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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1251 Session of 2009

INTRODUCED BY D. COSTA, BARRAR, BRADFORD, BRENNAN, CALTAGIRONE, CASORIO, COHEN, CONKLIN, DEASY, DeLUCA, FREEMAN, GEORGE, GOODMAN, GRUCELA, HALUSKA, HARKINS, HENNESSEY, JOSEPHS, MAHONEY, MANN, MELIO, M. O'BRIEN, PASHINSKI, READSHAW, SIPTROTH, K. SMITH, SOLOBAY, J. TAYLOR, VULAKOVICH, WALKO, BELFANTI, FRANKEL, SEIP AND KORTZ, APRIL 13, 2009

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, JANUARY 25, 2010

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~~; AND 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~~ APPEALING AN INSURER'S DETERMINATION THE BENEFIT TRIGGER IS NOT MET, FOR PROMPT PAYMENT OF CLEAN CLAIMS AND FOR APPLICABILITY.

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 definitions to read:

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.

* * *

"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.~~

* * *

"BENEFIT TRIGGER." A CONTRACTUAL PROVISION IN THE INSURED'S POLICY OF LONG-TERM CARE INSURANCE CONDITIONING THE PAYMENT OF BENEFITS ON A DETERMINATION OF THE INSURED'S ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING AND ON COGNITIVE IMPAIRMENT. FOR THE PURPOSES OF A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AS DEFINED IN SECTION 7702B OF THE INTERNAL REVENUE CODE OF 1986 (PUBLIC LAW 99-514, 26 U.S.C. § 7702B), THE TERM SHALL INCLUDE A DETERMINATION BY A LICENSED HEALTH CARE PRACTITIONER THE INSURED IS A CHRONICALLY ILL INDIVIDUAL.

* * *

"INDEPENDENT REVIEW ORGANIZATION." AN ORGANIZATION THAT CONDUCTS INDEPENDENT REVIEWS OF LONG-TERM CARE BENEFIT TRIGGER DECISIONS.

"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.

* * *

"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~~ 2. 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 employes 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 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 employes 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 care insurance issuer under section 1111.1.

(ii) 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 1111.1. APPEALING AN INSURER'S DETERMINATION THE BENEFIT TRIGGER IS NOT MET.--(A) AN AUTHORIZED REPRESENTATIVE IS AUTHORIZED TO ACT AS THE COVERED PERSON'S PERSONAL REPRESENTATIVE WITHIN THE MEANING OF 45 CFR § 164.502(G) (RELATING TO USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: GENERAL RULES) PROMULGATED UNDER THE ADMINISTRATIVE SIMPLIFICATION PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (PUBLIC LAW 104-191, 110 STAT. 1936) AND MEANS THE FOLLOWING:

(1) A PERSON TO WHOM A COVERED PERSON HAS GIVEN EXPRESS WRITTEN CONSENT TO REPRESENT THE COVERED PERSON IN AN EXTERNAL REVIEW;

(2) A PERSON AUTHORIZED BY LAW TO PROVIDE SUBSTITUTED CONSENT FOR A COVERED PERSON; OR

(3) A FAMILY MEMBER OF THE COVERED PERSON OR THE COVERED PERSON'S TREATING HEALTH CARE PROFESSIONAL ONLY WHEN THE COVERED PERSON IS UNABLE TO PROVIDE CONSENT.

(B) IF AN INSURER DETERMINES THE BENEFIT TRIGGER OF A LONG-TERM CARE INSURANCE POLICY HAS NOT BEEN MET, IT SHALL PROVIDE A CLEAR, WRITTEN NOTICE TO THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, OF THE FOLLOWING:

(1) THE REASON THE INSURER DETERMINED THE INSURED'S BENEFIT TRIGGER HAS NOT BEEN MET.

(2) THE INSURED'S RIGHT TO INTERNAL APPEAL UNDER SUBSECTION (C) AND THE RIGHT TO SUBMIT NEW OR ADDITIONAL INFORMATION RELATING TO THE BENEFIT TRIGGER DENIAL WITH THE APPEAL REQUEST.

