[J-94-2008]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

CASTILLE, C.J., SAYLOR, EAKIN, BAER, TODD, McCAFFERY, JJ.

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 Opinion and Order of the Commonwealth Court entered July 26, 2007, which denied the motion for judgment on the pleadings filed by the Insurance Federation of Pennsylvania and granted the motion for judgment on the pleadings filed by the Pennsylvania Insurance Department : 929 A.2d 1243 (Pa.Cmwlth. 2007)
v.	:	
COMMONWEALTH OF PENNSYLVANIA, INSURANCE DEPARTMENT,	:	
APPEAL OF: THE INSURANCE FEDERATION OF PENNSYLVANIA	:	ARGUED: May 14, 2008

OPINION ANNOUNCING THE JUDGMENT OF THE COURT

MR. JUSTICE McCAFFERY

The Insurance Federation of Pennsylvania ("the Federation") appeals from the order of the Commonwealth Court declaring that, by statute, group health insurers must provide specified minimum coverage for alcohol and drug abuse treatment once an insured

receives a certification and a referral for treatment from a licensed physician or a licensed psychologist.[1] The issue presented is whether the statutory mandate precludes the application of utilization review for medical necessity and appropriateness of the mandated treatment. We conclude that managed care plans may not apply utilization review to abrogate or alter the sole statutory prerequisites to obtaining treatment for alcohol and drug abuse, i.e., certification and referral by a licensed physician or licensed psychologist. Accordingly, we affirm the order of the Commonwealth Court.

The facts of the instant case are not in dispute, and are centered on two statutes and a Notice issued by the Pennsylvania Insurance Department ("the Department") interpreting those statutes. Specifically, in 1989, the General Assembly passed Act 106 , 40 P.S. §§ 908-1 - 908-8, which requires group health insurers to include specified minimum coverage for treatment of drug and alcohol abuse and dependency. Subsequently, in 1998, the General Assembly passed Act 68, 40 P.S. §§ 991.2101 - 991.2193,[2] a consumer-protection statute that sets forth the responsibilities of and requirements pertaining to managed care plans in the delivery of health care services.

The Notice in question, which the Department issued in August 2003, addressed the obligations of insurers to provide coverage for drug and alcohol abuse treatment under Act 106 and concluded that Act 68 does not alter Act 106's requirements. See Drug and Alcohol Use and Dependency Coverage; Notice 2003-06, 33 Pa.Bull. 4041-42 (August 9, 2003) ("the Notice"). The Notice in its entirety reads as follows:

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[1] Sections 601-A--608-A of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, added by Section 10 of the Act of June 11, 1986, P.L. 226, as amended by Section 8 of the Act of Dec. 22, 1989, P.L. 755.

[2] Sections 2101-2194 of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, added primarily by Section 1 of the Act of June 17, 1998, P.L. 464.

Drug and Alcohol Use and Dependency Coverage; Notice 2003-06

This notice is issued to advise all entities subject to Act 106 of 1989 (act) (40 P.S. §§ 908-1--908-8) of their obligations under Commonwealth law in the provision of coverage for alcohol or other drug abuse and dependency benefits. The act requires specific coverage of drug and alcohol treatment services in certain group insurance policies or contracts. Drug and alcohol use and dependency are recognized in this Commonwealth as public health problems with serious workplace, health care, community and criminal justice ramifications. The Insurance Department (Department) releases the following guidance concerning the provision of benefits under the act.

The act specifies that all group policies, contracts and certificates subject to the act providing hospital or medical/surgical coverage shall include within that coverage certain benefits for alcohol or other drug abuse and dependency. Under the act, the **only lawful prerequisite** before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug dependency treatment is a **certification and referral from a licensed physician or licensed psychologist**. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The **certification and referral** in all instances **controls both the nature and duration of treatment**. The location of treatment is subject to the insuring entity's requirements regarding the use of participating providers.

Act 68 of 1998 (40 P.S. §§ 991.2101-991.2193), governing quality health care accountability and protection, does not change the requirements under [Act 106] and should be read in conjunction with these existing requirements. Thus, **an entity subject to Act 68 may utilize precertification or utilization reviews, provided, however, that the decision of the precertification or utilization review does not limit [Act 106] certification and referral** by the licensed physician or licensed psychologist.

> Questions regarding this notice should be addressed to Ronald A. Gallagher, Jr., P.E., Deputy Commissioner, Office of Consumer and Producer Services, Insurance Department … .

Id. (emphasis added).

Following publication of the Notice, the Federation and other trade associations, insurers, and managed care plans challenged the Department's interpretation of Act 106 as applied to managed care plans by filing a petition for review in the nature of a complaint for declaratory judgment addressed to the Commonwealth Court's original jurisdiction. The petitioners, including the Federation, sought, inter alia, a declaration that Act 106 did not preclude, limit, or regulate the application of utilization review for medical necessity and appropriateness[3] by managed care providers. It was the petitioners' view that the General Assembly had not intended to exempt Act 106's mandated benefits from the managed care practice of utilization review for medical necessity and appropriateness, but rather had intended that utilization review be incorporated into Act 106's statutory scheme.

