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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

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INTRODUCED BY FABRIZIO, DeLUCA, SONNEY, COHEN, V. BROWN, CALTAGIRONE, D. COSTA, GEORGE, HALUSKA, HARKINS, HORNAMAN, JOSEPHS, KIRKLAND, KORTZ, KOTIK, KULA, LONGIETTI, MATZIE, MUNDY, MURT, M. O'BRIEN, READSHAW, SANTARSIERO, SANTONI, K. SMITH, STABACK AND WAGNER, APRIL 5, 2011

REFERRED TO COMMITTEE ON INSURANCE, APRIL 5, 2011

AN ACT

Providing for health carrier grievance procedures; and imposing penalties.

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

Section 1. Short title.

This act shall be known and may be cited as the Health Carrier Grievance Procedure Act.

Section 2. Purpose and intent.

The purpose of this act is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this act.

Section 3. Definitions.

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

"Adverse determination." The term means:

(1) a determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or

made, in whole or in part, for the benefit;

(2) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(3) any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

The term shall include a rescission of coverage determination.

"Ambulatory review." Utilization review of health care services performed or provided in an outpatient setting.

"Authorized representative." The term means:

(1) a person to whom a covered person has given express written consent to represent the covered person for purposes of this act;

(2) a person authorized by law to provide substituted consent for a covered person;

(3) a family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) a health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(5) in the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

"Case management." A coordinated set of activities conducted

for individual patient management of serious, complicated, protracted or other health conditions.

"Certification." A determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

"Clinical peer." A physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

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

"Closed plan." A managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Concurrent review." A utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

"Covered benefits" or "benefits." Those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person." A policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

"Department." The Insurance Department of the Commonwealth.

"Discharge planning." The formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

"Emergency medical condition." The sudden and, at the time, unexpected onset of a health condition or a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that requires the absence of immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

"Emergency services." With respect to an emergency medical condition, health care items and services furnished or required to evaluate and treat an emergency medical condition:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.

(2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

"Facility." An institution providing health care services or

a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

"Final adverse determination." An adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under section 7 or 10 or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 6(a)(2).

"Grievance." A written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(1) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) claims payment, handling or reimbursement for health care services; or

(3) matters pertaining to the contractual relationship between a covered person and a health carrier.

"Health benefit plan."

(1) A policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. The term includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. The term does not include:

(i) Coverage only for accident or disability income

insurance or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for onsite medical clinics.

(viii) Other similar insurance coverage, specified in Federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) The term does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof.

(iii) Other similar, limited benefits specified in Federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996.

(3) The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any

exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance.

(4) The term does not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.);

(ii) coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

(iii) similar supplemental coverage provided to coverage under a group health plan.

"Health care professional." A physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with State law.

"Health care provider" or "provider." A health care professional or a facility.

"Health care services." Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

"Health carrier." A company or health insurance entity licensed in this Commonwealth to offer or issue any individual or group health, sickness or accident policy or subscriber

contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is governed under this act or any of the following:

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

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(4) Article XXIV of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Health indemnity plan." A health benefit plan that is not a managed care plan.

"Managed care plan." A health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. The term includes:

(1) A closed plan, as defined in this section.

(2) An open plan, as defined in this section.

"Network." The group of participating providers providing services to a managed care plan.

"Open plan." A managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

"Participating provider." A provider who, under a contract

with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

"Person." An individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

"Prospective review." The utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

"Rescission." A cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. The term does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(1) the cancellation or discontinuance of coverage has only a prospective effect; or

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

"Retrospective review." Any review of a request for a benefit that is not a prospective review request. The term does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

"Second opinion." An opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally

making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

"Stabilized." With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur before an individual can be transferred, during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman delivered, including the placenta.

"Urgent care request."

(1) A request for a health care service or course of treatment with respect to which the time periods for making nonurgent care request determination:

(i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(2) (i) Except as provided in subparagraph (ii), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of paragraph (1)

shall be treated as an urgent care request.

"Utilization review." A set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

"Utilization review organization." An entity that conducts a utilization review other than a health carrier performing a utilization review for its own health benefit plans.

Section 4. Applicability and scope.

Except as otherwise specified, this act shall apply to all health carriers offering a health benefit plan.

Section 5. Grievance reporting and recordkeeping requirements.

(a) Records.--

(1) A health carrier shall maintain written records to document all grievances received, including the notices and claims associated with the grievances, during a calendar year in the register.

(2) Notwithstanding the provisions under subsection (f), a health carrier shall maintain the records required under paragraph (1) for at least six years related to the notices provided under sections 7(h) and 10(h).

(3) The health carrier shall make the records available for examination by covered persons, the department and the appropriate Federal oversight agency upon request.

(b) Review request.--A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with section 7 but is not required to be included

in the register.

