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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

## No. 2453 Session of 1998

INTRODUCED BY VEON, COLAFELLA, DeLUCA, SURRA, MANDERINO, CURRY, OLASZ, WALKO, OLIVER, LLOYD, SANTONI, MARKOSEK, HALUSKA, CAPPABIANCA, ITKIN, WOJNAROSKI, JOSEPHS, M. COHEN, DeWEESE, STABACK, BEBKO-JONES, ROBINSON, GORDNER, ORIE, STURLA, BELARDI, MUNDY, JAMES, TRAVAGLIO, BELFANTI, SCRIMENTI, CORPORA, BOSCOLA, READSHAW, WOGAN, ROONEY, WAUGH, COY, KENNEY, TRELLO, TRICH, CARN, SHANER, LAUGHLIN, McCALL, TANGRETTI, CASORIO, LUCYK, HORSEY, MELIO AND SAINATO, MARCH 23, 1998

REFERRED TO COMMITTEE ON INSURANCE, MARCH 23, 1998

AN ACT

Providing for confidentiality of medical records, for financial incentive restrictions on managed care plans, for health insurance policy disclosures, for the Office of Consumer Advocate for Insurance, for access to women's health care providers, for utilization review and appeals and for safeguards under managed care plans.

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

## CHAPTER 1

## PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Managed Care Bill of Rights Act.

Section 102. 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:

"Health information." Any individually identifiable data, description or medical record, regardless of medium, pertaining to the past, present or future health of a person.

"Health information user." Any physician, a hospital, an employer or an organization that processes bills, claims or

appeals, a pharmaceutical benefit management organization and any other service organization which in the course of conducting business comes in contact with health information.

"Health insurance policy." Any individual or group health insurance policy, contract or plan which provides medical or health care coverage by any health care facility or licensed health care provider on an expense-incurred service or prepaid basis and which is offered by or is governed under any of the following:

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

(2) Subarticle (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

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

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

(5) Act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(6) A nonprofit corporation subject to 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

"Medical record." The written, graphic or electronic documentation of a medical condition, course of treatment or test result, or lack thereof, regardless of medium pertaining to an individual person.

"Provider." A person providing medical, nursing or other health care services of any kind or a hospital, nursing home, hospice, drug and alcohol services provider, clinic, blood bank,

plasmapheresis or other blood product center, organ or tissue bank, sperm bank, clinical laboratory or a health care institution required to be licensed in this Commonwealth.

## CHAPTER 3

## CONFIDENTIALITY OF MEDICAL RECORDS

Section 301. Restriction on release or disclosure.

All health information in the possession or custody of a provider or health information user shall be confidential and may not be released or its contents disclosed to anyone, except:

(1) To the subject of the health information.

(2) To the subject's physician, provided that the subject has indicated the identity of that physician to whom such information may be released.

(3) To a person specifically designated in a written consent under section 302.

(4) To an agent, employee or medical staff member of a provider when disclosure is necessary for purposes of diagnosis or treatment.

(5) To prevent death or severe illness in an emergency where disclosure of health information is necessary for treatment of the subject of the health information.

(6) To a peer review organization or committee as defined in the act of July 20, 1974 (P.L.564, No.193), known as the Peer Review Protection Act, a nationally recognized accrediting agency, any Federal or State government agency with oversight responsibilities over health care providers, or as otherwise provided by law.

(7) To an insurer, but only to the extent necessary to reimburse a provider or to make payment of a claim submitted under an insured's policy.

(8) Pursuant to an order of a court of common pleas after application showing good cause with proper notice and an opportunity to be heard. The court shall weigh the need for disclosure against the privacy interest of the individual and possible harm resulting from disclosure.

Section 302. Written consent.

A written consent to disclose health information shall include:

(1) The specific name of the individual or organization permitted to make the disclosure.

(2) The name or title of the individual to whom or the name of the organization to which the disclosure is to be made.

(3) The name of the subject whose records are to be disclosed.

(4) The specific purpose or purposes of the disclosure.

(5) The amount and kind of information to be disclosed.

(6) One of the following:

(i) the signature of the subject;

(ii) if the subject is 12 years of age or younger, the signature of the subject's parent or guardian; or

(iii) if the subject is unable to sign, the signature of an individual authorized by law to make such decisions on behalf of the subject.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it.

