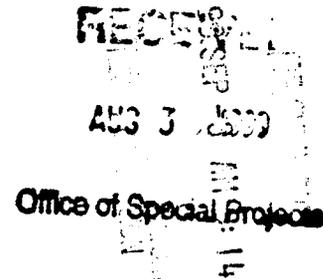


**PENNSYLVANIA CHAPTER, AMERICAN COLLEGE OF EMERGENCY
PHYSICIANS**

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820

August 30, 1999

Mr. Peter J. Salvatore
Regulatory Coordinator
Department of Insurance
13425 Strawberry Square
Harrisburg, PA 17120



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

On behalf of the Pennsylvania Chapter, American College of Emergency Physicians (PaACEP), an organization representing over 1,000 emergency physicians in the Commonwealth, I would like to submit the Chapter's comments regarding the Insurance Department's proposed regulations to implement the Quality Health Care Accountability and Protection Act – Act 68 of 1998.

First of all, I would like to thank the Department for including several of our recommendations in this re-draft. I would like to relay our comments regarding specific sections of the current version.

154.1 Applicability and Purpose.

I appreciate that the Department did accept our recommendation to include language regarding subcontracting entities, but it is still not clear what plans are covered by Act 68.

PaACEP Recommendation:

The Department should identify plans and entities that are included under the provisions of Act 68. The list should be made available to providers and the public.

154.13 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.

Unless the "format utilized to report (the) information" specifically mentions a time frame to make the report, the regulations should be clear as to the frequency to report the complaints and grievances.

PaACEP Recommendation:

Managed care plans shall issue timely information reports to the Department of Health and the Insurance Department, at least on a quarterly basis. These reports should contain data on the status of all complaints and grievances, whether or not they yet have a disposition.

154.14 Emergency Services.

The first draft of the regulations for subsection (a) stated that: "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." This language was removed in the new draft.

This important statement should be re-instated, for it clearly outlines the responsibility of the managed care company (MCO) to follow the prudent layperson standard. This concern is based on our Chapter keeping track of compliance rates in other states that have adopted the prudent layperson standard. Just this week I was informed that the Washington State Insurance Commissioner fined an MCO in that state for denying qualified prudent layperson claims. Also, in Maryland, the first state to adopt the prudent layperson standard, the ACEP chapter has been working with their insurance commissioner on prudent layperson non-compliance issues.

Subsection (c) requires plans to consider the presenting symptoms and the services provided when processing emergency services claims. Requiring MCOs to "consider" the presenting symptoms appears to allow plans the opportunity to retrospectively deny the service.

PaACEP Recommendation:

We suggest that rules and regulations follow a February 1998 directive of the Health Care Financing Administration (HCFA) regarding the implementation of the Balanced Budget Act (BBA), of 1997. HCFA stated that "Coverage of emergency services by a managed care organization (MCO) will be determined under the prudent layperson standard. MCOs may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability should be whether the beneficiary had acute symptoms of sufficient severity at the time of presentation. In these cases, the MCO must review the presenting symptoms of a beneficiary and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard."

Also, I would like to comment on the phrase "as documented by the claim." It is incumbent upon the physician to provide proper documentation of the presenting symptoms, but with the absence of any standardized claims forms it is often difficult to do so.

PaACEP Recommendation:

To insure appropriate and complete presenting symptoms information is provided, the phrase "or the medical record," should be inserted after "as documented by the claim." In addition, the Department is urged to require insurance companies to work together to produce a standardized claim form.

Subsection (e) requires plans to supply enrollees with information concerning the provision of emergency services.

Current language implies that only current enrollees will be automatically supplied with information regarding the plan's provision of emergency services. It seems that prospective enrollees can only obtain this important information by requesting it first in writing. The original draft language was much clearer.

PaACEP Recommendation:

Re-instate the original subsection (e) language.

I suggest that a Subsection (f) be added, which would address the provision of emergency services in an out-of-network situation.

PaACEP Recommendation:

Plan enrollees will have the protection of coverage regardless of where they seek emergency medical care according to the prudent layperson standard both in and out-of-network. There should be no cost differential for patients who access emergency services in and out-of-network. (In addition, PaACEP believes reasonable payment for emergency services provided should be made whether in or out-of-network.)

The proposed rules and regulations do not reference the last sentence of (c) Medical Services, Section 2116, of the Act which states: "If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary."

The language, " an enrollee's condition has stabilized *and* the enrollee can be transported..." is confusing and suggests that something more than stabilization is required before a patient can be transferred. A new Subsection (g) should be added to address this issue.

PaACEP Recommendation:

The rules and regulations include a definition of stabilization consistent with The Emergency Medical Treatment and Active Labor Act (EMTALA), which states: "The term 'stabilized' means, with respect to an emergency medical condition...that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility..."

Furthermore, we recommend that the rules and regulations explicitly state that the physician treating the patient must decide when the patient may be considered stabilized for transfer or discharge, and that decision must be binding on the health plan, as provided in the HCFA regulation regarding Medicare+Choice programs.

154.16 Information for Enrollees

As previously stated, plans should automatically provide current and prospective enrollees with information regarding the provision of emergency services. In addition, plans should provide for emergency services both in and out-of-network.

154.18 Prompt Payment

The Chapter has reviewed the comments submitted by the Pennsylvania Medical Society regarding this section.

PaACEP Recommendation:

PaACEP supports the prompt payment recommendations of the Pennsylvania Medical Society.

Again, I would like to thank the department for including several of our recommendations in this new version and appreciate the opportunity to provide further comment. If you have any questions, please contact David Blunk, our executive director at 558-7750, extension 1468.

We will accept electronic transmission of the rules and regulations in final form. This can be sent to: dblunk@paacep.org.

Sincerely,

Richard McDowell, MD, FACEP
Chairman, Governmental Affairs Committee

cc: Lori Gerhard, Acting Deputy Secretary for Quality Assurance, Department of Health

c/inuregs2



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**OFFICE OF SPECIAL PROJECTS
1326 Strawberry Square
Harrisburg, PA 17120**

**Phone: (717) 787-4429
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E-mail: psalvato@ins.state.pa.us**

September 1, 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

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

90 SEP - 3 PM 9:13

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,

A handwritten signature in cursive script that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator

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

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

Sister Clare Christi Schiefer, OSF President
Pennsylvania Catholic Health Association
223 North Street, Box 2835
Harrisburg PA 17105-

Date Received 8/30/1999

Phone: (717) 238-9613 X00000

EMail:

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COPIES: Harris
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Wilmarth
Sandusky
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Pennsylvania Catholic Health Association

223 North Street, Box 2835, Harrisburg, PA 17105
717-238-9613 • FAX 717-238-1473

Sister Clare Christi Schiefer, OSF
President

August 30, 1999

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

CO SEP - 1 PM 9:44
1999

Re: Proposed Regulations
Quality Health Care Accountability and Protection
[31 PA. CODE CHS. 154 and 301]
29 Pennsylvania Bulletin 4064-4071 (July 31, 1999)

Dear Mr. Salvatore:

On behalf of the Pennsylvania Catholic Health Association (PCHA), I submit the following comments in connection with proposed regulations relating to quality health care accountability and protection. The Pennsylvania Catholic Health Association is a statewide organization that represents the Catholic health ministry in public policy matters and numbers among its members twenty-eight hospitals, thirty-seven long-term care facilities, numerous related health care entities that include six national health care systems, and sponsoring congregations and dioceses.

It is recommended that Section 154.16(h) also include a requirement that managed care plans set forth the denial rate for service requests which result in a determination of "medically not/necessary/not meeting medical criteria" as well as a listing of the rate of occurrence of reductions in the level of care provided to inpatients.

Peter J. Salvatore

- 2 -

The act and the proposed regulations use the term "clean claim" as the standard to be met before the time begins to run on prompt payment questions. This continues to present a significant problem for providers and clarification, to the extent possible, is needed to avoid unreasonable criteria being imposed by a plan.

Your attention to these comments is appreciated.

Very truly yours,

Sister Clare Christi Schiefer, OSF

Sister Clare Christi Schiefer, OSF
President

SCC/vm

cc: PCHA Board of Directors
Richard E. Connell, Esq.
Robert J. O'Hara, Jr.
Representative Nicholas Micozzie
Senator Edwin Holl



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

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August 30, 1999

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

ORIGINAL: 2046
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Wilmarth
Sandusky

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

authorized in the regulations to possess supervisory and coordination authority or to practice independently of a primary care physician.

As § 2102 of Act 68 makes clear, Act 68 did not expand the scope of practice of any health care provider. Neither APNs nor PAs can practice independent of a primary care physician. Act 68 does not authorize substitution of a primary care physician with an APN or PA. Physician-approved protocols and standing orders, where appropriate, should guide the APN's or PA's approach to patient-described conditions. Standing orders should implement treatment following the diagnosis. An APN and a PA should be prohibited from being held out as a "primary care provider." Therefore, the regulations should define a "primary care provider" as "a physician who is Board certified or Board eligible in and limits his practice to family medicine, general internal medicine or pediatrics; or is a generalist physician who renders primary care at least 50% of the time in which he engages in the practice of medicine."

Primary Care – Act 68 mentions the phrase "primary care" several times, but fails to define this crucial term. The Academy believes the Insurance Department possesses regulatory authority to promulgate a definition of "primary care", and submits the following definition, which was developed and endorsed by both the American Academy of Family Physicians and PAFP, for adoption in the regulations:

"Primary Care." Care provided by physicians specifically trained for and skilled in comprehensive first contact and comprehensive continuing care for persons with any undiagnosed sign or symptom of health concern, the "undifferentiated" patient, not limited by problem origin, gender or diagnosis. The term includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings, including office, inpatient, critical care, long-term care and home care. Primary care is performed and managed by a personal physician, utilizing other health professions, consultation and referral, as appropriate; provides patient advocacy in the health care system to accomplish cost-effective case management and care coordination of health care services; and promotes effective doctor-patient communication and encourages the role of the patient as a partner in health care.

Direct Enrollee Access to OB/GYN - § 154.12

Enrollee Selection, Access to, Referral to, and Reimbursement for OB/GYN Services Provided by Family Physicians – Under § 154.12, the proposed regulations largely restate the direct access to obstetrical and gynecological services under § 2111(7) of Act 68. Many of the Academy's Board certified family physicians are well trained in and

actively practice obstetrics and gynecology. In fact, JCAHO standards require each family practice residency to have one Board certified family physician teach OB/GYN in residency. Scores of family practice residents then provide OB/GYN services in active practice.

