An Affiliate of the American Psychological Association

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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

FAX TO: Peter Salvatore

FROM: Sam Knapp DATE: 8/26/99

SUBJECT: Act 68 PAGES TO FOLLOW: 3

MESSAGE:

Copy of letter on Act 68 Regulations.

Hard Copy to Follow via Mail.

RECEIVED
AUG 26 1999
Office of Special Projects

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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

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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Regulatory Coordinator
1326 Strawberry Square
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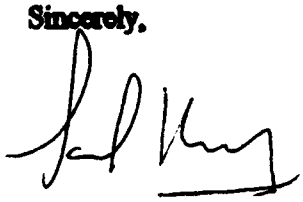

Samuel Knapp, Ed.D.
Professional Affairs Officer

COMMONWEALTH OF PENNSYLVANIA
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OFFICE OF SPECIAL PROJECTS
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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

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

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

The attached was submitted on August 26, 1999. However, the copy was not very readable. Therefore, the Department is re-submitting a copy of the comment from the letter received today.

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

Sincerely yours,

Peter J. Salvatore

Peter J. Salvatore
Regulatory Coordinator

11-195c

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Secretary

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Executive Vice President

Re: Pennsylvania Bulletin: Vol 29, July 31, 1999, Insurance Department: Quality Health Care Accountability and Protection; proposed regulations.

Dear Mr. Salvatore:

On behalf of the Pennsylvania Medical Society, the largest physician organization in the Commonwealth, I am submitting comments and recommendations related to the above captioned proposed regulations. These proposed regulations are intended to implement provisions of the Quality Health Care Accountability and Protection Act (Act 68 of 1998).

At the outset, I would like to compliment the Insurance Department for its openness during the drafting process and its willingness to share working drafts of the proposed regulations with interested stakeholders for input prior to submission for formal public comment through publication in the Pennsylvania Bulletin.

I will discuss first several issues which should be addressed in further detail in the regulations. I will also offer the Medical Society's comments and recommendations on specific sections of the proposed regulations.

§ 154.1Applicability and Purpose

Act 68 defines "managed care plans." The regulations repeat that definition and add examples. Unfortunately, there is no means for the Department to verify what entities are or aren't covered by the Act. The Medical Society was recently contacted by a physician's office who had received correspondence indicating that a number of their patient's employers "have elected not to abide by the provisions of Act 68." The Insurance Department was asked for clarification and was told that the employers named were in fact exempted from Act 68 either as self insured plans or as otherwise excluded because of federal (ERISA) protections.

The Department doesn't maintain a listing of plans or entities exempt from Act 68. Knowledge of the specific local employers mentioned in the correspondence enabled the Department to respond to the Society's inquiry.

The Medical Society recommends that the Department identify plans and entities that it (the Department) believes should be included under Act 68. That list should be available to the public, including health care providers, upon request. The Department should also be required to determine what plans and entities are <u>in fact</u> exempt from the provisions of the Act.

§ 154.2 Definitions

The Act defines "clean claim" as "a claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents payment being made on the claim."

The Medical Society is aware that, in other states where timely payments requirements similar to Act 68 have been legislated, there have been problems over the interpretation of what constitutes a clean claim. The Uniform Claim Form (Health Care Financing Administration (HCFA) 1500) has multiple lines for the physician to list services provided. Each of those services is a request for payment. What some insurers had done in other states is to suspend payment of a reported service but also not pay for other services listed on the same HCFA 1500.

The Department has attempted to correct that potential problem by including under section 154.18(d) language stating that "the prompt payment requirement of the Act also applies to the uncontested portion of a contested claim." The Medical Society thanks the Department for that language.

The Medical Society would suggest that further clarification be included under the clean claim definition by stating that each service listed on the HCFA 1500 be considered a claim. The Society recommends the addition of the following language "a claim is (1) a bill for service (2) a line item of service or, (3) all services for one recipient within a bill.

The Medical Society is also concerned that there is no stipulation requiring the payer to notify the provider that a claim has been suspended for lack of information, etc. Experiences in other states have been that the payer doesn't inform the provider that a claim is suspended as unclean or doesn't provide the reason(s) for the suspension.

The Society believes that the Insurance regulations should require payers to notify providers in a timely manner, which should be defined, when a claim is suspended and provide all of the reasons for suspension, especially when there may be more than one reason.

The requirements for provider access to the grievance process under the definition section, needs clarification. Normally, when a patient presents to a provider for treatment, he or she offers proof of insurance to be used to reimburse the provider for that care. The service is rendered and a claim is submitted for reimbursement. If the claim is subsequently challenged for medical necessity reasons, the provider should not be precluded from being able to defend the claim. The Society is concerned that the language of the statute and the regulations may be narrowly interpreted to require a written consent from the enrollee at the time the application for grievance is made. This would place an unnecessary burden on the provider and the patient, and may prevent the provider from pursuing a legitimate grievance. Securing a new consent from the patient could also delay the timing of the submission of the grievance.

The Medical Society suggests that the consent to treatment approval by the patient be permitted to serve as authorization to pursue the claim with the patient's insurer in the event of a medical necessity denial.

The Society doesn't object to informing the patient of the provider's intention to seek a grievance, both as continuation of the patient-physician relationship and to avoid duplicate filing of a grievance. The Society does object to an added requirement to seek the patient's consent to fight for payment of the provider's claim. Use of the consent to treatment or authorization by the patient to submit a claim for payment is not unlike the insurers' contention that submission of a claim by a subscriber authorizes the insurer to obtain information and to act to adjudicate that claim.

§ 154.16 Information for Enrollees

The next issue relates to requirements for disclosure of information for enrollees. Section 154.16 of the proposed regulations outlines the general disclosure requirements for enrollee information. Subsection (h) describes some of the specific information to be supplied to enrollees, prospective enrollees, and health care providers. Such information includes a description of emergency services, how to access care, etc.

The Medical Society believes that the list of information to be disclosed should include the plans' definition of "medical necessity," as approved by the Department of Health. Just as the definition of "emergency services" describes how such services are accessed, a medical necessity definition permits the enrollee and the provider to understand the rationale to be used by the plan to determine whether or not the care rendered was necessary.

The Medical Society requests that the plan's definition of "medical necessity", as approved by the Department of Health, be disclosed to the enrollee and, upon request, to the health care provider.

§154.18 Prompt Payment

Last but certainly not least, is the process for investigation and adjudication of complaints involving timely payment. As mentioned previously, other states which have implemented a timely payment requirement are having a variety of problems enforcing the provision.

The first problem is determining when the 45 days begins. Is it the date the providers' office submits the claim, the date of receipt of the claim by the insurer, or the date the insurer determines the claim is "clean" and refers the claim for processing?

The Medical Society has suggested that the date starting the 45 day clock should be the date the claim was submitted by the provider. Allowance should be made for time of mail delivery, i.e. three days at either end of the process. Insurers should be required to give the provider notice of claims suspended and the reasons for suspension in a timely manner (may require Insurance Department to define "timely"). The time taken by the insurer for such notification should not be deducted from the 45 day limit.

I would like to recount a recent experience with the timely payment complaint process. I believe the experience points out problems which weren't anticipated when the language of Act 68 was crafted or when the Insurance Department developed its process for investigating timely payment complaints.

In May, the Medical Society became aware of a situation where a large health care insurer had experienced a major computer malfunction which prevented the insurer from entering new covered patients into the system, correctly identifying participating providers within the network, and processing claims. At the time we heard of the problem, many providers' claims were well over the 45 day time limit, some claims were over 5 months old.

The Society immediately informed the Insurance Department of the situation but were told that the complaints had to be filed by individual physicians. Further, complaints had to be for specific claims and not be submitted as a collective complaint representing numerous claims or providers.

Fortunately, several physicians had already written to the Insurance Commissioner and the investigations were undertaken.

Approximately one month later the insurer notified participating providers of their problem (to the Society's knowledge, the first acknowledgement of the problem since it occurred in early April) and the steps being taken to correct the problem. The notification gave no assurances as to when the problem would be corrected or how previously submitted claims would be processed or recreated if necessary.

My reason for citing this experience is to point out that more attention and resources from the Insurance Department are needed to aggressively deal with the timely payment problem. The insurer in question operates in over ½ of the state. The payment problems affected thousands of physicians and other provider practices. The delayed payments and associated interest due amounted to millions of dollars. The problems with past claims which were submitted during the malfunction may never be addressed. Claims for patients never entered into the system or from providers inaccurately identified as non network providers may not be settled or may have to be resubmitted. Calculations of correct payment and interest must be made and verified for accuracy. Correction of these problems demands the active involvement of the Department.

The Medical Society recommends that the following remedies and solutions should be added to the Insurance regulations to correct problems which may arise in the implementation of Act 68:

- A requirement for insurer notification of network and non-network providers of any suspension of claims or situations affecting processing of the claim. Notification must include a proposed time for completion of claim processing and what, if any, information from the provider is required

- A requirement for Insurer notification of the Insurance Department of any interruption of services including processing of claims.

- A requirement for uniformity of complaint submission (Development of a Department complaint form and complaint tracking mechanism is needed.)

- A requirement for regular communication between insurers and providers during any prolonged payment difficulties.

- Providing an opportunity to batch complaints related to the timely payment of claims by services and/or provider.

- Pursuit of penalties and other disciplinary actions against insurers with pattern of abuse of timely payment provisions.

- A survey, conducted by the Insurance Department, of insurers and providers to determine compliance with timely payment requirements.

The remainder of the Medical Society's comments relate to specific sections of the proposed regulations.

154.12(b) Direct enrollee access to obstetrical and gynecological services.

The Department has confused "enrollee access to ob/gyn services" with the providers' requirement for prior authorization of services.

The Medical Society supports the Pennsylvania Section of the American College of Obstetricians in recommending that only services, such as reproductive endocrinology, gynecologic oncology, and maternal and fetal medicine, should have restrictions as to enrollee access.

154.12(c) Informing primary care providers within 30 days.

The Medical Society believes that services other than those related to a pregnancy should be reported to the enrollee's primary care provider every 30 days. However, the report visits during pregnancy and related services would place an unnecessary reporting burden and would offer little usable information to the primary care provider.

The Medical Society recommends that section 154.12 (c) be amended to require the obstetrician gynecologist to provide a report to the primary care provider which covers the duration of the enrollee's pregnancy following the postpartum visit. Other conditions not related to the pregnancy could be reported within 30 days.

154.15 (e) (2) AND (G) (5) Continuity of care and the use of participating providers.

These subsections require clarification to permit the enrollee to receive care appropriate to the needs of the patient even if that care must be provided by a non network provider or at a non participating facility.

Situations may arise where the physician providing care under the continuity of care provision doesn't have privileges at a network facility approved by the enrollee's new plan. There may also be situations where the provider may be part of a highly specialized treatment

team or the provider may require a specific subspecialty referral or ancillary service which is not part of the plan's network.

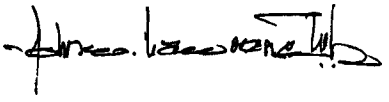
Subsections (e) (2) and (g) (5) would be restrictive and would preclude the enrollee from accessing appropriate care.

The Medical Society recommends that Section 154.15 (e) (2) be amended by the addition of the following after the word "enrollees" consistent with the health care needs of the enrollee, as determined by the provider.

The Medical Society further recommends that Section 154.15 (g) (5) be deleted from the proposed regulations.

The Pennsylvania Medical Society appreciates the opportunity to comment on these proposed regulations. If you have any questions or would like to discuss the Society's comments further, please contact Mr. Donald McCoy, the Society's Director of Policy and Regulatory Affairs.

Sincerely,



John W. Lawrence, MD
President

Cc: Deputy Commissioner Gregg Martino
The Honorable Nicholas Micozzie
Independent Regulatory Review Commission

DNM/doc/cor/Salvatore

The Insurance Federation of Pennsylvania, Inc.

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Danielle Witwer
Director of
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August 25, 1999

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

Re: Proposed Chapter 154 - Quality Health Care Accountability and Protection

Dear Mr. Salvatore:

The Insurance Federation offers the following comments on the Department's proposed regulation implementing those portions of Act 68 under its jurisdiction. We offer these comments on behalf of our members and our national counterpart, the Health Insurance Association of America.

Generally, we support the proposed regulation as consistent with Act 68 and a practical implementation of the requirements the Department intends to impose on managed care plans and, with respect to the act's prompt payment provisions, health insurers generally. We recommend, however, certain clarifications and refinements to several of the regulation's provisions.

Section 154.1 - Applicability and purpose

We recommend clarification of what the Department means by its reference to "cost plus products" in subsection (4). None of our members understood the term.

Section 154.2 - Definitions

We support the definitions as matching or correctly clarifying those in Act 68. We have, however, some questions based on comments made by the Department, legislators and others at yesterday's House Insurance Committee hearing on the regulation.

"Emergency service:" The inclusion of chronic conditions within the definition may prompt the need for further clarification. An enrollee may have a chronic condition that flares up from time to time (presumably a "sudden onset") and that needs immediate medical attention; examples might be asthma or arthritis. That would not necessarily justify a trip to the emergency room.

"Licensed insurer:" This matches the definition in Act 68 but may merit added clarification. As used in Act 68, the term applies only to the 45 day prompt payment rule. The Department may want to clarify that the prompt payment rule applies to all claims submitted under health policies, but that claims filed under auto and workers compensation policies are subject to their own rules under those acts. As will be detailed in our comments on Section 154.11, that is the fairest result given of the definitions for "clean claim" and "health care service."

"Managed care plan:" At yesterday's legislative hearing, there was some question as to whether this regulation would apply to managed care plans that do not use gatekeepers.

My understanding is that this proposal, unlike an earlier draft circulated by the Department, includes managed care plans that use only passive gatekeepers. Nonetheless, it would seem not to include - consistent with Act 68 - managed care plans that do not use any gatekeeper. Perhaps the best way to clarify this is to provide that where a plan does not require the enrollee to obtain a referral from any primary care provider in its network as a condition to receiving specialty care, it shall not be considered a "managed care plan" under this regulation.

Section 154.6 - Reporting of complaints and grievances

We recommend that the Insurance and Health Departments work together to ensure that the formats required by each agency match. Otherwise, managed care plans will face the needless administrative burden of reporting the same information to two agencies under two different formats.

A possible correction that avoids this potential administrative waste is to amend the second sentence to read that plans "report this information to the Department**s**," not just the Department. This would clarify that this information, while reported to two agencies, need only be reported under one format.

Section 154.7 - Emergency services

We recommend that subsection (b)'s reference to "all reasonably necessary costs associated with the emergency services provided during the period of the emergency" be clarified to refer to the evaluation and, if necessary, the stabilization of the condition of the enrollee.

That language comes from Section 2116 of Act 68. Further, it is consistent with how other states with similar laws have interpreted "reasonably necessary costs." Absent this, the regulation risks being interpreted to allow for tests and procedures that are more in-patient than emergency-oriented.

Section 154.10 - Complaints

As with Section 154.6, this is an instance where the Insurance and Health Departments will have to work together to ensure an effective system of resolving complaints and grievances.

The ambiguity here is with the determination of whether a dispute is a complaint or a grievance. The two departments should ensure that this determination is made on a uniform basis, regardless of which agency is asked to make the

determination. Otherwise, patients, providers and plans will be subject to uneven regulation and disparate results depending not on the facts, but the agency to which the facts are presented.