(9) The date, event or condition upon which the consent

will expire if not earlier revoked. In no event shall a written consent under this act be deemed valid more than one year after the date the consent was signed.

Section 303. Disclosure.

A disclosure may not be made on the basis of a consent which:

(1) has expired;

(2) on its face substantially fails to conform to any of the requirements set forth under section 302;

(3) is known to have been revoked; or

(4) is known by the person holding the information to be materially false.

Section 304. Statement.

Each disclosure made under this chapter must be accompanied by the following written statement:

> This information has been disclosed to you from records the confidentiality of which is protected by Commonwealth law. Commonwealth law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of health or other information or medical records is not sufficient for this purpose.

Section 305. Duty of recipient or health information user.

In the event that health information is disclosed under this chapter, the recipient of the health information or the health information user shall maintain the confidentiality of the health information, and necessary steps shall be taken to ensure the confidentiality of the health information consistent with the express purpose for which the information was released. The

health information disclosed shall not be disclosed by the recipient of the health information or a health information user to another source without the consent of the subject of the information as provided in section 302.

Section 306. Identity of subject.

Unless there is a compelling need to disclose the actual identity of the subject, all information relating to the identity of the subject or from which the identity can be reasonably determined shall not be disclosed.

Section 307. Record of disclosures.

Providers shall maintain, as a permanent part of the individual's medical records, a record of all disclosures of health information to any person or entity not employed by or directly affiliated with it. The records shall include the name and address of each person receiving the health information and a description of the information disclosed.

Section 308. Employers.

Health information may not be disclosed to an individual's employer without the written consent of the individual under section 302. No employer, including a self-insured employer, may maintain health information in an employee's personnel file or any file which is maintained for purposes other than health care delivery. Any health information in the possession of an employer or its agents shall be confidential and may not be disclosed, released or used for internal job-related purposes without the individual's consent as provided under section 302.

Section 309. Availability of information.

(a) General rule.--Any person, provider or other entity subject to the laws of this Commonwealth in possession of health information shall upon request of the subject of the health

information disclose to the subject of the health information or his designee the health information in its possession, or portion thereof, upon the request of the subject of the health information, at a cost not to exceed 30ç per page. Such disclosure shall be made within 14 days.

(b) Errors.--

(1) If the subject of the health information, or a designee, discovers an error in the subject's health information, the subject, or a designee, shall be provided the opportunity to submit evidence of the error to the person or entity in possession of the health information.

(2) Any person or entity which had been notified of a possible error in a subject's health information shall within 30 days either:

(i) correct the error and notify all parties to whom that person or entity has made a disclosure of the erroneous health information; or

(ii) notify the subject of the health information, or a designee, that to the best of its ability it believes that the health information in its possession is accurate and shall note the exception in the health information.

Section 310. Duty of Department of Health.

Within one year of the effective date of this chapter, the Department of Health shall promulgate standards for the implementation of administrative, technological and physical safeguards by providers, their agents and health information users to protect against unauthorized disclosure of individually identifiable health information.

Section 311. Construction.

Nothing in this chapter is intended to alter limitations on disclosure or release of health information or medical records that are prescribed in the laws of this Commonwealth.

Section 312. Penalties and remedies.

(a) Civil action.--Any person aggrieved by a violation of this chapter shall have a cause of action against the person or entity which committed the violation and may recover:

(1) Compensatory damages, but not less than liquidated damages, computed at the rate of $1,000 for each violation.

(2) Punitive damages.

(3) Reasonable attorney fees and litigation costs.

(b) Criminal penalty.--Any person misrepresenting himself in an effort to obtain confidential health information on any individual or any person who knowingly releases or discloses health information contrary to this chapter commits a felony of the third degree.

(c) Each disclosure separate.--Each disclosure of health information in violation of this chapter shall be considered a separate violation for purposes of civil liability.

## CHAPTER 5

## FINANCIAL INCENTIVE RESTRICTIONS

Section 501. Certain compensation prohibited.

A managed care plan may not use any financial incentives that compensate a health care provider for ordering or providing less than medically necessary and appropriate care to enrollees.

Section 502. Renegotiation of contracts.

