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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 920 Session of 2019

INTRODUCED BY PHILLIPS-HILL, COLLETT, MARTIN, YUDICHAK, BAKER, MENSCH, STEFANO, J. WARD AND LEACH, DECEMBER 16, 2019

REFERRED TO BANKING AND INSURANCE, DECEMBER 16, 2019

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 quality health care accountability and protection, further providing for definitions and for responsibilities of managed care plans; providing for preauthorization standards and for preauthorization costs; further providing for continuity of care; providing for step therapy protocols; further providing for information for enrollees, for required disclosure and for operational standards; providing for preauthorization and adverse determinations, for appeals, for access requirements in service areas, for uniform preauthorization form, for preauthorization exemptions and for data collection and reporting.

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

Section 1. The definitions of "emergency service," "health care service," "prospective utilization review," "utilization review" and "utilization review entity" in section 2102 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance

Company Law of 1921, are amended and the section is amended by adding definitions to read:

Section 2102. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

* * *

"Administrative defect." A deficiency, error, mistake or missing information that serves as the basis of an adverse determination issued by a utilization review entity as justification to deny preauthorization.

"Adverse determination." The following apply:

(1) The term means a decision made by a utilization review entity from a preauthorization request that:

(i) the health care services furnished or proposed to be furnished to an insured:

(A) are not medically necessary;

(B) are experimental or investigational; or

(C) result from an administrative denial; or

(ii) denies, reduces or terminates benefit coverage.

(2) The term includes a decision to deny a step therapy exception request under section 2118.

(3) The term does not include a decision to deny, reduce or terminate services which are not covered for reasons other than their medical necessity or experimental or investigational nature.

* * *

"Appeal." A formal request, either verbal or in writing, to reconsider a determination to not authorize a health care service prior to the service being provided. The term does not apply to grievances filed under section 2161.

"Appeal procedure." A formal process that permits an insured or an attending physician or a designee, health care practitioner or facility on an insured's behalf, to appeal an adverse determination rendered by a utilization review entity or its designee utilization review entity or agent.

"Appropriate use criteria." Criteria that:

(1) define when and how often it is medically necessary and appropriate to perform a specific test or procedure; and

(2) are derived from documents of professional societies that are evidence-based or, when evidence is conflicting or lacking, from expert consensus panels and which documents include published clinical guidelines for appropriate use for the specific clinical scenario under consideration.

"Authorization." A determination by a utilization review entity that:

(1) a health care service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity;

(2) the health care service reviewed is a covered service; and

(3) payment will be made for the health care service.

* * *

"Clinical criteria." Policies, screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines and medical protocols set forth in a written document available for peer-to-peer review by a peer within the same profession and specialty and subject to challenge by an insured when used as a basis to withhold preauthorization, deny coverage or otherwise modify coverage which are used by a utilization review entity to determine the

medical necessity of health care services. Clinical criteria shall:

(1) Be based on nationally recognized standards.

(2) Be developed in accordance with the current standards of national accreditation entities.

(3) Reflect community standards of care.

(4) Ensure quality of care and access to needed health care services.

(5) Be evidence-based or based on generally accepted expert consensus standards.

(6) Be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

(7) Be evaluated and updated if necessary at least annually.

"Clinical practice guidelines." A systematically developed statement to assist in decision making by health care providers and enrollees relating to appropriate healthcare for specific clinical circumstances and conditions.

* * *

"Emergency service." Any health care service provided to an enrollee, including prehospital transportation or treatment by emergency medical services providers, after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

* * *

"Expedited appeal." A formal request, either verbal or in writing, to reconsider an adverse determination to not authorize emergency health care services or urgent health care services.

"Final adverse determination." An adverse determination that has been upheld by a utilization review entity at the completion of the utilization review entity's internal appeals process.

* * *

"Health care service." Any [covered] treatment, admission, procedure, test used to aid in diagnosis or the provision of the applicable treatment, pharmaceutical products, 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 an enrollee under a managed care plan contract.

