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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 225 Session of 2021

INTRODUCED BY PHILLIPS-HILL, MARTIN, J. WARD, MENSCH, COLLETT, MUTH, KANE, STEFANO, AUMENT, CAPPELLETTI, BAKER, BROOKS, BOSCOLA, HUTCHINSON, SABATINA, TOMLINSON, LAUGHLIN, MASTRIANO, SANTARSIERO, KEARNEY, SCHWANK, DUSH, COMITTA, FLYNN, L. WILLIAMS AND DILLON, MARCH 18, 2021

AS AMENDED ON SECOND CONSIDERATION, JUNE 22, 2022

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," in quality healthcare accountability and protection, further providing for definitions and for responsibilities of managed care plans, providing for preauthorization review standards and for preauthorization costs, further providing for continuity of care, providing for step therapy, further providing for required disclosure and for operational standards and providing for initial review of preauthorization requests and adverse determinations, for preauthorization denial grievances and for access requirements in service areas; and making an editorial change.~~ <--

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," IN QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION, FURTHER PROVIDING FOR DEFINITIONS, FOR RESPONSIBILITIES OF MANAGED CARE PLANS, FOR FINANCIAL INCENTIVES PROHIBITION, FOR MEDICAL GAG CLAUSE PROHIBITION, FOR EMERGENCY SERVICES, FOR CONTINUITY OF CARE, PROVIDING FOR MEDICATION ASSISTED TREATMENT, FURTHER PROVIDING FOR PROCEDURES, FOR CONFIDENTIALITY, FOR REQUIRED DISCLOSURE, PROVIDING FOR MEDICAL POLICY AND CLINICAL REVIEW CRITERIA ADOPTED BY INSURER, MCO OR CONTRACTOR, FURTHER PROVIDING FOR INTERNAL COMPLAINT PROCESS, FOR APPEAL OF COMPLAINT, FOR COMPLAINT RESOLUTION, FOR CERTIFICATION, FOR OPERATIONAL STANDARDS, PROVIDING FOR STEP THERAPY CONSIDERATIONS, FOR PRIOR AUTHORIZATION REVIEW AND FOR PROVIDER PORTAL, FURTHER PROVIDING FOR INTERNAL GRIEVANCES PROCESS, FOR RECORDS, FOR EXTERNAL GRIEVANCE PROCESS, FOR PROMPT PAYMENT OF CLAIMS, FOR HEALTH CARE PROVIDER AND MANAGED CARE PLAN, FOR DEPARTMENTAL POWERS AND DUTIES, FOR PENALTIES AND SANCTIONS, FOR COMPLIANCE WITH NATIONAL ACCREDITING STANDARDS; AND MAKING EDITORIAL CHANGES.

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

~~Section 1. The definitions of "emergency service," "grievance," "health care service," "prospective utilization review," "retrospective utilization review," "utilization review" and "utilization review entity" in section 2102 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, are amended and the section is amended by adding definitions to read:~~ **<--**

~~Section 2102. Definitions. As used in this article, the following words and phrases shall have the meanings given to them in this section:~~

~~* * *~~

~~"Administrative defect." Any deficiency, error, mistake or missing information other than medical necessity or an uncovered benefit that serves as the basis of an adverse determination issued by a utilization review entity as justification to deny prior utilization review or preauthorization.~~

~~"Adverse determination." The following shall apply:~~

~~(1) A decision made by a utilization review entity following~~

a preauthorization request that denies coverage for one or more the following reasons:

(i) The health care service requested through preauthorization are not medically necessary.

(ii) The preauthorization or prior utilization review request contains an administrative defect.

(iii) The health care services requested through preauthorization are subject to the benefit coverage of a managed care plan that has been denied, modified or terminated either prior to the request for preauthorization or as a result of the requested preauthorization.

(2) The term includes a decision to deny a step therapy exception request under section 2118.

(3) The term does not include a decision to deny, reduce or terminate services that are not covered for reasons other than medical necessity, experimental or investigational nature.

* * *

"Authorization." A determination by a managed care plan or utilization review entity that:

(1) A health care service has been reviewed and, based on the information provided, is medically necessary.

(2) The health care service reviewed is a covered service under the plan.

(3) Payment will be made for the health care service subject to copay, deductible and health care network restrictions.

* * *

"Clinical criteria." Policies, screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines and medical protocols that are specified in a written document available for peer to peer

review by a peer within the same profession and specialty and subject to challenge by an enrollee, a provider or a provider organization when used as a basis to withhold preauthorization, deny or otherwise modify coverage and that is used by a utilization review entity to determine the medical necessity of health care services. The criteria shall:

(1) Be based on nationally recognized standards.

(2) Be developed in accordance with the current standards of national accreditation entities.

(3) Reflect community standards of care.

(4) Ensure quality of care and access to needed health care services.

(5) Be evidence-based or based on generally accepted expert consensus standards.

(6) Be sufficiently flexible to allow deviations from the standards when justified on a case-by-case basis.

(7) Be evaluated and updated annually.

* * *

"Emergency service." Any health care service provided to an enrollee, including prehospital transportation or treatment by emergency medical services providers, after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or 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 enrollee 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.~~

~~Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.~~

~~* * *~~

~~"Final adverse determination." An adverse determination that has been upheld by a utilization review entity or managed care plan at the completion of the internal grievance process.~~

~~"Grievance." As provided in subdivision (i), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity [and appropriateness] of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:~~

~~(1) disapproves full or partial payment for a requested health care service;~~

~~(2) approves the provision of a requested health care service for a lesser scope or duration than requested; 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.~~

~~The term does not include a complaint.~~

~~* * *~~

~~"Health care service." Any [covered] treatment, admission, procedure, test used to aid in diagnosis or the provisions of the applicable treatment, pharmaceutical product, medical supplies and equipment or other services, including behavioral health[, prescribed or otherwise] provided or proposed to be provided by a health care provider to an enrollee under a~~

managed care plan contract.

* * *

"Medically necessary health care services" or "medically necessary." Health care services that a prudent health care provider would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that meets all the following:

(1) In accordance with generally accepted standards of medical practice based on clinical criteria.

(2) Appropriate in terms of type, frequency, extent, site and duration in accordance with clinical criteria.

"Nonurgent health care service." A health care service provided to an enrollee that is not considered an emergency service or an urgent health care service.

* * *

"Prospective utilization review[.]," "preauthorization" or "prior authorization." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

* * *

"Retrospective utilization review[.]" or "retrospective review." A review by a utilization review entity of all reasonably necessary supporting information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

* * *

"Urgent health care service." The following shall apply:

(1) A health care service deemed by a provider to require expedited preauthorization review in the event a delay may jeopardize life or health of the enrollee or a delay in treatment could do any of the following:

(i) Negatively affect the ability of the enrollee to regain maximum function.

(ii) Subject the enrollee to severe pain that cannot be adequately managed without receiving the care or treatment that is the subject of the utilization review as quickly as possible.

(2) The term does not include an emergency service or nonurgent health care service.

"Utilization review." A system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity [and appropriateness] of 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 or health care service verification.

(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of a managed care plan. The term includes all the following:

(1) An insurer that writes health insurance policies, including preferred provider organizations as defined in section 630.

(2) Pharmacy benefits managers responsible for managing access of enrollees to available pharmaceutical or

pharmacological care.

(3) A health insurer if the health insurere performs utilization review.

Section 2. Section 2111(3) of the act is amended and the section is amended by adding paragraphs to read:

Section 2111. Responsibilities of Managed Care Plans. A managed care plan shall do all of the following:

* * *

(3) [Adopt and maintain a definition of medical necessity used by the plan in determining health care services.] Establish an electronic platform and process for the submission and receipt of prior authorization requests by network providers. The following shall apply:

(i) Each managed care plan must provide written instructions and training to network providers who may submit requests using the electronic platform that set forth protocols addressing submission of preauthorization requests if any of the following apply:

(A) The electronic platform is not available due to technological failure or electronic failure.

(B) Documents requested by the managed care plan or utilization review entity exceed the submission capacity limitations of the electronic platform.

(ii) Each managed health care plan shall establish mutually agreeable terms for submission of preauthorization requests and communication regarding preauthorization in circumstances where a network provider or health care facility does not have either of the following:

(A) Internet access.

(B) An electronic health record systems.

* * *

(14) Publish available health care services subject to prior authorization on its publicly accessible Internet website in an easily accessible manner and shall provide the information upon request of a participating network provider.

(15) Provide sixty (60) days notice to participating network providers of any changes to existing prior authorization criteria or implementation of new prior authorization requirements.

(16) Establish a protocol to obtain an exception from any step therapy requirements and publish that process in an easily accessible manner on its publicly accessible Internet website.

(17) Provide the rules and criteria related to the step therapy protocol upon request to all prescribing network providers.

Section 3. The act is amended by adding sections to read:

Section 2114. Preauthorization Review Standards.--(a) Preauthorization approval requests may be submitted electronically through a secure electronic transmission platform established and maintained by a managed care plan under section 2111(3). An electronic submission shall not be required in circumstances where the managed care plan has not published protocols or provided training as required by section 2111(3).

(b) Any restriction that a utilization review entity places on the preauthorization of health care services shall be in accordance with the following:

(1) Based on the medical necessity of those services and on any additional clinical criteria information submitted by the provider seeking authorization of the health care service on behalf of the enrollee.

(2) Applied consistently.

(3) Disclosed by the managed care plan or utilization review entity under sections 2111 and 2136.

(c) Adverse determinations and final adverse determinations made by a utilization review entity or agent thereof shall be based on medical necessity and supporting clinical criteria submitted by the provider seeking authorization for the health care service on behalf of the enrollee.

(d) A utilization review entity shall not deny coverage of a health care service solely based on the grounds that the health care service does not meet clinical criteria.

(e) Preauthorization shall not be required in any of the following:

(1) If a prescribed medication is a noncontrolled generic medication.

(2) If a procedure to be performed is customary and properly indicated or is a treatment for the clinical indication as supported by peer reviewed medical publications.

(3) For the provision of MAT for the treatment of an opioid use disorder.

(f) If a provider contacts a utilization review entity seeking preauthorization for a medically necessary health care service under section 2111(14) and the utilization review entity, through an agent, contractor, employe or representative informs the provider that preauthorization is not required for the health care service subject to the request, coverage for the service shall be deemed approved.

Section 2115. Preauthorization Costs.--(a) In the event that an insured is covered by more than one health plan that requires preauthorization:

(1) A secondary managed health care plan shall not deny preauthorization for a health care service solely on the basis that the preauthorization procedures of the secondary insurer were not followed if the enrollee subject to the plan received preauthorization from the enrollee's primary managed health care plan.

(2) Nothing in this section shall be construed to preclude a secondary insurer from requiring preauthorization for a health care service denied preauthorization by a primary insurer.

(b) Any internal grievance or internal review of an adverse determination of a final adverse determination shall be provided without charge to the enrollee or enrollee's health care provider.

Section 4. Section 2117 of the act is amended by adding subsections to read:

Section 2117. Continuity of Care. * * *

(g) If the appeal of an adverse determination from a preauthorization request concerns ongoing health care services provided under an initially authorized admission or course of treatment, the health care services shall continue to be provided to the enrollee and paid for by the managed care plan without liability to the enrollee or the enrollee's health care provider for no less than sixty (60) days.

(h) The managed care plan or utilization review entity shall not be permitted to retroactively review the decision to authorize and provide health care services through preauthorization, including preauthorization for extending the term or course of treatment unless the managed care plan or utilization review entity can demonstrate by clear and convincing evidence that preauthorization was authorized using

knowingly inaccurate clinical information submitted by the provider or fraud.

(i) Notwithstanding any other provision of law, the managed care plan shall not retroactively recover the cost of treatment either for the initial period of treatment subject to preauthorization or the period of treatment provided to the enrollee as part of the preauthorization decision-making process to authorize coverage of additional treatment periods.

(j) Continued care shall not be subject to concurrent review if the treatment regimen or continuity of care follows from a authorizing previous preauthorization request unless the managed care plan or utilization review entity can demonstrate by clear and convincing evidence that preauthorization was authorized using knowingly inaccurate clinical information submitted by the provider or fraud.

Section 5. The act is amended by adding a section to read:

Section 2118. Step Therapy. (a) (1) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a managed care plan or utilization review entity through a step therapy protocol, the enrollee and provider shall have access to a clear, readily accessible and convenient process to request a step therapy exception under section 2111(16). Failure of the managed care plan to meet its obligation under section 2111 shall result in all step therapy exceptions being deemed approved until the managed care plan complies with the requirements of section 2111(16).

(2) No step therapy shall be required if the medication being prescribed is being prescribed in response to an emergency.

(3) A step therapy exception shall be granted if any of the

following apply:

(i) The required prescription drug is contraindicated, not in the best interest of the enrollee or will likely cause an adverse reaction by or physical or mental harm to the enrollee.

(ii) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the enrollee and the known characteristics of the prescription drug regimen.

(iii) The enrollee has tried the required prescription drug while under the enrollee's current or previous health care plan or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event.

(iv) The enrollee is stable on a prescription drug previously selected by the enrollee's provider and previously approved by a managed care plan or utilization review entity.

(4) Granting the step therapy exception shall authorize coverage for the prescription drug prescribed by the enrollee's treating health care provider.

(b) Step therapy exception requests or an appeal thereof shall be granted or denied within five (5) business days of receipt, subject to the following:

(1) In cases where the requested exception is related to an urgent healthcare treatment, the managed care plan or utilization review entity evaluating the exception shall respond within twenty-four (24) hours of receipt of the request.

(2) If a request for an exception under this section is incomplete or additional clinically relevant information is required, the managed care plan or utilization review entity

shall notify the prescribing practitioner within five (5) business days of submission, or twenty-four (24) hours in an urgent health care request, that additional or clinically relevant information is required in order to approve or deny the step therapy exception request or appeal under this section. The request for additional information may only extend the deadlines herein an additional forty-eight (48) hours for nonurgent healthcare services subject to step therapy.

(c) If a determination is not rendered within the applicable deadlines, the requested exception shall be deemed approved, and treatment authorized. In a circumstance where the exception has been deemed approved and treatment has been authorized shall not be subject to concurrent review or retroactive review because of the failure of the managed care plan to render a determination under this section.

(d) In the event of a denial, the managed care plan or utilization review entity shall inform the enrollee of the right to a grievance process. This subsection shall not be construed to prevent:

(1) A managed care plan or utilization review entity from requiring a pharmacist to effect substitutions of prescription drugs consistent with the laws of this Commonwealth.

(2) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

(e) As used in this section, the following words and phrases shall have the meanings given to them in this section:

"Step therapy exception." When a step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug.

"Step therapy protocol." A protocol, policy or program that

establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered by an insurer or health plan.

Section 6. Article XXI, Subdivision (f) heading of the act is amended to read:

(f) Information for Enrollees and Health Care Providers.

Section 7. Section 2136 of the act is amended by adding a subsection to read:

Section 2136. Required Disclosure.--* * *

(c) If either a managed care plan or utilization review entity intends to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the managed care plan or utilization review entity shall provide network providers and enrollees with written notice of the new or amended requirement or amendment not less than sixty (60) days before implementation. The notice shall be in writing which may be satisfied by any of the following:

(1) Mail through the United States Postal Service.

(2) Electronic mail read receipt requested.

(3) Publication on the publicly accessible Internet website of the managed care plan or utilization review entity with an electronic mail message to network providers and enrollees that identifies the location of the publication on the website.

(4) Web exchange, provided that an electronic mail message on how to access the web exchange is sent to network providers and enrollees.

(5) Any other contractually agreed upon method, specifying the details of the communication which include some proof of receipt by the network providers and enrollees.

Section 8. Section 2152(a)(4) and (6) of the act are

amended, subsection (a) is amended by adding paragraphs and the section is amended by adding a subsection to read:

Section 2152. Operational Standards. (a) A utilization review entity shall do all of the following:

* * *

(4) Conduct utilization reviews based on the medical necessity [and appropriateness] of the health care service being reviewed and provide notification within the following time frames:

(i) [A prospective utilization review decision shall be communicated within two (2) business days of the receipt of all supporting information reasonably necessary to complete the review.] A prospective utilization review or preauthorization decision shall be rendered not more than seven (7) days after initial submission of the request for authorization. The decision to authorize or deny the requested health care service shall be communicated within five (5) business days of the receipt of all supporting information reasonably necessary to complete the review. If the initial submission does not contain all of the supporting information reasonably necessary to complete the review, the utilization review entity may request additional information from the provider but the request shall only extend the seven (7) day deadline for a decision either authorizing or denying the health care service an additional forty eight (48) hours.

(ii) A concurrent utilization review decision shall be communicated within one (1) business day of the receipt of all supporting information reasonably necessary to complete the review.

(iii) A retrospective utilization review decision shall be

communicated within thirty (30) days of the receipt of all supporting information reasonably necessary to complete the review. Utilization review entities shall not retroactively review the medical necessity of a preauthorization that has been previously approved or granted under section 2117.

(iv) A utilization review entity shall allow an enrollee and the enrollee's health care provider a minimum of one (1) business day following an inpatient admission under emergency health care service or urgent health care service to notify the utilization review entity of the admission and any health care services performed.

