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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2797 Session of 1996

INTRODUCED BY VANCE, DRUCE, KING, NYCE, MICOZZIE, NICKOL, ITKIN, GEORGE, COLAIZZO, GORDNER, WAUGH, KENNEY, THOMAS, HALUSKA, FARMER, MILLER, BOSCOLA, TRELLO, DeLUCA, JOSEPHS, BARD, HENNESSEY, SAYLOR, MICHLOVIC, STEELMAN, D. W. SNYDER, E. Z. TAYLOR, MUNDY AND YOUNGBLOOD, JUNE 26, 1996

REFERRED TO COMMITTEE ON INSURANCE, JUNE 26, 1996

AN ACT

Requiring certification of utilization review entities; providing for appeal process for patients and providers and for delivery of health care in a cost-effective manner.

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Section 13. Severability.

Section 14. Repeals.

Section 15. Effective date.

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

Section 1. Short title.

This act shall be known and may be cited as the Health Plan Accountability Act.

Section 2. Purpose.

The purpose of this act is to:

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

(2) Foster greater coordination between health care providers, patients and insurers.

(3) Ensure that patients have access to quality patient care in a timely fashion.

(4) Safeguard patients by ensuring that insurers and utilization review entities are qualified to perform utilization review activities.

(5) Ensure that patients and providers are sufficiently informed regarding utilization review processes, criteria and the procedures for appealing utilization review determinations.

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

Section 3. Definitions.

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

"Active clinical practice." A health care practitioner who practices clinical medicine for not less than 20 hours per week.

Agency." A nationally recognized accrediting agency.

"Clinical review criteria." The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health care insurer to determine the necessity and appropriateness of health care services.

"Commissioner." The Insurance Commissioner of Pennsylvania.

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

"Credentialling criteria." Any standards used to evaluate the qualifications of a health care practitioner or health care facility during the credentialling process for a provider network, including, but not limited to, economic profiles.

"Department." The Department of Health of Pennsylvania.

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

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

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

(3) other benefit programs providing payment, reimbursement or indemnification for the costs of health care for the covered individual.

"Health care facility." Any health care facility providing clinically related health services, including, but not limited to, a general or special hospital, including psychiatric hospitals, rehabilitation hospitals, ambulatory surgical facilities, long-term care nursing facilities, cancer treatment

centers using radiation therapy on an ambulatory basis and inpatient drug and alcohol treatment facilities.

"Health care insurer." Any entity operating under any of the laws listed in section 11.

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

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

"Licensing authority." The licensing authority of the health insurers listed in section 12.

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

"Provider of record." The physician, licensed practitioner or health care facility identified to a utilization review entity or insurer as having primary responsibility for the care, treatment and services rendered to a covered individual.

"Secretary." The Secretary of Health of Pennsylvania.

"Utilization review." A system for prospective, concurrent,

retrospective review or case management of the medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual. The term does not include the following:

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

(2) a provider's internal quality assurance or utilization review unless such review results in a coverage or benefit payment determination.

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

(1) The necessity or appropriateness of the allocations of resources.

(2) The provision or proposed provision of health care services to a covered individual.

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

(1) A business entity doing business in this Commonwealth.

(2) An integrated delivery system which enters into a contractual arrangement with a health care insurer.

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

Commonwealth.

The term shall not include entities conducting general in-house utilization review for health care facilities, home health agencies, health maintenance organizations, preferred provider organizations or other managed care entities or private health care professional offices, so long as the review does not result in a coverage or benefit payment determination.

Section 4. Certification of utilization review entity.

(a) Certification required.--A utilization review entity may not conduct utilization review services in this Commonwealth unless the entity is certified by the department to perform such services. A utilization review entity that has been operating in this Commonwealth prior to the effective date of this act may continue to conduct utilization review pending an initial certification determination by the department regarding that entity.

(b) Criteria.--The department shall grant certification to any utilization review entity that satisfies the following criteria, submits the following application information to the department and meets the utilization review standards included in section 5:

(1) The name, address, telephone number and hours of operation of the utilization review entity.

(2) A utilization review plan that includes a description of review guidelines, criteria, protocols and procedures to be used in evaluating proposed inpatient hospital care, inpatient medical care and outpatient surgical care, behavioral health care, and the provisions by which patients, providers or hospitals may seek reconsideration or appeal of decisions made by the utilization review entity.

(3) The professional qualifications of the personnel either employed or under contract to perform the utilization review.

