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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, GRUPPO, BOYES, ROSS, RAMOS, BARRAR, ZUG, ORIE, DENT, SEYFERT, BAKER, McNAUGHTON AND SCRIMENTI, MARCH 19, 1997

AS AMENDED ON THIRD CONSIDERATION, HOUSE OF REPRESENTATIVES, APRIL 27, 1998

AN ACT

Providing for managed health care utilization review; imposing duties on managed care entities; providing for disclosure, civil immunity and penalties; and conferring powers and duties on the Department of Health and the Insurance Department.

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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 Managed Care Accountability Act.

Section 2. Purpose.

The purposes of this act are to:

(1) Promote the delivery of accessible, quality and cost-effective health care in a timely fashion in this Commonwealth.

(2) Promote cooperation among health care providers, patients and health care insurers.

(3) Provide for the certification of and standards to be used by utilization review entities.

(4) Establish a process for health care providers to appeal denials based on medical necessity and appropriateness.

(5) Require the establishment, use and disclosure of provider credentialing standards.

(6) Require uniform format and disclosure of the terms and conditions of health care insurer contracts.

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:

"Active clinical practice." The practice of clinical medicine by a health care practitioner for an average of not less than 20 hours per week.

"Clean claim." As defined in section 1816(c)(2)(B)(i) of the

Social Security Act (49 Stat. 648, 42 U.S.C. § 1395h(c)(2)(B)(i)) which has no defect or impropriety. A defect or impropriety under this definition includes lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payments from being made on the claim.

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

"Concurrent utilization review." A review by a utilization review entity of all necessary supporting information which occurs during an enrollee's hospital stay or course of treatment and which results in a decision to approve or deny payment for a health care service.

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

"Denial." A determination by a managed care entity or utilization review entity which is based upon the medical necessity and appropriateness of health care services covered under the terms and conditions of the contract which are prescribed, provided or proposed to be provided and which:

(1) disapproves payment for a requested health care service completely;

(2) approves the provision of a requested health care service for a lesser scope or duration than requested by a health care practitioner or health care facility; or

(3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

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

"Emergency medical condition." The sudden onset of a medical or psychiatric condition which manifests itself by acute symptoms of a sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of a bodily organ or part.

"Emergency health care services." Health care services which are furnished by a provider as a result of an emergency medical condition.

"Enrollee." A policy holder, subscriber, covered person or other individual, including a dependent, entitled to receive health care coverage under a managed care entity's insurance policy or contract issued in this Commonwealth.

"Health care facility." A facility providing clinically related health care services. The term includes a general or special hospital, a psychiatric hospital, a rehabilitation hospital, an ambulatory surgical facility, a long-term NURSING <— care facility, a cancer treatment center using radiation therapy on an ambulatory basis, a ~~birthing~~ BIRTH center, an inpatient or <— outpatient drug and alcohol treatment facility, a home health care facility and a hospice facility.

"Health care practitioner." An individual who is licensed, certified or otherwise authorized to provide health care services under the laws of this Commonwealth and whose license, certificate or authorization is in good standing and without restrictions from the appropriate professional licensing agency.

"Health care services." Any treatment, admission, procedure, service, medical supplies and equipment, continuing treatment or extension of a stay, which is prescribed, provided or proposed to be provided by a health care practitioner or health care facility. The term includes services covered under the terms and conditions of a managed care plan contract.

"Integrated delivery system." Any partnership, association, affiliation, corporation, limited liability corporation or other legal entity which:

(1) enters into contractual, risk-sharing arrangements with managed care entities to provide or arrange for the provision of health care services;

(2) assumes some responsibility for quality assurance, utilization review, provider credentialing and related functions; and

(3) assumes to some extent, through capitation reimbursement or other risk-sharing arrangement, the financial risk for provision of health care services to enrollees.

"Managed care entity." A comprehensive health care plan which integrates the financing and delivery of health care services, including behavioral health, to enrollees through a network, with participating providers selected to participate on the basis of specific standards and which provides financial incentives for enrollees to use the network providers in

accordance with the plan's procedures. The term does not include a network which is primarily fee-for-service, indemnity arrangement ~~with no managed care component~~. The term includes <—
health care plans provided through a policy or contract authorized under any 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) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(5) A fraternal benefit society charter.

