MANAGED CARE ASSOCIATION OF PENNSYLVANIA

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December 21, 1999

ORIGINAL: 2046
BUSH
COPIES: Coccodrilli
Harris
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Peter J. Salvatore
Regulatory Coordinator
Office of Special Projects
Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Salvatore:

Thank you for forwarding the Insurance Department's (DOI) final form proposed rulemaking pursuant to Act 68, 1998, the "Quality Health Care Accountability and Protection Act." Having reviewed the rulemaking, the Managed Care Association of Pennsylvania (MCAP) has outlined the following remaining concerns with the regulations as written and submitted to the Independent Regulatory Review Commission (IRRC) and standing committees of the House and Senate on December 9, 1999.

1) Prompt Payment - Section 154.18

The Association appreciates and supports the Department's decision NOT to require managed care plans to notify providers in writing in the event of receipt of an unclean claim. Such a requirement would clearly be beyond the legislative intent and scope of Act 68. As an alternative, the Association supports the Department's requirement that managed care plans inform providers of the specific elements necessary to constitute a clean claim.

However, the Association is sincerely disappointed in the remaining prompt payment requirements within the final form rulemaking which does not address the serious concerns raised by MCAP over the past several months. As submitted, the final form regulations differ significantly from the Insurance Department's October 3, 1998 Statement of Policy - a factor which will raise a number of compliance issues for managed care plans. The changes necessary to implement the proposed regulations will be costly and time consuming and are likely to exacerbate the already contentious issue of timely claims payment. Specifically, the Association notes the following:

- ✓ As continuously raised by MCAP since publication of draft regulations, applying the 45 day prompt payment standard to "clean" portions of "unclean" claims will require major systems changes for many managed care plans, both large and small. As noted in the public comments section of the proposed final form regulations, other organizations opposed to this requirement include Highmark, Keystone Health Plan Central and Independence Blue Cross. While the technology necessary to split claims is available, it is currently NOT in place

among the vast majority of our 12 member managed care plans. In absence of the necessary technology, splitting claims must be done manually which significantly slows the efficiency of claims processing systems. This requirement alone will cost millions of dollars to implement and will undoubtedly and ultimately NOT help alleviate provider concerns about prompt payment.

✓ The proposed final form regulations state that a claim is paid on the date a check is mailed by the managed care plan to the provider. This, once again, represents a significant change from the Department's October 3, 1998 Statement of Policy which states that claims are determined to be paid "on the date of issuance" by the managed care plan. Our member plans will have difficulty adhering to this requirement as current information systems have the ability to track when a check is issued - not when a check is placed in the mail. The Association advocates that the language used in the October 3, 1998 Statement of Policy be reinserted

✓ A previously released version of the DOI regulations stated that "the 45 day prompt payment provisions are not in effect if premium payments covering the period when the health care service was to be provided have not been received by the licensed insurer or managed care plan." MCAP continues to support that this language be reinserted and that managed care plans should not have to comply with prompt payment requirements in absence of premium payments from purchasers.

✓ The proposed final form regulations state that the accrued interest on a clean claim shall be paid at the time of payment of the claim - either on the same check as the claim payment or on a separate check. Again, this requirement is extremely unwieldy to administer from a current systems perspective. The Association supports less prescriptive standards which would enable the Department to work with the managed care plans to allow flexibility on how interest payments are made to providers.

✓ To ensure that providers do not file complaints prior to the conclusion of the 45-day period set forth in the Act, the Association strongly suggested that the following language be included in the final regulations: ***"If 45 days from receipt of the claim have elapsed and providers have followed the Department's advisory on prompt payment of claims, health care providers may file a complaint with the Department."***

2) Definitions - Section 154.2

✓ **Emergency Service** - The definition has been amended to reflect the exact language which appears in Act 68. This means, as MCAP had advocated, that the phrase "including a chronic condition" is not included in the definition. However, the phrase "including a chronic condition" has been moved to section 154.14 (c) of the final regulations. The Association objects to inclusion of this phrase anywhere in the regulations due to the potential negative effect on manage care

plan efforts to reduce inappropriate emergency room use, particularly among those with chronic conditions. Many managed care plans have successfully implemented disease management programs for members with chronic conditions (diabetes, asthma, etc.) Major thrusts of such programs are to educate enrollees about proper care and reducing the use of emergency room services. Inclusion of the phrase "including a chronic condition" will only serve to undermine those efforts by creating a double standard for emergency room use. Removal of the phrase from this legislation would have no effect on those who are experiencing an emergency situation, either due to a chronic or acute condition. MCAP supports removal of this phrase from the regulations.

✓ **Grievance** - The Association continues to recommend adding the following to the grievance definition: ***"This term does not include a provider appeal for clarification of claims payment."*** The Association is aware of providers, specifically hospitals, that are attempting to utilize the Act 68 grievance process for purposes of recourse in the event of an adverse retrospective utilization review determination. In such situations, while payment may be in dispute, consumer services have already been rendered. This is an inappropriate use of the grievance process, the intent of which is to benefit consumers OR providers on a consumer's behalf. In addition, National Committee for Quality Assurance (NCQA) standards require that managed care plans have an appeals process in place for providers. These provider-specific processes are the appropriate venue for these claims payment clarifications.

3) **Managed Care Plan Requirements - Section 154.11**

✓ Subsection (a)(2) notes that an enrollee may designate a specialist to provide and coordinate the enrollee's primary care. Similar to continuity of care requirements under the final form regulations, MCAP urges the addition of the following: ***"If the specialist agrees to act as the enrollee's primary care provider, the specialist shall agree to the managed care plan's terms and conditions."*** In it's comments released along with the final proposed regulation, the DOI indicated in regard to this language that, "The Department did not expand this area as it is taken directly from the statute." Interestingly, there are numerous other areas where the Department has chosen to expand upon what appeared in the original statute. Absent the language, specialists will be free not to agree to the managed care plan's quality assurance or other standards designed to enhance care delivery.

4) **Continuity of Care - Section 154.5**

✓ MCAP appreciates that the Department has amended Subsection (h) which now states that managed care plans may not require providers to undergo the plan's "full" credentialing process. Nonetheless, NCQA standards require managed care plans to use only credentialed providers. In addition, NCQA standards are quite prescriptive in terms of credentialing processes. In its comments, DOI notes that, "The Department believes that NCQA recognizes the need for plans to comply

with individual state statutory requirements." As proposed, however, this language specifically prohibits plans from requiring non-network providers to undergo the plan's established credentialing process and therefore may effect a plan's ability to adhere to NCQA standards. MCAP supports removal of this section.