Moreover, § 2111(7) of Act 68, as well as Act 68's access to care requirements, **obligate** MCPs to permit enrollees to obtain direct access to OB/GYN services (regardless of the type of provider); to provide reimbursement coverage for such services; to allow self-referral to a family physician other than the patient's primary care physician for such services without prior approval from the enrollee's primary care provider; and, implicitly, to credential family physicians for the provision of OB/GYN services where they have obtained requisite training and experience. MCPs are routinely ignoring these obligations to the detriment of enrollees. Accordingly, § 154.12 should be amended to expressly include these rights inuring to the benefit of enrollees.

Furthermore, pursuant to § 2136(a)(14) of Act 68 (requiring MCPs to automatically publish the list of specialty providers by name, address and telephone number), MCPs should be expressly required to include family physicians with training and experience in OB/GYN on the *list of OB/GYN providers*. A specific provision should be added to the final form regulations clarifying this obligation.

Finally, when enrollees seek direct access to a specific OB/GYN provider, the regulations should specifically state that an MCP cannot penalize a family physician economically or in any other manner, including a negative credentialing decision, based upon an enrollee's direct access to OB/GYN services. A family physician's lack of control over an enrollee's direct access decision mandates this conclusion.

Continuity of Care - § 154.15

Physician Rights – Under § 154.15, the proposed regulations outline a series of obligations imposed on physicians if a patient chooses the continuity of care option. The regulations should make it clear that physicians possess *rights* under the Act as well as obligations. For example, under the continuity of care rules, a physician would have standing to initiate a utilization review challenge.

Information for Enrollees - § 154.16

MCP Response Time and Delegation – Act 68 is silent in terms of the amount of time an MCP has to provide information to enrollees and physicians under § 2136(a). The proposed regulations would allow MCPs 30 days to respond to an enrollee and 45 days to provide written information to physicians. See § 154.16(g)(3), (4). This is far too long. Time exigencies may drive the physician or patient's need to obtain crucial

information such as the definition of medical necessity required to be disclosed under § 2136(a)(1), utilization review dispute procedures under § 2136(a)(7), etc. The time limitation imposed on MCPs should be 15 days from the date of the written request. The 15 day limit should be applicable to both enrollees and physicians' requests.

The proposed regulations are also silent as to the time constraints imposed on MCPs to provide the information requested under § 2136(b). Enrollees are entitled to crucial information under this subsection, including for example whether a drug is included or excluded from coverage under § 2136(b)(5), drug formulary information under § 2136(b)(6), and physician credentialing processes under § 2136(b)(3). The same 15 day time constraint should be imposed on MCPs to respond to enrollees' requests under § 2136(b).

Finally, proposed § 154.16(e) appears to create some authority for an MCP to delegate its information disclosure obligation to a group policy holder or other designated entity. The Act provides no such delegation authority. Even if such authority to delegate is within the Insurance Department's realm of constitutional regulatory authority, § 154.16(e) should expressly state that the MCP retains responsibility for timely disclosure of the material requested.

Complaints - § 154.17

Medical Necessity Parameters - Act 68 does not contain an objective definition of the term "medical necessity." MCPs, however, must adopt and maintain a definition of medical necessity of their own. § 2111(3). MCPs must also disclose to enrollees and physicians the definition of medical necessity it utilizes. § 2136(1). If an MCP's contract prohibits or restricts disclosure of medically necessary and appropriate health care information by a physician, that provision is void and unenforceable. § 2113(b). The "gag clause" provisions in § 2113(c)(1)-(3) address the prohibition against squelching the disclosure of medically necessary information from physicians to patients. Thus, medical necessity definitions are an integral part of MCP operations, and (quite obviously) the physician's practice of medicine.

The provisions of Act 68 cited above permit the Insurance Department's regulation of the parameters of an acceptable "medical necessity" definition used by MCPs. In fact, Greg Martino testified to the House Insurance Committee that the Insurance Department already uses a series of "key characteristics" in determining whether to approve or disapprove an MCP's contract in terms of the medical necessity definition. The Academy has not seen those parameters, but believes medical necessity parameters should be included in the regulations.

The definition of medical necessity has emerged as one of the two most contentious issues in the managed care reform debate. States are beginning to enact statutory

definitions of this phrase. It is simply too important to patients (and physicians) to allow this crucial term to go undefined. Accordingly, the Academy believes the Insurance Department possesses sufficient statutory authority to include the following medical necessity definition parameters in its final form regulations, as follows:

- Any therapeutic treatment, care or services reasonably expected by a prudent physician to improve, restore or prevent the worsening of any illness, injury, disease, disability, defect, condition or the functioning of any body member.
- Objective clinical determinations which will be or are reasonably expected by a prudent physician to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical or mental effects of an illness, condition, injury or disability; or alleviate the patient's pain or mitigate the severity of the patient's symptoms.
- All relevant clinical data pertaining to the patient's condition as a whole must be taken into consideration.
- The prevailing practice and standards of the medical profession and community must be taken into consideration.

These parameters strike the necessary balance between patient protection and utilization control. The Insurance Department should work collaboratively with the Department of Health to ensure that each agency's medical necessity contractual parameters are identical.

"Hospitalist" Issue – Some managed care companies are attempting to force family physicians to utilize "hospitalists" for their patients' hospital care. A "hospitalist" is generally defined as a physician who devotes the entirety of his or her practice to treating patients inside the hospital setting. Family physicians are well trained and have substantial knowledge and experience in practicing inpatient hospital medicine, and cannot and should not be mandated to utilize "hospitalists" for their patients' hospital care. A specific provision should be included in the regulations addressing this crucial issue.

MCP Time to Make Denial Decision – Act 68 is silent on the time required by an MCP to make a decision to deny payment as well as the amount of time an enrollee or physician has to assert a challenge to the MCP's denial decision. In § 154.17(e) of the proposed regulations, the Insurance Department proposes to allow an MCP to impose a

Peter J. Salvatore
August 27, 1999
Page 6

minimum time period (30 days) for an enrollee to file a complaint. The proposed regulations, however, **impose no time limitations on an MCP to make the initial denial decision.** Because the Insurance Department has apparently seen fit to impose a time limitation on an enrollee, the same 30-day time limitation should be imposed upon an MCP. That is, an MCP should have only 30 days to deny payment for a particular treatment or service on the basis of a contract exclusion and non-covered benefit decision from the date the physician submitted the bill for payment.

Moreover, § 154.17(f) allows 5 days in addition to the statutory 30-day period in which the MCP must review a complaint. In fact, mail typically is delivered from one end of the Commonwealth to another in 2 days. The Pennsylvania Rules of Appellate Procedure only assume 3 days for mailing. *See* Pa. R.A.P. 121(e). The 5-day time limitation should be reduced to 2 days, or 3 days at the most. There is no valid factual basis to assume 5 days for mailing, and no legislative intent exists to support creation of the additional week for MCP compliance. These principles apply to the other subsections of § 154.17 where the 5-day rule is discussed.

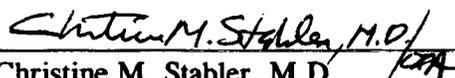
Prompt Payment - § 154.18

The requirement under § 154.18(e) that imposes the burden on *providers* to spend their resources to ascertain whether the MCP has sufficient documentation finds no basis in Act 68 and conflicts with the clean claim notion under HCFA regulations from which it was adapted. This provision should be stricken.

* * * *

Thank you for your consideration of the Academy's issues and concerns relating to these important public policy and legal matters. Should you have any questions, please contact us at your convenience.

Sincerely,



Christine M. Stabler, M.D. *CS*
President

cc: PAFP Board of Directors
PAFP Public Policy Commission
Wanda D. Filer, M.D. - Chair, PAFP Public Policy Commission
John S. Jordan, PAFP Executive Vice President
Charles I. Artz, Esq. - PAFP General Counsel
John A. Nikoloff - PAFP Lobbyist



**COMMONWEALTH OF PENNSYLVANIA
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99 SEP -1 AM 9:42

August 30, 1999

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

ORIGINAL: 2046
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Re: Insurance Department
Proposed Regulation No.
11-195, Quality Health Care
Accountability and Protection

Dear Mr. Nyce:

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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,

A handwritten signature in cursive script that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator

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

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

Mr. John C. Hickey, Esq.
Kesystone Health Plan Central, Inc.
P.O. Box 898812
Camp Hill PA 17089-8812

Vice President, Legal and Government Programs

Date Received 8/30/1999

Phone: (717) 703-3458 X00000

EMail:

Page 1

Date sent to Committees and IRRC 8/31/1999

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8/31/99

From: "Martin, Gail" <Gail.Martin@khpc.com>
To: "'psalvato@ins.state.pa.us'" <psalvato@ins.state.pa.us>
Cc: "Hickey, John" <John.Hickey@khpc.com>,
"McGowan, Laurie"
<Laurie.McGowan@khpc.com>
Subject: Proposed Regulations-31 Pa. Code Chs. 154 and 301
Date: Mon, 30 Aug 1999 17:18:04 -0400
X-Mailer: Internet Mail Service (5.5.2448.0)

Keystone Health Plan Central, Inc. fully concurs with the comments submitted by Highmark, Inc. to the Department's proposed rulemaking which proposes to add Chapter 54 to 31 Pa. Code (pertaining to quality health care accountability and protection). In addition, KHP Central submits the attached comments to the proposed regulations for your consideration.

Please feel free to contact me with any questions. Thank you for the opportunity to comment on the proposed regulations.

John C. Hickey, Esq.
Vice President, Legal and Government Programs

This letter, along with the attached comments, were faxed to your office on Monday, August 30, 1999. Please confirm that the comments were received.

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PID comments.doc

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AUG 30 1999

Office of Special Projects

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Comments to PID Proposed Rulemaking – 31 Pa. Code, Chapter 54

Section 154.12(a)-Direct enrollee access to obstetrical and gynecological services

Section 2111(7) of Act 68 provides that a managed care plan shall provide direct access to participating obstetrical and gynecological services so that members can “obtain maternity and gynecological care, including medically necessary and appropriate *follow-up care and referrals for diagnostic testing* related to maternity and gynecological care....”