Agreeing that the issue presented was solely a legal one, the petitioners and the Department filed cross-motions for judgment on the pleadings. Following oral argument before a three-judge panel and then an en banc panel, the Commonwealth Court concluded that the controversy was not ripe and therefore declined to exercise jurisdiction. The Federation and the Managed Care Association of Pennsylvania appealed to this Court, which on February 21, 2006, vacated the Commonwealth Court order and remanded for a consideration of the merits of the declaratory judgment action. Insurance Federation of

[3] "Utilization review" is defined in Act 68 as follows: "A system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee." 40 P.S. § 991.2102.

Pennsylvania, Inc. v. Commonwealth of Pennsylvania, Insurance Department, 893 A.2d 69 (Pa. 2006) (per curiam order).[4]

Following oral argument on the merits, a unanimous en banc panel of the Commonwealth Court granted the Department's motion for judgment on the pleadings, denied the Federation's motion for judgment on the pleadings, and dismissed the petition with prejudice. Insurance Federation of Pennsylvania, Inc. v. Commonwealth of Pennsylvania, Insurance Department, 929 A.2d 1243 (Pa.Cmwlth. 2007) (en banc). The Commonwealth Court concluded that the Department's interpretation of Act 106, as set forth by the Notice, was logical, rational, and consistent with legislative intent. Id. at 1250. More specifically, the Commonwealth Court determined that Act 106 plainly and clearly mandates coverage of the specified drug and alcohol abuse treatment once an insured has received a certification and a referral by a licensed physician or licensed psychologist. Id. at 1250-51, 1252. In agreement with the Department, the Commonwealth Court expressly concluded that the General Assembly did not intend for a managed care plan to have authority to overrule the certification and referral by a licensed physician or psychologist. Id. at 1251.

The Federation has now appealed to this Court for review of the Commonwealth Court's order, raising the following four issues:

> 1. Whether, in the absence of any supporting express statutory language or other indicia of legislative intent, it is legal error to conclude that the General Assembly intended to prohibit managed care plans ("MCPS") from applying managed care princip[les] in the delivery of Act 106 mandated benefits for alcohol and other drug abuse and dependency?

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[4] In vacating and remanding by per curiam order, this Court cited Arsenal Coal Co. v. Department of Environmental Resources, 477 A.2d 1333 (Pa. 1984), in which this Court addressed the propriety of invoking the Commonwealth Court's original jurisdiction to obtain pre-enforcement review.

> 2. Whether an interpretation of Act 106 that prohibits any management of the delivery of Act 106 benefits by MCPs is against the public interest of ensuring the cost-effective delivery of quality health care benefits?
>
> 3. Whether the Commonwealth Court erred by affording deference to an administrative agency's interpretation that is offered to justify the agency's position in litigation or in interpretive rules or statements of policy?
>
> 4. Whether the Insurance Department's Drug and Alcohol Use and Dependency Coverage, Notice 2003-06, 33 Pa.Bull. 4041 (Aug. 9, 2003) is more than a mere "press release" or statement of policy and should have been promulgated as a regulation?

Federation's Brief at 5.

We will address the Federation's issues in turn, but initially we note our standard and scope of review when considering the grant of a motion for judgment on the pleadings. "A motion for judgment on the pleadings will be granted where, on the facts averred, the law says with certainty that no recovery is possible." In re Weidner, 938 A.2d 354, 358 (Pa. 2007) (citation omitted). Because the question presented is a legal one, our scope of review is plenary. Id.

The Federation's first issue requires interpretation of a statute, which is a question of law. Tritt v. Cortes, 851 A.2d 903, 905 (Pa. 2004). Accordingly, we must be guided by the Statutory Construction Act of 1972, 1 Pa.C.S. §§ 1501-91, the relevant principles of which we have recently described as follows:

> The goal of statutory interpretation is to ascertain and effectuate the intent of the Legislature. 1 Pa.C.S. § 1921(a). The best indication of legislative intent is the language used in the statute. When the words of a statute are clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit. 1 Pa.C.S. § 1921(b). We look beyond the language employed by the General Assembly only when the words are not explicit. 1 Pa.C.S. § 1921(c).

Commonwealth of Pennsylvania, Office of Administration v. Pennsylvania Labor Relations Board, 916 A.2d 541, 547-48 (Pa. 2007).

In determining legislative intent, we must read all sections of a statute "together and in conjunction with each other," construing them "with reference to the entire statute" and giving effect to all the statutory provisions. Housing Authority of the County of Chester v. Pennsylvania State Civil Service Commission, 730 A.2d 935, 945 (Pa. 1999); 1 Pa.C.S. § 1921(a).