(3) THE INSURED'S RIGHT TO HAVE THE BENEFIT TRIGGER DETERMINATION REVIEWED UNDER THE INDEPENDENT REVIEW PROCESS UNDER SUBSECTION (D) AFTER THE EXHAUSTION OF THE INSURER'S INTERNAL APPEAL PROCESS.

(C) THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE MAY APPEAL THE INSURER'S ADVERSE BENEFIT TRIGGER DETERMINATION BY SENDING A WRITTEN REQUEST TO THE INSURER, ALONG WITH ADDITIONAL SUPPORTING INFORMATION, WITHIN ONE HUNDRED TWENTY (120) CALENDAR DAYS AFTER THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, RECEIVED THE INSURER'S BENEFIT DETERMINATION NOTICE. THE INTERNAL APPEAL SHALL BE CONSIDERED BY AN INDIVIDUAL OR GROUP OF INDIVIDUALS DESIGNATED BY THE INSURER PROVIDED THE INDIVIDUAL MAKING THE INTERNAL APPEAL DECISION MAY NOT BE THE SAME INDIVIDUAL WHO MADE THE INITIAL BENEFIT DETERMINATION. THE INTERNAL APPEAL SHALL BE COMPLETED AND WRITTEN NOTICE OF THE INTERNAL APPEAL DECISION

SHALL BE SENT TO THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, WITHIN THIRTY (30) CALENDAR DAYS OF THE INSURER'S RECEIPT OF THE NECESSARY INFORMATION UPON WHICH A FINAL DETERMINATION CAN BE MADE AND THE FOLLOWING SHALL APPLY:

(1) IF THE INSURER'S ORIGINAL DETERMINATION IS UPHELD UPON INTERNAL APPEAL, THE NOTICE OF THE INTERNAL APPEAL DECISION SHALL DESCRIBE THE ADDITIONAL INTERNAL APPEAL RIGHTS OFFERED BY THE INSURER. NOTHING IN THIS SECTION SHALL REQUIRE THE INSURER TO OFFER INTERNAL APPEAL RIGHTS OTHER THAN THOSE DESCRIBED IN THIS SUBSECTION.

(2) IF THE INSURER'S ORIGINAL DETERMINATION IS UPHELD AFTER THE INTERNAL APPEAL PROCESS HAS BEEN EXHAUSTED AND NEW OR ADDITIONAL INFORMATION HAS NOT BEEN PROVIDED TO THE INSURER, THE INSURER SHALL PROVIDE A WRITTEN DESCRIPTION OF THE INSURED'S RIGHT TO REQUEST AN INDEPENDENT REVIEW OF THE BENEFIT DETERMINATION AS DESCRIBED IN SUBSECTION (D) TO THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE.

(3) AS PART OF THE WRITTEN DESCRIPTION OF THE INSURED'S RIGHT TO REQUEST AN INDEPENDENT REVIEW, AN INSURER SHALL INCLUDE THE FOLLOWING OR SUBSTANTIALLY EQUIVALENT LANGUAGE:

WE HAVE DETERMINED THAT THE BENEFIT ELIGIBILITY CRITERIA ("BENEFIT TRIGGER") OF YOUR (POLICY) (CERTIFICATE) HAS NOT BEEN MET. YOU MAY HAVE THE RIGHT TO AN INDEPENDENT REVIEW OF OUR DECISION CONDUCTED BY LONG-TERM CARE PROFESSIONALS WHO ARE NOT ASSOCIATED WITH US. PLEASE SEND A WRITTEN REQUEST FOR INDEPENDENT REVIEW TO US AT (ADDRESS). YOU MUST INFORM US, IN WRITING, OF YOUR ELECTION TO HAVE THIS DECISION REVIEWED WITHIN 120 DAYS OF RECEIPT OF THIS LETTER. LISTED BELOW ARE THE NAMES AND CONTACT INFORMATION OF THE INDEPENDENT REVIEW ORGANIZATIONS APPROVED OR CERTIFIED BY YOUR STATE INSURANCE

DEPARTMENT'S OFFICE TO CONDUCT LONG-TERM CARE INSURANCE BENEFIT ELIGIBILITY REVIEWS. IF YOU WISH TO REQUEST AN INDEPENDENT REVIEW, PLEASE CHOOSE ONE OF THE LISTED ORGANIZATIONS AND INCLUDE ITS NAME WITH YOUR REQUEST FOR INDEPENDENT REVIEW. IF YOU ELECT INDEPENDENT REVIEW, BUT DO NOT CHOOSE AN INDEPENDENT REVIEW ORGANIZATION WITH YOUR REQUEST, WE WILL CHOOSE ONE OF THE INDEPENDENT REVIEW ORGANIZATIONS FOR YOU AND REFER THE REQUEST FOR INDEPENDENT REVIEW TO IT.

