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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2146 Session of 1995

INTRODUCED BY McGEEHAN, THOMAS, BELARDI, LEDERER, PESCI, TRELLO, JAMES, STURLA, SHANER, YOUNGBLOOD, CURRY, ROEBUCK, MANDERINO, TRICH, DeLUCA, KING, VAN HORNE, HORSEY AND PISTELLA, OCTOBER 24, 1995

REFERRED TO COMMITTEE ON HEALTH AND HUMAN SERVICES, OCTOBER 24, 1995

AN ACT

Providing for the certification of managed care health benefits plans.

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Section 14. Rules and regulations.

Section 15. Effective date.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Patient Protection Act.

Section 2. Findings and declaration.

The General Assembly finds and declares that:

(1) Because managed care health benefits plans use techniques that include decisions regarding health benefits coverage and the appropriateness of health care services, it is a vital function of State government to protect patients from unfair managed care practices.

(2) Some insurance companies and other managed care organizations are discontinuing health care providers from their networks after their names have been used to attract new plan members, making decisions to refuse or terminate health care services and other decisions that affect patient health and restricting patients' options regarding their choice of health care provider.

(3) It is essential to ensure fairness in managed care plans and to provide a mechanism for delineating necessary protections for both providers and patients, and it is therefore in the public interest to require the establishment of standards for the certification of managed care plans which will prevent the indirect redlining of certain patients by discontinuing providers who treat those patients and ensure provider fairness, utilization review safeguards and health benefits coverage options for all covered persons.

Section 3. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Carrier." An insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this Commonwealth.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Covered person." A person on whose behalf a managed care entity is obligated to pay benefits pursuant to the managed care plan.

"Covered service." A health care service provider to a covered person under a managed care plan for which the managed care entity is obligated to pay benefits.

"Department." The Department of Health of the Commonwealth.

"Emergency services." Health care services provided after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in placing that person's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

"Health benefits plan." A policy, contract or other agreement delivered or issued for delivery in this Commonwealth by a carrier.

"Health care practitioner." A health care practitioner as

defined in the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Health care provider. A health care facility as defined in the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or a health care practitioner or other provider recognized under Commonwealth law.

"Health care service." A service that is provided by a health care provider, including admitting a patient to a health care facility, and that is involved in or incident to the furnishing to a person of preventive, diagnostic, therapeutic or rehabilitative care for the purpose of ensuring the restoration, protection, maintenance and support of physical, mental or emotional health.

"Managed care entity." A carrier that operates a managed care plan.

"Managed care plan." A health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan. Managed care includes, but is not limited to, a health maintenance organization or HMO, a preferred provider organization or PPO, an exclusive provider organization or EPO, a point-of-service plan or POS or any other similar health benefits delivery system, whether issued by or through a carrier.

"Participating provider." A health care provider that has entered into an agreement with a managed care entity to provide

health care services to a covered person.

"Point-of-service plan." A health benefits delivery system which permits covered persons to choose participating providers outside the managed care plan at the time the health care service is rendered.

"Qualified managed care plan." A managed care plan certified by the Secretary of Health under this act.

"Secretary." The Secretary of Health of the Commonwealth.

"Utilization review program." A system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether or to what extent a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for or otherwise provided under the health benefits plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures and retrospective review.

Section 4. Managed care plan certificate.

(a) General rule.--Except as provided in section 12, beginning of the 180th day after the effective date of this act, a managed care entity shall not operate or offer a managed care plan in this Commonwealth which does not meet the requirements for certification established by the secretary in accordance with the provisions of this act.

(b) Form.--An application for a managed care plan certificate shall be submitted on such a form and in such a manner as the secretary requires, shall be signed under oath by the chief executive officer of the managed care entity or by a

legal representative of the managed care entity and shall include the following:

(1) The name, address, telephone number and normal business hours of the managed care entity.

(2) The name, address and telephone number of a person who is employed by or otherwise represents the managed care entity and who is available to answer questions concerning the application which may be posed by department staff.

(3) The proposed plan of operation for the managed care plan, including the mechanism by which the plan will provide or arrange for the provision of health care services.

(4) Such other information as the secretary may require to ensure that the managed care entity can and will comply with the requirements for certification.

If there is a material change in any of the information included in the application subsequent to its initial submission, including a change subsequent to the issuance or renewal of the certificate, the managed care entity shall inform the secretary of the change on such a form and in such a manner as the secretary requires.

