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*House of Representatives*
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

COMMITTEES

INSURANCE COMMITTEE, CHAIRMAN
HEALTH & HUMAN SERVICES

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

Dear Mr. Nyce:

I am writing to request that the Independent Regulatory Review Commission disapprove the Department of Health final form regulation of Act 68 of 1998. As Chairman of the House Insurance Committee and the sponsor of the amendment that ultimately became the managed care reforms of Act 68, I was very involved in the development and enactment of the act. I believe that the regulation should be disapproved for the following reasons:

- The regulation requires prior approval of contracts between health plans and providers which is not provided for by statute. The Department has even indicated that they intend to require plans to submit contracts in place prior to the effective date of the regulations for review and approval (p 407 of the Preamble). This disruption of business practice should not be permitted. Prior approval of contracts is a legislative decision, not one that can be claimed by the regulator. Again, as the sponsor of the amendment, I can tell you prior approval was never something we intended.

- The regulation would require health plans to provide written notification of all utilization review determinations to both the member and the provider. Members do not need written notices of approvals. In Secretary Zimmerman's March 20, 2001 letter to you in Attachment II he states "the Act requires written notice of all utilization review decisions to approve or deny coverage." The Act states that a Utilization Review Entity shall: "Provide all decisions in writing to include the basis and clinical rationale for the decision." **It does not require two notices,** one to the member and one to the provider. Standard business practice is to notify providers of all approvals (since they are the ones who will bill the health plan for services) and to notify both the provider and the member of any adverse coverage

- determination. Two notices each time a plan approves coverage is costly and will only confuse the member. The Department has only agreed to "waive" the requirement for hospitalized patients and issue "technical advisories" describing acceptable written notice to enrollees. Health plans have no assurance that future administrations will "waive" existing regulations.

- The regulation adds additional regulation of provider directories which are already reviewed and approved by the Insurance Department.

- The regulation requires plans to disclose, copy and provide to members all internal documents relating to an appeal. There must be some limit to the information that must be disclosed to members.

- The regulation fails to provide for joint regulation between the Insurance and Health Departments. Act 68 provides for the two agencies to jointly work together in certain key areas. The regulation – but does not – explain how the two agencies are to do this. Saying in the preamble that they will work together is not enough. We need to know how, and it should be guaranteed.

- The regulation should clear up the confusion on the 30 and 45 day deadlines we imposed on managed care plans for complaints and grievances. In Act 68, we meant these to be binding – not something that anybody could open up. The regulation allows that, and it should be corrected.

Thank you for considering my concerns about the overreaching of the Department of Health final form regulation.

Sincerely,

Nicholas A. Micozzie