When the words of a statute are not explicit, our determination of legislative intent may be informed by other factors, including administrative interpretations of the statute, the consequences of a particular interpretation, and analysis of other statutes addressing the same or similar subjects. Colville v. Allegheny Retirement Board, 926 A.2d 424, 432 (Pa. 2007) (citing 1 Pa.C.S. § 1921(c)). We emphasize that while "an interpretation of a statute by those charged with its administration and enforcement is entitled to deference, such consideration most appropriately pertains to circumstances in which the provision is not explicit or is ambiguous." Tritt, supra at 905 (internal citation omitted).

If possible, we avoid a reading that would lead to a conflict between different statutes or between individual parts of a statute. Housing Authority of the County of Chester, supra at 946. Finally, we presume that when enacting any statute, the General Assembly intended to favor the public interest as against any private interest. 1 Pa.C.S. § 1922(5); Vitac Corporation v. Workers' Compensation Appeal Board (Rozanc), 854 A.2d 481, 485 (Pa. 2004).

The principal statute at issue in the instant case is Act 106 of 1989, which requires group health insurers to include, in their policies offered to subscribers, specified minimum coverage for treatment of drug and alcohol abuse and dependency:

> All group health … insurance policies … and all group subscriber contracts … **shall** … **include within the coverage**

> **those benefits for alcohol or other drug abuse and dependency** as provided in sections [-3, -4, and -5].

40 P.S. § 908-2.

The specific benefits mandated by Act 106 fall into three categories: (1) inpatient detoxification; (2) non-hospital residential alcohol or other drug services; and (3) outpatient alcohol or other drug services. See 40 P.S. §§ 908-3, -4, and -5, reproduced in relevant part below:

> **§ 908-3. Inpatient detoxification**
>
> (a) Inpatient detoxification as a covered benefit under this article shall be provided either in a hospital or in an inpatient non-hospital facility which has a written affiliation agreement with a hospital …, meets minimum standards for client-to-staff ratios and staff qualifications … and is licensed as an alcoholism and/or drug addiction treatment program.
>
> (b) The following services shall be covered under inpatient detoxification:
> (1) Lodging and dietary services.
> (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
> (3) Diagnostic X-ray.
> (4) Psychiatric, psychological and medical laboratory testing.
> (5) Drugs, medicines, equipment use and supplies.
>
> (c) Treatment under this section may be subject to a lifetime limit, for any covered individual, of four admissions for detoxification and reimbursement per admission may be limited to seven (7) days of treatment or an equivalent amount.

40 P.S. § 908-3. "Detoxification" is defined in the statute as follows.

> **"Detoxification."** The process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in

combination with drugs **as determined by a licensed physician,** while keeping the physiological risk to the patient at a minimum.

40 P.S. § 908-1 (emphasis added).

§ 908-4. Non-hospital residential alcohol or other drug services

(a) Minimal additional treatment as a covered benefit under this article shall be provided in a facility which meets minimum standards for client-to-staff ratios and staff qualifications … and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. **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 other drug abuse or dependency and refer the insured for the appropriate treatment.**

(b) The following services shall be covered under this section:
(1) Lodging and dietary services.
(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(3) Rehabilitation therapy and counseling.
(4) Family counseling and intervention.
(5) Psychiatric, psychological and medical laboratory tests.
(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this act, for a minimum of thirty (30) days per year for residential care. Additional days shall be available as provided in section [908-5(d)]. Treatment may be subject to a lifetime limit, for any covered individual, of ninety (90) days.

40 P.S. § 908-4 (emphasis added).

§ 908-5. Outpatient alcohol or other drug services

(a) Minimal additional treatment as a covered benefit under this article shall be provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. **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 other drug abuse or dependency and refer the insured for the appropriate treatment.**
>
> (b) The following services shall be covered under this section:
> (1) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
> (2) Rehabilitation therapy and counseling.
> (3) Family counseling and intervention.
> (4) Psychiatric, psychological and medical laboratory tests.
> (5) Drugs, medicines, equipment use and supplies.
>
> (c) Treatment under this section shall be covered as required by this act for a minimum of thirty outpatient, full-session visits or equivalent partial visits per year. Treatment may be subject to a lifetime limit, for any covered individual, of one hundred and twenty outpatient, full-session visits or equivalent partial visits.
>
> (d) In addition, treatment under this section shall be covered as required by this act for a minimum of thirty separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to fifteen additional non-hospital, residential alcohol treatment days.

40 P.S. § 908-5 (emphasis added).

The Federation does not dispute that managed care plans are subject to the provisions of Act 106. However, as stated by the Federation, "the question at the heart of this case is whether Act 106 prohibits [managed care plans] from reviewing the physician's or psychologist's medical necessity determination" prior to providing treatment for drug and alcohol abuse as mandated by the Act. Federation's Brief at 20-21.