Proposed regulation §154.12(a) states that plans shall permit direct access 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....” The wording of the proposed regulation at §154.12(a) is slightly different and broader than the Act in that it could permit the ob/gyn provider to refer the enrollee on to a subspecialist without going through the PCP. Act 68 allows for direct access to the ob/gyn, permits that ob/gyn to follow-up with the member without a subsequent PCP referral and to refer the member for diagnostic testing but does not provide that the ob/gyn may refer the member to a subspecialist.

We agree with the wording in subsection (b) of proposed regulation §154.12 which recognizes that plans may continue to require prior authorization for certain tests, however, services of subspecialists often will not require a prior authorization but would instead require a referral from the member’s PCP. In permitting the ob/gyn to refer on to a subspecialist, we respectfully suggest the proposed regulation goes beyond the scope of Act 68.

Proposed Change- Delete the word “and” after “referrals” in §154.12(a) so that the wording is identical to that in Section 2117(7) in Act 68: “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.”

Section 154.16(g)(2)-Information for enrollees

We fully agree with Highmark, Inc.’s comments and proposed change in language to this subsection dealing with annual updates to provider directories. We suggest that there be flexibility in the PID’s approach to this requirement. As members are directly informed if their PCP or specialist participation status changes, we agree with the suggestion that updates may be “supplied” by way of a quarterly newsletter and web site posting.

We are afraid that the requirement of an annual updated PCP and specialist directory mailing to all members could be a very expensive mandate and could potentially result in increased premiums down the line to our members.

Section 154.17(d)-Complaints

Section 154.17(d) of the proposed regulations states that plans may establish an appeal deadline of at least 30 days. We assume the 30 days is from the date of the denial of benefits as well as between the first and second level complaint review. We suggest that the subsection specify when the time begins to run and that it specifically apply to both levels of appeal.

Section 154.18-Prompt Payment

We fully agree with and support Highmark, Inc.'s comments to and proposed change in language for this section of the proposed regulations. More specifically, with regard to proposed regulation §154.18(c), Act 68 only requires that interest be calculated from the day after the required payment date and end on the date the claim is paid. It does not address when the interest is to be paid. We respectfully suggest that mandating that interest be included with the payment of the claim itself is problematic in that it would require major systems changes to administer.

Subsection (d) as written presents serious implementation problems for our plan in that it would require us to revise our claims payment system. Currently, our claims payment system does not contain detailed logic to specifically measure readjudicated claims and to do so would require us to build expensive logic to include and exclude adjustments.

We are also concerned about subsection (d) as not every readjudicated claim is initiated for lack of information from the provider or member. In certain instances we may internally identify a reason to readjudicate a claim. It is unclear whether these types of claims could be measured under the current wording of §154.18(d).

We agree fully with Highmark, Inc.'s comments regarding the splitting of claims into contested and uncontested portions. This would be very difficult and expensive for our plan to track and administer.

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

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

Ms. Deb Cohen
Capital Blue Cross

Senior Director, POS Programs

Harrisburg PA 17177-

Date Received 8/30/1999

Phone: (717) 541-7412 X00000

Email:

Page 1

Date sent to Committees and IRRC 9/2/1999

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Capital BlueCross

Agent for Pennsylvania Blue Shield

Independent Licensees of the
Blue Cross and Blue Shield Association



Harrisburg, PA 17177

(717) 541-7000

www.capbluecross.com

50 SEP -3 PM 1:48

August 30, 1999

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SEP 01 1999

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

Office of Special Projects

Re: Questions and Comments Regarding Proposed Rulemaking under the Quality Health Care Accountability and Protection Provisions, 31 Pa Code Chapter 154

Dear Mr. Salvatore:

On behalf of Capital Blue Cross, we appreciate the opportunity to comment upon the Department of Insurance's (the "Department") proposed regulations found in Chapter 154, Quality Health Care Accountability and Protection, 29 Pa. B. 4064, to implement the provisions of Act 68 of 1998 ("Act 68").

This response includes general comments to the proposed regulations, followed by comments on specific sections. To facilitate your review of our comments and questions, quoted sections of the proposed regulations appear in *italics* and our comments are highlighted in **bold**.

GENERAL COMMENTS

We recognize the effort required to develop regulations to implement the requirements of a comprehensive and complex statute, such as Act 68. In general, we found the regulations to be clearly written and generally consistent with the purposes and scope of the Act. In a few instances, we have some questions or request clarification of the sections noted below.

We appreciate the opportunity to provide comments, and hope they are helpful to the Department.

SPECIFIC COMMENTS

Section 154.1. Applicability and Purpose

- Section 154.1(c) provides as follows:

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. (Emphasis added.)

We respectfully request clarification of the meaning, intent and applicability of the underlined phrase. A specific example would also help to clarify the phrase.

Section 154.2. Definitions

- Section 154.2 includes the following definition of "gatekeeper":

A primary care provider selected by an enrollee or 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. (Emphasis added.)

We are concerned that the highlighted phrase may be ambiguous. We request clarification that the phrase is not intended to broaden the regulations to apply to traditional PPOs or indemnity plans with no primary care provider referral requirements, but which may have pre-certification requirements which an enrollee must meet in order to have certain types of care, e.g., inpatient hospitalization, covered at the highest level of benefits available.

Section 154.12(b). Direct Enrollee Access to Obstetrical and Gynecological Services

- Section 154.12(b) provides as follows:

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.

As previously stated in our April 12, 1999 letter to Mr. Geoff Dunaway regarding the informal draft regulations (copy attached), we are concerned that the Department has gone beyond the requirements of Act 68 in this section.

Section 2111(7) of Act 68 provides that managed care plans shall: "provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the plan to obtain maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological care, without prior approval from a primary care provider."

Section 154.12(b) of the proposed regulations implies that a managed care plan cannot require prior authorization for maternity and the other services listed in subsection 154.12(a), including maternity care. We are concerned that the Department may inadvertently be undercutting one of the most important tools used by managed care plans to improve clinical outcomes — specifically, prior authorization for maternity services.

We believe that the elimination of prior authorization for maternity services is not required by Act 68. We interpret Act 68 to require the elimination of a gatekeeper for OB/GYN services, including maternity care — not the elimination of tools designed to achieve better outcomes and promote member wellness.

We are extremely concerned about the potential elimination of an important tool which benefits pregnant women at high-risk for complications, and we believe the Department may inadvertently be taking a step which is not in the long-term best interests of our members.

Our prior authorization for maternity care consists of a one-time global authorization. This tool is used to identify pregnant women at high-risk for complications who are suitable candidates for coordinated maternity care. We are concerned that the elimination of this tool will make it more difficult for us to identify high-risk mothers, resulting in lower overall member health and well-being. Our experience confirms that high-risk mothers who enroll in our maternity program receive better care and have fewer complications than those who choose not to participate in this program.

Because of the important public health considerations involved, we respectfully request that subsection (b) be amended to include routine pregnancy. If prior authorization is too strong a phrase to use, we recommend that the Department consider adding the following language to the end of subsection (b): "A managed care plan may require an obstetrical or gynecological provider to notify the plan of a covered member's seeking pregnancy care, so that the plan can inform the pregnant member of additional maternal and child health services available from the plan."

Section 154.13. Managed Care Plan Reporting of Complaints and Grievances

- The initial draft of Section 154.13(d) stated as follows:

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.

- Section 154.13(d), as modified, now reads:

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.

We are not certain to what format the Department is referring. We believe that a format utilized prior to Act 68 would not be appropriate, since Act 68 calls for different treatment of complaints and grievances, especially with regard to external appeals.

We believe it would be in everyone's best interests to have uniform reporting of complaint and grievance data under Act 68. We would ask the Department to work with the Department of Health to develop a uniform format and timetable for the reporting of complaint/grievance information, to minimize confusion and duplication of effort.

Section 154.14. Emergency Services

- Section 154.14(d)(2) provides:

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.

We support this provision and believe that emergency claims can be reviewed and processed in such manner as to preclude the need for past traditional coverage requirements that an enrollee notify his/her primary care physician or the plan within 24 or 48 hours of receiving emergency care. However, as a matter of policy, we believe plans should continue to be allowed to request that enrollees contact their PCP after the receipt of emergency services to enhance coordination of care.

Section 154.15. Continuity of Care

- Section 154.15(i) provides, in pertinent part:

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.

Ten days notice (which may mean as little as 6 business days (or less depending upon holidays) may not be sufficient time in all cases to provide the notice. The Department should consider making this either 10 business days or 15 calendar days. In addition, the Department should include a similar time frame for the provider to respond whether or not he/she elects not to continue care under the terms and conditions under the managed care plan's applicable provider contract.

Section 154.17. Complaints

- Section 154.17 deletes the following example of a complaint which was included in the Department's prior informal draft:

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 provision.

We would appreciate clarification as to why the Department eliminated this example. Is this deletion intended to signify that experimental, investigational and cosmetic service disputes are no longer appealable, or that they are now considered to be grievances, or that they are appealable to the Department of Health?

Section 154.18. Prompt Payment

- Section 154.18(c) provides, in pertinent part:

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan and to the 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. . . . (emphasis added).

Mr. Peter J. Salvatore
August 30, 1999

Page 5

Depending upon claims processing systems, it may be very difficult to issue checks for payment of both the claim and any interest due "at the same time". The Department should allow plans some reasonable leeway to calculate and pay interest due on such claims.

We appreciate your consideration of Capital Blue Cross' questions and comments. If you have any questions or like to discuss any of these issues further, please feel free to contact me at (717) 541-7412.

Sincerely,



Deb Cohen
Senior Director
POS Programs

cc: Anita M. Smith, Executive Vice-President
Capital Blue Cross



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

OFFICE OF SPECIAL PROJECTS
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Harrisburg, PA 17120

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99 SEP -3 PM 1:48

September 2, 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
Wyatte

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,

A handwritten signature in cursive script that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator



99 SEP -1 AM 9:43
RECEIVED
TELETYPE UNIT

facsimile
TRANSMITTAL

to: Peter J. Salvatore
fax #: 717-705-3873
re: Proposed regulations
date: Aug. 27, 1999
pages: 7, including this cover sheet

COMMENTS:

NOTE: The comments on and attachment(s) to this cover sheet are intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return this original to us, at the above address, via the U.S. Postal Service. Thank you.

