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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 225 Session of 2021

INTRODUCED BY PHILLIPS-HILL, MARTIN, J. WARD, MENSCH, COLLETT, MUTH, KANE, STEFANO, AUMENT, CAPPELLETTI AND BAKER, MARCH 18, 2021

REFERRED TO BANKING AND INSURANCE, MARCH 18, 2021

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in quality healthcare accountability and protection, further providing for definitions, for responsibilities of managed care plans, providing for preauthorization standards and for preauthorization costs, further providing for continuity of care, providing for step therapy protocols, further providing for required disclosure, for operational standards and providing for preauthorization and adverse determinations, for appeals, for access requirements in service areas, for uniform preauthorization form, for preauthorization exemptions and for data collection and reporting; and making an editorial change.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The General Assembly finds that:

(1) Preauthorization of medical treatment, testing and procedures was initially designed to reduce unnecessary cost

placed on insurers, insureds and providers.

(2) The process of preauthorization and the process to appeal a preauthorization decision has not been updated in 20 years.

(3) The current preauthorization process has become overly expansive, to the point where it is interfering with the patient-provider relationship by inserting a third party into the treatment decision-making process.

(4) The basic minimum requirements of this act are necessary to ensure that the patient-provider relationship remains paramount in making any decision on the course of treatment.

Section 2. It is the intent of the General Assembly to create clear definitions, notice requirements and processes for the determination of authorizing insurance coverage for medical treatment, procedures and testing prior to the patient receiving the treatment, procedure and testing.

Section 3. The definitions of "emergency service," "enrollee," "grievance," "health care service," "prospective utilization review," "retrospective utilization review," "utilization review" and "utilization review entity" in section 2102 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, are amended and the section is amended by adding definitions to read:

Section 2102. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

* * *

"Administrative defect." Any deficiency, error, mistake or missing information other than medical necessity that serves as

the basis of an adverse determination issued by a utilization review entity as justification to deny preauthorization.

"Adverse determination." A decision made by a utilization review entity from a preauthorization request that:

(1) the health care services furnished or proposed to an insured are not medically necessary or result from an administrative denial; or

(2) denies, reduces or terminates benefit coverage.

The term includes a decision to deny a step therapy exception request under section 2118. The term does not include a decision to deny, reduce or terminate services that are not covered for reasons other than their medical necessity or experimental or investigational nature.

* * *

"Appeal." A formal request, either orally or in writing, to reconsider a determination not to authorize a health care service prior to the service being provided. This does not include a grievance filed under section 2161, relating to reconsideration of a decision made after coverage has been provided.

"Appeal procedure." A formal process that permits an insured, attending physician or his designee, facility or health care practitioner on an insured's behalf to appeal an adverse determination rendered by the utilization review entity or its designee utilization review entity or agent.

"Authorization." A determination by a utilization review entity that:

(1) A health care service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity.

(2) The health care service reviewed is a covered service.

(3) Payment will be made for the health care service.

* * *

"Clinical criteria." Policies, screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines and medical protocols that are specified in a written document available for peer-to-peer review by a peer within the same profession and specialty and subject to challenge by an insured, a provider or a provider organization when used as a basis to withhold preauthorization, deny or otherwise modify coverage and that is used by a utilization review entity to determine the medical necessity of health care services. The criteria shall:

(1) Be based on nationally recognized standards.

(2) Be developed in accordance with the current standards of national accreditation entities.

(3) Reflect community standards of care.

(4) Ensure quality of care and access to needed health care services.

(5) Be evidence-based or based on generally accepted expert consensus standards.

(6) Be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

(7) Be evaluated and updated if necessary at least annually.

"Clinical practice guidelines." A systematically developed statement to assist in decision-making by health care providers and enrollees relating to appropriate health care for specific clinical circumstances and conditions.

* * *

"Emergency service." Any health care service provided to an

enrollee, including prehospital transportation or treatment by emergency medical services providers, after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

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

"Expedited appeal." A formal request, either orally or in writing, to reconsider an adverse determination not to authorize emergency health care services or urgent health care services.

"Final adverse determination." An adverse determination that has been upheld by a utilization review entity at the completion of the utilization review entity's internal appeals process.