The Federation invokes Act 68, 40 P.S. §§ 991.2102 - 991.2194, to support its contention. The consumer-protective nature of Act 68 has been properly recognized by the Commonwealth Court, see Insurance Federation of Pennsylvania, 929 A.2d at 1246, and is

emphasized by the statutory description of its scope, which is the governance of "quality health care accountability and protection." 40 P.S. § 991.2101.

As defined in Act 68, a "managed care plan" is characterized by, inter alia, the use of a gatekeeper to manage the insured's use of health care services:

> A health care plan that **uses a gatekeeper to manage the utilization of health care services**; integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards; and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. … .

40 P.S. § 991.2102 (emphasis added).

The Federation also points out that the definition of "health care service" in Act 68 includes behavioral health:

> "Health care service." Any covered treatment, admission, procedure, medical supplies and equipment or other services, **including behavioral health**, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

Id. (emphasis added). The Federation asserts, without challenge, that "behavioral health," as the term is used in the "health care industry," includes drug and alcohol abuse and dependency. Federation's Brief at 26.

Based on the above-quoted provisions of Act 68, the Federation argues that all the practices and procedures of managed care plans, most particularly utilization review for medical necessity and appropriateness, should be directly applicable to and superimposable upon the certification and referral process set forth by the General Assembly in Act 106. The Department's position, in contrast, is that under Act 106, "the only lawful prerequisite before an insured obtains … coverage for alcohol and drug

dependency treatment is a certification and referral from a licensed physician or licensed psychologist." Notice, 33 Pa.Bull. at 4042. After careful analysis of the statutory text of Act 106, we conclude that the Department has correctly interpreted the Act, as we explain in detail immediately below.

Managed care plans are a well-established mechanism for delivering health care in this Commonwealth, but they do not lie outside the purview of the General Assembly's continuing judgments as to the most efficient and most effective policies and practices with respect to the delivery of health care services. The Federation does not dispute this general point.[5] However, the Federation does argue that, because Act 106 does not expressly proscribe the application of utilization review for medical necessity and appropriateness, managed care plans may apply utilization review in the context of Act 106 and may decline to provide treatment that does not satisfy the managed care plan's utilization review criteria. While it is true that the text of Act 106 does not include the terms "medical necessity" or "utilization review," we cannot agree with the Federation's assertion that "Act 106 is simply **silent** as to who makes the ultimate and controlling 'medical necessity' determination with respect to the benefits actually delivered to the insured and paid for by the insurer." Federation's Brief at 28 (emphasis added).

Contrary to the Federation's assertion, the text of Sections 908-4 and 908-5 specifies that both the authority to determine that an insured is suffering from alcohol or drug abuse/dependency, as well as the authority to refer the insured for appropriate treatment, are entrusted to a licensed physician or licensed psychologist. Specifically, the relevant text is as follows:

> Before an insured may qualify to receive benefits under this section, a **licensed physician or licensed psychologist**

[5] See text infra, discussion of 40 P.S. § 764d, "Mastectomy and breast cancer reconstruction."

> **must certify** the insured as a person suffering from alcohol or other drug abuse or dependency **and refer** the insured for the appropriate treatment.

40 P.S. §§ 908-4 and -5 (emphasis added).

As the above-quoted sentence makes clear, Sections 908-4 and -5 expressly provide for a two-part procedure to be completed by a licensed physician or psychologist before an insured can receive non-hospital residential or outpatient alcohol or drug services: (1) a certification that the insured is suffering from alcohol or drug abuse or dependency; and (2) a referral for appropriate treatment. Nothing in Sections 908-4 and 908-5 implies or suggests that managed care plans may superimpose an additional, potentially overriding review process, such as utilization review for medical necessity and appropriateness, once a licensed professional has made the explicitly required certification and referral. We will not read an additional step into Sections 908-4 and 908-5--a step that would have the potential to weaken if not effectively eliminate the mandatory language of Act 106.

Based on our analysis of the statutory text of Act 106, we also conclude, in agreement with the Department, that "[t]he certification and referral in all instances controls both the nature and duration of treatment." Notice, 33 Pa.Bull. at 4042. Any other interpretation of the plain text of the Act would render hollow the express statutory grant of authority to a licensed physician (or a psychologist in some cases) to certify and to refer the insured for "appropriate treatment." 40 P.S. §§ 908-4 and 908-5. For example, if a physician certifies an insured as suffering from drug or alcohol abuse/dependency and refers the insured for **residential** treatment services, the statute does not permit the insurer to conclude that **outpatient** treatment services would be adequate and could be substituted, based on utilization review or other criteria. Likewise, in another illustrative example, if the referring physician determines that the "appropriate treatment" for an insured requires seven days of services, then the insurer cannot conclude that one day of

services is adequate based on utilization review. These examples are of course not exhaustive, but are provided merely to make clear the general principle that the certification and referral of an insured under Act 106 are not subject to utilization review for medical necessity and appropriateness.