* * *

(6) Provide all decisions in writing to include the basis and clinical rationale for the decision. For adverse determinations from preauthorization requests, a utilization review entity shall provide notice of all adverse determinations to the enrollee and the enrollee's health care provider. The notice of adverse determination shall include instructions concerning how a grievance may be filed for an adverse determination based on medical necessity. If the adverse determination is based on an administrative defect, the determination shall provide information on how the defect may be cured and instructions for resubmitting the preauthorization request.

* * *

(9) Post the following to the utilization review entity's publicly accessible Internet website:

(i) A current list of services and supplies requiring preauthorization.

(ii) Written clinical criteria for preauthorization

decisions.

(10) Ensure that a preauthorization shall be valid for no longer than one hundred eighty (180) days or the duration of treatment, whichever is greater, from the date the health care provider receives the preauthorization so long as the enrollee is a member of the plan.

(11) When performing preauthorization, only request copies of medical records relevant to determining the medical necessity of a health care service requested.

(12) In the event an administrative defect is discovered, a managed care plan shall allow a health care provider the opportunity to remedy the administrative defect within forty-eight hours (48) hours of receiving notice of the defect. If a health care provider remedies the administrative defect, a determination of preauthorization shall be rendered within forty-eight (48) hours. If the administrative defect remains uncured, the managed care plan may deny preauthorization.

* * *

(e) Failure by a utilization review entity to comply with deadlines and other requirements specified for preauthorization shall result in the requested preauthorization for the health care service to be deemed authorized and paid by the managed care plan. Failure of the provider cure any administrative defects in preauthorization requests in a timely manner under this section may result in the preauthorization being denied.

Section 9. The act is amended by adding sections to read:

Section 2161.1. Initial Review of Preauthorization Requests and Adverse Determinations. (a) A utilization review entity shall ensure that:

(1) A denial based on the medical necessity of a

preauthorization request is made by a qualified licensed health care provider who has knowledge of the items, services, products, tests or procedures submitted for preauthorization.

(2) If an adverse determination is made by a physician and based on medical necessity, then the physician must possess a current and valid nonrestricted license to practice medicine in this Commonwealth and be board certified. If the preauthorization review requires a peer-to-peer review in the specialty or subspecialty where a review is requested by the submitting provider, then the physician conducting the review on behalf of the utilization review entity shall be of a similar specialty to the health care service for which preauthorization is requested.

(b) Notification of a preauthorization shall be accompanied by a unique preauthorization number and indicate:

(1) The specific health care services preauthorized.

(2) The next date for review.

(3) The date of admission or initiation of services, if applicable.

(c) In the event a health care provider obtains preauthorization for one (1) service but the service provided is not an exact match to the service that was preauthorized a utilization review entity or managed care plan shall grant authorization for the health care service provided and remit payment at a rate of reimbursement that is associated with either the preauthorized health care service or the service appropriately substituted based on common procedural terminology and clinical criteria.

(d) (1) If a utilization review entity challenges the medical necessity of a health care service, the utilization

review entity shall notify the enrollee's health care provider that medical necessity is being challenged and provide the basis of the challenge in sufficient detail to allow the provider requesting authorization of the health care service to meaningfully address the challenge raised by the utilization review entity prior to issuing an adverse determination.

(2) The enrollee's health care provider or designee and the enrollee or enrollee's designee shall have the right to discuss the medical necessity of the health care service with the utilization review physician.

(3) A utilization review entity questioning medical necessity of a health care service which may result in an adverse determination shall ensure a reviewing physician making the decision is available telephonically at a specifically appointed mutually agreeable time scheduled in advance between the provider requesting the health care service and reviewing physician between the hours of seven (7) o'clock antemeridian and seven (7) o'clock postmeridian. If the utilization review entity fails to make the reviewing physician available as required by this paragraph, the health care service subject to the preauthorization request shall be deemed authorized.

(e) When making a determination based on medical necessity, a utilization review entity shall base the determination on an enrollee's presenting symptoms, diagnosis and information available through the course of treatment or at the time of admission. Such information may also include any medical information collected at the time the enrollee presented to the emergency department if the information is relevant to the determination.

(f) In the event a utilization review entity determines an

alternative level of care is appropriate, the utilization review entity shall provide notice of the alternative level of care to the provider requesting preauthorization for a health care service and cite the specific criteria used as the basis for the alternative level of care determination to the health care provider prior to denying preauthorization. An alternative level of care decision shall be subject to a peer-to-peer review as under this section.

(g) A utilization review entity may not issue an adverse determination for a procedure due to lack of preauthorization if the procedure is medically necessary or clinically appropriate for the patient's medical condition and rendered at the same time as a related procedure for which preauthorization was required and received.

(h) A utilization review entity shall make a preauthorization adverse determination decision and notify the enrollee and the enrollee's health care provider as follows:

(1) For nonurgent health care services, within five (5) days of obtaining all the necessary information to make the preauthorization or adverse determination, so long as the entire review process is completed either seven (7) days following the initial request if no additional information is requested by the utilization review entity or nine (9) days following the initial submission if additional information is requested.

(2) For urgent health care services, within forty-eight (48) hours from submission of the request for prior authorization. No utilization review entity may require preauthorization for an emergency service, including post evaluation and poststabilization services.

Section 2161.2. Preauthorization Denial Grievances. (a) An

~~enrollee or the enrollee's health care provider may submit a grievance and request an expedited review of an adverse determination via telephone, facsimile, electronic mail or other method. Within one (1) day of receiving an expedited request and all information necessary to make a determination, the utilization review entity shall provide the enrollee and the enrollee's health care provider written confirmation of the expedited review determination.~~

~~(b) A grievance shall be reviewed only by a physician who satisfies any of the following conditions:~~

~~(1) Is board certified in the same specialty as a health care practitioner who typically manages the medical condition or disease.~~

~~(2) Is currently in active practice, provided that in events where circumstances justify it or where the provider seeking preauthorization specifically requests a health care provider actively engaged in the specialty who typically manages the medical condition or disease, the physician shall be made available for the review.~~

~~(3) Is knowledgeable of, and has experience in, providing the health care services under grievance.~~

~~(4) Is under contract with a utilization review entity to perform reviews of grievances and payment of fees due under the contract, but the performance and payment is not subject to or contingent upon the outcome of the appeal. The following shall apply:~~

~~(i) The physician may also be subject to a provider agreement with the managed care plan as a network provider, but shall not receive any other fee or compensation from the managed care plan.~~

~~(ii) The physician's receipt of compensation from either the managed care plan or the utilization review entity shall not be considered by the physician in determining the conclusion reached by the physician.~~

~~(iii) The physician shall at all times render independent and accurate medical judgment in reaching an opinion or conclusion.~~

~~(iv) Failure to comply with this provision shall render the physician subject to licensure disciplinary action by the appropriate licensing board.~~

~~(5) Not involved in making the adverse determination.~~

~~(6) Familiar with all known clinical aspects of the health care services under review, including all pertinent medical records provided to the utilization review entity by the enrollee's health care provider and any relevant record provided to the utilization review entity by a health care facility.~~

~~(c) The utilization review entity shall ensure that grievance review procedures satisfy the following requirements:~~

~~(1) The enrollee and the enrollee's health care provider may challenge the adverse determination and have the right to appear in person before the utilization review entity, including the reviewing physician, who reviews the adverse determination.~~

~~(2) The utilization review entity shall provide the enrollee and the enrollee's health care provider written notice of the time and place concerning where the review meeting will take place. Notice shall be given to the enrollee's health care provider at least fourteen (14) days in advance of the review meeting.~~

~~(3) If the enrollee or the enrollee's health care provider appear in person, the utilization review entity shall offer the~~

enrollee or enrollee's health care provider the opportunity to communicate with the reviewing physician, at the utilization review entity's expense, by conference call, video conferencing or other available technology.

(4) The physician performing the review of the grievance shall consider all information, documentation or other material submitted in connection with the grievance without regard to whether the information was considered in making the adverse determination.

(d) The following deadlines shall apply to the utilization review entities:

(1) A utilization review entity shall decide a grievance submitted for expedited review and notify the enrollee and the enrollee's health care provider of the determination within two (2) days after receiving a notice of the expedited review request by the enrollee or the enrollee's health care provider and all information necessary to render a decision.

(2) A utilization review entity shall issue a written determination concerning a nonexpedited grievance not later than thirty (30) days after receiving a notice of the grievance from an enrollee or enrollee's health care provider.

(e) Written notice of final an adverse determination shall be provided to the enrollee and the enrollee's health care provider.

(f) If the enrollee or the enrollee's health care provider or a designee on behalf of either the enrollee or the enrollee's health care provider has satisfied all necessary requirements for the grievance review determination of an adverse determination through the preauthorization process and the determination has resulted in a continued adverse determination

either based on lack of medical necessity or an administrative defect, the enrollee, the enrollee's health care provider or a designee on behalf of either the enrollee or the enrollee's health care provider or a designee may file a consumer complaint with the Department of Health if for continued lack of medical necessity and the Insurance Department if for administrative defect. The complaint shall be adjudicated without unnecessary delay in accordance with current law and a determination issued by the relevant department with appropriate sanctions, if applicable, under the authority given to that department.

(g) To the extent that an enrollee, an enrollee's health care provider or a designee on behalf of either the enrollee or the enrollee's health care provider or a designee files a consumer complaint with either department or the Office of Attorney General under the authority to receive the complaints, a copy of the complaint filed with either department or the Office of Attorney General shall be forwarded to the Insurance Department and the copy shall serve as a new consumer complaint to be adjudicated under the terms of this section and all other applicable law.

Section 2195. Access Requirements in Service Areas. If an enrollee's safe discharge is delayed for any reason, including lack of available posthospitalization services, including skilled nursing facilities, home health services and postacute rehabilitation, the managed care plan shall reimburse the hospital for each subsequent date of service at the greater of the contracted rate with the managed care plan for the current level of care and service or the full diagnostic related group payment divided by the mean length of stay for the particular diagnostic related group.

~~Section 11. Nothing in this act shall be construed to preclude an insurer from developing a program exempting a health care provider from preauthorization protocols.~~

~~Section 12. This act shall take effect in 60 days.~~

SECTION 1. THE DEFINITIONS OF "COMPLAINT," "DRUG FORMULARY," **<--** "ENROLLEE," "GRIEVANCE," "HEALTH CARE SERVICE," "PROSPECTIVE UTILIZATION REVIEW," "PROVIDER NETWORK," "RETROSPECTIVE UTILIZATION REVIEW," "UTILIZATION REVIEW" AND "UTILIZATION REVIEW ENTITY" IN SECTION 2102 OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921, ARE AMENDED AND THE SECTION IS AMENDED BY ADDING DEFINITIONS TO READ:

SECTION 2102. DEFINITIONS.--AS USED IN THIS ARTICLE, THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION:

* * *

"ADMINISTRATIVE POLICY." A WRITTEN DOCUMENT OR COLLECTION OF DOCUMENTS REFLECTING THE TERMS OF THE CONTRACTUAL OR OPERATING RELATIONSHIP BETWEEN AN INSURER, MCO, CONTRACTOR AND A HEALTH CARE PROVIDER.

"ADMINISTRATIVE DENIAL." A DENIAL OF PRIOR AUTHORIZATION, COVERAGE OR PAYMENT BASED ON A LACK OF ELIGIBILITY, FAILURE TO SUBMIT COMPLETE INFORMATION OR OTHER FAILURE TO COMPLY WITH WRITTEN ADMINISTRATIVE STANDARDS FOR THE ADMINISTRATION OF BENEFITS UNDER A HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT. THE TERM DOES NOT INCLUDE A DENIAL BASED ON MEDICAL NECESSITY.

"ADVERSE BENEFIT DETERMINATION." A DETERMINATION BY AN INSURER, MCO, CONTRACTOR OR A UTILIZATION REVIEW ENTITY DESIGNATED BY THE INSURER, MCO OR CONTRACTOR THAT A HEALTH CARE

SERVICE HAS BEEN REVIEWED AND, BASED UPON THE INFORMATION PROVIDED, DOES NOT MEET THE INSURER'S, MCO'S OR CONTRACTOR'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS AND THE REQUESTED SERVICE OR PAYMENT FOR THE SERVICE IS THEREFORE DENIED, REDUCED OR TERMINATED.

* * *

"APPLICABLE GOVERNMENTAL GUIDELINES." CLINICAL PRACTICE AND ASSOCIATED GUIDELINES ISSUED UNDER THE AUTHORITY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES FOOD AND DRUG ADMINISTRATION, CENTERS FOR DISEASE CONTROL AND PREVENTION, DEPARTMENT OF HEALTH OR OTHER SIMILARLY SITUATED FEDERAL OR STATE AGENCY, DEPARTMENT OR SUBUNIT THEREOF FOCUSED ON THE PROVISION OR REGULATION OF MEDICAL CARE, PRESCRIPTION DRUGS OR PUBLIC HEALTH WITHIN THE UNITED STATES.

"CHILDREN'S HEALTH INSURANCE PROGRAM" OR "CHIP." THE CHILDREN'S HEALTH CARE PROGRAM UNDER ARTICLE XXIII-A.

"CHIP CONTRACT." THE AGREEMENT BETWEEN AN INSURER AND THE DEPARTMENT OF HUMAN SERVICES TO PROVIDE FOR SERVICES TO A CHIP ENROLLEE.

* * *

"CLINICAL REVIEW CRITERIA." THE SET OF WRITTEN SCREENING PROCEDURES, DECISION ABSTRACTS, CLINICAL PROTOCOLS AND PRACTICE GUIDELINES USED BY AN INSURER, MCO OR CONTRACTOR TO DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE SERVICES.

"CLOSELY RELATED SERVICE." ONE OR MORE HEALTH CARE SERVICES SUBJECT TO PRIOR AUTHORIZATION THAT ARE CLOSELY RELATED IN PURPOSE, DIAGNOSTIC UTILITY OR DESIGNATED HEALTH CARE BILLING CODE AND PROVIDED ON THE SAME DATE OF SERVICE SUCH THAT A PRUDENT HEALTH CARE PROVIDER, ACTING WITHIN THE SCOPE OF THE

HEALTH CARE PROVIDER'S LICENSE AND EXPERTISE, MIGHT REASONABLY BE EXPECTED TO PERFORM SUCH SERVICE IN CONJUNCTION WITH OR IN LIEU OF THE ORIGINALLY AUTHORIZED SERVICE IN RESPONSE TO MINOR DIFFERENCES IN OBSERVED PATIENT CHARACTERISTICS OR NEEDS FOR DIAGNOSTIC INFORMATION THAT WERE NOT READILY IDENTIFIABLE UNTIL THE HEALTH CARE PROVIDER WAS ACTUALLY PERFORMING THE ORIGINALLY AUTHORIZED SERVICE. THE TERM DOES NOT INCLUDE AN ORDER FOR OR ADMINISTRATION OF A PRESCRIPTION DRUG OR ANY PART OF A SERIES OR COURSE OF TREATMENTS.

"COMPLAINT." A DISPUTE OR OBJECTION REGARDING A PARTICIPATING HEALTH CARE PROVIDER OR THE COVERAGE, OPERATIONS OR MANAGEMENT POLICIES OF [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR, WHICH HAS NOT BEEN RESOLVED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR AND HAS BEEN FILED WITH THE [PLAN] INSURER, MCO OR CONTRACTOR OR WITH THE DEPARTMENT OF HEALTH OR THE INSURANCE DEPARTMENT OF THE COMMONWEALTH. THE TERM DOES NOT INCLUDE A GRIEVANCE.

"COMPLETE PRIOR AUTHORIZATION REQUEST." A REQUEST FOR PRIOR AUTHORIZATION THAT MEETS AN INSURER'S, MCO'S OR CONTRACTOR'S ADMINISTRATIVE POLICY REQUIREMENTS FOR SUCH A REQUEST AND THAT INCLUDES THE SPECIFIC CLINICAL INFORMATION NECESSARY ONLY TO EVALUATE THE REQUEST UNDER THE TERMS OF THE APPLICABLE MEDICAL POLICY. TO THE EXTENT A HEALTH CARE PROVIDER NETWORK AGREEMENT REQUIRES MEDICAL RECORDS TO BE TRANSMITTED ELECTRONICALLY, OR A HEALTH CARE PROVIDER IS CAPABLE OF TRANSMITTING MEDICAL RECORDS ELECTRONICALLY TO SUPPORT A COMPLETE PRIOR AUTHORIZATION REQUEST FOR A HEALTH CARE SERVICE, THE HEALTH CARE PROVIDER SHALL ENSURE THE INSURER HAS ELECTRONIC ACCESS TO, INCLUDING THE ABILITY TO PRINT, THE MEDICAL RECORDS THAT HAVE BEEN TRANSMITTED ELECTRONICALLY, SUBJECT TO ANY APPLICABLE LAW AND THE HEALTH

CARE PROVIDER'S CORPORATE POLICIES. THE INABILITY OF A HEALTH CARE PROVIDER TO PROVIDE SUCH ACCESS SHALL NOT CONSTITUTE A REASON TO DENY AN AUTHORIZATION REQUEST.

* * *

"CONTRACTOR." AN INSURER AWARDED A CONTRACT UNDER SECTION 2304-A TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES AN ENTITY AND AN ENTITY'S SUBSIDIARY WHICH IS ESTABLISHED UNDER THIS ACT, THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT OR 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATION) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

* * *

"DRUG FORMULARY." A LISTING OF [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR PREFERRED THERAPEUTIC DRUGS.