"Insured." A policyholder, subscriber, covered person or other individual who is entitled to receive health care services or benefits from a health insurer under a health plan or other health insurance coverage under a managed care plan. Where applicable, the term includes an individual's legally authorized representative.

* * *

"Medically necessary health care services." Health care services that a prudent health care provider would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury or disease or its symptoms in a manner that is:

(1) in accordance with generally accepted standards of medical practice based on clinical criteria;

(2) appropriate in terms of type, frequency, extent, site and duration pursuant to clinical criteria; and

(3) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.

"Medication assisted treatment" or "MAT." The use of Food and Drug Administration-approved medications, including methadone, buprenorphine, alone or in combination with naloxone, or naltrexone, in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of substance use disorders.

"NCPDP SCRIPT standard." The National Council for Prescription Drug Programs SCRIPT Standard Version 201310, the most recent standard adopted by the Department of Health and Human Services or a subsequently related version, provided that the new version is backwards-compatible to the current version adopted by the Department of Health and Human Services. The NCPDP SCRIPT standard applies to the provision of pharmaceutical or pharmacological products.

"Nonurgent health care service." A health care service provided to an enrollee that is not considered an emergency service or an urgent health care service.

* * *

"Preauthorization." The process by which a utilization review entity determines the medical necessity of otherwise covered health care services prior to authorizing coverage and the rendering of the health care services, including, but not limited to, preadmission review, pretreatment review,

utilization management and case management. The term includes a health insurer's or utilization review entity's requirement that an insured or health care practitioner notify the health insurer or utilization review agent prior to providing a health care service.

* * *

["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.]

* * *

"Step therapy exception." A step therapy protocol that is overridden in favor of immediate coverage of the health care provider's selected prescription drug.

"Step therapy protocol." A protocol, policy or program that establishes the specific sequence in which medically appropriate prescription drugs for a specified medical condition are used by a particular patient and are covered by a managed care plan.

"Urgent health care service." The following apply:

(1) A health care service deemed by a provider to require expedited preauthorization review in the event that any delay may jeopardize the life or health of the insured or that a delay in treatment could:

(i) negatively affect the ability of the insured to regain maximum function; or

(ii) subject the insured to severe pain that cannot be adequately managed without receiving the care or treatment that is the subject of the utilization review as quickly as possible.

(2) The term does not include an emergency service or

nonurgent 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 an enrollee. The term includes preauthorization but 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 subdivision (h) that performs utilization review on behalf of a managed care plan. The term includes:

(1) An employer with employees in this Commonwealth who are covered under a health benefit plan or health insurance policy.

(2) An insurer that writes health insurance policies, including preferred provider organizations as provided under section 630.

(3) Pharmacy benefits managers responsible for managing access of insureds to available pharmaceutical or pharmacological care.

(4) Any other individual or entity that provides, offers to provide or administers hospital, outpatient, medical or other health benefits to an individual treated by a health care provider in this Commonwealth under a policy, plan or contract.

(5) A health insurer if the health insurer performs utilization review.

Section 2. Section 2111 of the act is amended by adding

paragraphs to read:

Section 2111. Responsibilities of Managed Care Plans.--A managed care plan shall do all of the following:

* * *

(14) Make updates to its enrollment eligibility information within thirty (30) days of receiving updated enrollment information. Updates in enrollment eligibility may occur due to new enrollments, coordination of benefits or termination of benefits. If a managed care plan fails to update eligibility information in a timely manner, the managed care plan may not deny payment due to enrollment information being inaccurate for a date of service if current eligibility information was available. In the event of a retroactive termination or a determination that an enrollee was ineligible for benefits, a health plan may recover any payments made in error within thirty (30) days of the date of service.

(15) Establish rules pertaining to the timely filing of health care provider claims that require a health care provider's filing duty to commence based on the following, whichever occurs last:

(i) when the patient is discharged;

(ii) when the patient presents complete and accurate insurance information; or

(iii) when authorization or approval is confirmed by the managed care plan.

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

Section 2114. Preauthorization Standards.--(a) No later than one hundred eighty (180) days after the effective date of this section, preauthorization requests shall be accessible to health care providers and accepted by insurers and utilization

review organizations electronically through a secure electronic transmission platform. NCPDP SCRIPT standard shall be acceptable for pharmaceutical or pharmacological care.