In contrast to Sections 908-4 and 908-5, Section 908-3, which describes the mandatory inpatient detoxification benefits, does not include a provision regarding certification or referral by a physician or any other licensed professional. However, Section 908-3's benefits require **inpatient** care, which by definition requires admission to a hospital or similar facility and thus necessarily involves determinations by a licensed physician. See 40 P.S. §§ 908-1 and 908-3. Most relevantly, detoxification is statutorily defined as a process whereby an alcohol- or drug-dependent or intoxicated person is assisted, in a licensed facility, through the period of time necessary to eliminate the alcohol and/or drugs from the body "as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum." 40 P.S. § 908-1. Thus, the statutory definition of detoxification expressly states that the inpatient detoxification process is to be "determined" by a licensed physician.[6] Conspicuously absent from Section 908-3, as well as from Sections 908-4 and 908-5, is any provision granting to managed care plans the authority to conduct an additional or overriding review via the application of utilization review for medical necessity and appropriateness.

If we were to accept the Federation's position in the instant case, we would effectively assign the General Assembly's judgments, as they are manifested in Act 106, to a subservient position relative to the judgments of managed care plans. We discern no

[6] We must respectfully disagree with the dissent's statement that under Act 106 "a patient may self-refer to detoxification." Dissenting Opinion at 8. 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.

indication in either Act 106 or Act 68 that the General Assembly intended such a result. Indeed, it is difficult to imagine how Act 106's statutory mandates could remain mandates in practice if the Federation's view of the Act were to prevail. There is simply no legal basis for the Federation's position that a managed care plan may decline to provide alcohol or drug abuse treatment, as mandated by Act 106, under the guise of utilization review for medical necessity and appropriateness of a licensed physician's or psychologist's certification and referral.

Accordingly, based on the text of Act 106, we hold that the Commonwealth Court and the Department did not err in concluding that the intent of the General Assembly was to require group health insurers to provide mandatory coverage for drug and alcohol abuse treatment once an insured has received a certification and a referral for treatment from a licensed physician or licensed psychologist. Furthermore, we hold that managed care plans may not abrogate or alter the licensed professional's certification and referral via the practice of utilization review for medical necessity and appropriateness.

We must note that in enacting Act 106 the General Assembly chose language that is very similar to several other mandated-benefit statutes, e.g., statutes that require health insurance policies and contracts to provide coverage for annual gynecological examinations, mammograms, inpatient care for women who have just delivered a child, and childhood immunizations. The statutory language conferring each of these benefits is reproduced below:

For annual gynecological examinations:

> A health insurance policy … **shall provide that the health insurance benefits applicable under the policy include coverage** for periodic health maintenance to include:
>
> (1) Annual gynecological examination, including a pelvic examination and clinical breast examination.

> (2) Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

40 P.S. § 1574 (emphasis added).[7]

For mammograms:

> All group or individual health … insurance policies … and all group or individual subscriber contracts or certificates … **shall also provide coverage** for mammographic examinations. The **minimum coverage required shall include all costs** associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.

40 P.S. § 764c (emphasis added).[8]

For inpatient care for new mothers:

> Every health insurance policy that provides maternity benefits … **shall provide coverage** for a minimum of 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following Caesarean delivery.

40 P.S. § 1583(a) (emphasis added).[9]

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[7] Section 4 of the Women's Preventive Health Services Act, Act of April 22, 1994, P.L. 136, 40 P.S. § 1571-77.

[8] Section 632 of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, added by Section 4 of the Act of July 7, 1989, P.L. 755, as amended by Section 1 of the Act of Dec. 15, 1992, P.L. 1129.

[9] Section 3 of the Health Security Act, Act of July 2, 1996, P.L. 514. This Section also provides as follows:

> [A] health insurance policy may also provide for a shorter length of stay, but only if the treating or attending physician determines that the mother and newborn meet [specified] medical criteria for safe discharge ….

40 P.S. § 1583(b).

For childhood immunizations:

> any health insurance policy … **shall provide that the health insurance benefits applicable under the policy include coverage** for child immunizations.

40 P.S. § 3503.[10]

The language in the above provisions regarding gynecological examinations, mammograms, mothers' inpatient care, and childhood immunizations, is very similar to the portion of Act 106 that sets forth the requirement for coverage of drug and alcohol abuse and dependency benefits:

> All group health … insurance policies … and all group subscriber contracts … **shall … include within the coverage those benefits** for alcohol or other drug abuse and dependency as provided in sections [-3, -4, and -5].