5) Complaints - Section 154.17

✓ The Association continues to support insertion of specific language in subsection (g) which requires enrollees to follow and complete the managed care plan's internal complaint process before appealing the decision to either the Health or Insurance Department. In discussions with the DOI, MCAP provided specific examples of instances where consumers (or legislators on behalf of a constituent) contacted the DOI directly, bypassing the managed care plan and Act 68 processes entirely. In such circumstances, managed care plans receive a letter or notice from DOI which gives the plan 15 days to respond to the complaint. While the DOI assured MCAP previously and reiterated in its comments that consumers would be assisted by referring them back to the insurer, this is still not the case. The DOI has not made the internal changes necessary to prevent 15-day notices from going to managed care plans which causes confusion for plans and does nothing to encourage consumers to follow the processes established by Act 68.

The Association appreciates the opportunity to comment on the final form regulations and would be happy to discuss any aspect of our comments.

Sincerely,

Kimberly J. Kockler
Executive Director

cc: ✓Independent Regulatory Review Commission
The Honorable Ed Holl
The Honorable Nicholas Micozzie
The Honorable Timothy Murphy
The Honorable Dennis O'Brien
The Honorable Patricia Vance

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

416 Forster Street • Harrisburg, Pennsylvania 17102-1714 • Telephone 717-232-3817 • Fax 717-232-7294

An affiliate of the American Psychological Association

February 22, 2000

Original: 2046
Bush
cc: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Legal

Peter J. Salvatore
Regulatory Coordinator
Office of Special Projects
1326 Strawberry Square
Harrisburg, PA 17120

RE: Insurance Department Regulations to Act 68

Dear Mr. Salvatore:

Thank you for your email of February 16 in which you apologized for failing to notify PPA of the filing of the final form regulations and explaining why we had not been notified.

It appears that I had misunderstood your letter of December 22 in which you wrote that "upon resubmission to the IRRC and the Committees, the Department will also forward you a copy of the final form as resubmitted." I had not written a letter to you requesting final form regulations because I read your letter as indicating that I would be receiving them.

As it has been explained to me, it appears that the Insurance Department had fulfilled its legal responsibility. However, it also appears that I, and representatives of several other health care groups, misread your letter of December 22, 1999. I believe that this explains why many groups commented on the original publication of the proposed regulations and few commented on the final form proposed regulations.

There is another matter of which you should be aware. The final form submission which you emailed to me on February 16 erroneously attributed numerous comments to PPA. I am enclosing a copy of the statements which I believe to be in error and a copy of our original letter of August 26, 1999. If the publication time line for the *Pennsylvania Bulletin* permits, I would appreciate a correction of those errors.

I have no reason to think that this was nothing but an honest misunderstanding, but I hope you can appreciate that we, and other health care groups, really wanted an opportunity to review and comment on the proposed regulations further.

Anecdotal information from our members suggests that the non-payment of clean claims has actually gotten worse since Act 68 was passed. One middle size practice reported an average of 69 days between submission and payment of claims. We hope that the regulations adopted will rectify this problem. It is hardly in the public interest to have health professionals diverting much of their resources away from patient care and on to tracking clean claims.

We also have a significant investment in the grievance and complaint process as a means to protect patient welfare. As health care professionals with direct contact with patients, we have seen the serious consequences that can occur when needed treatments are unjustly denied.

Thank you again for your response.

Sincerely,

Samuel Knapp, Ed.D.
Director of Professional Affairs

cc: The Honorable Robert Nyce, Executive Director, Independent Regulatory Review Commission
The Honorable Edwin Holl, Chair, Senate Banking and Insurance Committee
The Honorable Jay Costa, Minority Chair, Senate Banking and Insurance Committee
The Honorable Harold Mowery, Chair, Public Health and Welfare Committee
The Honorable Vincent Hughes, Minority Chair, Public Health and Welfare Committee
The Honorable Timothy Murphy, Vice Chair, Public Health and Welfare Committee
The Honorable Nicholas Micozzie, Chair, House Insurance Committee
The Honorable Tony DeLuca, Minority Chair, House Insurance Committee
The Honorable Dennis O'Brien, Chair, House Health and Human Services Committee
The Honorable Frank Oliver, Minority Chair, House Health and Human Services Committee
The Honorable Patricia Vance

This is the final form combination of Preamble, Comment and Response and Annex that was submitted to the Committees and the IRRC.

IBC wanted additional language in subsection (a) and clarification to subsection (c).

IFP wanted clarification to the term "cost plus products."

PMS wanted the Department to add a subsection to clarify when the Plan will apply to subcontracts from an otherwise exempt entity and wanted the phrase "which issues subscriber contracts covering enrollees." clarified.

PPA wanted "cost plus products" defined.

The IRRC suggested clarification to: 1) the term "entity", 2) the phrase "which issues subscriber contracts covering enrollees" and 3) whether the regulation is applicable to subcontracted services that are subcontracted for an exempt entity if the subcontract is with a Plan that were mentioned in subsection (c). The IRRC also suggested that the Department define or clarify the term "cost plus products" in subsection (d).

The Department agrees that the term "cost plus products" is confusing and has eliminated the reference to "cost plus products" and replaced it with the term "policies" which is more applicable. The Department is also clarifying subsection (a) to exclude health care services and claims processed under automobile and workers' compensation policies and to clarify that the Department and the Department of Health share regulatory authority under the act and subsection (c) to include integrated delivery systems and by deleting "which issues subscriber contracts covering enrollees." The regulations would not apply in IRRC's comment #3 because the act's applicability is based on the entity issuing the enrollee contract. The Department believes it is both unnecessary and impossible to produce a list of all insured and self-insured plans that are not covered by the act. The act clearly defines those entities that are managed care plans.

Section 154.2. Definitions.

AARP, CBC, CMC, DPW, DVHC, EPVA, HIGHMARK, HAP, IBC, MCAP, PAFP, PHLP, PMS, PPA, PPS and the IRRC commented on the definition section.

AARP wanted clarification on whether disputes about benefits are included as part of "coverage issues" in the term *complaint* and wanted to specifically know if quality of care could be considered a *complaint.* AARP wanted to know if the three provisions address a reduction or termination in an existing service under the definition and wanted *grievance* to ensure a grievance can be filed about any aspect of the provision. AARP also felt that the definition *utilization review* severely limits the functions of a plan's utilization review program.