(4) IF THE INSURER DOES NOT BELIEVE THE BENEFIT TRIGGER DECISION IS ELIGIBLE FOR INDEPENDENT REVIEW, THE INSURER SHALL INFORM THE INSURED, THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, AND THE DEPARTMENT IN WRITING AND INCLUDE IN THE NOTICE THE REASONS FOR ITS DETERMINATION OF INDEPENDENT REVIEW INELIGIBILITY.

(5) THE APPEAL PROCESS DESCRIBED IN THIS SUBSECTION DOES NOT INCLUDE A NOTICE REQUIREMENT AS TO THE AVAILABILITY OF NEW LONG-TERM CARE SERVICES OR PROVIDERS.

(D) (1) THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE MAY REQUEST AN INDEPENDENT REVIEW OF THE INSURER'S BENEFIT TRIGGER DETERMINATION AFTER THE INTERNAL APPEAL PROCESS OUTLINED IN SUBSECTION (C) HAS BEEN EXHAUSTED. A WRITTEN REQUEST FOR INDEPENDENT REVIEW MAY BE MADE BY THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE TO THE INSURER WITHIN ONE HUNDRED TWENTY (120) CALENDAR DAYS AFTER THE INSURER'S WRITTEN NOTICE OF THE FINAL INTERNAL APPEAL DECISION IS RECEIVED BY THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE.

(2) THE COST OF THE INDEPENDENT REVIEW SHALL BE BORNE BY THE INSURER.

(3) (I) WITHIN FIVE (5) BUSINESS DAYS OF RECEIVING A WRITTEN REQUEST FOR INDEPENDENT REVIEW, THE INSURER SHALL REFER THE REQUEST TO THE INDEPENDENT REVIEW ORGANIZATION THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE HAS CHOSEN FROM THE LIST OF CERTIFIED OR APPROVED ORGANIZATIONS THE INSURER HAS PROVIDED TO THE INSURED. IF THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE DOES NOT CHOOSE AN APPROVED INDEPENDENT REVIEW ORGANIZATION TO PERFORM THE REVIEW, THE INSURER SHALL CHOOSE AN INDEPENDENT REVIEW ORGANIZATION APPROVED OR CERTIFIED BY THE COMMONWEALTH. THE INSURER SHALL VARY ITS SELECTION OF AUTHORIZED INDEPENDENT REVIEW ORGANIZATIONS ON A ROTATING BASIS.

(II) THE INSURER SHALL REFER THE REQUEST FOR INDEPENDENT REVIEW OF A BENEFIT TRIGGER DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION, SUBJECT TO THE FOLLOWING:

(A) THE INDEPENDENT REVIEW ORGANIZATION SHALL BE ON A LIST OF CERTIFIED OR APPROVED INDEPENDENT REVIEW ORGANIZATIONS THAT SATISFY THE REQUIREMENTS OF A QUALIFIED LONG-TERM CARE INSURANCE INDEPENDENT REVIEW ORGANIZATION CONTAINED IN THIS SECTION.

(B) THE INDEPENDENT REVIEW ORGANIZATION SHALL NOT HAVE ANY CONFLICTS OF INTEREST WITH THE INSURED, THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, OR THE INSURER.

(C) THE REVIEW SHALL BE LIMITED TO THE INFORMATION OR DOCUMENTATION PROVIDED TO AND CONSIDERED BY THE INSURER IN MAKING ITS DETERMINATION, INCLUDING ANY INFORMATION OR DOCUMENTATION CONSIDERED AS PART OF THE INTERNAL APPEAL PROCESS.

