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 long-term care, further providing for definitions and for outline of coverage provisions; providing for adverse decisions, for complaints, for utilization review, for grievances and for prompt processing and payment of claims; further providing for authority to promulgate regulations; and providing for annual report.

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

Section 1. The definition of "long-term care insurance" in section 1103 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, amended July 17, 2007 (P.L.134, No.40) is amended and the section is amended by adding
Section 1103. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Adverse decision." A determination by a long-term care insurance policy issuer that results in denial of payment of benefits. The term includes the failure to pay a clean claim within forty-five (45) days of receipt of the clean claim.

"Clean claim." A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

"Complaint." A dispute or objection regarding the coverage, operations or management policies of a long-term care insurance issuer, which has not been resolved by the long-term care insurance issuer and has been filed with the long-term care issuer or with the Department of Health or the Insurance Department. The term does not include a grievance.

"Concurrent utilization review." A review by a utilization review entity of all reasonably necessary supporting information, which occurs during a policyholder or certificate holder's course of treatment and results in a decision to approve or deny payment for the health care service.

"Grievance." A request by a policyholder, certificate holder...
or health care provider, with the written consent of the
policyholder or certificate holder, to have a long-term care
insurance issuer or utilization review entity reconsider a
decision solely concerning the medical necessity and
appropriateness of a health care service. If the long-term care
insurance issuer 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.

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"Health care provider." A licensed hospital or health care
facility, medical equipment supplier or person who is licensed,
certified or otherwise regulated to provide health care services
under the laws of this Commonwealth, including a physician,
podiatrist, optometrist, psychologist, physical therapist,
certified nurse practitioner, registered nurse, nurse midwife,
physician's assistant, chiropractor, dentist, pharmacist or an
individual accredited or certified to provide behavioral health
services.

"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 a
policyholder or certificate holder under a long-term care
insurance contract.

"Long-term care insurance." Any insurance policy or rider advertised, marketed, offered or designed to provide [comprehensive] coverage for each covered person on an expense-incurred, indemnity, prepaid or other basis for functionally necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. The term includes a policy, rider or prepaid home health or personal care service policy [which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity]. The term includes group and individual policies or riders issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, health maintenance organizations or similar organizations. The term does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage or limited benefit health coverage.

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"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.

"Retrospective utilization 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.

"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 a policyholder or certificate holder. 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 section 1111.3 that performs utilization review on behalf of
a long-term care insurance issuer.

Section 2. Section 1111 of the act, added December 15, 1992
(P.L.1129, No.148), is amended to read:

Section 1111. Outline of Coverage Provisions.--(a) An
outline of coverage shall be delivered to a prospective
applicant for long-term care insurance at the time of initial
solicitation through means which prominently direct the
attention of the recipient to the document and its purpose.

(b) The department shall prescribe a standard format,
including style, arrangement and overall appearance, and the
content of an outline of coverage.

(c) In the case of agent solicitations, an agent must
deliver the outline of coverage prior to the presentation of an
application or enrollment form.

(d) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(e) The outline of coverage shall include all of the following:

(1) A description of the benefits and coverage provided in the policy.

(2) A statement of the exclusions, reductions and limitations contained in the policy.

(3) A statement of the terms under which the policy or certificate may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions.

(5) A description of the terms under which the policy or certificate may be returned and premium refunded.

(6) A brief description of the relationship of cost of care and benefits.

(7) A summary of the long-term care insurance policy's utilization review policies and procedures.

(8) A summary of all complaint and grievance procedures used to resolve disputes between the long-term care insurance policy issuer and a policyholder, certificate holder 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 right of a policyholder or certificate holder 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 benefits will be decided 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.

(f) An additional copy of the outline of coverage required by subsection (a) shall be provided to consumers:

(i) at least once every five (5) years beginning upon the policyholder's or certificate holder's sixtieth birthday;

(ii) upon receipt by the long-term care issuer of the first claim for benefits under the policy filed by the policyholder or certificate holder.