CBC wanted to tighten the definition *gatekeeper* so that PPOs and indemnity plans are not included.

insurer or managed care plan." MCAP also suggested that *grievance* "not include a provider appeal for clarification of claims payment." MCAP suggested that term "provider" be changed to "practitioner" in the definition *health care service*. MCAP also suggested removing "including chronic condition" from *emergency services*.

PAFP recommended that *primary care provider* not include advanced practice nurses or physician assistants. PAFP also suggested that the Department add the definition of "primary care" to the proposed rulemaking.

PHLP suggested that *enrollee* include "parents of minor enrollees as well as designees or legal representatives who are entitled or authorized to act on behalf of an enrollee." PHLP suggested revising the definition of *ongoing course of treatment*. PHLP also suggested that the definition of *grievance* be deleted in its entirety. PHLP suggested that the Department delete "the highest level of and available" from the definition of *gatekeeper*. PHLP wanted "or a plan authorized non-participating provider" added after "health care provider" in the definition of *complaint*.

PMS suggested that services listed on the HCFA 1500 be considered a claim in the definition of *clean claim*. PMS also suggested that the consent to treatment by the patient should serve as authorization to pursue the claim with the client's insurer and that this consent should be considered under the definition of *grievance*.

PPA suggested that the definition of *emergency service* be clarified with regards to "chronic condition." PPA suggested that *managed care plan* be clarified so that a plan that does not require the enrollee to obtain a referral from any PCP in its network as a condition to receiving specialty care shall not be considered a managed care plan. PPA suggested that *licensed insurer* should be clarified so that this applies only to health policies, while claims submitted under auto and worker's compensation policies are subject to their own rules under those acts.

PPS raised concerns about the definition of *primary care provider* as it relates to the definition of gatekeeper.

The IRRC objected to the reiteration of statutory definitions. IRRC recommended that the Department should reference the statutory definition in *emergency services*. IRRC recommended that the Department add a provision to § 154.14 that clarifies a severe and sudden onset of a chronic condition that meet the prudent layperson standard can be classified as emergency services. IRRC recommended that the Department clarify whether *gatekeeper* includes plans using a passive or multiple-choice gatekeeper structure. IRRC recommended that the Department clarify whether the enrollee must select a primary care provider from a list provided by the Plan in the definition of *gatekeeper*. IRRC also wanted to know the propose of the phrase "or the plan or an agent of the plan serving as the primary care provider?" that is in the definition of *gatekeeper*. IRRC suggested that *plan* should be used consistently in place of managed care plan. IRRC recommended that the Department clarify the application of the

This is the final form combination of Preamble, Comment and Response and Annex that was submitted to the Committees and the IRRC.

Department should clarify that there are no time restrictions that apply to direct access to these services.

The Department agrees with the IRRC on subsection (a) and has made the change by adding the following to subsection (a): "No time restrictions shall apply to the direct accessing of these by enrollees." The act and regulations specifically apply to direct access for both obstetrical and gynecological services. No further clarification is necessary that this section applies to more than pregnancy.

Section 154.13. Managed care plan reporting of complaints and grievances.

AARP, ACEP, CBC, PHLP, PPA and the IRRC commented on the managed care plan reporting of complaints and grievances section.

AARP Strongly supports accurate and standardized reporting of complaint and grievance information. Also would like consumers to have access to standardized comparative grievance information.

ACEP wanted the regulations to address the frequency as to which plans are required to report complaints and grievances. Suggests that managed care plan issue timely reports to the Department of Health and Insurance Department at least quarterly. These reports should contain a status report on all complaints and grievances, whether or not they have a disposition.

CBC believed it would be in everyone's best interests to have uniform reporting of complaint and grievance data under the act.

IFP recommended amending this provision to state "report this information to the Departments," not just the Department. This would clarify the information need only be reported in one format.

PPA suggested that the Departments of Health and Insurance work together to ensure the formats required by each agency match as to avoid undue administrative burden on managed care plans.

PHLP stated that the utilization of the old reporting format does not comply with the act's requirements and recommended deleting "based on the format utilized to report information prior to the effective date of the act" and adding "per the format designated by the Department detailing for each complaint, the reason the enrollee is contesting the managed care plan's action, the disposition of the complaint at each level and the product line in which the enrollee is enrolled. The Department should also report the number of expedited complaints and the disposition of each complaint."

The IRRC suggested that the Department coordinate reporting requirements with the Department

This is the final form combination of Preamble, Comment and Response and Annex that was submitted to the Committees and the IRRC.

HAP and PACHA suggested clarifying the term "clean claim" and HAP recommended subsection (a) require plans to provide health care providers with the criteria used to classify a claim as clean. PPA suggested § 154.18 require plans to notify both enrollees and providers if a claim is clean or not. Additionally, PPA recommended § 154.18 require plans to notify providers of changes in claim submissions so providers know how to submit a clean claim.
The IRRC and PMS recommended requiring plans to notify providers of deficiencies that delay processing of a claim as well as notifying providers when a claim is suspended in subsection (a).
→ PPA would like to extend the prompt payment rule to those insurance plans that the act expressly excludes from its definition.

HAP recommended a provision to subsection (b), which would require insurers to notify providers and enrollees of a claim status within 45 days of submission. MCAP recommended using language in the October 3, 1998 Statement of Policy rather than the current language in subsection (b).

While HAP believes that the Department has the statutory authority to require licensed insurers or managed care plans to notify providers that a claim is not a clean claim or the reasons it is not a clean claim, the Department does not believe it has the statutory authority to implement these proposed requirements. However, the Department does have the authority to require licensed insurers or managed care plans to provide health care providers with the criteria used to classify a claim as clean. This change was requested by HAP and has been made in the new subsection (e). In addition, (g)(1) requires licensed insurers and managed care plans to respond to health care providers inquiries regarding unpaid claims within a set timeframe.

Licensed insurers and managed care plans are urged to work together with providers to address issues related to payment of claims, in order to assure the provisions of the act are achieved.

Blair recommended using the highest WSJ national prime rate to determine the interest due to a health care provider on a clean claim in subsection (c). Blair also recommended adding an additional two-percent onto the interest rate in subsection (c) to cover administrative costs of providers and requiring providers to pay interest payments of less than $2.00. DVCH, DVH and DPW would like subsection (c) to specify a 10% interest payment be paid on a clean claim which is not paid within 45 days.