(III) IF THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE HAS NEW OR ADDITIONAL INFORMATION NOT PREVIOUSLY PROVIDED TO THE INSURER, WHETHER SUBMITTED TO THE INSURER OR THE INDEPENDENT REVIEW ORGANIZATION, THE INFORMATION SHALL FIRST BE

CONSIDERED IN THE INTERNAL REVIEW PROCESS, AS SET FORTH IN SUBSECTION (C).

(A) WHILE THIS INFORMATION IS BEING REVIEWED BY THE INSURER, THE INDEPENDENT REVIEW ORGANIZATION SHALL SUSPEND ITS REVIEW AND THE TIME PERIOD FOR REVIEW IS SUSPENDED UNTIL THE INSURER COMPLETES ITS REVIEW.

(B) THE INSURER SHALL COMPLETE ITS REVIEW OF THE INFORMATION AND PROVIDE WRITTEN NOTICE OF THE RESULTS OF THE REVIEW TO THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, AND THE INDEPENDENT REVIEW ORGANIZATION WITHIN FIVE (5) BUSINESS DAYS OF THE INSURER'S RECEIPT OF THE NEW OR ADDITIONAL INFORMATION.

(C) IF THE INSURER MAINTAINS ITS DENIAL AFTER SUCH REVIEW, THE INDEPENDENT REVIEW ORGANIZATION SHALL CONTINUE ITS REVIEW AND RENDER ITS DECISION WITHIN THE TIME PERIOD SPECIFIED IN SUBPARAGRAPH (IX). IF THE INSURER OVERTURNS ITS DECISION FOLLOWING ITS REVIEW, THE INDEPENDENT REVIEW REQUEST SHALL BE CONSIDERED WITHDRAWN.

(IV) THE INSURER SHALL ACKNOWLEDGE IN WRITING TO THE INSURED, THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, AND THE DEPARTMENT THE REQUEST FOR INDEPENDENT REVIEW HAS BEEN RECEIVED, ACCEPTED AND FORWARDED TO AN INDEPENDENT REVIEW ORGANIZATION FOR REVIEW. THE NOTICE WILL INCLUDE THE NAME AND ADDRESS OF THE INDEPENDENT REVIEW ORGANIZATION.

(V) WITHIN FIVE (5) BUSINESS DAYS OF RECEIPT OF THE REQUEST FOR INDEPENDENT REVIEW, THE INDEPENDENT REVIEW ORGANIZATION ASSIGNED UNDER THIS PARAGRAPH SHALL NOTIFY THE INSURED AND THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, THE INSURER AND THE DEPARTMENT IT HAS ACCEPTED THE INDEPENDENT REVIEW REQUEST AND IDENTIFY THE TYPE OF LICENSED HEALTH CARE

PROFESSIONAL ASSIGNED TO THE REVIEW. THE ASSIGNED INDEPENDENT REVIEW ORGANIZATION SHALL INCLUDE IN THE NOTICE A STATEMENT THE INSURED OR INSURED'S AUTHORIZED REPRESENTATIVE MAY SUBMIT IN WRITING TO THE INDEPENDENT REVIEW ORGANIZATION WITHIN SEVEN (7) DAYS FOLLOWING THE DATE OF RECEIPT OF THE NOTICE ADDITIONAL INFORMATION AND SUPPORTING DOCUMENTATION THE INDEPENDENT REVIEW ORGANIZATION SHOULD CONSIDER WHEN CONDUCTING ITS REVIEW.

(VI) THE INDEPENDENT REVIEW ORGANIZATION SHALL REVIEW ALL OF THE INFORMATION AND DOCUMENTS RECEIVED UNDER SUBPARAGRAPH (V) THAT HAVE BEEN PROVIDED TO THE INDEPENDENT REVIEW ORGANIZATION. THE INDEPENDENT REVIEW ORGANIZATION SHALL PROVIDE COPIES OF THE DOCUMENTATION OR INFORMATION PROVIDED BY THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE TO THE INSURER FOR ITS REVIEW IF IT IS NOT PART OF THE INFORMATION OR DOCUMENTATION SUBMITTED BY THE INSURER TO THE INDEPENDENT REVIEW ORGANIZATION. THE INSURER SHALL REVIEW THE INFORMATION AND PROVIDE ITS ANALYSIS OF THE NEW INFORMATION UNDER SUBPARAGRAPH (VIII).