"Grievance." As provided in subdivision (i), a request by an [enrollee] insured or a health care provider, with the written consent of the [enrollee] insured, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service after the service has been provided to the insured.

If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

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

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

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

The term [does] shall not include a complaint.

* * *

"Health care service." Any [covered] treatment, admission, procedure, test used to aid in diagnosis or the provision of the applicable treatment, pharmaceutical product, medical supplies and equipment or other services, including behavioral health[, prescribed] or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

* * *

"Medically necessary health care services." Health care services that a prudent health care provider would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(1) in accordance with generally accepted standards of medical practice based on clinical criteria;

(2) appropriate in terms of type, frequency, extent, site and duration pursuant to clinical criteria; and

(3) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.

"Medication assisted treatment" or "MAT." The use of medications approved by the United States Food and Drug Administration, including methadone, buprenorphine, alone or in combination with naloxone, or naltrexone, in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of substance use disorders.

"NCPDP SCRIPT Standard." The National Council for Prescription Drug 10 Programs SCRIPT Standard Version 201310, the most recent standard adopted by the Department of Health and Human Services or a subsequently related version, provided that the new version is backwards-compatible to the current version adopted by the Department of Health and Human Services. The NCPDP SCRIPT Standard applies to the provision of pharmaceutical or pharmacological products.

"Nonurgent health care service." A health care service provided to an enrollee that is not considered an emergency service or an urgent health care service.

* * *

"Preauthorization" or "prior authorization." The process by which a utilization review entity managed care organization or health care insurer determines the medical necessity of otherwise covered health care services prior to authorizing coverage and the rendering of the health care services, including, but not limited to, preadmission review, pretreatment review, utilization and case management. The term includes a health insurer's or utilization review entity's requirement that an insured or health care practitioner notify the health insurer or utilization review agent prior to providing a health care service. This determination and any appeal therefrom shall be conducted prior to the delivery or provision of a health care

service and result in a decision to approve or deny payment for the health care service.

* * *

["Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.]

* * *

"Retrospective utilization [review."] review" or "retrospective review." A review by a utilization review entity of all reasonably necessary supporting information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service[.], but may not be used to review a decision to approve payment for health care services through preauthorization.

* * *

"Urgent health care service." A health care service deemed by a provider to require expedited preauthorization review in the event a delay may jeopardize life or health of the insured or a delay in treatment could:

(1) negatively affect the ability of the insured to regain maximum function; or

(2) subject the insured to severe pain that cannot be adequately managed without receiving the care or treatment that is the subject of the utilization review as quickly as possible. The term shall not include an emergency service or nonurgent health care service.

"Utilization review." A system of prospective, concurrent or

retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee. The term includes preauthorization, but does not include any of the following:

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

(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of a managed care plan. The term includes:

(1) an employer with employes in this Commonwealth who are covered under a health benefit plan or health insurance policy;

(2) an insurer that writes health insurance policies, including preferred provider organizations defined in section 630;

(3) pharmacy benefits managers responsible for managing access of insureds to available pharmaceutical or pharmacological care;

(4) any other individual or entity that provides, offers to provide or administers hospital, outpatient, medical or other health benefits to an individual treated by a health care provider in this Commonwealth under a policy, plan or contract; or

(5) a health insurer if the health insurer performs utilization review.

Section 4. Section 2111 of the act is amended by adding paragraphs to read:

Section 2111. Responsibilities of Managed Care Plans.--A managed care plan shall do all of the following:

* * *

(14) Make updates to its enrollment eligibility information within thirty (30) days of receiving updated enrollment information. Updates in enrollment eligibility may occur due to new enrollments, coordination of benefits or termination of benefits. If a managed care plan fails to update eligibility information in a timely manner, the managed care plan may not deny payment due to enrollment information being inaccurate for a date of service if current eligibility information was available. In the event of a retroactive termination or a determination that an enrollee was ineligible for benefits, a health plan may recover any payments made in error within thirty (30) days of the date of service.

(15) When establishing rules pertaining to the timely filing of health care provider claims, provide that a health care provider's filing requirement will commence based on the following, whichever occurs latest:

(i) the time of patient discharge; or

(ii) when authorization or approval is confirmed by the managed care plan.