The interest rate and $2.00 minimum interest requirements are set by section 2166(a) of the act; therefore, the Department does not possess the statutory authority to change the interest rate.

Highmark, KHPC, CBC, BCNE, IBC, MCAP opposed the requirement set forth in subsection (c) which requires plans to pay interest and claim payments simultaneously.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
OFFICE OF SPECIAL PROJECTS
1326 Strawberry Square
Harrisburg, PA 17120

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E-mail: psalvato@ins.state.pa.us

December 22, 1999

Mr. Samual Knapp, Ed.D.
Professional Affairs Officer
Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1714

Re: Insurance Department Final Form Regulation No. 11-195, Quality Health Care Accountability and Protection

Dear Mr. Knapp:

The Insurance Department sent, via fax and letter, the following to the Independent Regulatory Review Commission and the Standing Committees of the Senate and House today:

"The Insurance Department is hereby withdrawing regulation number 11-195, Quality Health Care Accountability and Protection, from consideration at this time.

The regulation will be resubmitted for final consideration at a later date.

If you have any questions regarding this matter, please contact me at (717) 787-4429."

Upon resubmission to the IRRC and the Committees, the Department will also forward you a copy of the final form as resubmitted.

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

11-195w1

Copies: Tom, Michol, Susan Shanaman

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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An affiliate of the American Psychological Association

August 26, 1999

Peter J. Salvatore
Regulatory Coordinator
1326 Strawberry Square
Harrisburg, PA 17120

RE: Regulations to Act 68

Dear Mr. Salvatore:

On behalf of the Pennsylvania Psychological Association, I am responding to the proposed regulations of the Insurance Department dealing with Act 68.

Welcome Clarification of Section 154.17 Regarding Referrals

The clarification in Section 154.17 (a) (1) is most welcome. That section states that "A primary care provider's refusal to make an enrollee referral to a specialist, on the basis that the referral is not medically necessary, would be considered a grievance." This clarifies a point that was our concern in an earlier draft of regulations from the Department of Health that failed to make that clarification. We hope that the Department of Health will similarly clarify its intent in subsequent drafts of its regulations.

Clarification Regarding Emergency Treatment in Section 154.14 and Section 154.16

Section 154.14 should make it clear that emergency service refers to the entire continuum of services needed for an emergency including ambulance transport, reasonable diagnostic tests, and services to stabilize the patient.

In addition, in Section 154.16 (h), the information to enrollees should include the fact that the "prudent layperson" standard is used in determining what is or is not an emergency.

Clarification Needed in Section 15.15 Dealing with Continuity of Care

PPA has a concern with Section 15.15 (g) (5) which states that nonparticipating providers will comply with the terms of the contract including "agreeing to make referrals for specialty care, diagnostic testing, and related services to the enrollees current managed care plans' participating providers." The problem with this section is that it is in direct violation of Section 2113 of Act 68 which states that managed care plans may not prohibit a health care provider from discussing "medically necessary and appropriate care with or on behalf of an enrollee" and which prohibits managed care plans from terminating health care providers for "advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable standard of care."

The reality is that, at some times, the pool of specialists or facilities offered by a closed panel may be so restrictive that none of the available providers in the pool have the necessary skills to provide the necessary services to the patients. Act 68 clearly prohibits 15.15 (g) (5).

Insurance Department Oversight Should Be Specified in Section 154.16

Section 154.16 (dealing with Information to Enrollees) needs to make it explicit that the Insurance Department will provide oversight of the written information sent to enrollees or prospective enrollees. The regulations give managed care plans wide discretion in the format they use as long as the required information is "easily identifiable." However, consumers need some kind of redress for managed care information which does not meet a reasonable standard of "easily identifiable." Such an oversight is mandated by Section 2181(d) of Act 68 which clearly states that "the department [of Health] and Insurance Department shall ensure compliance with this article. The appropriate department shall investigate potential violations of the article based upon information received from enrollees, health care providers and other sources in order to ensure compliance with this article." This mandate placed upon the Insurance Department should be made explicit in these regulations.

Clarification Needed for Timely Payments in Section 154.18

Section 154.18 deals with the issue of timely payments to providers and hospitals. It is important for the Insurance Department to appreciate the importance of this problem and the way that it is impacting on the public health of Pennsylvanians. Publicly funded community mental health centers have had to restrict services to avoid bankruptcy. This does not occur because they are mismanaged, but because they are owed millions of dollars in unpaid clean claims from

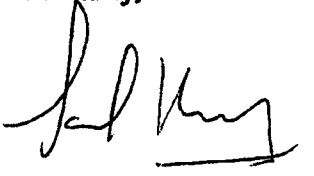
insurance companies. These agencies are providing those services which are mandated by the Mental Health Procedures Act of 1976 (emergency services, inpatient and outpatient mental health, and partial hospitalization programs). The curtailment of these programs has harmed the safety and health of thousands of needy Pennsylvanians.

Furthermore, literally thousands of psychologists, physicians, and other health care professionals practice independently or in small businesses and have smaller amounts owed to them individually. Many of these "small business" health care professionals have similarly had to make cutbacks in their services such as laying off or reducing the hours of professional or support staff. Consequently, it is vital to the public safety that insurance companies pay the money which they legally owe to health care professionals.

We believe it is important that the regulations protect health care professionals against those insurers who would abuse the "clean claim" requirement. Section 154.18 should require insurers and managed care plans to inform providers and enrollees whether or not a claim is clean. Furthermore, they should be required to informed providers about changes regarding claims submissions which providers would have to know to submit a clean claim.

Thank you for the opportunity to respond to these draft regulations.

Sincerely,



Samuel Knapp, Ed.D.
Professional Affairs Officer

Original: 2046
Bush
cc: Harris
Jewett
Markham
Smith, Sandusky
Wilmarth, Legal

Gelnett, Wanda B.

From: Lu [lu@paproviders.org]
Sent: Monday, February 21, 2000 9:02 AM
To: IRRC@irrc.state.pa.us
Cc: Pete Salvatore; Phyllis Mundy; Kathy Manderino; Rick Speese; Carol Williams
Subject: DOI regs

I am concerned that the regulations pursuant to Act 68 were released with no prior notice to stake holders. I had submitted comments to the Insurance Department and had spoken with DOI staff, but received no notice of the release of the revised regulations.

This process is too important to be rushed or to ignore the input of those of us who will be directly affected by these regulations. Our association represents over 200 community based agencies across the Commonwealth, and we are very concerned about the new regulations' changes regarding prompt payment.