(6) A contract with the Department of Public Welfare to provide medical assistance on a capitated basis.

"MEDICAL NECESSITY." CLINICAL DETERMINATIONS TO ESTABLISH A <—
SERVICE OR BENEFIT WHICH WILL OR IS REASONABLY EXPECTED TO:

(1) PREVENT THE ONSET OF AN ILLNESS, CONDITION OR DISABILITY;

(2) REDUCE OR AMELIORATE THE PHYSICAL, MENTAL, BEHAVIORAL OR DEVELOPMENTAL EFFECTS OF AN ILLNESS, CONDITION, INJURY OR DISABILITY; OR

(3) ASSIST THE INDIVIDUAL TO ACHIEVE OR MAINTAIN MAXIMUM FUNCTIONAL CAPACITY IN PERFORMING DAILY ACTIVITIES, TAKING INTO ACCOUNT BOTH THE FUNCTIONAL CAPACITY OF THE INDIVIDUAL AND THOSE FUNCTIONAL CAPACITIES APPROPRIATE FOR INDIVIDUALS OF THE SAME AGE.

"PRIMARY CARE PROVIDER" OR "PCP." A PROVIDER WHO SUPERVISES, COORDINATES AND PROVIDES INITIAL AND BASIC CARE TO ENROLLEES,

WHO INITIATES THEIR REFERRAL FOR SPECIALIST CARE AND WHO MAINTAINS CONTINUITY OF PATIENT CARE. PROVIDERS MAY ONLY PROVIDE CARE WITHIN THE SCOPE OF THEIR PRACTICE.

"Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information which:

(1) results in a decision to approve or deny payment for a health care service; and

(2) occurs prior to the delivery or provision of the health care service.

"Provider network." The health care practitioners and health care facilities designated by a managed care entity to provide covered health care services to an enrollee.

"Provider." The health care practitioner or health care facility that prescribes, provides or proposes to provide a health care service to an enrollee.

"Retrospective utilization review." A review by a utilization review entity of all necessary supporting information which:

(1) results in a decision to approve or deny payment for a health care service; and

(2) occurs following delivery or provision of the health care service.

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

(1) Requests for clarification of coverage, eligibility

verification or benefits verification.

(2) An internal quality assurance or utilization review process of a provider unless the review results in a denial.

"Utilization review entity." An entity that performs utilization review on behalf of a managed care entity providing coverage to residents of this Commonwealth.

Section 4. Certification of utilization review entity.

(a) Certification required.--

(1) Except as set forth in paragraph (2), a utilization review entity may not conduct utilization review regarding health care services delivered or proposed to be delivered in this Commonwealth unless the entity is certified by the department to perform a utilization review.

(2) Paragraph (1) shall not apply to a utilization review entity operating in this Commonwealth on July 1, 1998, for one year following the effective date of this section.

(b) Renewal.--Certification must be renewed every three years unless otherwise suspended or revoked by the department.

(c) Accrediting bodies.--The department may utilize a nationally recognized accrediting body's standards to certify utilization review entities to the extent that the accrediting body's standards meet or exceed the standards set forth in section 5 if the entity agrees to do all of 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 addressed by the accrediting body.

(d) Standard.--The department shall grant certification to a utilization review entity which meets the applicable requirements of sections 5, 6, 7 and 8.

(e) Fees.--The department may prescribe fees for application for and renewal of certification. The fees shall reflect the administrative costs of certification.

(f) Managed care entities and integrated delivery systems.--

(1) A managed care entity shall comply with the standards and procedures of this act, but is not required to be separately certified as a utilization review entity.

(2) An integrated delivery system under a contract which has been approved by the department is not required to be separately certified as a utilization review entity.

Section 5. Utilization review operational standards.

(a) Requirements.--Utilization review entities providing services in this Commonwealth shall comply with all of the following:

(1) Respond to inquiries relating to the entity's utilization review determinations by:

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

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

(iii) responding by mail or other means to each telephone call regarding a review determination received by the answering service or recording system within one business day after the receipt of the call.