Section 5. The act is amended by adding sections to read:

Section 2114. Preauthorization Standards.--(a) No later than one hundred eighty (180) days after the effective date of this section, preauthorization requests shall be accessible to health care providers and accepted by insurers, managed care organizations and utilization review organizations electronically through a secure electronic transmission platform. The electronic preauthorization requirements under

this subsection shall not apply:

(1) under circumstances when electronic transmission is not available to be issued or received due to a temporary technological or electrical failure and, in the instance of a temporary technological failure, a practitioner shall, within seventy-two (72) hours, seek to correct any cause for the failure that is reasonably within the practitioner's control.

(2) when a practitioner who or health care facility that does not have either of the following:

(i) Internet access; or

(ii) an electronic health record system.

(b) NCPDP SCRIPT Standard shall be acceptable for pharmaceutical or pharmacological care, subject to the terms and limitations under subsection (a).

(c) Any restriction that a utilization review entity places on the preauthorization of health care services shall be:

(1) based on the medical necessity of those services and on clinical criteria;

(2) applied consistently; and

(3) disclosed by the managed care plan or utilization review entity pursuant to section 2136.

(d) Adverse determinations and final adverse determinations made by a utilization review entity or agent thereof shall be based on clinical criteria.

(e) A utilization review entity shall not deny coverage of a health care service solely based on the grounds that the health care service does not meet clinical criteria.

(f) Preauthorization shall not be required:

(1) where a medication, including noncontrolled generic medication or procedure prescribed for a patient is customary

and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or

(2) for the provision of MAT for the treatment of an opioid-use disorder.

(f.1) A managed care plan may not deny preauthorization for a health care service for an insured currently managed with an established treatment regimen or for continuity of care. The continued care may not be subject to concurrent review if the treatment regimen or continuity of care follows from a previous preauthorization approval.

(g) If a provider contacts a utilization review entity seeking preauthorization, a medically necessary health care service and the utilization review entity, through any agent, contractor, employe or representative informs the provider that preauthorization is not required for the particular service that is sought, coverage for the service shall be deemed approved.

(h) No later than one hundred eighty (180) days after the effective date of this section, the payer shall accept and respond to preauthorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

Section 2115. Preauthorization Costs.--(a) In the event that an insured is covered by more than one health plan that requires preauthorization:

(1) If preauthorization for a health care service has been approved by a primary insurer, then a secondary insurer or defined benefits plan may not refuse payment for health care services solely on the basis that the procedures of the secondary insurer for preauthorization were not followed.

(2) Nothing in this section shall be construed to preclude a secondary insurer or defined benefits plan from preauthorizing a health care service that may have been denied preauthorization by a primary insurer.

(b) An appeal of an adverse determination or external review of a final adverse determination shall be provided without charge to the insured or insured's health care provider.

Section 6. Section 2117 of the act is amended by adding subsections to read:

Section 2117. Continuity of Care.--* * *

(g) If the appeal of an adverse determination of a preauthorization request concerns ongoing health care services that are being provided pursuant to an initially authorized admission or course of treatment, the health care services shall be continued to be paid and provided without liability to the insured or insured's health care provider until the latest of:

(1) thirty (30) days following the insured or insured's health care provider's receipt of a notice of final adverse determination satisfying the requirements of this act, if the decision on adverse determination has been appealed through an external review proceeding;

(2) the duration of treatment; or

(3) sixty (60) days.

(h) The insured shall receive services for the longest possible time calculated under this section.

(i) The insurer shall not be permitted to retroactively review the decision to approve and provide health care services through preauthorization, including preauthorizing for extending the term or course of treatment.

(j) Notwithstanding any other provision of law, the insurer

shall not retroactively recover the cost of treatment either for the initial period of treatment or the period of treatment provided to the insured as part of the decision-making process to authorize coverage of additional treatment periods.

Section 7. The act is amended by adding a section to read:

Section 2118. Step Therapy.--(a) The following shall apply:

(1) Clinical review criteria used to establish a step therapy protocol shall be based on clinical practice guidelines that:

(i) Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol.

(ii) Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

(A) Requiring members to disclose any potential conflict of interests with entities, including insurers, health plans and pharmaceutical manufacturers and recuse themselves from voting if the member has a conflict of interest.