(c) Certificate.--The secretary shall issue a managed care plan certificate to a managed care entity if, in the determination of the secretary, the application demonstrates that:

(1) The proposed managed care plan will provide health care services in a manner to assure adequate availability and accessibility of participating providers and to enhance availability, accessibility and continuity of health care services, including emergency services.

(2) The proposed managed care plan provides a continuous

quality of health care assurance program, a utilization review program which meets standards adopted by the secretary and a complaint resolution mechanism to provide reasonable procedures for the resolution of complaints by participating providers and covered persons.

(3) The managed care entity has established a mechanism to ensure that covered persons are provided an opportunity to participate in matters of policy and operation with respect to the managed care plan through an advisory panel, advisory referenda on major policy decisions, or by other means.

(4) The managed care entity is financially sound and may reasonably be expected to meet its obligations to prospective and actual covered persons, as evidenced by its compliance with financial reserve requirements to be established by the secretary in consultation with the commissioner.

(5) The managed care entity has a procedure to establish and maintain a uniform system of cost accounting approved by the secretary and a uniform system of reports and audits meeting the requirements of the secretary.

(6) The managed care entity has adopted procedures to ensure compliance with all Federal and State laws governing the confidentiality of its records with respect to covered persons and participating providers.

(d) Approval.--Upon receipt of an application for a managed care plan certificate, the secretary shall transmit a copy thereof to the commissioner, whose approval shall be required to the extent that the proposed managed care plan involves the doing of an insurance business or a contract with an insurance company or a hospital service, medical service or health service corporation.

(e) Rejection.--If an application is rejected by the secretary, the commissioner shall specify in what respect it fails to comply with the requirements for certification and, if applicable, the requirements of the commissioner.

(f) Term.--A managed care plan certificate issued pursuant to subsection (a) shall be valid for three years from the date of issuance by the secretary and shall be renewed thereafter upon payment of the renewal fee by the managed care entity if the managed care entity meets such standards for recertification as the secretary may adopt.

(g) Fees.--The secretary shall establish uniform application and renewal fees for the certificate, the amount of which shall be no greater than is reasonably necessary to enable the secretary to carry out the provisions of this act.

Section 5. Notification to covered person.

(a) Notification.--A managed care entity shall notify a prospective covered person in writing as to the terms and conditions of its qualified managed care plan and shall notify a covered person in writing of any changes in those terms and conditions, on a form and in a manner to be prescribed by the secretary. The notice shall be in a uniform format applicable to all qualified managed care plans and written in easily understandable language which is consistent with standards for health insurance coverage offered as a supplement to the Federal Medicare program established pursuant to section 1801 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

(b) Contents.--The notice required pursuant to subsection (a) shall include, but need not be limited to, a description of:

(1) Treatment policies, practice standards and restrictions on covered services.

(2) Prior authorization and any other review requirements with respect to covered services as well as the covered person's right to appeal a utilization review action taken by the managed care plan's utilization review program.

(3) Contractual arrangements with participating providers which limit a covered person's options with respect to the receipt of covered services, as well as a list of the names and professional office addresses of participating providers by provider category.

(4) The ratio of the value of health care benefits provider by the managed care plan to the value of its premiums based upon the plan's preceding year of operation, or, in the case of a new managed care plan, the ratio of the present value of expected health care benefits provided by the plan to the present value of expected premiums.

(5) Financial responsibility requirements for covered persons for covered services provided by a participating provider and for those provided by a nonparticipating provider.

(6) The number of covered persons enrolled during the preceding year, the number at the end of that year and the number whose enrollments were terminated during that year.

(7) The number of providers who contracted with the managed care plan during the preceding year, the number of participating providers at the end of that year and the number who were terminated during that year.

(c) Providing information.--A managed care entity shall also make the information provided under subsection (b)(5) and any changes in the information provided under subsection (b)(1) through (3) available to each of its covered persons on an

annual basis. The information provided under this subsection shall be transmitted to each covered person no later than 45 days preceding the commencement of the person's annual open enrollment period.

Section 6. Utilization review program.

(a) Utilization review.--A qualified managed care plan shall include a utilization review program overseen by a medical director responsible for all decisions made by the program, who shall be a physician licensed by the State Board of Medicine to practice medicine and surgery.

(b) Standards.--The criteria and procedures used by the utilization review program shall be developed in consultation with participating providers, shall be based upon nationally recognized standards and shall be disseminated to each participating provider and to a covered person upon his request.

(c) Inquiries.--The utilization review program shall respond to inquiries regarding or requests for prior authorization for nonemergency health care services from participating providers or covered persons within two business days and shall be available on a 24-hour basis to respond to prior authorization requests for emergency services.