(c) Voluntary review.--A request for an additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to section 9 shall be included in the register.

(d) Register.--For each grievance the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the grievance, if applicable.

(5) The date of resolution at each level, if applicable.

(6) The name of the covered person for whom the grievance was filed.

(e) Maintenance.--The register shall be maintained in a manner that is reasonably clear and accessible to the department.

(f) Report.--

(1) Subject to the provisions of subsection (a), a health carrier shall retain the register compiled for a calendar year for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

(2) (i) A health carrier shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(ii) The report shall include for each type of health benefit plan offered by the health carrier:

(A) The certificate of compliance required by section 6.

(B) The number of covered lives.

(C) The total number of grievances.

(D) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to section 9.

(E) The number of grievances resolved at each level, if applicable, and their resolution.

(F) The number of grievances appealed to the commissioner of which the health carrier has been informed.

(G) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation.

(H) A synopsis of actions being taken to correct problems identified.

Section 6. Grievance review procedures.

(a) General rule.--

(1) Except as specified in section 10, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in sections 7, 8 and 9.

(2) Whenever a health carrier fails to strictly adhere to the requirements of section 7 or 10, with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this act and may take action

under subsection (b) regardless of whether the health carrier asserts that it substantially complied with the requirements of section 7 or 10, as applicable, or that any error it committed was de minimus.

(b) External review and remedies.--

(1) A covered person may file a request for external review.

(2) In addition to paragraph (1), a covered person is entitled to pursue any available remedies under Federal or State law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(c) Procedures.--

(1) A health carrier shall file a copy of the procedures required under subsection (a), including all forms used to process requests made pursuant to sections 7, 8 and 9, with the department. Any subsequent material modifications to the documents also shall be filed.

(2) The department may disapprove a filing received in accordance with paragraph (1) that fails to comply with this act or applicable regulations.

(d) Certificate of compliance.--In addition to subsection (b), a health carrier shall file annually with the department, as part of its annual report required by section 5, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this act.

(e) Description of procedures.--A description of the grievance procedures required under this section shall be set

forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

Section 7. First level reviews of grievances involving adverse determination.

(a) General rule.--Within 180 days after the date of receipt of a notice of an adverse determination, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination.

(b) Coordinator of review.--

(1) The health carrier shall provide the covered person with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier.

(2) (i) In providing for a first level review under this section, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the first level review decision.

(ii) In ensuring the independence and impartially of individuals involved in making the first level review decision, the health carrier shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

(c) Utilization review.--

(1) (i) In the case of an adverse determination involving utilization review, the health carrier shall

designate an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer shall not have been involved in the initial adverse determination.

(ii) In designating an appropriate clinical peer or peers pursuant to subparagraph (i), the health carrier shall ensure that, if more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

(2) In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person or the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

(d) Covered person's rights.--

(1) A covered person does not have the right to attend, or to have a representative in attendance, at the first level review, but the covered person or, if applicable, the covered person's authorized representative is entitled to:

(i) Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review.

(ii) Receive from the health carrier, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to

the covered person's request for benefits.

(2) For purposes of paragraph (1)(ii), a document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:

(i) Was relied upon in making the benefit determination.

(ii) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination.

(iii) Demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons.

(iv) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

(3) The health carrier shall make the provisions of paragraph (1) known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receipt of the grievance.

(f) Decision.--

(1) A health carrier shall notify and issue a decision

in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the time frames provided in paragraph (2) or (3).

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than 30 days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to subsection (a).

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than 60 days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to subsection (a).

(g) Additional evidence.--

(1) Prior to issuing a decision in accordance with the time frames provided in subsection (f), the health carrier shall provide free of charge to covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

(2) Before the health carrier issues or provides notice of a final adverse determination in accordance with the time frames provided in subsection (f) that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

(h) Manner of decision.--The decision issued pursuant to subsection (f) shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative:

(1) The titles and qualifying credentials of the person or persons participating in the first level review process.

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

(3) A statement of the reviewers' understanding of the covered person's grievance.

(4) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position.

(5) A reference to the evidence or documentation used as the basis for the decision.

(6) For a first level review decision issued pursuant to subsection (f) involving an adverse determination that upholds the grievance:

(i) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial.

(ii) The reference to the specific plan provisions on which the determination is based.

(iii) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is used in subsection (d)(2), to the covered person's benefit request.

(iv) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request.

(v) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for

making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request.

(vi) If applicable, instructions for requesting:

(A) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination, as provided in paragraph (4).

(B) The written statement of the scientific or clinical rationale for the determination, as provided in subsection (f)(1).

(vii) If applicable, a statement indicating:

(A) A description of the process to obtain an additional voluntary review of the first level review decision involving an adverse determination, if the covered person wishes to request a voluntary review pursuant to section 9.