(B) Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus.

(C) Offering opportunities for public review and comments.

(iii) Are based on high quality studies, research and medical practice.

(iv) Are created by an explicit and transparent process that:

(A) minimizes biases and conflicts of interest;

(B) explains the relationship between treatment options and outcomes;

(C) rates the quality of the evidence supporting recommendations; and

(D) considers relevant patient subgroups and preferences.

(v) Are continually updated through a review of new evidence, research and newly developed treatments.

(2) In the absence of clinical guidelines that meet the requirements under paragraph (1), peer reviewed publications may be substituted.

(3) When establishing a step therapy protocol, a utilization review agent shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical review criteria.

(4) An insurer, pharmacy benefit manager or utilization review organization shall:

(i) upon written request, provide all specific written clinical review criteria relating to the particular condition or disease, including clinical review criteria relating to a step therapy protocol override determination; and

(ii) make the clinical review criteria and other clinical information available on its publicly accessible Internet website and to a health care professional on behalf of an insured upon written request.

(5) This subsection shall not be construed to require insurers, health plans or the Commonwealth to set up a new entity to develop clinical review criteria used for step therapy protocols.

(b) The following shall apply:

(1) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan or utilization review organization through the use

of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception. An insurer, health plan or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible on the publicly accessible Internet website of the insurer, health plan or utilization review organization. An insurer, health plan or utilization review organization must disclose all rules and criteria related to the step therapy protocol upon request to all prescribing practitioners, including the specific information and documentation that must be submitted by a prescribing practitioner or patient to be considered a complete exception request.

(2) A step therapy exception shall be granted if:

(i) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(ii) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.

(iii) The patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event.

(iv) The required prescription drug is not in the best interest of the patient, based on medical necessity.

(v) The patient is stable on a prescription drug selected by the patient's health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(3) Upon the granting of a step therapy exception, the insurer, health plan or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider.

(4) The insurer, health plan or utilization review organization shall grant or deny a step therapy exception request or an appeal within seventy-two (72) hours of receipt. The following shall apply:

(i) In cases where exigent circumstances exist, an insurer, health plan or utilization review organization shall respond within twenty-four (24) hours of receipt.

(ii) If a request for a step therapy override exception is incomplete or additional clinically relevant information is required, the insurer, health plan or utilization review organization shall notify the prescribing practitioner within seventy-two (72) hours of submission, or twenty-four (24) hours in exigent circumstances, what additional or clinically relevant information is required in order to approve or deny the step therapy exception request or appeal under this section.

(iii) Once the requested information is submitted, the applicable time period to grant or deny a step therapy exception request or appeal shall apply.

(iv) Should a determination or request for incomplete or clinically relevant information by an insurer, health plan or utilization review organization not be received by the prescribing practitioner within the time allotted, the exception

or appeal shall be deemed granted.

(v) In the event of a denial, the insurer, health plan or utilization review organization must inform the patient of a potential appeal process.

(5) Any step therapy exception under this subsection shall be eligible for appeal by an insured.

(6) This subsection shall not be construed to prevent:

(i) An insurer, health plan or utilization review organization from requiring a patient to try an AB-rated generic equivalent or interchangeable biological product, as defined in 42 U.S.C. § 262(i)(3) (relating to regulation of biological products), unless the requirement meets any of the criteria under this subsection for a step therapy exception request, prior to providing coverage for the equivalent branded prescription drug;

(ii) An insurer, health plan or utilization review organization from requiring a pharmacist to effect substitutions of prescription drugs consistent with the laws of this Commonwealth.

(iii) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

(c) Notwithstanding any provision of law to the contrary, the Insurance Department shall promulgate any regulations necessary to enforce this section.

(d) An insurer, health plan or a utilization review organization shall annually report to the Insurance Department, in a format prescribed by the Insurance Department:

(i) the number of step therapy exception requests received by exception;

(ii) the type of health care providers or the medical

specialties of the health care providers submitting step therapy exception requests;

(iii) the number of step therapy exception requests by exception that were denied and the reasons for the denials;

(iv) the number of step therapy exception requests by exception that were approved;

(v) the number of step therapy exception requests by exception that were initially denied and then appealed;

(vi) the number of step therapy exception requests by exception that were initially denied and then subsequently reversed by internal appeals or external reviews; and

(vii) the medical conditions for which patients are granted exceptions due to the likelihood that switching from the prescription drug will likely cause an adverse reaction by or physical or mental harm to the insured.