(VII) THE INSURED OR THE INSURED'S AUTHORIZED REPRESENTATIVE MAY SUBMIT, AT ANY TIME, NEW OR ADDITIONAL INFORMATION NOT PREVIOUSLY PROVIDED TO THE INSURER BUT PERTINENT TO THE BENEFIT TRIGGER DENIAL. THE INSURER SHALL CONSIDER THE INFORMATION AND AFFIRM OR OVERTURN ITS BENEFIT TRIGGER DETERMINATION. IF THE INSURER AFFIRMS ITS BENEFIT TRIGGER DETERMINATION, THE INSURER SHALL PROMPTLY PROVIDE THE NEW OR ADDITIONAL INFORMATION TO THE INDEPENDENT REVIEW ORGANIZATION FOR ITS REVIEW ALONG WITH THE INSURER'S ANALYSIS OF THE INFORMATION.

(VIII) IF THE INSURER OVERTURNS ITS BENEFIT TRIGGER DETERMINATION:

(A) THE INSURER SHALL PROVIDE NOTICE TO THE INDEPENDENT REVIEW ORGANIZATION AND THE INSURED, THE INSURED'S AUTHORIZED

REPRESENTATIVE, IF APPLICABLE, AND THE COMMISSIONER OF ITS DECISION.

(B) THE INDEPENDENT REVIEW PROCESS SHALL IMMEDIATELY CEASE.

(IX) THE INDEPENDENT REVIEW ORGANIZATION SHALL PROVIDE THE INSURED, THE INSURED'S AUTHORIZED REPRESENTATIVE, IF APPLICABLE, THE INSURER AND THE DEPARTMENT WRITTEN NOTICE OF ITS DECISION WITHIN THIRTY (30) CALENDAR DAYS FROM RECEIPT OF THE REFERRAL REFERENCED IN PARAGRAPH (3)(II). IF THE INDEPENDENT REVIEW ORGANIZATION OVERTURNS THE INSURER'S DECISION, IT SHALL:

(A) ESTABLISH THE PRECISE DATE WITHIN THE SPECIFIC PERIOD OF TIME UNDER REVIEW THE BENEFIT TRIGGER WAS DEEMED TO HAVE BEEN MET.

(B) SPECIFY THE SPECIFIC PERIOD OF TIME UNDER REVIEW FOR WHICH THE INSURER DECLINED ELIGIBILITY, BUT DURING WHICH THE INDEPENDENT REVIEW ORGANIZATION DEEMED THE BENEFIT TRIGGER TO HAVE BEEN MET.

(C) FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS, PROVIDE A CERTIFICATION THE INSURED IS A CHRONICALLY ILL INDIVIDUAL. THE CERTIFICATION SHALL BE MADE ONLY BY A LICENSED HEALTH CARE PRACTITIONER AS DEFINED IN SECTION 7702B(C)(4) OF THE INTERNAL REVENUE CODE OF 1986 (PUBLIC LAW 99-514, 26 U.S.C. § 7702B(C)(4)).

(X) THE DECISION OF THE INDEPENDENT REVIEW ORGANIZATION REGARDING WHETHER THE INSURED MET THE BENEFIT TRIGGER SHALL BE SUBJECT TO APPEAL TO A COURT OF COMPETENT JURISDICTION WITHIN SIXTY (60) DAYS OF RECEIPT OF NOTICE OF THE INDEPENDENT REVIEW ORGANIZATION'S DECISION. THERE SHALL BE A REBUTTABLE PRESUMPTION IN FAVOR OF THE DECISION OF THE INDEPENDENT REVIEW ORGANIZATION.

(XI) THE INDEPENDENT REVIEW ORGANIZATION'S DETERMINATION SHALL BE USED SOLELY TO ESTABLISH LIABILITY FOR BENEFIT TRIGGER

DECISIONS AND IS INTENDED TO BE ADMISSIBLE IN A PROCEEDING ONLY TO THE EXTENT IT ESTABLISHES THE ELIGIBILITY OF BENEFITS PAYABLE.