Making Better Health Easier

From the desk of...

Claris Blaudin
Government Affairs Representative
Blue Cross of Northeastern Pennsylvania
70 North Main Street
Wilkes-Barre, PA 18711

717-819-8611
Fax: 717-819-8606



BlueCross of Northeastern Pennsylvania

An Independent Licensee of the Blue Cross and Blue Shield Association

70 North Main Street, Wilkes-Barre, PA 18711
Information: (800) 829-8599

August 27, 1999

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RECEIVED
INSURANCE DIVISION

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

Dear Mr. Salvatore:

We appreciate the opportunity to provide comments on the draft regulations as proposed by the Pennsylvania Insurance Department as applicable to HMOs and managed care plans covered by Act 68 of 1998, commonly known as the Quality Health Care Accountability and Protection Act of 1998.

We commend the efforts of your department for the ongoing involvement with the stakeholders and the perseverance in the oversight of these regulations. We do, however, have serious concerns over several areas which continue to have problematic consequences. We will limit our comments to the following areas: direct enrollee access to OB/GYN services; emergency services; continuity of care; information for enrollees and prompt payment.

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

(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..

First Priority Health sees this regulation as excessive. Effective coordination of care requires much more timely communication..

Our recommendation would be:

"(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 14 days of the services being provided under procedures established by the managed care plan."

Section 154.14 Emergency Services.

(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.

(2) If the enrollee is not admitted to a hospital or 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.

The Plan should be notified within 48 hours of the provision of emergency services regardless if the enrollee was admitted to a hospital or not. The Plan will need notification to authorize the recommended outcome of the emergency, regardless of the level of care that was provided. The Plan still needs to coordinate the care and benefits, once the emergency is over, and preferably within the participating provider network.

Our recommendation would be:

"(1)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, regardless if the enrollee has been admitted to a hospital."

(2) Eliminate this section since it is combined with (1).

Section 154.15 Continuity of Care.

(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. Based on NCQA 2000 MCO Surveyor Guidelines, page 91, "The MCO must allow continued treatment for up to 90 days for members in active treatment for an acute

condition or through the acute phase of the condition being treated and through the postpartum period (six weeks post-delivery) for women in the second and third trimester of pregnancy. However, the MCO may allow for continued treatment for more or less than 90 days or beyond the postpartum period; the duration of such treatment depends upon the goals agreed upon in the transition plan."

Our recommendation would be:

"(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. 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 to 6 weeks postpartum care related to the delivery. 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"

"(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. For an enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall be extended to 6 weeks postpartum care related to the delivery. 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."

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

This is in direct conflict with NCQA requirements by stating that Managed Care Plans may not require nonpar providers to undergo the plan's credentialing process as part of the continuity of care provision. NCQA requires that providers (par or non-par) who will be taking care of members for a period of time undergo credentialing.

Our recommendation would be:

"(h) Managed care plans may require nonparticipating providers to undergo the plan's credentialing process as part of the continuity of care provision."

Section 154.16. Information for enrollees.

(c) *The written disclosure of information shall include:*

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.

First Priority Health agrees that providing members a list of the names, addresses and telephone numbers of participating providers is beneficial to our members. With over 550 PCPs and 1,650 specialists in the First Priority Health network, however, the idea of providing this information in one voluminous document would frustrate the intent of the act in that it would be both confusing and of no value to our members to have a listing of providers outside of their area. It will also prove to be extremely costly from a mailing and distribution standpoint and such costs will ultimately become the burden of our membership (i.e. factor which will influence premium rates).

We would like to propose a regional directory approach for mass distribution to all members. These regional directories would include primary care physicians, specialists and facilities, and would list the providers based on the geographic location of our four main areas - the Wilkes-Barre, Scranton, Williamsport and Pocono markets.

There would be a disclaimer in the front that would inform members that they received a partial directory and we have other regional directories and the complete listing of physicians printed and available upon their request. Members will also be notified that they have the ability to access on-line our complete PCP and specialist listings via the Internet at www.bcnepa.com.

Our recommendation would be:

"(2) A list by specialty of the name, address and telephone number of all participating health care providers or regional directories with the stipulation that members can receive a complete directory upon request. 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."

Section 154.18. Prompt payment.

(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. 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.

In reviewing Act 68, we note that it states: "Interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim." The Act does not specifically state that payment is to be made at the same time as the claim is paid. The proposed regulations have added the statement: "The Interest is to be paid at the time of payment of the claim."

We believe that the payor should have the option of adding the payment to the claim or making payment within a reasonable time of payment of the claim. We make this suggestion since we feel that there are circumstances which must be reviewed in order to determine if interest is, in fact, payable and to do so at the same time payment is being processed would be costly from a systems perspective and could add time to the payment process, thus exacerbating the problem of paying claims within the required time frame.

Further, our claims system cannot add interest payments without a major reprogramming effort. It is our desire to pay the claims and follow up within a reasonable time with an interest payment check. In this way, we feel we are meeting the intent of the law which was meant to ensure that clean claims are paid promptly.

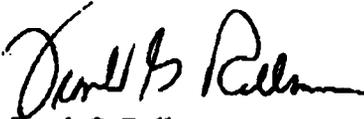
We think it is prudent and cost effective to allow the payor to accumulate interest payments and make payment to the provider within a reasonable time after the claim has been paid.

Our recommendation would be:

"(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 or within a reasonable period of time after the claim is paid. 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. 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."

Once again, we appreciate the opportunity afforded us to bring our concerns/comments to your attention in order to continue to enhance Act 68 for all parties. Please contact me at 570 829-6069 should you have any questions or concerns.

Sincerely,



Frank G. Rollman
Senior Director, Research & Development
Legal Department

- cc: Denise S. Cesare, President & CEO
- Michael P. Gallagher, Senior Vice-President & CFO
- Robert R. Brittain, Jr., Esq., Vice-President, Legal/General Counsel
- John E. Gardner, Vice-President, Administrative Services
- Linda Kanyuck, Acting Vice-President, Customer Service Division
- William J. Phelps, Vice-President, Sales & Marketing
- Brian J. Rinker, Vice-President, Provider Services
- Edward J. Rolde, M.D., Vice-President, Medical Affairs & CMO



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

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99 SEP -1 AM 9:42

August 30, 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

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,

A handwritten signature in cursive script that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator



PENNSYLVANIA STATE OFFICE
225 Market Street, Suite 502
Harrisburg, PA 17101
(717) 238-2277
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AUG 30 1999

August 30, 1999

Office of Special Projects

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

RE: 31 PA. Code Chs. 154 and 301
(Health Care Accountability and Protection)

Dear Mr. Salvatore:

SEP 09 1999
7:16 AM '99
11-6-99

AARP is pleased to provide the attached comments on the proposed rulemaking to help implement P.L. 464 (1998). It is evident that the Department of Insurance has been thoughtful and has worked hard to develop the proposed regulations. AARP appreciates the efforts of the Department and the opportunity to comment.

Generally, AARP is pleased with the proposed rules, and believe that their full implementation will provide additional, much needed protection for managed care consumers in the Commonwealth. However, we do have a number of questions and comments of a relative minor nature that we believe would strengthen the final regulation when implemented.

We hope you find our comments helpful. Please feel free to contact me at (717) 238-2277 if you have any questions.

Again, AARP appreciates the work of the Department on these issues and looks forward to working with you on continuing to improve managed care standards in the months to come.

Sincerely,

Ray Landis
Acting State Director

601 E Street, NW Washington, DC 20049 (202) 434-2277 www.aarp.org
Joseph S. Perkins President Horace B. Deets Executive Director



**AARP COMMENTS ON PROPOSED RULES
ON
QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION
August 30, 1999**

Specific comments on a section-by-section basis are as follows:

Section 154.1 Applicability and purpose.

Based on the definition of "managed care plan" it would appear that the proposed rule would apply to all managed care entities, including provider networks. AARP is particularly concerned about networks that contract directly with employers, and therefore, often falls outside of HMO or other regulatory requirements.

Also, to what degree does this proposed rule apply to PPOs? Since some PPOs now assume some risk and exhibit other similarities to HMO or other forms of managed care, AARP would like the rules, where appropriate to apply to PPOs as well.

Section 154.2 Definitions.

Under "Complaint", would disputes about "benefits" be included as part of coverage issues? AARP would also like questions about the quality of care—not just denials of care—to be the subject of complaints. We are not sure that this would clearly fall under any of the proposed categories of complaints, such as "operations".

Under "Grievance", AARP would like to make sure that a grievance can be filed about ANY aspect of the provision of health care access, quality, and service delivery, including access to specialists, such as through the standing referrals or direct access provisions, or out of plan providers, if appropriate. Also, would the three proposed decisions address a reduction or termination in an existing service ?

Under "Utilization Review", the definition, as drafted, severely limits the functions of a plan's utilization review program and should be reconsidered, if appropriate. The NAIC's model UR regulation outlines a full UR program that is not limited internally to denials of payment. According to the NAIC, a good UR program, whether internal or external to the plan, will address procedures to evaluate clinical necessity, data sources and clinical review criteria, the appeals process, mechanisms to assure consistent application of review criteria, data collection processes, confidentiality, the internal organizational structure and staff responsibilities.

Section 154.11 Managed Care Plan Requirements

Under (b), continuity of care provisions also require the non-network physician, to meet the plans quality standards, to accept the same payment required of network physicians, and to communicate relevant patient care information to the PCP, as appropriate, to keep them informed.

Section 154.12 Direct enrollee access to obstetrical and gynecological services.

AARP supports direct access to OB-GYNs, as well as allowing OB-GYNs to serve as an enrollee's PCP.

Section 154.13 Managed care plan reporting of complaints and grievances.

AARP strongly supports the accurate reporting of standardized reporting of complaint and grievance information. Unfortunately, states often do not pay enough attention to the "type" of complaint/grievance experiences, which is fundamental to understand what kinds of problems the consumers are experiencing and how plans are performing compared to one another. So, AARP is pleased that this kind of information will be reviewed in PA. AARP would also like consumers, including employers, to have access to standardized, comparative grievance information. This kind of disclosure will provide a strong incentive for plans to address complaints in an expeditious and fair manner.

Section 154.14 Emergency services.