* * *

"ENROLLEE." ANY POLICYHOLDER, SUBSCRIBER, COVERED PERSON OR OTHER INDIVIDUAL WHO IS ENTITLED TO RECEIVE HEALTH CARE SERVICES UNDER A [MANAGED CARE PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

"GRIEVANCE." AS PROVIDED IN SUBDIVISION (I), A REQUEST BY AN ENROLLEE OR A HEALTH CARE PROVIDER, WITH THE WRITTEN CONSENT OF THE ENROLLEE, TO HAVE [A MANAGED CARE PLAN] AN INSURER, MCO, CONTRACTOR OR UTILIZATION REVIEW ENTITY RECONSIDER A DECISION SOLELY CONCERNING THE MEDICAL NECESSITY [AND], APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OF A HEALTH CARE SERVICE. IF THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR IS UNABLE TO RESOLVE THE MATTER, A GRIEVANCE MAY BE FILED REGARDING THE DECISION THAT:

(1) DISAPPROVES FULL OR PARTIAL PAYMENT FOR A REQUESTED HEALTH CARE SERVICE;

(2) APPROVES THE PROVISION OF A REQUESTED HEALTH CARE SERVICE FOR A LESSER SCOPE OR DURATION THAN REQUESTED; 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.

THE TERM DOES NOT INCLUDE A COMPLAINT.

* * *

"HEALTH CARE SERVICE." ANY COVERED TREATMENT, ADMISSION, PROCEDURE, MEDICAL SUPPLIES AND EQUIPMENT OR OTHER SERVICES, INCLUDING BEHAVIORAL HEALTH, PRESCRIBED OR OTHERWISE PROVIDED OR PROPOSED TO BE PROVIDED BY A HEALTH CARE PROVIDER TO AN ENROLLEE [UNDER A MANAGED CARE PLAN CONTRACT.]

"HEALTH INSURANCE POLICY." A POLICY, SUBSCRIBER CONTRACT, CERTIFICATE OR PLAN ISSUED BY AN INSURER THAT PROVIDES MEDICAL OR HEALTH CARE COVERAGE. THE TERM DOES NOT INCLUDE ANY OF THE FOLLOWING:

(1) AN ACCIDENT ONLY POLICY.

(2) A CREDIT ONLY POLICY.

(3) A LONG-TERM CARE OR DISABILITY INCOME POLICY.

(4) A SPECIFIED DISEASE POLICY.

(5) A MEDICARE SUPPLEMENT POLICY.

(6) A TRICARE POLICY, INCLUDING A CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT POLICY.

(7) A FIXED INDEMNITY POLICY.

(8) A HOSPITAL INDEMNITY POLICY.

(9) A DENTAL ONLY POLICY.

(10) A VISION ONLY POLICY.

(11) A WORKERS' COMPENSATION POLICY.

(12) AN AUTOMOBILE MEDICAL PAYMENT POLICY.

(13) A HOMEOWNERS' INSURANCE POLICY.

(14) A SHORT-TERM LIMITED DURATION POLICY.

(15) ANY OTHER SIMILAR POLICY PROVIDING FOR LIMITED BENEFITS.

"INPATIENT ADMISSION." ADMISSION TO A FACILITY FOR PURPOSES OF RECEIVING A HEALTH CARE SERVICE AT THE INPATIENT LEVEL OF CARE.

"INSURER." AN ENTITY LICENSED BY THE DEPARTMENT TO ISSUE A HEALTH INSURANCE POLICY, SUBSCRIBER CONTRACT, CERTIFICATE OR PLAN THAT PROVIDES MEDICAL OR HEALTH CARE COVERAGE THAT IS OFFERED OR GOVERNED UNDER ANY OF THE FOLLOWING:

(1) ARTICLE XXIV, SECTION 630 OR ANY OTHER PROVISION OF THIS ACT.

(2) A PROVISION OF 40 PA.C.S. CH. 61 OR 63.

* * *

"MCO CONTRACT." THE AGREEMENT BETWEEN A MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION OR MCO AND THE DEPARTMENT OF HUMAN SERVICES TO PROVIDE FOR SERVICES TO A MEDICAID ENROLLEE.

"MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION" OR "MCO." A MEDICAID MANAGED CARE ORGANIZATION AS DEFINED IN SECTION 1903(M)(1)(A) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396B(M)(1)(A)) THAT IS A PARTY TO A MEDICAID MANAGED CARE CONTRACT WITH THE DEPARTMENT OF HUMAN SERVICES. THE TERM DOES NOT INCLUDE A BEHAVIORAL HEALTH MANAGED CARE ORGANIZATION THAT IS A PARTY TO A MEDICAID MANAGED CARE CONTRACT WITH THE DEPARTMENT OF HUMAN SERVICES.

"MEDICAL POLICY." A WRITTEN DOCUMENT FORMALLY ADOPTED, MAINTAINED AND APPLIED BY AN INSURER, MCO OR CONTRACTOR THAT COMBINES THE CLINICAL COVERAGE CRITERIA AND ANY ADDITIONAL ADMINISTRATIVE REQUIREMENTS, AS APPLICABLE, NECESSARY TO

ARTICULATE THE INSURER'S, MCO'S OR CONTRACTOR'S STANDARDS FOR COVERAGE OF A GIVEN SERVICE OR SET OF SERVICES UNDER THE TERMS OF A HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

"MEDICAL OR SCIENTIFIC EVIDENCE." EVIDENCE FOUND IN ANY OF THE FOLLOWING SOURCES:

(1) A PEER-REVIEWED SCIENTIFIC STUDY PUBLISHED IN OR ACCEPTED FOR PUBLICATION BY A MEDICAL JOURNAL THAT MEETS NATIONALLY RECOGNIZED REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS AND WHICH JOURNAL SUBMITS MOST OF ITS PUBLISHED ARTICLES FOR REVIEW BY EXPERTS WHO ARE NOT PART OF THE JOURNAL'S EDITORIAL STAFF.

(2) PEER-REVIEWED MEDICAL LITERATURE, INCLUDING LITERATURE RELATING TO A THERAPY REVIEWED AND APPROVED BY A QUALIFIED INSTITUTIONAL REVIEW BOARD, BIOMEDICAL COMPENDIA AND OTHER MEDICAL LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL INSTITUTES OF HEALTH'S LIBRARY OF MEDICINE FOR INDEXING IN INDEX MEDICUS (MEDLINE) AND ELSEVIER SCIENCE LIMITED FOR INDEXING IN EXCERPTA MEDICA (EMBASE).

(3) A MEDICAL JOURNAL RECOGNIZED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES UNDER SECTION 1861(T)(2) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395X(T)(2)).

(4) ONE OF THE FOLLOWING STANDARD REFERENCE COMPENDIA:

(I) THE AMERICAN HOSPITAL FORMULARY SERVICE-DRUG INFORMATION.

(II) DRUG FACTS AND COMPARISON.

(III) THE AMERICAN DENTAL ASSOCIATION ACCEPTED DENTAL THERAPEUTICS.

(IV) THE UNITED STATES PHARMACOPOEIA-DRUG INFORMATION.

(5) FINDINGS, STUDIES OR RESEARCH CONDUCTED BY OR UNDER THE AUSPICES OF A FEDERAL GOVERNMENT AGENCY OR NATIONALLY RECOGNIZED

FEDERAL RESEARCH INSTITUTE, INCLUDING:

(I) THE FEDERAL AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

(II) THE NATIONAL INSTITUTE OF HEALTH.

(III) THE NATIONAL CANCER INSTITUTE.

(IV) THE NATIONAL ACADEMY OF SCIENCES.

(V) THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(VI) THE FOOD AND DRUG ADMINISTRATION.

(VII) ANY NATIONAL BOARD RECOGNIZED BY THE NATIONAL INSTITUTES OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL VALUE OF HEALTH CARE SERVICES.

(6) OTHER MEDICAL OR SCIENTIFIC EVIDENCE THAT IS COMPARABLE TO THE SOURCES SPECIFIED IN PARAGRAPHS (1), (2), (3), (4) AND (5).

"MEDICATION ASSISTED TREATMENT." UNITED STATES FOOD AND DRUG ADMINISTRATION APPROVED PRESCRIPTION DRUGS USED IN COMBINATION WITH COUNSELING AND BEHAVIORAL HEALTH THERAPIES IN THE TREATMENT OF OPIOID USE DISORDERS.

"NATIONALLY RECOGNIZED MEDICAL STANDARDS." CLINICAL CRITERIA, PRACTICE GUIDELINES AND RELATED STANDARDS ESTABLISHED BY NATIONAL QUALITY AND ACCREDITATION ENTITIES GENERALLY RECOGNIZED IN THE UNITED STATES HEALTH CARE INDUSTRY.

"PARTICIPATING PROVIDER." A HEALTH CARE PROVIDER THAT HAS ENTERED INTO A CONTRACTUAL OR OPERATING RELATIONSHIP WITH AN INSURER, MCO OR CONTRACTOR TO PARTICIPATE IN ONE OR MORE DESIGNATED NETWORKS OF THE INSURER, MCO OR CONTRACTOR AND TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES UNDER THE TERMS OF THE INSURER'S, MCO'S OR CONTRACTOR'S ADMINISTRATIVE POLICY.

* * *

"PRIOR AUTHORIZATION." A REVIEW BY AN INSURER, MCO, CONTRACTOR OR BY A UTILIZATION REVIEW ENTITY ACTING ON BEHALF OF

AN INSURER, MCO OR CONTRACTOR OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION THAT OCCURS PRIOR TO THE DELIVERY OR PROVISION OF A HEALTH CARE SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR THE HEALTH CARE SERVICE. THE TERM INCLUDES STEP THERAPY AND ASSOCIATED EXCEPTIONS FOR PRESCRIPTION DRUGS.

["PROSPECTIVE UTILIZATION REVIEW." A REVIEW BY A UTILIZATION REVIEW ENTITY OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION THAT OCCURS PRIOR TO THE DELIVERY OR PROVISION OF A HEALTH CARE SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR THE HEALTH CARE SERVICE.]

"PROVIDER NETWORK." THE HEALTH CARE PROVIDERS DESIGNATED BY [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR TO PROVIDE HEALTH CARE SERVICES.

"PROVIDER PORTAL." A DESIGNATED SECTION OR FUNCTIONAL SOFTWARE MODULE ACCESSIBLE VIA AN INSURER'S, MCO'S OR CONTRACTOR'S PUBLICLY ACCESSIBLE INTERNET WEBSITE THAT FACILITATES HEALTH CARE PROVIDER SUBMISSION OF ELECTRONIC PRIOR AUTHORIZATION REQUESTS.

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"RETROSPECTIVE UTILIZATION REVIEW." A REVIEW BY [A] AN INSURER, MCO, CONTRACTOR OR UTILIZATION REVIEW ENTITY ACTING ON BEHALF OF AN INSURER, MCO OR CONTRACTOR OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION WHICH OCCURS FOLLOWING DELIVERY OR PROVISION OF A HEALTH CARE SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR THE HEALTH CARE SERVICE.

* * *

"STEP THERAPY." A COURSE OF TREATMENT WHERE CERTAIN DESIGNATED DRUGS OR TREATMENT PROTOCOLS MUST BE EITHER CONTRAINDICATED OR USED AND FOUND TO BE INEFFECTIVE PRIOR TO

APPROVAL OF COVERAGE FOR OTHER DESIGNATED DRUGS. THE TERM DOES NOT INCLUDE REQUESTS FOR COVERAGE OF NONFORMULARY DRUGS.

"URGENT HEALTH CARE SERVICE." A COVERED HEALTH CARE SERVICE SUBJECT TO PRIOR AUTHORIZATION IN WHICH THE APPLICATION OF THE TIME PERIODS FOR MAKING NON-URGENT CARE DETERMINATIONS:

(1) COULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE ENROLLEE OR THE ABILITY OF THE ENROLLEE TO REGAIN MAXIMUM FUNCTION; OR

(2) IN THE OPINION OF A PHYSICIAN WITH KNOWLEDGE OF THE ENROLLEE'S MEDICAL CONDITION WOULD SUBJECT THE ENROLLEE TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE CARE OR TREATMENT THAT IS THE SUBJECT OF THE PRIOR AUTHORIZATION.

"UTILIZATION REVIEW." A SYSTEM OF [PROSPECTIVE, CONCURRENT] PRIOR AUTHORIZATION, CONCURRENT UTILIZATION REVIEW OR RETROSPECTIVE UTILIZATION REVIEW PERFORMED BY [A] AN INSURER, MCO, CONTRACTOR OR UTILIZATION REVIEW ENTITY ON BEHALF OF AN INSURER, MCO OR CONTRACTOR OF THE MEDICAL NECESSITY [AND], APPROPRIATENESS, HEALTH CARE SETTING AND LEVEL OF CARE OR EFFECTIVENESS OF 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 OR HEALTH CARE SERVICE VERIFICATION.

(2) A HEALTH CARE PROVIDER'S INTERNAL QUALITY ASSURANCE OR UTILIZATION REVIEW PROCESS UNLESS THE REVIEW RESULTS IN DENIAL OF PAYMENT FOR A HEALTH CARE SERVICE.

"UTILIZATION REVIEW ENTITY." ANY ENTITY CERTIFIED PURSUANT TO SUBDIVISION (H) THAT PERFORMS UTILIZATION REVIEW ON BEHALF OF [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR.

SECTION 2. SUBARTICLE (B) HEADING OF ARTICLE XXI AND

SECTIONS 2111, 2112 AND 2113 OF THE ACT ARE AMENDED TO READ:

(B) [MANAGED CARE PLAN] INSURER, MCO AND CONTRACTOR REQUIREMENTS.

SECTION 2111. RESPONSIBILITIES OF [MANAGED CARE PLANS] INSURER, MCOS AND CONTRACTORS.--[A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL DO ALL OF THE FOLLOWING:

(1) ASSURE AVAILABILITY AND ACCESSIBILITY OF ADEQUATE HEALTH CARE PROVIDERS IN A TIMELY MANNER, WHICH ENABLES ENROLLEES TO HAVE ACCESS TO QUALITY CARE AND CONTINUITY OF HEALTH CARE SERVICES.

(2) CONSULT WITH HEALTH CARE PROVIDERS IN ACTIVE CLINICAL PRACTICE REGARDING PROFESSIONAL QUALIFICATIONS AND NECESSARY SPECIALISTS TO BE INCLUDED IN THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

(3) ADOPT AND MAINTAIN A DEFINITION OF MEDICAL NECESSITY USED BY THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT IN DETERMINING HEALTH CARE SERVICES.

(4) ENSURE THAT EMERGENCY SERVICES ARE PROVIDED TWENTY-FOUR (24) HOURS A DAY, SEVEN (7) DAYS A WEEK AND PROVIDE REASONABLE PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES.

(5) ADOPT AND MAINTAIN PROCEDURES BY WHICH AN ENROLLEE CAN OBTAIN HEALTH CARE SERVICES OUTSIDE THE [PLAN'S] HEALTH INSURANCE POLICY'S, MCO CONTRACT'S OR CHIP CONTRACT'S SERVICE AREA.

(6) ADOPT AND MAINTAIN PROCEDURES BY WHICH AN ENROLLEE WITH A LIFE-THREATENING, DEGENERATIVE OR DISABLING DISEASE OR CONDITION SHALL, UPON REQUEST, RECEIVE AN EVALUATION AND, IF THE [PLAN'S] INSURER'S, MCO'S OR CONTRACTOR'S ESTABLISHED STANDARDS ARE MET, BE PERMITTED TO RECEIVE:

(I) A STANDING REFERRAL TO A SPECIALIST WITH CLINICAL

EXPERTISE IN TREATING THE DISEASE OR CONDITION; OR

(II) THE DESIGNATION OF A SPECIALIST TO PROVIDE AND COORDINATE THE ENROLLEE'S PRIMARY AND SPECIALTY CARE. THE REFERRAL TO OR DESIGNATION OF A SPECIALIST SHALL BE PURSUANT TO A TREATMENT PLAN APPROVED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR IN CONSULTATION WITH THE PRIMARY CARE PROVIDER, THE ENROLLEE AND, AS APPROPRIATE, THE SPECIALIST. WHEN POSSIBLE, THE SPECIALIST MUST BE A HEALTH CARE PROVIDER PARTICIPATING IN THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

(7) PROVIDE DIRECT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES BY PERMITTING AN ENROLLEE TO SELECT A HEALTH CARE PROVIDER PARTICIPATING IN THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT TO OBTAIN MATERNITY AND GYNECOLOGICAL CARE, INCLUDING MEDICALLY NECESSARY AND APPROPRIATE FOLLOW-UP CARE AND REFERRALS FOR DIAGNOSTIC TESTING RELATED TO MATERNITY AND GYNECOLOGICAL CARE, WITHOUT PRIOR APPROVAL FROM A PRIMARY CARE PROVIDER. THE HEALTH CARE SERVICES SHALL BE WITHIN THE SCOPE OF PRACTICE OF THE SELECTED HEALTH CARE PROVIDER. THE SELECTED HEALTH CARE PROVIDER SHALL INFORM THE ENROLLEE'S PRIMARY CARE PROVIDER OF ALL HEALTH CARE SERVICES PROVIDED.