Based on yesterday's hearing, we have another concern, again probably relating more to grievances than complaints but one that should be "put on the record" now. The Pennsylvania Medical Society recommended that patients be allowed to "sign over" their rights to file grievances (and possibly complaints) to their providers - even before they might have grievances or complaints.

Nothing in Act 68 suggests such a "carte blanche," and we recommend the Insurance and Health Departments prevent it. First, only the enrollee, not the provider, can file a complaint; that is not a transferable right. Further, with respect to grievances, it makes no sense to allow the provider to get the enrollee's consent before there is even a grievance; nor does it make sense to allow for appeals of grievance rulings without separate consent. To adopt some medical and legal phrases, the key here should be informed consent, not a blanket power of attorney.

Section 154.11 - Prompt payment

As noted in our earlier comments on the definition of "licensed insurer," we believe this section should clarify that the prompt payment rule applies only to claims submitted under health insurance policies. The two major areas for this are auto and workers compensation; the timeliness of medical payments in both areas are covered under separate laws, and nothing in Act 68 suggests that those laws were amended by the act.

In fact, a strict reading of Act 68 limits the prompt payment rule to claims submitted under managed care plans only, not all other health plans. Section 2166 of Act 68 states that insurers and managed care plans "shall pay a clean claim submitted by a health care provider within 45 days of receipt" of the claim.

Section 2102 defines a clean claim as "a claim for payment for a health care service." It also defines a "health care service" as one "prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan." It also defines an enrollee as one covered under a managed care plan.

This leaves the Department with an inconsistency in Act 68 that must be reconciled: On the one hand, the act expressly adds "licensed insurers" to managed care plans in its prompt payment rule; on the other hand, its definitions - which control for the entire act, including the prompt payment provision, limit "clean claims" to those for services paid by managed care plans.

We recommend that inconsistency be resolved by extending the prompt payment rule to those insurance plans that Act 68 expressly excludes from its definition of "managed care plan," namely "ancillary service plans or an indemnity arrangement which is primarily fee for service."

We look forward to working with the Insurance Department, the Health Department and other interested parties in the promulgation of this regulation and that still to come from the Health Department, so that all of Act 68 can be effectively implemented.

Sincerely,

Samuel Marshall

Samuel R. Marshall

c: Gregory Martino, Deputy Insurance Commissioner

Stacy Mitchell, Director, Bureau of Managed Care
Pennsylvania Department of Health

Robert E. Nyce, Executive Director
Independent Regulatory Review Commission

FAX

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

Date **August 26, 1999**

Number of pages including cover sheet 6

To:	From:
Robert Nyce, Executive Director	Samuel Marshall
IRRC	

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

REMARKS:

Garner, Kim

99 AUG 25 PM 1:42

From: Markham, Christopher L.
Sent: Wednesday, August 25, 1999 11:54 AM
To: IRRC
Subject: FW: Highmark Inc. response to Act 68 Proposed Rulemaking

Support,

Please transfer these comments to the 2046 folder.

Thanks.

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth

----Original Message----
From: candy.gallaher@highmark.com [SMTP:candy.gallaher@highmark.com]
Sent: Wednesday, August 25, 1999 10:41 AM
To: cmarkham@irrc.state.pa.us
Subject: Highmark Inc. response to Act 68 Proposed Rulemaking

Chris, our comments are attached. We appreciate your review of our comments. Several areas in
the prompt payment provisions have created great consternation in our systems/programming
division. Thus you will see many comments there.

Please feel free to share a copy of the attached with other interested staff at the IRRC.
Sincerely,
Candy
---------- Forwarded by Candy Gallaher/CorpAffairs/CORP/Highmark on 08/25/99 10:37 AM ----------
(Embedded image moved to file: pic03207.pcx)

From: Colleen M Gallaher on 08/25/99 09:52 AM

Sent by: Candy Gallaher

To: psalvato@ins.state.pa.us
cc: gmartino@ins.state.pa.us, bruce.hironimus@highmark.com
Subject: Highmark Inc. response to Act 68 Proposed Rulemaking

The attached document, in MS Word .doc format, provides our comments on the proposed rulemaking
published July 30.

We appreciate the opportunity for input on these important regulations. The impact on our business
and customers cannot be understated.

A copy of the attachment will also be place in the US Mail, in order that you receive it within the 30-day
comment period.

If you have any difficulty with the attachment, please contact me at (717) 975-7426, and I will be happy
to fax, or resend in an alternative file format.

And, of course, if we can further clarify any of the information in the attached, please do not hesitate to
let us know. Thank you.

(See attached file: Act68CommentLetter.doc)


pic03207.pcx


Mac Word 3.0

93 AUG 25 PM 1:43

August 24, 1999

99 AUG 25 PM 1:43

Pennsylvania Insurance Department
Regulatory Coordinator
1326 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Salvatore:

Highmark Inc. hereby submits comments regarding the Department's proposed rulemaking adding Chapter 154 (relating to quality health care accountability and protection).

First, we wish to note our appreciation for the balanced and deliberative process with which the proposed rulemaking has been undertaken. We note, however, that several areas of the proposed rules, and the added clarifying language, may have unintended consequences. We are therefore providing comments highlighting those areas of concern, and proposing ways to address them in the following paragraphs.

Our key areas of concern include: 1) the definition of emergency, 2) some items in the complaints section, 3) flexibility needed regarding provider directories, and 4) administratively costly and burdensome new requirements regarding prompt payment of claims.

Definitions (Section 154.2)

Emergency Services (i):

Comments-The use of the phrase "including a chronic condition" is clearly intended to assure that enrollees with chronic conditions receive emergency care when an emergency occurs. We understand and support that intent. As drafted, however, the language is unnecessarily broad and could result in unnecessary grievances. Enrollees with chronic conditions might interpret this as permitting the use of the emergency room for routine medical treatment to treat chronic conditions.

Proposed change- To address this unintended consequence, insert new language as underlined in the following: "(i) Any healthcare service provided to an enrollee after the sudden onset of a medical condition, including a <u>sudden and unexpected medical event involving</u> a chronic condition...."

Ongoing course of treatment:

Comments-Managed care plans have been wrestling with the scope of "ongoing course of treatment", in order to appropriately administer the continuity of care requirements of the Act. It is believed that the intent is to provide for care and treatment *in progress*, when an enrollee is currently

under a doctor's care. For example, seeing a provider once, a year prior, for a condition such as arthritis, would not be considered an ongoing course of treatment, since the enrollee is not under doctor's orders or scheduled for visits or follow-up. We respectfully suggest that additional language in the definition could assist in clarifying this.

Proposed change-Insert new language as underlined in the following: "Continuous healthcare treatment which arises out of a single diagnosis provided to an enrollee by a health care provider. Continuous healthcare treatment means treatment has been rendered within the 3 (three) most recent months of the enrollee's coverage, and for which the enrollee continues to require the provider's care."

Licensed insurer:

Comments-The definition refers to corporations and other legal entities engaged in the business of insurance. This definition is unlike others we have seen which clearly specify when nonprofit hospital and professional health plan corporations are intended to be considered as "licensed insurers". The definition may be construed as exempting those entities, especially since Fraternal Benefit Societies and Preferred Provider Organizations are enumerated.

Information for Enrollees (Section 154.16)

Provider Directories, item(c)(2):

Comments-The written disclosure may be in a format determined by the managed care plan, and as stated may include only "a list of participating providers for only a specific type of provider or service" {see item (c)(2)}. Thus, we seek specific language that recognizes provider directories may be regional or county-based listings. Full directories of all providers for large plans are large documents, which entail high printing and postage costs. Managed care plans should, of course, make such directories available upon request, but to do so routinely represents unnecessarily high costs. Providing regional or county-based lists have satisfactorily met members' needs to date.

Proposed Change-Insert new language as underlined in the following: "(2) A list by specialty of the name, address and telephone number of all participating health care providers shall be available upon request. The list maybe a separate document, and may be a regional or county directory, and shall be updated at least annually...."

Disclosure following initial enrollment, item (g)(2):

Comment-This provision requires a re-issue to enrollees at renewal of materials (e.g. provider directories) if the network has changed since initial enrollment. This requirement is unnecessarily burdensome. Managed care plans directly contact members when there is a change to their PCP or specialists status. Moreover, managed care plans provide updates of new providers or providers who have moved, retired or died in quarterly newsletters. (At least one of those events will happen in any given network over the course of a year.) Thus, we recommend the following change.

Proposed change-Delete existing language as struck through in the following: "(2) Following initial enrollment, or upon renewal if benefits ~~or networks~~ have changed since the initial enrollment...."

Complaints (Section 154.17)

Comments-In item (2) the Department notes that disputes involving a contract exclusion are an appropriate item for complaints directed to the Insurance Department. Since experimental treatments and cosmetic procedures are standard contract exclusions, we suggest they also be enumerated as examples. Additionally, in its previous Statement of Policy from October 1998, it cited "failure to approve requests for standing referrals" as another example of a complaint, not a grievance. Such clarifications are helpful, and thus we recommend their continued usage in the language of the regulations.

Proposed change-Delete existing language as struck through and insert language as underlined in the following: "(2) Disputes involving a non-covered benefit ~~or contract exclusion~~ - for example a request for additional physical therapy services, even if medically necessary, beyond the number specified in the enrollee contract, or contract exclusions – such as exclusions for experimental or cosmetic procedures, or failure to approve requests for standing referral to a specialist for an enrollee with a life threatening, degenerative or disabling disease."

Comments- In item (e) managed care plans are required to complete the initial review within 30 days of receipt of the complaint. If, however, the plan has not received responses from providers substantiating a claim for additional benefits or review, the plan must make a determination using the materials on hand, often the same information used for the initial determination. We propose that the enrollee should have the right to approve an extension of the period for review. Thus we recommend the inclusion of additional language, as a new paragraph to item (e).

Proposed change- Add the following underlined paragraph to item (e) "The enrollee may approve an extension of the 30 day time period if the plan has not received the necessary medical records or documentation necessary to review the complaint by the 25th day of the 30 day period. The enrollee's approval must be received in writing."

Comments-Plans need to know the final disposition of complaints, thus we suggest a new item be included requiring such notice be provided.

Proposed change-Insert new item (m) at the end of the current section 154.17: "(m) The Department will provide the managed care plan and the enrollee with a written copy of the final determination of an appealed complaint."

Comments -In the questions and answers on the Department of Health web page intended to provide guidance on Act 68, question 66 asked whether a managed care plan can require that an enrollee submit the grievance under the plan's internal grievance process before going to court. The answer was "Yes. This process is designed to solve enrollee grievances at the most appropriate level. If an enrollee is dissatisfied with the outcome of the grievance process they can pursue other legal remedies." It is reasonable that the same be required in the complaint process. It is to everyone's advantage to attempt to resolve the complaint before costs of litigation are incurred.

Proposed change - Based on the foregoing, we suggest that another subsection added to the complaint section as follows: "(n) A managed care plan may require that enrollees exhaust the plan's complaint process prior to filing a lawsuit against the plan regarding issues of contract exclusions and noncovered benefits."

Prompt Payment (Section 154.18)

Comments-Item (c) specifies that interest payment must be made at the same time as payment of the claim and "added to amount owed on a clean claim". We do not understand the rationale for this requirement. It is extremely problematic for several reasons.

1) The interest payment should not be included as a medical claims expense, or the allowance for a procedure. First, the penalty is an administrative expense, not a health care expense and thus should not be reflected in a group's claim experience. And second, we do not want member's cost sharing - if any - based on a higher payment that is due to administrative expenses.

2) We seek to make the claims payment as promptly as possible. If we have exceeded the 45 days, we do not want to "hold claims" for payment for any longer. Yet, in order to do what is required in item (c), such an unintended consequence might occur.

Let us explain. We can only calculate interest *after* a claim has finalized and paid. Currently, we run a monthly report of paid claims to identify late claim payments, and make penalty payments out of the financial system as an administrative expense, not out of the claims system. Thus, "penalty" checks are mailed on a monthly basis, and at a later date than when payment for the claim was made. The only way we could meet the requirements as proposed would be by holding claims until the interest penalty check could be produced, resulting in unnecessarily later claim payments and higher interest expenses, neither of which is intended by the legislation.

3) We also note that these changes, and the additional requirements in paragraph (d) of the prompt payment provision, noted on the next page, represent programming costs of a significant magnitude. Changes to claims/financial systems to automate this requirement are impossible to implement at this time, given freezes on any new system changes that are in effect due to Y2K system priorities. This type of freeze on new programming is not unusual. HCFA and NAIC have both placed freezes on many system changes due to Y2K priorities as well. Given these concerns, we recommend the following change.

Proposed change- Delete existing language as struck through and insert language as underlined in the following: "(c) Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to a health care provider and shall be ~~added~~ in addition to the amount owed on a clean claim. The interest shall be paid ~~at the time of payment of the claim~~. within a reasonable time period but no later than 6 weeks after payment of claim...."

Prompt Payment item (d)

Comments-This provision is very problematic. The first sentence makes *all* paid claims subject to the late payment provision of the act, an inappropriate broadening of its intent. It also appears to require split claims, and includes language on re-adjudicated claims, which is unclear.

First, *not all* paid claims are clean claims. If a claim is pended awaiting documenting evidence of a medical condition such as X-rays, or for development of other party liability for an accident, it is not a clean claim.

Even once all information is received and the claim paid, it is *not* a clean claim.

Any requirement for processing systems to begin routinely "splitting claims" to create separate contested and uncontested portions of a claim would create havoc in a number of providers' accounting and billing systems as well, since they would have difficulty reconciling the claims payments sent with the claims submissions on their billing systems, and electronic billings. In addition, the automated claim system requirements necessary to split one claim for service into multiple claims (with separate claim numbers and tracking) are quite significant, and *not* achievable in the near term due to the aforementioned Y2K priorities as previously noted.

For these reasons we are opposed to the proposed language, and suggest the following changes to item (d), deleting the problematic language and inserting clarifying language regarding re-adjudicated claims.

Proposed change- "(d) ~~Claims paid by a licensed insurer or managed care plans are considered clean claims and are subject to the interest provisions of the act~~. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, ~~the~~ a new 45-day period for the prompt payment provision, separate from the initial claim, begins ~~again~~ at the time additional information prompting the re-adjudication is provided to the plan and the claim is re-opened. Additional monies which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter. ~~The prompt payment requirement of the act also applies to the uncontested portion of a contested claim. A contested claim is a claim for which required substantiating documentation has been supplied to the licensed insurer or managed care plan, but where the licensed insurer or managed care plan has determined that it is not obligated to make payment."~~

As previously noted, we appreciate the opportunity to provide these comments, We are available to discuss them at your convenience. I can be reached at (717) 975-7426, by fax at (717) 731-2337, or email at Candy.Gallaher@Highmark.com. Thank you.

Sincerely,

C. M. (Candy) Gallaher
Regulatory Affairs Director

Cc: G. Martino
B. Hironimus

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

August 17, 1999

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

Dear Mr. Salvatore:

We are writing on behalf of the Pennsylvania Section of the American College of Obstetricians and Gynecologists (ACOG), the Pennsylvania Chapter of the American College of Nurse Midwives (ACNM), and the patients we serve. Let us begin by thanking the Department of Insurance for incorporating some of the comments we made on the last version of the proposed regulations. After reviewing the revised proposed regulations, we would like to comment on three issues.