(d) Conditions.--The utilization review program shall not take an adverse utilization review action unless:

(1) the proposed adverse action is reviewed and approved by a health care professional who is competent and legally authorized to perform the health care service that is the subject of the adverse action; and

(2) the utilization review program establishes a procedure whereby any covered person subjected to an adverse utilization review action may appeal that adverse action.

(e) Adverse action.--The utilization review program shall not affirm an adverse utilization review action which is appealed by a covered person unless the appellate review of the action is conducted by a health care professional who was not involved in approving the adverse action, is competent to provide the health care service that is the subject of the adverse action, and is a member of the same health care profession as, or of a health care profession that requires the same level of education as, or a higher level of education than, the covered person's provider of record.

(f) Retrospective coverage.--The utilization review program shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the program for those services, unless the approval was based upon fraudulent information submitted by the covered person or the participating provider.

(g) Prior authorization.--No prior authorization shall be required for emergency service rendered outside of the geographic service area of a managed care plan.

Section 7. Participating provider.

(a) Participating provider.--A managed care entity shall provide an opportunity for any health care provider doing business within the managed care entity's geographic service area to apply to be a participating provider in its plan if the provider is willing to meet the terms and conditions of the plan and also meets the provider credentialing requirements of the plan.

(b) Denial.--A managed care entity shall not deny an application to enter into a contract with a prospective participating provider or terminate a contract with a

participating provider unless the entity provides the provider with written notice of the reasons for denial or termination, as applicable.

(c) Participation.--The managed care entity shall establish a mechanism to ensure that participating providers are able to participate in the development of policies and procedures governing health care services delivery by a qualified managed care plan, including, but not limited to, provider credentialing requirements, coverage of new technology and procedures, quality assurance and health care management procedures.

Section 8. Point-of-service plan option.

(a) Enrollment.--A managed care entity shall provide each covered person in its managed care plan with the opportunity, at the time of enrollment and during a one-month period in each subsequent year, to enroll in a point-of-service plan option, subject to the provisions of subsection (b). The managed care entity shall provide written notice of the point-of-service plan option to each covered person upon enrollment and annually thereafter and shall include in that notice a detailed explanation of the financial costs to be incurred by a covered person who selects that option.

(b) Covered service.--A covered person who enrolls in a point-of-service plan option may receive a covered service from a health care provider who is not a participating provider, but the covered person may be required to pay a higher annual premium which reflects the actuarial value of this expanded coverage, or an annual deductible plus a coinsurance charge which shall not exceed 20% of the cost of the service provided, or both.

Section 9. Termination of contract.

Notwithstanding the provisions of any law to the contrary, if a managed care plan terminates its contract with a participating provider at the plan's initiative, a covered person who has selected that provider to receive covered services may continue to receive covered services from that provider, at the covered person's option, until the end of the covered person's period of enrollment, or for up to one year of treatment, whichever date is later, in the case of postoperative follow-up care, oncological treatment and psychiatric treatment, or, in the case of obstetrical care, through the duration of a pregnancy, including childbirth and, during that period, those health care services shall be covered by the managed care plan under the same terms and conditions as they were covered while the provider was participating in the managed care plan.

Section 10. Misleading or deceptive advertising.

A managed care entity which uses any materially misleading or deceptive advertising copy, advertising practice or plan of solicitation in connection with the solicitation of enrollment in a qualified managed care plan is subject to a denial, suspension or revocation of its managed care plan certificate.

Section 11. Denial, revocation or suspension of certificate.

The secretary may deny, revoke or suspend a certificate issued under this act for a violation of the provisions of this act or the rules and regulations adopted pursuant thereto, after serving a notice on the managed care entity which sets forth the reasons for the secretary's action. The secretary shall provide for an appropriate and timely right of appeal for the managed care entity.

Section 12. Health maintenance organization.

A health maintenance organization which holds a certificate

of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, on the effective date of this act is exempted from the requirement of obtaining a managed care plan certificate under section 4 but shall comply with the provisions of sections 5 through 9.

Section 13. Private purchase of health care services.

Nothing in this act shall be construed as prohibiting a person from purchasing any health care service with that person's own funds, whether or not the service is covered under the person's health benefits plan, or an employer from providing coverage for benefits in addition to those included in the employer's health benefits plan.

Section 14. Rules and regulations.

The secretary shall adopt rules and regulations to carry out the purposes of this act. Regulations shall be adopted in conformity with the provisions of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law and the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

Section 15. Effective date.

This act shall take effect in six months, but the secretary may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.