40 P.S. § 908-2.

In each of the five provisions reproduced immediately above, the General Assembly determined that it was in the public interest that health insurance policies throughout the Commonwealth be required to cover the specified benefits. We discern no indication that the General Assembly intended to confer upon managed care plans the authority to second-guess its legislative judgment via the application of utilization review for the medical necessity and appropriateness of annual gynecological examinations or mammograms, inpatient care for new mothers, childhood immunizations[11]--or drug and alcohol abuse and dependency treatment.

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[10] Section 3 of the Childhood Immunization Insurance Act, Act of May 21, 1992, P.L. 239.

[11] The dissent points out that these other mandated-benefit statutes set forth required coverage for preventative measures that follow a typical regimen and are available to a whole class of persons, in contrast to drug and alcohol treatment, "which is specific to individual patients and has aspects that are substantially remedial." Dissenting Opinion at 3-4. We do not dispute this characterization. However, we must respectfully disagree with (continued…)

Although the Federation does not address the statutes mandating annual gynecological examinations or mammograms, inpatient care for new mothers, or childhood immunizations, the Federation **does** concede that there is at least one mandated-benefit statute in which the General Assembly has precluded managed care plans from conducting utilization review for medical necessity and appropriateness of the mandated benefits. See Federation's Brief at 27 (discussing 40 P.S. § 764d). This statute provides for inpatient and home health care following a mastectomy, as follows:

(…continued)
the inference that such characterization somehow negates the significance of the similarities between the text of these statutes and the text of Act 106, § 908-2. We see no indication that the General Assembly drew a distinction between preventative versus remedial treatment measures. Furthermore, although, as the dissent suggests, persons can certainly be divided into classes based on gender, age, or new motherhood, individuals who engage in "a pattern of pathological use" of drugs or alcohol may also be considered to constitute a class. 40 P.S. § 908-1 (definition of alcohol or drug abuse);

Finally, we cannot fully understand the distinction that the dissent infers between 40 P.S. § 764c, which mandates coverage for mammograms, and Act 106. Section 764c provides that the "minimum coverage required shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram **based on a physician's recommendation** for women under 40 years of age." 40 P.S. § 764c (emphasis added). The dissent concludes that, for women under 40, the phrase "'based on a physician's recommendation' … clearly foreclose[s] utilization review upon such a recommendation." Dissenting Opinion at 4 n.4. However, with regard to Act 106, §§ 908-4 and 908-5, the dissent concludes that the certification and referral steps set forth therein do not preclude utilization review before an insured may qualify to receive drug or alcohol treatment benefits.

In sum, we are unconvinced by the dissent's attempts to distinguish Act 106 from other mandated-benefit statutes. Accordingly, if this Court were to hold that the physician's or psychologist's certification and referral under Act 106 were subject to utilization review for medical necessity and appropriateness prior to the provision of the mandated benefits, then we can see no principled reason why other statutorily mandated benefits, as discussed in the text, would not likewise be subject to utilization review. We cannot conclude that the statutory text chosen by the General Assembly is consistent with such a result.

> **§ 764d. Mastectomy and breast cancer reconstruction**
>
> (a)(1) No health insurance policy … shall require outpatient care following a mastectomy performed in a health care facility.
>
> (2) Policies described in clause (1) of this subsection shall provide coverage for inpatient care following a mastectomy for the length of stay **that the treating physician determines is necessary** to meet generally accepted criteria for safe discharge.
>
> (3) Such policies shall also provide coverage for a home health care visit **that the treating physician determines is necessary** within forty-eight hours after discharge when the discharge occurs within forty-eight hours following admission for the mastectomy.

40 P.S. § 764d(a) (emphasis added).[12]

Based on the clear text of Section 764d(a), the Federation acknowledges--as it must--that inpatient care and home health care following a mastectomy are benefits that must be covered as "the treating physician determines is necessary." 40 P.S. § 764d(a)(2) and (3). Thus, at least in the case of Section 764d(a), the Federation concedes that the General Assembly has precluded the application of utilization review for medical necessity and appropriateness, because the statutory text expressly places the responsibility to determine what post-mastectomy care is necessary exclusively with the treating physician.[13]

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[12] Section 633 of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, added by Section 3 of the Act of Nov. 4, 1997, P.L. 492.

[13] The dissent agrees that Section 764d(a) forecloses utilization review. See Dissenting Opinion at 4. However, the dissent also argues that because Act 106 was not included in the list of enactments and programs to which Act 68 did not apply, see 40 P.S. § 991.2192, then the reach of Act 68 must extend to Act 106 and utilization review must be permitted in connection with the mandated benefits of Act 106. See Dissenting Opinion at 2. In our view, this argument is severely weakened by the recognition that neither Section 764d(a), (continued…)

The Federation attempts to distinguish Section 764d(a) from Act 106 by asserting that the latter does not expressly place the authority to make a determination of medical necessity for the benefits at issue exclusively with the certifying and referring physician or psychologist, and thus does not preclude utilization review for medical necessity and appropriateness. We cannot agree. Although Act 106 does not use the exact language of Section 764d(a), Act 106 does indeed specify with whom the authority lies for establishing the need for treatment for drug and alcohol abuse/dependency. As we have discussed supra, for an insured to obtain non-hospital residential or outpatient drug or alcohol services under Act 106, a licensed physician or licensed psychologist must certify that the insured is suffering from drug or alcohol abuse or dependency and refer him or her for appropriate treatment. In the case of inpatient detoxification, the process is to be determined by a physician. See 40 P.S. §§ 908-1, 908-4, and 908-5. That the specific language of Act 106 differs from that of Section 764d(a) is not determinative.