(2) Protect the confidentiality of individual medical records by:

(i) complying with all applicable Federal and State laws and professional ethical standards to ensure that an enrollee's medical records and other confidential medical

information obtained in the performance of utilization review are not improperly disclosed or redisclosed;

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

(iii) adopting mechanisms to allow a provider of record to verify that an individual requesting information on behalf of the managed care entity is a legitimate representative of the entity; and

(iv) deeming a Commonwealth official, who is acting on behalf of a consumer and who requests in writing specific information from the managed care entity or its agents, to have the consent of the consumer to release the information specific to the request.

(3) Render utilization review decisions based on the medical necessity and appropriateness of the health care service being reviewed.

(4) Provide an appeals process consistent with the provisions of this act.

(5) Maintain and make available a written description of all appeals and related procedures by which a provider may seek review of a denial.

(6) Ensure that personnel conducting utilization review have current licenses in good standing and without restrictions from the appropriate professional licensing agency.

(7) Comply with all time frames set forth in this act.

(8) Provide written denials to include:

(i) the specific clinical criteria and the principal

reasons for the decision; and

(ii) a description of the procedure by which the provider may appeal a denial, including the name and telephone number of the person to contact in regard to an appeal and the deadline for filing an appeal.

(9) Maintain for not less than three years a written record of each utilization review denial, including a detailed justification of the denial and the notification to the provider and the enrollee.

(10) Notify the provider of record of the specific facts or documents required to complete the utilization review within 48 hours of receipt of the request for review if the utilization review entity lacks necessary supporting information.

(11) Provide a period of at least 24 hours following an emergency health care service during which the provider, enrollee or enrollee's designee may notify a managed care entity and request the approval for continuation of health care services for the condition under review.

(b) Compensation.--Compensation to any person performing utilization review activities may not contain incentives, direct or indirect, for the person to approve or deny payment for the delivery or coverage of health care services.

(c) Alternative resolution.--Managed care entities and providers may establish by contract alternative utilization review standards, practices and procedures which meet or exceed the requirements of subsection (a) and are approved by the department.

Section 6. Initial utilization review decisions.

(a) Review.--An initial utilization review which results in

a denial must be made by a licensed physician.

(b) Notification.--Notification of an initial utilization review decision shall be made within the following time frames:

(1) A prospective utilization review decision shall be communicated to the provider and, in the case of a denial, to the enrollee within 48 hours of the receipt of all supporting information necessary to complete the review.

(2) A concurrent utilization review decision shall be communicated to the provider and, in the case of a denial, to the enrollee within 24 hours of the receipt of all supporting information necessary to complete the review.

(3) A retrospective utilization review decision shall be communicated to the provider and, in the case of a denial, to the enrollee within 30 days of the receipt of all supporting information necessary to complete the review.

Section 7. Internal appeals.

A denial may be appealed by the provider, with the consent of the enrollee, to an internal appeals process under section 5(a)(4). The internal appeals process must do all of the following:

(1) Include a time period of 45 days following receipt of the written notification of denial within which an appeal may be filed. The notification of denial must include the name, address and telephone number of the entity to which the provider may appeal the denial.

(2) Notify the provider and the enrollee of a decision no later than 45 days from the date the appeal and all necessary supporting information is filed.

(3) Ensure that a denial resulting from an internal appeal under this section is made by a licensed physician in

the same or similar specialty which typically manages or consults on the health care services. The physician who rendered an initial denial may not render a decision on an appeal of that denial.

(4) Provide an expedited internal appeals process for a situation in which the enrollee's life or health would be seriously jeopardized or the enrollee's ability to regain maximum function would be jeopardized. This paragraph includes notification of the provider and enrollee within 48 hours of the time the appeal was filed.

(5) Maintain records of internal appeals and the resulting determinations for not less than three years and provide the records to the department upon request.

Section 8. Independent external review process.

(a) Requirements.--A managed care entity shall establish an independent external review process to which a provider may appeal a denial by the internal process. The independent external review process must meet the following requirements:

(1) The provider may, WITH THE CONSENT OF THE ENROLLEE, <—
initiate the independent external review within 15 days of receipt of a denial by the internal appeals process by:

(i) submitting a written notice, including any material justification and all necessary supporting information, to the managed care entity; and

(ii) notifying the enrollee and the department that an independent external review has been requested.