In addition to the reasons specified in section 8(a) of the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, the Secretary of Health shall have the authority to require renegotiations of any managed care

provider contract if the contract includes incentives for providers to provide inadequate or poor quality care of if the payment arrangement could have the capacity to lead to inadequate or poor quality care.

Section 503. Construction.

Nothing in this chapter shall be deemed to prohibit a managed care plan from using a capitation payment arrangement.

## CHAPTER 7

## HEALTH INSURANCE POLICY DISCLOSURES

Section 701. Health insurance policy disclosure.

(a) General rule.--Each health insurance policy offered to the public within this Commonwealth shall provide disclosure forms as required by this section. The disclosure form shall be in a form prescribed by the Insurance Commissioner.

(b) Content of disclosure form.--Each disclosure form shall contain at least all of the following information:

(1) A separate roster of the health insurer's primary care physicians who are licensed under the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, including the physician's degree, practice specialty, initial year of licensure and year licensed to practice in Pennsylvania.

(2) In concise and specific terms:

(i) The full premium cost of the health insurance policy.

(ii) Any copayment, coinsurance or deductible requirements that an insured or the insured's family may incur in obtaining coverage under the health insurance policy and any reservation by the health insurance policy

to change premiums.

(iii) The health care benefits to which an insured would be entitled. The disclosure shall state where and in what manner an insured may obtain services, including the procedures for selecting or changing primary care physicians and the locations of hospitals and outpatient treatment centers that are under contract with the health insurer.

(3) Any limitations of the services, kinds of service, benefits and exclusions that apply to the health insurance policy. A description of limitations shall include:

(i) Procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians.

(ii) Whether services received outside the health insurance policy are covered and in what manner they are covered.

(iii) Procedures an insured must follow, if any, to obtain prior authorization for services.

(iv) A statement regarding whether or not providers must comply with any specified numbers, targeted averages or maximum durations of patient visits. If any of these are required of providers, the disclosure shall state the specific requirements.

(v) The procedure to be followed by an insured for consulting a physician other than the primary care physician and whether the insured's primary care physician, the health insurer's medical director or a committee must first authorize the referral.

(vi) Whether a point of service option is available and, if so, how it is structured.

(4) Grievance procedures for claim or treatment denials, dissatisfaction with care and access to care issues.

(5) A response to whether an insurer's physician is restricted to prescribing drugs from the health insurer's list or formulary and the extent to which an insured will be reimbursed for costs of a drug that is not on the health insurer's list or formulary.

(6) A response to whether provider compensation programs include any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists. If these types of incentives or penalties are included, the health insurer shall provide a concise description of them. The health insurer may also include, in a separate section, a concise explanation or justification for the use of these incentives or penalties.

(7) A statement that the disclosure form is a summary only and that evidence of coverage is determined by the governing contractual provisions of the health insurance policy.

(c) Approval prerequisite.--A health insurer shall not disseminate a completed disclosure form until that form has been approved by the Insurance Commissioner. For purposes of this section, a health insurer is not required to submit to the Insurance Commissioner its separate roster of plan physicians or any roster updates.

(d) Information to employers.--Upon request, a health insurer shall provide the information required under subsection (b) to all employers who are considering participating in a health insurance policy that is offered by the health insurer or to an employer that is considering renewal of a health insurance

policy that is provided by the health insurer.

Section 702. Duty of employers.

(a) Disclosure to employees.--An employer shall provide to its eligible employees the disclosures required under section 701(b) no later than the initiation of any open enrollment period or at least ten days before any employee enrollment deadline that is not associated with an open enrollment period.

(b) Contract without disclosure prohibited.--An employer shall not execute a contract with a health insurer until the employer receives the information required under section 701(b).

## CHAPTER 9

## OFFICE OF CONSUMER ADVOCATE FOR INSURANCE

Section 901. Definitions.

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

"Consumer." Any person who is a named insured, insured or beneficiary of a policy of insurance or any other person who may be affected in any way by the Insurance Department's exercise of or the failure to exercise its authority.

"Department." The Insurance Department of the Commonwealth. The term includes the Insurance Commissioner.

"Fund." The Consumer Advocate for Insurance Fund established pursuant to section 906.

"Insurer." Any "company," "association" or "exchange" as such terms are defined in section 101 of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

Section 902. Office of Consumer Advocate for Insurance.