(8) ADOPT AND MAINTAIN A COMPLAINT PROCESS AS SET FORTH IN SUBDIVISION (G).

(9) ADOPT AND MAINTAIN A GRIEVANCE PROCESS AS SET FORTH IN SUBDIVISION (I).

(10) ADOPT AND MAINTAIN CREDENTIALING STANDARDS FOR HEALTH CARE PROVIDERS AS SET FORTH IN SUBDIVISION (D).

(11) ENSURE THAT THERE ARE PARTICIPATING HEALTH CARE PROVIDERS THAT ARE PHYSICALLY ACCESSIBLE TO PEOPLE WITH

DISABILITIES AND CAN COMMUNICATE WITH INDIVIDUALS WITH SENSORY DISABILITIES IN ACCORDANCE WITH TITLE III OF THE AMERICANS WITH DISABILITIES ACT OF 1990 (PUBLIC LAW 101-336, 42 U.S.C. § 12181 ET SEQ.).

(12) PROVIDE A LIST OF HEALTH CARE PROVIDERS PARTICIPATING IN THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT TO THE DEPARTMENT EVERY TWO (2) YEARS OR AS MAY OTHERWISE BE REQUIRED BY THE DEPARTMENT. THE LIST SHALL INCLUDE THE EXTENT TO WHICH [HEALTH CARE] PARTICIPATING PROVIDERS [IN THE PLAN] ARE ACCEPTING NEW ENROLLEES.

(13) REPORT TO THE DEPARTMENT AND THE INSURANCE DEPARTMENT IN ACCORDANCE WITH THE REQUIREMENTS OF THIS ARTICLE. SUCH INFORMATION SHALL INCLUDE THE NUMBER, TYPE AND DISPOSITION OF ALL COMPLAINTS AND GRIEVANCES FILED WITH THE [PLAN] INSURER, MCO OR CONTRACTOR.

SECTION 2112. FINANCIAL INCENTIVES PROHIBITION.--NO [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL USE ANY FINANCIAL INCENTIVE THAT COMPENSATES A HEALTH CARE PROVIDER FOR PROVIDING LESS THAN MEDICALLY NECESSARY AND APPROPRIATE CARE TO AN ENROLLEE. NOTHING IN THIS SECTION SHALL BE DEEMED TO PROHIBIT [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR FROM USING A CAPITATED PAYMENT ARRANGEMENT OR OTHER RISK-SHARING ARRANGEMENT.

SECTION 2113. MEDICAL GAG CLAUSE PROHIBITION.--(A) NO [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR MAY PENALIZE OR RESTRICT A HEALTH CARE PROVIDER FROM DISCUSSING:

(1) THE PROCESS THAT THE [PLAN] INSURER, MCO OR CONTRACTOR OR ANY ENTITY CONTRACTING WITH THE [PLAN] INSURER, MCO OR CONTRACTOR USES OR PROPOSES TO USE TO DENY PAYMENT FOR A HEALTH CARE SERVICE;

(2) MEDICALLY NECESSARY AND APPROPRIATE CARE WITH OR ON

BEHALF OF AN ENROLLEE, INCLUDING INFORMATION REGARDING THE NATURE OF TREATMENT; RISKS OF TREATMENT; ALTERNATIVE TREATMENTS; OR THE AVAILABILITY OF ALTERNATE THERAPIES, CONSULTATION OR TESTS; OR

(3) THE DECISION OF ANY [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR TO DENY PAYMENT FOR A HEALTH CARE SERVICE.

(B) A PROVISION TO PROHIBIT OR RESTRICT DISCLOSURE OF MEDICALLY NECESSARY AND APPROPRIATE HEALTH CARE INFORMATION CONTAINED IN A CONTRACT WITH A HEALTH CARE PROVIDER IS CONTRARY TO PUBLIC POLICY AND SHALL BE VOID AND UNENFORCEABLE.

(C) NO [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL TERMINATE THE EMPLOYMENT OF OR A CONTRACT WITH A HEALTH CARE PROVIDER FOR ANY OF THE FOLLOWING:

(1) ADVOCATING FOR MEDICALLY NECESSARY AND APPROPRIATE HEALTH CARE CONSISTENT WITH THE DEGREE OF LEARNING AND SKILL ORDINARILY POSSESSED BY A REPUTABLE HEALTH CARE PROVIDER PRACTICING ACCORDING TO THE APPLICABLE LEGAL STANDARD OF CARE.

(2) FILING A GRIEVANCE PURSUANT TO THE PROCEDURES SET FORTH IN THIS ARTICLE.

(3) PROTESTING A DECISION, POLICY OR PRACTICE THAT THE HEALTH CARE PROVIDER, CONSISTENT WITH THE DEGREE OF LEARNING AND SKILL ORDINARILY POSSESSED BY A REPUTABLE HEALTH CARE PROVIDER PRACTICING ACCORDING TO THE APPLICABLE LEGAL STANDARD OF CARE, REASONABLY BELIEVES INTERFERES WITH THE HEALTH CARE PROVIDER'S ABILITY TO PROVIDE MEDICALLY NECESSARY AND APPROPRIATE HEALTH CARE.

(D) NOTHING IN THIS SECTION SHALL:

(1) PROHIBIT [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR FROM MAKING A DETERMINATION NOT TO PAY FOR A PARTICULAR MEDICAL TREATMENT, SUPPLY OR SERVICE, ENFORCING

REASONABLE PEER REVIEW OR UTILIZATION REVIEW PROTOCOLS OR MAKING A DETERMINATION THAT A HEALTH CARE PROVIDER HAS OR HAS NOT COMPLIED WITH APPROPRIATE PROTOCOLS.

(2) BE CONSTRUED AS REQUIRING [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR TO PROVIDE, REIMBURSE FOR OR COVER COUNSELING, REFERRAL OR OTHER HEALTH CARE SERVICES IF THE [PLAN] INSURER, MCO OR CONTRACTOR:

(I) OBJECTS TO THE PROVISION OF THAT SERVICE ON MORAL OR RELIGIOUS GROUNDS; AND

(II) MAKES AVAILABLE INFORMATION ON ITS POLICIES REGARDING SUCH HEALTH CARE SERVICES TO ENROLLEES AND PROSPECTIVE ENROLLEES.

SECTION 3. SECTION 2116(A) AND (B) OF THE ACT ARE AMENDED AND THE SECTION IS AMENDED BY ADDING A SUBSECTION TO READ:

SECTION 2116. EMERGENCY SERVICES.--(A) IF AN ENROLLEE SEEKS EMERGENCY SERVICES AND THE [EMERGENCY] HEALTH CARE PROVIDER DETERMINES THAT EMERGENCY SERVICES ARE NECESSARY, THE [EMERGENCY] HEALTH CARE PROVIDER SHALL INITIATE NECESSARY INTERVENTION TO EVALUATE AND, IF NECESSARY, STABILIZE THE CONDITION OF THE ENROLLEE WITHOUT SEEKING OR RECEIVING AUTHORIZATION FROM THE [MANAGED CARE PLAN. THE MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR. NO INSURER, MCO OR CONTRACTOR SHALL REQUIRE A HEALTH CARE PROVIDER TO SUBMIT A REQUEST FOR PRIOR AUTHORIZATION FOR AN EMERGENCY SERVICE. THE INSURER, MCO OR CONTRACTOR SHALL PAY ALL REASONABLY NECESSARY COSTS ASSOCIATED WITH EMERGENCY SERVICES PROVIDED DURING THE PERIOD OF EMERGENCY, SUBJECT TO ALL COPAYMENTS, COINSURANCES OR DEDUCTIBLES[.], INCLUDING TESTING AND OTHER DIAGNOSTIC SERVICES THAT ARE MEDICALLY NECESSARY TO EVALUATE OR TREAT AN EMERGENCY MEDICAL CONDITION PRIOR TO THE POINT AT WHICH THE CONDITION IS

STABILIZED. WHEN PROCESSING A REIMBURSEMENT CLAIM FOR EMERGENCY SERVICES, [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL CONSIDER BOTH THE PRESENTING SYMPTOMS AND THE SERVICES PROVIDED. THE [EMERGENCY] HEALTH CARE PROVIDER SHALL NOTIFY THE ENROLLEE'S [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR OF THE PROVISION OF EMERGENCY SERVICES AND THE CONDITION OF THE ENROLLEE. IF AN ENROLLEE'S CONDITION HAS STABILIZED AND THE ENROLLEE CAN BE TRANSPORTED WITHOUT SUFFERING DETRIMENTAL CONSEQUENCES OR AGGRAVATING THE ENROLLEE'S CONDITION, THE ENROLLEE MAY BE RELOCATED TO ANOTHER FACILITY TO RECEIVE CONTINUED CARE AND TREATMENT AS NECESSARY. IF AN ENROLLEE IS ADMITTED TO INPATIENT CARE OR PLACED IN OBSERVATION IMMEDIATELY FOLLOWING RECEIPT OF A COVERED EMERGENCY SERVICE, THE INPATIENT FACILITY SHALL HAVE A MINIMUM OF TWENTY-FOUR (24) HOURS TO NOTIFY THE ENROLLEE'S INSURER, MCO OR CONTRACTOR OF THE ADMISSION OR PLACEMENT WITH SUCH TIMEFRAME TO START AT THE LATER OF:

(1) THE TIME OF THE INPATIENT ADMISSION OR PLACEMENT; OR

(2) IN THE CASE OF AN ENROLLEE THAT IS UNCONSCIOUS, COMATOSE OR OTHERWISE UNABLE TO EFFECTIVELY COMMUNICATE PERTINENT INFORMATION, THE TIME AT WHICH THE INPATIENT FACILITY KNEW OR REASONABLY SHOULD HAVE KNOWN, THROUGH DILIGENT EFFORTS, THE IDENTITY OF THE ENROLLEE'S INSURER, MCO OR CONTRACTOR.

(B) FOR EMERGENCY SERVICES RENDERED BY A LICENSED EMERGENCY MEDICAL SERVICES AGENCY, AS DEFINED IN 35 PA.C.S. § 8103 (RELATING TO DEFINITIONS), THAT HAS THE ABILITY TO TRANSPORT PATIENTS OR IS PROVIDING AND BILLING FOR EMERGENCY SERVICES UNDER AN AGREEMENT WITH AN EMERGENCY MEDICAL SERVICES AGENCY THAT HAS THAT ABILITY, THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR MAY NOT DENY A CLAIM FOR PAYMENT SOLELY BECAUSE THE

ENROLLEE DID NOT REQUIRE TRANSPORT OR REFUSED TO BE TRANSPORTED.

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(E) NOTHING IN THIS SECTION SHALL REQUIRE AN INSURER, MCO OR CONTRACTOR TO WAIVE APPLICATION OF OTHERWISE APPLICABLE CLINICAL REVIEW CRITERIA.

SECTION 4. SECTION 2117 OF THE ACT IS AMENDED TO READ:

SECTION 2117. CONTINUITY OF CARE.--(A) EXCEPT AS PROVIDED UNDER SUBSECTION (B), IF [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR INITIATES TERMINATION OF ITS CONTRACT WITH A PARTICIPATING HEALTH CARE PROVIDER, AN ENROLLEE MAY CONTINUE AN ONGOING COURSE OF TREATMENT WITH THAT HEALTH CARE PROVIDER AT THE ENROLLEE'S OPTION FOR A TRANSITIONAL PERIOD OF UP TO SIXTY (60) DAYS FROM THE DATE THE ENROLLEE WAS NOTIFIED BY THE [PLAN] INSURER, MCO OR CONTRACTOR OF THE TERMINATION OR PENDING TERMINATION. THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR, IN CONSULTATION WITH THE ENROLLEE AND THE HEALTH CARE PROVIDER, MAY EXTEND THE 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 OR PENDING TERMINATION, THE TRANSITIONAL PERIOD SHALL EXTEND THROUGH POSTPARTUM CARE RELATED TO THE DELIVERY. ANY HEALTH CARE SERVICE PROVIDED UNDER THIS SECTION SHALL BE COVERED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR UNDER THE SAME TERMS AND CONDITIONS AS APPLICABLE FOR PARTICIPATING HEALTH CARE PROVIDERS.

(B) IF THE [PLAN] INSURER, MCO OR CONTRACTOR TERMINATES THE CONTRACT OF A PARTICIPATING HEALTH CARE PROVIDER FOR CAUSE, INCLUDING BREACH OF CONTRACT, FRAUD, CRIMINAL ACTIVITY OR POSING A DANGER TO AN ENROLLEE OR THE HEALTH, SAFETY OR WELFARE OF THE PUBLIC AS DETERMINED BY THE [PLAN] INSURER, MCO OR CONTRACTOR,

THE [PLAN] INSURER, MCO OR CONTRACTOR SHALL NOT BE RESPONSIBLE FOR HEALTH CARE SERVICES PROVIDED TO THE ENROLLEE FOLLOWING THE DATE OF TERMINATION.

(C) IF THE [PLAN] INSURER, MCO OR CONTRACTOR TERMINATES THE CONTRACT OF A PARTICIPATING PRIMARY CARE PROVIDER, THE [PLAN] INSURER, MCO OR CONTRACTOR SHALL NOTIFY EVERY ENROLLEE SERVED BY THAT PROVIDER OF THE [PLAN'S] INSURER'S, MCO'S OR CONTRACTOR'S TERMINATION OF ITS CONTRACT AND SHALL REQUEST THAT THE ENROLLEE SELECT ANOTHER PRIMARY CARE PROVIDER.

(D) A NEW ENROLLEE MAY CONTINUE AN ONGOING COURSE OF TREATMENT WITH A NONPARTICIPATING HEALTH CARE PROVIDER FOR A TRANSITIONAL PERIOD OF UP TO SIXTY (60) DAYS FROM THE EFFECTIVE DATE OF ENROLLMENT IN A [MANAGED CARE PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT. THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR, IN CONSULTATION WITH THE ENROLLEE AND THE HEALTH CARE PROVIDER, 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 UNDER THIS SECTION SHALL BE COVERED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR UNDER THE SAME TERMS AND CONDITIONS AS APPLICABLE FOR PARTICIPATING HEALTH CARE PROVIDERS.

(E) [A PLAN] AN INSURER, MCO OR CONTRACTOR MAY REQUIRE A NONPARTICIPATING HEALTH CARE PROVIDER WHOSE HEALTH CARE SERVICES ARE COVERED UNDER THIS SECTION TO MEET THE SAME TERMS AND CONDITIONS AS A PARTICIPATING HEALTH CARE PROVIDER.

(F) NOTHING IN THIS SECTION SHALL REQUIRE [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR TO PROVIDE HEALTH CARE

SERVICES THAT ARE NOT OTHERWISE COVERED UNDER THE TERMS AND CONDITIONS OF THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

SECTION 5. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

SECTION 2118. MEDICATION ASSISTED TREATMENT.--(A) AN INSURER, MCO OR CONTRACTOR SHALL MAKE AVAILABLE WITHOUT INITIAL PRIOR AUTHORIZATION COVERAGE OF AT LEAST ONE UNITED STATES FOOD AND DRUG ADMINISTRATION APPROVED PRESCRIPTION DRUG CLASSIFIED AS MEDICATION ASSISTED TREATMENT.

(B) NOTHING IN THIS SECTION SHALL PROHIBIT AN INSURER, MCO OR CONTRACTOR FROM DESIGNATING PREFERRED MEDICATIONS FOR THE RELEVANT COMPONENT OF MEDICATION ASSISTED TREATMENT WHEN MULTIPLE MEDICATIONS ARE AVAILABLE, SUBJECT TO APPLICABLE REQUIREMENTS FOR DOCUMENTING AND POSTING ANY RELEVANT MEDICAL POLICY OR PRESCRIPTION DRUG FORMULARY INFORMATION.

(C) WITH THE EXCEPTION OF PRIOR AUTHORIZATION FOR INITIAL COVERAGE, NOTHING IN THIS SECTION SHALL PROHIBIT AN INSURER, MCO OR CONTRACTOR FROM REQUIRING PRIOR AUTHORIZATION ON SUBSEQUENT REQUESTS FOR MEDICATION ASSISTED TREATMENT TO ENSURE ADHERENCE WITH CLINICAL GUIDELINES.

SECTION 6. SECTIONS 2121, 2131 AND 2136 OF THE ACT ARE AMENDED TO READ:

SECTION 2121. PROCEDURES.--(A) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL ESTABLISH A CREDENTIALING PROCESS TO ENROLL QUALIFIED HEALTH CARE PROVIDERS AND CREATE AN ADEQUATE PROVIDER NETWORK. THE PROCESS SHALL BE APPROVED BY THE DEPARTMENT AND SHALL INCLUDE WRITTEN CRITERIA AND PROCEDURES FOR INITIAL ENROLLMENT, RENEWAL, RESTRICTIONS AND TERMINATION OF CREDENTIALS FOR HEALTH CARE PROVIDERS.

(B) THE DEPARTMENT SHALL ESTABLISH CREDENTIALING STANDARDS

FOR [MANAGED CARE PLANS.] INSURERS, MCOS AND CONTRACTORS. THE DEPARTMENT MAY ADOPT NATIONALLY RECOGNIZED ACCREDITING STANDARDS TO ESTABLISH THE CREDENTIALING STANDARDS FOR [MANAGED CARE PLANS] INSURERS, MCOS AND CONTRACTORS.