(2) The utilization review entity which conducted the internal appeal shall forward copies of all written documentation associated with the denial, including all necessary supporting information, a summary of applicable

issues, a statement of the utilization review entity's decision, the criteria used and the clinical reasons for the decision, to the independent external review entity within 15 days of the receipt of the request for review. The managed care entity shall notify the provider of the name, address and telephone number of the selected independent review entity.

(3) Independent external review decisions shall be made by:

(i) one or more licensed physicians in active clinical practice or in the same or similar specialty which typically manages or recommends treatment for the health care service under review; or

(ii) one or more physicians currently certified by a board approved by the American Board of Medical Specialties or the American Board of Osteopathic Specialties, in the same or similar specialty which typically manages or recommends treatment for the health care service under review.

(4) The independent external review entity shall evaluate and analyze the case and render a written decision to the managed care entity and the provider within 30 days. The standard of review shall be whether the denial by the internal appeal ~~was medically necessary and appropriate.~~ <—
PROCESS SHOULD BE SUSTAINED BECAUSE THE PROPOSED COURSE OF <—
TREATMENT WAS NOT MEDICALLY NECESSARY AND APPROPRIATE. The decision shall be subject to appeal to a court of competent jurisdiction within 60 days of receipt of the external review entity's written decision. There shall be a rebuttable presumption in favor of the decision of the independent

external review entity.

(5) The managed care entity shall authorize any ~~covered~~ health care service or pay any claim determined to be medically necessary and appropriate under paragraph (4), whether or not an appeal to a court of competent jurisdiction has been filed. If the managed care entity fails to authorize the health care service or pay the claim within 15 days of receipt of notice of approval by the independent external review entity, interest shall be assessed at a rate of 10% per year, notwithstanding the 45-day period in section 12. <—

(6) All fees and costs related to an independent external review shall be paid by the nonprevailing party. The provider and the utilization review entity or managed care entity shall each place in escrow an amount equal to one-half of the estimated costs of the independent external review. The escrow shall be held by the independent external review entity.

(b) Certified utilization review.--The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this section and that are qualified to perform independent external reviews. The department may remove an independent external review entity from the list if the department determines that the entity is incapable of performing its responsibilities or violates this act.

(c) Assignment.--

(1) The department shall randomly assign requests for an independent external review to those certified utilization review entities listed in subsection (b) within one business day of receiving a request pursuant to subsection (a)(1).

(2) If the 8 hours during which the department is open to the public expire and the department fails to select the utilization review entity at random, the managed care entity shall designate the utilization review entity certified under section 4 and subsection (b) to conduct the independent external review.

(3) The department shall report annually to the General Assembly its findings based on information it receives pursuant to subsection (d)(4). The report shall include a summary of any complaints it has received concerning entities listed under this section and any corrective actions it has taken as a result of such complaints. ~~The department shall make its annual report available to the public.~~ <—

(d) Procedure.--The independent external review entity shall do all of the following:

(1) Mail written acknowledgment of the receipt of the notice of appeal to the provider, the managed care entity and the utilization review entity which performed the internal appeal.

(2) Review the information considered by the entities which conducted the initial utilization review and the internal appeal to reach a decision to deny payment for health care services and any other written submissions by the provider.

(3) Mail to the provider, the utilization review entity and the managed care entity a written notice describing specific utilization review criteria and the principal reasons for the denial of payment for health care services by the independent external review entity. Notice of the decision shall also be sent to the enrollee.

(4) Report to the department the number, type and disposition of each appeal every six months. The report shall include the names of the providers, utilization review entities and managed care entities involved and whether the utilization review entity was selected at random or chosen by the managed care entity.

(e) Fees.--Fees to file for an independent external review may not exceed fees established by the Medicare program for similar consultations, unless otherwise agreed by the parties to the appeal and the independent external review entity.

(f) Alternative dispute resolution.--Written contracts between managed care entities and providers may provide for an alternative dispute resolution system to the independent external review if the department approves the contract. The alternative dispute resolution system must include specific time limitations to initiate appeal, receive written information, conduct a hearing and render a final decision; provide for impartial reviewers that meet the requirements of section 5(a); and require that reviewers be licensed consistent with subsection (a)(3). A written decision pursuant to an alternative dispute resolution system shall be final and binding on all parties.