154.12 (b) Direct enrollee access to obstetrical and gynecological services
It is our understanding that the purpose of Section 154.12 is to define "*enrollee* access to obstetrical and gynecological services." In subsection (b), the Department strays from this definition by addressing the ob-gyn *providers'* requirement to obtain prior authorization for selected services. Preauthorization for selected services is a contractual issue between managed care plans and providers that is not addressed in the law.

We recommended in our previous comments that the Department considers language that states that subspecialty services such as reproductive endocrinology, gynecologic-oncology, and maternal and fetal medicine are the only restrictions for *enrollee* direct access to ob-gyn care. Replacing your current language in subsection (b) with our recommended language would be in keeping with the law and with the intent of Section 154.12.

154.12 (c) Informing primary care providers within 30 days
We agree that ob-gyn providers should inform the enrollee's primary care provider within 30 days of health services rendered. However, we strongly encourage the Department to define obstetrical care as the duration of the pregnancy since pregnancy related visits are frequent and ongoing for close to one year. Reporting each obstetrical visit within 30 days would be time consuming, cumbersome, and burdensome for both the obstetrical provider and the primary care physician.

Moreover, such a definition would be consistent with the billing entity of obstetrical care which is done subsequent to the postpartum visit and not on a visit-by-visit basis. Other conditions not related to the pregnancy would be reported to the primary care provider within 30 days.

PENNSYLVANIA
SECTION
OF ACOG
District III

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820
888-PA OBGYN (726-2496)
717-558-7841 Fax

Chair
Peter A. Schwartz, MD

Vice Chair
William R. Crombleholme, MD

Secretary/Treasurer
Ann L. Honebrink, MD

Executive Director
Kristi Wasson

154.15 (g)(5) Continuity of care and the use of participating hospitals or facilities
We would like to reiterate our concerns about this subsection. Clause 154.15 (f) reads: "health care *services* provided under the continuity of care requirement must be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers." In the case of the pregnant patient who is exercising her continuity of care benefit, PA ACOG and PA ACNM interprets this sentence to mean that her hospital labor and delivery "services" will be covered at the hospital where her ob-gyn has admitting privileges (which may be a non-participating hospital).

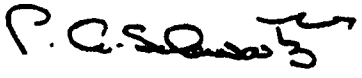
This interpretation is contradicted by term (g)(5), which states that "managed care plans may require non-participating providers to agree that all non-emergency inpatient care will be provided at the new managed care plan's participating hospital or facility." If the pregnant patient's provider does not have admitting privileges at the managed care plan's participating hospital, the ob-gyn cannot manage her labor and delivery - thus she is being denied the continuity of care benefit that the Act chose to protect.

Term (g)(5) should be removed because there are several scenarios where the patient's provider will not have admitting privileges at the managed care plan's participating hospital or facility, and the patient's continuity of care will be interrupted as soon as hospitalization is required. Clearly, this is at a time when continuity of care by the provider is of utmost importance and exactly what the Act was attempting to protect. We strongly urge the Department to remove this term that completely contradicts the intent of the Act.

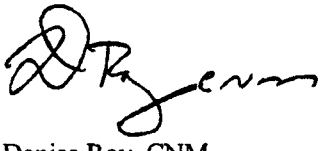
Thank you for allowing PA ACOG and PA ACNM to comment on the draft regulations of Act 68. We hope you will carefully consider our comments as we hope to optimize the benefits for our patients.

Please feel free to contact Kristi Wasson, PA ACOG Executive Director at 888-726-2496 if you have questions about our comments.

Sincerely,



Peter A. Schwartz, MD
Chair
PA ACOG



Denise Roy, CNM
President
PA ACNM

cc: Don McCoy – PA Medical Society
John Jewett – Independent Regulatory Review Commission

kaw/acog/regcomments-ins2.doc

Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Ms. Denise Roy,CNM — *President*
PA ACNM
777 East Park Drive
Harrisburg PA 17105-8820

Date Received *8/25/1999*

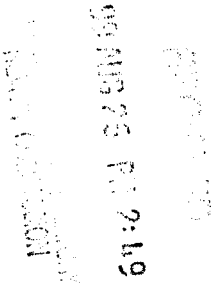
Phone: (888) 726-2496 X00000 *EMail:*

Dr. Peter A. SchwartzMD — *Chair*
PA ACOG
777 East Park Drive
Harrisburg PA 17105-8820

Date Received *8/25/1999*

Phone: (888) 726-2496 X00000 *EMail:*

Date sent to Committes and IRRC 8/25/1999



Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Mr. Harry D. Madonna
Blank Rome Comisky & McCauley LLP
One Logan Square
Philadelphia PA 19103-6998

Phone: (215) 569-5520 X00000

EMail: madonna@blankrome.com

Date Received *8/17/1999*

Date sent to Committes and IRRC 8/18/1999

ORIGINAL: 2046
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Email Address: madonna@blankrome.com

August 12, 1999

RECEIVED

AUG 17 1999

Office of Special Projects

Gregory S. Martino
Deputy Insurance Commissioner
Office of Regulation of Rates and Policies
Pennsylvania Department of Insurance
1311 Strawberry Square
Harrisburg, PA 17120

Re: Proposed Act 68 Regulations

Dear Mr. Martino:

As you are aware, this firm has been engaged to represent five health systems operating in the Delaware Valley area and the Delaware Valley Hospital Council of the Healthsystems Association of Pennsylvania (collectively, the "Clients") concerning certain practices and activities of Independence Blue Cross and its affiliates (collectively, "IBS") and in certain of matters before the Pennsylvania Insurance Department ("PID"). One of the pending matters before PID that we have been asked to comment upon are the proposed regulations to be enacted pursuant to the Quality Health Care Accountability and Protection Provisions of Article XXI of Act 68 of 1998 ("Act 68").

Enclosed for your review is a blacklined copy of the proposed regulations with our recommended additions and deletions.

This letter will briefly summarize the changes we are recommending and the reasons for the changes. The primary reasons for the changes we are recommending are to improve the time period within which claims are paid and to reduce the risks of improper denials of payments, which are clearly two of the mandates of Act 68. We believe our proposed changes will also make it easier for PID to policy compliance with Act 68 without adding any undue burdens on licensed insurers and managed care plans.

We propose changes to the following sections:

A. Definitions.

1. Amend Section 154.2, Counterclaim, to define with more clarity the nature of a "defect or impropriety" which would permit a licensed insurer or managed care plan to delay payment of a claim:

(i) the defect or impropriety should be those disclosed on the face of the claim; and

(ii) the defect or impropriety should not include (a) information that has no reasonable impact on the ability of the licensed insurer or managed care plan to evaluate its obligation to make a payment; (b) acts or omissions or fault of the licensed insurer or managed care plan; or (c) the fact that a claim that might be subject to the licensed insured's or managed care plan's coordination of benefits policies or to retrospective utilization review.

2. We propose addition of a definition for a "clean portion" of a claim, which definition would be used in the prompt payment provisions to require a licensed insurer or a managed care plan to pay that portion of the claim which is clean and delay that portion of the claim with respect to which a defect or impropriety exists.

3. We are proposing amending the description of "gatekeeper" to include not only the primary care provider selected by the enrollee but also any other persons or entities appointed by the managed care plan from whom an enrollee must obtain a referral or approval for a covered non-emergency healthcare services. This change is consistent with the intent of Act 68 and is required because many licensed insurers and managed care plans now require referrals or approvals for non-emergency services from a party other than the enrollee's primary care physician and such a person clearly acts a gatekeeper within the intent of Act 68.

4. We propose to amend the definition of "licensed insurer" to move to preferred provider organizations under the definition of managed care plans. A preferred provider organization is more similar to a managed care arrangement than a traditional indemnity plan and thus should be subject to the requirements of Act 68.

B. Emergency Services.

1. We propose amendments to Section 154.14 (a) to provide that managed care plans are prohibited not only from requiring a prior authorization, but also from requiring a referral from a gatekeeper or any managed care plan.

2. Amendment to Section 154.14 (b) to clarify the provisions regarding the scope of emergency services to make it clear that emergency services are interpreted under a prudent layperson definition and include all related services, including transportation, screening, diagnosis, stabilization and treatment of the patients.

3. Amendment to Section 154.14 (d)(1) to modify the provision requiring notice for circumstances in which an enrollee is admitted to a hospital or other healthcare facility by excluding cases in which the condition of the patient or information provided by the patient precludes the hospital or healthcare provider from accurately determining the indemnity of the enrollee's insurer. If the healthcare facility after reasonable efforts cannot accurately obtain this information, there clearly should not be a penalty imposed upon the healthcare provider to be reimbursed for its services and the licensed insurer or managed care plan should not be able to delay payment for such services.

4. Amendment to Section 154.14(e) to require the prudent layperson definition of emergency services and the specific claims payment policies be incorporated in all subscriber, master group, contracts, and all other documents including marketing materials.

C. Prompt Payment Provisions.

We propose modification of Section 154.18, Prompt Payment, of the proposed regulations, as follows:

1. Amend 154.18 (a) to define the date that a claim is "received" and to use that date to give a clear test by which to measure the commencement of the 45-day period.

2. Amend 154.18 (e) to incorporate the concept of the payment of a clean portion of the claim in order to require a licensed insurer or managed care plan to pay that portion of the claim which is clean and delay the portion of the claim with respect to which a defect or impropriety exists. This change will facilitate the timely payment of those portions of the claim with respect to which there are no questions and avoid the withholding of payment on a substantial claim for small claims related to a discreet portion of such claim;

3. Amend Section 154.18 (c) to specify a 10% rate of interest to be paid on any clean claim which is not paid within the 45-day period and require the licensed insurer or managed care plan to identify the specific amount of interest paid on such claim. This change will facilitate the analysis of any payments especially in the event of a dispute or reconciling question concerning the amount of interest paid on any claim.

4. Amend Section 154.18 (d) to clarify that the 45-day period does not restart for re-adjudicated claims process because of a mistake or error on the part of the licensed insurer or managed care plan.

5. Amend Section 154.18 (e) to provide a time period of seven days within which licensed insurers or managed care plans are to respond to inquiries regarding the status of unpaid claim.

6. Amend Section 154.18 (g)(3) to remove the requirement that a complaint specify the name of the patient's employer, as that information may or may not be available to the healthcare provider, and the disclosure of this information may not be relevant to any dispute concerning the claim.

7. Amend Section 154.18 (g)(6) to give the provider the ability to submit complaints in batches and permit challenges by appeal to the PID of any unreasonably burdensome claims processing guideline employed by the licensed insurers or managed care plans. Batching claims filings will reduce the potential number of appeals and consolidate challenges of burdensome payment guidelines and help to identify and resolve issues at an early stage before the claims processing is substantially delayed.

8. Amend Section 154.18 to include a section (h) which requires the licensed insurer or managed care plan to notify the policy holder and the healthcare provider in writing within 15 days after a claim is received if the licensed insurer or managed care plan determines it will not pay a portion of the claim.

9. Amend Section 154.18 to include a section (i) to add a requirement that the licensed insured or managed care plan establish and maintain an adequate recording, tracking and auditing system for all claims.

10. Amend Section 154.18 to include a section (j) to require licensed insurer or managed care plan to provide written guidelines to the healthcare providers concerning its claims processing procedures and requirements and provide at least 16 days notice to providers prior to amending such requirements. This is consistent with the concept of providing all parties concerned with the information necessary to understand the guidelines and properly provide to the licensed insurer or managed care plan the information necessary to process claims.

11. Amend Section 154.18 to include a section (i) that provides that the prompt payment provisions apply to out of area claims which are administered by licensed insurers and managed care plans.

We believe that these changes are not only consistent with the statutory mandate but also further insure full compliance with the spirit as well as the letter of the Act 68.

Sincerely,

HARRY D. MADONNA

HDM/mtb
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PROPOSED RULEMAKING

INSURANCE DEPARTMENT

[31 PA. CODE CHS. 154 AND 301]

~~<ttlstrt>~~Quality Health Care Accountability and Protection~~<ttlend>~~

[29 Pa.B. 4064]

The Insurance Department (Department) proposes to add Chapter 154 (relating to quality health care accountability and protection), to read as set forth in Annex A. The Department is publishing these regulations as a proposed rulemaking. The Department proposes the regulations under the authority of section 2181 of The Insurance Company Law of 1921 (40 P. S. § 991.2181), added by the act of June 17, 1998 (P. L. 464, No. 68) and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412).

Purpose

Proposed Chapter 154 is being promulgated to implement the quality health care accountability and protection provisions of the act of June 17, 1998 (P. L. 464, No. 68)(40 P. S. §§ 991.2101–991.2193) (act). The act was signed into law by the Governor on June 17, 1998. Article XXI, the Quality Health Care Accountability and Protection provisions, became effective January 1, 1999. The Department originally issued a statement of policy to provide interim guidance to entities subject to the act, specifically managed care plans, as defined by the act, and licensed insurers. See Chapter 301, Subchapter J (relating to quality health care accountability and protection–statement of policy). Upon adoption of these proposed regulations, the statement of policy shall be rescinded.

The proposed regulations are necessary to carry out the provisions of the act. These proposed regulations establish a framework of requirements to be followed by managed care plans and licensed insurers for implementation of, and ongoing operations under, the provisions of the act. Managed care plans and licensed insurers covered by the act are subject to regulation by both the Insurance Department and the

Department of Health. Department of Health regulations are scheduled to be promulgated separately from these regulations.

Explanation of Proposed Regulatory Requirements

Section 154.1 (relating to applicability and purpose) sets forth the applicability of this chapter to entities under the Department's authority.

Section 154.2 (relating to definitions) sets forth the definitions necessary to clearly understand this chapter. Most of the definitions in this section have been adopted from the act to provide greater clarity and understanding to this chapter. The terms "act," "Commissioner," "Department," "gatekeeper," "licensed insurer," "ongoing course of treatment" and "prospective enrollee," and their corresponding definitions have been added to provide greater clarity and understanding to this chapter.

Section 154.3 (relating to changes, modifications and disclosures in subscriber and other contracts and in other materials) sets forth how managed care plans shall implement changes to identified contracts and other materials to meet the requirements of the act.

Section 154.11 (relating to managed care plan requirements) sets forth the requirements under which managed care plans will allow enrollees with life threatening, degenerative or disabling diseases or conditions, to request and receive an evaluation and, if the plan's established standards are met, a standing referral to a specialist, or the designation of a specialist as a primary care provider. This section also establishes standards which plans may impose in meeting this requirement.

Section 154.12 (relating to direct enrollee access to obstetrical and gynecological services) sets forth the requirements under which managed care plans will allow enrollees direct access to obstetrical and gynecological services without prior approval from a primary care provider. This section clarifies that a plan may require the obstetrical or gynecological provider to obtain prior authorization for selected services such as diagnostic testing or subspecialty care. This section also establishes the time frame by which participating providers who provide direct obstetrical or gynecological services to enrollees must inform the enrollee's primary care provider of the services rendered. This section further sets forth coverage responsibilities for managed care plans with self-referral options.

Section 154.13 (relating to managed care plan reporting of complaints and grievances) sets forth the requirements for managed care plans to follow to report enrollee complaints and grievances to the Department.

Section 154.14 (relating to emergency services) sets forth the requirements applicable to coverage of emergency services by managed care plans. This section amplifies and clarifies the emergency services requirements of the act. This section also clarifies the requirements for emergency health care providers to notify managed care plans of the provision of emergency services to an enrollee.

