Original; #2079

31ST DISTRICT
HAROLD F. MOWERY, JR.

SENATE BOX 203031
MAIN CAPITOL BUILDING
HARRISBURG, PA 17120-3031
(717) 787-8524
FAX (717) 772-0576
EMAIL:hmowery@pasen.gov

DISTRICT OFFICE:
1023 MUMMA ROAD
LEMOYNE, PA 17043
717-763-7623
1-800-734-5287

DISTRICT OFFICE:
POST OFFICE BOX 329
NEW BLOOMFIELD, PA 17068
717-582-4600

Senate of Pennsylvania

COMMITTEES

PUBLIC HEALTH & WELFARE, CHAIRMAN
BANKING & INSURANCE,VICE CHAIRMAN
EDUCATION
LAW & JUSTICE
RULES & EXECUTIVE NOMINATIONS

CAPITOL PRESERVATION COMMITTEE
INTERGOVERNMENTAL COUNCIL ON LONG TERM CARE
LEGISLATIVE DATA PROCESSING COMMITTEE
LEGISLATIVE SPORTSMEN'S CAUCUS
PENNSYLVANIA INFRASTRUCTURE INVESTMENT AUTHORITY

March 19, 2001

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

Dear Mr. McGinley:

This letter is to offer this Committee's support of tolling the Department of Health's final form regulations pertaining to Act 68. The Department of Health has done a tremendous amount of work to draft the Act 68 regulations. However, it is the opinion of this Committee that additional changes should be considered. As a result, we believe these regulations should be tolled in order to provide an opportunity for changes to be made to the following sections:

1. The Department of Health and the Department of Insurance should work collaboratively when dealing with issues of continuity of care (Section 9.684), complaints and grievances (Sections 9.702, 9.703, 9.705 and 9.706) and emergency services (Section 9.672). The legislation clearly establishes joint responsibility in the Department of Health and the Department of Insurance to oversee the provisions of the Act. It was envisioned that the departments would work together to determine coverage and designation of complaints and grievances.

2. Prior approval of contracts (Sections 9.722, 9.675) between health plan purchasers and insurance providers should be reconsidered. Prior approval authority for the Department of Health was not implicitly or explicitly granted in the Act. There are considerable checks on insurers if provisions are included in their respective contracts that violate the Act.

3. There was a great deal of discussion during the consideration of Act 68 regarding the scope of coverage under the Act. The determination was clearly made that only insurance plans having a "gatekeeper" are under the purview of the Act.

Hence, utilization review (Sections 9.741 and 9.742) should only be applicable to those types of insurance plans.

4. There are three areas in which the regulations may have exceeded statutory authority.

   (a) Nothing in the regulations should obstruct the statutory requirement that grievances and complaints be resolved in 30 and 45 days.

   (b) The regulations of the Act regarding the specialties of physicians who are required to make determinations concerning each grievance/complaint should not be abridged. The language in Section 9.705 seems to violate the Act.

   (c) Further, the idea of sending written notice of approvals (Section 9.750) seems to be unnecessary and adds unwarranted paperwork that may cause health care insurance costs to escalate further.

We realize that the Executive Director of IRRC has requested that the tolling be based on specific criteria and have endeavored to do so. The letter drafted March 16, 2001, and signed by Robert Zimmerman, Secretary of Health, is incorporated by reference. All sections cited in his correspondence should be considered as language which may need amendment prior to final form approval. It is also our understanding that the Health Law Project has a suggested change to 9.705(c)(iii)(l), which we hope the Department of Health will consider.

Thank you for the consideration of this letter.

Sincerely,

Harold F. Mowery, Chairman
Senate Public Health & Welfare Committee

Sincerely,

Vincent J. Hughes, Minority Chairman
Senate Public Health & Welfare Committee

cc: Robert E. Nyce

Original: 2079

MANAGED CARE REGULATIONS
Tolling Memo Changes

§9.675 Delegation of Medical Management Contracts

In order to clarify the intent of Act 68, the Health and Human Services Committee would recommend deleting the following sentences from §9.675(a) "However, the Department may at a later date require the plan to correct any deficiencies identified by the Department. A plan shall submit medical management contracts entered into or renewed prior to the effective date of the regulations for review and approval, but approval before use will not be required for these contracts."