(g) Consumer grievances.--Nothing in this section shall interfere with an enrollee's right to access a consumer grievance process.

(h) Confidentiality.--The proceedings, deliberations and records of a managed care entity regarding utilization review of health care services shall be confidential and may not be subject to discovery or entered into evidence in any civil action with the exception of appeals under subsection (a)(4)

against a managed care entity to the same degree that such information is protected by the act of July 20, 1974 (P.L.564, No.193), known as the Peer Review Protection Act. Individuals supplying such information or participating in their use shall be entitled to the same immunities as provided under that act.

Section 9. Participating providers.

(a) Requirements.--A managed care entity shall do all of the following:

(1) Ensure that there are sufficient health care practitioners and health care facilities within a provider network to provide enrollees with access to quality health care services in a timely fashion AND WITHIN A REASONABLE <—
DISTANCE. A MANAGED CARE ENTITY SHALL NOT SELL A HEALTH CARE PLAN IN ANY COUNTY UNLESS THE PROVIDER NETWORK FOR THAT PLAN INCLUDES AT LEAST ONE PRIMARY CARE PROVIDER WHO PRACTICES IN THAT COUNTY.

(2) Consult with health care practitioners in active clinical practice regarding the professional qualifications, specialty and geographic composition of the provider network.

(3) Report the composition of its provider network, including the extent to which providers in the network are accepting new enrollees, to the department:

(i) every two years;

(ii) after significant changes in the provider network; and

(iii) as often as required by the department.

(4) PERMIT ENROLLEES TO DO ALL OF THE FOLLOWING: <—

(I) RECEIVE CHIROPRACTIC CARE WITHOUT PRIOR APPROVAL FROM A PRIMARY HEALTH CARE PRACTITIONER WHO IS PARTICIPATING IN THE MANAGED CARE ENTITY'S PROVIDER

NETWORK.

(II) RECEIVE COVERAGE FOR 80% OF THE COST OF CHIROPRACTIC CARE FROM A HEALTH CARE PROVIDER WHO IS NOT PARTICIPATING IN THE MANAGED CARE ENTITY'S PROVIDER NETWORK.

(b) Prohibitions.--A managed care entity may not discriminate against patients with expensive medical conditions by excluding from its network health care practitioners with practices which include a substantial number of such patients, consistent with the criteria set forth in section 10.

Section 10. Provider credentialing.

(a) Process.--

(1) A managed care entity shall establish a formal credentialing process to enroll the participating health care practitioners and health care facilities for a provider network. The process shall include written criteria and processes for initial enrollment, renewal, restrictions and termination. The managed care entity shall report on the established credentialing criteria and procedures to the department:

(i) every two years;

(ii) after significant changes in the criteria or process; and

(iii) as often as required by the department.

(2) The criteria and procedures must be approved by the department. The department may utilize a nationally recognized accrediting body's standards for provider credentialing.

(3) The managed care entity's compliance with the purposes of section 2 shall be monitored by the department to

ensure compliance.

(b) Disclosure.--A managed care entity shall disclose all credentialing criteria and procedures to health care practitioners and health care facilities that apply to participate or are participating in its network. The proceedings, deliberations and records of a managed care entity regarding the credentialing of health care providers shall be confidential, may not be subject to discovery and may not be entered into evidence in a civil action against a managed care entity, to the same degree that such information is protected by ~~the Peer Review Protection Act.~~ THE ACT OF JULY 20, 1974 (P.L.564, NO.193), KNOWN AS THE PEER REVIEW PROTECTION ACT. Individuals supplying such information or participating in ~~their~~ ITS use shall be entitled TO the same immunities as provided under that act.

(c) Exclusion prohibited.--A managed care entity may not exclude or terminate a health care practitioner or health care facility from its provider network because the practitioner or facility advocated for medically appropriate health care; advocated on behalf of a patient or health care service in any utilization review, appeal or other dispute regarding the provision of health care services; or protested a decision, policy or practice of a managed care entity or other health insurer.

(d) Provider conscience clause.--A managed care entity may not exclude, discriminate against or penalize any provider for its refusal to allow, perform, participate in or refer for health care services, when such refusal of the provider is by reason of moral or religious grounds provided that provider makes available such information to enrollees or, if applicable,

prospective enrollees.