Section 154.15 (relating to continuity of care) sets forth the requirements under which managed care plans shall provide the continuity of care option to an enrollee who is currently in an ongoing course of treatment with a provider that is terminated by the plan, or to a new enrollee, joining the plan, who is in an ongoing course of treatment with a nonparticipating provider. This section clarifies that the continuity of care provision is at the option of the enrollee. Providers under this section must agree to the managed care plan's terms and conditions for providing health care services.

Section 154.16 (relating to information for enrollees) sets forth the information that managed care plans shall provide to enrollees and, on written request, to prospective enrollees and health care providers. The information disclosed shall be in writing and shall be easily understandable to the layperson. This section also establishes the time periods for the disclosure of information to enrollees, prospective enrollees and health care providers.

Section 154.17 (relating to complaints) sets forth the requirements which managed care plans shall follow in accordance with the complaint processes established under the act. Managed care plans shall establish an internal complaint process with two levels of review. Examples of complaints, which could then be appealed by an enrollee to the Department, are listed in this section. This section also includes the information that an enrollee needs to provide to the Department, when appealing a managed care plan's second level complaint decision.

Section 154.18 (relating to prompt payment) applies to managed care plans and licensed insurers (insurers). This section sets forth the requirements that insurers and managed care plans shall comply with to meet the prompt payment provisions of the act. The prompt payment provisions of the act and this chapter are not intended to supersede the unfair claims settlement practices provisions of the Department's

regulations under the Unfair Insurance Practices Act (31 Pa. Code §§ 146.1–146.10) for the direct payment of claims to an insured or claimant. This section also sets forth the information health care providers need to provide to the Department to file a complaint.

Fiscal Impact

Adoption of these proposed regulations, consistent with the mandates of the act, may result in additional costs for the Commonwealth, managed care plans and licensed insurers. However, these proposed regulations are necessary for the Department to effectively implement, and for managed care plans and licensed insurers to comply with the act. Costs to the Commonwealth are not expected to be significant.

Paperwork

Adoption of these proposed regulations, consistent with the mandates of the act, may result in additional paperwork for the Commonwealth, managed care plans and licensed insurers. However, these proposed regulations are necessary for the Department to effectively implement, and for managed care plans and licensed insurers to comply with the act.

Persons Regulated

These proposed regulations apply to all managed care plans and licensed insurers issuing or underwriting health insurance contracts and policies in this Commonwealth.

Contact Person

Questions or comments regarding the proposed rulemaking may be addressed in writing to Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120 within 30 days following the publication of this notice in the

Pennsylvania Bulletin.

Questions or comments may also be e-mailed to psalvato@ins.state.pa.us or faxed to (717) 705-3873.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745(a)), on July 20, 1999, the Department submitted a copy of the proposed regulations to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. In addition to submitting these proposed regulations, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1. A copy of this material is available to the public upon request.

If IRRC has objections to any portion of the proposed regulations, it will notify the Department within 10 days of the close of the Committees' review period. The notification shall specify the regulatory review criteria that have not been met by that portion. The Regulatory Review Act specifies detailed procedures for review of objections raised, prior to final publication of the regulations by the Department, the General Assembly and the Governor.

DIANE KOKEN,
Insurance Commissioner

(*Editor's Note:* See a notice regarding the Department of Health's proposed rulemaking at 29 Pa.B. 4064 (July 30, 1999).)

Fiscal Note: 11-195. No fiscal impact; (8) recommends adoption. These regulations may result in some additional costs to the Commonwealth. These costs are not considered to be significant.

~~Annex~~ ANNEX A

TITLE 31. INSURANCE

PART VIII. MISCELLANEOUS PROVISIONS

CHAPTER 154. QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION

GENERAL PROVISIONS

Sec.

~~GENERAL PROVISIONS~~

GENERAL PROVISIONS

§ 154.1. Applicability and purpose.

(a) This chapter governs quality health care accountability and protection and applies to managed care plans and licensed insurers subject to the act.

(b) The terms and conditions of group and individual contract renewals and new business written by managed care plans on or after January 1, 1999, shall conform to the act.

(c) An entity subcontracting with a managed care plan to provide services to enrollees which issues subscriber contracts covering enrollees shall meet the requirements of the act and this chapter for services provided to those enrollees.

(d) Cost plus products, or their equivalent, which partially insure an entity's risk, shall meet the requirements of the act if they are issued by a managed care plan.

§ 154.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act–Article XXI of The Insurance Company Law of 1921 (40 P. S. §§ 991.2101–991.2193).

Clean claim –

~~(i)~~(i)A claim for payment for a health care service which has no defect or impropriety on the face of the claim. A defect or impropriety shall include lack of reasonably required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim, provided that the documentation requirements have been communicated to the provider in accordance with § 154.18(j). A defect or impropriety shall not include the absence or existence of information that has no reasonable impact upon a licensed insurer's or managed care plan's ability to adjudicate or evaluate its obligation to pay the claim; the absence or existence of any information that is attributable to any act or omission or fault of the licensed insurer or managed care plan; or the fact that a claim might be subject to the licensed insurer's or managed care plan's coordination of benefits policies, or to retrospective utilization review, including a review of the medical necessity of the service.

(ii) The term does not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

Clean portion (of a claim) –

(i) A portion of a claim for payment for a health care service that has no defect or impropriety on the face of the claim. A defect or impropriety shall include lack of reasonably required substantiating documentation which prevents timely payment from being made on that portion of the claim, provided that the documentation requirements have been communicated to the provider in accordance with § 154.18(j). A defect or impropriety shall not include the absence

or existence of information that has no reasonable impact upon a licensed insurer's or managed care plan's ability to adjudicate or evaluate its obligations to pay that portion of the claim; the absence or existence of any information that is attributable to any act or omission or fault of the licensed insurer or managed care plan; or the fact that a claim might be subject to the licensed insurer's or managed care plan's coordination of benefits policies or to retrospective utilization review, including a review of the medical necessity of the service.

(ii) The term shall not include any portion of a claim relating to a health care provider who is under investigation for fraud or abuse regarding that claim.

Commissioner –The Insurance Commissioner of the Commonwealth.

Complaint –

(i) A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan, which has not been resolved by the managed care plan and has been filed with the plan or with the Department of Health or the Department.

(ii) The term does not include a grievance.

Department – The Insurance Department of the Commonwealth.

Emergency service –

(i) Any health care service provided to an enrollee after the sudden onset of a medical condition, including a chronic condition, that manifests itself by acute symptoms of sufficient severity or severe pain, so 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 one of the following:

(A) 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.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(ii) Emergency transportation and related emergency service provided by a licensed ambulance service constitutes an emergency service.

Enrollee – A policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan.

Gatekeeper – A primary care provider selected by an enrollee or other person or entity appointed by a managed care plan, or the plan or an agent of the plan serving as the primary care provider, from whom an enrollee shall obtain covered health care services, a referral, or approval for covered, nonemergency health services as a precondition to receiving the highest level of coverage available under the managed care plan.

Grievance –

(i) As provided in section 2161 of the act (40 P. S. § 991.2161), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that does one of the following:

(A) Disapproves full or partial payment for a requested health care service.

(B) Approves the provision of a requested health care service for a lesser scope or duration than requested.

(C) Disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

(ii) The term does not include a complaint.

Health care provider – A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse

practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

Health care service – Any covered treatment, admission, procedure, medical supplies and equipment, or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

Licensed insurer – An individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer and other legal entity engaged in the business of insurance, and fraternal benefit societies as defined in the Fraternal Benefits Societies Code (40 P. S. §§ 1142-101–1142-701)~~, and preferred provider organizations as defined in section 630 of the The Insurance Company Law of 1921 (40 P. S. § 764a) and § 152.2 (relating to definitions).~~.

Managed care plan –

(i) A health care plan that: uses a gatekeeper to manage the utilization of health care services; integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards; and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:

(A) Section 630 of The Insurance Company Law of 1921.

(B) The Health Maintenance Organization Act (40 P. S. §§ 1551–1568).

(C) The Fraternal Benefit Societies Code.

(D) 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations).

(E) 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations).

(F) **Preferred provider organizations as defined in section 630 of the The Insurance Company Law of 1921 (40 P. S. § 764a) and 31 Pa. Code § 152.2 (relating to definitions).**

(ii) The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees.

(iii) The term does not include ancillary service plans as defined by the act or an indemnity arrangement which is primarily fee for service.

Ongoing course of treatment – Continuous health care treatment which arises out of a single diagnosis provided to an enrollee by a health care provider.

Plan – A managed care plan.

Primary care provider – A health care provider who, within the scope of the provider's practice:

(i) Supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to an enrollee.

(ii) Initiates enrollee referral for specialist care.

(iii) Maintains continuity of enrollee care.

Prospective enrollee – For group contracts or policies, those persons eligible for coverage as either a subscriber or dependent of a subscriber. For individual contracts or policies, a person who meets the eligibility requirements of the managed care plan.

Provider network –The health care providers designated by a managed care plan to provide health care services.

Utilization review – A system of prospective, concurrent or retrospective utilization review, as defined by the act, 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 does not include any of the following:

(i) Requests for clarification of coverage, eligibility or health care service verification.

(ii) 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 – An entity certified under section 2151 of the act (40 P. S. § 991.2151), which relates to utilization review certification, that performs utilization review on behalf of a managed care plan.

§ 154.3. Changes, modifications and disclosures in subscriber and other contracts and in other materials.

(a) Managed care plans shall implement changes, modifications and disclosures to subscriber and other contracts, marketing materials, member handbooks and other appropriate materials to meet the requirements of the act. Modifications can be implemented in several different ways including, contract endorsements, contract amendments and modification to the contract then in effect.

REQUIRED PROVISIONS AND ENROLLEE DISCLOSURES

§ 154.11. Managed care plan requirements.

(a) Managed care plans shall adopt and maintain procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation, and, if the plan's established standards are met, be permitted to receive either:

(1) A standing referral to a specialist with clinical expertise in treating the disease or condition.

(2) The designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

(b) A managed care plan's established standards, as referenced in subsection (a) may include:

(1) Time restrictions on approved treatment plans which include standing referrals or specialist designations.

(2) Requirements that treatment plans be periodically reviewed and reapproved by the plan.

(3) Requirements that the specialist notify the enrollee's primary care provider of all care provided.

§ 154.12. Direct enrollee access to obstetrical and gynecological services.

(a) Managed care plans shall permit enrollees direct access to obstetrical and gynecological services for maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals, and for diagnostic testing related to maternity and gynecological care from participating health care providers without prior approval from a primary care provider.

(b) 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.

(c) A directly accessed participating health care provider providing services to an enrollee who has direct access to the provider in accordance with section 2111(7) of the act (40 P. S. § 991.2111(7)) and this section, shall inform the enrollee's primary care provider, of all health care services provided to the enrollee. The health care provider shall communicate the information within 30 days of the services being provided under procedures established by the managed care plan.

(d) Managed care plans with enrollee self-referral options shall cover benefits provided by participating health care providers at the benefit level applicable to referred services.

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

(a) Section 2111(13) of the act (40 P. S. § 991.2111(13)) requires managed care plans to report specific information to the Department of Health and the Department with respect to the number, type and disposition of all complaints and grievances filed with the managed care plan. Managed care plans shall report this information to the Department based on the format utilized to report information prior to the effective date of the act.

(b) Notice of changes or amendments to the format required by the Department for reporting complaint and grievance information to the Department will be published in the *Pennsylvania Bulletin*. The notice will provide for a 30-day public comment period. Changes in format will become effective 30 days after publication of the revised format in a subsequent edition of the *Pennsylvania Bulletin*.

§ 154.14. Emergency services.

(a) Managed care plans are prohibited from requiring that enrollees or health care providers obtain prior authorization **or a referral from a gatekeeper or managed care plan** for emergency services as defined by section 2101 of the act (40 P. S. § 991.2102).

(b) Plans are required to pay all reasonably necessary costs associated with the ~~emergency services provided during the period of the emergency.~~ **provision of emergency services to a patient meeting the prudent layperson definition for emergency services, including, without limitation, the following: (i) emergency transportation and related services; (ii) all services reasonably necessary to screen the patient (including, without limitation, triage, examination, medical tests or any screening or diagnostic service) whether or not the patient is ultimately determined to be in need of emergency treatment; and (iii) all services reasonably necessary to diagnose, stabilize and treat the patient. Plans are prohibited from requiring an enrollee to utilize any particular emergency transportation services organization for emergency care or a participating emergency transportation services organization for emergency care.**

(c) Plans are required to consider the presenting symptoms as documented by the claim, and the services provided, when processing claims for emergency services.

(d) The emergency health care provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee.

(1) If the enrollee is admitted to a hospital or other health care facility, the emergency health care provider shall notify the enrollee's managed care plan of the emergency services delivered within 48 hours or on the next business day, whichever is later, **except in cases where the condition of, or information provided**

by, the patient precludes the hospital or health care provider from accurately determining the identify of the enrollee's insurer or managed care plan.

(2) If the enrollee is not admitted to a hospital or other health care facility, the claim for reimbursement for emergency services provided shall serve as notice to the enrollee's managed care plan of the emergency services provided by the emergency health care provider.

~~(e)~~(d) Managed care plans shall supply each enrollee, and upon written request, each prospective enrollee or health care provider, with the information concerning emergency services in § 154.16(h) (relating to information for enrollees).

(e) **Plans shall incorporate the prudent layperson definition of emergency services set forth in the act and this chapter, and specific plan policies concerning the provision of and payment for emergency services in the claims processing and payment, enrollee complaint, and enrollee and provider grievance systems in all of their subscriber, master group contracts and provider contracts, and in all other appropriate documents including marketing materials.**

§ 154.15. Continuity of care.

(a) Managed care plans are required to provide the option of continuity of care for enrollees when one of the following applies:

(1) A managed care plan terminates a contract with a participating provider for reasons other than for cause and the enrollee is then in an ongoing course of treatment with that provider.

(2) A new enrollee enters a managed care plan and is then in an ongoing course of treatment with a nonparticipating provider.

(b) A current enrollee shall be allowed to continue an ongoing course of treatment with a provider whose contract has been terminated for reasons other than for cause for a transitional period of up to 60 days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. For an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or

pending termination, the transitional period shall be extended through postpartum care related to the delivery.

(c) A new enrollee shall be allowed to continue an ongoing course of treatment with a nonparticipating provider when joining a managed care plan for a transitional period of up to 60 days from the effective date of enrollment in the managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. For an enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall be extended through postpartum care related to the delivery.

(d) Continuity of care is at the option of the enrollee.

(e) Nonparticipating and terminated providers shall agree to the same terms and conditions which are applicable to the managed care plan's participating providers. If multiple providers are involved in an ongoing course of treatment, one of the following conditions shall be met:

(1) All of the providers involved shall agree to the plan's terms and conditions.

(2) Those providers who accept the plan's terms and conditions shall agree to utilize participating providers for the provision of all other health care services to enrollees.

(f) Health care services provided under the continuity of care requirements shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers. To be eligible for payment by plans, providers shall agree to the terms and conditions of the managed care plan prior to providing service under the continuity of care provisions.

(g) Managed care plans may require nonparticipating or terminating providers to agree to terms that include:

(1) Accepting the plan's payment as payment in full for covered services, without balance billing, except for permitted deductibles, copayments or coinsurance.