(b) Facsimiles, proprietary payer portals and electronic forms shall not be considered electronic transmissions.

(c) Any restrictions that a utilization review entity places on the preauthorization of health care services shall be:

(1) based on the medical necessity of those services and on clinical criteria;

(2) applied consistently; and

(3) disclosed by the managed care plan or utilization review entity under section 2136.

(d) Adverse determinations and final adverse determinations made by a utilization review entity or agent of a utilization review entity shall be based on clinical criteria.

(e) A utilization review entity may not deny coverage of a health care service solely based on the grounds that the health care service does not meet an evidence-based standard in the event that:

(1) no independently developed, evidence-based standards can be derived from documents published by professional societies;

(2) evidence-based standards are conflicting;

(3) evidence-based standards are lacking from expert consensus panels; or

(4) existing standards for a particular health care item, service, pharmaceutical product, test or imaging procedure are not directly applicable to the health care service as being applied.

(f) The following apply:

(1) Preauthorization shall not be required:

(i) when a medication, including noncontrolled generic medication, or procedure prescribed for a patient is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications;

(ii) for a patient currently managed with an established treatment regimen; or

(iii) for the provision of MAT for the treatment of an opioid-use disorder.

(2) When a utilization review entity, through any agent, contractor, employee or representative, informs a provider seeking preauthorization for a medically necessary service that preauthorization is not required, coverage for the service shall be deemed approved.

(g) No later than one hundred eighty (180) days after the effective date of this section, a payer shall accept and respond to preauthorization requests under a pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT standard.

Section 2115. Preauthorization Costs.--(a) In the event that an insured is covered by more than one health plan that requires preauthorization, the following provisions shall apply:

(1) Only the primary health plan may require that the insured comply with the primary health plan's preauthorization requirements.

(2) A secondary insurer or defined benefits plan may not refuse payment for health care services solely on the basis that the procedures set forth by the secondary insurer for preauthorization were not followed. If the treatment is approved by the primary insurer, the secondary insurer shall be bound by the determination of medical necessity made by the primary insurer.

(b) An appeal of an adverse determination or external review of a final adverse determination shall be provided without charge to the insured or insured's health care provider.

Section 4. Section 2117 of the act is amended by adding a subsection to read:

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

(g) The following apply:

(1) If the appeal of an adverse determination of a preauthorization request concerns ongoing health care services that are being provided pursuant to an initially authorized admission or course of treatment, the health care services shall continue to be paid for and provided without liability to the insured or insured's health care provider until the later of the following:

(i) thirty (30) days after the insured or insured's health care provider receives notice of a final adverse determination satisfying the requirements under section 2114(d) or the determination of an external review entity if the decision on adverse determination has been appealed through an external review proceeding;

(ii) the duration of treatment; or

(iii) sixty (60) days.

(2) An insurer may not retroactively review the insurer's decision to approve and provide health care services through preauthorization, including preauthorizing for extending the term or course of treatment. Notwithstanding any other provision of law, the insurer may not retroactively recover the cost of treatment either for the initial period of treatment or the period of treatment provided to the insured as part of the decision-making process to authorize coverage of additional

treatment periods.

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

Section 2118. Step Therapy Protocols.--(a) Clinical criteria used to establish a step therapy protocol shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

(i) requiring members to disclose any potential conflicts of interest with entities, including managed care plans and pharmaceutical manufacturers, and recuse themselves from voting if they have a conflict of interest;

(ii) using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(iii) offering opportunities for public review and comments;

(3) are based on research and medical practice published in peer review medical journals;

(4) are created by an explicit and transparent process that:

(i) minimizes biases and conflicts of interest;

(ii) explains the relationship between treatment options and outcomes;

(iii) rates the quality of evidence supporting recommendations; and

(iv) considers relevant patient subgroups and preferences;

(5) are continually updated through a review of new evidence, research and newly developed treatments;

(6) use peer-reviewed publications in the absence of clinical guidelines that meet the requirements of this act; and

(7) consider the needs of atypical patient populations and diagnoses when establishing clinical criteria.