(e) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Clinical practice guidelines." A systematically developed statement to assist decision making by health care providers and patient decisions about appropriate healthcare for specific clinical circumstances and conditions.

"Clinical review criteria." The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by an insurer, health plan or utilization review organization to determine the medical necessity and appropriateness of healthcare services.

"Medically necessary." Health services and supplies that under the applicable standard of care are appropriate:

(1) to improve or preserve health, life or function;

(2) to slow the deterioration of health, life or function; or

(3) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury.

"Step therapy exception." When a step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug.

"Step therapy protocol." A protocol, policy or program that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered by an insurer or health plan.

"Utilization review organization." An entity that conducts utilization review, other than an insurer or health plan performing utilization review for its own health benefit plans.

Section 8. Article XXI, Subdivision (f) subheading of the act is amended to read:

(f) Information for Enrollees and Health Care Providers.

Section 9. Section 2136 of the act is amended by adding a subsection to read:

Section 2136. Required Disclosure.--* * *

(c) If a utilization review entity intends to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the utilization review entity shall provide contracted health care providers and insureds with written notice of the new or amended requirement or amendment not less than sixty (60) days before the requirement or restriction is implemented. The notice shall be in writing which may be satisfied by any of the following:

(1) certified mail return receipt requested;

(2) electronic mail read receipt requested;

(3) publication on the publicly accessible Internet website of the insurer with an electronic mail message to providers and insureds that identifies the location of the publication on the website;

(4) web-exchange, provided that an electronic mail message on how to access the web-exchange is sent to the providers and insured; or

(5) any other contractually agreed upon method, specifying the details of the communication which include some proof of receipt by the providers and insureds.

Section 10. Section 2152(a)(4) and (6) of the act are amended and the section is amended by adding subsections to read:

Section 2152. Operational Standards.--(a) A utilization review entity shall do all of the following:

* * *

(4) Conduct utilization reviews based on the medical necessity and appropriateness of the health care service being reviewed and provide notification within the following time frames:

(i) A prospective utilization review decision shall be communicated within two (2) business days of the receipt of all supporting information reasonably necessary to complete the review.

(ii) A concurrent utilization review decision shall be communicated within one (1) business day of the receipt of all supporting information reasonably necessary to complete the review.

(iii) A retrospective utilization review decision shall be

communicated within thirty (30) days of the receipt of all supporting information reasonably necessary to complete the review.

(iv) A utilization review entity shall allow an insured and the insured's health care provider a minimum of one (1) business day following an inpatient admission pursuant to an emergency health care service or urgent health care service to notify the utilization review entity of the admission and any health care services performed.

* * *

(6) Provide all decisions in writing to include the basis and clinical rationale for the decision. For adverse determinations of preauthorization decisions, a utilization review entity shall provide all decisions to the insured and the insured's health care provider, which decisions shall also include instructions concerning how an appeal may be perfected. Utilization review entities may not retroactively review the medical necessity of a preauthorization that has been previously approved or granted.

* * *

(9) Post to the utilization review entity's publicly accessible Internet website:

(i) A current list of services and supplies requiring preauthorization.

(ii) Written clinical criteria for preauthorization decisions.

(10) Ensure that a preauthorization shall be valid for no less than one hundred eighty (180) days or the duration of treatment, whichever is greater, from the date the health care provider receives the preauthorization so long as the insured is

a member of the plan. A duration of less than one hundred and eighty (180) days may be approved upon an agreement between a provider and payer.

(11) When performing preauthorization, only request copies of medical records if a difficulty develops in determining the medical necessity of a health care service. In that case, the utilization review agent may only request the necessary and relevant sections of the medical record.

(12) Not deny preauthorization nor delay preauthorization for administrative defects. In the event an administrative defect is discovered, a managed care plan shall allow a health care provider the opportunity to remedy the administrative defect within thirty (30) days of receiving notice.

* * *

(e) Failure by a utilization review entity to comply with deadlines and other requirements specified for preauthorization shall result in the health care service subject to review to be deemed preauthorized and paid by the managed care plan.