I urge the IRRC to assure that all stake holders have an adequate chance to comment on the Act 68 regulations.

Lu Conser, MPH
Director of Government Relations
PA Community Providers Assn.
717-657-7078

Gelnett, Wanda B.

From: Peter J. Salvatore [psalvato@ins.state.pa.us]
Sent: Tuesday, February 22, 2000 8:27 AM
To: 'irrc@irrc.state.pa.us'
Subject: FW: DOI regs

-----Original Message-----
From: Peter J. Salvatore [SMTP:psalvato@ins.state.pa.us]
Sent: Tuesday, February 22, 2000 8:22 AM
To: 'lu@paproviders.org'
Cc: 'IRRC@state.pa.us'
Subject: RE: DOI regs

You were sent (electronically) a copy of the final form regulation on January 24, 2000. This is the day that it was submitted to the IRRC and the Committees.

This final form was sent to 'Abraham, Nina (Blank Rome)'; 'Blunk, David (PA ACEP)'; 'Booher, Marian (DPW)'; 'Bucher, Nancy (Crozer)'; 'Bussard, Paula (HAP)'; 'Cohen, Debra (CAPBLUE)'; 'Conser, C. Lu (PA Providers)'; 'Doane Christopher'; 'Dunaway Geoffrey'; 'Farrick, David (Blair)'; 'Franklin, Harriet (Stevens & Lee)'; 'Gallaher, Candy (Highmark)'; 'Halperin, A (PHLP)'; 'Hickey, John (KHPC)'; 'Hope, Scott (IBC)'; 'Jones, Robert (DPW)'; 'Jordan, John (PAFP)'; 'Knapp Timothy'; 'Kockler, Kimberly (MCAP)'; 'Koken M. Diane'; 'Lehman, Gwen Yackee (PAMEDSOC)'; 'Levins, Richard (IBC)'; 'Madonna, Harry (Blank Rome)'; 'Marshall, Samuel (IFP)'; 'Martin, Gail (KHPC)'; 'Martin, Stephen (Saul Ewing)'; 'Martino, Gregg (Aetna/USHC)'; 'McGowan, Laurie (KHPC)'; 'McNulty Arthur'; 'Melusky, Linda (CAPBLUE)'; 'Plaskowski, Roxanne'; 'Rohrbaugh Randy'; 'Slavin, Jill (Crozer)'; 'Wasson, Kristi (PAMEDSOC)' on Mon 1/24/2000 10:57 AM.

I will gladly forward another copy. This is not a public comment period during the final form, however, the IRRC usually accepts comments.

-----Original Message-----
From: Lu [SMTP:lu@paproviders.org]
Sent: Monday, February 21, 2000 9:02 AM
To: IRRC@irrc.state.pa.us
Cc: Pete Salvatore; Phyllis Mundy; Kathy Manderino; Rick Speese; Carol Williams
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I urge the IRRC to assure that all stake holders have an adequate chance to comment on the Act 68 regulations.

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An affiliate of the American Psychological Association

February 16, 2000 **EMBARGOED MATERIAL**

TO: Independent Regulatory Review Commission

FROM: Samuel Knapp, Pennsylvania Psychological Association

RE: Insurance Department Regulation No. 11-95 Quality Health Care Accountability and Protection

Please be informed that we object to the manner in which the above named regulations are being handled.

On December 22, 1999 we received a copy of the enclosed letter from the Insurance Department stating that the proposed regulations were being withdrawn and "upon submission to the IRRC and the Committees, the Department will also forward you a copy of the final form as resubmitted."

This was not done. Only upon our initiative today did we learn that the public comment period has ended and that IRRC will vote on the regulations tomorrow.

The failure of the Insurance Department to forward us a copy of the final form as resubmitted, as they promised, has deprived us of the opportunity to comment.

We would like a clarification from IRRC as to whether this violates the Regulatory Review Act.

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COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
OFFICE OF SPECIAL PROJECTS
1326 Strawberry Square
Harrisburg, PA 17120

Phone: (717) 787-4429
Fax: (717) 772-1969
E-mail: pesalvato@ins.state.pa.us

December 22, 1999

Mr. Samual Knapp, Ed.D.
Professional Affairs Officer
Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1714

Re: Insurance Department Final Form Regulation No. 11-195, Quality Health Care Accountability and Protection

Dear Mr. Knapp:

The Insurance Department sent, via fax and letter, the following to the Independent Regulatory Review Commission and the Standing Committees of the Senate and House today:

"The Insurance Department is hereby withdrawing regulation number 11-195, Quality Health Care Accountability and Protection, from consideration at this time.

The regulation will be resubmitted for final consideration at a later date.

If you have any questions regarding this matter, please contact me at (717) 787-4429."

Upon resubmission to the IRRC and the Committees, the Department will also forward you a copy of the final form as resubmitted.

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

11-195wl

INDEPENDENT REGULATORY REVIEW COMMISSION

To:	Pete Salvatore OR Terry Seneca
Agency:	Insurance Department
Phone	(717) 787-4429
Fax:	(717) 772-1969
From:	Kristine M. Shomper Deputy Director for Administration
Company:	Independent Regulatory Review Commission
Phone:	(717) 783-5419 or (717) 783-5417
Fax:	(717) 783-2664
Date:	February 16, 2000
# of Pages:	3

Comments: Embargoed mail received.

The Insurance Federation of Pennsylvania, Inc.

1600 Market Street
Suite 1520
Philadelphia, PA 19103
Tel: (215) 665-0500 Fax: (215) 665-0540

February 14, 2000

Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

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Re: Regulation 11-195 - Insurance Department's final form regulation of Article XXI of the Insurance Company Law, Quality Health Care Accountability and Protection

Dear Mr. Nyce:

This is to recommend approval of the Insurance Department's final form regulation to be considered by the IRRC on February 17. The regulation implements those portions of Article XXI of the Insurance Company Law covering quality health care accountability and protection placed under the Insurance Department's jurisdiction.

The regulation is in the public interest. First, it meets - but does not exceed - the Insurance Department's statutory authority granted in Article XXI, and it fulfills the General Assembly's goals in enacting that article. It does so with clarity and reasonableness, and its requirements are feasible not just for those complying with them, but for those who may exercise rights under them (e.g., aggrieved providers or consumers) or have to monitor or enforce them (e.g., the Department).

We understand several provider groups recommend disapproval of the regulation, despite changes since its first final form submission last year that were made at the request of those groups.