(b) When a managed care plan or utilization review entity restricts coverage of a prescription drug for the treatment of a medical condition using a step therapy protocol, the enrollee and health care provider shall have the right to request a step therapy exception. A managed care plan or utilization review entity may use its existing medical exceptions process to satisfy this requirement. Information regarding the process shall be made available on the managed care plan's or utilization review entity's publicly accessible Internet website.

(c) A step therapy exception shall be granted if any of the following apply:

(1) The required prescription drug is contraindicated or likely will cause an adverse reaction by, or physical or mental harm to, the patient.

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.

(3) The patient has tried the required prescription drug while under the current or a previous managed care plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event.

(4) The required prescription drug is not in the best

interests of the patient based on medical necessity.

(5) The patient is stable on a prescription drug selected by the patient's health care provider for the medical condition under consideration while on a current or previous managed care plan.

(d) Decisions rendered pursuant to a step therapy request shall be transmitted in writing to the enrollee and the enrollee's health care provider.

(e) Upon the granting of a step therapy exception, the managed care plan or utilization review entity shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider.

(f) The managed care plan or utilization review entity shall grant or deny a step therapy exception request within seventy-two (72) hours of receipt. In situations where exigent circumstances exist, the managed care plan or utilization review entity shall grant or deny a step therapy request within twenty-four (24) hours of receipt. An insured or an insured's health care provider may appeal an adverse determination of a step therapy exception request via telephone, facsimile, e-mail or other expeditious method. The managed care plan or utilization review entity shall grant or deny the appeal within the same time frames as provided in this subsection. Failure of the managed care plan or utilization review entity to comply with the deadlines and other requirements specified in this subsection shall result in the step therapy exception request being deemed granted and paid by the managed care plan.

(g) Nothing in this section may be construed to:

(1) Require a managed care plan or other entity to establish a new entity to develop clinical criteria used for step therapy

protocols.

(2) Prevent a managed care plan or utilization review entity from requiring a pharmacist to effect substitutions of prescription drugs consistent with State law.

(3) Prevent a health care provider from prescribing a prescription drug that is determined to be medically necessary.

Section 6. The heading of Subarticle (f) of Article XXI of the act is amended to read:

(f) Information for Enrollees and Health Care Providers.

Section 7. Section 2136 of the act is amended by adding a subsection to read:

Section 2136. Required Disclosure.--* * *

(c) If a utilization review entity intends to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the utilization review entity shall provide contracted health care providers and insureds with written notice of the new or amended requirement or amendment not less than sixty (60) days before the requirement or restriction is implemented. The notice shall be in writing and if served upon health care providers, be provided by certified mail, return receipt requested. The requirement of certified mail return receipt requested can be satisfied if the utilization review entity provides notice to a specified individual named in the contract with the health care provider for service of notices, under which circumstances the specified person may receive notice by e-mail, return receipt requested.

Section 8. Section 2152(a)(4) and (6) are amended, the subsection is amended by adding paragraphs and the section is amended by adding subsections to read:

Section 2152. Operational Standards.--(a) A utilization

review entity shall do all of the following:

* * *

(4) 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:

(i) 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.

(ii) 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.

(iii) 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.

(iv) A utilization review entity shall allow an insured and the insured's health care provider a minimum of one (1) business day following an inpatient admission pursuant to an emergency health care service or urgent health service to notify the utilization review entity of the admission and any health care services performed.

* * *

(6) Provide all decisions in writing to include the basis and clinical rationale for the decision. For adverse determinations of preauthorization decisions, a utilization review entity shall provide all decisions to the insured and insured's health care provider which shall also include

instructions concerning how an appeal may be filed. A utilization review entity may not retroactively review the medical necessity of any preauthorization which has been previously approved or granted.

* * *

(9) Post to its publicly accessible Internet website:

(i) a current list of services and supplies requiring preauthorization; and

(ii) written clinical criteria for preauthorization decisions.