(XII) NOTHING IN THIS SECTION SHALL RESTRICT THE INSURED'S RIGHT TO SUBMIT A NEW REQUEST FOR BENEFIT TRIGGER DETERMINATION AFTER THE INDEPENDENT REVIEW DECISION, IF THE INDEPENDENT REVIEW ORGANIZATION UPHOLDS THE INSURER'S DECISION.

(XIII) THE DEPARTMENT SHALL UTILIZE THE CRITERIA ESTABLISHED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS FOR ITS GUIDELINES FOR LONG-TERM CARE INDEPENDENT REVIEW ENTITIES IN CERTIFYING ENTITIES TO REVIEW LONG-TERM CARE INSURANCE BENEFIT TRIGGER DECISIONS.

(XIV) THE DEPARTMENT SHALL ACCEPT ANOTHER STATE'S CERTIFICATION OF AN INDEPENDENT REVIEW ORGANIZATION, PROVIDED THE STATE REQUIRES THE INDEPENDENT REVIEW ORGANIZATION TO MEET SUBSTANTIALLY SIMILAR QUALIFICATIONS AS THOSE ESTABLISHED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

(XV) THE DEPARTMENT SHALL MAINTAIN AND PERIODICALLY UPDATE A LIST OF APPROVED INDEPENDENT REVIEW ORGANIZATIONS.

(E) THE DEPARTMENT SHALL CERTIFY OR APPROVE A QUALIFIED LONG-TERM CARE INSURANCE INDEPENDENT REVIEW ORGANIZATION, PROVIDED THE INDEPENDENT REVIEW ORGANIZATION DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER THAT IT IS UNBIASED AND MEETS THE FOLLOWING QUALIFICATIONS:

(1) HAS ON STAFF OR CONTRACTS WITH A QUALIFIED AND LICENSED HEALTH CARE PROFESSIONAL IN AN APPROPRIATE FIELD, SUCH AS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, NEUROLOGY, PHYSICAL MEDICINE OR REHABILITATION, FOR DETERMINING AN INSURED'S FUNCTIONAL OR COGNITIVE IMPAIRMENT TO CONDUCT THE REVIEW.

(2) SHALL NOT BE RELATED TO OR AFFILIATED WITH AN ENTITY

PREVIOUSLY PROVIDING MEDICAL CARE TO THE INSURED.

(3) UTILIZES A LICENSED HEALTH CARE PROFESSIONAL WHO IS NOT AN EMPLOYE OF THE INSURER OR RELATED TO THE INSURED.

(4) SHALL NOT RECEIVE COMPENSATION OF ANY TYPE THAT IS DEPENDENT ON THE OUTCOME OF THE REVIEW AND SHALL NOT UTILIZE A LICENSED HEALTH CARE PROFESSIONAL WHO RECEIVES COMPENSATION OF ANY TYPE THAT IS DEPENDENT ON THE OUTCOME OF THE REVIEW.

(5) IS APPROVED OR CERTIFIED BY THE COMMONWEALTH TO CONDUCT THE REVIEWS IF THE COMMONWEALTH REQUIRES THE APPROVALS OR CERTIFICATIONS.

(6) PROVIDES A DESCRIPTION OF THE FEES TO BE CHARGED BY IT FOR INDEPENDENT REVIEWS OF A LONG-TERM CARE INSURANCE BENEFIT TRIGGER DECISION. THE FEES SHALL BE REASONABLE AND CUSTOMARY FOR THE TYPE OF LONG-TERM CARE INSURANCE BENEFIT TRIGGER DECISION UNDER REVIEW.

(7) PROVIDES THE NAME OF THE MEDICAL DIRECTOR OR HEALTH CARE PROFESSIONAL RESPONSIBLE FOR THE SUPERVISION AND OVERSIGHT OF THE INDEPENDENT REVIEW PROCEDURE.

(8) HAS ON STAFF OR CONTRACTS WITH A LICENSED HEALTH CARE PRACTITIONER AS DEFINED UNDER SECTION 7702B(C)(4) OF THE INTERNAL REVENUE CODE OF 1986 WHO IS QUALIFIED TO CERTIFY THAT AN INDIVIDUAL IS CHRONICALLY ILL FOR PURPOSES OF A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.