(e) Written decisions.--If a managed care entity denies credentialing or recredentialing to an applicant, the managed care entity shall provide the ~~health care practitioner or health care facility~~ APPLICANT with written notice of the decision to deny credentialing. The notice must include a clear explanation of the basis for the decision.

Section 11. Uniform disclosure.

(a) Format.--The Insurance Department shall adopt a uniform format for the disclosure to enrollees of the terms and conditions of health insurance plans and contracts to provide health care services.

(b) Contents.--The uniform format shall include, at a minimum, the following provisions written in terms understandable to the general public:

(1) The benefits and any and all exclusions.

(2) All enrollee coinsurance, copayments and deductibles.

(3) All maximum benefit limitations.

(4) All requirements or limitations regarding the choice of provider AND AN ANNUALLY UPDATED LIST OF THE PROVIDERS WHICH A COVERED INDIVIDUAL MAY CHOOSE.

(5) Description of any and all restrictions or limitations on prescription drugs and biologicals, including any prior authorization or other review requirements.

(6) Disclosure of provider incentive plans.

(7) Enrollee satisfaction statistics.

(c) Mandatory use.--Managed care entities shall use the format adopted by the Insurance Department to make the required information available to purchasers and potential enrollees.

Section 12. Prompt payment of clean claims.

(a) Requirements.--A managed care entity shall ~~pay a clean claim submitted by a provider within 45 days of a receipt of the claim. The entity shall be deemed to have received the claim and documentation three business days after being mailed by the provider to the appropriate department within the entity. Contractual agreements between entities and providers shall meet or exceed the requirements set forth in this section.~~ MAKE REQUIRED PAYMENTS TO A PROVIDER WITHIN 45 DAYS. IF PAYMENT CANNOT BE MADE WITHIN 45 DAYS OF RECEIPT OF A CLAIM, THE MANAGED CARE ENTITY SHALL NOTIFY THE PROVIDER IN WRITING WITHIN THE 45-DAY PERIOD OF THE REASON FOR THE DELAY AND WHEN PAYMENT IS EXPECTED TO BE MADE. CONTRACTUAL AGREEMENTS BETWEEN MANAGED CARE ENTITIES AND PROVIDERS SHALL MEET OR EXCEED THE REQUIREMENTS OF THIS SECTION.

(b) Failure to pay.--If ~~an~~ A MANAGED CARE entity fails to make payment under subsection (a), interest at 10% per annum shall be added to the amount of the claim, beginning on the day after the required payment date and ending on the date on which payment of the claim is made. Interest imposed for failure to comply with subsection (a) which remains unpaid at the end of any 30-day period shall be added to the principal; and, thereafter, interest shall accrue on the added amount.

~~(c) Administrative remedy.--The Insurance Commissioner shall investigate a written complaint from a health care provider concerning a managed care entity's compliance with this section. A violation of this section shall be considered an unfair insurance practice and be subject to the procedures and penalties under the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.~~

(C) VIOLATIONS.--EACH VIOLATION OF THIS SECTION SHALL <—
CONSTITUTE A VIOLATION OF THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS THE UNFAIR INSURANCE PRACTICES ACT, AND SHALL BE SUBJECT TO THE PROCEDURES AND PENALTIES CONTAINED IN THAT ACT.

SECTION 13. CONSUMER INFORMATION.

(A) DEVELOPMENT OF STANDARDS.--NOT LATER THAN DECEMBER 31, 1999, THE PHYSICIAN GENERAL SHALL DEVELOP A HEALTH INSURANCE PLAN REPORT CARD TO AID CONSUMERS OF THIS COMMONWEALTH IN CHOOSING A HEALTH INSURANCE PLAN. THE REPORT CARD SHALL INCLUDE SUFFICIENT COMPARATIVE INFORMATION TO PERMIT CONSUMERS TO COMPARE AND EVALUATE HEALTH INSURANCE PLANS.