(4) A description of the policies and procedures that ensure that a representative of the utilization review entity is reasonably accessible to patients and providers in this Commonwealth and the department by a toll-free telephone line or by acceptance of long-distance collect calls for at least 40 hours each week during normal business hours.

(5) A description of the policies and procedures that ensure that the utilization review entity will follow applicable Federal and state laws to protect the confidentiality of individual medical records.

(6) A copy of the materials or a description of the procedure designed to inform patients and providers, as appropriate, of the requirements of the utilization review plan.

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

(d) Accrediting agencies.--After a utilization review entity has been certified by the department under this act, the department may rely on nationally recognized accrediting agencies to the extent the standards of the agency are determined by the department to substantially meet or exceed the standards of the department and if the entity agrees to:

(1) direct the agency to provide a copy of its findings to the department; and

(2) permit the department to verify compliance with standards not covered by the agency.

(e) Fees.--The secretary is authorized to prescribe fees for

initial application and renewal of certification. These fees shall not exceed the administrative costs of the certification process.

(f) Procedures.--Licensed health insurers are required to follow the standards and procedures contained in this act but are not required to be separately certified for utilization review by the department.

Section 5. Utilization review standards.

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

(1) Provide toll-free telephone access at least 40 hours each week during normal business hours.

(2) Maintain a telephone call answering service or recording system during hours other than normal business hours.

(3) Respond to each telephone call left on the recording system within two business days after receiving the call.

(4) Protect the confidentiality of the medical records of covered individuals as required by Federal and State law and ensure that a covered individual's medical records or confidential medical information obtained in the performance of utilization review are not disclosed or published.

(5) Ensure that personnel conducting utilization review have current licenses that are in good standing and without restrictions from a state health care professional licensing agency in the United States and are members of a profession that practices inpatient hospital, behavioral health care or outpatient surgical care.

(6) Within one business day after receiving a request

for a utilization review determination other than retrospective review that includes all information necessary to complete the utilization review determination, notify the enrollee and the provider of record of the utilization review determination by mail or other means of communication.

(7) Include the following in the notification of a utilization review determination denying the coverage for an admission, a or a service procedure:

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

(ii) the procedures to initiate an appeal of the determination.

(8) Ensure that every adverse utilization review determination as to the necessity or appropriateness of an admission, a service or a procedure is:

(i) concurred with by a physician or, if appropriate, a psychologist, in the same or similar specialty as typically manages the medical condition, procedure or treatment under review; or

(ii) determined in accordance with standards or guidelines approved by a physician or, if appropriate, a psychologist in the same or similar specialty as typically manages or recommends treatment for the medical condition, procedure or treatment under review.

(9) Ensure that every physician and psychologist making a utilization determination for the utilization review entity has a current, unrestricted license issued by a State licensing authority.

(10) Provide a period of at least 48 hours following an emergency admission, service or procedure during which an enrollee or representative of an enrollee may notify the utilization review entity and request approval or continuing treatment for the condition involved in the admission, services or procedure.

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

(12) Disclose clinical review criteria used to make a utilization review determination to providers.

(13) Develop and file with the department a utilization review plan which includes, but is not limited to, provisions for any out-of-network penalty, out-of-network care for required specialty care not available in the network and emergency or urgent care obtained out of network.

(b) Alternative practices.--Health insurers and providers may establish alternative utilization practices and procedures by contract that are approved by the department.

Section 6. Utilization review decisions and internal appeals.

Utilization review decision and appeals processes of utilization review entities or health care insurers shall conform to the following:

(1) Notification of a utilization review determination shall be communicated with the provider of record within one business day of the receipt of all information necessary to complete the review. For retrospective determinations, notice shall be given within 30 days.

(2) Any notification of a determination to deny the coverage for an admission, procedure or extension of stay shall include the principal reason for the determination and

the written description of the appeal procedure, including the name and telephone number of the person to contact in regard to an appeal.

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

(4) The internal appeals process shall be established by the utilization review entity or health care insurer and must include a reasonable time period of not less than 60 days within which an appeal must be filed to be considered.

(5) The utilization review entity or health care insurer shall complete the review of appeals of determinations no later than 30 days from the appeal is filed.

(6) The utilization review entity or health care insurer shall provide for an expedited appeals process for emergency or life-threatening situations. Adjudication of expedited appeals shall be completed within two business days of the date the appeal is filed.

(7) All utilization review determinations to deny coverage for an admission, service, procedure or extension of stay that had been ordered by a physician shall be made by a licensed physician.

(8) Compensation to any persons providing utilization review services shall not contain incentives, direct or indirect, for these persons to make inappropriate review decisions.

