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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1355 Session of 2001

INTRODUCED BY BROWNE, MANN, BELFANTI, BOYES, CAPPELLI, CIVERA, CORNELL, CORRIGAN, CREIGHTON, CURRY, DALLY, FEESE, FLICK, FORCIER, FRANKEL, FREEMAN, GEORGE, GORDNER, GRUCELA, HARHAI, HENNESSEY, HERMAN, HERSHEY, JAMES, JOSEPHS, KELLER, LAUGHLIN, LEDERER, LEWIS, MYERS, ORIE, READSHAW, ROSS, RUBLEY, SCHRODER, SCRIMENTI, SEMMEL, SHANER, SOLOBAY, SURRA, E. Z. TAYLOR, THOMAS, TIGUE, TRELLO, WATSON, WILT AND YUDICHAK, APRIL 17, 2001

REFERRED TO COMMITTEE ON INSURANCE, APRIL 17, 2001

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," further providing for managed care plans, for continuity of care, for utilization review, for internal grievance process and for external grievance process.

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

Section 1. The definition of "managed care plan" in section 2102 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, added June 17, 1998 (P.L.464, No.68), is amended 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:

* * *

"Managed care plan." A health care plan that [uses a gatekeeper to manage the utilization of health care services,] integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan <u>or which performs utilization review of any services directly or through a subcontract</u>. A managed care plan includes health care arranged through an entity operating under any of the following:

(1) Section 630.

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

(3) The act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."

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

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

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. [The term does not include ancillary service plans or an indemnity arrangement which is primarily fee for service.]

* * *

Section 2. Section 2117 of the act is amended by adding a

subsection to read:

Section 2117. Continuity of Care.--* * *

(g) When a determination of referral for specialty is made, a plan shall provide an enrollee with access to any participating or nonparticipating specialist licensed to provide the required service covered by the plan at the time the services are required. When an enrollee accesses a nonparticipating specialist, the plan shall reimburse the enrollee for the covered service at a rate equal to at least eighty per centum (80%) of the payment that the plan would have paid had the covered service been provided by a participating specialist. The following shall apply:

(1) In the case of a nonparticipating pharmacy, medical equipment supplier or distributor of orthotics or prosthetics, the minimum eighty per centum (80%) reimbursement provided for in the section shall apply to the professional services or dispensing fee, as distinct from reimbursement for the product itself. Reimbursement for the product shall be made at the rate that the plan normally reimburses participating providers.

(2) The plan shall provide to the enrollee intending to access an out-of-network specialist information containing adequate disclosure of coverage limitations and conditions including the enrollees' liability for copayments. This information shall also be provided to the nonparticipating specialist upon written request as well as information regarding the use of diagnostic and ancillary services and other requirements or limitations on treatments, including selection of treatment facilities.

(3) The enrollee and nonparticipating specialists shall be informed of any certification requirements for nonemergency

hospital admissions or treatment services.

(4) The plan shall provide claim forms and billing information to the nonparticipating specialist. The plan shall also provide the enrollee's primary care physician with claims information concerning usage of a nonparticipating specialist so that the primary care physician will be prepared to care for the enrollee when the enrollee returns to the network.

(5) The plan shall pay nonparticipating specialists in accordance with the procedures and within the time periods established by the plan for participating specialists.

(6) Out-of-network access to licensed health care providers for services covered by the plan shall be available at no extra cost to enrollees when no network provider has offices within twenty (20) minutes in urban areas or thirty (30) minutes in rural areas, or no appointment is available within three (3) weeks for nonurgent care or within twenty-four (24) hours for urgent care. In such circumstances, the provider would be reimbursed at the same rate as a network provider.

Section 3. Sections 2152 heading, (c) and (d), 2161(d) and 2162(c)(4) of the act, added June 17, 1998 (P.L.464, No.68), are amended to read:

Section 2152. Operational Standards for Certification as a Utilization Review Entity.--* * *

(c) Utilization review that results in a denial of payment for a health care service shall be made by a licensed physician[, except as provided in subsection (d).] or, in the case of advance practice nurses, chiropractors, clinical social workers, dentists, optometrists, pharmacists, physical therapists, podiatrists or psychologists, a health care practitioner licensed in the same profession as the attending

health care practitioner. The use of these professionals to perform utilization review shall be approved by the department as part of the certification process under section 2151.

(d) A licensed psychologist may perform a utilization review for behavioral health care services within the psychologist's scope of practice if the psychologist's clinical experience provides sufficient experience to review that specific behavioral health care service. [The use of a licensed psychologist to perform a utilization review of a behavioral health care service shall be approved by the department as part of the certification process under section 2151.] A licensed psychologist shall not review the denial of payment for a health care service involving inpatient care or a prescription drug.

Section 2161. Internal Grievance Process.--* * *

(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[.] or, in the case of advance practice nurses, chiropractors, dentists, clinical social workers, optometrists, pharmacists, physical therapists, podiatrists or psychologists, a health care practitioner licensed in the same profession as the attending health care practitioner.

* * *

Section 2162. External Grievance Process.--* * *

(c) The external grievance process shall meet all of the following requirements:

* * *

(4) An external grievance decision shall be made by:

(i) one or more licensed physicians [or approved licensed

psychologists] or in the case of advance practice nurses, chiropractors, clinical social workers, dentists, optometrists, pharmacists, physical therapists, podiatrists or psychologists, a health care practitioner licensed in the same profession as the attending health care practitioner 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) if the health care provider is a physician, 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.

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Section 4. This act shall take effect in 60 days.