Under (b), most state rules on emergency care, as well as the NAIC, call for payment of costs for "screening and stabilization" of an emergency episode, which seems to provide a clearer guideline to follow than the proposed language—"during the period of the emergency."

Section 154.15 Continuity of care.

Under (b), it might add some clarity to the regulation to define "ongoing course of treatment", so that consumers, insurers, and providers share a clearer understanding of what may be expected.

Section 154.16 Information for enrollees.

AARP would suggest that the disclosure information should be structured in a way that would allow consumers to compare the information from plan to plan. Plans are indeed allowed to determine the entire format, the state should monitor this closely to assess how this works or does not work for consumers.

Section 154.17 Complaints.

Under (a), in an attempt to clarify areas of jurisdiction, it appears that typology may not cover all issues (e.g., adequacy of plan network, plan operations) on which consumers may want to file a complaint or a grievance. ? This complaint section needs to be carefully reviewed so that consumers are not limited in the kinds of complaints/grievance they can file, and have clear guidance on these rights.

CHARLES I. ARTZ & ASSOCIATES

ATTORNEYS AT LAW

207 STATE STREET

HARRISBURG, PA 17101

(717) 238-9905

FAX (717) 238-2443

August 30, 1999

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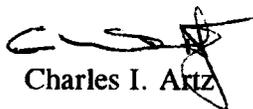
Mr. John H. Jewett
Regulatory Analyst
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

**Re: Pennsylvania Academy of Family Physicians;
Official Comments to Insurance Department's
Proposed Regulations Implementing Act 68 of 1998**

Dear Mr. Jewett:

As you may know, I serve as general counsel to the Pennsylvania Academy of Family Physicians. Enclosed please find a copy of the Academy's official comments submitted to the Insurance Department in response to its proposed regulations implementing Act 68 of 1998. John Nikoloff, the Academy's lobbyist, suggested I forward a copy of the Academy's comments to you and follow-up with a telephone call after you have had the opportunity to review them. I look forward to speaking with you soon.

Sincerely,


Charles I. Artz

CIA/kr

Enclosure

cc: Pennsylvania Academy of Family Physicians

000001-1 111 0:112

COPY



PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

August 27, 1999

VIA FACSIMILE (717) 705-3873
AND U.S. MAIL

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

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Wyatte

99 SEP -1 PM 9:42

Re: Insurance Department Proposed Regulations;
Quality Health Care Accountability and Protection
Act Implementation (Act 68 of 1998)

Dear Mr. Salvatore:

The Pennsylvania Academy of Family Physicians ("the Academy") represents approximately 4,500 physician members. The following comments are submitted in response to the Insurance Department's proposed regulations implementing Act 68 of 1998, the Quality Health Care Accountability and Protection Act, which were published at 29 *Pa. Bulletin* 4064-4071 (July 31, 1999).

Definitions - § 154.2

Primary Care Provider - The definition of this phrase in the proposed regulation tracks the statutory definition of the phrase. A potential ambiguity in that definition, however, should be addressed and resolved in the regulations.

The existing HMO regulations require HMOs to make available to each subscriber "a primary care **physician** to supervise and coordinate the health care of the subscriber." 28 Pa. Code § 9.75(c). Nothing in Act 68 changed the accessibility requirements under § 1555.1(b)(1)(i) of the HMO Act upon which § 9.75(c) was based. Accordingly, no authority exists in Act 68 to alter the primary care physician supervision and coordination requirement. Therefore, the regulations should clearly state that a "primary care **physician** shall supervise and coordinate the health care of an enrollee." Advanced practice nurses and physician assistants should not be expressly or impliedly

authorized in the regulations to possess supervisory and coordination authority or to practice independently of a primary care physician.

As § 2102 of Act 68 makes clear, Act 68 did not expand the scope of practice of any health care provider. Neither APNs nor PAs can practice independent of a primary care physician. Act 68 does not authorize substitution of a primary care physician with an APN or PA. Physician-approved protocols and standing orders, where appropriate, should guide the APN's or PA's approach to patient-described conditions. Standing orders should implement treatment following the diagnosis. An APN and a PA should be prohibited from being held out as a "primary care provider." Therefore, the regulations should define a "primary care provider" as "a physician who is Board certified or Board eligible in and limits his practice to family medicine, general internal medicine or pediatrics; or is a generalist physician who renders primary care at least 50% of the time in which he engages in the practice of medicine."

Primary Care – Act 68 mentions the phrase "primary care" several times, but fails to define this crucial term. The Academy believes the Insurance Department possesses regulatory authority to promulgate a definition of "primary care", and submits the following definition, which was developed and endorsed by both the American Academy of Family Physicians and PAFP, for adoption in the regulations:

"Primary Care." Care provided by physicians specifically trained for and skilled in comprehensive first contact and comprehensive continuing care for persons with any undiagnosed sign or symptom of health concern, the "undifferentiated" patient, not limited by problem origin, gender or diagnosis. The term includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings, including office, inpatient, critical care, long-term care and home care. Primary care is performed and managed by a personal physician, utilizing other health professions, consultation and referral, as appropriate; provides patient advocacy in the health care system to accomplish cost-effective case management and care coordination of health care services; and promotes effective doctor-patient communication and encourages the role of the patient as a partner in health care.

Direct Enrollee Access to OB/GYN - § 154.12

Enrollee Selection, Access to, Referral to, and Reimbursement for OB/GYN Services Provided by Family Physicians – Under § 154.12, the proposed regulations largely restate the direct access to obstetrical and gynecological services under § 2111(7) of Act 68. Many of the Academy's Board certified family physicians are well trained in and

actively practice obstetrics and gynecology. In fact, JCAHO standards require each family practice residency to have one Board certified family physician teach OB/GYN in residency. Scores of family practice residents then provide OB/GYN services in active practice.

Moreover, § 2111(7) of Act 68, as well as Act 68's access to care requirements, **obligate** MCPs to permit enrollees to obtain direct access to OB/GYN services (regardless of the type of provider); to provide reimbursement coverage for such services; to allow self-referral to a family physician other than the patient's primary care physician for such services without prior approval from the enrollee's primary care provider; and, implicitly, to credential family physicians for the provision of OB/GYN services where they have obtained requisite training and experience. MCPs are routinely ignoring these obligations to the detriment of enrollees. Accordingly, § 154.12 should be amended to expressly include these rights inuring to the benefit of enrollees.

Furthermore, pursuant to § 2136(a)(14) of Act 68 (requiring MCPs to automatically publish the list of specialty providers by name, address and telephone number), MCPs should be expressly required to include family physicians with training and experience in OB/GYN on the *list of OB/GYN providers*. A specific provision should be added to the final form regulations clarifying this obligation.

Finally, when enrollees seek direct access to a specific OB/GYN provider, the regulations should specifically state that an MCP cannot penalize a family physician economically or in any other manner, including a negative credentialing decision, based upon an enrollee's direct access to OB/GYN services. A family physician's lack of control over an enrollee's direct access decision mandates this conclusion.

Continuity of Care - § 154.15

Physician Rights – Under § 154.15, the proposed regulations outline a series of obligations imposed on physicians if a patient chooses the continuity of care option. The regulations should make it clear that physicians possess *rights* under the Act as well as obligations. For example, under the continuity of care rules, a physician would have standing to initiate a utilization review challenge.

Information for Enrollees - § 154.16

MCP Response Time and Delegation – Act 68 is silent in terms of the amount of time an MCP has to provide information to enrollees and physicians under § 2136(a). The proposed regulations would allow MCPs 30 days to respond to an enrollee and 45 days to provide written information to physicians. *See* § 154.16(g)(3), (4). This is far too long. Time exigencies may drive the physician or patient's need to obtain crucial

information such as the definition of medical necessity required to be disclosed under § 2136(a)(1), utilization review dispute procedures under § 2136(a)(7), etc. The time limitation imposed on MCPs should be **15 days** from the date of the written request. The 15 day limit should be applicable to both enrollees and physicians' requests.

The proposed regulations are also silent as to the time constraints imposed on MCPs to provide the information requested under § 2136(b). Enrollees are entitled to crucial information under this subsection, including for example whether a drug is included or excluded from coverage under § 2136(b)(5), drug formulary information under § 2136(b)(6), and physician credentialing processes under § 2136(b)(3). The same **15 day** time constraint should be imposed on MCPs to respond to enrollees' requests under § 2136(b).

Finally, proposed § 154.16(e) appears to create some authority for an MCP to delegate its information disclosure obligation to a group policy holder or other designated entity. The Act provides no such delegation authority. Even if such authority to delegate is within the Insurance Department's realm of constitutional regulatory authority, § 154.16(e) should expressly state that the MCP retains responsibility for timely disclosure of the material requested.

Complaints - § 154.17

Medical Necessity Parameters - Act 68 does not contain an objective definition of the term "medical necessity." MCPs, however, must adopt and maintain a definition of medical necessity of their own. § 2111(3). MCPs must also disclose to enrollees and physicians the definition of medical necessity it utilizes. § 2136(1). If an MCP's contract prohibits or restricts disclosure of medically necessary and appropriate health care information by a physician, that provision is void and unenforceable. § 2113(b). The "gag clause" provisions in § 2113(c)(1)-(3) address the prohibition against squelching the disclosure of medically necessary information from physicians to patients. Thus, medical necessity definitions are an integral part of MCP operations, and (quite obviously) the physician's practice of medicine.

The provisions of Act 68 cited above permit the Insurance Department's regulation of the parameters of an acceptable "medical necessity" definition used by MCPs. In fact, Greg Martino testified to the House Insurance Committee that the Insurance Department already uses a series of "key characteristics" in determining whether to approve or disapprove an MCP's contract in terms of the medical necessity definition. The Academy has not seen those parameters, but believes medical necessity parameters should be included in the regulations.

The definition of medical necessity has emerged as one of the two most contentious issues in the managed care reform debate. States are beginning to enact statutory

definitions of this phrase. It is simply too important to patients (and physicians) to allow this crucial term to go undefined. Accordingly, the Academy believes the Insurance Department possesses sufficient statutory authority to include the following medical necessity definition parameters in its final form regulations, as follows:

- Any therapeutic treatment, care or services reasonably expected by a prudent physician to improve, restore or prevent the worsening of any illness, injury, disease, disability, defect, condition or the functioning of any body member.
- Objective clinical determinations which will be or are reasonably expected by a prudent physician to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical or mental effects of an illness, condition, injury or disability; or alleviate the patient's pain or mitigate the severity of the patient's symptoms.
- All relevant clinical data pertaining to the patient's condition as a whole must be taken into consideration.
- The prevailing practice and standards of the medical profession and community must be taken into consideration.