(f) A utilization review entity shall approve claims for health care services for which a preauthorization was required and received from the managed care plan prior to the rendering of the health care services, unless one of the following occurs:

(1) The enrollee was not eligible for coverage at the time the health care service was rendered. A managed care plan may not deny payment for a claim on this basis if the enrollee's coverage was retroactively terminated more than one hundred twenty (120) days after the date of service, provided the claim is submitted timely. If the claim is submitted after the timely filing deadline, the managed care plan shall have no more than thirty (30) days after the claim is received to deny the claim

on the basis the enrollee was not eligible for coverage on the date of the health care service.

(2) The preauthorization was based on materially inaccurate or incomplete information provided by the enrollee, the enrollee's designee or the health care provider, such that if the correct or complete information had been provided, the preauthorization would not have been granted.

(3) There is a reasonable basis supported by material facts available for review that the enrollee, the enrollee's designee or the health care provider has engaged in fraud or abuse.

Section 11. The act is amended by adding sections to read:

Section 2161.1. Preauthorization and Adverse Determinations.--(a) A utilization review entity shall ensure that:

(1) Preauthorization is made by a qualified licensed health care provider who has knowledge of the items, services, products, tests or procedures submitted for preauthorization.

(2) Adverse determinations are made by a physician. The reviewing physician must possess a current and valid nonrestricted license to practice medicine in this Commonwealth and be board certified. The insurer shall make available a physician in a like specialty if the review requires a peer-to-peer review in the specialty or subspecialty or a review is requested by the submitting provider. A utilization review entity may seek approval from the Insurance Commissioner to use a reviewing physician that is not board-certified due to unavailability or difficulty in finding a board-certified reviewing physician in a given specialty. The Insurance Commissioner shall develop a form and parameters for the requests and shall transmit all requests as notices to the

Legislative Reference Bureau for publication in the Pennsylvania Bulletin. The Insurance Commissioner shall provide at least ten (10) days for comment before rendering a decision, which decision shall be transmitted to the Legislative Reference Bureau as a separate notice for publication in the Pennsylvania Bulletin.

(b) Notification of a preauthorization shall be accompanied by a unique preauthorization number and indicate:

(1) The specific health care services preauthorized.

(2) The next date for review.

(3) The total number of days approved.

(4) The date of admission or initiation of services, if applicable.

(c) Neither the utilization review entity nor the payer or health insurer that has retained the utilization review entity may retroactively deny coverage for emergency or nonemergency care that had been preauthorized when the care was provided, if the information provided was accurate.

(d) In the event a health care provider obtains preauthorization for one (1) service but the service provided is not an exact match to the service that was preauthorized, but the service does not materially depart from the service that was preauthorized, a health plan shall not deny payment for the service only if:

(1) the date of service differs by less than thirty (30) days;

(2) the physician or health care provider rendering the service differs from the physician or health care provider that was indicated on the preauthorization, but is otherwise licensed and qualified to provide the preauthorized service; or

(3) the service provided is different than what was preauthorized but is commonly and appropriately a substitute based on common procedural terminology.

(e) If the denial of preauthorization is conditioned upon incomplete information or administrative error, the health plan shall allow the health care provider to resubmit the claim with corrected information for appropriate reimbursement up to thirty (30) days after receiving notice.

(f) (1) If a utilization review entity questions the medical necessity of a health care service, the utilization review entity shall notify the insured's health care provider that medical necessity is being questioned and provide the basis of the challenge in sufficient detail to allow the provider to meaningfully address the concern of the utilization review entity prior to issuing an adverse determination.

(2) The insured's health care provider or the health care provider's designee and the insured or insured's designee shall have the right to discuss the medical necessity of the health care service with the utilization review physician.

(3) A utilization review entity questioning medical necessity of a health care service which may result in an adverse determination shall make the reviewing physician or a physician who is part of a team making the decision available telephonically between the hours of seven (7) o'clock antemeridian and seven (7) o'clock postmeridian.

(g) When making a determination based on medical necessity, a utilization review entity shall base the determination on an insured's presenting symptoms, diagnosis and information available through the course of treatment or at the time of admission or presentation at the emergency department.