(2) Agreeing to hold the enrollee harmless for any moneys which may be owed by the managed care plan to the provider.

(3) Complying with the plan's utilization review and quality assurance requirements.

(4) Agreeing to make referrals for specialty care, diagnostic testing and related services to the enrollee's current managed care plan's participating providers.

(5) Agreeing that ~~nonemergency~~ **non-emergency** inpatient care will be provided at one of the enrollee's current managed care plan's participating hospitals or facilities.

(6) Agreeing that the provider will provide copies of the enrollee's medical records to the plan or the enrollee's participating primary care provider, or both, prior to the conclusion of the ongoing course of previously authorized treatment.

(7) Agreeing to follow the plan's procedures for precertification or prior approval of specified ~~nonemergency~~ **non-emergency** services or procedures.

(h) Managed care plans may not require nonparticipating providers to undergo the plan's credentialing process as part of the continuity of care provision.

(i) Written disclosure of the continuity of care benefit requirements imposed under the act and this chapter shall be incorporated into the subscriber and master group contracts and all other appropriate documents. This information and other information necessary to provide continuity of care services shall also be provided in written form to terminated or terminating and nonparticipating providers within 10 days of notice to the plan that an enrollee is requesting continuity of care benefits.

§ 154.16. Information for enrollees.

(a) Managed care plans shall provide the written information in section 2136(a) of the act (40 P. S. § 991.2136(a)), which relates required disclosures, to enrollees and, on written request, to prospective enrollees and health care providers. Managed care plans may determine the format for disclosure of the required information. If the information is disclosed through materials such as subscriber

contracts, schedules of benefits and enrollee handbooks, the information should be easily identifiable within the materials provided.

(b) The information disclosed to enrollees, prospective enrollees and health care providers shall be easily understandable to the layperson.

(c) The written disclosure of information shall include:

(1) The information specified in section 2136(a) of the act.

(2) A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at least annually. If a list of participating providers for only a specific type of provider or service is provided, it shall include all participating providers authorized to provide those services.

(3) The information covered under section 2113(d)(2)(ii) of the act (40 P. S. § 991.2113(d)(2)(ii)), which relates to a medical "gag clause" prohibition. If applicable, managed care plans shall disclose in their subscriber contracts, schedule of benefits and other appropriate material, circumstances under which the managed care plan does not provide for, reimburse for or cover counseling, referral, or other health care services due to a managed care plan's objections to the provision of the services on moral or religious grounds.

(d) For the purposes of the specified disclosure statement required by section 2136(a)(1) of the act, subscriber and group master contracts and riders, amendments and endorsements, do not constitute "marketing materials" subject to the specified disclosure statement.

(e) For group contracts and policies, the managed care plan shall assure that the required disclosure information is provided to prospective enrollees upon written request. The managed care plan can either provide the information directly to prospective enrollees or allow the group policy holder or another entity to provide the information to prospective enrollees on behalf of the managed care plan.

(f) For individual contracts and policies, the managed care plan shall provide the required disclosure information directly to prospective enrollees upon written request.

(g) The disclosure of information to enrollees, prospective enrollees and health care providers as required by section 2136 of the act shall be provided as follows:

(1) During open enrollment periods managed care plans may disclose summary information to enrollees and prospective enrollees. If the disclosure of information does not include all the information required by the act and this chapter, the managed care plan shall simultaneously provide enrollees and prospective enrollees with a list of other information which has not been included with the open enrollment information. The listed information shall be made available to enrollees and prospective enrollees upon request.

(2) Following initial enrollment, or upon renewal, if benefits or networks have changed since the initial enrollment or last renewal, disclosure information should be provided to enrollees within 30 days of the effective date of the contract or policy, renewal date of coverage, if appropriate, or the date of request for the information.

(3) Disclosure information requested by prospective enrollees shall be provided to prospective enrollees within 30 days of the date of the written request for the information.

(4) Disclosure information requested by health care providers shall be provided to health care providers within 45 days of the date of the written request for the information.

(h) Managed care plans shall supply each enrollee, and upon written request, each prospective enrollee or health care provider, with the following information which shall be contained and incorporated into subscriber and master group contracts and all other appropriate documents:

(1) A description of the procedures for providing emergency services 24 hours a day.

(2) A definition of "emergency services," consistent with the act.

(3) Notice that emergency services are not subject to prior approval.

(4) The enrollee's financial and other responsibilities regarding emergency services, including the receipt of these services outside the managed care plan's service area.

(i) Managed care plans, upon written request by enrollees or prospective enrollees, shall provide written information as specified in section 2136(b) of the act. This information shall be easily understandable to the layperson.

§ 154.17. Complaints.

(a) Under the complaint process established by the act, the Department will consider complaints regarding issues of contract exclusions and noncovered benefit disputes. The grievance process, which is administered by the Department of Health, includes review of the medical necessity and appropriateness of services otherwise covered by the managed care plan. Examples of the types of complaints which may be filed with the Department include:

(1) Denial of payment by the plan based upon contractual limitation rather than on medical necessity--for example, denial of payment for a visit by an enrollee on the basis that the enrollee failed to meet the contractual requirement of obtaining a referral from a primary care provider. However, 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.

(2) Disputes involving a ~~noncovered~~ **non-covered** benefit or contract exclusion--for example, a request for additional physical therapy services, even if medically necessary, beyond the number specified in the enrollee contract.

(3) Problems relating to one or more of the following:

(i) Coordination of benefits.

(ii) Subrogation.

(iii) Conversion coverage.

(iv) Alleged nonpayment of premium.

(v) Dependent coverage.

(vi) Involuntary disenrollment.

(4) **Problems relating to claims submissions requirements imposed by a licensed insurer or managed care plan which are (1) unduly burdensome, (2) not reasonably related to the licensed insurer or managed care plan's ability to evaluate its obligation to pay the claim; and/or (3) resulting in an unreasonably high number of initial rejections of claims as not meeting the definition of "clean claims."**

(b) Managed care plans shall establish an internal complaint process with two levels of review to allow enrollees to file oral and written complaints regarding a participating health care provider or the coverage, operations or management policies of the plan.

(c) Inquiries regarding premium rate increases do not constitute "appeals" and may be filed with the Department without the necessity of following the plan's internal complaint process.

(d) Managed care plans may establish time frames, of at least 30 days, for the filing of complaints and grievances with the plan.

(e) Managed care plans shall complete the initial level of review of an enrollee complaint within 30 days of receipt of the complaint. The plan shall notify the enrollee in writing of the plan's decision following the initial review within 5 business days of the decision. The notification shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee.

(f) Managed care plans shall complete the second level of review of an enrollee complaint within 45 days of receipt of the enrollee's request for review. The plan shall notify the enrollee in writing within 5 business days of the rendering of a decision by the second level complaint review committee, including the basis for the decision and the procedure for appealing the decision to the Department or the Department of Health.

(g) Enrollees shall follow and complete the plan's internal complaint process before filing an appeal of the complaint decision with the Department or the Department of Health.

(h) Appeals of complaints shall be submitted to the Department within 15 days of receipt of notice of the second level review committee's decision.

(i) Appeals of complaints to the Department shall include information such as:

(1) The enrollee's name, address and daytime phone number.

(2) The enrollee's policy number, identification number and group number (if applicable).

(3) A copy of the complaint submitted to the managed care plan.

(4) The reasons for appealing the managed care plan's decision.

(5) Correspondence and decisions from the managed care plan regarding the complaint.

(j) If the Department believes that the appeal more appropriately relates to issues and matters under the jurisdiction of the Department of Health–for example, an issue involving quality of care–the Department will notify the enrollee and the managed care plan in writing of this determination and promptly transmit the appeal to the Department of Health for consideration. The original submission date of the appeal will be utilized to determine compliance with the filing time frame provided for in section 2142(a) of the act (40 P. S. § 991.2142(a)), which relates to the appeal of a complaint.

(k) The Department and the Department of Health share the statutory responsibility to regulate the enrollee and managed care plan complaint process. The Department will focus on the review of cases which concern the potential violation of insurance statutes, including the Unfair Insurance Practices Act (40 P. S. §§ 1171.1–1171.15). The Department of Health will focus on complaint issues primarily involving enrollee quality of care and quality of service.

(l) Complaint appeals under subsection (i) may be filed with the Department at the following address:

Pennsylvania Insurance ~~Department~~**Bureau** Department
Bureau of Consumer ~~Services~~**1321** Services
1321 Strawberry ~~Square~~**Harrisburg** Square
Harrisburg, Pennsylvania 17120

§ 154.18. Prompt payment.

(a) Licensed insurers and managed care plans shall pay clean claims or the **clean portion of claims** submitted by a health care provider for services provided on or after January 1, 1999, within 45 days ~~of the licensed insurer's or managed care plan's receipt of the clean claim~~ **after the claim is received by the licensed insurer or managed care plan** from the health care provider.

(b) For purposes of prompt payment, a claim shall be deemed to have been "paid" upon one of the following:

(1) A check is mailed by the licensed insurer or managed care plan to the health care provider.

(2) An electronic transfer of funds is made from the licensed insurer or managed care plan to the health care provider. **For purposes of prompt payment, a claim is considered "received" by the licensed insurer or managed care plan 3 days after it is mailed and, if it is submitted electronically, is considered "received" by the licensed insurer or managed care plan the day it is submitted.**

(c) **If a licensed insurer or a managed care plan fails to remit payment on a clean claim within 45 days after the claim is received, the licensed insurer or managed care plan shall add 10% interest per annum to the amount owed on the clean claim.** ~~(c)~~ Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid at the time of payment of the claim. Interest owed of less than $2 on a single claim does not have to be paid by the licensed insurer or managed care plan. Interest can be paid on the same check as the claim payment or on a separate check. **In making payment, the licensed insurer or managed care plan shall identify in**

writing, per claim, the specific amount paid on the claim and the specific amount paid as interest. If the licensed insurer or managed care plan combines interest payments for more than one late clean claim, the check shall include information listing each claim covered by the check and the specific amount of interest being paid for each claim.

(d) All claims~~(d) Claims~~ paid in full by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, the 45-day period for the prompt payment provision begins again at the time additional information prompting the ~~readjudication~~ re-adjudication is provided to the plan, except that the 45-day period shall not restart if the claim was not able to be processed because of a mistake, error or failure to coordinate information on the part of the licensed insurer or managed care plan. Additional moneys which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter. The prompt payment requirement of the act also applies to the uncontested portion of a contested claim. A contested claim is a claim for which required substantiating documentation has been supplied to the licensed insurer or managed care plan, but where the licensed insurer or managed care plan has determined that it is not obligated to make payment. A licensed insurer or managed care plan must pay interest on any re-adjudicated claim, or the re-adjudicated portion of a claim, from the date of the submission of the information necessary for the claim or portion thereof to be considered clean.

(e) Prior to filing a complaint with the Department, health care providers ~~who~~ that believe that a licensed insurer or managed care plan has not paid a clean claim or a clean portion of a claim in accordance with the act and this chapter should first contact the licensed insurer or managed care plan to determine the status of the claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim or portion of the claim is considered by the licensed insurer or the managed care plan to be ~~a~~"clean ~~claim.~~." Licensed insurers and managed care plans shall respond to the health care provider's inquiries regarding the status of unpaid claims within a reasonable period of time, not to exceed seven (7) calendar days.

(f) Health care providers may file a complaint with the Department prior to receipt of a determination from a licensed insurer or managed care plan as to whether a claim is considered a clean claim if one of the following applies:

(1) The licensed insurer or managed care plan has not responded to a health care provider's inquiries regarding the status of an unpaid claim within a reasonable period of time.

(2) The health care provider believes that the licensed insurer or managed care plan is otherwise not complying with the prompt payment provisions of the act.

(g) Complaints to the Department regarding the prompt payment of claims by a licensed insurer or managed care plan under the act and this chapter shall contain the following information:

(1) The provider's name, address and daytime telephone number and the claim number.

(2) The name and address of the licensed insurer or managed care plan.

(3) The name of the patient ~~and employer.~~;

(4) The dates of service and the dates the claims were submitted to the licensed insurer or managed care plan.

(5) Relevant correspondence between the provider and the licensed insurer or managed care plan, including requests for additional information from the licensed insurer or managed care plan.

(6) Additional information which the provider believes would be of assistance in the Department's review.

A provider may submit complaints in batches, which batches shall be reviewed by the Department within at least three months of submission. If the Department receives documentation from one or more providers indicating that a managed care plan or a licensed insurer has engaged in a pattern of failing to timely pay claims or otherwise violate the requirements of this section, the Department shall initiate an investigation pursuant to its authority under the act and hold, if requested by the provider, public hearings to determine the reason(s) therefor. The Department may also investigate other alleged violations of this section. Following an investigation, the Department may impose penalties or

sanctions under the act. A provider is not required to file a claim with the Department, and the procedures set forth in this regulation are not intended to preempt or prevent review before a court of competent jurisdiction.

(h) A licensed insurer or managed care plan shall notify the policyholder, covered person and health care provider in writing within 15 days after a claim is received if the licensed insurer or managed care plan determines that (1) it is not obligated to pay a portion or all of a claim, stating the reason(s) for the denial of the claim, or portion thereof, or (2) it disputes a portion or all of a claim, stating the reason(s) for the denial of a portion or all of the claim and the additional information necessary to determine if it will pay or deny the claim or disputed portion. If the licensed insurer or managed care plan fails to make notification regarding a denied or disputed claim, or portion thereof, within 15 days after the claim is received, the claim or portion thereof shall be deemed to be approved, and shall be paid within 45 days of submission as set forth in subsection (a) above.

(i) Each licensed insurer and managed care plan shall establish and maintain an adequate system for recording, tracking and auditing all claims, clearly indicating the date on which a claim is received and the date(s) of any action(s) on the claim.

(j) Each licensed insurer and managed care plan shall provide written guidelines to health care providers with which the licensed insurer or managed care plan regularly conducts business concerning (1) its claim submission process, including specific claims submission requirements for providers, and (2) the specific types of data and information reasonably required by the licensed insurer or managed care plan to deem a claim a "clean claim" for processing. Health care providers may file complaints in accordance with the provisions of Section 154.17 with regard to any such requirements which are (1) unduly burdensome, (2) not reasonably related to the licensed insurer or managed care plan's ability to evaluate its obligation to pay the claim; and/or (3) resulting in an unreasonably high number of initial rejections of claims as not meeting the definition of "clean claim." A licensed insurer or managed care plan shall comply with all applicable contractual obligations relating to its claims submission requirements, but in any event shall provide no less than 60 days written notice to providers prior to amending any such requirements.

(k) The requirements of this section shall also apply to any claim submitted by a health care provider to a licensed insurer or managed are plan for any service rendered to a patient who is not a subscriber or enrollee of that licensed insurer or managed care plan, but whose health care costs are reimbursed to the provider by the licensed insurer or managed care plan through an arrangement between the entity providing health insurance to that patient and the licensed insurer or managed care plan to which the claim is submitted.

PART X. HEALTH MAINTENANCE ORGANIZATIONS

CHAPTER 301. HEALTH MAINTENANCE ORGANIZATIONS

(*Editor's Note*: Chapter 301, Subchapter J is proposed to be deleted. For the text of the existing statement of policy, see 31 Pa. Code pages 301-33 to 301-41, serial pages (249129) to (249137).)

Subchapter J. (Reserved)

§§ 301.401--301.403. (Reserved).