(a) Office created.--There is hereby created as an

independent office within the Office of Attorney General an Office of Consumer Advocate for Insurance appointed by the Attorney General to represent the interest of consumers before the department.

(b) Appointment of Consumer Advocate for Insurance.--The Office of Consumer Advocate for Insurance shall be headed by the Consumer Advocate for Insurance appointed by the Attorney General who by reason of training, experience and attainment is qualified to represent the interest of consumers. Compensation shall be set by the Executive Board.

(c) Limitation on other employment and interests.--No individual who serves as a Consumer Advocate for Insurance shall, while serving in the position, engage in any business, vocation or other employment, or have other interests, inconsistent with the official responsibilities, nor shall the individual seek or accept employment nor render beneficial services for compensation with any insurer subject to the authority of the office during the tenure of the appointment and for a period of two years immediately after the appointment is served or terminated.

(d) Restriction on holding political office.--Any individual who is appointed to the position of Consumer Advocate for Insurance shall not seek election nor accept appointment to any political office during the tenure as Consumer Advocate for Insurance and for a period of two years after the appointment is served or terminated.

Section 903. Assistants and employees.

The Consumer Advocate for Insurance shall appoint attorneys as assistant consumer advocates for insurance and additional clerical, technical and professional staff as may be appropriate

and may contract for additional services as shall be necessary for the performance of the duties imposed by this chapter. The compensation of assistant consumer advocates for insurance and clerical, technical and professional staff shall be set by the Executive Board. No assistant consumer advocate for insurance or other staff employee shall, while serving in the position, engage in any business, vocation or other employment, or have other interests, inconsistent with official responsibilities.

Section 904. Powers and duties of Consumer Advocate for Insurance.

(a) General powers and duties.--In addition to any other authority conferred by this chapter, the Consumer Advocate for Insurance is authorized to and shall, in carrying out the responsibilities under this chapter, represent the interest of consumers as a party, or otherwise participate for the purpose of representing an interest of consumers, before the department in any matter properly before the department, and before any court or agency, initiating proceedings if, in the judgment of the Consumer Advocate for Insurance, the representation may be necessary, in connection with any matter involving regulation by the department or the corresponding regulatory agency of the Federal Government, whether on appeal or otherwise initiated.

(b) Consideration of public interest.--The Consumer Advocate for Insurance may exercise discretion in determining the interests of consumers which will be advocated in any particular proceeding and in determining whether or not to participate in or initiate any particular proceeding and, in so determining, shall consider the public interest, the resources available and the substantiality of the effect of the proceeding on the interest of consumers. The Consumer Advocate for Insurance may

refrain from intervening when, in the judgment of the Consumer Advocate for Insurance, intervention is not necessary to represent adequately the interest of consumers.

(c) Representation of consumers upon petition.--In addition to any other authority conferred by this article, the Consumer Advocate for Insurance is authorized to represent an interest of consumers which is presented for consideration, upon petition in writing, by a substantial number of persons who are consumers of an insurer subject to regulation by the department. The Consumer Advocate for Insurance shall notify the principal sponsors of the petition within a reasonable time after receipt of the petition of the action taken or intended to be taken with respect to the interest of consumers presented in that petition. If the Consumer Advocate for Insurance declines or is unable to represent the interest, written notification and the reasons for the action shall be given to the sponsors.

(d) Style of action.--

(1) Any action brought by the Consumer Advocate for Insurance before a court or an agency of this Commonwealth shall be brought in the name of the Consumer Advocate for Insurance.

(2) Notwithstanding paragraph (1), the Consumer Advocate for Insurance may name a consumer or group of consumers in whose name the action may be brought or may join with a consumer or group of consumers in bringing the action.

(e) Public statement of consumer interest.--At a time as the Consumer Advocate for Insurance determines, in accordance with applicable time limitations, to initiate, intervene or otherwise participate in any department, agency or court proceeding, the Consumer Advocate for Insurance shall issue publicly a written

statement, a copy of which shall be filed in the proceeding in addition to any required entry of appearance, stating concisely the specific interest of consumers to be protected.