The Committee does not intend the regulations to disrupt on-going business relationships with medical management organizations and health care providers that are based on contracts already approved by the Department. These contracts are always available to the Department as necessary to conduct investigations of complaints. These recommendations reflect the concerns of the Committee and the changes as above are based on the consensus of the committee.

§9.722 Plan and Health Care Provider Contracts

The Committee would recommend deleting the following sentence from §9.722(a) "A plan shall submit provider contracts entered into or renewed prior to the effective date of the regulations for review and approval, but approval before use will not be required for these contracts." The Committee also would recommend deleting the following from the last sentence in §9.722(a) "...however, the plan (Department) may at a later date require the plan to correct any deficiencies identified by the Department."

The Committee does not intend the regulations to disrupt on-going business relationships with medical management organizations and health care providers that are based on contracts already approved by the Department. These contracts are always available to the Department as necessary to conduct investigations of complaints. These recommendations reflect the concerns of the Committee and the changes as above are based on the consensus of the Committee.

§9.741 Applicability and §9.742 CREs

The Committee would recommend deleting section §9.741(c) and §9.742(c) . The Committee is concerned that these sections could be construed to mean that all Licensed Insurers are required to comply with the Act. The Committee believes that the intention of Act 68 and appropriate

interpretation was to require only Licensed Insurers who do utilization review for enrollees of a managed care plan to comply with the utilization review requirements of the Act.

§9.601 Definition

The Committee would recommend deleting the definition of Licensed Insurer as it is defined by the Insurance Department in its regulations and is no longer necessary in light of the changes discussed above.

§9.705 Internal Grievance Process

The Committee would recommend adding the following language at the end of §9.705(c)(2)(III)(L), "The Committee shall not base its decision upon any document obtained on behalf of the plan which sets out medical policies, standards or opinions or specifies opinions supporting the decision of the plan unless the plan has made available, in person or by telephone, an individual, of the plan's choice, who is familiar with the policies, standards or opinions set out in the document and has sufficient knowledge regarding the basis of the policies, standards or opinions to answer questions from the review committee or the enrollee."

This language further defines the use of materials and documents presented at the review.

The Committee would recommend changing the language in §9.705(c)(3)(v) from "For the purposes of this section, a primary care provider does not qualify as a licensed physician, or an approved licensed psychologist, in a same or similar specialty, unless the service in question was provided by a primary care provider." To "For the purposes of this section, if a specialist is requesting the health care service in dispute, the reviewing physician or psychologist must be a specialist in the same or similar specialty."

The language clears up any ambiguity regarding the credentials of the reviewing physician or psychologist.

§9.673 Plan Provision of Prescription Drug Benefits to Enrollees

The Committee would recommend deleting the following language from §9.673(d) "...regarding the coverage of or amount of the coverage for one drug versus another," as a dispute solely concerning the dollar amount of coverage would more accurately be a complaint and not a grievance.

§9.679 Access Requirements In Service Areas

The Committee would recommend deleting the word "potential" in §9.679(c) and replacing it with the word "probable" as the Department should only be concerned with receiving notice of a "probable" loss of any general acute care hospital and any primary care provider, whether an individual practice or a group practice, with 2000 or more assigned enrollees.

Coordination of Implementation Of The Regulations with the Insurance Department

The Committee would recommend that the Department add to the Preamble that the DOH will work with the Insurance Department pursuant to the Administrative Procedures at 71 P.S. §181. The Department should also state in this section of the Preamble that Act 68 does not permit enforcement by both agencies for the same violation and restate the specific provision of Act 68 which states that "In no event shall the (health) department and the Insurance Department impose a penalty for the same violation".

§9.681(a)(3) Health Care Providers

The Committee would recommend deleting the requirement in this section of the regulation which requires a CRNP to list the name, address and telephone number of the physician with whom the CRNP has a collaborative relationship.