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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 327 Session of 2001

INTRODUCED BY TARTAGLIONE, MELLOW, EARLL, SCHWARTZ, HUGHES, KUKOVICH, KITCHEN, KASUNIC, COSTA, BOSCOLA AND LOGAN, FEBRUARY 6, 2001

REFERRED TO BANKING AND INSURANCE, FEBRUARY 6, 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," defining "insurer" for purposes of quality health care accountability and protection; and further providing for internal grievance process, for external grievance process, for records and for departmental powers and duties relating to quality health care accountability and protection.

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

Section 1. 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 by adding a definition 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:

* * *

"Insurer." Any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer and any other legal entity engaged in the business of insurance, including agents and brokers.

* * *

Section 2. Sections 2161, 2162, 2163 and 2181 of the act, added June 17, 1998 (P.L.464, No.68), are amended to read:

Section 2161. Internal Grievance Process.--(a) [A] Each managed care plan and insurer shall establish and maintain an internal grievance process with two levels of review and an expedited internal grievance process by which an enrollee, insured or a health care provider, with the written consent of the enrollee or insured, shall be able to file a written grievance regarding the denial of payment for a health care service. An enrollee or insured 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 review that includes all of the following:

(1) A review by one or more persons selected by the managed care plan or insurer 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 or insured 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.

(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, insured 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 or insured 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] Each managed care plan and insurer shall establish and maintain an

external grievance process by which an enrollee, insured or a health care provider with the written consent of the enrollee or insured 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.

(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 or insurer 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 or insurer shall designate and notify a certified utilization review entity to conduct the external grievance.

(2) The managed care plan or insurer shall notify the enrollee, insured 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 or insurer 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 managed care plan or insurer shall

notify the enrollee or insured 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, insured 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, insured 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, [the] insurer, enrollee, insured 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. With respect to an insurer, the standard of review shall be whether the health care service denied by the internal grievance process was covered under the terms of the insurance policy. 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 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.

(6.1) The insurer shall pay a claim determined to be covered under the terms of the insurance policy 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 or insurer 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 or insured, all fees and costs related thereto shall be paid by the managed care plan or insurer. 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 or insurer for filing an external grievance pursuant to this article which shall not exceed twenty-five ($25) dollars.

(f) Written contracts between managed care plans 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 or insurer 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 2181. Departmental Powers and Duties.--(a) The department shall require that records and documents submitted to a managed care plan, insurer 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 or insurer on an annual basis regarding the number, type and disposition of complaints and grievances filed with a managed care plan or insurer 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, health care providers, insureds 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 insureds, 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 3. This act shall take effect in 60 days.