(f) Service of documents filed by insurers.--The Consumer Advocate for Insurance shall be served with copies of all filings, correspondence or other documents filed by insurers with the department unless the Consumer Advocate for Insurance informs the insurer that specific types of classes of documents need not be so served. The department shall not accept a document as timely filed if the document is also required to be served on the Consumer Advocate for Insurance and the insurer has not indicated that service has or is being made on the Consumer Advocate for Insurance. Insurers shall provide any other nonpriviledged information or data requested by the Consumer Advocate for Insurance to the extent that the request is reasonably related to the performance of his duties under this chapter.

Section 905. Duties of department.

In dealing with any proposed action which may substantially affect the interest of consumers, including, but not limited to, a proposed change of rates and the adoption of rules, regulations, guidelines, orders, standards or final policy decisions, the department shall:

(1) Notify the Consumer Advocate for Insurance and provide, free of charge, copies of all related documents when notice of the proposed action is given to the public or at a time fixed by agreement between the Consumer Advocate for Insurance and the department in a manner to assure the Consumer Advocate for Insurance reasonable notice and adequate time to determine whether to intervene in the

matter.

(2) Consistent with its other statutory responsibilities, take action with due consideration to the interest of consumers.

Section 906. Consumer Advocate for Insurance Fund.

(a) Fund established.--There is hereby established a separate account in the State Treasury to be known as the Consumer Advocate for Insurance Fund. This fund shall be administered by the State Treasurer.

(b) Moneys held in trust.--All moneys deposited into the fund shall be held in trust and shall not be considered general revenue of the Commonwealth but shall be used only to effectuate the purposes of this chapter. The fund shall be subject to audit by the Auditor General.

(c) Assessment imposed upon insurers.--Prior to the first day of April following the effective date of this chapter and prior to the first day of April of each year thereafter so long as this chapter shall remain in effect, each insurer who writes coverages for fire and casualty, accident and health, credit accident and health under life/annuity/accident, health and life, including annuities in this Commonwealth, as a condition of its authorization to transact business in this Commonwealth, shall pay into the fund in trust an amount equal to the product obtained by multiplying $5,000,000 by a fraction, the numerator of which is the direct premium collected for all coverages by that insurer in this Commonwealth during the preceding calendar year and the denominator of which is the direct premium written on such coverages in this Commonwealth by all insurers in the same period. Any insurer who fails to pay the required assessment under this section shall be prohibited from writing

any insurance within this Commonwealth.

(d) Base amount.--In succeeding years the General Assembly may vary the base amount of $5,000,000 based upon the actual funding experience and requirements of the Office of Consumer Advocate for Insurance.

(e) Assessments not burdens and prohibitions.--Assessments made under this section shall not be considered burdens and prohibitions under section 212 of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

(f) Dissolution of fund.--In the event that the trust fund is dissolved or the Office of Consumer Advocate for Insurance is terminated by operation of law, any balance remaining in the fund, after deducting administrative costs for liquidation, shall be returned to insurers in proportion to their financial contributions to the fund in the preceding calendar year.

Section 907. Reports.

The Consumer Advocate for Insurance shall annually transmit to the Governor and to the General Assembly and shall make available to the public, an annual report on the conduct of the Office of Consumer Advocate for Insurance. The Consumer Advocate for Insurance shall make recommendations as may, from time to time, be necessary or desirable to protect the interest of consumers.

Section 908. Construction.

(a) Consumer rights preserved.--Nothing contained in this chapter shall in any way limit the right of any consumer to bring a proceeding before either the department or a court.

(b) Authority of department unaffected.--Nothing contained in this chapter shall be construed to impair the statutory

authority or responsibility of the department to regulate insurers in the public interest.

## CHAPTER 11

## ACCESS TO WOMEN'S HEALTH CARE PROVIDERS

Section 1101. Definitions.

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

"Enrollee." An individual who has contracted for or who participates in coverage offered by a health insurer.

"Health insurer." An entity that issues a health insurance policy and is governed by any of the following:

(1) 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) Act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(5) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(6) Medical assistance.

"Pregnancy care." The care necessary to support a healthy pregnancy and care related to labor and delivery.

"Provider network." Health care practitioners and health care facilities designated by a health care insurer for enrollee use in obtaining covered health services.

"Women's health care provider." An obstetrician and gynecologist, a certified registered nurse practitioner with a clinical specialty area of obstetrics/gynecology or women's health, or a certified nurse-midwife, practicing within the applicable lawful scope of practice.