§§ 301.411--301.416. (Reserved).

[Pa.B. Doc. No. 99-1228. Filed for public inspection July 30, 1999, 9:00 a.m.]

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August 18, 1999

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Legal

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

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

Attached is a list of commentators that have submitted comment on the above-mentioned regulation and the respective comment that was received.

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

Sincerely yours,

Peter J. Salvatore

Peter J. Salvatore
Regulatory Coordinator

11-195c2.doc

Original: 2046
Bush
cc: Harris
Jewett
Sandusky
Marksham
Smith
Legal

August 24, 1999

99 AUG 25 PM 2:19

Pennsylvania Insurance Department
Regulatory Coordinator
1326 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Salvatore:

Highmark Inc. hereby submits comments regarding the Department's proposed rulemaking adding Chapter 154 (relating to quality health care accountability and protection).

First, we wish to note our appreciation for the balanced and deliberative process with which the proposed rulemaking has been undertaken. We note, however, that several areas of the proposed rules, and the added clarifying language, may have unintended consequences. We are therefore providing comments highlighting those areas of concern, and proposing ways to address them in the following paragraphs.

Our key areas of concern include: 1) the definition of emergency, 2) some items in the complaints section, 3) flexibility needed regarding provider directories, and 4) administratively costly and burdensome new requirements regarding prompt payment of claims.

Definitions (Section 154.2)

Emergency Services (i):

Comments-The use of the phrase "including a chronic condition" is clearly intended to assure that enrollees with chronic conditions receive emergency care when an emergency occurs. We understand and support that intent. As drafted, however, the language is unnecessarily broad and could result in unnecessary grievances. Enrollees with chronic conditions might interpret this as permitting the use of the emergency room for routine medical treatment to treat chronic conditions.

Proposed change- To address this unintended consequence, insert new language as underlined in the following: "(i) Any healthcare service provided to an enrollee after the sudden onset of a medical condition, including a sudden and unexpected medical event involving a chronic condition...."

Ongoing course of treatment:

Comments-Managed care plans have been wrestling with the scope of "ongoing course of treatment", in order to appropriately administer the

continuity of care requirements of the Act. It is believed that the intent is to provide for care and treatment *in progress*, when an enrollee is currently under a doctor's care. For example, seeing a provider once, a year prior, for a condition such as arthritis, would not be considered an ongoing course of treatment, since the enrollee is not under doctor's orders or scheduled for visits or follow-up. We respectfully suggest that additional language in the definition could assist in clarifying this.

Proposed change-Insert new language as underlined in the following: "Continuous healthcare treatment which arises out of a single diagnosis provided to an enrollee by a health care provider. Continuous healthcare treatment means treatment has been rendered within the 3 (three) most recent months of the enrollee's coverage, and for which the enrollee continues to require the provider's care."

Licensed insurer:

Comments-The definition refers to corporations and other legal entities engaged in the business of insurance. This definition is unlike others we have seen which clearly specify when nonprofit hospital and professional health plan corporations are intended to be considered as "licensed insurers". The definition may be construed as exempting those entities, especially since Fraternal Benefit Societies and Preferred Provider Organizations are enumerated.

Information for Enrollees (Section 154.16)

Provider Directories, item(c)(2):

Comments-The written disclosure may be in a format determined by the managed care plan, and as stated may include only "a list of participating providers for only a specific type of provider or service" {see item (c)(2)}. Thus, we seek specific language that recognizes provider directories may be regional or county-based listings. Full directories of all providers for large plans are large documents, which entail high printing and postage costs. Managed care plans should, of course, make such directories available upon request, but to do so routinely represents unnecessarily high costs. Providing regional or county-based lists have satisfactorily met members' needs to date.

Proposed Change-Insert new language as underlined in the following: "(2) A list by specialty of the name, address and telephone number of all participating health care providers shall be available upon request. The list maybe a separate document, and may be a regional or county directory, and shall be updated at least annually...."

Disclosure following initial enrollment, item (g)(2):

Comment-This provision requires a re-issue to enrollees at renewal of materials (e.g. provider directories) if the network has changed since initial enrollment. This requirement is unnecessarily burdensome. Managed care plans directly contact members when there is a change to their PCP or specialists status. Moreover, managed care plans provide updates of new providers or providers who have moved, retired or died in quarterly newsletters. (At least one of those events will happen in any given network over the course of a year.) Thus, we recommend the following change.

Proposed change-Delete existing language as struck through in the following: "(2) Following initial enrollment, or upon renewal if benefits ~~or networks~~ have changed since the initial enrollment...."

Complaints (Section 154.17)

Comments-In item (2) the Department notes that disputes involving a contract exclusion are an appropriate item for complaints directed to the Insurance Department. Since experimental treatments and cosmetic procedures are standard contract exclusions, we suggest they also be enumerated as examples. Additionally, in its previous Statement of Policy from October 1998, it cited "failure to approve requests for standing referrals" as another example of a complaint, not a grievance. Such clarifications are helpful, and thus we recommend their continued usage in the language of the regulations.

Proposed change-Delete existing language as struck through and insert language as underlined in the following: "(2) Disputes involving a non-covered benefit ~~or contract exclusion~~ - for example a request for additional physical therapy services, even if medically necessary, beyond the number specified in the enrollee contract, or contract exclusions – such as exclusions for experimental or cosmetic procedures, or failure to approve requests for standing referral to a specialist for an enrollee with a life threatening, degenerative or disabling disease."

Comments- In item (e) managed care plans are required to complete the initial review within 30 days of receipt of the complaint. If, however, the plan has not received responses from providers substantiating a claim for additional benefits or review, the plan must make a determination using the materials on hand, often the same information used for the initial determination. We propose that the enrollee should have the right to

approve an extension of the period for review. Thus we recommend the inclusion of additional language, as a new paragraph to item (e).

Proposed change- Add the following underlined paragraph to item (e) "The enrollee may approve an extension of the 30 day time period if the plan has not received the necessary medical records or documentation necessary to review the complaint by the 25th day of the 30 day period. The enrollee's approval must be received in writing."

Comments-Plans need to know the final disposition of complaints, thus we suggest a new item be included requiring such notice be provided.

Proposed change-Insert new item (m) at the end of the current section 154.17: "(m) The Department will provide the managed care plan and the enrollee with a written copy of the final determination of an appealed complaint."

Comments -In the questions and answers on the Department of Health web page intended to provide guidance on Act 68, question 66 asked whether a managed care plan can require that an enrollee submit the grievance under the plan's internal grievance process before going to court. The answer was "Yes. This process is designed to solve enrollee grievances at the most appropriate level. If an enrollee is dissatisfied with the outcome of the grievance process they can pursue other legal remedies." It is reasonable that the same be required in the complaint process. It is to everyone's advantage to attempt to resolve the complaint before costs of litigation are incurred.

Proposed change - Based on the foregoing, we suggest that another subsection added to the complaint section as follows: "(n) A managed care plan may require that enrollees exhaust the plan's complaint process prior to filing a lawsuit against the plan regarding issues of contract exclusions and noncovered benefits."

Prompt Payment (Section 154.18)

Comments-Item (c) specifies that interest payment must be made at the same time as payment of the claim and "added to amount owed on a clean claim". We do not understand the rationale for this requirement. It is extremely problematic for several reasons.

1) The interest payment should not be included as a medical claims expense, or the allowance for a procedure. First, the penalty is an administrative expense, not a health care expense and thus should not be

reflected in a group's claim experience. And second, we do not want member's cost sharing - if any - based on a higher payment that is due to administrative expenses.

2) We seek to make the claims payment as promptly as possible. If we have exceeded the 45 days, we do not want to "hold claims" for payment for any longer. Yet, in order to do what is required in item (c), such an unintended consequence might occur.

Let us explain. We can only calculate interest *after* a claim has finalized and paid. Currently, we run a monthly report of paid claims to identify late claim payments, and make penalty payments out of the financial system as an administrative expense, not out of the claims system. Thus, "penalty" checks are mailed on a monthly basis, and at a later date than when payment for the claim was made. The only way we could meet the requirements as proposed would be by holding claims until the interest penalty check could be produced, resulting in unnecessarily later claim payments and higher interest expenses, neither of which is intended by the legislation.

3) We also note that these changes, and the additional requirements in paragraph (d) of the prompt payment provision, noted on the next page, represent programming costs of a significant magnitude. Changes to claims/financial systems to automate this requirement are impossible to implement at this time, given freezes on any new system changes that are in effect due to Y2K system priorities. This type of freeze on new programming is not unusual. HCFA and NAIC have both placed freezes on many system changes due to Y2K priorities as well. Given these concerns, we recommend the following change.

Proposed change- Delete existing language as struck through and insert language as underlined in the following: "(c) Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to a health care provider and shall be ~~added~~ in addition to the amount owed on a clean claim. The interest shall be paid ~~at the time of payment of the claim~~. within a reasonable time period but no later than 6 weeks after payment of claim...."

Prompt Payment item (d)

Comments-This provision is very problematic. The first sentence makes *all* paid claims subject to the late payment provision of the act, an inappropriate broadening of its intent. It also appears to require split claims, and includes language on re-adjudicated claims, which is unclear.

First, *not all* paid claims are clean claims. If a claim is pended awaiting documenting evidence of a medical condition such as X-rays, or for development of other party liability for an accident, it is not a clean claim. Even once all information is received and the claim paid, it is *not* a clean claim.

Any requirement for processing systems to begin routinely "splitting claims" to create separate contested and uncontested portions of a claim would create havoc in a number of providers' accounting and billing systems as well, since they would have difficulty reconciling the claims payments sent with the claims submissions on their billing systems, and electronic billings. In addition, the automated claim system requirements necessary to split one claim for service into multiple claims (with separate claim numbers and tracking) are quite significant, and *not* achievable in the near term due to the aforementioned Y2K priorities as previously noted.

For these reasons we are opposed to the proposed language, and suggest the following changes to item (d), deleting the problematic language and inserting clarifying language regarding re-adjudicated claims.

Proposed change- "(d) ~~Claims paid by a licensed insurer or managed care plans are considered clean claims and are subject to the interest provisions of the act~~. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, ~~the~~ a new 45-day period for the prompt payment provision, separate from the initial claim, begins ~~again~~ at the time additional information prompting the re-adjudication is provided to the plan and the claim is re-opened. Additional monies which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter. ~~The prompt payment requirement of the act also applies to the uncontested portion of a contested claim. A contested claim is a claim for which required substantiating documentation has been supplied to the licensed insurer or managed care plan, but where the licensed insurer or managed care plan has determined that it is not obligated to make payment."~~

As previously noted, we appreciate the opportunity to provide these comments, We are available to discuss them at your convenience. I can be reached at (717) 975-7426, by fax at (717) 731-2337, or email at Candy.Gallaher@Highmark.com. Thank you.

Sincerely,

C. M. (Candy) Gallaher
Regulatory Affairs Director

Cc: G. Martino
B. Hironimus

Comments on the regulation listed below have been received from the following:

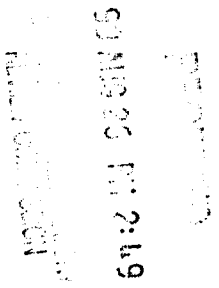
Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Ms. Candy Gallaher — *Regulatory Affairs Director*
Highmark, Inc.
1800 Center Street
Camp Hill PA 17011-

Phone: (717) 975-7426 X00000 *EMail:* candy.gallaher@highmark.com

Date Received *8/25/1999*

Date sent to Committes and IRRC 8/25/1999



COMMONWEALTH OF PENNSYLVANIA
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August 25, 1999

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

99 AUG 25 PM 2:19

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

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

Attached is a list of commentators that have submitted comment on the above-mentioned regulation and the respective comment that was received.

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

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

11-195c

Commonwealth of Pennsylvania

Department of Health

HARRISBURG
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99 SEP 14 PM 2:03

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte

DATE: August 3, 1995

SUBJECT: "Effective Communication" Provisions of the ADA and the Rehabilitation Act As They Apply to HMOs

TO: Chief Executive Officers of All Licensed Health Maintenance Organizations
Chief Executive Officers of All Pending HMO Certificate of Authority Applicants

FROM: Thomas J. Chepel, C.L.U., C.P.C.U.
Acting Director
Bureau of Health Care Financing

The Developmental Disabilities Planning Council is an independent State Council authorized under the federal Developmental Disabilities Assistance and Bill of Rights Act of 1990. The Council is comprised of twenty individuals appointed by the Governor, and its mandate is to work toward the maximum integration, independence and productivity of Pennsylvanians with developmental disabilities.

The Council has requested that the Bureau of Health Care Financing distribute to all licensed HMOs and applicants for licensure a reminder of HMO responsibility under federal legislation to communicate effectively with their members with disabilities. Thus, I am enclosing for your information and appropriate action a memorandum prepared on the Council's behalf by the Pennsylvania Health Law Project.

It is our intent to work with the Council to include a few basic questions regarding effective communication with disabled members in our 1995 HMO Annual Report form.

If you have any general questions, please feel free to contact me. If you have specific questions regarding the enclosure, you may contact The Pennsylvania Health Law Project's Harrisburg office directly at the address and number included in the enclosure.

Thank you for your cooperation and assistance.

Enclosure

"Effective Communication" provisions of the ADA and the Rehabilitation Act as they apply to HMOs

For HMOs having contracts with Medical Assistance or Medicare

Section 504 of the Rehabilitation Act of 1973 as amended, 29 U.S.C. 794, would apply to HMOs having contracts with Medical Assistance or Medicare as they are a "program or activity receiving Federal financial assistance" (Medical Assistance is a form of "Federal financial assistance" since roughly half the financing comes from the Federal government). Title II of the Americans with Disabilities Act ("ADA") would also apply to HMOs with Medical Assistance contracts as they are State contractors. See Department of Justice summary discussion accompanying the implementing regulations, 28 CFR Part 35, published at 56 FedReg 35696, July 26, 1991. It is important to note that the §504 requirements apply to the entire HMO (as defined by its Certificate of Authority), not just to those subscribers on Medical Assistance or Medicare. §504(b)(3)(A)(ii) of the Rehabilitation Act.

The requirements of §504 regarding effective communication that apply to recipients of Federal financial assistance (e.g. HMOs with Medicare or Medical Assistance Contracts) are found at 45 CFR §84.52(d). It states: "A recipient [of an MA or Medicare contract]...shall provider appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question." The regulation goes on to state that "auxiliary aids may include brailled and taped material, interpreters, and other aids for persons with impaired hearing or vision." §84.52(d)(3). A similar provision is contained in regulations implementing Title II of the ADA (applying to HMOs with MA contracts). See 28 CFR §35.160. The Title II regulations define auxiliary aids as: "(1) Qualified interpreters, notetakers, transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDD's), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments; (2) Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments...." 28 CFR §35.103 Applying these requirements to HMOs with MA or Medicare contracts, there appear to be several areas where HMOs must make special provisions to comply with the law.

<u>General informational printed materials</u>

HMOs are responsible for making available in alternative formats general informational printed materials provided to subscribers including, but not limited to the subscriber/member handbook and the explanation of grievance procedures (required to be provided annually). In determining the type of alternative format, the Title II ADA regulations require that the HMO "shall give primary consideration to the requests of the individual with disabilities." 28 CFR §35.160(b)(2). It should be recognized that no single alternative format will meet the needs of all persons sensory disabilities.