(10) Ensure that a preauthorization shall be valid for one hundred eighty (180) days or the duration of treatment, whichever is greater, from the date the health care provider receives the preauthorization, so long as the insured is a member of the plan.

(11) When performing preauthorization, only request copies of medical records when a difficulty develops in determining the medical necessity of a health care service. In that case, the utilization review agent may only request the necessary and relevant sections of the medical record.

(12) Not deny preauthorization nor delay preauthorization for administrative defects. In the event an administrative defect is discovered, a managed care plan shall allow a health care provider the opportunity to remedy the administrative defect within thirty (30) days of receiving notice.

* * *

(e) Failure by a utilization review entity to comply with deadlines and other requirements specified for preauthorization shall result in the health care service subject to review to being deemed preauthorized and paid by the managed care plan.

(f) A utilization review entity shall approve claims for health care services for which a preauthorization was required and received from the managed care plan prior to the rendering of the health care services, unless:

(1) the enrollee was not eligible for coverage at the time the health care service was rendered. A managed care plan may not deny payment for a claim on this basis if the enrollee's coverage was retroactively terminated more than one hundred twenty (120) days after the date of service, provided the claim is submitted timely. If the claim is submitted after the timely filing deadline, the managed care plan shall have no more than thirty (30) days after the claim is received to deny the claim on the basis the enrollee was not eligible for coverage on the date of the health care service;

(2) the preauthorization was based on materially inaccurate or incomplete information provided by the enrollee, their designee or the health care provider, such that if the correct or complete information had been provided, the preauthorization would not have been granted; or

(3) there is a reasonable basis supported by material facts available for review that the enrollee, the enrollee's designee or the health care provider has engaged in fraud or abuse.

Section 9. The act is amended by adding sections to read:

Section 2161.1. Preauthorization and Adverse Determinations.--(a) A utilization review entity shall ensure that:

(1) Preauthorizations are made by a qualified licensed health care provider who has knowledge of the items, services, products, tests or procedures submitted for preauthorization.

(2) Adverse determinations are made by a physician. The

reviewing physician must possess a current and valid nonrestricted license to practice medicine in this Commonwealth and be board-certified in the specialty subject to the adverse determination. A utilization review entity may seek approval from the Insurance Commissioner to use a reviewing physician that is not board-certified due to the unavailability of or difficulty in finding a board-certified reviewing physician in a given specialty. The Insurance Commissioner shall develop a form and parameters for the request and shall transmit notice of the request to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. The Insurance Commissioner shall provide at least ten (10) days for comment before rendering a decision. The decision shall be transmitted to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(b) Notice of a preauthorization shall be accompanied by a unique preauthorization number and state all of the following:

(1) The specific health care services preauthorized.

(2) The next date for review.

(3) The total number of days approved.

(4) The date of admission or initiation of services, if applicable.

(c) Neither the utilization review entity nor the payer or health insurer that has retained the utilization review entity may retroactively deny coverage for emergency or nonemergency care that had been preauthorized when it was provided, if the information provided was accurate.

(d) In the event a health care provider obtains preauthorization for a service but the service provided is not an exact match to the service that was preauthorized, but does not materially depart from the service that was preauthorized, a

health plan shall not deny payment for the service only if:

(1) the date of service differs by less than thirty (30) days;

(2) the physician or health care provider rendering the service differs from the person indicated on the preauthorization but is otherwise licensed and qualified to provide the preauthorized service; or

(3) the service provided is different than what was preauthorized but is commonly and appropriately a substitute based on common procedural terminology.

(e) A health plan shall allow a health care provider to resubmit a claim with corrected information for appropriate reimbursement within thirty (30) days of receiving notice of an adverse determination.

(f) The following apply:

(1) If a utilization review entity questions the medical necessity of a health care service, the utilization review entity shall notify the insured's health care provider that medical necessity is being questioned and provide the basis of the challenge in sufficient detail to allow the provider to meaningfully address the concern of the utilization review entity prior to issuing an adverse determination.

(2) The insured's health care provider or the health care provider's designee and the insured or insured's designee shall have the right to discuss the medical necessity of the health care service with the utilization review physician.