(B) DUTIES OF PHYSICIAN GENERAL.--IN DEVELOPING A HEALTH INSURANCE PLAN REPORT CARD, THE PHYSICIAN GENERAL SHALL:

(1) SELECT FROM EXISTING COMPARATIVE HEALTH CARE MEASURES, WHERE SUCH MEASURES EXIST, OR DEVELOP ADDITIONAL COMPARATIVE HEALTH CARE MEASURES TO GUIDE CONSUMER CHOICE. IN SELECTING SUCH MEASURES, THE PHYSICIAN GENERAL MAY USE ANY MEASURES FROM THE NATIONAL COMMITTEE ON QUALITY ASSURANCE'S HEDIS.3 SYSTEM, THE FOUNDATION FOR ACCOUNTABILITY (FACCT) MEASUREMENT SETS, THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH'S CAHPS SYSTEM, THE OREGON CONSUMER SCORECARD PROJECT, THE NEW JERSEY HMO REPORT CARD PROJECT OR PUBLIC HEALTH DATA BASES.

(2) ENSURE THAT COMPARATIVE INFORMATION IS TAILORED TO CONSIDER THE NEEDS OF INDIVIDUAL HEALTH CARE CONSUMERS, INCLUDING CONSUMERS WITH SPECIAL OR EXTRAORDINARY HEALTH CARE NEEDS.

(3) ENSURE THAT COMPARATIVE INFORMATION IS GEOGRAPHICALLY SENSITIVE TO REFLECT THE HEALTH PLAN

EXPERIENCES OF RURAL CONSUMERS.

(4) DEVELOP PROCEDURES TO CONSOLIDATE AND REDUCE THE DATA BURDEN ON HEALTH INSURANCE PLANS THROUGH THE DEVELOPMENT OF UNIFORM DATA SPECIFICATIONS AND SHARING OF HEALTH CARE INFORMATION WHERE APPROPRIATE.

(5) IMPLEMENT A PROGRAM TO PROVIDE CONSUMERS WITH ACCESS TO APPROPRIATE COMPARATIVE INFORMATION IN A MANNER WHICH WILL ENABLE CONSUMERS TO MAKE INFORMED HEALTH CARE DECISIONS BY COMPARING THE VARIOUS HEALTH INSURANCE PLANS IN WHICH CONSUMERS ARE ELIGIBLE TO ENROLL.

(6) ENSURE THAT COMPARATIVE INFORMATION IS IN A STANDARDIZED FORM AND UNDERSTANDABLE TO A REASONABLE LAYPERSON.

(7) ENSURE THAT COMPARATIVE INFORMATION INCLUDES CONSUMER AND PROVIDER SATISFACTION DATA. SUCH DATA SHALL BE DERIVED FROM ANNUAL SURVEYS OF CONSUMERS ENROLLED IN A PARTICULAR HEALTH INSURANCE PLAN AND THOSE CONSUMERS WHO HAVE WITHDRAWN FROM SUCH PLAN DURING THE PRECEDING 12-MONTH PERIOD. THE SURVEY SHALL BE CONDUCTED BY AN ORGANIZATION INDEPENDENT OF THE HEALTH PLAN.

(C) DUTIES OF SECRETARY AND COMMISSIONER.--THE SECRETARY AND COMMISSIONER SHALL SUPPLY ALL NECESSARY ASSISTANCE TO THE PHYSICIAN GENERAL IN CARRYING OUT THE PROVISIONS OF THIS SECTION.

(D) DEFINITIONS.--AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SUBSECTION:

"COMPARATIVE INFORMATION." INFORMATION ON ACCESS TO CARE, COST OF CARE, USE OF HEALTH SERVICES, SATISFACTION WITH CARE AND SERVICES, MANAGEMENT PRACTICES OF HEALTH PLANS AND ANY OTHER

ASPECT OF HEALTH CARE DELIVERY WHICH MAY BE USED BY CONSUMERS TO JUDGE THE OVERALL QUALITY OF CARE AND TO DISTINGUISH BETWEEN THE CARE PROVIDED BY HEALTH PLANS.

"CAHPS." THE FEDERAL AGENCY FOR HEALTH CARE POLICY AND RESEARCH'S "CONSUMER ASSESSMENT OF HEALTH PLANS STUDY" DESIGNED TO PROVIDE AN INTEGRATED SET OF STANDARDIZED SURVEY QUESTIONNAIRES AND REPORT FORMATS WHICH CAN BE USED TO COLLECT AND REPORT INFORMATION FROM HEALTH PLAN ENROLLEES ABOUT THEIR HEALTH CARE EXPERIENCES WITH A PARTICULAR HEALTH PLAN.