Methods for accepting inquiries, complaints and grievances

HMOs are responsible for accepting inquiries, complaints and grievances from subscribers with disabilities which are in alternative formats including: text telephones (TDD) for telephone inquiries and complaints from persons who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. HMO employees who receive telephone inquiries or complaints should also be made aware of the speech limitations of some persons with disabilities (severe cerebral palsy for example) so they can treat these individuals with patience, understanding and respect.

Assistance in presenting one's case at a 2nd level grievance hearing

HMOs would be responsible to provide assistance to persons with disabilities in presenting their case at a 2nd level grievance hearing. This would include:

* Providing qualified sign language interpreters for persons who are severely hearing impaired;
* Providing information submitted on behalf of the HMO at the grievance hearing in an alternative format accessible to the subscriber filing the grievance. The alternative format version should be supplied to the subscriber at or before the grievance hearing, not after, so the subscriber can discuss and/or refute the content before the Grievance Committee.
* Providing personal assistance to individuals with other physical limitations in copying and presenting documents and other evidence.

Enrolled Providers

In addition to the requirements set out supra., any physician or other health care provider, including those enrolled in an HMO's network, would be subject to the requirements of Title III of the ADA as Title III applies to "public accommodations". 28 CFR §36.104. "Public accommodations" include: "professional office of a health care provider, hospital, or other service establishment". 28 CFR §36.104(6).

Title III requires that: "A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities." 28 CFR §36.303. The definition of auxiliary aids under Title III is identical to the definition under Title II set out on the first page.

While it is the responsibility of the providers themselves to comply with ADA rather than the HMO (except for HMOs that own physician practices), HMOs should be encouraged to include compliance with Title III of the ADA as one of their provider credentialing standards.

Purchased Group Practices

While compliance with Title III of the ADA would normally be the responsibility of the provider, where a subsidiary of the HMO owns a group practice which is located in an office that is identified with the HMO's name or logo (so that the general public would be lead to believe it was an office of that HMO), the HMO may also be responsible for Title III compliance. Note that this compliance would also include compliance with Title III's requirements as to physical and sensory accessibility of the offices (although the specifics of those provisions are beyond the scope of this memo).

Prepared for the PA Developmental Disabilities Planning Council (an independent State council)
by the PA Health Law Project
931 N. Front St.
Harrisburg, PA 17102
(717) 236-6310

September 13, 1995

PA Health Law Project

20 N. Market Sq., 3rd flr., Harrisburg, PA 17101

Phone: (717) 236-6310 Fax: (717) 236-6311

Date : 09/14/1999 **Subject : ADA & information for HMO enrollees**

To: John Jewett

Company : IRRC

From : David Gates **Pages : 5**

Message:

Here's a memo I did on this topic that was distributed by the Department of Health. Will call you.

SEP 14 PM 2:03

99 AUG 26 AM 8:35

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

August 17, 1999

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

Dear Mr. Salvatore:

PENNSYLVANIA

SECTION
OF ACOG
District III

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820
888-PA OBGYN (726-2496)
717 558-7841 Fax

Chair
Peter A. Schwartz, MD

Vice Chair
William R. Crombleholme, MD

Secretary/Treasurer
Ann L. Honebrink, MD

Executive Director
Kristi Wasson

We are writing on behalf of the Pennsylvania Section of the American College of Obstetricians and Gynecologists (ACOG), the Pennsylvania Chapter of the American College of Nurse Midwives (ACNM), and the patients we serve. Let us begin by thanking the Department of Insurance for incorporating some of the comments we made on the last version of the proposed regulations. After reviewing the revised proposed regulations, we would like to comment on three issues.

154.12 (b) Direct enrollee access to obstetrical and gynecological services
It is our understanding that the purpose of Section 154.12 is to define "*enrollee* access to obstetrical and gynecological services." In subsection (b), the Department strays from this definition by addressing the ob-gyn *providers'* requirement to obtain prior authorization for selected services. Preauthorization for selected services is a contractual issue between managed care plans and providers that is not addressed in the law.

We recommended in our previous comments that the Department considers language that states that subspecialty services such as reproductive endocrinology, gynecologic-oncology, and maternal and fetal medicine are the only restrictions for *enrollee* direct access to ob-gyn care. Replacing your current language in subsection (b) with our recommended language would be in keeping with the law and with the intent of Section 154.12.

154.12 (c) Informing primary care providers within 30 days
We agree that ob-gyn providers should inform the enrollee's primary care provider within 30 days of health services rendered. However, we strongly encourage the Department to define obstetrical care as the duration of the pregnancy since pregnancy related visits are frequent and ongoing for close to one year. Reporting each obstetrical visit within 30 days would be time consuming, cumbersome, and burdensome for both the obstetrical provider and the primary care physician.

Moreover, such a definition would be consistent with the billing entity of obstetrical care which is done subsequent to the postpartum visit and not on a visit-by-visit basis. Other conditions not related to the pregnancy would be reported to the primary care provider within 30 days.

154.15 (g)(5) Continuity of care and the use of participating hospitals or facilities
We would like to reiterate our concerns about this subsection. Clause 154.15 (f) reads: "health care *services* provided under the continuity of care requirement must be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers." In the case of the pregnant patient who is exercising her continuity of care benefit, PA ACOG and PA ACNM interprets this sentence to mean that her hospital labor and delivery "services" will be covered at the hospital where her ob-gyn has admitting privileges (which may be a non-participating hospital).

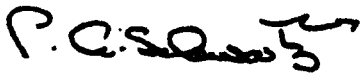
This interpretation is contradicted by term (g)(5), which states that "managed care plans may require non-participating providers to agree that all non-emergency inpatient care will be provided at the new managed care plan's participating hospital or facility." If the pregnant patient's provider does not have admitting privileges at the managed care plan's participating hospital, the ob-gyn cannot manage her labor and delivery - thus she is being denied the continuity of care benefit that the Act chose to protect.

Term (g)(5) should be removed because there are several scenarios where the patient's provider will not have admitting privileges at the managed care plan's participating hospital or facility, and the patient's continuity of care will be interrupted as soon as hospitalization is required. Clearly, this is at a time when continuity of care by the provider is of utmost importance and exactly what the Act was attempting to protect. We strongly urge the Department to remove this term that completely contradicts the intent of the Act.

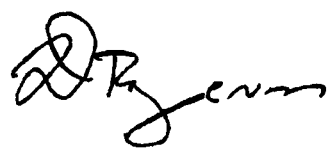
Thank you for allowing PA ACOG and PA ACNM to comment on the draft regulations of Act 68. We hope you will carefully consider our comments as we hope to optimize the benefits for our patients.

Please feel free to contact Kristi Wasson, PA ACOG Executive Director at 888-726-2496 if you have questions about our comments.

Sincerely,



Peter A. Schwartz, MD
Chair
PA ACOG



Denise Roy, CNM
President
PA ACNM

cc: Don McCoy – PA Medical Society
John Jewett – Independent Regulatory Review Commission

kaw/acog/regcomments-ins2.doc

Garner, Kim

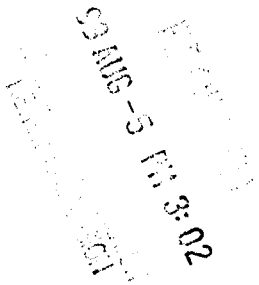
From: Pete Salvatore [psalvato@ins.state.pa.us]
Sent: Thursday, August 05, 1999 2:58 PM
To: costa@dem.pasen.gov; eholl@pasen.gov; tdeluca@pahouse.net; nmicozzi@pahousegop.com; irrc@irrc.state.pa.us
Subject: Comments on Proposed Rule "Quality Health Care Accountability and Protection"

ORIGINAL: 2046 - BUSH
COPIES: Harris, Jewett, Markham, Smith, Wilmarth, Sandusky, Legal


David Farrick.vcf


ATT00661.txt

Pursuant to 1 Pa. Code Section 305.2, relating to delivery of comments and information by an agency, the Department is forwarding the comment received from Mr. David Farrick. The Department will also send a hard copy of this comment to the appropriate chairs of the Committees and the Executive Director of the IRRC.



>From: "David Farrick, CMPE, MHA" <farrickd@blairortho.com>
>To: <psalvato@ins.state.pa.us>
>Subject: Comments on Proposed Rule "Quality Health Care Accountability and Protection"
>Date: Thu, 5 Aug 1999 13:23:58 -0400
>X-MSMail-Priority: Normal
>X-Mailer: Microsoft Outlook 8.5, Build 4.71.2173.0
>Importance: Normal
>X-MimeOLE: Produced By Microsoft MimeOLE V4.72.3110.3
>
>I have several comments regarding the proposed rule to implement Quality
>Health Care Accountability and Protection. Specifically, my comments focus
>on Section 154.18, Prompt Payments.
>
>paragraph 154.18 (c) The interest rate calculation should state a specific
>amount. A commonly used standard is the Highest WSJ National Prime Rate.
>This rate, however, does not take into account the additional administrative
>and record-keeping burdens of the late payments. Telephone calls must be
>placed, letters must be written, documentation kept, etc. by the providers
>due to the insurers late payments. An additional 2% added to the Highest
>WSJ National Prime Rate would serve not only as a disincentive for insurers
>to have late payments, but also assist providers in the additional expenses
>borne by the late payment of clean claims.
>
>paragraph 154.18 (c) Delete the statement "Interest owed of less than $2 on
>a single claim does not have to be paid by the licensed insurer or managed
>care plan." Since these are clean claims and will be processed through a
>computerized system, there is absolutely no reason why individual claims
>should be exempt and/or limits imposed on the amount or level of interest
>payments. Providers will inevitably share an undue burden to deal with
>these late payments and should not be denied interest penalty payments
>because of an arbitrary dollar limit. Today's claims processing systems are
>entirely capable of dealing with this level of accounting.
>
>paragraph 154.18 (e) The amount of reasonable time the licensed insurer has
>to respond to a provider's inquiry must be defined. 10 Days is a reasonable
>amount of time for the insurer to respond. This limit should be set so that
>delays do not continue to hamper the payment of a claim, nor should there be
>any misunderstanding about what is reasonable. Additionally, the licensed
>insurer should respond to the provider, in writing, as to the problems
>associated with the claim. This affords the provider written documentation
>should the licensed insurer fail to process a clean claim. Word of mouth or

>telephone conversations are unacceptable means of communication and do not
>provide enough proof under scrutiny.
>
>David Farrick, CMPE, MHA
>Administrator
>Blair Orthopedic Associates & Sports Medicine
>(814) 942-1166 ext 127
>farrickd@blairortho.com
>
>
>

Original: 2046
Bush

Wanda B. Gelnett

cc: Harris
Jewett
Markham
Smith
Sandusky
Legal

From: Kim Garner
Sent: Tuesday, March 30, 1999 4:42 PM
To: Wanda B. Gelnett
Cc: Kris Shomper
Subject: FW: Act 68 Draft Regulations

FORTHCOMING
Nyce
Sandusky
Gelnett

Smith
Jewett

-----Original Message-----
From: **Sherry Rollins [SMTP:srollins@ins.state.pa.us]**
Sent: Tuesday, March 30, 1999 12:26 PM
To: pbussard@hap2000.org; jjordan@pafp.com; irrc@irrc.state.pa.us; dmccoy@pamedsoc.org; HughAllen@usa.net; lgavin@paacep.org; dminich@pahouse.net; hburde@ogc.cmicpo1.state.pa.us; nwilson@pahouse.net; kwasson@pamedsoc.org; ajohnson@pahousegop.com; glehman@pamedsoc.org; dg931@ibm.net; gdunbar@aging.state.pa; kdawley@dolphin.upenn.edu; aleader@dechert.com; mrgnplant@aol.com; Doug.Reed@capbluecross.com; bhironimus@HIGHMARK.com; mgizzi@pasen.gov; Frank.Rollman@BCNEPA.com; info@managedcarepa.org; patricia.hatler@IBX.com; Kathy@LCGR.com; sammyl@voicenet.com; mbelonus@gois.state.pa.us; lgerhard@health.state.pa.us
Cc: gdunaway@ins.state.pa.us; gmartino@ins.state.pa.us; hleblanc@ins.state.pa.us
Subject: Act 68 Draft Regulations

The following is being distributed at the request of Deputy Insurance Commissioner Gregory Martino:
Attached is the Insurance Department's first draft of regulations to implement the Quality Health Care Accountability and Protection provisions of Act 68. These regulations are an expansion on the issues covered by the Department's Act 68 statement of policy published on October 3, 1998. The regulations have been drafted after meetings with and comments from various stakeholders including the legislative committees, consumers, payers and providers.

Please provide any comments to the Department by Friday April 9, 1999. These regulations will be revised after this initial review and will then be published in the Pennsylvania Bulletin for further public comment. Comments on this draft regulation can be submitted via e-mail or in writing as follows:

Geoff Dunaway, Director
Accident and Health Bureau
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120
e-mail: gdunaway@ins.state.pa.us

Thank you for your participation and assistance in this process. Please contact Geoff Dunaway at the above address or at 717/787-0684 if you have any questions regarding this matter.


ann154p.doc


ATT00456.txt

FORTHCOMING
Nyce _____
Sandusky _____
Gelnett _____

Draft: 3/30/99

CONTINUATION SHEET FOR FILING DOCUMENTS WITH THE LEGISLATIVE REFERENCE BUREAU
(Pursuant to commonwealth Documents Law)

Annex A
Title 31. Insurance
Chapter 154. Implementation of the Quality Health Care Accountability and Protection Provisions of Article XXI of Act 68 of 1998 (P.L. 464, No. 68)

General Provisions

Sec.

Required Provisions and Enrollee Disclosures

General Provisions

§ 154.1. Applicability and purpose.

(a) This chapter governs quality health care accountability and protection and applies to "managed care plans" and "licensed insurers" subject to the provisions of Act 68 of 1998.

(b) The terms and conditions of group and individual contract renewals and new business written by managed care plans on or after January 1, 1999, must conform to the provisions of the act.

(c) The applicability of the act and this chapter to subcontracting entities is based on the type of entity which issues the subscriber contract to the enrollee. An entity subcontracting with a managed care plan must meet the requirements of the act and this

chapter for services provided to those enrollees. An entity subcontracting with a entity that is not a managed care plan is not required to meet the requirements of the act and this chapter for services provided to those enrollees.

§ 154.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act – The Quality Health Care Accountability and Protection Provisions of Article XXI of Act 68 of 1998 (P.L. 464, No. 68).

Clean claim -- A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

Commissioner – The Insurance Commissioner of the Commonwealth.

Complaint -- A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan, which has not been resolved by the managed care plan and has been filed with the plan or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

Department -- The Insurance Department of the Commonwealth.

Emergency service -- Any health care service provided to an enrollee 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.

Enrollee -- Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan.

Gatekeeper – A primary care provider selected by an enrollee at the time of enrollment or appointed by a health plan from whom an enrollee shall obtain covered health care services or a referral or approval for covered, nonemergency health services as a condition for the payment of the highest level of benefits/services available under the health plan.

Grievance -- As provided in Subarticle (I) of the act, a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

(1) Disapproves full or partial payment for a requested health care service;

(2) Approves the provision of a requested health care service for a lesser scope or duration than requested; or

(3) Disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service. The term does not include a complaint.

Health care provider -- A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

Health care service -- Any covered treatment, admission, procedure, medical supplies and equipment, or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

Managed care plan -- A health care plan that: uses a gatekeeper to manage the utilization of health care services; integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards; and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:

(1) Section 630.