Section 1102. Policy requirements.

A health insurance policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by a health insurer that requires an enrollee to designate a primary care provider shall:

(1) Provide that an enrollee may designate from the insurer's provider network a women's health care provider so long as the women's health care provider requests the designation.

(2) Permit enrollees to obtain the following health services from their designated women's health care provider without prior approval or referral from the enrollee's primary care provider:

(i) Any primary and preventive gynecological care covered by the health insurance policy.

(ii) Services covered by the health insurance policy required as a result of any obstetrical or gynecological examination or as a result of a gynecological condition.

(iii) Pregnancy care.

(iv) Testing and treatment for infertility covered by the health insurance policy.

(3) Permit women's health care providers to refer enrollees to providers from the insurer's provider network for medically necessary obstetrical and gynecological services, including related testing, laboratory services and

treatment covered by the health insurance policy. Insurers may not require that these referrals be subject to the approval or review of an enrollee's primary care provider.

Section 1103. Insurer requirements.

Health insurers:

(1) May limit the number of women's health care providers in a provider network, but must ensure that there are sufficient women's health care providers within a provider network so that enrollees have access to women's health care providers in a timely fashion.

(2) Shall consult with practicing women's health care providers regarding the professional qualifications and geographic composition of its women's health care provider component of its provider network.

(3) Shall include in an enrollee handbook a written explanation of an enrollee's right to designate a women's health care provider and the enrollee's right to obtain the services listed in section 1102(b) and (c) from a women's health care provider who is part of the insurer's provider network without prior approval or referral from the enrollee's primary care provider. The written explanation shall be in clear, accurate and conspicuous language.

(4) May not impose cost-sharing, such as copayments or deductibles, for health care services on the basis that health care services were received under section 1102.

Section 1104. Delivery of policy.

If a health insurance policy provides coverage or benefits to a resident of this Commonwealth it shall be deemed to be delivered in this Commonwealth within the meaning of this chapter, regardless of whether the health care insurer issuing

or delivering the policy is located within or outside of this Commonwealth.

## CHAPTER 13

## UTILIZATION REVIEW AND APPEALS

Section 1301. Definitions.

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

"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 insurer." Any 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) 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.

"Payer." A health care insurer as well as any other entity employing, affiliated with or contracting with a utilization review entity or paying for credentialing activities.

"Provider." 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 1302. 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 chapter.

(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 1303. Appeals.

(a) Review.--An independent peer review entity 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 the independent peer review

entity.

(b) Time for decision.--The written decision of the independent peer review entity 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.

Section 1304. 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 or patient 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. The secretary shall randomly apportion the appeals to the independent review entities. Appeals shall be limited to adverse utilization review decisions regarding medical necessity and medical appropriateness. Appeals shall also be permitted for providers terminated without cause.

(2) The person conducting the independent peer review 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.

## CHAPTER 15

## SAFEGUARDS UNDER MANAGED CARE PLANS

Section 1501. Definitions.

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

"Emergency room services." Health care services provided after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the 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 any bodily organ or part.

"Enrollee." An individual who is enrolled in a managed care plan operated by a managed care entity.

"Health care provider." A clinic, hospital, physician organization, preferred provider organization, independent practice association or other appropriately licensed provider of health care services or supplies.

"Managed care entity." Any entity including a licensed insurance company, hospital or medical service plan, health maintenance organization, third party administrator or any person or entity that establishes, operates or contracts with a network of participating health care professionals.

"Managed care plan." A plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in the plan, with financial incentives for persons enrolled in the plan to use the participating health care professionals and procedures covered by the plan.

"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 administer care within the scope of their practice.

"Referral." A prior authorization from the managed care plan or an authorized provider that allows an enrollee to have one or more appointments with a health care provider for consultation, diagnosis or treatment of a medical condition, to be covered as a benefit under the enrollee's managed care plan contract. An enrollee or a primary care provider shall be able to select any specialist for referral within the plan's network.

"Specialist." A health care provider whose practice is not limited to primary care medical services and who has additional postgraduate or specialized training, board certification or practice in a licensed, specialized area of health care. The term shall include a provider who is not classified by a plan solely as a primary care provider.

Section 1502. Emergency room services.