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

Section 1111.1. Adverse Decisions.--When a long-term care insurance issuer renders an adverse decision, the issuer shall send, within five (5) working days after the adverse decision has been made, a written notice to the policyholder or certificate holder that states:

(1) The specific factual basis, in clear, understandable language for the issuer's decision.

(2) The specific criteria and standards on which the decision was based.

(3) The policyholder's or certificate holder's right to
appeal the adverse decision.

(4) The right of a policyholder or certificate holder to designate a representative to participate in the complaint or grievance process as set forth in this article.

(5) The procedure to file a complaint or grievance, as applicable.

(6) The issuer's toll-free telephone number to obtain information regarding the filing and status of a complaint or grievance.

Section 1111.2 Complaints.--(a) (1) An issuer of a long-term care insurance policy shall establish and maintain an internal complaint process with two levels of review by which a policyholder or certificate holder shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the long-term care insurance policy issuer.

(2) The complaint process shall consist of an initial review to include all of the following:

(i) A review by an initial review committee consisting of one or more employees of the long-term care insurance policy issuer.

(ii) The allowance of a written or oral complaint.

(iii) The allowance of written data or other information.

(iv) A review or investigation of the complaint which shall be completed within thirty (30) days of receipt of the complaint.

(v) A written notification to the policyholder or certificate holder 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.

(3) The complaint process shall include a second level review that includes all of the following:

(i) 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 long-term care insurance policy issuer.

(ii) A written notification to the policyholder or certificate holder of the right to appear before the second level review committee.

(iii) A requirement that the second level review be completed within thirty (30) days of receipt of a request for such review.

(iv) A written notification to the policyholder or certificate holder 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 Department of Health.

(b) (1) A policyholder or certificate holder shall have fifteen (15) days from receipt of the notice of the decision from the second level review committee to appeal the decision to the department or the Department of Health, as appropriate.

(2) All records from the initial review and second level review shall be transmitted to the appropriate department in the manner prescribed. The policyholder, certificate holder, the health care provider or the long-term care insurance policy issuer may submit additional materials related to the complaint.
(3) The appropriate department shall determine whether a violation of this article has occurred and may impose any penalties authorized by this article.

(c) Nothing in this article shall prevent the department or the Department of Health from communicating with the policyholder, certificate holder, the health care provider or the long-term care insurance policy issuer as appropriate to assist in the resolution of a complaint. Such communication may occur at any time during the complaint process.

(d) At any time throughout the complaint process in any forum, the policyholder or certificate holder may be assisted or represented by an attorney, Department of Aging long-term care insurance ombudsman or representative, or other individual.

Section 1111.3 Utilization Review.--(a) (1) A utilization review entity may not review health care services delivered or proposed to be delivered in this Commonwealth pursuant to a long-term care insurance policy unless the entity is certified by the Department of Health to perform utilization review. A utilization review entity operating in this Commonwealth on or before the effective date of this section shall have one (1) year from the effective date of this section to apply for certification.

(2) The Department of Health shall grant certification to a utilization review entity that meets the requirements of this section. Certification shall be renewed every three (3) years unless otherwise subject to additional review, suspension or revocation by the department.

(3) The Department of Health may adopt a nationally recognized accrediting body's standards to certify utilization review entities to the extent the standards meet or exceed the
standards set forth in this article.

(4) The Department of Health may prescribe application and renewal fees for certification. The fees shall reflect the administrative costs of certification and shall be deposited in the General Fund.

(b) (1) A utilization review entity shall do all of the following:

(i) Respond to inquiries relating to utilization review determinations by:

(A) providing toll-free telephone access at least forty (40) hours per week during normal business hours;

(B) maintaining a telephone answering service or recording system during nonbusiness hours; and

(C) responding to each telephone call received by the answering service or recording system regarding a utilization review determination within one (1) business day of the receipt of the call.

(ii) Protect the confidentiality of the medical records of a policyholder or certificate holder in compliance with all applicable Federal and State laws and regulations and professional ethical standards.