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

(3) The Act of December 14, 1992 (P.L. 835, No. 134), known as the "Fraternal Benefit Societies Code."

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. The term also includes products issued by a managed care plan which partially insure an entity's risk, including those products which are known as "cost plus" or their equivalent.

The term does not include ancillary service plans as defined by the act or an indemnity arrangement which is primarily fee for service. The term also does not include managed care plans utilizing a passive gatekeeper structure, whereby an enrollee must obtain a referral from any primary care provider in the network, rather than from a pre-selected primary care provider, before receiving specialty care.

Plan -- A managed care plan.

Primary care provider -- A health care provider who, within the scope of the provider's practice: supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to an enrollee; initiates enrollee referral for specialist care; and maintains continuity of enrollee care.

Prospective enrollee – For group policies, prospective enrollees are those persons that are eligible for coverage under a specific group as either a subscriber or dependent. For individual policies, prospective enrollees are any person who meet the eligibility requirements of the managed care plan.

Provider network -- The health care providers designated by a managed care plan to provide health care services.

Utilization review -- A system of prospective, concurrent or retrospective utilization review, as defined by the act, 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 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 subarticle (H) of the act that performs utilization review on behalf of a managed care plan.

§ 154.03. Changes, modifications and disclosures in subscriber and other contracts.

(a) Managed care plans and licensed insurers shall implement changes, modifications and disclosures to subscriber and other contracts and marketing materials to meet the requirements of the act. Modifications can be implemented in several different ways including, but not limited to, contract endorsements, contract amendments and modification to the contract then in effect.

(b) Licensed insurers performing utilization review services for or on behalf of managed care plans within the Commonwealth shall file with the Department of Health evidence of compliance with the standards and procedures set forth in Subarticle H, Section 2152, of the act, at the same time as the annual statement filing to the Insurance Department, beginning with annual statements for fiscal year 1999.

Required Provisions and Enrollee Disclosures

154.10. Direct enrollee access to obstetricians and gynecologists

(a) Managed care plans shall permit enrollees to directly access obstetrical and gynecological services from a participating health care provider without prior approval from a primary care provider. This direct access shall be for maternity and routine and annual wellness gynecological care and shall include medically necessary and appropriate follow-up care and referrals for diagnostic testing for these services.

(b) A managed care plan may require an enrollee to obtain prior authorization from the plan for obstetrical and gynecological services not designated in subsection (a).

(c) The directly accessed participating health care provider shall inform the enrollee's primary care provider of all health care services provided to the enrollee.

(d) Managed care plans with enrollee self-referral options shall cover benefits provided by a participating health care provider under this section at the higher non-self-referred benefit level. If an enrollee utilizes a non-participating health care provider for these benefits, the services may be covered at the lower self-referred benefit level.

§ 154.11. Managed care plan reporting of complaints and grievances.

Section 2111(13) of the act requires managed care plans to report specific information to the Department of Health and the Insurance Department with respect to the number, type and disposition of all complaints and grievances filed with the managed care plan. Managed care plans shall report this information to the Departments based on the current format utilized to report grievance information to the Department of Health. Any revisions to the format for reporting complaint and grievance information to the Departments will be published in the Pennsylvania Bulletin and shall be effective 30 days after publication.

§ 154.12. Emergency services.

(a) The act requires managed care plans to pay for emergency services based on the definition of emergency services set forth in the act and this chapter. The definition

establishes the concept of a prudent layperson, who possesses an average knowledge of health and medicine, when determining whether a medical emergency exists.

(b) Managed care plans are prohibited from requiring enrollees or health care providers to obtain prior authorization for emergency services. Plans are required to pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. Plans are also required to consider the presenting symptoms and the services provided when processing emergency services claims.

(c) The emergency health care provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee. If the enrollee is admitted to a hospital or other health care facility, the emergency health care provider shall notify the enrollee's managed care plan of the emergency services delivered within 48 hours or the next business day, whichever is later.

(d) The definition of emergency service, and the other written disclosures required by the act and this chapter, shall be incorporated into subscriber and master group contracts and in all other appropriate documents including marketing materials.

§ 154.13. Continuity of care.

(a) Managed care plans are required to provide the option of continuity of care for enrollees in instances where:

(i) a managed care plan terminates a contract with a participating provider for reasons other than cause;
(ii) a new enrollee enters a managed care plan and is currently in an ongoing course of treatment with a nonparticipating provider.

(b) A current enrollee must be allowed to continue an ongoing course of treatment with a provider whose contract has been terminated for reasons other than cause for a transitional period of up to 60 days from the date the enrollee was notified by the plan of the termination or pending termination. An enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination shall have the transitional period extended through postpartum care related to the delivery. An ongoing course of treatment is a health care service provided to an enrollee by a health care provider which was initiated prior to the occurrence of subsection (a) and will be continuing after the occurrence of subsection (a).

(c) A new enrollee must be allowed to continue an ongoing course of treatment with a nonparticipating provider when joining a new managed care plan for a transitional period of up to 60 days from the effective date of enrollment in the managed care plan. An enrollee in the second or third trimester of pregnancy on the effective date of enrollment shall have the transitional period extended through postpartum care related to the delivery.

(d) Continuity of care is at the option of the enrollee. However, the provider must agree to the managed care plan's terms which are applicable to the plan's participating

providers. If multiple providers are involved in an ongoing course of treatment, they must all agree to the plan's terms or those providers who accept the plan's terms must agree to utilize participating providers for providing health care services to enrollees.

(e) Health care services provided under the continuity of care requirements must be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers. Plan's may require non-participating or terminating providers to agree to terms that include, but are not limited to:

(i) Accepting the plan's payment as payment in full for covered services without balance billing except for permitted deductibles, copayments or coinsurance;
(ii) Agreeing to hold the enrollee harmless for any moneys which may be owed by the managed care plan to the provider;
(iii) Complying with the plan's utilization review and quality assurance requirements;
(iv) Agreeing to make all referrals for specialty care, diagnostic testing and related services be made to the new managed care plan's participating providers;
(v) Agreeing that all nonemergency inpatient care will be provided at the new managed care plan's participating hospitals or facilities.
(vi) Agreeing that the provider will provide copies of the enrollee's medical records to the plan or the enrollee's participating primary care provider, or both;
(vii) Agreeing to follow the plan's procedures requiring precertification or prior approval of specified nonemergency services or procedures.

(f) Written disclosure of the continuity of care benefit requirements imposed under the act and this chapter shall be incorporated into the subscriber and master group contracts and all other appropriate documents, including marketing materials. This information shall also be provided to terminated/terminating and nonparticipating providers when an enrollee requests continuity of care benefits.

§ 154.14. Information for enrollees.

(a) Managed care plans shall provide the information listed in section 2136(A) of the act to enrollees and, on written request, to prospective enrollees and health care providers. Managed care plans may determine the written format for disclosure of required information. If the information is disclosed through such materials as subscriber contracts, schedules of benefits and enrollee handbooks, the information should be easily identified within the materials provided. The information disclosed shall be easily understandable to the layperson. This information shall include:

(1) All of the information specified in Section 2136(A) of the act.

(2) A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at

least annually. If a list of participating providers is provided for only a specific type of provider/service, it shall include all participating providers authorized to provide those services.

(3) The information covered under Section 2113(D)(2) of the act, where applicable. If applicable, managed care plans shall disclose in their subscriber contracts, schedule of benefits and other appropriate material when the managed care plan does not provide, reimburse for or cover counseling, referral, or other health care services due to a managed care plan's objections to the provision of such services on moral or religious grounds.

(4) The specified disclosure statement required by Section 2136(A)(1). Subscriber and group master contracts and riders, amendments, and endorsements, are not considered to constitute marketing materials subject to the specified disclosure statement.

(b) The responsibility for the disclosure of information to prospective enrollee will differ based on whether the coverage is offered on a group or individual basis. Accordingly:

(1) For group policies, it is the managed care plan's responsibility to assure that the required information is provided to prospective enrollees. The managed care plan can either provide the information directly to prospective enrollees or allow the group policy holder or another entity to provide the information on behalf of the managed care plan.

(2) For individual policies, the managed care plan is responsible for providing the required information to a prospective enrollee.

(c) The disclosure of information required by Section 2136(A) of the act to enrollees, prospective enrollees and health care providers shall be provided as follows:

(1) During open enrollment periods managed care plans may disclose summary information to enrollees and prospective enrollees. If the disclosure of information does not include all the information required by the act and this chapter, the managed care plan shall simultaneously provide the enrollees and prospective enrollees (through the method in subsection (b)(1)) with a list of all other information which is required by this section but that has not been included with the open enrollment information. This information shall also be available to enrollees and prospective enrollees upon request.

(2) Disclosure of information required by the act and this chapter to enrollees following initial enrollment or upon renewal should be made within 30 days after the effective date, renewal date of coverage or the date of request for such information.

(3) Disclosure of information required by Section 2136(A) to health care providers should be made within 45 days from the date of the written request for such information.

(d) For the purposes of Section 2136, the information that shall be disclosed to enrollees will ordinarily be provided to the enrollee by the managed care plan. However, this information may also be provided to enrollees by the group policy holder or other designated entity.

(e) The act also requires that managed care plans, on written request of enrollees or prospective enrollees, provide written information specified in Section 2136(B) of the act. This information shall be easily understandable by the layperson.

§ 154.15. Complaints and grievances.

(a) The Department's complaint process includes issues of contract exclusions and non-covered benefit disputes. The "grievance" process includes review of the medical necessity and appropriateness of services otherwise covered by the managed care plan. Examples of complaints to be filed with the Department include:

(1) denial of payment by the plan based upon contractual limitation rather than on medical necessity, e.g. denial of payment for a visit by an enrollee on the basis that the enrollee failed to meet the contractual requirement of obtaining a referral from a primary care provider;

(2) refusal of the plan to provide, arrange for or pay for a procedure, drug or treatment on the basis that such procedure, drug or treatment is experimental, investigational or a cosmetic service excluded under the contract's provisions;

(3) disputes involving a non-covered benefit or contract exclusion, e.g. a request for additional physical therapy services, even if medically necessary, beyond the number specified in the enrollee contract;

(4) problems relating to:
(i) coordination of benefits;
(ii) subrogation;
(iii) conversion coverage;
(iv) alleged non-payment of premium;
(v) dependent coverage; or
(vi) involuntary disenrollment.

(b) Managed care plans are required to establish a two level internal complaint process to allow enrollees to file complaints regarding a participating health care provider or the coverage, operations or management policies of the plan.

(c) Enrollees must follow the plan's internal complaint process before filing a complaint appeal with the Insurance Department or the Department of Health.

(d) Inquiries regarding premium rate increases do not fall under subsection (c) and can be filed with the Department without first following the plan's internal complaint process.

(e) Managed care plans can require enrollees to file complaints with the plan within a set period of time from the occurrence of the issue being complained about or notice from the plan concerning the issue being complained about is received by the enrollee. The minimum time period that a plan can set for an enrollee to file a complaint is 30 days.

(f) Managed care plans must complete the first level of review of an enrollee complaint within 30 days on receipt of the complaint. A complaint is considered received by the plan 5 days after it is mailed. The plan must notify the enrollee of the plan's decision within five business days of the decision. The notification shall include the basis for the decision.

(g) Managed care plans must complete the second level of review within 45 days of receipt of the enrollee's request for review. A request for a second level review is considered received by the plan 5 days after it is mailed. The plan must notify the enrollee within five business days of the rendering of a decision by the second level complaint review committee, including the basis for the decision and the procedure for appealing the decision to the Insurance Department or the Department of Health.

(h) Appeals of enrollee complaints to the Insurance Department should include such information as the enrollee's name, address and daytime phone number; the enrollee's policy number, identification number and group number (if applicable); a copy of the complaint submitted to the managed care plan; the reasons for appealing the managed care plan's decision and all correspondence and decisions from the managed care plan regarding the complaint.

(i) If the Insurance Department believes that the appeal more appropriately relates to issues and matters under the jurisdiction of the Department of Health e.g. an issue involving quality of care, the Insurance Department will notify the enrollee in writing of its finding and promptly transmit the appeal to the Department of Health for consideration. The original submission date of the appeal will be utilized to determine compliance with the filing time frame provided for in Section 2142(A) of the act.

(j) The Insurance Department and the Department of Health will jointly regulate the enrollee and managed care plan complaint process. The Insurance Department shall focus on the review of cases which concern the potential violation of insurance statutes, including, but not limited to, those that fall under the Unfair Insurance Practices Act (40 P.S. §1171.1 et seq.). The Department of Health shall focus on complaint issues primarily involving enrollee quality of care and quality of service.

(k) Complaint appeals can be filed with the Insurance Department at the following address:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120

(l) Managed care plans can require enrollees to file grievances with the plan within a set period of time from the occurrence of the issue being grieved about or notice from the

plan concerning the issue being grieved about is received by the enrollee. The minimum time period that a plan can set for an enrollee to file a grievance is 30 days.

(m) Managed care plans can require enrollees to utilize the plan's internal grievance process and the external grievance process before filing a court case. However, the managed care plan can not apply any penalty or loss of coverage if an enrollee pursues a court case before utilizing the grievance process.

§ 154.16. Prompt payment.

(a) Licensed insurers and managed care plans shall pay clean claims for health care services provided on or after January 1, 1999 within 45 days of the licensed insurer's or managed care plan's receipt of the clean claim from the health care provider. A claim is considered received by the licensed insurer or managed care plan 5 days after it is mailed.

(b) The 45 day prompt payment provisions are not in effect if premium payments covering the period when the health care service was provided have not been received by the licensed insurer or managed care plan. In this case, the prompt payment provisions begin on the date the premium payment covering the period of time the health care service was provided is received by the licensed insurer or managed care plan.

(c) A claim is considered to have been "paid" on either the date: 1) a check is mailed by the licensed insurer or managed care plan to the provider or 2) an electronic transfer of funds from the licensed insurer or managed care plan to the provider occurs.

(d) Any interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the provider and shall be added to the amount owed on the clean claim. Any interest owed of less than $2.00 on a single claim does not have to be paid by the licensed insurer or managed care plan. The interest can be paid on the same or a separate check. If the licensed insurer or managed care plan combines interest payments for more than one late clean claim, the check shall include a listing of each claim covered by the check and the specific amount of interest being paid for each claim.

(e) Claims paid by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insured or managed care plan and additional monies are owed/paid to the health care provider, the additional payment is subject to the prompt payment provisions of the act. The prompt payment requirement of the act also applies to the uncontested portion of a contested claim.

(f) Prior to filing a complaint with the Insurance Department, providers who believe that a licensed insurer or managed care plan has not paid a clean claim in accordance with the act and this chapter should first contact the licensed insurer or managed care plan to determine the status of the claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered by the licensed insurer or the managed care plan to be a clean claim.

(g) Complaints to the Insurance Department regarding the prompt payment of claims by a licensed insurer or managed care plan under the act and this chapter shall contain such information as: the provider's name, address and daytime phone number; the claim number; the name and address of the licensed insurer or managed care plan; the name of the patient and employer; the date(s) of service and the date(s) the claims were filed with the licensed insurer or managed care plan; any relevant correspondence between the provider and the licensed insurer or managed care plan, including requests for additional information from the licensed insurer or managed care plan; and any additional information which the provider believes would be of assistance in the Department's review.