(F) EACH CERTIFIED INDEPENDENT REVIEW ORGANIZATION SHALL COMPLY WITH THE FOLLOWING:

(1) MAINTAIN WRITTEN DOCUMENTATION ESTABLISHING THE DATE IT RECEIVES A REQUEST FOR INDEPENDENT REVIEW, THE DATE EACH REVIEW IS CONDUCTED, THE RESOLUTION, THE DATE THE RESOLUTION WAS COMMUNICATED TO THE INSURER AND THE INSURED, THE NAME AND PROFESSIONAL STATUS OF THE REVIEWER CONDUCTING THE REVIEW IN AN

EASILY ACCESSIBLE AND RETRIEVABLE FORMAT FOR THE YEAR IN WHICH IT RECEIVED THE INFORMATION PLUS TWO CALENDAR YEARS.

(2) BE ABLE TO DOCUMENT MEASURES TAKEN TO APPROPRIATELY SAFEGUARD THE CONFIDENTIALITY OF THE RECORDS AND PREVENT UNAUTHORIZED USE AND DISCLOSURES UNDER APPLICABLE FEDERAL AND STATE LAW.

(3) REPORT ANNUALLY TO THE DEPARTMENT BY JUNE 1 IN THE AGGREGATE AND FOR EACH LONG-TERM CARE INSURER THE FOLLOWING:

(I) THE TOTAL NUMBER OF REQUESTS RECEIVED FOR INDEPENDENT REVIEW OF LONG-TERM CARE BENEFIT TRIGGER DECISIONS.

(II) THE TOTAL NUMBER OF REVIEWS CONDUCTED AND THE RESOLUTION OF THE REVIEWS SUCH AS THE NUMBER OF REVIEWS THAT UPHELD OR OVERTURNED THE LONG-TERM CARE INSURER'S DETERMINATION THE BENEFIT TRIGGER WAS NOT MET.

(III) THE NUMBER OF REVIEWS WITHDRAWN PRIOR TO REVIEW.

(IV) THE PERCENTAGE OF REVIEWS CONDUCTED WITHIN THE PRESCRIBED TIMEFRAME SET FORTH IN SUBSECTION (C)(3).

(V) THE OTHER INFORMATION THE DEPARTMENT MAY REQUIRE.

(4) REPORT IMMEDIATELY TO THE DEPARTMENT A CHANGE IN ITS STATUS WHICH WOULD CAUSE IT TO CEASE MEETING A QUALIFICATION REQUIRED OF AN INDEPENDENT REVIEW ORGANIZATION PERFORMING INDEPENDENT REVIEWS OF LONG-TERM CARE BENEFIT TRIGGER DECISIONS.

(G) NOTHING IN THIS SECTION SHALL LIMIT THE ABILITY OF AN INSURER TO ASSERT RIGHTS AN INSURER MAY HAVE UNDER THE POLICY RELATED TO:

(1) AN INSURED'S MISREPRESENTATION.

(2) CHANGES IN THE INSURED'S BENEFIT ELIGIBILITY.

(3) TERMS, CONDITIONS AND EXCLUSIONS OF THE POLICY OTHER THAN FAILURE TO MEET THE BENEFIT TRIGGER.

(H) THE DEPARTMENT SHALL COMPILE AND MAINTAIN A LIST OF

CERTIFIED, QUALIFIED LONG-TERM CARE INSURANCE INDEPENDENT REVIEW ORGANIZATIONS AND SHALL PUBLISH THE LIST ON ITS INTERNET WEBSITE AND ANNUALLY IN THE PENNSYLVANIA BULLETIN BY JULY 1.

(I) THIS SECTION SHALL NOT APPLY TO LONG-TERM CARE INSURANCE CLAIMS MADE UNDER A GROUP LONG-TERM CARE INSURANCE POLICY THAT IS GOVERNED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (PUBLIC LAW 93-406, 88 STAT. 829), REFERRED TO AS ERISA.

