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

RE: **Quality Health Care Accountability and Protection** Proposed Regulations (*Reg. # 11-195 amends Title 31 Pennsylvania Code by adding Chapter 154 and deleting Chapter 31; published at 29 PA Bulletin 4064*)

Dear Mr. Salvatore:

I am writing to offer comments on the Insurance Department's proposed regulations concerning Quality Health Care Accountability and Protection. These regulations are to be promulgated under the authority of Act 68 of 1998, the Quality Health Care Accountability and Protection Act. Act 68 amended Act 284 of 1921, the Insurance Company Law of 1921.

My specific concern arises from the need for the Insurance Department to promulgate clear regulations regarding the treatment of both clean and contested claims submitted for payment to a licensed insurer or managed care plan. Section 2166 of the Insurance Company Law of 1921 requires clean claims (or the uncontested portion thereof) to be paid within 45 days of receipt after a health care provider submits the claim. A clean claim is defined in the act as a claim that has no defect or impropriety. However, while section 2166 (B) provides for a 10% interest penalty should a licensed insurer or managed care plan fail to pay a clean claim within 45 days, there is no set criteria or established timetable regarding the notification to a health care provider that a claim is contested.

I have heard from several health care providers within my legislative district regarding this concern. Often, the health care provider is notified very late in the process after it has submitted a presumably clean claim for payment. Several times the health care provider has received a call on the 44th day after the insurer or managed care plan has received the claim notifying the provider that the claim will be contested. This is a particular hardship on small health care providers, many with ties to charitable organizations, which rely on prompt payment for financial solvency. I believe such a practice certainly violates the spirit and intent of Act 68.

Often the reason for contesting a claim is relatively insignificant. For example, documentation necessary to substantiate the claim is erroneously excluded; the health care provider may improperly complete a form; etc. Much of this information is readily accessible and rectifiable within a reasonable period of time. Under current practice, however, a licensed insurer or managed care plan may withhold notifying the health care provider of the need for additional or proper documentation until the 45-day clean claim period is nearly expired.

The regulations proposed by the Insurance Department fail to adequately address this important issue. There is no formal definition of what constitutes a contested claim. Section 154.18 (a) of the proposed regulations informally defines a contested claim as a claim where a licensed insurer or managed care plan has determined it is not obligated to make payment on the claim. There is no provision, after the 45-day period has begun, requiring the licensed insurer or managed care plan to notify a health care provider within a set number of days that problems exist with the submitted claim. Instead, section 154.18 (e) attempts to address this issue by requiring licensed insurers and managed care plans to respond to a health care provider's inquiries regarding the status of unpaid claims "within a reasonable period of time."

Without a specific requirement or method to address this issue, the potential to abuse the intent for prompt payment under Act 68 will continue to exist. I do not wish to suggest that a licensed insurer or managed care plan should forfeit their right to review or contest a claim simply because they have failed to identify/notify a health care provider of a problem with a submitted claim within such time period. However, since section 154.18 allows for the 45-day clean claim period to begin *again* after a health care provider has responded to the initial concerns of a contested claim, such a process could theoretically proceed indefinitely. It may be more reasonable to establish a total length of the review/payment process that is tied into the original date the claim was received (i.e. all matters pertaining to a claim must be resolved within 75, 85, 100 days of receipt etc.).

I am aware that an appeals process to the Insurance Department or Department of Health exists, however such a process should be turned to as a last resort. With respect to the Insurance Department's proposed regulations, I offer the following recommendations:

- Establish a formal definition for contested claims under section 154.2 (Definitions). Such a definition should reflect that a contested claim is one where additional/proper documentation is needed, or the licensed insurer or managed care plan determines that it is not obligated to pay such claim.

- Establish a specific time period after receipt of claim (i.e. 20 days) during which time a licensed insurer or health care plan must notify a health care provider that they are contesting the claim. Such a provision should clearly outline the responsibilities of the licensed insurer or health care plan in notifying the health care provider; and/or

- Establish a cumulative time frame, based on the original date the claim was received, by which all matters pertaining to the claim have been resolved, and a final decision to either pay the claim or deny payment has been reached.

Thank you for the opportunity to review and comment on the Insurance Department's proposed regulations on Quality Health Care Accountability and Protection. I am hopeful that these recommendations will assist the Insurance Department in implementing regulations that uphold both the spirit and intent of the Quality Health Care Accountability and Protection Act.

Sincerely,

MARY JO WHITE
SENATOR, 21ST DISTRICT

MJW/ph

cc: The Honorable Ed Holl, Chairman
Senate Banking and Insurance Committee
The Honorable Hal Mowery, Chairman
Senate Public Health and Welfare Committee
The Honorable Tim Murphy
Robert E. Nyce, Executive Director
Independent Regulatory Review Commission
Sister Donna Zwigart
St. Francis Hospital of New Castle