(C) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL SUBMIT A REPORT TO THE DEPARTMENT REGARDING ITS CREDENTIALING PROCESS AT LEAST EVERY TWO (2) YEARS OR AS MAY OTHERWISE BE REQUIRED BY THE DEPARTMENT.

(D) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL DISCLOSE RELEVANT CREDENTIALING CRITERIA AND PROCEDURES TO HEALTH CARE PROVIDERS THAT APPLY TO PARTICIPATE OR THAT ARE PARTICIPATING IN THE [PLAN'S] INSURER'S, MCO'S OR CONTRACTOR'S PROVIDER NETWORK. [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL ALSO DISCLOSE RELEVANT CREDENTIALING CRITERIA AND PROCEDURES PURSUANT TO A COURT ORDER OR RULE. ANY INDIVIDUAL PROVIDING INFORMATION DURING THE CREDENTIALING PROCESS OF [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL HAVE THE PROTECTIONS SET FORTH IN THE ACT OF JULY 20, 1974 (P.L.564, NO.193), KNOWN AS THE "PEER REVIEW PROTECTION ACT."

(E) NO [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL EXCLUDE OR TERMINATE A HEALTH CARE PROVIDER FROM PARTICIPATION IN THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT DUE TO ANY OF THE FOLLOWING:

(1) THE HEALTH CARE PROVIDER ENGAGED IN ANY OF THE ACTIVITIES SET FORTH IN SECTION 2113(C).

(2) THE HEALTH CARE PROVIDER HAS A PRACTICE THAT INCLUDES A SUBSTANTIAL NUMBER OF PATIENTS WITH EXPENSIVE MEDICAL CONDITIONS.

(3) THE HEALTH CARE PROVIDER OBJECTS TO THE PROVISION OF OR REFUSES TO PROVIDE A HEALTH CARE SERVICE ON MORAL OR RELIGIOUS

GROUNDS.

(F) IF [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR DENIES ENROLLMENT OR RENEWAL OF CREDENTIALS TO A HEALTH CARE PROVIDER, THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL PROVIDE THE HEALTH CARE PROVIDER WITH WRITTEN NOTICE OF THE DECISION. THE NOTICE SHALL INCLUDE A CLEAR RATIONALE FOR THE DECISION.

SECTION 2131. CONFIDENTIALITY.--(A) [A MANAGED CARE PLAN] AN INSURER, MCO, CONTRACTOR AND A UTILIZATION REVIEW ENTITY SHALL ADOPT AND MAINTAIN PROCEDURES TO ENSURE THAT ALL IDENTIFIABLE INFORMATION REGARDING ENROLLEE HEALTH, DIAGNOSIS AND TREATMENT IS ADEQUATELY PROTECTED AND REMAINS CONFIDENTIAL IN COMPLIANCE WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS AND PROFESSIONAL ETHICAL STANDARDS.

(B) TO THE EXTENT [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR MAINTAINS MEDICAL RECORDS, THE [PLAN] INSURER, MCO OR CONTRACTOR SHALL ADOPT AND MAINTAIN PROCEDURES TO ENSURE THAT ENROLLEES HAVE TIMELY ACCESS TO THEIR MEDICAL RECORDS UNLESS PROHIBITED BY FEDERAL OR STATE LAW OR REGULATION.

(C) (1) INFORMATION REGARDING AN ENROLLEE'S HEALTH OR TREATMENT SHALL BE AVAILABLE TO THE ENROLLEE, THE ENROLLEE'S DESIGNEE OR AS NECESSARY TO PREVENT DEATH OR SERIOUS INJURY.

(2) NOTHING IN THIS SECTION SHALL:

(I) PREVENT DISCLOSURE NECESSARY TO DETERMINE COVERAGE, REVIEW COMPLAINTS OR GRIEVANCES, CONDUCT UTILIZATION REVIEW OR FACILITATE PAYMENT OF A CLAIM.

(II) DENY THE DEPARTMENT, THE INSURANCE DEPARTMENT OR THE DEPARTMENT OF [PUBLIC WELFARE] HUMAN SERVICES ACCESS TO RECORDS FOR PURPOSES OF QUALITY ASSURANCE, INVESTIGATION OF COMPLAINTS OR GRIEVANCES, ENFORCEMENT OR OTHER ACTIVITIES RELATED TO

COMPLIANCE WITH THIS ARTICLE AND OTHER LAWS OF THIS COMMONWEALTH. RECORDS SHALL BE ACCESSIBLE ONLY TO DEPARTMENT EMPLOYES OR AGENTS WITH DIRECT RESPONSIBILITIES UNDER THE PROVISIONS OF THIS SUBPARAGRAPH.

(III) DENY ACCESS TO INFORMATION NECESSARY FOR A UTILIZATION REVIEW ENTITY TO CONDUCT A REVIEW UNDER THIS ARTICLE.

(IV) DENY ACCESS TO THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR FOR INTERNAL QUALITY REVIEW, INCLUDING REVIEWS CONDUCTED AS PART OF THE [PLAN'S] INSURER'S, MCO'S AND CONTRACTOR'S QUALITY OVERSIGHT PROCESS. DURING SUCH REVIEWS, ENROLLEES SHALL REMAIN ANONYMOUS TO THE GREATEST EXTENT POSSIBLE.

(V) DENY ACCESS TO [MANAGED CARE PLANS] INSURERS, MCOS, CONTRACTORS, HEALTH CARE PROVIDERS AND THEIR RESPECTIVE DESIGNEES FOR THE PURPOSE OF PROVIDING PATIENT CARE MANAGEMENT, OUTCOMES IMPROVEMENT AND RESEARCH. FOR THIS PURPOSE, ENROLLEES SHALL PROVIDE CONSENT AND SHALL REMAIN ANONYMOUS TO THE GREATEST EXTENT POSSIBLE.

SECTION 2136. REQUIRED DISCLOSURE.--(A) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL SUPPLY EACH ENROLLEE AND, UPON WRITTEN REQUEST, EACH PROSPECTIVE ENROLLEE OR HEALTH CARE PROVIDER WITH THE FOLLOWING WRITTEN INFORMATION. SUCH INFORMATION SHALL BE EASILY UNDERSTANDABLE BY THE LAYPERSON AND SHALL INCLUDE, BUT NOT BE LIMITED TO:

(1) A DESCRIPTION OF COVERAGE, BENEFITS AND BENEFIT MAXIMUMS, INCLUDING BENEFIT LIMITATIONS AND EXCLUSIONS OF COVERAGE, HEALTH CARE SERVICES AND THE DEFINITION OF MEDICAL NECESSITY USED BY THE [PLAN] HEALTH INSURANCE, MCO CONTRACT OR CHIP CONTRACT IN DETERMINING WHETHER THESE BENEFITS WILL BE COVERED. THE FOLLOWING STATEMENT SHALL BE INCLUDED IN ALL

MARKETING MATERIALS IN BOLDFACE TYPE:

THIS [MANAGED CARE PLAN] HEALTH INSURANCE POLICY OR CONTRACT MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES. READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH HEALTH CARE SERVICES ARE COVERED.

THE NOTICE SHALL BE FOLLOWED BY A TELEPHONE NUMBER TO CONTACT THE [PLAN] INSURER, MCO OR CONTRACTOR.

(2) A DESCRIPTION OF ALL NECESSARY PRIOR AUTHORIZATIONS OR OTHER REQUIREMENTS FOR NONEMERGENCY HEALTH CARE SERVICES AS REQUIRED IN SECTION 2154(B).

(3) AN EXPLANATION OF AN ENROLLEE'S FINANCIAL RESPONSIBILITY FOR PAYMENT OF PREMIUMS, COINSURANCE, COPAYMENTS, DEDUCTIBLES AND OTHER CHARGES, ANNUAL LIMITS ON AN ENROLLEE'S FINANCIAL RESPONSIBILITY AND CAPS ON PAYMENTS FOR HEALTH CARE SERVICES PROVIDED UNDER THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

(4) AN EXPLANATION OF AN ENROLLEE'S FINANCIAL RESPONSIBILITY FOR PAYMENT WHEN A HEALTH CARE SERVICE IS PROVIDED BY A NONPARTICIPATING HEALTH CARE PROVIDER, WHEN A HEALTH CARE SERVICE IS PROVIDED BY ANY HEALTH CARE PROVIDER WITHOUT REQUIRED AUTHORIZATION OR WHEN THE CARE RENDERED IS NOT COVERED BY THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

(5) A DESCRIPTION OF HOW THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR ADDRESSES THE NEEDS OF NON-ENGLISH-SPEAKING ENROLLEES.

(6) A NOTICE OF MAILING ADDRESSES AND TELEPHONE NUMBERS NECESSARY TO ENABLE AN ENROLLEE TO OBTAIN APPROVAL OR AUTHORIZATION OF A HEALTH CARE SERVICE OR OTHER INFORMATION REGARDING THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

(7) A SUMMARY OF THE [PLAN'S] HEALTH INSURANCE POLICY'S, MCO CONTRACT'S OR CHIP CONTRACT'S UTILIZATION REVIEW POLICIES AND PROCEDURES.

(8) A SUMMARY OF ALL COMPLAINT AND GRIEVANCE PROCEDURES USED TO RESOLVE DISPUTES BETWEEN THE [MANAGED CARE PLAN] INSURER, MCO CONTRACTOR AND AN ENROLLEE OR A HEALTH CARE PROVIDER, INCLUDING:

(I) THE PROCEDURE TO FILE A COMPLAINT OR GRIEVANCE AS SET FORTH IN THIS ARTICLE, INCLUDING A TOLL-FREE TELEPHONE NUMBER TO OBTAIN INFORMATION REGARDING THE FILING AND STATUS OF A COMPLAINT OR GRIEVANCE.

(II) THE RIGHT TO APPEAL A DECISION RELATING TO A COMPLAINT OR GRIEVANCE.

(III) THE ENROLLEE'S RIGHT TO DESIGNATE A REPRESENTATIVE TO PARTICIPATE IN THE COMPLAINT OR GRIEVANCE PROCESS AS SET FORTH IN THIS ARTICLE.

(IV) A NOTICE THAT ALL DISPUTES INVOLVING DENIAL OF PAYMENT FOR A HEALTH CARE SERVICE WILL BE MADE BY QUALIFIED PERSONNEL WITH EXPERIENCE IN THE SAME OR SIMILAR SCOPE OF PRACTICE AND THAT ALL NOTICES OF DECISIONS WILL INCLUDE INFORMATION REGARDING THE BASIS FOR THE DETERMINATION.

(9) A DESCRIPTION OF THE PROCEDURE FOR PROVIDING EMERGENCY SERVICES TWENTY-FOUR (24) HOURS A DAY. THE DESCRIPTION SHALL INCLUDE:

(I) A DEFINITION OF EMERGENCY SERVICES AS SET FORTH IN THIS ARTICLE.

(II) NOTICE THAT EMERGENCY SERVICES ARE NOT SUBJECT TO PRIOR APPROVAL.

(III) THE ENROLLEE'S FINANCIAL AND OTHER RESPONSIBILITIES REGARDING EMERGENCY SERVICES, INCLUDING THE RECEIPT OF THESE SERVICES OUTSIDE THE [MANAGED CARE PLAN'S] INSURER'S, MCO'S OR

CONTRACTOR'S SERVICE AREA.

(10) A DESCRIPTION OF THE PROCEDURES FOR ENROLLEES TO SELECT A PARTICIPATING HEALTH CARE PROVIDER, INCLUDING HOW TO DETERMINE WHETHER A PARTICIPATING HEALTH CARE PROVIDER IS ACCEPTING NEW ENROLLEES.

(11) A DESCRIPTION OF THE PROCEDURES FOR CHANGING PRIMARY CARE PROVIDERS AND SPECIALISTS.

(12) A DESCRIPTION OF THE PROCEDURES BY WHICH AN ENROLLEE MAY OBTAIN A REFERRAL TO A HEALTH CARE PROVIDER OUTSIDE THE PROVIDER NETWORK WHEN THAT PROVIDER NETWORK DOES NOT INCLUDE A HEALTH CARE PROVIDER WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE HEALTH CARE SERVICE NEEDS OF AN ENROLLEE.

(13) A DESCRIPTION OF THE PROCEDURES THAT AN ENROLLEE WITH A LIFE-THREATENING, DEGENERATIVE OR DISABLING DISEASE OR CONDITION SHALL FOLLOW AND SATISFY TO BE ELIGIBLE FOR:

(I) A STANDING REFERRAL TO A SPECIALIST WITH CLINICAL EXPERTISE IN TREATING THE DISEASE OR CONDITION; OR

(II) THE DESIGNATION OF A SPECIALIST TO PROVIDE AND COORDINATE THE ENROLLEE'S PRIMARY AND SPECIALTY CARE.

(14) A LIST BY SPECIALTY OF THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PARTICIPATING HEALTH CARE PROVIDERS. THE LIST MAY BE A SEPARATE DOCUMENT AND SHALL BE UPDATED AT LEAST ANNUALLY.

(15) A LIST OF THE INFORMATION AVAILABLE TO ENROLLEES OR PROSPECTIVE ENROLLEES, UPON WRITTEN REQUEST, UNDER SUBSECTION (B).

(B) EACH [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL, UPON WRITTEN REQUEST OF AN ENROLLEE OR PROSPECTIVE ENROLLEE, PROVIDE THE FOLLOWING WRITTEN INFORMATION:

(1) A LIST OF THE NAMES, BUSINESS ADDRESSES AND OFFICIAL POSITIONS OF THE MEMBERSHIP OF THE BOARD OF DIRECTORS OR

OFFICERS OF THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR.

(2) THE PROCEDURES ADOPTED TO PROTECT THE CONFIDENTIALITY OF MEDICAL RECORDS AND OTHER ENROLLEE INFORMATION.

(3) A DESCRIPTION OF THE CREDENTIALING PROCESS FOR HEALTH CARE PROVIDERS.

(4) A LIST OF THE PARTICIPATING HEALTH CARE PROVIDERS AFFILIATED WITH PARTICIPATING HOSPITALS.

(5) WHETHER A SPECIFICALLY IDENTIFIED DRUG IS INCLUDED OR EXCLUDED FROM COVERAGE.

(6) A DESCRIPTION OF THE PROCESS BY WHICH A HEALTH CARE PROVIDER CAN PRESCRIBE SPECIFIC DRUGS, DRUGS USED FOR AN OFF-LABEL PURPOSE, BIOLOGICALS AND MEDICATIONS NOT INCLUDED IN THE DRUG FORMULARY FOR PRESCRIPTION DRUGS OR BIOLOGICALS WHEN THE FORMULARY'S EQUIVALENT HAS BEEN INEFFECTIVE IN THE TREATMENT OF THE ENROLLEE'S DISEASE OR IF THE DRUG CAUSES OR IS REASONABLY EXPECTED TO CAUSE ADVERSE OR HARMFUL REACTIONS TO THE ENROLLEE.

(7) A DESCRIPTION OF THE PROCEDURES FOLLOWED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR TO MAKE DECISIONS ABOUT THE EXPERIMENTAL NATURE OF INDIVIDUAL DRUGS, MEDICAL DEVICES OR TREATMENTS.

(8) A SUMMARY OF THE METHODOLOGIES USED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR TO REIMBURSE FOR HEALTH CARE SERVICES. NOTHING IN THIS PARAGRAPH SHALL BE CONSTRUED TO REQUIRE DISCLOSURE OF INDIVIDUAL CONTRACTS OR THE SPECIFIC DETAILS OF ANY FINANCIAL ARRANGEMENT BETWEEN [A MANAGED CARE PLAN] AN INSURER, MCO, CONTRACTOR AND A HEALTH CARE PROVIDER.

(9) A DESCRIPTION OF THE PROCEDURES USED IN THE [MANAGED CARE PLAN'S] INSURER'S, MCO'S OR CONTRACTOR'S QUALITY ASSURANCE PROGRAM.

(10) OTHER INFORMATION AS MAY BE REQUIRED BY THE DEPARTMENT

OR THE INSURANCE DEPARTMENT.

SECTION 7. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

SECTION 2137. MEDICAL POLICY AND CLINICAL REVIEW CRITERIA ADOPTED BY AN INSURER, MCO OR CONTRACTOR.--(A) AN INSURER, MCO OR CONTRACTOR SHALL MAKE AVAILABLE ITS CURRENT MEDICAL POLICIES ON THE INSURER'S, MCO'S AND CONTRACTOR'S PUBLICLY ACCESSIBLE INTERNET WEBSITE OR PROVIDER PORTAL. THE INSURER'S, MCO'S OR CONTRACTOR'S MEDICAL POLICIES SHALL INCLUDE REFERENCE TO THE CLINICAL REVIEW CRITERIA USED IN DEVELOPING THE MEDICAL POLICY. IF AN INSURER'S, MCO'S OR CONTRACTOR'S MEDICAL POLICY INCORPORATES LICENSED THIRD-PARTY STANDARDS THAT ALSO LIMIT THE INSURER'S, MCO'S OR CONTRACTOR'S ABILITY TO PUBLISH THOSE STANDARDS IN FULL, THE INSURER'S, MCO'S OR CONTRACTOR'S POSTED POLICIES SHALL CLEARLY IDENTIFY THESE SOURCES.