SECTION 1111.2. PROMPT PAYMENT OF CLEAN CLAIMS.--(A) WITHIN THIRTY (30) BUSINESS DAYS AFTER RECEIPT OF A CLAIM FOR BENEFITS UNDER A LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE, AN INSURER SHALL PAY THE CLAIM IF IT IS A CLEAN CLAIM OR SEND A WRITTEN NOTICE ACKNOWLEDGING THE DATE OF RECEIPT OF THE CLAIM AND ONE OF THE FOLLOWING:

(1) THE INSURER IS DECLINING TO PAY ALL OR PART OF THE CLAIM AND THE SPECIFIC REASON FOR DENIAL; OR

(2) ADDITIONAL INFORMATION IS NECESSARY TO DETERMINE IF ALL OR PART OF THE CLAIM IS PAYABLE AND THE SPECIFIC ADDITIONAL INFORMATION THAT IS NECESSARY.

(B) WITHIN THIRTY (30) BUSINESS DAYS AFTER RECEIPT OF THE REQUESTED ADDITIONAL INFORMATION, AN INSURER SHALL PAY A CLAIM FOR BENEFITS UNDER A LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE IF IT IS A CLEAN CLAIM OR SEND A WRITTEN NOTICE THE INSURER IS DECLINING TO PAY ALL OR PART OF A CLAIM AND THE SPECIFIC REASON OR REASONS FOR DENIAL.

(C) IF AN INSURER FAILS TO COMPLY WITH SUBSECTION (A) OR (B), THE INSURER SHALL PAY INTEREST AT THE RATE OF ONE PER CENTUM (1%) PER MONTH ON THE AMOUNT OF THE CLAIM THAT SHOULD HAVE BEEN PAID BUT REMAINS UNPAID FORTY-FIVE (45) BUSINESS DAYS AFTER THE RECEIPT OF THE CLAIM WITH RESPECT TO SUBSECTION (A) OR ALL REQUESTED ADDITIONAL INFORMATION WITH RESPECT TO SUBSECTION

(B). THE INTEREST PAYABLE UNDER THIS SUBSECTION SHALL BE INCLUDED IN A LATE REIMBURSEMENT WITHOUT REQUIRING THE PERSON WHO FILED THE ORIGINAL CLAIM TO MAKE AN ADDITIONAL CLAIM FOR THE INTEREST.

(D) THE PROVISIONS OF THIS SECTION SHALL NOT APPLY TO WHERE THE INSURER HAS REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMATION THE CLAIM WAS FRAUDULENTLY SUBMITTED.

(E) A VIOLATION OF SECTION 1111.1 OR THIS SECTION BY AN INSURER IF COMMITTED FLAGRANTLY AND IN CONSCIOUS DISREGARD OF THE PROVISIONS OF THIS ACT OR WITH FREQUENCY SUFFICIENT TO CONSTITUTE A GENERAL BUSINESS PRACTICE SHALL BE CONSIDERED A VIOLATION OF THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS THE "UNFAIR INSURANCE PRACTICES ACT." A VIOLATION OF SECTION 1111.1 OR THIS SECTION IS DEEMED AN UNFAIR METHOD OF COMPETITION AND AN UNFAIR DECEPTIVE ACT OR PRACTICE PURSUANT TO THE "UNFAIR INSURANCE PRACTICES ACT."

(F) AS USED IN THIS SECTION THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SUBSECTION:

"CLAIM" MEANS A REQUEST FOR PAYMENT OF BENEFITS UNDER A POLICY IN EFFECT REGARDLESS OF WHETHER THE BENEFIT CLAIMED IS COVERED UNDER THE POLICY OR TERMS OR CONDITIONS OF THE POLICY HAVE BEEN MET.

"CLEAN CLAIM" MEANS A CLAIM THAT HAS NO DEFECT OR IMPROPRIETY, INCLUDING ANY LACK OF REQUIRED SUBSTANTIATING DOCUMENTATION, SUCH AS SATISFACTORY EVIDENCE OF EXPENSES INCURRED, OR A PARTICULAR CIRCUMSTANCE REQUIRING SPECIAL TREATMENT THAT PREVENTS TIMELY PAYMENT FROM BEING MADE ON THE CLAIM.

SECTION 3. THE PROVISIONS OF THIS ACT SHALL APPLY TO BENEFIT TRIGGER REQUESTS MADE ON OR AFTER 60 DAYS AFTER THE EFFECTIVE

DATE OF THIS ACT.

Section ~~6~~ 4. This act shall take effect in 60 days.