aetna's actions also violate its duty of good faith and fair dealing. Equally clearly, Aetna should not be rewarded for having done so.

For these reasons, the trial court erred in concluding that there was no timely payment obligation in the HMO contract. The trial court, having reached the contrary conclusion, did not therefore reach the related issue of interest due on late-paid claims. But the right to interest follows directly from the existence of a timely payment provision. Under the Restatement (Second) of Contracts §354, adopted in Penneys v. Pennsylvania Railroad Co., 183 A.2d 544 (Pa. 1962); Pennsylvania statutory law, 41 P.S. §202; and case law, all breach of contract awards, including those relating to violations of timely payment obligations, bear

statutory interest at 6% simple from the date payment was due until the date payment was made. See, e.g., Somerset Community Hospital v. Mitchell & Associates, Inc., 685 A.2d 141 (Pa. Super. 1996); Oxford Manufacturing Co. v. Cliff House Building Corp., 307 A.2d 343, 345 (Pa. Super. 1973). To conclude, as the trial court did, that the contract does not provide for interest on late-paid claims simply overlooks this principle. It is not a question of whether the terms of this contract provide for interest but that the law requires that interest be paid.

## IV. PHYSICIANS HAVE A PRIVATE CAUSE OF ACTION AGAINST AN HMO TO ENFORCE THE TIMELY PAYMENT AND ENHANCED INTEREST PROVISIONS OF §2166 OF ACT 68

Section 2166 of The Quality Health Care Accountability and Protection Act ("Act 68"), 40 P.S. §991.2166(a), provides a particularized and targeted two-part benefit for an HMO's medical providers. Medical providers are entitled under §2166(a) to receive payment within 45 days of submitting a "clean claim" (a term defined at 40 P.S. §991.2102). Giving force to that requirement, providers are entitled under §2166(b), 40 P.S. §991.2166(b), to interest at an enhanced statutory rate of 10% for non-timely payments. As *amici* demonstrate below and contrary to the conclusion of the trial court, physicians have the right to enforce those provisions in court.

In Witthoeft v. Kiskaddon, 733 A.2d 623, 626 (Pa. 1999), the Supreme Court adopted the three-prong analysis from Cort v. Ash, 422 U.S. 66 (1975) as "a beneficial framework within which to analyze whether the statute at issue implicitly creates a private right of action." The three Cort factors are:

> [f]irst, is the plaintiff 'one of the class for whose *especial* benefit the statute was enacted,' -- that is, does the statute create a … right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?

Several distinctive aspects of §2166 and Act 68 generally strongly support finding a private cause of action here.

First, §2166 represents an the unusually specific statutorily established contractual entitlement to the particularized financial benefit of medical providers, thus satisfying the "especial benefit" prong of the Cort/Wittheoft test. The benefits of §2166 are not aimed to the public at large, a factor that traditionally militates against finding a private cause of action. See Wittheoft, 733 at 626; Cannon v. University of Chicago, 441 U.S. 677, 692 n.13 (1979). Indeed, §2166 was intended to address precisely the issues that are raised in this action -- a history of tardy payment of approved claims with late paid claims unaccompanied by interest.

The "indication of legislative intent" prong contributes not at all here and certainly does not support the trial court's holding that there is no private cause of action.[6] Indeed, there is little floor debate or reliable legislative history and none of it pertinent to this issue.[7] But evidence that legislators "actually had in mind the creation of a private cause of action" is not commonly required. Thompson v. Thompson, 484 U.S. 174, 179 (1988). In Thompson, the Supreme Court noted that "the implied cause of action doctrine would be a virtual dead letter were it limited to correcting drafting errors when Congress simply forgot to codify its evident intention to provide a cause of action," further explaining that "as an *implied* cause of action doctrine suggests, 'the legislative history of a statute that does not expressly