(3) A utilization review entity questioning medical necessity of a health care service which may result in an adverse determination shall make the reviewing physician or a physician who is part of a team making the decision available

telephonically between the hours of seven o'clock in the morning (7 a.m.) and seven o'clock in the evening (7 p.m.).

(g) When making a determination based on medical necessity, a utilization review entity shall base its determination on an insured's presenting symptoms, diagnosis and information available through the course of treatment, or at the time of admission or presentation at the emergency department.

(h) A utilization review entity may not deny preauthorization based solely on its determination that the inpatient level of care is not appropriate. In the event a utilization review entity determines an alternative level of care is appropriate, it shall provide and cite the specific criteria it has used as its basis for its level of care determination to the health care provider. A health care provider may appeal the determination.

(i) A utilization review entity may not issue an adverse determination for a procedure due to lack of preauthorization if the procedure is medically necessary or clinically appropriate for the patient's medical condition and rendered at the same time as a related procedure for which preauthorization was required and received.

(j) When making a medical necessity determination, a utilization review entity shall deem any hospital stay of at least forty-eight (48) hours as meeting inpatient level of care criteria.

(k) A utilization review entity shall make a preauthorization or adverse determination and notify the insured and the insured's health care practitioner as follows:

(1) For nonurgent health care services: within seventy-two (72) hours of obtaining all of the necessary information to make

the preauthorization or adverse determination.

(2) For urgent health care services: within twenty-four (24) hours of obtaining all of the necessary information to make the preauthorization or adverse determination.

(l) No utilization review entity may require preauthorization for an emergency service, including postevaluation and poststabilization services.

Section 2161.2. Appeals.--(a) An expedited appeal shall be provided as follows:

(1) An insured or the insured's health care provider may request an expedited appeal of an adverse determination via telephone, facsimile, e-mail or other expeditious method.

(2) Within one (1) day of receiving an expedited appeal and all information necessary to decide the appeal, the utilization review entity shall provide the insured and the insured's health care provider written confirmation of the expedited review determination.

(b) An appeal shall be reviewed only by a physician who is:

(1) Board-certified in the same specialty as a health care practitioner who typically manages the medical condition or disease.

(2) Currently in active practice in the same specialty as the health care provider who typically manages the medical condition or disease.

(3) Knowledgeable of, and has experience in, providing the health care services under appeal.

(4) Under contract with a utilization review entity to perform reviews of appeals, and payment of fees due to the physician under the contract may not be made subject to or contingent upon the outcome of the appeal. The physician may

also be subject to a provider agreement with the insurer as a provider but may not receive any other fees or compensation from the insurer. The physician's receipt of compensation from the utilization review entity may not be considered by the physician in determining the outcome of the appeal. The physician shall render independent and accurate medical judgment in reaching the physician's opinion or conclusion. Failure to comply with this provision shall render the physician subject to licensure disciplinary action by the appropriate State licensing board.

(5) Not involved in making the adverse determination.

(6) Familiar with all known clinical aspects of the health care services under review, including, but not limited to, all pertinent medical records provided to the utilization review entity by the insured's health care provider and any relevant records provided to the utilization review entity by a health care facility.

(c) The utilization review entity shall ensure that appeal procedures satisfy the following requirements:

(1) The insured and the insured's health care provider may challenge the adverse determination and have the right to appear in person before the physician who reviews the adverse determination.

(2) The utilization review entity shall provide the insured and the insured's health care provider with written notice of the time and place concerning where the review meeting will take place. Notice shall be given to the insured's health care provider at least fifteen (15) days in advance of the review meeting.

(3) If the insured or the insured's health care provider appear in person, the utilization review entity shall offer the

insured or insured's health care provider the opportunity to communicate with the reviewing physician, at the utilization review entity's expense, by conference call, video conferencing or other available technology.

(4) The physician performing the review of the appeal shall consider all information, documentation or other material submitted in connection with the appeal without regard to whether the information was considered in making the adverse determination.

(d) The following deadlines apply:

(1) A utilization review entity shall decide an expedited appeal and notify the insured and health care provider of the determination within one (1) day after receiving a notice of expedited appeal by the insured or the insured's health care provider and all information necessary to decide the appeal.