(B) AN INSURER, MCO OR CONTRACTOR SHALL REVIEW EACH ADOPTED MEDICAL POLICY ON AT LEAST AN ANNUAL BASIS.

(C) AN INSURER, MCO OR CONTRACTOR SHALL NOTIFY HEALTH CARE PROVIDERS OF DISCRETIONARY CHANGES TO MEDICAL POLICIES AT LEAST THIRTY (30) DAYS PRIOR TO APPLICATION OF THE CHANGES. THE FOLLOWING APPLY:

(1) IN THE CASE OF POLICY CHANGES DUE TO CHANGES IN FEDERAL OR STATE LAW, REGULATION OR BINDING AGENCY GUIDANCE, AN INSURER, MCO OR CONTRACTOR SHALL NOTIFY HEALTH CARE PROVIDERS AT LEAST THIRTY (30) DAYS PRIOR TO THE APPLICATION OF THE CHANGES, EXCEPT THAT IN CASES WHERE THE TIMING OF CHANGES IN BINDING GUIDANCE MAKES SUCH ADVANCE NOTICE IMPRACTICABLE, AN INSURER, MCO OR CONTRACTOR SHALL MAKE COMMERCIALLY REASONABLE EFFORTS TO NOTIFY PROVIDERS OF SUCH CHANGES PRIOR TO THEIR APPLICATION.

(2) NOTIFICATION OF CHANGES MAY BE PROVIDED THROUGH THE POSTING OF AN UPDATED AND DATED MEDICAL POLICY REFLECTING THE

CHANGE OR THROUGH OTHER REASONABLE MEANS.

(3) IN THE CASE OF CHANGES TO MEDICAL POLICIES THAT MODIFY, ELIMINATE OR SUSPEND EITHER CLINICAL OR ADMINISTRATIVE CRITERIA AND THAT DIRECTLY RESULT IN LESS RESTRICTIVE COVERAGE OF A GIVEN SERVICE, AN INSURER, MCO OR CONTRACTOR SHALL NOTIFY HEALTH CARE PROVIDERS WITHIN (30) DAYS AFTER APPLICATION OF SUCH CHANGE.

(D) CLINICAL REVIEW CRITERIA ADOPTED BY AN INSURER, MCO OR CONTRACTOR AT THE TIME OF MEDICAL POLICY DEVELOPMENT OR REVIEW SHALL:

(1) BE BASED ON NATIONALLY RECOGNIZED MEDICAL STANDARDS.

(2) BE CONSISTENT WITH APPLICABLE GOVERNMENTAL GUIDELINES.

(3) PROVIDE FOR THE DELIVERY OF A HEALTH CARE SERVICE IN A CLINICALLY APPROPRIATE TYPE, FREQUENCY, SETTING AND DURATION.

(4) REFLECT THE CURRENT QUALITY OF MEDICAL AND SCIENTIFIC EVIDENCE REGARDING EMERGING PROCEDURES, CLINICAL GUIDELINES AND BEST PRACTICES AS ARTICULATED IN INDEPENDENT, PEER-REVIEWED MEDICAL LITERATURE.

(E) NOTHING IN THIS SECTION SHALL REQUIRE AN INSURER, MCO OR CONTRACTOR TO PROVIDE COVERAGE FOR A HEALTH CARE SERVICE THAT IS OTHERWISE EXCLUDED FROM COVERAGE UNDER A HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

SECTION 8. SECTIONS 2141, 2142(A) AND (B), 2143, 2151(E) AND 2152(A)(3), (4)(I) AND (7) AND (C) OF THE ACT ARE AMENDED TO READ:

SECTION 2141. INTERNAL COMPLAINT PROCESS.--(A) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL ESTABLISH AND MAINTAIN AN INTERNAL COMPLAINT PROCESS [WITH TWO LEVELS OF REVIEW] BY WHICH AN ENROLLEE SHALL BE ABLE TO FILE A COMPLAINT [REGARDING A PARTICIPATING HEALTH CARE PROVIDER OR THE COVERAGE, OPERATIONS OR MANAGEMENT POLICIES OF THE MANAGED CARE PLAN].

(B) THE COMPLAINT PROCESS SHALL CONSIST OF [AN INITIAL] A REVIEW [TO] BY A COMMITTEE OF THREE OR MORE INDIVIDUALS, A THIRD OF WHICH SHALL NOT BE EMPLOYED BY THE INSURER, MCO OR CONTRACTOR AND SHALL INCLUDE ALL OF THE FOLLOWING:

[(1) A REVIEW BY AN INITIAL REVIEW COMMITTEE CONSISTING OF ONE OR MORE EMPLOYES OF THE MANAGED CARE PLAN.]

(2) THE ALLOWANCE OF A WRITTEN OR ORAL COMPLAINT.

(3) THE ALLOWANCE OF WRITTEN DATA OR OTHER INFORMATION.

(4) A REVIEW OR INVESTIGATION OF THE COMPLAINT WHICH SHALL BE COMPLETED WITHIN THIRTY (30) DAYS OF RECEIPT OF THE COMPLAINT.

(5) A WRITTEN NOTIFICATION TO THE ENROLLEE REGARDING THE DECISION OF THE [INITIAL] REVIEW COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. [NOTICE SHALL INCLUDE THE BASIS FOR THE DECISION AND THE PROCEDURE TO FILE A REQUEST FOR A SECOND LEVEL REVIEW OF THE DECISION OF THE INITIAL REVIEW COMMITTEE.

(C) THE COMPLAINT PROCESS SHALL INCLUDE A SECOND LEVEL REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

(1) A REVIEW OF THE DECISION OF THE INITIAL REVIEW COMMITTEE BY A SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR MORE INDIVIDUALS WHO DID NOT PARTICIPATE IN THE INITIAL REVIEW. AT LEAST ONE THIRD OF THE SECOND LEVEL REVIEW COMMITTEE SHALL NOT BE EMPLOYED BY THE MANAGED CARE PLAN.

(2) A WRITTEN NOTIFICATION TO THE ENROLLEE OF THE RIGHT TO APPEAR BEFORE THE SECOND LEVEL REVIEW COMMITTEE.

(3) A REQUIREMENT THAT THE SECOND LEVEL REVIEW BE COMPLETED WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF A REQUEST FOR SUCH REVIEW.

(4) A WRITTEN NOTIFICATION TO THE ENROLLEE REGARDING THE

DECISION OF THE SECOND LEVEL REVIEW COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION.] THE NOTICE SHALL INCLUDE THE BASIS FOR THE DECISION AND THE PROCEDURE FOR APPEALING THE DECISION TO THE DEPARTMENT OR THE INSURANCE DEPARTMENT.

SECTION 2142. APPEAL OF COMPLAINT.--(A) AN ENROLLEE SHALL HAVE [FIFTEEN (15) DAYS] FOUR (4) MONTHS FROM RECEIPT OF THE NOTICE OF THE DECISION FROM THE [SECOND LEVEL] REVIEW COMMITTEE TO APPEAL THE DECISION TO THE DEPARTMENT OR THE INSURANCE DEPARTMENT, AS APPROPRIATE.

(B) ALL RECORDS FROM THE [INITIAL] REVIEW [AND SECOND LEVEL REVIEW] SHALL BE TRANSMITTED TO THE APPROPRIATE DEPARTMENT IN THE MANNER PRESCRIBED. THE ENROLLEE, THE HEALTH CARE PROVIDER OR THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR MAY SUBMIT ADDITIONAL MATERIALS RELATED TO THE COMPLAINT.

* * *

SECTION 2143. COMPLAINT RESOLUTION.--NOTHING IN THIS SUBDIVISION SHALL PREVENT THE DEPARTMENT OR THE INSURANCE DEPARTMENT FROM COMMUNICATING WITH THE ENROLLEE, THE HEALTH CARE PROVIDER OR THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR AS APPROPRIATE TO ASSIST IN THE RESOLUTION OF A COMPLAINT. SUCH COMMUNICATION MAY OCCUR AT ANY TIME DURING THE COMPLAINT PROCESS.

SECTION 2151. CERTIFICATION.--* * *

(E) [A LICENSED] AN INSURER [OR A MANAGED CARE PLAN], MCO OR CONTRACTOR WITH A CERTIFICATE OF AUTHORITY SHALL COMPLY WITH THE STANDARDS AND PROCEDURES OF THIS SUBDIVISION BUT SHALL NOT BE REQUIRED TO OBTAIN SEPARATE CERTIFICATION AS A UTILIZATION REVIEW ENTITY.

SECTION 2152. OPERATIONAL STANDARDS.--(A) A UTILIZATION REVIEW ENTITY SHALL DO ALL OF THE FOLLOWING:

* * *

(3) ENSURE THAT A HEALTH CARE PROVIDER IS ABLE TO VERIFY THAT AN INDIVIDUAL REQUESTING INFORMATION ON BEHALF OF THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR IS A LEGITIMATE REPRESENTATIVE OF THE [PLAN] INSURER, MCO OR CONTRACTOR.

(4) CONDUCT UTILIZATION REVIEWS BASED ON THE MEDICAL NECESSITY [AND], APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OF THE HEALTH CARE SERVICE BEING REVIEWED AND PROVIDE NOTIFICATION WITHIN THE FOLLOWING TIME FRAMES:

(I) A [PROSPECTIVE UTILIZATION REVIEW] PRIOR AUTHORIZATION DECISION SHALL BE COMMUNICATED [WITHIN TWO (2) BUSINESS DAYS OF THE RECEIPT OF ALL SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE REVIEW.] PURSUANT TO THE REVIEW TIMELINES CONTAINED IN SECTION 2154(G).

* * *

(7) NOTIFY THE HEALTH CARE PROVIDER OF ADDITIONAL FACTS OR DOCUMENTS REQUIRED TO COMPLETE THE UTILIZATION REVIEW WITHIN FORTY-EIGHT (48) HOURS OF RECEIPT OF THE REQUEST FOR REVIEW[.] OR PURSUANT TO SECTION 2154(H) FOR MISSING CLINICAL INFORMATION FOR ALL REQUESTS FOR PRIOR AUTHORIZATION.

* * *

(C) UTILIZATION REVIEW THAT RESULTS IN A DENIAL OF PAYMENT FOR A HEALTH CARE SERVICE, NOT INCLUDING AN ADMINISTRATIVE DENIAL, SHALL BE MADE BY A LICENSED PHYSICIAN, EXCEPT AS PROVIDED IN SUBSECTION (D) OR SECTION 2154(C) FOR ALL REQUESTS FOR PRIOR AUTHORIZATION.

* * *

SECTION 9. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

SECTION 2153. STEP THERAPY CONSIDERATIONS.--THE FOLLOWING:

(1) IF AN INSURER'S, MCO'S OR CONTRACTOR'S MEDICAL POLICY

ADOPTED UNDER SECTION 2137 INCORPORATES STEP THERAPY CRITERIA FOR PRESCRIPTION DRUGS, AN INSURER, MCO OR CONTRACTOR SHALL CONSIDER AS PART OF THE INSURER'S, MCO'S OR CONTRACTOR'S INITIAL PRIOR AUTHORIZATION PROCESS OR A REQUEST FOR AN EXCEPTION TO THE INSURER'S, MCO'S OR CONTRACTORS STEP THERAPY CRITERIA, AND BASED ON THE ENROLLEE'S INDIVIDUALIZED CLINICAL CONDITION, THE FOLLOWING:

(I) CONTRAINDICATIONS, INCLUDING ADVERSE REACTIONS.

(II) CLINICAL EFFECTIVENESS OR INEFFECTIVENESS OF THE REQUIRED PREREQUISITE PRESCRIPTION DRUGS OR THERAPIES.

(III) PAST CLINICAL OUTCOME OF THE REQUIRED PREREQUISITE PRESCRIPTION DRUG OR THERAPY.

(IV) THE EXPECTED CLINICAL OUTCOMES OF THE REQUESTED PRESCRIPTION DRUG PRESCRIBED BY THE ENROLLEE'S HEALTH CARE PROVIDER.

(V) FOR NEW ENROLLEES, WHETHER THE ENROLLEE HAS ALREADY SATISFIED A STEP THERAPY PROTOCOL WITH THEIR PREVIOUS HEALTH INSURER THAT REQUIRED TRIALS OF DRUGS FROM EACH OF THE CLASSES THAT ARE REQUIRED BY THE CURRENT INSURER'S, MCO'S OR CONTRACTOR'S STEP THERAPY PROTOCOL.

(2) THE PROVISIONS OF SECTION 2154 SHALL APPLY TO STEP THERAPY REVIEWS CONDUCTED UNDER THIS SECTION.

SECTION 2154. PRIOR AUTHORIZATION REVIEW.--(A) (1) INSURER, MCO OR CONTRACTOR REVIEW OF A REQUEST FOR PRIOR AUTHORIZATION SHALL BE BASED UPON THE INSURER'S, MCO'S OR CONTRACTOR'S MEDICAL POLICY, ADMINISTRATIVE POLICY AND ALL MEDICAL INFORMATION AND EVIDENCE SUBMITTED BY THE REQUESTING PROVIDER.

(2) AT THE TIME OF REVIEW, AN INSURER, MCO OR CONTRACTOR SHALL ALSO VERIFY THE ENROLLEE'S ELIGIBILITY FOR COVERAGE UNDER

THE TERMS OF THE APPLICABLE HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT.

(3) APPEALS OF ADMINISTRATIVE DENIALS SHALL BE SUBJECT TO THE COMPLAINT PROCESS UNDER SUBARTICLE (G).

(B) AN INSURER, MCO OR CONTRACTOR SHALL MAKE AVAILABLE A LIST, POSTED IN A PUBLICLY ACCESSIBLE FORMAT AND LOCATION ON THE INSURER'S, MCO'S OR CONTRACTOR'S PUBLICLY ACCESSIBLE INTERNET WEBSITE, AND PROVIDER PORTAL, THAT INDICATES THE HEALTH SERVICES FOR WHICH THE INSURER, MCO OR CONTRACTOR REQUIRES PRIOR AUTHORIZATION.

(C) OTHER THAN AN ADMINISTRATIVE DENIAL, A REQUEST FOR PRIOR AUTHORIZATION MAY ONLY BE DENIED UPON REVIEW BY A PROPERLY LICENSED MEDICAL PROFESSIONAL WITH APPROPRIATE TRAINING, KNOWLEDGE OR EXPERIENCE IN THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS ON THE HEALTH CARE SERVICE IN QUESTION. ALTERNATIVELY, AN INSURER, MCO OR CONTRACTOR MAY SATISFY THIS REQUIREMENT THROUGH THE COMPLETION OF THE REVIEW BY A LICENSED MEDICAL PROFESSIONAL IN CONSULTATION WITH AN APPROPRIATELY QUALIFIED THIRD-PARTY MEDICAL PROFESSIONAL, LICENSED IN THE SAME OR SIMILAR MEDICAL SPECIALTY AS THE REQUESTING HEALTH CARE PROVIDER OR TYPE OF HEALTH CARE PROVIDER THAT TYPICALLY MANAGES THE ENROLLEE'S ASSOCIATED CONDITION, PROVIDED THAT ANY COMPENSATION PAID TO THE CONSULTING PROFESSIONAL MAY NOT BE CONTINGENT UPON THE OUTCOME OF THE REVIEW. NOTHING IN THIS SECTION SHALL COMPEL AN INSURER, MCO OR CONTRACTOR TO OBTAIN THIRD-PARTY MEDICAL PROFESSIONALS IN THE SAME SPECIALTY OR SUBSPECIALTY.

(D) IN THE CASE OF A DENIED PRIOR AUTHORIZATION, THE INSURER, MCO OR CONTRACTOR SHALL MAKE AVAILABLE TO THE REQUESTING HEALTH CARE PROVIDER A LICENSED MEDICAL PROFESSIONAL

FOR A PEER-TO-PEER REVIEW DISCUSSION. THE PEER-TO-PEER REVIEWER PROVIDED BY THE INSURER, MCO OR CONTRACTOR SHALL MEET THE STANDARDS UNDER SUBSECTION (C) AND HAVE AUTHORITY TO MODIFY OR OVERTURN THE PRIOR AUTHORIZATION DECISION. THE PROCEDURE FOR REQUESTING A PEER-TO-PEER REVIEW SHALL BE AVAILABLE ON THE INSURER'S, MCO'S OR CONTRACTOR'S PUBLICLY ACCESSIBLE INTERNET WEBSITE AND PROVIDER PORTAL. AN INSURER'S, MCO'S OR CONTRACTOR'S PEER-TO-PEER PROCEDURE SHALL INCLUDE, BUT NOT BE LIMITED TO, ABILITY TO REQUEST A PEER-TO-PEER DISCUSSION:

(1) DURING NORMAL BUSINESS HOURS; OR

(2) OUTSIDE NORMAL BUSINESS HOURS SUBJECT TO REASONABLE LIMITATIONS ON THE AVAILABILITY OF QUALIFIED INSURER, MCO OR CONTRACTOR STAFF. IN THE EVENT AN INSURER, MCO OR CONTRACTOR USES A THIRD-PARTY VENDOR OR UTILIZATION REVIEW ENTITY TO CONDUCT PEER-TO-PEER REVIEWS FOR DENIALS ADMINISTERED BY THE VENDOR OR ENTITY, THE PROCEDURE UNDER SUBSECTION (I) SHALL INCLUDE CONTACT INFORMATION AND INFORMATION ON THE HOURS OF AVAILABILITY OF THE VENDOR OR ENTITY NECESSARY FOR A REQUESTING HEALTH CARE PROVIDER TO SCHEDULE A PEER-TO-PEER DISCUSSION.