These parameters strike the necessary balance between patient protection and utilization control. The Insurance Department should work collaboratively with the Department of Health to ensure that each agency's medical necessity contractual parameters are identical.

"Hospitalist" Issue - Some managed care companies are attempting to force family physicians to utilize "hospitalists" for their patients' hospital care. A "hospitalist" is generally defined as a physician who devotes the entirety of his or her practice to treating patients inside the hospital setting. Family physicians are well trained and have substantial knowledge and experience in practicing inpatient hospital medicine, and cannot and should not be mandated to utilize "hospitalists" for their patients' hospital care. A specific provision should be included in the regulations addressing this crucial issue.

MCP Time to Make Denial Decision - Act 68 is silent on the time required by an MCP to make a decision to deny payment as well as the amount of time an enrollee or physician has to assert a challenge to the MCP's denial decision. In § 154.17(e) of the proposed regulations, the Insurance Department proposes to allow an MCP to impose a

Peter J. Salvatore
August 27, 1999
Page 6

minimum time period (30 days) for an enrollee to file a complaint. The proposed regulations, however, **impose no time limitations on an MCP to make the initial denial decision.** Because the Insurance Department has apparently seen fit to impose a time limitation on an enrollee, the same 30-day time limitation should be imposed upon an MCP. That is, an MCP should have only 30 days to deny payment for a particular treatment or service on the basis of a contract exclusion and non-covered benefit decision from the date the physician submitted the bill for payment.

Moreover, § 154.17(f) allows 5 days in addition to the statutory 30-day period in which the MCP must review a complaint. In fact, mail typically is delivered from one end of the Commonwealth to another in 2 days. The Pennsylvania Rules of Appellate Procedure only assume 3 days for mailing. *See* Pa. R.A.P. 121(e). The 5-day time limitation should be reduced to 2 days, or 3 days at the most. There is no valid factual basis to assume 5 days for mailing, and no legislative intent exists to support creation of the additional week for MCP compliance. These principles apply to the other subsections of § 154.17 where the 5-day rule is discussed.

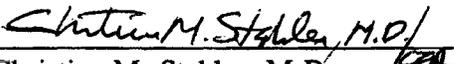
Prompt Payment - § 154.18

The requirement under § 154.18(e) that imposes the burden on *providers* to spend their resources to ascertain whether the MCP has sufficient documentation finds no basis in Act 68 and conflicts with the clean claim notion under HCFA regulations from which it was adapted. This provision should be stricken.

* * * *

Thank you for your consideration of the Academy's issues and concerns relating to these important public policy and legal matters. Should you have any questions, please contact us at your convenience.

Sincerely,



Christine M. Stabler, M.D. *CS*
President

cc: PAFP Board of Directors
PAFP Public Policy Commission
Wanda D. Filer, M.D. - Chair, PAFP Public Policy Commission
John S. Jordan, PAFP Executive Vice President
Charles I. Artz, Esq. - PAFP General Counsel
John A. Nikoloff - PAFP Lobbyist

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

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

Ms. Kimberly J. Kockler
Managed Care Association of Pennsylvania
240 North Third Street, Suite 203
Harrisburg PA 17108-2108

Executive Director

Date Received 8/27/1999

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Page 1

Date sent to Committees and IRRC 8/27/1999

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MANAGED CARE ASSOCIATION OF PENNSYLVANIA

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August 27, 1999

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

Dear Mr. Salvatore:

On behalf of the Managed Care Association of Pennsylvania (MCAP), I would like to submit the following comments to the proposed regulations pursuant to Act 68, 1998, the Quality Health Care Accountability and Protection Act. The proposed regulations have been reviewed by MCAP's internal Act 68 workgroup which consists of member health plan representatives with expertise in numerous and varied areas of managed care plan operations.

In reviewing the proposed regulations, the Association was pleased to note that a number of changes previously suggested by MCAP were included by the Department. These changes include:

Emergency Services - Section 154.14

- ✓ Requiring emergency health care providers in subsection (d)(1) to notify managed care plans within 48 hours or the next business day in the event that a member is admitted to a hospital or other health care facility following an emergency room visit.

Continuity of Care - Section 154.15

- ✓ Under subsection (f), inclusion of language requiring that, in order to be eligible for payment, providers shall agree to the terms and conditions of the managed care plan prior to providing service under the continuity of care provisions.

Complaints - Section 154.17

- ✓ Permitting managed care plans to establish time frame limits of at least 30 days (subsection d) for the filing of complaints and grievances with the plan.
- ✓ The inclusion of language in subsection (g) that requires enrollees to follow and complete the plan's internal complaint process before filing an appeal.

The following represent MCAP's concerns and comments with the draft regulations. Please note that our suggested changes are italicized and underlined for your reference.

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Office of Special Projects

- 1) **Explanation of Proposed Regulatory Requirements** - Section 154.18 (relating to prompt payment), states that "the prompt payment provisions of the act 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." Would the Department please provide clarification as to whether the Unfair Insurance Practices Act applies only to claims submitted directly by the insured and not those submitted by out-of-network providers? It is our understanding that the primary objective of the Unfair Insurance Practices Act is to protect consumers, while the Act 68 prompt payment provisions are designed to protect providers. If so, to apply the Unfair Insurance Practices Act and Act 68 requirements to out-of-network claims submitted by providers would be of no benefit to consumers and onerous for managed care plans. Clarification from the Department would be extremely helpful for managed care plans, especially during the Department's HMO market conduct reviews.

- 2) **Paperwork requirements** - In order to meet the compliance requirements of the Act which became effective January 1, 1999, managed care plans were required to revise marketing as well as other materials including subscriber contracts, group master contracts and member handbooks and submit the revisions to the Insurance Department by December 31, 1998. In light of the requirements and changes in the draft regulations, will managed care plans be required to resubmit the aforementioned materials to the Department for review upon implementation of the final regulations? If so, by what date would the plans need to resubmit their documents for review? The Association would subsequently note, and would like it stated in either the "Fiscal Impact" or "Paperwork" section of the regulations that, "Implementation of the Act will impose significant additional costs on managed care plans in terms of material revisions, re-submissions, regulatory approvals, printing and distribution."

- 3) **Definitions - Section 154.2**
 - ✓ **Emergency service** - MCAP suggests that the phrase "including a chronic condition" be removed from the definition of emergency service. Managed care plans are successfully utilizing disease management programs for chronic conditions (i.e., diabetes and asthma) in order to educate enrollees and to avoid unnecessary use of emergency services. MCAP believes inclusion of the phrase "including a chronic condition" will only serve to undermine those efforts by creating a double standard for emergency room use. Removal of the phrase should have no effect on those who are experiencing an emergency situation, either due to a chronic or acute situation. MCAP supports the "emergency service" definition as it appears in Act 68.

 - ✓ **Grievance** - At the end of subsection (i), MCAP strongly recommends adding the following: "This term does not include a provider appeal for clarification of claims payment." The Association is aware of providers, specifically hospitals, that are attempting to utilize the grievance process for this purpose. MCAP is aware of hospitals that are trying to use the Act 68 grievance process as recourse in the event of an adverse retrospective utilization review determination. In such situations, while payment may be in dispute, consumer services have already been provided. This is an inappropriate use of the grievance process which is intended for the benefit of consumers OR providers ON A CONSUMER'S BEHALF. In addition, National Committee for Quality Assurance

(NCQA) standards require that managed care plans have an appeals process for providers. These provider-specific processes are the appropriate venue for claims payment clarifications.

- ✓ **Health care service** - The Association recommends that the definition of health care service specifically exclude prescription drugs. Prescription drug benefits are an additional benefit to be provided at the discretion of the purchaser and should not be assumed to be included as a covered health care service. Additionally, the definition suggests that such services be provided by a "health care provider." Because the term "provider" typically includes health care facilities, the Association believes it is inappropriate for inclusion here. MCAP suggests that the definition be limited to health care practitioners—not providers as is currently stated.
- ✓ **Ongoing course of treatment** - The Association appreciates the addition of this definition, however, we seek clarification on the meaning and purpose of the phrase "treatment that arises out of a *single* diagnosis." MCAP supports the following definition: "Continuous health care services provided to an enrollee and authorized by the previous insurer or managed care plan."
- ✓ **Prospective enrollee** - For clarity, the Association urges the addition of the following in the definition of a prospective enrollee: "For group contracts or policies, those persons eligible, but not yet enrolled, for coverage . . ."
- 4) **Changes, modifications and disclosures in subscriber and other contracts and in other materials - Section 154.3**
- ✓ MCAP supports the addition of language in the last sentence of this section as follows: "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." This will allow flexibility as to how required changes are made.
- 5) **Managed care plan requirements - Section 154.11**
- ✓ Subsection (a) (2) notes that an enrollee may designate a specialist to provide and coordinate the enrollee's primary care. Similar to continuity of care requirements under the proposed regulations, MCAP urges the addition of the following sentence: "If the specialist agrees to act as the enrollee's primary care provider, the specialist shall agree to the plan's terms and conditions."
- ✓ Subsection (b)(3) requires the specialist to notify the enrollee's primary care provider of all care provided. The Association suggests that the phrase within a reasonable time be added at the end of the sentence.
- 6) **Direct enrollee access to obstetrical and gynecological services - Section 154.12**
- ✓ Subsection (b) permits managed care plans to require an ob/gyn provider to obtain prior authorization for selected services. The Association suggests that additional language be included: "to obtain prior authorization for selected services, to be determined by the health plan, such as diagnostic testing . . ."

- ✓ The last sentence of subsection (c) should be revised as follows: **"The health care provider shall communicate the information to the primary care provider within 30 days of the service being provided."**

- 7) **Emergency services - Section 154.14**
- ✓ Subsection (a) includes a reference to section 2101 of the Act. The Association believes that **section 2102** of the Act should be cited.
- ✓ The Association suggests that subsection (b) be amended since emergency room claims submitted by a health care provider do not typically include information about the presenting symptoms. Presenting symptom information is typically included as an addendum or attachment to the claim. The recommended language is: "Plans are required to consider the presenting symptoms as documented **along with** the claim, and the services provided, when processing claims for emergency services."