We understand the provider groups' primary complaint to be that the regulation does not require health insurers to notify providers within 45 days of submission of a claim as to whether it is "clean."

That, however, is a complaint the provider groups should bring to the General Assembly, not the IRRC. For all the detail in Act 68, the underlying legislation here, specifically including its prompt payment provisions, nowhere does the act require insurers to notify providers within 45 days as to whether their claims are "clean."

The Department would be exceeding its statutory authority to assert by implication or inference such a notice requirement here. It already "pushes the envelope" by requiring insurers to respond to a provider's inquiry on a claim within 45 days if the inquiry is made within 45 days of submission of the claim, and within 30 days if the inquiry is made after that time.

The lack of statutory authority for this notice requirement is highlighted by the January 13 letter of House Insurance Committee Chairman Nicholas Micozzie, the sponsor of the amendment setting forth Article XXI and the prompt payment requisite. Chairman Micozzie, writing in support of the regulation, noted the issue and concluded that he would "investigate the need for legislation that grants the Insurance Department clear authority to require proper notification." If the sponsor of the prompt payment provision does not see it as requiring this notice requisite, nor should the Department and nor should the IRRC.

This regulation is needed and long overdue. It is a well-drafted implementation of Act 68 that meets both the letter and the spirit of the act, and it should be approved.

Sincerely,

Samuel Marshall

Samuel R. Marshall

c: Honorable Edwin G. Holl, Chairman
Senate Banking and Insurance Committee

Honorable Harold F. Mowery, Jr., Chairman
Senate Public Health and Welfare Committee

Honorable Nicholas A. Micozzie, Chairman
House Insurance Committee

Honorable Dennis M. O'Brien, Chairman
House Health and Human Services Committee

Honorable M. Diane Koken
Insurance Commissioner

FAX

INSURANCE FEDERATION OF PENNSYLVANIA
1600 MARKET STREET
SUITE 1520
PHILADELPHIA, PA 19103

Date 2/14/00

Number of pages including cover sheet 4

To: Robert Nyce	From: Sam Marshall

TEL: 717-783-5596	TEL: 215-665-0500
FAX: 717-783-2664	FAX: 215-665-0540

REMARKS:

Pennsylvania
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February 10, 2000

Commissioner John R. McGinley, Jr., Chair
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Re: Department of Insurance: Quality Health Care Accountability and Protection Act (Act 68) Regulations – Final Form Rulemaking.

Dear Commissioner McGinley:

I am writing as President of the Pennsylvania Medical Society to offer comments on the above captioned final form rulemaking currently before the Independent Regulatory Review Commission (IRRC). The Medical Society would like to be able to strongly support these regulations and urge that they be approved by the IRRC. Unfortunately, final language of the regulations in several areas previously commented on by the Society makes such support impossible. Therefore, the Society wishes only to offer these comments as information to the IRRC.

The Medical Society is concerned over IRRC's recommendation and the Department's subsequent action to delete the definitions of terms used in the regulations. While the Society recognizes the structural reasons for not duplicating definitions already included in the statute, we believe there are practical reasons to repeat the definitions for clarity purposes. For the public, the regulations will serve as the operating document outlining the provisions of Act 68 and describing how the Act is to be carried out and interpreted. I have already heard that at least one managed care plan has its own interpretation of what the "prudent layperson standard" is. Physicians and other health care practitioners, and managed care plan claims personnel will have to refer to the regulations until they become familiar with the process. There is a need for the definitions to be included in the regulations so that the regulations can serve as a complete reference to the workings of the Act.

The Medical Society objects to changes to the regulations permitting insurers and managed care plans to pay interest due on late payments separately up to 30 days after the claim payment is made. The Society is not aware of any major hardship for insurers and plans to pay the claim and the interest simultaneously and explain both payments on the explanation of benefits accompanying the payment. Physician's offices will face an added administrative burden of having to process and account for two separate payments on the same claim at separate times. This will add to the office's operating costs. It would also permit interest payments to be "lost" in the process. The Society believes that the payment and interest due on claims not paid in accordance with the timely payment provisions of the statute can and should be paid at the same time.

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E-Mail: *stat@pamedsoc.org*
www.pamedsoc.org

The Society shares the concern expressed by the Hospital and Healthsystems Association of Pennsylvania that managed care plans should be required to notify health care providers that a claim is not clean and for what reasons. I have heard from many physicians who report that they have submitted claims with supporting documentation just as they do for Medicare and commercial insurance and for which they receive payment. When they have not received payment from the managed care plan, they call the plan only to be told the claim was suspended as incomplete, or the documentation wasn't received, or that the claim was never received or they are told that the person assigned that claim is away from their desk but doesn't return the call. Even electronically submitted claims aren't immune to these problems. Claims in the middle of a batch transmission are lost. Other physicians submit added documentation to support a claim only to be given another reason for the suspension or denial – one not given when they first inquired as to the status of the claim. All this time, the timely payment remedy hasn't kicked in and the 45 day time limit hasn't begun.

While we may not agree with the Department's contention that it doesn't have the statutory authority to require insurer to notify providers regarding unclean claims, we would like to have seen the Department go to the limit of their authority in influencing plans to create a notification and claim status inquiry process. The Society believes that failure to require insurers to provide claim status notification is a major flaw in assuring that the timely payment provisions of the statute are fully and fairly implemented.

For these reasons, the Pennsylvania Medical Society cannot support the proposed final rulemaking.

Sincerely,

Donald H. Smith, MD
President

Cc: Insurance Commissioner
The Honorable Nicholas Micozzie, Chair
House Insurance Committee
The Honorable Edwin Holl, Chair
Senate Banking and Insurance Committee

DNM/doc/cor/IRRC

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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February 10, 2000

Mr. John McGinley, Jr.
Chairperson
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. McGinley:

The Hospital & Healthsystem Association of Pennsylvania (HAP), on behalf of its members (more than 225 acute and specialty care hospitals and health systems in the commonwealth), appreciates the opportunity to comment on the Insurance Department's final-form rulemaking for the Quality Health Care Accountability and Protection Act (Act 68) regulations.

HAP has appreciated the efforts of the Insurance Department and House Insurance Committee Chairman Nicholas Micozzie to resolve issues regarding the prompt payment section of the regulations. With four of every five Pennsylvania hospitals and health systems losing money on patient care, they have no ability to sustain inordinate delays or unreasonable denials in regard to insurance payments.