In sum, with regard to the Federation's first issue, we conclude that under Act 106, a managed care plan may not employ utilization review for medical necessity and appropriateness to abrogate or alter the statutory prerequisites of certification and referral by a licensed physician or licensed psychologist. We hold that the sole prerequisite before an insured can obtain non-hospital residential or outpatient coverage under Act 106 is certification and referral from a licensed physician or licensed psychologist; similarly, the

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(…continued)
nor Section 764c, both of which the dissent concludes foreclose utilization review, is included in the list of enactments and programs to which Act 68 does not apply. In fact, none of the statutes mandating certain health-care benefits is included in the list of enactments and programs to which Act 68 does not apply. Rather, the enumerated exceptions to Act 68 involve alternative financing programs, specifically workers' compensation, financial responsibility under the Motor Vehicle Code, and fee-for-service programs under the Social Security Act.

need for inpatient detoxification treatment is to be determined solely by a licensed physician.[14]

In the second issue raised for our review, the Federation contends that it is contrary to the public interest in ensuring cost-effective health care to preclude the application of utilization review for medical necessity and appropriateness in the context of Act 106's certification and referral provisions. We are mindful that questions of public policy rest in the first instance with the General Assembly. See Program Administration Services, Inc. v. Dauphin County General Authority, 928 A.2d 1013, 1017-18 (Pa. 2007) (reiterating that "it is the Legislature's chief function to set public policy and the courts' role to enforce that policy, subject to constitutional limitations"). Furthermore, we have resolved the question of the General Assembly's intent with regard to Act 106 based on the plain language of the statute; accordingly, it would be improper to stray into the arena of public policy in resolving this case, and we decline to do so.[15] See 1 Pa.C.S. § 1921(c).

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[14] The Department acknowledges that the Notice incorrectly suggested that a licensed psychologist could certify and refer an insured for inpatient detoxification under Section 908-3. The Department recognizes that a determination for inpatient detoxification can only be made by a licensed physician, not a psychologist. See Department's Brief at 12.

[15] Although we have not considered public policy in resolving the instant case, we can not fail to note that the Federation's public interest argument is based entirely on very general policy considerations underlying managed care as a mechanism for controlling the cost of health care. These very general policy considerations surrounding managed care need not constrict the choices of the General Assembly when it seeks to address concerns with regard to the availability or delivery of **specific** health care services. As we have discussed, the General Assembly has chosen to legislate on the delivery of several specific health care services, e.g., annual gynecological examinations, mammography, inpatient care for new mothers, childhood immunizations, and treatment for drug and alcohol abuse. See text supra. In these cases, the General Assembly's judgment was properly informed by the individual characteristics and cost-benefit analyses of the specific medical examination, test, or treatment under consideration.

Briefs from amici illustrate the complex and factual nature of any cost-benefit analysis of drug and alcohol abuse treatment, involving not just the cost of providing treatment, but (continued…)

In the third issue presented for our review, the Federation contends that the Commonwealth Court erred by affording deference to the Department's interpretation of Act 106. We are aware that while "an interpretation of a statute by those charged with its administration and enforcement is entitled to deference, such consideration most appropriately pertains to circumstances in which the provision is not explicit or is ambiguous." Tritt, supra at 905 (internal citation omitted). As discussed supra, we have resolved this case based on the plain text of the statute, not based on deference to the Department. Therefore, to the extent that the Commonwealth Court may have extended improper deference to the Department's interpretation, any such error is harmless.

In the fourth and final issue presented for our review, the Federation contends that the Department's Notice as to Act 106 should have been promulgated as a regulation rather than as a statement of policy.

We have previously explained that "[s]tatements of policy are agency pronouncements that declare [the agency's] future intentions but which are applied prospectively on a case-by-case basis and without binding effect." Borough of Pottstown v. Pennsylvania Municipal Retirement Board, 712 A.2d 741, 743 n.8 (Pa. 1998) (emphasis in original). As the Commonwealth Court has previously pointed out, a statement of policy is "one that tracks a statute and does not expand upon its plain meaning." Eastwood Nursing and Rehabilitation Center v. Department of Public Welfare, 910 A.2d 134, 142 (Pa.Cmwlth.