(iii) Ensure that a health care provider is able to verify that an individual requesting information on behalf of the long-term care insurance policy issuer is a legitimate representative of the long-term care insurance policy issuer.

(iv) 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:

(A) 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.

(B) 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.

(C) 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.

(v) Ensure that personnel conducting a utilization review have current licenses in good standing or other required credentials, without restrictions, from the appropriate agency.

(vi) Provide all decisions in writing to include the basis and clinical rationale for the decision.

(vii) 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.

(viii) Maintain a written record of utilization review decisions adverse to policyholders or certificate holders for not less than three (3) years, including a detailed justification and all required notifications to the health care provider and the policyholder or certificate holder.

(2) Compensation to any person or entity performing utilization review may not contain incentives, direct or indirect, for the person or entity to approve or deny payment for the delivery of any health care service.

(3) 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 clause (4).

(4) 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 of Health 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 1111.4 Grievances.--(a) (1) An issuer of a long-term care insurance policy shall establish and maintain an internal grievance process with two levels of review and an expedited internal grievance process by which a policyholder, certificate holder or a health care provider, with the written consent of the policyholder or certificate holder, shall be able to file a written grievance regarding the denial of payment for a health care service. A policyholder or certificate holder who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.

(2) The internal grievance process shall consist of an initial review that includes all of the following:

(i) A review by one or more persons selected by the long-term care insurance policy issuer who did not previously participate in the decision to deny payment for the health care service.

(ii) The completion of the review within thirty (30) days of receipt of the grievance.
(iii) A written notification to the policyholder or certificate holder 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 the decision.

(3) The grievance process shall include a second level review that includes all of the following:

(i) A review of the decision issued pursuant to clause (2) 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.

(ii) A written notification to the policyholder or certificate holder or the health care provider of the right to appear before the second level review committee.

(iii) The completion of the second level review within thirty (30) days of receipt of a request for such review.

(iv) A written notification to the policyholder or certificate holder 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.

(4) 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.

(5) Should the policyholder's or certificate holder'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 policyholder or certificate holder and health care provider be made within forty-eight (48) hours of the filing of the expedited grievance.

(b) (1) An issuer of a long-term care insurance policy shall establish and maintain an external grievance process by which a policyholder, certificate holder or a health care provider with the written consent of the policyholder or certificate holder 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 long-term care insurance policy issuer.

(2) To conduct external grievances filed under this section:
   (i) The Department of Health shall randomly assign a utilization review entity on a rotational basis from the list maintained under clause (4) and notify the assigned utilization review entity and the long-term care insurance policy issuer within two (2) business days of receiving the request. If the Department of Health fails to select a utilization review entity under this subsection, the long-term care insurance policy issuer shall designate and notify a certified utilization review entity to conduct the external grievance.
   (ii) The long-term care insurance policy issuer shall notify the policyholder, certificate holder or health care provider of the name, address and telephone number of the utilization review entity assigned under this clause within two (2) business days.

(3) The external grievance process shall meet all the following requirements:
(i) Any external grievance shall be filed with the long-term care insurance policy issuer within fifteen (15) days 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 long-term care insurance policy issuer shall notify the policyholder, certificate holder or the health care provider, the utilization review entity that conducted the internal grievance and the Department of Health that an external grievance has been filed.

(ii) 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 policyholder, certificate holder or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.

(iii) 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 policyholder, certificate holder or the health care provider.

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

(A) 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

(B) 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.

(v) 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 long-term care insurance issuer, policyholder, certificate holder 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. 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.

(vi) The long-term care insurance policy issuer shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under subclause (v) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.

(vii) 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 long-term care insurance policy issuer shall each place in escrow an amount

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equal to one-half of the estimated costs of the external
grievance process. If the external grievance was filed by the
policyholder or certificate holder, all fees and costs related
thereto shall be paid by the long-term care insurance policy
issuer. For purposes of this clause, fees and costs shall not
include attorney fees.

(4) The Department of Health shall compile and maintain a
list of certified utilization review entities that meet the
requirements of this article. The Department of Health 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.