We are, however, still disappointed that the regulations do not require insurers and managed care plans to establish a claims notification process. HAP believes it is essential to establish such a requirement whereby insurers and managed care plans notify providers in a timely manner that a claim is being suspended, delayed, or denied because of deficiencies. Absent this requirement, we believe it will be far too easy for some insurers and managed care plans to unduly delay or suspend claims. Therefore, we can not support the final rulemaking as proposed.

HAP remains committed to improving accountability to patients receiving care through managed care plans. We have offered our complete cooperation and assistance in whatever capacity is needed to enable the department to require insurers and managed care plans to notify providers regarding the status of claims. We believe that the absence of this requirement is a major flaw in assuring prompt payment and as such, can not support the proposed final rulemaking.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
Policy and Regulatory Services

c: M. Diane Koken, Insurance Commissioner
Nicholas Micozzie, Chair, House Insurance Committee
Anthony DeLuca, Minority Chair, House Insurance Committee
Edwin Holl, Chair, Senate Banking & Insurance Committee
Jay Costa, Minority Chair, Senate Banking & Insurance Committee

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THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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pbussard@hap2000.org

FAX TRANSMISSION

2 page(s), including cover sheet

TO: John R. McGinley, Jr.

FAX: 783-2664

FROM: Paula Bussard

DATE: February 10, 2000

SUBJECT: Act 68 Regulations

MESSAGE:

Original hard copy to follow via regular mail. Please call if you have any questions.

MANAGED CARE ASSOCIATION OF PENNSYLVANIA

240 North Third Street, Suite 203
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February 11, 2000

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Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street
14th Floor
Harrisburg, PA 17101

Re: Final Form Regulation #11-195
Insurance Department

Dear Mr. Nyce:

The following is on behalf of the members of the Managed Care Association of Pennsylvania (MCAP) in regard to the Insurance Department's final form rulemaking (#11-195) pursuant to Act 68, 1998, the "Quality Health Care Accountability and Protection Act." The Association represents 12 Commonwealth HMOs that enroll over 1.5 million Pennsylvanians in various commercial, Medicare and Medicaid health plans. MCAP would like the following comments entered as part of the public record during the upcoming Independent Regulatory Review Commission (IRRC) hearing on the final form regulation.

The Association would like to acknowledge and thank Insurance Commissioner Koken and House Insurance Committee Chairman Nick Micozzie for the stakeholder meeting held January 5, 2000, the purpose of which was for interested parties to discuss and resolve issues associated with the prompt payment provisions of the proposed regulations. The stakeholder meeting did, in fact, result in resolution of our Association's primary concerns with the final form rulemaking.

In previous comments to the Insurance Department, the IRRC and the legislature, the Association raised strong objections to requirements within the prompt payment section (§154.18) of the proposed regulations. MCAP's primary concern was the potentially negative and costly impact on managed care plans in regard to the following requirements: 1) that managed care plans "split claims" and pay the "clean" portions of "unclean" claims; and, 2) that interest payments on late claims be paid at the same time as the claim. The Association believes that both issues have been resolved favorably through the final form regulations.

The Association also appreciates the Insurance Commissioner's decision NOT to include in the regulations a requirement that managed care plans furnish specific, written notice to providers upon receipt of an "unclean" claim. The Association's position is that such a requirement would have proved administratively burdensome and costly to our member plans. We appreciate the Commissioner's position that, since this requirement was not included by the legislature as part of Act 68, 1998, such a provision should not be imposed through regulation.

Other prompt payment provisions of the final form regulations which are supported by the Association include:

- ✓ Requiring that providers wishing to file a prompt payment complaint with the Insurance Department "SHALL" (as opposed to "may") contact the managed care plan prior to contacting the Department. (Subsection (F)).

- ✓ Extending the time period for managed care plans to respond to provider inquiries about the status of unpaid claims from 30 to 45 days OR within 30 days of the inquiry, if the inquiry is made after the 45-day period. (Subsections (F) and (G)(1)).

The Association has appreciated the opportunity to discuss our concerns and recommendations with IRRC staff throughout the review process. Thank you.

Sincerely,

Kimberly J. Kockler
Executive Director

cc: Insurance Commissioner Koken
The Honorable Nicholas A. Micozzie

PENNSYLVANIA HEALTH LAW PROJECT

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PITTSBURGH, PA 15222
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February 11, 2000

Mr. John R. McGinley, Jr. Chairman
Independent Regulatory Review Commission
14th Floor Harristown 2
333 Market Street
Harrisburg, PA 17101

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REVIEW COMMISSION

Re: Act 68 - DOI Regulations

Dear Chairman McGinley:

We write on behalf of our client, the Consumer Health Coalition, to request IRRC disapproval of the Insurance Department's Act 68 Regulations.

Our clients' concerns arise from their experience as consumers and consumer representatives. The final-form regulations do not adequately protect consumers. Of particular importance to your review is the fact that these regulations contradict Act 68, and conflict with the proposed regulations of Department of Health.

1. Contradicting the Letter of the Act

Under the Act, prior authorization for OB/GYN may only be required for services that are outside the scope of practice. The final-form regulations state "A managed care plan may require an obstetrical or gynecological provider to obtain prior authorization for selected services such as diagnostic testing or subspecialty care - for example, reproductive endocrinology, oncologic gynecology and maternal and fetal medicine." This provision is contrary to §2111(7). The listed services are well within the scope of practice of an OB/GYN.

2. Conflicts with DOH Proposed Regulations

Our clients urged the Department to work with the Department of Health to insure that both Departments defined terms the same way. The Department failed to do this and its definitions differ from those proposed by the Department of Health. For

example, the Departments differ in their definitions of enrollee. The Department's definition includes parents of minor enrollees as well as designees or legal representatives who are entitled or authorized to act on behalf of an enrollee. Unfortunately, the Department limits this inclusion to complaint and grievance process purposes. The Department of Health, however, makes no inclusion of parents of minor children or legal representatives. Similarly, the Department refused to set criteria for granting of standing referrals (which are extremely important to persons with complex chronic illnesses). The Department refused to do this on the grounds that the Department of Health could handle it. The Department of Health regulations do not.