(E) A HEALTH CARE PROVIDER MAY DESIGNATE, AND AN INSURER, MCO OR CONTRACTOR SHALL ACCEPT, ANOTHER LICENSED MEMBER OF THE HEALTH CARE PROVIDER'S AFFILIATED OR EMPLOYED CLINICAL STAFF WITH KNOWLEDGE OF THE ENROLLEE'S CONDITION AND REQUESTED PROCEDURE AS A QUALIFIED PROXY FOR PURPOSES OF COMPLETING A PEER-TO-PEER DISCUSSION. INDIVIDUALS ELIGIBLE TO RECEIVE A PROXY DESIGNATION SHALL BE LIMITED TO LICENSED HEALTH CARE PROVIDERS WHOSE ACTUAL AUTHORITY AND SCOPE OF PRACTICE IS INCLUSIVE OF PERFORMING OR PRESCRIBING THE REQUESTED HEALTH CARE SERVICE. SUCH AUTHORITY MAY BE ESTABLISHED THROUGH A SUPERVISING PHYSICIAN CONSISTENT WITH APPLICABLE STATE LAW FOR NON-PHYSICIAN

PRACTITIONERS. THE INSURER, MCO OR CONTRACTOR MUST ACCEPT AND REVIEW THE INFORMATION SUBMITTED BY OTHER MEMBERS OF A HEALTH CARE PROVIDER'S AFFILIATED OR EMPLOYED STAFF IN SUPPORT OF A PRIOR AUTHORIZATION REQUEST. THE INSURER, MCO OR CONTRACTOR MAY NOT LIMIT INTERACTIONS WITH AN INSURER'S, MCO'S OR CONTRACTOR'S CLINICAL STAFF SOLELY TO THE REQUESTING HEALTH CARE PROVIDER.

(F) A PEER-TO-PEER DISCUSSION SHALL BE AVAILABLE TO A REQUESTING HEALTH CARE PROVIDER FROM THE TIME OF A DENIAL OF PRIOR AUTHORIZATION UNTIL THE INTERNAL GRIEVANCE PROCESS COMMENCES. IF A PEER-TO-PEER DISCUSSION IS AVAILABLE PRIOR TO ADJUDICATING A PRIOR AUTHORIZATION REQUEST, THE PEER-TO-PEER SHALL BE OFFERED WITHIN THE TIMELINE IN SUBSECTION (G).

(G) AN INSURER'S, MCO'S OR CONTRACTOR'S DECISION TO APPROVE OR DENY PRIOR AUTHORIZATION SHALL BE RENDERED WITHIN THE FOLLOWING TIMEFRAMES AND FOLLOWING THE SUBMISSION OF A PRIOR AUTHORIZATION REQUEST:

(1) AN INSURER, MCO OR CONTRACTOR SHALL ISSUE A PRIOR AUTHORIZATION DETERMINATION FOR A MEDICAL HEALTH CARE SERVICE IN ACCORDANCE WITH THE FOLLOWING TIMEFRAMES:

(I) REVIEW OF REQUEST FOR URGENT HEALTH CARE SERVICES AS EXPEDITIOUSLY AS THE ENROLLEE'S HEALTH CONDITION REQUIRES BUT NO MORE THAN SEVENTY-TWO (72) HOURS.

(II) REVIEW OF REQUEST FOR NON-URGENT MEDICAL SERVICES NOT MORE THAN FIFTEEN (15) CALENDAR DAYS.

(2) INSURERS, MCOS AND CONTRACTORS SHALL ISSUE A PRIOR AUTHORIZATION DETERMINATION FOR A PRESCRIPTION DRUG MEDICATION OR RENDER A DECISION ON STEP THERAPY UNDER SECTION 2153 IN ACCORDANCE WITH THE FOLLOWING TIMEFRAMES:

(I) REVIEW OR URGENT REQUEST NOT MORE THAN TWENTY-FOUR (24) HOURS.

(II) REVIEW OF STANDARD REQUEST NOT MORE THAN TWO (2) BUSINESS DAYS AND NOT TO EXCEED SEVENTY-TWO (72) HOURS.

(3) IF AT ANY TIME AFTER REQUESTING PRIOR AUTHORIZATION THE HEALTH CARE PROVIDER DETERMINES THE ENROLLEE'S MEDICAL CONDITION REQUIRES EMERGENCY SERVICES, SUCH SERVICES MAY BE PROVIDED UNDER SECTION 2116.

(H) (1) IN THE EVENT THAT A PRIOR AUTHORIZATION REQUEST IS MISSING CLINICAL INFORMATION THAT IS REASONABLY NECESSARY TO COMPLETE A REVIEW, THE INSURER, MCO OR CONTRACTOR SHALL NOTIFY THE HEALTH CARE PROVIDER OF ANY MISSING CLINICAL INFORMATION NECESSARY TO COMPLETE THE REVIEW WITHIN TWENTY-FOUR (24) HOURS OF RECEIPT OF THE PRIOR AUTHORIZATION REQUEST FOR URGENT HEALTH CARE SERVICES OR WITHIN TWO (2) BUSINESS DAYS OF RECEIPT OF ALL OTHER TYPES OF PRIOR AUTHORIZATION REQUESTS AND ALLOW THE REQUESTING HEALTH CARE PROVIDER OR ANY MEMBER OF THE REQUESTING HEALTH CARE PROVIDER'S CLINICAL OR ADMINISTRATIVE STAFF TO SUBMIT SUCH INFORMATION WITHIN THE ESTABLISHED REVIEW TIME LINES. A REQUEST FOR INFORMATION UNDER THIS SUBSECTION SHALL BE MADE WITH SUFFICIENT SPECIFICITY TO ENABLE THE HEALTH CARE PROVIDER TO IDENTIFY THE NECESSARY CLINICAL OR OTHER SUPPORTING INFORMATION NECESSARY TO COMPLETE REVIEW.

(2) THE PERIOD OF TIME IN WHICH THE HEALTH CARE PROVIDER IS GATHERING THE REQUESTED DOCUMENTATION SHALL BE ADDED TO THE TIME FRAME PROVIDED UNDER SUBSECTION (G).

(I) AN INSURER, MCO OR CONTRACTOR MAY SUPPLEMENT SUBMITTED INFORMATION BASED ON CURRENT CLINICAL RECORDS OR OTHER CURRENT MEDICAL INFORMATION FOR AN ENROLLEE AS AVAILABLE, PROVIDED THAT THE SUPPLEMENTAL INFORMATION IS ALSO MADE AVAILABLE TO THE ENROLLEE OR HEALTH CARE PROVIDER AS PART OF THE ENROLLEE'S AUTHORIZATION CASE FILE UPON REQUEST. IN RESPONSE TO ANY REQUEST

FOR MISSING INFORMATION, AN INSURER, MCO OR CONTRACTOR SHALL ALSO ACCEPT SUPPLEMENTAL INFORMATION FROM ANY MEMBER OF THE HEALTH CARE PROVIDER'S CLINICAL STAFF.

(J) IF A HEALTH CARE PROVIDER PERFORMS A CLOSELY RELATED SERVICE, THE INSURER, MCO OR CONTRACTOR MAY NOT DENY A CLAIM FOR THE CLOSELY RELATED SERVICE FOR FAILURE OF THE HEALTH CARE PROVIDER TO SEEK OR OBTAIN PRIOR AUTHORIZATION, PROVIDED THAT:

(1) THE HEALTH CARE PROVIDER NOTIFIES THE INSURER, MCO OR CONTRACTOR OF THE PERFORMANCE OF THE CLOSELY RELATED SERVICE NO LATER THAN SEVENTY TWO (72) HOURS FOLLOWING COMPLETION OF THE SERVICE BUT PRIOR TO THE SUBMISSION OF THE CLAIM FOR PAYMENT. THE SUBMISSION OF THE NOTIFICATION SHALL INCLUDE THE SUBMISSION OF ALL RELEVANT CLINICAL INFORMATION NECESSARY FOR THE INSURER, MCO OR CONTRACTOR TO EVALUATE THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE SERVICE.

(2) NOTHING IN THIS SUBSECTION SHALL BE CONSTRUED TO LIMIT AN INSURER'S, MCO'S OR CONTRACTOR'S CONSIDERATION OF MEDICAL NECESSITY AND APPROPRIATENESS OF THE CLOSELY SERVICE, NOR LIMIT THE NEED FOR VERIFICATION OF THE ENROLLEE'S ELIGIBILITY FOR COVERAGE.

SECTION 2155. PROVIDER PORTAL.--(A) WITHIN EIGHTEEN (18) MONTHS FOLLOWING THE EFFECTIVE DATE OF THIS SECTION, AN INSURER, MCO OR CONTRACTOR SHALL ESTABLISH A PROVIDER PORTAL THAT INCLUDES, AT MINIMUM, THE FOLLOWING FEATURES:

(1) ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATION REQUESTS.

(2) ACCESS TO AN INSURER'S, MCO'S OR CONTRACTOR'S APPLICABLE MEDICAL POLICIES.

(3) INFORMATION NECESSARY TO REQUEST A PEER-TO-PEER REVIEW.

(4) CONTACT INFORMATION FOR AN INSURER'S, MCO'S OR CONTRACTOR'S RELEVANT CLINICAL OR ADMINISTRATIVE STAFF.

(5) FOR ANY PRIOR AUTHORIZATION SERVICE NOT SUBJECT TO ELECTRONIC SUBMISSION VIA THE PROVIDER PORTAL, COPIES OF ANY APPLICABLE SUBMISSION FORMS.

(6) INSTRUCTIONS FOR THE SUBMISSION OF PRIOR AUTHORIZATION REQUESTS IN THE EVENT THAT AN INSURER'S, MCO'S OR CONTRACTOR'S PROVIDER PORTAL IS UNAVAILABLE FOR ANY REASON.

(B) WITHIN SIX (6) MONTHS FOLLOWING THE ESTABLISHMENT OF PROVIDER PORTALS UNDER SUBSECTION (A), AN INSURER, MCO OR CONTRACTOR SHALL MAKE AVAILABLE TO HEALTH CARE PROVIDERS AND THEIR AFFILIATED OR EMPLOYED STAFF ACCESS TO TRAINING ON THE USE OF THE INSURER'S, MCO'S OR CONTRACTOR'S PROVIDER PORTAL.

(C) WITHIN EIGHTEEN (18) MONTHS FOLLOWING THE ESTABLISHMENT OF PROVIDER PORTALS UNDER SUBSECTION (A), A HEALTH CARE PROVIDER SEEKING PRIOR AUTHORIZATION SHALL SUBMIT SUCH REQUEST VIA AN INSURER'S, MCO'S OR CONTRACTOR'S PROVIDER PORTAL, PROVIDED THAT:

(1) SUBMISSION VIA PROVIDER PORTAL SHALL ONLY BE REQUIRED TO THE EXTENT AN INSURER'S, MCO'S OR CONTRACTOR'S PROVIDER PORTAL IS AVAILABLE AND OPERATIONAL AT THE TIME OF ATTEMPTED SUBMISSION.

(2) SUBMISSION VIA AN INSURER'S, MCO'S OR CONTRACTOR'S PROVIDER PORTAL SHALL ONLY BE REQUIRED TO THE EXTENT THE HEALTH CARE PROVIDER HAS ACCESS TO THE INSURER'S, MCO'S OR CONTRACTOR'S OPERATIONAL PROVIDER PORTAL.

(3) INSURERS, MCOS AND CONTRACTORS MAY ELECT TO MAINTAIN ALLOWANCES FOR SUBMISSION OF PRIOR AUTHORIZATION REQUESTS OUTSIDE OF THE PROVIDER PORTAL.

SECTION 10. SECTIONS 2161, 2162, 2163, 2166, SUBARTICLE (K) HEADING OF ARTICLE XXI AND SECTIONS 2171, 2181, 2182 AND 2191 OF THE ACT ARE AMENDED TO READ:

SECTION 2161. INTERNAL GRIEVANCE PROCESS.--(A) [A MANAGED

CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL ESTABLISH AND MAINTAIN AN INTERNAL GRIEVANCE PROCESS [WITH TWO LEVELS OF REVIEW] AND AN EXPEDITED INTERNAL GRIEVANCE PROCESS BY WHICH AN ENROLLEE OR A HEALTH CARE PROVIDER, WITH THE WRITTEN CONSENT OF THE ENROLLEE, SHALL BE ABLE TO FILE A WRITTEN GRIEVANCE REGARDING THE DENIAL OF PAYMENT FOR A HEALTH CARE SERVICE WITHIN FOUR (4) MONTHS OF RECEIVING AN ADVERSE BENEFIT DETERMINATION. AN ENROLLEE WHO CONSENTS TO THE FILING OF A GRIEVANCE BY A HEALTH CARE PROVIDER UNDER THIS SECTION MAY NOT FILE A SEPARATE GRIEVANCE.

(B) THE INTERNAL GRIEVANCE PROCESS SHALL CONSIST OF [AN INITIAL] A REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

(1) A REVIEW BY [ONE] THREE OR MORE PERSONS SELECTED BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR WHO DID NOT PREVIOUSLY PARTICIPATE IN THE DECISION TO DENY PAYMENT FOR THE HEALTH CARE SERVICE.

(2) THE COMPLETION OF THE REVIEW WITHIN THIRTY (30) DAYS OF RECEIPT OF THE GRIEVANCE.

(3) A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE PROVIDER[.] OF THE RIGHT TO APPEAR BEFORE THE REVIEW COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF RECEIVING THE INTERNAL GRIEVANCE.

(4) A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE PROVIDER REGARDING THE DECISION WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. THE NOTICE SHALL INCLUDE THE BASIS AND CLINICAL RATIONALE FOR THE DECISION AND THE PROCEDURE TO FILE A REQUEST [FOR A SECOND LEVEL REVIEW OF] APPEALING THE DECISION AS AN EXTERNAL GRIEVANCE.

[(C) THE GRIEVANCE PROCESS SHALL INCLUDE A SECOND LEVEL REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

(1) A REVIEW OF THE DECISION ISSUED PURSUANT TO SUBSECTION (B) BY A SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR MORE PERSONS WHO DID NOT PREVIOUSLY PARTICIPATE IN ANY DECISION TO DENY PAYMENT FOR THE HEALTH CARE SERVICE.

(2) A WRITTEN NOTIFICATION TO THE ENROLLEE OR THE HEALTH CARE PROVIDER OF THE RIGHT TO APPEAR BEFORE THE SECOND LEVEL REVIEW COMMITTEE.

(3) THE COMPLETION OF THE SECOND LEVEL REVIEW WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF A REQUEST FOR SUCH REVIEW.

(4) A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE PROVIDER REGARDING THE DECISION OF THE SECOND LEVEL REVIEW COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. THE NOTICE SHALL INCLUDE THE BASIS AND CLINICAL RATIONALE FOR THE DECISION AND THE PROCEDURE FOR APPEALING THE DECISION.]

(D) ANY [INITIAL REVIEW OR SECOND LEVEL] REVIEW CONDUCTED UNDER THIS SECTION SHALL INCLUDE A LICENSED PHYSICIAN, OR, WHERE APPROPRIATE, AN APPROVED LICENSED PSYCHOLOGIST, IN THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS ON THE HEALTH CARE SERVICE.

(E) SHOULD THE ENROLLEE'S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION BE IN JEOPARDY, AN EXPEDITED INTERNAL GRIEVANCE PROCESS SHALL BE AVAILABLE WHICH SHALL INCLUDE A REQUIREMENT THAT A DECISION WITH APPROPRIATE NOTIFICATION TO THE ENROLLEE AND HEALTH CARE PROVIDER BE MADE WITHIN FORTY-EIGHT (48) HOURS OF THE FILING OF THE EXPEDITED GRIEVANCE.

SECTION 2162. EXTERNAL GRIEVANCE PROCESS.--(A) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTTRACTOR SHALL ESTABLISH AND MAINTAIN AN EXTERNAL GRIEVANCE PROCESS BY WHICH AN ENROLLEE OR A HEALTH CARE PROVIDER WITH THE WRITTEN CONSENT OF THE ENROLLEE MAY APPEAL THE DENIAL OF A GRIEVANCE FOLLOWING COMPLETION OF THE

INTERNAL GRIEVANCE PROCESS. THE EXTERNAL GRIEVANCE PROCESS SHALL BE CONDUCTED BY AN INDEPENDENT UTILIZATION REVIEW ENTITY NOT DIRECTLY AFFILIATED WITH THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR.

(B) TO CONDUCT EXTERNAL GRIEVANCES FILED UNDER THIS SECTION:

(1) THE DEPARTMENT SHALL RANDOMLY ASSIGN A UTILIZATION REVIEW ENTITY ON A ROTATIONAL BASIS FROM THE LIST MAINTAINED UNDER SUBSECTION (D) AND NOTIFY THE ASSIGNED UTILIZATION REVIEW ENTITY AND THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR WITHIN TWO (2) BUSINESS DAYS OF RECEIVING THE REQUEST. IF THE DEPARTMENT FAILS TO SELECT A UTILIZATION REVIEW ENTITY UNDER THIS SUBSECTION, THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL DESIGNATE AND NOTIFY A CERTIFIED UTILIZATION REVIEW ENTITY TO CONDUCT THE EXTERNAL GRIEVANCE.