(9) On appeal, all determinations not to certify an admission, service, procedure or extension of stay must be

made by a licensed health care practitioner in active clinical practice in the same or similar general specialty as typically manages or recommends treatment for the medical condition, procedure or treatment. No physician or other reviewer who has been involved in prior reviews of the case under appeal may participate as the sole reviewer of a case under appeal.

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

(11) The department may, in response to a written complaint by a patient, review any adverse determination following completion of an internal review process.

Section 7. External utilization review appeals.

The utilization review plan of utilization review entities or health care insurers must provide for independent external adjudication process beyond the second level of appeal that adheres to the following:

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

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

(3) At least one arbitrator shall be a licensed physician or, if appropriate, a psychologist in the same or similar specialty as typically manages or recommends treatment for the medical condition under review. The remaining arbitrators shall also be licensed health care practitioners.

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

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

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

(7) Written contracts between health care insurers and providers may provide for an alternative to the external appeal process. In such cases, a provider may appeal to a physician committee appointed by the governing body of the utilization review entity or health care insurer. No physician serving on the committee to review such appeals may be an employee of the utilization review entity or health care insurer. The provider of record may present information supporting his position either in writing or may appear before the committee in person to do so. The committee shall make a determination within 30 days of receiving written

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

Section 8. Provider credentialling.

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

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

(2) Health care insurers shall consult with practicing physicians regarding the professional qualifications, specialty and geographic composition of its physician component of its network. The health care insurer shall report the composition of its provider network to its licensing authority every two years or as otherwise required by the licensing authority.

(3) A health care insurer shall select the participating health care practitioners and health care facilities for its provider network through a formal credentialling mechanism that includes criteria and processes for initial selection, recredentialling and termination. The health care insurer shall report the credentialling criteria and processes to its licensing authority every two years or as otherwise required

by the licensing authority.

(4) A health care insurer shall disclose the credentialling criteria and processes to applicants for the provider network.

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

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

(7) In the event a health care insurer renders an adverse credentialling decision the plan shall provide the affected health care practitioner or health care facility with written notice of the decision that includes a clear explanation of the basis for determination and a summary of the provider's appeal rights.

(8) A health care insurer shall provide health care practitioners and health care facilities with a reasonable opportunity for reconsideration of adverse credentialling determinations.

(9) The licensing authority of the health care insurer may establish an administrative process to consider complaints by a health care provider for actions which are in violation of this section of the act. Administrative actions initiated pursuant to this section shall be governed by 2 Pa.C.S. Chs. 5 Subch. A (relating to practice and procedure

of Commonwealth agencies) and 7 Subch. A (relating to judicial review of Commonwealth agency action). The licensing authority shall require health care providers to exhaust their rights under the provider credentialling system established by the health care insurer pursuant to this act prior to filing an administrative complaint.

Section 9. Uniform disclosure.

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

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

(1) The benefits and any and all exclusions.

(2) Any and all enrollee cost-sharing requirements.

(3) Any and all maximum benefit limitations.

(4) Any and all limitations on choice of provider.

(5) Whether the plan uses a physician incentive plan that affects the use of referral services and the type or types of incentive arrangements.

(6) Enrollee satisfaction statistics.

(c) Mandatory use.--Health care insurers shall use the uniform disclosure form adopted by the commissioner when providing information to purchasers or potential enrollees.

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

Section 10. Penalties.

The department may impose a fine of not more than $10,000 for each violation of this act. In addition, the department may deny, suspend, revoke or refuse to renew the certification of a utilization review entity or health care insurer that fails to

satisfy the utilization review standards set forth in section 5 or that otherwise violates the provisions of this act. The utilization review entity or health care insurer shall be entitled to notice and the right to a hearing pursuant to 2 Pa.C.S. (relating to administrative law and procedure).

Section 11. Applicability.

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

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

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

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

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

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

(6) a fraternal benefit society;

(7) 31 Pa.Code Ch. 69 Subch. A (relating to automobile insurance medical cost containment);

(8) 34 Pa.Code Ch.127 (relating to workers' compensation medical cost containment);

(9) nothing in this act shall be deemed to affect the application of 40 Pa.C.S. § 6324 (relating to rights of health service doctors), to health service doctors contracting with professional service, corporations; or

(10) successor laws.

Section 12. Rulemaking.

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

Section 13. Severability.

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

Section 14. Repeals.

All other acts and parts of acts in conflict with this act are repealed.

Section 15. Effective date.

This act shall take effect in 120 days.