(…continued)
also issues of cost-shifting from private to public funds, drug-related criminal behavior, and other social costs of drug or alcohol abuse and dependency. It was for the General Assembly to balance the cost of requiring insurers to provide drug and alcohol abuse treatment against the potential benefits of doing so. That the General Assembly was aware of treatment costs and intended to limit them is clear from the fact that each portion of Act 106 contains strict limits on the mandated number of days of care or treatment sessions. Our role is distinctly **not** to second-guess the policy choices of the General Assembly.

2006) (citation and emphasis omitted). We have quoted the Court of Appeals for the District of Columbia to explain the utility of a statement of policy:

> As an informational device, the general statement of policy serves several beneficial functions. By providing a formal method by which an agency can express its views, the general statement of policy encourages public dissemination of the agency's policies prior to their actual application in particular situations. Thus the agency's initial views do not remain secret but are disclosed well in advance of their actual application. Additionally, the publication of a general statement of policy facilitates long range planning within the regulated industry and promotes uniformity in areas of [ ] concern.

Pennsylvania Human Relations Commission v. Norristown Area School District, 374 A.2d 671, 676 n.17 (Pa. 1977) (quoting Pacific Gas & Electric Co. v. Federal Power Commission, 506 F.2d 33, 38 (D.C.Cir. 1974)).

Also in Pennsylvania Human Relations Commission, we distinguished a statement of policy from a regulation thusly:

> An administrative agency has available two methods for formulating policy that will have the force of law. An agency may establish binding policy through rulemaking procedures by which it promulgates substantive rules, or through adjudications which constitute binding precedents. A general statement of policy is the outcome of neither a rulemaking nor an adjudication; it is neither a rule nor a precedent but is merely an announcement to the public of the policy which the agency hopes to implement in future rulemakings or adjudications. A general statement of policy, like a press release, presages an upcoming rulemaking or announces the course which the agency intends to follow in future adjudications.
>
> The critical distinction between a substantive rule and a general statement of policy is the different practical effect that these two types of pronouncements have in subsequent administrative proceedings. A properly adopted substantive rule establishes a standard of conduct which has the force of

> law. The underlying policy embodied in the rule is not generally subject to challenge before the agency.
>
> A general statement of policy, on the other hand, does not establish a "**binding norm**". A policy statement announces the agency's tentative intentions for the future. When the agency applies the policy in a particular situation, it must be prepared to support the policy just as if the policy statement had never been issued.

Pennsylvania Human Relations Commission, supra at 679 (quoting Pacific Gas & Electric, supra at 41 (emphasis added)); see also Home Builders Association of Chester and Delaware Counties v. Department of Environmental Protection, 828 A.2d 446, 450-51 (Pa.Cmwlth. 2003), affirmed, 844 A.2d 1227 (Pa. 2004) (same).[16]

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[16] The statutory definitions of a statement of policy and a regulation are as follows:

> **"Regulation"** means any rule or regulation, or order in the nature of a rule or regulation, promulgated by an agency under statutory authority in the administration of any statute administered by or relating to the agency, or prescribing the practice or procedure before such agency.

45 P.S. § 1102(12).

> **"Statement of policy"** means any document, except an adjudication or a regulation, promulgated by an agency which sets forth substantive or procedural personal or property rights, privileges, immunities, duties, liabilities or obligations of the public or any part thereof, and includes, without limiting the generality of the foregoing, any document interpreting or implementing any act of Assembly enforced or administered by such agency.

45 P.S. § 1102(13).

With regard to the above statutory definitions, the Commonwealth Court has pointed out that a statement of policy is defined by what it is, while a regulation is defined by how it is issued. Home Builders Association, supra at 450.

Finally, we note that "a]n agency may revise its policies and amend its regulations in interpreting its statutory mandates." Elite Industries, Inc. v. Pennsylvania Public Utility Commission, 832 A.2d 428, 431-32 (Pa. 2003)

Based on all of the above principles, we have no difficulty concluding that the Department did not err in issuing the Notice as a statement of policy. A straightforward reading of the plain language of the Notice demonstrates that it was meant to advise and to provide guidance as to the legal obligations of those entities subject to Act 106. No additional or more specific duties under Act 106 were placed on any entity by the Notice. Through publication of the Notice, the Department merely announced the policy that it planned to apply in the future, based on the plain text of Act 106. The Department did not abuse its discretion in choosing to follow such a course, and the Federation's fourth and final issue is entirely meritless.

In sum, having concluded that none of the Federation's issues has any merit, we affirm the Commonwealth Court's order granting the Department's motion for judgment on the pleadings.

Order affirmed.

Messrs. Justice Eakin and Baer join the opinion.

Madame Justice Todd files a concurring opinion.

Mr. Justice Saylor files a dissenting opinion in which Mr. Chief Justice Castille joins.