(a) General rule.--A managed care plan shall include provisions approved by the secretary that, in the event an enrollee seeks emergency room services and if in the opinion of the emergency health care provider responsible for the enrollee's emergency care and treatment these services are necessary, the emergency provider may initiate necessary intervention to evaluate and stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan.

(b) Payment of costs.--The managed care plan shall be required to pay for all reasonably necessary costs associated with the emergency services provided during the period of the emergency.

(c) Criteria for claim processing.--When processing a claim for reimbursement of emergency services, a managed care plan shall consider both the symptoms and services provided using the prudent layperson standard described under the definition of "emergency room services" in section 1501. The provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee.

(d) Relocation to another facility.--If an enrollee's condition has stabilized and the enrollee can be transported to another facility or service without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility which will provide continued care and treatment as necessary.

Section 1503. Continuing care upon termination of provider.

(a) General rule.--Except as provided in subsection (b), if a managed care plan terminates its contract with a participating health care provider or a primary care provider at the plan's initiative, an enrollee who has selected that provider or PCP to receive covered services may continue an ongoing course of treatment with that provider or PCP, at the enrollee's option, for a transitional period of up to 90 days from the date the enrollee was notified by the plan of the termination. The managed care plan, in consultation with the enrollee and the provider or PCP, may extend this transitional period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided in accordance with this section shall be covered by the managed care plan under the same terms

and conditions extended to the enrollee while the provider or PCP was participating in the managed care plan.

(b) Exception.--If a participating health care provider or PCP is terminated at the plan's initiative for fraud, criminal activity or posing a danger to an enrollee or the public health, safety or welfare as determined by the plan, the plan shall not be responsible for covered services provided to the enrollee following the date of termination for cause of the provider or PCP.

(c) Notice of contract termination.--Whenever a plan terminates its contract with a PCP, each of the PCP's enrollees shall be notified by the plan of the termination and shall be requested to select another PCP.

(d) Option of new enrollee.--A new enrollee, at the enrollee's option, may continue an ongoing course of treatment with a nonparticipating health care provider or PCP for a transitional period of up to 90 days from the effective date of enrollment in a managed care plan. The managed care plan, in consultation with the enrollee and the provider or PCP, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided in accordance with this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating providers and primary care providers.

(e) Nonparticipating health care provider.--A managed care plan may require a nonparticipating health care provider or PCP

whose services are covered in accordance with this section to meet the same terms and conditions as participating providers and primary care providers.

(f) Construction.--Nothing in this section shall require a managed care plan to cover services or provide benefits that are not otherwise covered under the terms and provisions of the plan.

Section 1504. Referral to specialist.

(a) Procedure.--A managed care plan shall have procedures approved by the secretary by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, be evaluated and, if the enrollee meets the plan's established standards as approved by the secretary, the enrollee shall subsequently be afforded:

(1) a standing referral to a specialist with expertise in treating the disease or condition; or

(2) a referral to a specialist designated as responsible for providing and coordinating the enrollee's primary and speciality care.

(b) Treatment plan.--The referral or designation shall be pursuant to a treatment plan approved by the managed care plan, in consultation with the primary care provider, the enrollee and, where appropriate, the specialist. Where possible, the specialist should be a member of the plan's network.

Section 1505. Recertification of managed care entities.

(a) Application for reissuance of license required.--All managed care entities holding a license issued by the Insurance Department of the Commonwealth on the effective date of this chapter shall, as a condition of doing business in this Commonwealth, within one year of the effective date of this

chapter make an application to the department for reissuance of their licenses. Each application shall contain sufficient evidence that the managed care entity satisfies the requirements for licensure.

(b) Rules and regulations.--The Insurance Commissioner of the Commonwealth shall promulgate rules and regulations to administer and enforce this section.

## CHAPTER 17

## MISCELLANEOUS PROVISIONS

Section 1701. Repeals.

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

Section 1702. Applicability.

Chapters 7 and 11 shall apply to all health insurance policies issued on or after or renewed on or after January 1, 1999.

Section 1703. Effective date.

This act shall take effect as follows:

(1) Section 906(c) shall take effect in 90 days.

(2) The remainder of Chapter 9 shall take effect July 1, 1998.

(3) The remainder of this act shall take effect in 60 days.