- 8) **Continuity of care - Section 154.15**
- ✓ MCAP believes that subsection (a)(1) requires clarification and suggests the following: "A managed care plan terminates a contract with a participating provider for reasons other than for cause, and the enrollee is **currently** in an ongoing course of treatment with that provider."
- ✓ A similar suggestion is noted in subsection (a)(2) where the word "then" should be replaced with **"currently."**
- ✓ To clarify that the continuity of care option in subsection (b) is available only to providers who have been terminated by the managed care plan and not those who self-terminate, we would urge the addition of the following in the first sentence: "... a provider whose contract has been terminated **by the managed care plan** for reasons other than for cause ..."
- ✓ In reviewing subsection (e)(1) and (e)(2), the Association felt that the language was somewhat confusing and suggests the following:

(e) Nonparticipating providers and providers terminated by the managed care plan shall agree to the same terms and conditions which are applicable to the managed care plan's participating providers.

(1) If multiple providers are involved in an ongoing course of treatment, all of the providers involved shall agree to the managed care plan's terms and conditions and agree to utilize participating providers for the provision of all other health care services to enrollees.

(2) The continuity of care option for enrollees is not available to nonparticipating providers who do not agree to the managed care plan's terms and conditions.

Mr. Peter J. Salvatore

August 27, 1999

Page 5

- ✓ MCAP agrees that subsection (g) should require nonparticipating or terminated providers to agree to terms, but suggests inclusion of the following language: "... terms that include, **but are not limited to:**"
- ✓ Subsection (h) states that managed care plans may not require nonparticipating providers to undergo the plan's credentialing process. NCQA accreditation standards require managed care plans to include only credentialed providers in provider networks. By prohibiting nonparticipating providers who are participating in the continuity of care provision of Act 68 to undergo credentialing, managed care plans may be out of compliance with NCQA accreditation standards. We strongly urge the Department to remove this prohibition.
- ✓ The Association advocates the addition of the following language in the last sentence of subsection (i): "... shall be provided in written form to terminated or terminating and nonparticipating providers within 10 **business** days of notice to the plan that an enrollee is requesting continuity of care benefits."

9) **Information for enrollees - Section 154.16**

- ✓ Subsection (3)(d) notes that subscriber and group master contracts and riders, amendments and endorsement do not constitute "marketing materials" subject to the specified disclosure statement. MCAP would ask that the Department provide clarification as to what information and documents do constitute "marketing materials."
- ✓ Subsection (g)(2) specifically states that disclosure information should be provided to enrollees within 30 days of the effective or renewal date of the contract or policy. In light of the volume of contracts that become effective or renew on January 1 of each year, it would be difficult, if not impossible, to meet the disclosure requirements of the regulations within 30 days. The Association would respectfully request that the 30 day time frame be extended to **within 45 days of the receipt of the enrollee request.**
- ✓ MCAP also suggests that, since provider networks frequently change, the requirement that provider network directories be provided at initial enrollment or renewal be removed (subsection (g)(2)). The Association suggests the following language in its place:
(2) If benefits have changed since initial enrollment or last renewal, disclosure information should be provided to enrollees within 45 days of the effective date of the contract or policy, renewal date of coverage or receipt of an enrollee request for the information.
- ✓ For consistency, MCAP suggests that the 30 day time frame in subsection (g)(3) be extended to **"within 45 days of the receipt of the potential enrollee's written request."**
- ✓ MCAP also suggests that subsection (g)(4) be revised to state that disclosure information requested by health care providers be provided **"within 45 days of the receipt of the provider's written request."**

10) **Complaints - Section 154.17**

- ✓ In subsection (c), MCAP recommends removing the words "do not constitute "appeals"

and.” The term “appeal” may prove confusing in light of the complaint and grievance processes outlined in Act 68.

- ✓ MCAP believes that the intent of Act 68 is that enrollees follow and complete the plan’s internal complaint process before appealing a complaint decision with the Department as noted in subsection (g). **However, we are aware that there have been instances where enrollees directly contact the Department with a complaint and bypass the managed care plan entirely.** In those circumstances, plans receive a notice from the Department giving the plan 15 days to respond to the complaint. While MCAP can certainly appreciate the Insurance Department’s role in serving the interests of consumers, this essentially creates two different consumer complaint systems and a disincentive to utilize the provisions set forth in law under Act 68 which allows 30 days for an initial review. This will create confusion for both consumers and managed care plans. We respectfully ask that the process set forth under Act 68 be followed in all instances - and most especially when enrollee complaints are received directly by the Department without first being filed with the managed care plan.
- ✓ MCAP also suggests that, due to the importance of the enrollee following and completing the plan’s internal complaint process, subsection (g) be incorporated with the language of subsection (a) as follows:

(a) “Under the complaint process established by the act, the Department will consider complaints regarding issues of contract exclusions and noncovered benefit disputes ***only after enrollees follow and complete the plan’s internal complaint process.*** The grievance process . . . “

11) **Prompt payment - Section 154.18**

The Association’s strongest concerns and objections in regard to the draft regulations are found in the proposed prompt payment provisions.

- ✓ A previously released draft of the regulations included language stating “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.” **The Association advocates that this language is not outside the scope of the Act and that it be reinserted in the proposed regulations.**
- ✓ Subsection (b)(1) states that a claim is paid on the date a check is mailed by the managed care plan to the provider. This represents a significant change from the October 3, 1998 Statement of Policy which states that claims are determined to be paid on the “date of issuance” by the managed care plan. MCAP’s member plans will have significant difficulty adhering to the requirement in the draft regulations as information systems have the ability to track when a check is issued—not when a check is mailed. **The Association advocates that the language used in the October 3, 1998 Statement of Policy be reinstated.**
- ✓ Subsection (c) states that the accrued interest on a clean claim shall be paid at the time of payment of the claim—either on the same check as the claim payment or on a separate check. This requirement is extremely unwieldy to administer from a systems perspective.

The Association respectfully requests that, instead of including this specific requirement in regulation, the Department work with the plans to allow flexibility on how interest payments are made to providers.

- ✓ MCAP continues to be disturbed by the requirement set forth in subsection (d) that the prompt payment provision also applies to the uncontested portion of a contested claim and strongly urges the Department to reconsider this language. This provision is not possible to comply with from a current claims tracking or processing systems perspective. **To be able to administer the requirement, managed care plans would have to manually process the claim which slows the processing time, thereby increasing the likelihood of errors and payment delays.** The unreasonableness of this requirement can best be documented with an example:

A provider submits a claim with five line items. Four of the line items appear to be "clean," while the remaining item is determined to be "unclean." The resolution of the "unclean" item may impact what is paid for in the other four items and change the entire composition of the claim and payment by the plan.

- ✓ To ensure providers do not file a complaint prior to the conclusion of the 45-day requirement set forth in the Act, MCAP strongly suggests removal of subsections (f) (1) and (f) (2). These subsections significantly weaken the 45-day provision of the Act. MCAP recommends the following language:

(f) Once 45 days from receipt of the claim have elapsed and providers have followed the Department's advisory on prompt payment of claims, health care providers may file a complaint with the Department.

- ✓ To ensure that complete information is provided to the Department, MCAP urges the inclusion of the following language in subsection (g)(4):

(g) The dates of service, **member identification number, provider identification number, the disputed amount** and the date the claims was submitted to the licensed insurer or managed care plan.

The Managed Care Association of Pennsylvania appreciates the opportunity to review and comment on the draft regulations. We hope that our comments are useful to the Department. Please contact me directly with any questions or concerns you might have.

Sincerely,



Kimberly J. Kockler
Executive Director



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**OFFICE OF SPECIAL PROJECTS
1326 Strawberry Square
Harrisburg, PA 17120**

**Phone: (717) 787-4429
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August 27, 1999

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Jewett

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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

9/11/99 10:18 AM

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

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Office of General Counsel

DATE: August 27, 1999

FAX NUMBER: 717-705-3873

TO: Peter J. Salvatore, Regulatory Coordinator
Pennsylvania Insurance Department

FROM: Richard F. Levins, Esq.
Phone: (215) 241-3805
Fax: (215) 241-3824

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GENERAL COUNSEL
AUG 27 1999

We are transmitting 8 pages, including this cover sheet, to the person listed above.

If this transmittal is not complete please contact:
Karen Kinney at (215) 241-3816.

COMMENTS:

The information in this fax message is intended only for the personal and confidential use of the recipient(s) named above. This message may be an attorney-client communication and as such is privileged and confidential. In addition, it may contain information that is confidential, proprietary, or trade secret information intended only for the addressee(s) and exempt from disclosure under applicable law. If you are not the intended recipient or an agent responsible for delivering this to the intended recipient, you are hereby notified that you have received this document in error, and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please notify us immediately and return the original message to us by mail. Thank you.



Independence
Blue Cross

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1901 MARKET STREET
PHILADELPHIA, PA 19103-1400

August 27, 1999

Office of Special Projects

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

VIA FACSIMILE AND REGULAR MAIL

Re: Proposed Regulations Implementing the Quality Health Care
Accountability and Protection Provisions of Article XXI of Act 68

Dear Mr. Salvatore:

On behalf of the subsidiaries of Independence Blue Cross ("IBC") which are subject to the provisions of Act 68 (the "Act"), thank you for the opportunity to respond to the Insurance Department's (the "Department") recent publication of proposed regulations implementing the Act. IBC's comments are as follows:

1. **§154.1 Applicability and Purpose**

- ◊ The Act requires, in certain sections, the participation and cooperation of providers. IBC therefore suggests that §154.1(a) be revised as follows to include health care providers:

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

- ◊ Prior to adoption of the provision, IBC requests clarification of the meaning of §154.1(c) which reads:

(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.

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2. §154.2 Definitions

◊ Emergency service:

The proposed regulation expands upon the definition of Emergency Service in the act to include "a chronic condition." IBC suggests that this reference be clarified to indicate that only an emergent medical event related to a chronic condition will satisfy the definition of emergency service. Thus, the routine administration of an inhaler to an asthmatic would not automatically qualify as an emergency service. Administration of services to treat an individual who is in respiratory crisis due to complications of asthma, however, could qualify as an emergency service.