(B) The written procedures governing the voluntary review, including any required time frame for the review.

(C) A description of the procedures for obtaining an independent external review of the final adverse determination if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination.

(D) The covered person's right to bring a civil action in a court of competent jurisdiction.

(viii) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."

(ix) Notice of the covered person's right to contact the department's Bureau of Consumer Services for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the department's Bureau of Consumer Services.

(i) Appropriate notice.--

(1) A health carrier shall provide the notice required under subsection (h) in a culturally and linguistically appropriate manner if required in accordance with Federal regulations.

(2) If a health carrier is required to provide the notice required under this subsection in a culturally and linguistically appropriate manner in accordance with Federal regulations, the health carrier shall:

(i) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language.

(ii) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language.

(iii) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing

claims and appeals, the health carrier shall provide this assistance in the non-English language.

Section 8. Standard reviews of grievances not involving adverse determination.

(a) General rule.--A health carrier shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

(b) Procedures.--

(1) The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under this section.

(2) (i) A covered person does not have the right to attend, or to have a representative in attendance at the standard review, but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection (c) to consider when conducting the review.

(ii) The health carrier shall make the provisions of subparagraph (i) known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receiving the grievance.

(c) Standard review.--

(1) Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance.

(2) The health carrier shall not designate the same person or persons to conduct the standard review of the

grievance that denied the claim or handled the matter that is the subject of the grievance.

(3) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

(d) Notification.--

(1) The health carrier shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision within 20 working days after the date of receipt of the request for a standard review of a grievance filed pursuant to subsection (b).

(2) (i) Subject to subparagraph (ii), if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notify the covered person or, if applicable, the covered person's authorized representative pursuant to paragraph (1) within 20 working days, the health carrier may take up to an additional ten working days to issue a written decision.

(ii) A health carrier may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with subparagraph (i) if, on or before the 20th working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or, if applicable, the covered person's authorized representative of the extension and the reasons for the delay.

(e) Written decision.--The written decision issued pursuant to subsection (d) shall contain:

(1) The titles and qualifying credentials of the person or persons participating in the standard review process.

(2) A statement of the reviewers' understanding of the covered person's grievance.

(3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health carrier's position.

(4) A reference to the evidence or documentation used as the basis for the decision.

(5) If applicable, a statement indicating:

(i) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to section 9.

(ii) The written procedures governing the voluntary review, including any required time frame for the review.

(6) Notice of the covered person's right, at any time, to contact the department, including the telephone number and address of the department.

Section 9. Voluntary level of reviews of grievances.

(a) General rule.--

(1) A health carrier that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons who are dissatisfied with the first level review decision made pursuant to section 7, or who are dissatisfied with the standard review decision made pursuant to section 8, the option to request an additional voluntary review, at which the covered person or

the covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier.

(2) This section shall not apply to health indemnity plans.

(b) Notice.--

(1) A health carrier required by this section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice, as appropriate, of the option to file a request with the health carrier for an additional voluntary review of the first level review decision received under section 7 or the standard review decision received under section 8.

(2) Upon receipt of a request for an additional voluntary review, the health carrier shall send notice to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:

(i) Request, within the time frame specified in paragraph (3)(i), the opportunity to appear in person before a review panel of the health carrier's designated representatives.

(ii) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits.

(iii) Present the covered person's case to the review panel.

(iv) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review

both before and, if applicable, at the review meeting.

(v) If applicable, ask questions of any representative of the health carrier on the review panel.

(vi) Be assisted or represented by an individual of the covered person's choice.

(3) (i) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within five working days after the date of receipt of the notice sent in accordance with paragraph (2).

(ii) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

(c) Review panel for first level review.--

(1) (i) With respect to a voluntary review of a first level review decision made pursuant to section 7, a health carrier shall appoint a review panel to review the request.

(ii) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to subsection (b)(2), without regard to whether the information was submitted or considered in reaching the first level review decision.

(iii) The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2) (i) Except as provided in subparagraph (ii), a majority of the panel shall be comprised of individuals who were not involved in the in the first level review decision made pursuant to section 7.

(ii) An individual who was involved with the first level review decision may be a member of the panel or appear before the panel to present information or answer questions.

(iii) The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to section 7 are health care professionals who have appropriate expertise.

(iv) Except, when such a reviewing health care professional is not reasonably available, in cases where there has been a denial of a health care service, the reviewing health care professional shall not:

(A) Be a provider in the covered person's health benefit plan.

(B) Have a financial interest in the outcome of the review.

(d) Review panel for standard review.--

(1) (i) With respect to a voluntary review of a standard review decision made pursuant to section 8, a health carrier shall appoint a review panel to review the request.

(ii) The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2) (i) Except as provided in subparagraph (ii), a majority of the panel shall be comprised of employees or

representatives of the health carrier who were not involved in the standard review decision made pursuant to section 8.

