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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2808 Session of 1998

INTRODUCED BY LLOYD, THOMAS, BELARDI, M. COHEN, HARHAI, GORDNER, ITKIN, JAMES, MANDERINO, OLASZ, RAMOS, READSHAW, SHANER, STURLA, SURRA, TANGRETTI, TRAVAGLIO, TRELLO AND YOUNGBLOOD, SEPTEMBER 29, 1998

REFERRED TO COMMITTEE ON INSURANCE, SEPTEMBER 29, 1998

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing for consumer information.

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

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding a section to read:

Section 2164. Consumer Information.--(a) Not later than December 31, 1999, the Physician General shall develop a managed care plan report card to aid consumers of this Commonwealth in choosing a managed care plan. The report card shall include sufficient comparative information to permit consumers to

compare and evaluate managed care plans.

(b) In developing a managed care 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 of 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 managed care plan experiences of rural consumers.

(4) Develop procedures to consolidate and reduce the data burden on managed care 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 managed care plans in which consumers are eligible to enroll.

(6) Ensure that comparative information is in a standardized form and in plain language which is readable and understandable

to the average consumer.

(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 managed care plan and those consumers who have withdrawn from such plan during the preceding twelve-month period. The survey shall be conducted by an organization independent of the managed care plan.

(8) Compile data received from each managed care plan regarding the number, type and disposition of complaints and grievances filed with each managed care plan during the preceding twelve-month period.

(9) Ensure that comparative information includes data relating to the following:

(i) the number, type and disposition of grievances and complaints filed with each managed care plan during the preceding twelve-month period calculated as a percentage of enrollees;

(ii) the percentage of grievances and complaints resolved during the preceding twelve-month period in favor of the enrollee and the percentage resolved in favor of the managed care plan;

(iii) each managed care plan's success rate during the preceding twelve-month period for the delivery or provision of health care services, including health care services related to the treatment of cancer, heart attack, stroke and other serious or life-threatening medical conditions;

(iv) the number of claims for health care services for which payments were denied by each managed care plan during the preceding twelve-month period as a percentage of all claims

filed with the plan during such period; and

(v) the percentage of enrollees who voluntarily left each managed care plan during the preceding twelve-month period.

(c) The Insurance Commissioner and the Secretary of Health shall supply all necessary assistance to the Physician General in carrying out the provisions of this section.

(d) 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 health care, cost of care, use of health services, satisfaction with care and services, management practices of managed care 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 the care provided among managed care 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 managed care plan enrollees about their health care experiences with a particular managed care 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 managed care plans.

"HEDIS.3." 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 managed care plans.

"Performance measures." A set of measures, such as a standard or indicator, used to assess the performance of a managed care plan.

Section 2. This act shall take effect in 60 days.