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6 Before the trial court, Aetna cited to legislative floor comments by Reps. Veon and Vance (1998 Pa. Legislative Journal (June 9, 1998 at 1493, 1495)) concerning the adequacy of the "grievance procedure." But as explained in the text of this Brief, the grievance procedure the legislators were discussing does not extend to the slow payment/interest issues; accordingly, the legislators' views of the procedure's adequacy or inadequacy say nothing at all about the existence of a private right of action to enforce §2166. Additionally, the remarks of individual legislators are not useful legislative history under Pennsylvania law because they "represent only the individual's view and not necessarily that of the entire body." See Elder v. Orluck, 515 A.2d 517, 521-522 (Pa. 1986); Zemprelli v. Thornburgh, 407 A.2d 102, 109 (Pa.Cmwlth. 1979); 1 Pa.C.S. §1939 (outlining legislative sources that may be "consulted in the construction or application" of a statute).

7 The House of Representatives discussed Act 68, then Senate Bill 91, PN 89, on June 9, 1998, at Legislative Journal-House, 1491-1514. SB 91 addressed three important and distinct issues -- automobile cancellation, the HMO provisions, and the Children's Health Insurance Program. Little of the discussion concerned the HMO provisions. The Senate also discussed SB 91 on June 9, 1998, although even less extensively. See Legislative Journal-Senate, 2092-94.

create or deny a private remedy will typically be equally silent or ambiguous on the question.'" Id. at 179 (emphasis in original) (quoting in part Cannon v. University of Chicago, 441 U.S. at 694). In such circumstances, legislative intent needs to be "inferred" from such sources as the language of the statute or the statutory structure. Id. at 179.

Third, it is "consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff." Indeed, as *amici* show below, if §2166's entitlements to timely payment and interest cannot be enforced in this manner, they are wholly illusory, absent an HMO's voluntary compliance. If plaintiffs cannot collect the interest that enhanced §2166 establishes they were entitled to in an action such as this one, they cannot collect it anywhere at all. A private cause of action is not merely consistent with the purpose of §2166, but is necessary to vindicate the rights there established.

In this respect, it is important to recognize that the elaborate grievance mechanism that Act 68 requires HMOs to establish, see 40 P.S. §§991.2152, 991.2162, does **not** encompass a claim for late or even non-payment (absent limited circumstances inapplicable here). An Act 68 "grievance" is "a request ... to have a[n HMO] reconsider a decision solely concerning the medical necessity and appropriateness of a healthcare service." (emphasis supplied). 40 P.S. §991.2102. Thus, the scope of the grievance does not encompass challenges to late or non-payment, unless based on a denial of payment based on issues of "medical necessity [or] appropriateness." In contrast, the issue here concerns when payment will be made with respect to medical services for which "medical necessity and appropriateness" are not at issue. Underscoring the inapplicability of the "grievance" mechanism, a physician can bring a grievance only with the patient's consent. 40 P.S. §991.2102. Similarly, the "internal complaint process" established under 40 P.S. §991.2141 addresses complaints about a participating health care provider or the HMO's coverage, operations, or management policies." While the latter categories could conceivably encompass the "slow pay/no interest" complaints, the process is available only to "an enrollee," not a provider. See §§991.2141(a), 991.2102 (definition of

"enrollee"). Thus neither the grievance nor internal complaint processes address the providers' rights under §2166.

It is also important to recognize that neither the Insurance nor Health Departments, both of whom enforce Act 68, has authority to vindicate the providers' right to timely payment and, in the absence of timely payment, statutory interest. The Departments can penalize a non-compliant HMO, can enjoin it, and can require submission of a plan of correction. See 40 P.S. §§991.2182(a, c, and e) (listing "[p]enalties and sanctions" the Departments may impose on a non-compliant HMO, which do not include reimbursement for providers). But they cannot order "make whole" relief to those medical providers whose right to timely payment/interest the HMO has violated.

In this respect, the Insurance Department recently completed a "market conduct" examination of Aetna at which it examined, *inter alia*, Aetna's Act 68 Compliance. The Department's website summary states:

> Numerous violations were noted for failure to pay clean claims submitted by providers within 45 days, as required by Section 2166 (a) of Act 68. Violations also were noted for failure to pay interest on overdue claims within 30 days as required by Section 2166 (b) of Act 68 and Title 31, Pa. Code, Section 154.18.