(2) THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL NOTIFY THE ENROLLEE OR HEALTH CARE PROVIDER OF THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE UTILIZATION REVIEW ENTITY ASSIGNED UNDER THIS SUBSECTION WITHIN TWO (2) BUSINESS DAYS.

(C) THE EXTERNAL GRIEVANCE PROCESS SHALL MEET ALL OF THE FOLLOWING REQUIREMENTS:

(1) ANY EXTERNAL GRIEVANCE SHALL BE FILED WITH THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR WITHIN [FIFTEEN (15) DAYS] FOUR (4) MONTHS OF RECEIPT OF A NOTICE OF DENIAL RESULTING FROM THE INTERNAL GRIEVANCE PROCESS. THE FILING OF THE EXTERNAL GRIEVANCE SHALL INCLUDE ANY MATERIAL JUSTIFICATION AND ALL REASONABLY NECESSARY SUPPORTING INFORMATION. WITHIN FIVE (5) BUSINESS DAYS OF THE FILING OF AN EXTERNAL GRIEVANCE, THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL NOTIFY THE ENROLLEE OR THE HEALTH CARE PROVIDER, THE UTILIZATION REVIEW ENTITY THAT CONDUCTED THE INTERNAL GRIEVANCE AND THE DEPARTMENT

THAT AN EXTERNAL GRIEVANCE HAS BEEN FILED.

(2) THE UTILIZATION REVIEW ENTITY THAT CONDUCTED THE INTERNAL GRIEVANCE SHALL FORWARD COPIES OF ALL WRITTEN DOCUMENTATION REGARDING THE DENIAL, INCLUDING THE DECISION, ALL REASONABLY NECESSARY SUPPORTING INFORMATION, A SUMMARY OF APPLICABLE ISSUES AND THE BASIS AND CLINICAL RATIONALE FOR THE DECISION, TO THE UTILIZATION REVIEW ENTITY CONDUCTING THE EXTERNAL GRIEVANCE WITHIN FIFTEEN (15) DAYS OF RECEIPT OF NOTICE THAT THE EXTERNAL GRIEVANCE WAS FILED. ANY ADDITIONAL WRITTEN INFORMATION MAY BE SUBMITTED BY THE ENROLLEE OR THE HEALTH CARE PROVIDER WITHIN FIFTEEN (15) DAYS OF RECEIPT OF NOTICE THAT THE EXTERNAL GRIEVANCE WAS FILED.

(3) THE UTILIZATION REVIEW ENTITY CONDUCTING THE EXTERNAL GRIEVANCE SHALL REVIEW ALL INFORMATION CONSIDERED IN REACHING ANY PRIOR DECISIONS TO DENY PAYMENT FOR THE HEALTH CARE SERVICE AND ANY OTHER WRITTEN SUBMISSION BY THE ENROLLEE OR THE HEALTH CARE PROVIDER.

(4) AN EXTERNAL GRIEVANCE DECISION SHALL BE MADE BY:

(I) ONE OR MORE LICENSED PHYSICIANS OR APPROVED LICENSED PSYCHOLOGISTS IN ACTIVE CLINICAL PRACTICE OR IN THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE HEALTH CARE SERVICE BEING REVIEWED; OR

(II) ONE OR MORE PHYSICIANS CURRENTLY CERTIFIED BY A BOARD APPROVED BY THE AMERICAN BOARD OF MEDICAL SPECIALISTS OR THE AMERICAN BOARD OF OSTEOPATHIC SPECIALTIES IN THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE HEALTH CARE SERVICE BEING REVIEWED.

(5) WITHIN SIXTY (60) DAYS OF THE FILING OF THE EXTERNAL GRIEVANCE, THE UTILIZATION REVIEW ENTITY CONDUCTING THE EXTERNAL GRIEVANCE SHALL ISSUE A WRITTEN DECISION TO THE [MANAGED CARE

PLAN] INSURER, MCO OR CONTRACTOR, THE ENROLLEE AND THE HEALTH CARE PROVIDER, INCLUDING THE BASIS AND CLINICAL RATIONALE FOR THE DECISION. THE STANDARD OF REVIEW SHALL BE WHETHER THE HEALTH CARE SERVICE DENIED BY THE INTERNAL GRIEVANCE PROCESS WAS MEDICALLY NECESSARY AND APPROPRIATE UNDER THE TERMS OF THE [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT. THE EXTERNAL GRIEVANCE DECISION SHALL BE SUBJECT TO APPEAL TO A COURT OF COMPETENT JURISDICTION WITHIN SIXTY (60) DAYS OF RECEIPT OF NOTICE OF THE EXTERNAL GRIEVANCE DECISION. THERE SHALL BE A REBUTTABLE PRESUMPTION IN FAVOR OF THE DECISION OF THE UTILIZATION REVIEW ENTITY CONDUCTING THE EXTERNAL GRIEVANCE.

(6) THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL AUTHORIZE ANY HEALTH CARE SERVICE OR PAY A CLAIM DETERMINED TO BE MEDICALLY NECESSARY AND APPROPRIATE UNDER PARAGRAPH (5) PURSUANT TO SECTION 2166 WHETHER OR NOT AN APPEAL TO A COURT OF COMPETENT JURISDICTION HAS BEEN FILED.

(7) ALL FEES AND COSTS RELATED TO AN EXTERNAL GRIEVANCE SHALL BE PAID BY THE NONPREVAILING PARTY IF THE EXTERNAL GRIEVANCE WAS FILED BY THE HEALTH CARE PROVIDER. THE HEALTH CARE PROVIDER AND THE UTILIZATION REVIEW ENTITY OR [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL EACH PLACE IN ESCROW AN AMOUNT EQUAL TO ONE-HALF OF THE ESTIMATED COSTS OF THE EXTERNAL GRIEVANCE PROCESS. IF THE EXTERNAL GRIEVANCE WAS FILED BY THE ENROLLEE, ALL FEES AND COSTS RELATED THERETO SHALL BE PAID BY THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR. FOR PURPOSES OF THIS PARAGRAPH, FEES AND COSTS SHALL NOT INCLUDE ATTORNEY FEES.

(D) THE DEPARTMENT SHALL COMPILE AND MAINTAIN A LIST OF CERTIFIED UTILIZATION REVIEW ENTITIES THAT MEET THE REQUIREMENTS OF THIS ARTICLE. THE DEPARTMENT MAY REMOVE A UTILIZATION REVIEW

ENTITY FROM THE LIST IF SUCH AN ENTITY IS INCAPABLE OF PERFORMING ITS RESPONSIBILITIES IN A REASONABLE MANNER, CHARGES EXCESSIVE FEES OR VIOLATES THIS ARTICLE.

(E) A FEE MAY BE IMPOSED BY [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR FOR FILING AN EXTERNAL GRIEVANCE PURSUANT TO THIS ARTICLE WHICH SHALL NOT EXCEED TWENTY-FIVE ($25) DOLLARS.

(F) WRITTEN CONTRACTS BETWEEN [MANAGED CARE PLANS] INSURERS, MCO OR CONTRACTOR AND HEALTH CARE PROVIDERS MAY PROVIDE AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM TO THE EXTERNAL GRIEVANCE PROCESS SET FORTH IN THIS ARTICLE IF THE DEPARTMENT APPROVES THE CONTRACT. THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM SHALL BE IMPARTIAL, INCLUDE SPECIFIC TIME LIMITATIONS TO INITIATE APPEALS, RECEIVE WRITTEN INFORMATION, CONDUCT HEARINGS AND RENDER DECISIONS AND OTHERWISE SATISFY THE REQUIREMENTS OF THIS SECTION. A WRITTEN DECISION PURSUANT TO AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM SHALL BE FINAL AND BINDING ON ALL PARTIES. AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM SHALL NOT BE UTILIZED FOR ANY EXTERNAL GRIEVANCE FILED BY AN ENROLLEE.

SECTION 2163. RECORDS.--RECORDS REGARDING GRIEVANCES FILED UNDER THIS SUBDIVISION THAT RESULT IN DECISIONS ADVERSE TO ENROLLEES SHALL BE MAINTAINED BY THE [PLAN] INSURER, MCO OR CONTRACTOR FOR NOT LESS THAN THREE (3) YEARS. THESE RECORDS SHALL BE PROVIDED TO THE DEPARTMENT, IF REQUESTED, IN ACCORDANCE WITH SECTION 2131(C)(2)(II).

SECTION 2166. PROMPT PAYMENT OF CLAIMS.--(A) [A LICENSED] AN INSURER [OR A MANAGED CARE PLAN], MCO OR CONTRACTOR SHALL PAY A CLEAN CLAIM SUBMITTED BY A HEALTH CARE PROVIDER WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF THE CLEAN CLAIM.

(B) IF [A LICENSED] AN INSURER [OR A MANAGED CARE PLAN], MCO

OR CONTRACTOR FAILS TO REMIT THE PAYMENT AS PROVIDED UNDER SUBSECTION (A), INTEREST AT TEN PER CENTUM (10%) PER ANNUM SHALL BE ADDED TO THE AMOUNT OWED ON THE CLEAN CLAIM. INTEREST SHALL BE CALCULATED BEGINNING THE DAY AFTER THE REQUIRED PAYMENT DATE AND ENDING ON THE DATE THE CLAIM IS PAID. THE LICENSED INSURER OR [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR SHALL NOT BE REQUIRED TO PAY ANY INTEREST CALCULATED TO BE LESS THAN TWO ($2) DOLLARS.

(K) HEALTH CARE PROVIDER [AND MANAGED CARE PLAN], INSURER, MCO AND CONTRACTOR PROTECTION.

SECTION 2171. HEALTH CARE PROVIDER [AND MANAGED CARE PLAN], INSURER, MCO AND CONTRACTOR PROTECTION.--(A) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL NOT EXCLUDE, DISCRIMINATE AGAINST OR PENALIZE ANY HEALTH CARE PROVIDER FOR ITS REFUSAL TO ALLOW, PERFORM, PARTICIPATE IN OR REFER FOR HEALTH CARE SERVICES WHEN THE REFUSAL OF THE HEALTH CARE PROVIDER IS BASED ON MORAL OR RELIGIOUS GROUNDS AND THAT PROVIDER MAKES ADEQUATE INFORMATION AVAILABLE TO ENROLLEES OR, IF APPLICABLE, PROSPECTIVE ENROLLEES.

(B) NO PUBLIC INSTITUTION, PUBLIC OFFICIAL OR PUBLIC AGENCY MAY TAKE DISCIPLINARY ACTION AGAINST, DENY LICENSURE OR CERTIFICATION OR PENALIZE ANY PERSON, ASSOCIATION OR CORPORATION ATTEMPTING TO ESTABLISH A [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT, CHIP CONTRACT OR OPERATING, EXPANDING OR IMPROVING AN EXISTING [PLAN] HEALTH INSURANCE POLICY, MCO CONTRACT OR CHIP CONTRACT BECAUSE THE PERSON, ASSOCIATION OR CORPORATION REFUSES TO PROVIDE ANY PARTICULAR FORM OF HEALTH CARE SERVICES OR OTHER SERVICES OR SUPPLIES COVERED BY OTHER [PLANS] HEALTH INSURANCE POLICIES, MCO CONTRACTS OR CHIP CONTRACTS WHEN THE REFUSAL IS BASED ON MORAL OR RELIGIOUS GROUNDS.

SECTION 2181. DEPARTMENTAL POWERS AND DUTIES.--(A) THE DEPARTMENT SHALL REQUIRE THAT RECORDS AND DOCUMENTS SUBMITTED TO [A MANAGED CARE PLAN] AN INSURER, MCO, CONTRACTOR OR UTILIZATION REVIEW ENTITY AS PART OF ANY COMPLAINT OR GRIEVANCE BE MADE AVAILABLE TO THE DEPARTMENT, UPON REQUEST, FOR PURPOSES OF ENFORCEMENT OR COMPLIANCE WITH THIS ARTICLE.

(B) THE DEPARTMENT SHALL COMPILE DATA RECEIVED FROM [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR ON AN ANNUAL BASIS REGARDING THE NUMBER, TYPE AND DISPOSITION OF COMPLAINTS AND GRIEVANCES FILED WITH [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR UNDER THIS ARTICLE.

(C) THE DEPARTMENT SHALL ISSUE GUIDELINES IDENTIFYING THOSE PROVISIONS OF THIS ARTICLE THAT EXCEED OR ARE NOT INCLUDED IN THE "STANDARDS FOR THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS" PUBLISHED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE. THESE GUIDELINES SHALL BE PUBLISHED IN THE PENNSYLVANIA BULLETIN AND UPDATED AS NECESSARY. COPIES OF THE GUIDELINES SHALL BE MADE AVAILABLE TO [MANAGED CARE PLANS] INSURERS, MCOS, CONTRACTORS, HEALTH CARE PROVIDERS AND ENROLLEES UPON REQUEST.

(D) THE DEPARTMENT AND THE INSURANCE DEPARTMENT SHALL ENSURE COMPLIANCE WITH THIS ARTICLE. THE APPROPRIATE DEPARTMENT SHALL INVESTIGATE POTENTIAL VIOLATIONS OF THE ARTICLE BASED UPON INFORMATION RECEIVED FROM ENROLLEES, HEALTH CARE PROVIDERS AND OTHER SOURCES IN ORDER TO ENSURE COMPLIANCE WITH THIS ARTICLE.

(E) THE DEPARTMENT AND THE INSURANCE DEPARTMENT SHALL PROMULGATE SUCH REGULATIONS AS MAY BE NECESSARY TO CARRY OUT THE PROVISIONS OF THIS ARTICLE.

(F) THE DEPARTMENT IN COOPERATION WITH THE INSURANCE DEPARTMENT SHALL SUBMIT AN ANNUAL REPORT TO THE GENERAL ASSEMBLY

REGARDING THE IMPLEMENTATION, OPERATION AND ENFORCEMENT OF THIS ARTICLE.

SECTION 2182. PENALTIES AND SANCTIONS.--(A) THE DEPARTMENT OR THE INSURANCE DEPARTMENT, AS APPROPRIATE, MAY IMPOSE A CIVIL PENALTY OF UP TO FIVE THOUSAND ($5,000) DOLLARS FOR A VIOLATION OF THIS ARTICLE.

(B) [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR SHALL BE SUBJECT TO THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS THE "UNFAIR INSURANCE PRACTICES ACT."

(C) THE DEPARTMENT OR THE INSURANCE DEPARTMENT MAY MAINTAIN AN ACTION IN THE NAME OF THE COMMONWEALTH FOR AN INJUNCTION TO PROHIBIT ANY ACTIVITY WHICH VIOLATES THE PROVISIONS OF THIS ARTICLE.

(D) THE DEPARTMENT MAY ISSUE AN ORDER TEMPORARILY PROHIBITING [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR WHICH VIOLATES THIS ARTICLE FROM ENROLLING NEW MEMBERS.

(E) THE DEPARTMENT MAY REQUIRE [A MANAGED CARE PLAN] AN INSURER, MCO OR CONTRACTOR TO DEVELOP AND ADHERE TO A PLAN OF CORRECTION APPROVED BY THE DEPARTMENT. THE DEPARTMENT SHALL MONITOR COMPLIANCE WITH THE PLAN OF CORRECTION. THE PLAN OF CORRECTION SHALL BE AVAILABLE TO ENROLLEES OF THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR UPON REQUEST.

(F) IN NO EVENT SHALL THE DEPARTMENT AND THE INSURANCE DEPARTMENT IMPOSE A PENALTY FOR THE SAME VIOLATION.

SECTION 2191. COMPLIANCE WITH NATIONAL ACCREDITING STANDARDS.--NOTWITHSTANDING ANY OTHER PROVISION OF THIS ARTICLE TO THE CONTRARY, THE DEPARTMENT SHALL GIVE CONSIDERATION TO [A MANAGED CARE PLAN'S] AN INSURER'S, MCO'S OR CONTRACTOR'S DEMONSTRATED COMPLIANCE WITH THE STANDARDS AND REQUIREMENTS SET FORTH IN THE "STANDARDS FOR THE ACCREDITATION OF MANAGED CARE

ORGANIZATIONS" PUBLISHED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR OTHER DEPARTMENT-APPROVED QUALITY REVIEW ORGANIZATIONS IN DETERMINING COMPLIANCE WITH THE SAME OR SIMILAR PROVISIONS OF THIS ARTICLE. THE [MANAGED CARE PLAN] INSURER, MCO OR CONTRACTOR, HOWEVER, SHALL REMAIN SUBJECT TO AND SHALL COMPLY WITH ANY OTHER PROVISIONS OF THIS ARTICLE THAT EXCEED OR ARE NOT INCLUDED IN THE STANDARDS OF THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR OTHER DEPARTMENT-APPROVED QUALITY REVIEW ORGANIZATIONS.

SECTION 11. THIS ACT SHALL APPLY TO HEALTH INSURANCE POLICIES OFFERED, ISSUED OR RENEWED ON OR AFTER JANUARY 1, 2024.

SECTION 12. THIS ACT SHALL TAKE EFFECT IN 30 DAYS.