"FACCT." THE FOUNDATION FOR ACCOUNTABILITY'S CONSUMER INFORMATION FRAMEWORK DESIGNED TO GIVE CONSUMERS CLEAR, CONCISE AND UNDERSTANDABLE PERFORMANCE MEASURES FOR COMPARING THE CLINICAL QUALITY OF HEALTH PLANS.

"HEALTH INSURANCE PLAN." A HEALTH INSURANCE PLAN WHICH USES A GATEKEEPER TO MANAGE THE UTILIZATION OF HEALTH CARE SERVICES BY ENROLLEES INCLUDING ANY SUCH PLAN PROVIDED BY OR ARRANGED THROUGH AN ENTITY OPERATING UNDER ANY 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) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(3) THE ACT OF DECEMBER 14, 1992 (P.L.835, NO.134), KNOWN AS THE FRATERNAL BENEFIT SOCIETIES CODE.

(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).

(6) A CONTRACT WITH THE DEPARTMENT OF PUBLIC WELFARE TO PROVIDE MEDICAL ASSISTANCE BENEFITS THROUGH A CAPITATION PLAN.

"HEDIS." THE "HEALTH PLAN EMPLOYER DATA AND INFORMATION SET" DEVELOPED BY THE NATIONAL COMMITTEE ON QUALITY ASSURANCE (NCQA) AS A SET OF STANDARDIZED PERFORMANCE MEASURES DESIGNED TO ENSURE THAT CONSUMERS HAVE THE INFORMATION NECESSARY TO COMPARE THE PERFORMANCE OF HEALTH PLANS.

"PERFORMANCE MEASURES." A SET OF MEASURES, SUCH AS A STANDARD OR INDICATOR, USED TO ASSESS THE PERFORMANCE OF A HEALTH PLAN.

Section ~~13~~ 14. Investigations ~~and~~, penalties AND SANCTIONS. <——

(a) Investigation.--Except as set forth in section 12, the ~~department shall investigate a managed care entity's compliance with this act in response to a written complaint by a health care provider.~~ DEPARTMENT SHALL ENFORCE COMPLIANCE WITH THIS ACT, ENFORCEMENT TO INCLUDE THE INVESTIGATION OF ALL COMPLAINTS. <—— <——

(b) Penalties.--The department may impose an administrative penalty of up to $10,000 for each violation of this act. ~~In addition, the~~ <——

(C) SANCTIONS.--THE department may deny, suspend, revoke or refuse to renew the certification of a utilization review entity that fails to comply with the provisions of this act. This subsection is subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action). <——

Section ~~14~~ 15. Regulations. <——

The department and Insurance Department shall promulgate regulations necessary to implement the provisions of this act.

Section ~~15~~ 16. Exceptions. <——

This act shall not apply to any of the following:

(1) Peer review or utilization review performed under

the act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

(2) The act of July 1, 1937 (P.L.2532, No.470), known as the Workers' Compensation Security Fund Act.

(3) Peer review, utilization review or mental or physical examinations performed under 75 Pa.C.S. Ch. 17 (relating to financial responsibility).

(4) The fee-for-service programs operated by the Department of Public Welfare under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

Section ~~16~~ 17. Applicability. <—

Nothing in this act shall regulate or authorize regulation which would be ineffective by reason of the State law preemption provisions of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

Section ~~17~~ 18. Discrimination on moral or religious grounds prohibited. <—

No public institution, public official or public agency may impose penalties, take disciplinary action against, or deny or limit public funds, licenses, authorizations, or other approvals or documents of qualification to any person, association, or corporation:

(1) attempting to establish a plan; or

(2) operating, expanding or improving an existing plan, because the person, association or corporation refuses to pay for or arrange for the payment of any particular form of health care services or other services or supplies covered by other plans when such refusal is by reason of objection thereto on moral or religious grounds.

Section ~~18~~ 19. Effective date. <—

This act shall take effect in 180 days.