After noting other violations, the summary concludes: "The HMO was fined $225,000 [payable to the Commonwealth] in settlement of all violations identified during the examination." The Insurance Department action provided no relief for the physicians who were harmed by those violations of the timeliness and interest requirements.[8]

*Amici* note in this respect that although neither the "grievance" nor "internal complaint" provisions of Act 68 apply to providers challenging late payment/non-payment of interest, the Insurance Department has, via regulation, established a complaint process under which providers can present the Department with information on late-payment. See 31 Pa. Code

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8 See http://www.insurance.state.pa.us/html/enf2001jul.html.

§154.18(f). Although this process may assist the Department in learning which HMOs are not paying providers on a timely basis, it provides no useful benefit to the providers themselves because the Department cannot award them with contractual type damages. The regulations do not indicate that the Department will award contract damages to the complaining physicians, and the decision in Pennsylvania Blue Shield v. Com., Dept. of Health, 500 A.2d 1244, 1249-52 (Pa.Cmwlth. 1985), appeal denied, 522 A.2d 560 (Pa. 1987) strongly suggests that the Department does not do so because it cannot do so. In Pennsylvania Blue Shield, Commonwealth Court held that analogous regulatory authority in the Professional Health Care Service Corporations Act, 40 P.S. §§6301-6335, did not confer on the Department of Health authority to "adjudicate and award [monetary] damages" in disputes between Blue Shield and its participating doctors. The Court reversed that portion of the Department of Health's Order requiring Blue Shield to refund $59,947 "improperly withheld" from the provider. Thus, the Department's complaint process does not meaningfully help physicians vindicate their Act 68 rights and does not negate the existence of a private cause of action that would allow physicians to do so.

The purpose of §2166 was to mandate that HMO-physician contracts meet certain minimum standards.[9] Under it, a contract that seeks to impose a longer time period for payment or a lower interest rate is illegal and unenforceable because it violates the public policy announced by the statute. See Caron v. Reliance Insurance Company, 703 A.2d 63, 67 (Pa. Super. 1997). Nor can an insurer avoid the force of §2166, as Aetna has tried to do, by simply not addressing the timeliness of payments or the consequences for late payment. These are mandatory minimum provisions. They are -- and are required to be -- part of the HMO-physician contract (absent an agreement to satisfy more stringent requirements), regardless of what the written document itself may state or, as here, leave silent. Aetna's contention that the

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9 That type of minimum standard-setting provision is common in the insurance field. See 40 P.S. §§510.1, 510a (life insurance), §636 (fire insurance), §§776.3-.4 (health insurance); §§908-2, 908-3 (alcohol or drug abuse dependency).

contract imposes no time requirement for payment at all is erroneous both under common law (as *amici* discussed in Parts II and III) and under §2166.

Finally, Act 68 also foils Aetna's argument, adopted by the lower court, that the physicians' claims to prompt payment were undercut by a prior course of dealing in which delayed payment was common cannot prevail in this context. Whatever the force of such an argument in the context of a purely privately negotiated contract, it can have no viability as to a contract that must meet and implement statutory mandates. For that argument to have any weight, Aetna must argue that because it has never fully complied with the timely payment/interest requirements of Act 68, it is relieved from the obligation to do so forever and this Court, in turn, would have to hold that Aetna is to be rewarded for its law-breaking behavior.[10] Even apart from the defects in those two points, Aetna's argument fails for a more practical reason: almost all of the prior dealings between Aetna and the plaintiff physicians (and physicians in general) necessarily preceded the January 1, 1999, effective date of Act 68. A course of dealing predating Act 68 can be of no significance at all.

For these reasons, the Court should hold that medical providers of an HMO can sue to enforce the timely payment/enhanced interest requirements of §2166 of the Quality Health Care Accountability and Protection Act.

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10 The Insurance Department's recent audit action against Aetna reflects that the Department does not share that view.

## CONCLUSION

For these reasons, *amici curiae* the Pennsylvania Medical Society and the American Medical Association respectfully request that the decision of the lower court be reversed.

REED SMITH LLP

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