3. Takes a Major Step Back the Existing Rules

In the area of complaints and grievances, the Department has taken a major leap backwards, by dismantling the pre-Act 68 system (embodied in the Department of Health's Operational Standards for Fundamental Fairness). When our clients questioned the Department's statutory authority to take away the existing standards, the Department refused to reinstate the standards and implemented only the Act 68 provisions, provisions that were designed solely to fill gaps. This substitution clearly violated the General Assembly's intent, and exceeded the Department's authority. What is left is an unfair and unworkable internal complaint and grievance process, in which a consumer has no mechanism for resolving procedural disputes regarding notices, hearing schedules, sharing of documents, timelines, or even the basic question of whether an issue is appropriately characterized as a complaint of a grievance.

4. Contradicting the Spirit of the Act

Finally, the Department's regulations fail to live up to the spirit of Act 68. Our clients urged the Department to define a reading level to ensure compliance with the Act's requirement that the information "be easily understandable by the layperson". The regulations do not. Our clients urged the Department to require that materials be provided in alternative formats and alternative languages for persons who are visually impaired or of Limited-English Proficiency, in accordance with the Americans with Disabilities Act and Title VI of the Civil Rights Act of 1964. The Department refused.

Additionally, there are several provisions of Act 68 and the Department's regulations (§154.12 and §154.14) that require providers to take certain steps to insure payment by a plan. Although the General Assembly never intended that enrollees suffer when their providers fail to follow reasonable billing timeframes, the Department has refused to insure that plans cannot bill enrollees where their provider has failed to follow the rules. Enrollees will suffer by the Department's unjustified refusal to hold them harmless.

For all of the above reasons, they respectfully request that the Act 68 Insurance Department regulations be voted down with instruction that they be resubmitted or rendered consistent with the spirit and the letter of the law.

Sincerely,

Ann S. Torregrossa
Executive Director

PENNSYLVANIA HEALTH LAW PROJECT

501 ARCH STREET • SUITE 610A • PHILADELPHIA, PA 19107-2421

FAX TRANSMITTAL

TO: John Jewett DATE: 2/14/99

COMPANY/ORGANIZATION/AGENCY: TOTAL NO. OF PAGES INCLUDING COVER:

FAX NUMBER: FROM: Ann Torma

TELEPHONE NUMBER: SENDER'S FAX NUMBER: 215-625-3879

RE: SENDER'S TELEPHONE NUMBER: 215-625-3663

☐ URGENT ☐ CONFIDENTIAL ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ FOR REVIEW

NOTES/COMMENTS:

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LAUREL
HEALTH SYSTEM

Laurel Health System
15 Meade Street
Wellsboro, Pennsylvania 16901-1813

January 17, 2000

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The Honorable Matthew E. Baker
House of Representatives of Pennsylvania
P.O. Box 202020
Harrisburg, PA 17120-2020

Dear Representative Baker:

I am sending this letter to inform you of the importance and the impact of Act 68, The Quality Health Care Accountability and Protection Act, enacted January 1, 1999, on our hospitals and health systems.

Act 68 has proven, thus far, to be an effective starting point in creating accountability in managed care organizations and has taken strides in improving health insurance practices. There are, however, some needed modifications to the Act to ensure a high quality of care to our patients. They are as follows:

1. The Department of Health has defined emergency services differently from the Insurance Department; they need to be similar. In reference to inpatient services, skilled nursing services need to be defined on their own and not included as inpatient time.

2. The section on co-payments and co-insurance is too vague and needs to be clarified to ensure patient access to care.

3. Insurance regulations do not coincide with the definition of emergency services. This definition needs to include evaluation, stabilization and treatment.

4. The definition of medical necessity needs to be similar at all Departments to ensure access to care, and a process of periodic evaluation for determining such medical necessity is needed.

-continued-

5. The term "access" needs to be clarified, as it implies the use of motor vehicles but does not address inaccessible or unaffordable transport.

6. The Department of Health has differentiated between routine and non-routine obstetric and gynecologic care, while the Act has not. This also needs to be similar to avoid conflict in the future.

7. The Department of Health and the Insurance Department differ on continuity of care. It is important that these also be similar.

8. There is a lack of clarity in regard to grievance issues. Denial letters have lacked, in the past, a clinical rationale; and at times, services which were pre-approved have been denied once submitted for billing.

9. In regard to internal complaints, the consumer needs additional time to file such complaints. Thirty days is recommended.

10. The dispute resolution needs to be simplified, such as not requiring written consent from the patient to allow the provider to seek a resolution in procedural errors and administrative denials.

11. It should be required that any changes to contract terms be mutually agreed upon and communicated to providers with thirty days notice.

12. The regulations need to include how monitoring of all those involved will take place to ensure compliance with state laws and regulations.

It is imperative that these issues be addressed and the needed corrections be made to the regulations of Act 68 so that the Laurel Health System, and hospitals and health systems across the state, may continue to provide the best possible care to our communities.

Thank you for your consideration.

Sincerely,

Ron

Ronald J. Butler
President and CEO

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

February 10, 2000

Mr. John McGinley, Jr.
Chairperson
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. McGinley:

The Hospital & Healthsystem Association of Pennsylvania (HAP), on behalf of its members (more than 225 acute and specialty care hospitals and health systems in the commonwealth), appreciates the opportunity to comment on the Insurance Department's final-form rulemaking for the Quality Health Care Accountability and Protection Act (Act 68) regulations.

HAP has appreciated the efforts of the Insurance Department and House Insurance Committee Chairman Nicholas Micozzie to resolve issues regarding the prompt payment section of the regulations. With four of every five Pennsylvania hospitals and health systems losing money on patient care, they have no ability to sustain inordinate delays or unreasonable denials in regard to insurance payments.

We are, however, still disappointed that the regulations do not require insurers and managed care plans to establish a claims notification process. HAP believes it is essential to establish such a requirement whereby insurers and managed care plans notify providers in a timely manner that a claim is being suspended, delayed, or denied because of deficiencies. Absent this requirement, we believe it will be far too easy for some insurers and managed care plans to unduly delay or suspend claims. Therefore, we can not support the final rulemaking as proposed.

HAP remains committed to improving accountability to patients receiving care through managed care plans. We have offered our complete cooperation and assistance in whatever capacity is needed to enable the department to require insurers and managed care plans to notify providers regarding the status of claims. We believe that the absence of this requirement is a major flaw in assuring prompt payment and as such, can not support the proposed final rulemaking.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
Policy and Regulatory Services

c: M. Diane Koken, Insurance Commissioner
Nicholas Micozzie, Chair, House Insurance Committee
Anthony DeLuca, Minority Chair, House Insurance Committee
Edwin Holl, Chair, Senate Banking & Insurance Committee
Jay Costa, Minority Chair, Senate Banking & Insurance Committee

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