The proposed regulation separates ambulance transportation and services into their own definitional subsection. IBC suggests that this results in a meaning not intended by the text of the Act. Specifically, the proposed regulation seems to suggest that ambulance services are by definition, in and of themselves, "Emergency Services." Ambulances are sometimes used for transportation in situations that do not rise to the level of emergencies. Therefore, IBC suggests that the provision be modified to track directly the language of the Act by merging subsection (ii) into subsection (i)(C) as follows:

(i)(C) 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.

Alternatively, IBC suggests that subsection (ii) be clarified to indicate that ambulance transportation and services shall constitute emergency services only when the condition or symptoms for which the transportation or services are required meet the definition of Emergency Services.

◊ Grievance:

The definition of Grievance in the proposed regulations appears to add a third level of "appeal" to the grievance process required by the Act. The Act states that a process shall be established,

...by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service... (Section 2161 of the Act (40 P.S. §991.2161))

The proposed regulations, however, require the managed care plan or utilization review entity to reconsider its decision upon the request of the enrollee or his or her provider. This reconsideration process apparently precedes, and is in addition to, the written grievance process required by the Act. IBC suggests that this reconsideration process be eliminated from the final regulations because it goes beyond the scope of the Act.

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◊ Managed Care Plan:

IBC would like to take this opportunity to clarify and confirm that, with the exception of their Prompt Payment provisions, Act 68 and its implementing regulations do not apply to non-gatekeeper PPO's such as IBC's Personal Choice product. The provisions of the Act and the proposed regulations which apply to "Managed care plans" define such plans as follows:

"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... (Section 2102 of the Act (40 P.S. §991.2102)).

The Personal Choice PPO product does not utilize a gatekeeper, either active or passive. Personal Choice members may go to any provider they choose, at their sole discretion. There is no referral requirement. Therefore, under the provisions of the Act, and of the proposed regulations, Personal Choice does not meet the definition of a "Managed care plan."

◊ Ongoing Course of Treatment:

IBC suggests that the final regulations incorporate an enhanced definition of "ongoing course of treatment." This will help to avoid disputes based solely upon whether a current enrollee's use of a terminated provider, or a new enrollee's use of a nonparticipating provider, constitutes an "ongoing course of treatment" giving rise to the continuity of care option under §154.15 of the proposed regulations. The current definition should be revised to read as follows:

Ongoing course of treatment—Health care treatment which arises out of a single diagnosis provided to an enrollee by a health care provider who is actively clinically managing the enrollee within 60 days prior to the occurrence of the events listed at §154.15(e)(1) or (2) and, but for the occurrence of such events, would continue to clinically manage the enrollee.

3. **§154.12 Direct Enrollee Access to Obstetrical and Gynecological Services**

IBC requests clarification of the Department's intent with respect to the effect of subsection (d) on managed care plans with enrollee self-referral options. The subsection states:

(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.

It appears to be the Department's intention that, for purposes of direct access to obstetrical and gynecological services only, self-referred services, which would otherwise be paid at a lower rate than referred services, shall be paid at the higher, referred rate.

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4. §154.15 Continuity of Care

◊ Notice:

In order to avoid the possibility of an enrollee purposely avoiding receipt of notice of a provider's termination, IBC suggests that §154.15(b) be revised to state that

(b)...A current enrollee shall be allowed to continue an ongoing course of treatment...for a transitional period of up to 60 days from the date the enrollee is notified by the plan of the termination or pending termination by mail or telephone.

5. §154.16 Information for Enrollees

◊ Directories:

Subsection (c)(2) requires Managed Care Plans to provide:

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.

A listing of literally all participating health care providers would be so voluminous and unmanageable it would be confusing to enrollees. It would include not only primary care physicians, OB/GYN's, and hospitals, but providers to whom enrollees have no direct access. For example, hospital-based physicians, durable medical equipment providers, and laboratory-based pathologists. Inclusion of this superfluous information would not benefit enrollees. It would not assist them in choosing a Primary Care Physician ("PCP") or OB/GYN to manage and direct their care.

IBC suggests, as an alternative, that the list of participating health care providers to be furnished to enrollees be limited to those providers to whom enrollees have direct access. When needing a referral, enrollees are encouraged to fully discuss the options and available list of specialists with their PCP. The PCP often has specialists with whom he/she has a close working relationship and to whom he/she prefers to refer all of his/her patients (traditional or managed care). The enrollee always has final say as to which specialist he/she would like to see. Information about participating health care providers is always available to enrollees via telephone, the internet, and in writing upon request. Our suggested alternative, in addition to maintaining administrative efficiencies, will better facilitate positive enrollee interactions with their PCPs, thereby enhancing patient satisfaction.

◊ Timing of Disclosure Information:

IBC suggests that the Department incorporate some flexibility into the regulations with respect to the timing of Managed Care Plans' issuance of disclosure information to enrollees. Although 30 days may be sufficient in most instances, there are legitimate circumstances, over which a

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plan has no control, which would make it impossible for the plan to meet the 30 day time frame. For example, sometimes a group does not furnish the plan with a complete listing of enrollees until after the effective date of coverage. To address these types of situations, §154.16(2) should be revised to state:

...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 the managed care plan's receipt of the request for the information, or as soon thereafter as is reasonably possible.

o Time of Receipt

To conform to the requirements of other sections of the proposed regulations, the time frames under §154.16(g)(2), (3), and (4) should be measured from the date of the Managed Care Plan's receipt of the request for information (as noted above). Measuring the time frame from the date of the written request does not account for lost or misdirected mail, or for the intentional or unintentional back-dating of requests.

6. **§154.17 Complaints**

Subsections (e) and (f) require that Managed Care Plans complete their reviews of enrollee complaints within 30 days of receipt of the complaint, and within 45 days of receipt of the enrollee's request for review, respectively. Because all necessary medical files and records may not be received by the Managed Care Plan in a timely manner, IBC suggests that the time frames for completion of the reviews be subject to extension with the enrollee's approval. For example, an extension of the time frame would benefit an enrollee whose complaint could be favorably resolved by information which is being delayed by a non-participating facility. The following language is proposed as an addition to this section of the regulations:

Managed care plans may request that the enrollee approve an extension of the time period for review if the plan has not received the necessary medical records or documentation to review the complaint five days prior to the end of the review period.

7. **§154.18 Prompt Payment**

o Interest

IBC has several concerns with respect to the Department's proposed requirements for the handling of interest payments. The Act does not require simultaneous payment of claims and interest. Paying interest at the time claims are paid will likely lead to confusion at providers' billing and accounting offices. The practice may also confuse group customers who receive claim payment reconciliations and settlements. This confusion can be avoided by allowing payors to adopt a monthly accrual system for interest payments.

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IBC suggests that the Department require that interest payments be made to providers by the 21st day following the end of the month in which the claim payment was issued. This will provide payors with sufficient time to review paid claims information needed to identify those claims requiring interest payments. At IBC this information is not available until 7-10 days following month end. It will also allow sufficient time for payors' claims and finance areas to review and verify the interest payments to be made – thus avoiding errors in the process.

Finally, in order for IBC to comply with the proposed regulations, it would have to undertake radical systems changes which would take a minimum of two years to complete. These changes would require a host of activities and resources which, due to Y2K activities, cannot be supported at this time. Other regulators, including the Health Care Financing Administration and the National Association of Insurance Commissioners ("NAIC") have recognized the impact Y2K activities have on carriers' ability to make systems modifications in response to new regulations. Specifically, the NAIC has adopted a resolution calling for a moratorium on new state regulations until later in the year 2000. IBC hopes that the Department shares these concerns, and will be sensitive to plans' Y2K initiatives in reviewing the reasonableness of the proposed regulations.

◊ Readjudication:

Please clarify that the Department's intention is that a new 45-day period for the prompt payment provision begins at the time additional information prompting the readjudication is provided to the plan. The original claim submission date is not the reference point for the 45-day readjudication period.

The proposed regulations regarding readjudication of paid claims present certain operational challenges. Information that would prompt readjudication of claims may come in many forms from many sources. Often the information does not come directly to the claims area, for example a letter from an enrollee directed to customer service. Furthermore, claims to be readjudicated are not systemically treated as new claims. Rather, the original claim is re-opened and adjusted using the original claim filing date as the reference point. The date on which additional information was received prompting the readjudication is not captured.

◊ Contested/Uncontested Claims:

The concept of splitting claims according to contested and uncontested portions seems to conflict with the concept of a clean claim. A claim that contains contested elements requires additional information and development before it can be adjudicated. It, therefore, does not meet the definition of a "clean claim" and should not be regarded as such.

Regardless of the number of services submitted, IBC handles each claim as a single claim which is kept in tact throughout the processing cycle until finalization. Splitting claims into contested and uncontested lines is not systemically possible. Doing so jeopardizes the integrity of the claim and, more importantly, compromises the application of medical policy. The result could be over or under payments to providers. Providers would also be faced with a difficult and unnecessarily complex reconciliation process if claims were split.

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IBC hopes that these comments will be useful to the Department as it works to finalize the proposed Act 68 regulations. Please do not hesitate to contact me at (215)241-3805 with any questions you may have.

Sincerely,



Richard F. Levins
Deputy General Counsel

RFL/kk

c: **G. Fred DiBona, Esq., President & CEO**
Gregory S. Martino, Deputy Insurance Commissioner
Nicholas A. Micozzie, Chairman, Pennsylvania House Insurance Committee



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

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August 27, 1999

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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.

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,

A handwritten signature in cursive script that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator

The Insurance Federation of Pennsylvania, Inc.

**1600 Market Street
Suite 1520
Philadelphia, PA 19103
TEL: (215) 665-0500 FAX: (215) 665-0540**

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Samuel R. Marshall
President &
Chief Executive Officer

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August 26, 1999

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

RECEIVED
AUG 26 1999
11:08:56

**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.

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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 Departments," 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

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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.

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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 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



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

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August 26, 1999

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
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Re: ^{Wyatte}Insurance Department
Proposed Regulation No.
11-195, Quality Health Care
Accountability and Protection

RECEIVED
INSURANCE DEPARTMENT
AUG 26 1999
5:55

Dear Mr. Nyce:

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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,

A handwritten signature in cursive script that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator

