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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 977 Session of 1997

INTRODUCED BY VANCE, DRUCE, MICOZZIE, COLAFELLA, SAYLOR, WAUGH, CURRY, COLAIZZO, YOUNGBLOOD, SEMMEL, SCHRODER, HENNESSEY, TIGUE, ALLEN, GORDNER, NICKOL, KENNEY, MUNDY, E. Z. TAYLOR, TRICH, HARHART, D. W. SNYDER, MANDERINO, RUBLEY, CARONE, BUNT, ITKIN, TRUE, PESCI, STEELMAN, DeLUCA, CLYMER, CORNELL, JOSEPHS, BOSCOLA, STURLA, BARD, OLASZ, MILLER, L. I. COHEN, SATHER, GEORGE, O'BRIEN, FLEAGLE, BUXTON, STRITTMATTER, MICHLOVIC, STERN, TULLI, HALUSKA, BROWNE, OLIVER, McGILL, THOMAS, BEBKO-JONES, TRELLO, BELFANTI AND GRUPPO, MARCH 19, 1997

REFERRED TO COMMITTEE ON HEALTH AND HUMAN SERVICES, MARCH 19, 1997

AN ACT

Requiring certification of utilization review entities; providing for appeal processes for providers, for the disclosure of certain uniform information and for delivery of health care in a cost-effective manner.

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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 Health Plan Accountability Act.

Section 2. Purposes.

The purposes of this act are to:

(1) Promote the delivery of health care in a cost-effective manner.

(2) Foster greater coordination among health care providers, patients and payers.

(3) Promote patient access to quality health care in a timely fashion.

(4) Safeguard patients by certifying the activities of utilization review entities.

(5) Provide sufficient information to providers regarding utilization review processes, criteria and the procedures for appealing utilization review determinations.

(6) Establish an appeals process that may be used by providers to appeal adverse utilization review determinations by utilization review entities.

(7) Establish minimum provider credentialing standards to be used by payers.

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:

"Accrediting body." A nationally recognized accrediting agency.

"Active clinical practice." A health care practitioner who practices clinical medicine on the average of not less than 20 hours per week.

"Clinical review criteria." The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a utilization review entity to evaluate the necessity and appropriateness of health care services delivered or proposed to be delivered.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Covered individual." An enrollee or an eligible dependent of an enrollee.

"Credentialing criteria." The standards used by a payer to evaluate the qualifications of a health care practitioner or health care facility to participate in the payer's provider network.

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

"Enrollee." An individual who has contracted for or who participates in coverage under:

(1) an insurance policy issued by a professional health service corporation, hospital plan corporation or a health and accident insurer;

(2) a contract issued by a health maintenance organization or a preferred provider organization; or

(3) other benefit programs providing payment,

reimbursement or indemnification for the costs of health care for the covered individual.

"Health care facility." Any health care facility providing clinically related health services, including, but not limited to, a general or special hospital, including psychiatric hospitals, rehabilitation hospitals, ambulatory surgical facilities, long-term care nursing facilities, cancer treatment centers using radiation therapy on an ambulatory basis and inpatient drug and alcohol treatment facilities.

"Health care insurer." Any entity operating under any of the laws listed in section 14.

"Health care practitioner." Any individual who is licensed, certified or otherwise regulated to practice health care under the laws of this Commonwealth, including, but not limited to, a physician, a dentist, a podiatrist, an optometrist, a psychologist, a physical therapist, a certified registered nurse practitioner, a registered nurse, a nurse midwife, a physician's assistant or a chiropractor.

"Integrated delivery system." A partnership, association, affiliation, corporation or other legal entity which enters into contractual, risk-sharing arrangements with health insurers to provide or arrange for the provision of health care services and assumes some responsibility for quality assurance, utilization review, provider credentialing and related functions and which assumes to some extent, through capitation reimbursement or other risk-sharing arrangement, the financial risk for provision of health care services to enrollees.

"Licensing authority." The licensing authority of the health insurers listed in section 14.

"Payer." Any entity operating under any of the laws listed

in section 14 as well as any other entity employing, affiliated with or contracting with a utilization review entity or paying for credentialing activities.

"Provider network." The health care practitioners and health care facilities designated by a payer for enrollee use in obtaining covered heath care services. This term shall not apply to broad-based networks that are primarily fee-for-service, indemnity arrangements with minimum participation requirements and limited utilization review procedures.

"Provider of record." The physician, licensed practitioner or health care facility identified to a utilization review entity or insurer as having prescribed, proposed to provide or provided health care services to a covered individual.

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

"Utilization review." A system for prospective, concurrent, retrospective review or case management of the medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual. The term does not include any of the following:

(1) requests for clarification of coverage, eligibility or benefits verification;

(2) a health care facility's or a health care practitioner's internal quality assurance or utilization review process unless such review results in a denial of payment, coverage or treatment; or

(3) refusal to contract with health care practitioners or health care facilities.

"Utilization review determination." The rendering of a decision based on utilization review that approves or denies either of the following:

(1) the necessity or appropriateness of the allocations of health care resources to a covered individual; or

(2) the provision or proposed provision of covered health care services to an enrollee.

"Utilization review entity." Any payer or any entity performing utilization review while employed by, affiliated with, under contract with or acting on behalf of any of the following:

(1) an entity doing business in this Commonwealth;

(2) an integrated delivery system;

(3) a party that provides or administers health care benefits to citizens of this Commonwealth, including a health care insurer, self-insured plan, professional health service corporation, hospital plan corporation, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts to pay for the delivery of health care services or treatment in this Commonwealth; or

(4) the Commonwealth or any of its political subdivisions or instrumentalities.

The term shall not include entities conducting internal utilization review for health care facilities, home health agencies, health maintenance organizations, preferred provider organizations or other managed care entities, or private health care professional offices, unless the performance of such utilization review results in the denial of payment, coverage or treatment.

Section 4. Certification of utilization review entity.

(a) Certification required.--A utilization review entity may not conduct utilization review regarding services delivered or

proposed to be delivered in this Commonwealth unless the entity is certified by the department to perform such services or unless the entity is an integrated delivery system whose utilization review standards have already been approved by the department and adopted for use by a certified utilization review entity. A utilization review entity that has been operating in this Commonwealth prior to the effective date of this act may continue to conduct utilization review for not more than one year after the effective date of this act pending an initial certification determination by the department regarding that entity. The department shall grant certification to any utilization review entity that satisfies the utilization review standards included in sections 5 and 6.

(b) Renewal.--Certification shall be renewed every three years unless sooner revoked or suspended by the secretary.

(c) Accrediting bodies.--The department may rely on nationally recognized accrediting bodies to the extent the standards of the bodies are determined by the department to substantially meet or exceed the criteria in section 5 and if the entity agrees to the following:

(1) Direct the accrediting body to provide a copy of its findings to the department.

(2) Permit the department to verify compliance with standards not covered by the accrediting body.

(d) Fees.--The secretary is authorized to prescribe fees for initial application and renewal of certification. The fees shall not exceed the administrative costs of the certification process.

(e) Procedures.--Licensed health insurers are required to follow the standards and procedures contained in this act, but

are not required to be separately certified as utilization review entities by the department.

Section 5. Utilization review standards.

(a) Requirements.--Utilization review entities providing services in this Commonwealth must satisfy all of the following requirements:

(1) For the purpose of responding to inquiries concerning the entity's utilization review determinations:

(i) provide toll-free telephone access at least 40 hours each week during normal business hours;

(ii) maintain a telephone call answering service or recording system during hours other than normal business hours; and

(iii) respond to each telephone call left with the answering service or on the recording system within one business day after the call is left with respect to the review determination.

(2) Protect the confidentiality of individual medical records:

(i) as required by all applicable Federal and State laws and ensure that a covered individual's medical records and other confidential medical information obtained in the performance of utilization review are not improperly disclosed or redisclosed;

(ii) by only requesting medical records and other information which are reasonably necessary to make utilization review determination for the care under review; and

(iii) have mechanisms in place that allow a provider to verify that an individual requesting information on

behalf of the organization is a legitimate representative of the organization.

(3) Unless required by law or court order, prevent third parties from obtaining a covered individual's medical records or confidential information obtained in the performance of utilization review.

(4) Assure that personnel conducting utilization review shall have current licenses that are in good standing and without restrictions from a state health care professional licensing agency in the United States.

(5) Within one business day after receiving a request for an initial utilization review determination that includes all information reasonably necessary to complete the utilization review determination, notify the enrollee and the provider of record of the utilization review determination by mail or other means of communication.

(6) Include the following in the written notification of a utilization review determination denying coverage for an admission, service, procedure, medical supplies and equipment or a request for approval of continuing treatment for the condition involved in previously approved admissions, services or procedures, medical supplies and equipment:

(i) the principal reasons for the determination if the determination is based on medical necessity or the appropriateness of the admission, service, procedure, medical supplies and equipment, or extension of service; and

(ii) the description of the appeal procedure, including the name and telephone number of the person to contact in regard to an appeal and the deadline for

filing an appeal.

(7) Ensure that initial adverse utilization review determination as to the necessity or appropriateness of an admission, service, procedure or medical supplies and equipment is made by a licensed physician or, if appropriate, a psychologist.

(8) Ensure that on appeal all determinations not to certify an admission, service, procedure, medical supplies and equipment or extension of stay must be made by a licensed physician or, if appropriate, a psychologist in the same or similar general specialty as typically manages or recommends treatment for the medical condition, procedure or treatment. Further, no physician or psychologist who has been involved in prior reviews of the case under appeal may participate as the sole reviewer of a case under appeal.

(9) Provide a period of at least 24 hours following an emergency admission, service, procedure or medical supplies and equipment during which an enrollee or representative of an enrollee may notify the health care insurer and request approval or continuing treatment for the condition under review in the admission, extension of stay, service, procedure, medical supplies and equipment.

(10) Provide an appeals procedure satisfying the requirements set forth in this act.

(11) Disclose utilization review criteria to providers upon denial.

(b) Alternative practices.--Payers and providers may establish alternative utilization review standards, practices and procedures by contract that meet or exceed the requirements in subsection (a) and that are approved by the department.

Section 6. Utilization review decisions and internal appeals.

Payers that encourage or require enrollees to obtain all or designated covered services through a provider network shall conform to the following provisions:

(1) Notification of a prospective or concurrent utilization review determination shall be communicated with the provider of record within one business day of the receipt of all information necessary to complete the review. For retrospective determinations, notice shall be given within 15 days.

(2) The utilization review entity shall maintain and make available a written description of the appeal procedure by which the provider of record may seek review of the determination to deny an admission, service, procedure, medical supplies and equipment or extension of stay.

(3) The internal appeals process shall be established by the utilization review entity and must include a reasonable time period of not less than 45 days following receipt of the written notification of the adverse determination within which an appeal must be filed to be considered.

(4) The utilization review entity shall render a determination of appeals of adverse determinations no later than 45 days from the date the appeal and all supporting documentation is filed.

(5) The utilization review entity shall provide for an expedited appeals process for emergency or life-threatening situations. Adjudication of expedited appeals shall be completed within 48 hours of the time the appeal is filed.

(6) Compensation to any person performing utilization review activities shall not contain incentives, direct or

indirect, for that person to approve or deny coverage for admissions, services, procedures, medical supplies and equipment or extension of stays.

(7) The utilization review entity shall maintain records of written appeals and their resolution and shall provide reports to their licensing authority or as requested by the department.

(8) The department may, in response to a written complaint by a provider, review the payer's adherence to the requirements of this act.

Section 7. External utilization review appeals.

The utilization review plan of utilization review entities or health care insurers must provide for independent external adjudication in cases where the second level of appeal to reverse an adverse determination is unsuccessful that adheres to the following provisions:

(1) The provider of record may initiate the external appeal within 60 days of the adverse determination by submitting written notice to the utilization review entity or health care insurer.

(2) The utilization review entity or health care insurer and the provider of record shall each select one competent arbitrator within 30 days from the date the appeal is initiated. The two selected arbitrators shall then select a competent third arbitrator. The arbitration shall take place in the county in which the appealing party resides or practices.

(3) At least one arbitrator shall be a licensed physician or, if appropriate, a psychologist, in active clinical practice in the same or similar specialty as

typically manages or recommends treatment for the medical condition under review. The remaining arbitrators shall also be licensed health care practitioners.

(4) The arbitrators shall review the information considered by the health care insurer in reaching its decision and any written submissions of the provider of record provided during the internal appeal process. The decision to hold a hearing or otherwise take evidence shall be within the sole discretion of a majority of the arbitrators.

(5) The written decision of any two arbitrators shall be issued no later than 30 days after receipt of all documentation necessary to rule upon the appeal and shall be binding upon each party.

(6) The arbitrators' fees and costs of the appeal shall be paid by the nonprevailing party.

(7) Written contracts between health care insurers and providers may provide for an alternative to the external appeal process as long as that contract or process has been approved by the department. In such cases, a provider may appeal to a physician committee appointed by the governing body of the utilization review entity or health care insurer. No physician serving on the committee to review such appeals may be an employee of the utilization review entity or health care insurer. The provider of record may present information supporting his or her position either in writing or by appearing before the committee in person to do so. The alternative appeals process must include time frames for initiating appeals, receiving written information, holding hearings and rendering final determinations. The committee's

decision is the utilization review entity's health care insurer's final determination. If the decision is unfavorable to the provider of record or health care insurer, the provider of record or health care insurer may seek additional remedies in the appropriate court of jurisdiction, as a matter of original jurisdiction pursuant to 42 Pa.C.S. § 761 (relating to original jurisdiction), to the extent such remedies are provided by law.

Section 8. Provider credentialing.

Payers that encourage or require enrollees to obtain all or designated covered services through a provider network shall conform to the following provisions:

(1) Payers must ensure that there are sufficient health care practitioners and health care facilities within a provider network to provide enrollees with access to quality patient care in a timely fashion.

(2) Payers shall consult with practicing physicians regarding the professional qualifications, specialty and geographic composition of the physician panel. The payer shall report the composition of its provider network, including the extent to which providers in the network are accepting new enrollees from the insurer, to its licensing authority every two years, or in response to significant changes in the provider network, or as otherwise required by the licensing authority.

(3) A payer shall select the participating health care practitioners and health care facilities for its provider network through a formal credentialing process that includes criteria and processes for initial selection, recredentialing and termination. The payer shall report the credentialing

criteria and processes to its licensing authority every two years, or in response to significant changes in the criteria and/or processes, or as otherwise required by the licensing authority.

(4) A payer shall disclose to applicants and to providers participating in its network all credentialing criteria and processes used by the payer and approved by the department or by a nationally recognized accrediting body. The proceedings, deliberations and records of a payer with respect to the credentialing of health care providers, however, shall be held in confidence and shall not be subject to discovery or entered into evidence in any civil action against a payer to the same degree that such deliberations, proceedings and records are protected under the act of July 20, 1974 (P.L.564, No.193), known as the Peer Review Protection Act.

(5) A payer shall not discriminate against patients with expensive medical conditions by excluding from its network health care practitioners with practices that include a substantial number of such patients and consistent with other credentialing criteria.

(6) A payer shall not exclude a health care practitioner or health care facility from its provider network because the practitioner or facility has advocated on behalf of a patient in a utilization appeal or another dispute with the plan over the provision of medical care.

(7) In the event a payer renders an adverse credentialing decision, the payer shall provide the affected health care practitioner or health care facility with written notice of the decision that includes a clear explanation of

the basis for the decision.

Section 9. Uniform disclosure.

(a) Format.--The commissioner shall adopt a uniform format for the disclosure of the terms and conditions of health insurance plans.

(b) Contents.--The uniform format shall include, at a minimum, the following provisions:

(1) The benefits and any and all exclusions.

(2) Any and all enrollee coinsurance, copayments and deductibles.

(3) Any and all maximum benefit limitations.

(4) Any and all requirements or limitations regarding the choice of provider.

(5) Disclosure of any and all physician incentive plans.

(6) Enrollee satisfaction statistics.

(c) Mandatory use.--Payers shall make the information required by the commissioner available to purchasers and potential enrollees in the format adopted by the commissioner.

(d) Understandable terms.--The information shall be written in terms understandable to the general public.

Section 10. Penalties.

The department may impose a fine of up to but not more than $10,000 for each violation of this act. In addition, the department may deny, suspend, revoke or refuse to renew the certification of a utilization review entity or health care insurer that fails to satisfy the utilization review standards set forth in section 5 or that otherwise violates the provisions of this act. The utilization review entity or health care insurer shall be entitled to notice and the right to a hearing pursuant to 2 Pa.C.S. (relating to administrative law and

procedure).

Section 11. Rulemaking.

The secretary and the commissioner are authorized to promulgate regulations to implement this act.

Section 12. Severability.

The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Section 13. Repeals.

All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 14. Applicability.

This act shall apply to health care utilization review entities or health care insurers operating under any one of the following:

(1) Section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) Act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) Act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch.61 (relating to hospital plan corporations).

(5) 40 Pa.C.S. Ch.63 (relating to professional health services plan corporations) except for section 6324 (relating to rights of health service doctors).

(6) A fraternal benefit society charter.

(7) Any successor laws.

Section 15. Effective date.

This act shall take effect in 120 days.