(5) A fee may be imposed by a long-term care insurance
policy issuer for filing an external grievance pursuant to this
article which shall not exceed twenty-five ($25) dollars.

(c) Records regarding grievances filed under this article
that result in decisions adverse to policyholders or certificate
holders shall be maintained by the long-term care insurance
issuer for not less than three (3) years. These records shall be
provided to the Department of Health, if requested 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 of Health employees or agents with
direct responsibilities under the provision of this subsection.

(d) At any time throughout the grievance process in any
forum, the policyholder or certificate holder may be assisted or
represented by an attorney, Department of Aging long-term care
insurance ombudsman or representative, or other individual.
Section 1111.5  Prompt Processing and Payment of Claims.--(a)  Upon receipt of a claim for benefits, an insurer shall determine whether it is complete. If it is not complete, within ten (10) days of receipt thereof the insurer shall postmark to the submitting person a statement of all items reasonably necessary to be submitted to make the claim complete. Upon receipt of those requested remaining items, the claim shall be complete and all clean and uncontested portions thereof shall be paid within thirty (30) days.

(b) A long-term care insurance issuer shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

(c) If a long-term care insurance issuer 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 long-term care insurance issuer shall not be required to pay any interest calculated to be less than two ($2) dollars.

(d) (1) In order to facilitate the prompt processing of claims, each claim form processed or otherwise used by a long-term care insurance issuer shall be the uniform claim form developed by the department. Each form shall be identical, except that the uniform claim form shall contain blank spaces at appropriate places in the document for approved additional information requests under clause (3).

(2) The department shall forward the uniform claim form to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin. A long-term care insurance issuer
shall be required to begin using the standard form as soon as practicable following the publication but in no event later than one hundred twenty (120) days following the publication.

(3) A long-term care insurance issuer may request departmental approval of additional information requests to be printed in blank spaces on the uniform claim form, and on subsequent pages if necessary, by submitting a written request to the department. Such a request shall be deemed approved by the department if not disapproved within sixty (60) days after receipt of the request. A disapproval shall be subject to the procedures under 2 Pa.C.S. (relating to administrative law and procedure).

Section 4. Section 1112 of the act, amended July 17, 2007 (P.L.134, No.40), is amended to read:

Section 1112. Authority to Promulgate Regulations.--(a) The department shall promulgate reasonable regulations to establish minimum standards for marketing practices, producer compensation arrangements, producer testing, penalties and reporting practices for long-term care insurance.

(b) The department and the Department of Health may promulgate reasonable regulations as may be necessary to carry out the provisions of sections 1111.1, 1111.2, 1111.3 and 1111.4.

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

Section 1114.1 Annual Report.--Each long-term care insurance issuer shall report annually to the commissioner on the form the commissioner requires, a report that includes, but is not limited to, the following information:

(1) Information relating to adverse decisions, including:

(i) The number of adverse decisions issued by the long-term
(i) The type of service at issue in the adverse decisions.

(2) Information relating to complaints, including:
   (i) The number of complaints filed with the long-term care insurance issuer.
   (ii) For each complaint filed with the long-term care insurance issuer:
       (A) The outcome of the complaint.
       (B) Whether the complaint was resolved pursuant to the first level internal review, second level internal review or before the department or Department of Health.
       (C) The time within which the long-term care insurance issuer resolved each complaint.

(3) Information relating to grievances, including:
   (i) The number of grievances filed with the long-term care insurance issuer.
   (ii) For each grievance filed with the long-term care insurance issuer:
       (A) The outcome of the grievance.
       (B) Whether the grievance was resolved pursuant to the first level internal review, second level internal review or external grievance process.
       (C) Whether the grievance was subject to an expedited review.
       (D) The time in which the long-term care insurance issuer resolved each grievance.

(4) Information relating to prompt payment of claims, including:
   (i) The number of clean claims submitted by health care providers not paid within forty-five (45) days of receipt of the
clean claim.

(ii) The total amount of interest paid on claims not paid within forty-five (45) days of receipt of the clean claim.

Section 6. This act shall take effect in 60 days.