(ii) An employee or representative of the health carrier who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions.

(e) Opportunity to appear in person.--

(1) (i) Whenever a covered person or the covered person's authorized representative requests within the time frame specified in subsection (b)(3)(i), the opportunity to appear in person before the review panel appointed pursuant to subsection (c) or (d), the procedures for conducting the review shall include the provisions described in this paragraph.

(ii) (A) The review panel shall schedule and hold a review meeting within 45 working days after the date of receipt of the request.

(B) The covered person or, if applicable, the covered person's authorized representative shall be notified in writing at least 15 working days in advance of the date of the review meeting.

(C) The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative.

(iii) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative.

(iv) In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or, if applicable, the covered person's authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing or other appropriate technology.

(v) If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative at least 15 working days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own.

(vi) The review panel shall issue a written decision, as provided in subsection (f), to the covered person or, if applicable, the covered person's authorized representative within five working days of completing the review meeting.

(2) Whenever the covered person or, if applicable, the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified time frame provided under subsection (b)(3)(i), the review panel shall issue a decision and notify the covered person or, if applicable, the covered person's authorized representative of the decision, as provided in subsection (f), in writing or electronically, within 45 working days after the earlier of:

(i) the date the covered person or the covered

person's authorized representative notifies the health carrier of the covered person's decision not to request the opportunity to appear in person before the review panel; or

(ii) the date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to subsection (b)(3)(i) ????.

(3) For purposes of calculating the time periods within which a decision is required to be made and notice provided under paragraphs (1) and (2), the time period shall begin on the date the request for an additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 6 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(f) Manner of decision.--A decision issued pursuant to subsection (e) shall include:

(1) The titles and qualifying credentials of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The rationale for the review panel's decision.

(4) A reference to evidence or documentation considered by the review panel in making that decision.

(5) In cases concerning a grievance involving an adverse determination:

(i) The instructions for requesting a written statement of the clinical rationale, including the

clinical review criteria used to make the determination.

(ii) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination.

(6) Notice of the covered person's right to contact the department's Bureau of Consumer Services for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the department.

Section 10. Expedited reviews of grievances involving adverse determination.

(a) General rule.--A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

(b) Expedited review.--In addition to subsection (a), a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

(c) Requests.--The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

(d) Appointments.--A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

(e) Transmission of information.--In an expedited review,

all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile or the most expeditious method available.

(f) Notification.--

(1) An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with subsection (h) as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the receipt of the request for the expedited review.

(2) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

(g) Time periods.--For purposes of calculating the time periods within which a decision is required to be made under subsection (f), the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 6 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(h) Manner of notification.--

(1) A notification of a decision under this section shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized

representative, set forth:

(i) The titles and qualifying credentials of the person or persons participating in the expedited review process.

(ii) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

(iii) A statement of the reviewers' understanding of the covered person's grievance.

(iv) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position.

(v) A reference to the evidence or documentation used as the basis for the decision.

(vi) If the decision involves a final adverse determination, the notice shall provide:

(A) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial.

(B) Reference to the specific plan provisions on which the determination is based.

(C) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why

the material or information is necessary to complete the request.

(D) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request.

(E) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request.

(F) If applicable, instructions for requesting:

(I) a copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subparagraph (iv); or

(II) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph (v).

(G) A statement describing the procedures for obtaining an independent external review of the adverse determination.

(H) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction.

(I) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."

(J) A notice of the covered person's right to contact the department's Bureau of Consumer Services for assistance with respect to the any claim, grievance or appeal at any time, including the telephone number and address of the department's Bureau of Consumer Services.

(2) (i) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with Federal regulations.

(ii) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with Federal regulations, the health carrier shall:

(A) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language.

(B) Once a utilization review or benefit

determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language.

(C) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

(3) (i) A health carrier may provide the notice required under this section orally, in writing or electronically.

(ii) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

Section 11. Regulations.

The department shall promulgate all necessary and proper regulations for implementation and administration of this act.

Section 12. Penalties.

(a) Civil penalty.--The department may impose a civil penalty of up to $5,000 for a violation of this act.

(b) Injunction.--The department may maintain an action in the name of the Commonwealth for an injunction to prohibit any activity which violates the provisions of this act.

(c) Prohibitions.--The department may issue an order temporarily prohibiting a health carrier which violates this act from enrolling new members.

(d) Plan of correction.--The department may require a health carrier to develop and adhere to a plan of correction approved

by the department. The department shall monitor compliance with the plan of correction. The plan of correction shall be available to enrollees of the health carrier.

Section 13. Administrative review.

The provisions of this act shall be subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies).

Section 14. Repeals.

The provisions of Article XXI of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, are repealed insofar as they are inconsistent with this act.

Section 15. Effective date.

This act shall take effect in 180 days.