(2) A utilization review entity shall issue a written determination concerning a nonexpedited appeal not later than ten (10) days after receiving a notice of appeal from an insured or insured's health care provider and all information necessary to decide the appeal.

(e) Written notice of final adverse determinations shall be provided to the insured and the insured's health care provider.

(f) If the insured or the insured's health care provider, or a designee on behalf of either the insured or the insured's health care provider, has satisfied the necessary requirements for the appeal of an adverse determination through the preauthorization process and the appeal has resulted in a continued adverse determination either based in lack of medical necessity or an administrative defect, the insured, the insured's health care provider or a designee on behalf of either

of them is authorized to file a consumer complaint with the Insurance Department. The complaint shall be adjudicated without unnecessary delay and a determination issued by the Insurance Department with appropriate sanctions if applicable pursuant to the authority given to the Insurance Department. The following apply:

(1) If an insured, the insured's provider or a designee on behalf of the insured or the insured's provider files a consumer complaint with the Department of Health or the Office of the Attorney General pursuant to their authority to receive complaints, a copy of the complaint filed with either of those agencies shall be forwarded to the Insurance Department and the copy shall serve as a new consumer complaint which shall be adjudicated pursuant to this section and all other applicable law.

(2) Nothing in this section is intended to preclude an insured or an insured's designee from filing a separate consumer complaint with the Insurance Department for failure to comply with the requirements of this act as it applies to preauthorization processes or denial of health insurance coverage generally.

Section 2195. Access Requirements in Service Areas.--If a patient's safe discharge is delayed for any reason, including lack of available posthospitalization services, including, but not limited to, skilled nursing facilities, home health services and postacute rehabilitation, the managed care plan shall reimburse the hospital for each subsequent date of service at the greater of the hospital's contracted rate with the managed care plan for the current level of care and service or the full diagnostic related group payment divided by the mean length of

stay for that particular diagnostic related group.

Section 2196. Uniform Preauthorization Form.--(a) Within three (3) months of the effective date of this section, the Insurance Department shall convene a panel to develop a uniform preauthorization form that health care providers in this Commonwealth shall use to request preauthorization and that health insurers shall accept as sufficient to request preauthorization of health care services.

(b) The panel shall consist of not fewer than ten (10) persons. Equal representation shall be afforded to the physician, health care facility, employer, health insurer and consumer protection communities within this Commonwealth.

(c) Within one (1) year of the effective date of this section, the panel shall conclude development of the uniform preauthorization form and the Insurance Department shall make the uniform preauthorization form available to health care providers in this Commonwealth and utilization review entities and agents.

Section 2197. Preauthorization Exemptions.--(a) When appropriate use criteria exist for a particular health care service, the health care service shall be exempt from preauthorization if the provision of the health care service comports with applicable appropriate use criteria.

(b) A health care service that has been provided following approval through the preauthorization procedures provided by the insurer or which is not subject to preauthorization procedures may not be subject to retrospective review based on medical necessity related to the preauthorization.

Section 2198. Data Collection and Reporting.--The Insurance Department shall maintain and collect data on the number of

appeals filed by enrollees, enrollee designees and health care providers with utilization review entities. The Insurance Department shall, on an annual basis, publish a report made accessible on its publicly accessible Internet website and serve a copy of the report on the Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives that identifies the following data by place and type of service:

(1) The total number of appeals filed against utilization review entities.

(2) The number and percentage of appeals filed against each utilization review entity.

(3) The total number of appeals found in favor of utilization review entities.

(4) The number and percentage of appeals found in favor of each managed care plan.

(5) The total number of appeals found in favor of the enrollee, designee or health care provider.

(6) The number and percentage of appeals found in favor of the enrollee, designee or health care provider against each managed care plan.

(7) The Insurance Department shall evaluate, monitor and track health plan statistics in accordance with the information gathered under this section and investigate negative trends and outliers. In addition, the Insurance Department shall facilitate meetings between health care providers and managed care plans to discuss and resolve disputes.

Section 10. This act shall take effect in 60 days.