(h) In the event a utilization review entity determines an alternative level of care is appropriate, the utilization review entity shall provide and cite the specific criteria used as the basis for the level of care determination to the health care provider, prior to denial to enable a meaningful peer-to-peer review. If, after the peer-to-peer has been completed, denial remains the determination, the health care provider shall have the right to appeal the determination.

(i) A utilization review entity may not issue an adverse determination for a procedure due to lack of preauthorization if the procedure is medically necessary or clinically appropriate for the patient's medical condition and rendered at the same time as a related procedure for which preauthorization was required and received.

(j) A utilization review entity shall make a preauthorization or adverse determination and notify the insured and the insured's health care practitioner as follows:

(1) For nonurgent health care services, within seventy-two (72) hours of obtaining all the necessary information to make the preauthorization or adverse determination.

(2) For urgent health care services, within twenty-four (24) hours of obtaining all the necessary information to make the preauthorization or adverse determination.

(k) No utilization review entity may require preauthorization for an emergency service, including postevaluation and poststabilization services.

Section 2161.2. Appeals.--(a) An insured or the insured's health care provider may request an expedited appeal of an adverse determination via telephone, facsimile, electronic mail or other expeditious method. Within one (1) day of receiving an

expedited appeal and all information necessary to decide the appeal, the utilization review entity shall provide the insured and the insured's health care provider written confirmation of the expedited review determination.

(b) An appeal shall be reviewed only by a physician who satisfies any of the following conditions:

(1) Is board certified in the same specialty as a health care practitioner who typically manages the medical condition or disease.

(2) Is currently in active practice, provided that in events where circumstances justify it or where the provider seeking preauthorization specifically requests a health care provider actively engaged in the specialty who typically manages the medical condition or disease, the physician shall be made available for the review.

(3) Is knowledgeable of, and has experience in, providing the health care services under appeal.

(4) Is under contract with a utilization review entity to perform reviews of appeals and payment of fees due under the contract, but the performance and payment is not subject to or contingent upon the outcome of the appeal.

The physician may also be subject to a provider agreement with the insurer as a provider, but may not receive any other fee or compensation from the insurer. The physician's receipt of compensation from the utilization review entity shall not be considered by the physician in determining the conclusion reached by the physician. The physician shall at all times render independent and accurate medical judgment in reaching an opinion or conclusion. Failure to comply with this provision shall render the physician subject to licensure disciplinary

action by the appropriate State licensing board.

(5) Not involved in making the adverse determination.

(6) Familiar with all known clinical aspects of the health care services under review, including, but not limited to, all pertinent medical records provided to the utilization review entity by the insured's health care provider and any relevant record provided to the utilization review entity by a health care facility.

(c) The utilization review entity shall ensure that appeal procedures satisfy the following requirements:

(1) The insured and the insured's health care provider may challenge the adverse determination and have the right to appear in person before the physician who reviews the adverse determination.

(2) The utilization review entity shall provide the insured and the insured's health care provider with written notice of the time and place concerning where the review meeting will take place. Notice shall be given to the insured's health care provider at least fifteen (15) days in advance of the review meeting.

(3) If the insured or the insured's health care provider appear in person, the utilization review entity shall offer the insured or insured's health care provider the opportunity to communicate with the reviewing physician, at the utilization review entity's expense, by conference call, video conferencing or other available technology.

(4) The physician performing the review of the appeal shall consider all information, documentation or other material submitted in connection with the appeal without regard to whether the information was considered in making the adverse

determination.

(d) The following deadlines shall apply to the utilization review entities:

(1) A utilization review entity shall decide an expedited appeal and notify the insured and the insured's health care provider of the determination within three (3) days after receiving a notice of expedited appeal by the insured or the insured's health care provider and all information necessary to decide the appeal.

(2) A utilization review entity shall issue a written determination concerning a nonexpedited appeal not later than thirty (30) days after receiving a notice of appeal from an insured or insured's health care provider and all information necessary to decide the appeal.

(e) Written notice of final adverse determinations shall be provided to the insured and the insured's health care provider.

(f) If the insured or the insured's health care provider or a designee on behalf of either the insured or the insured's health care provider has satisfied all necessary requirements for the appeal of an adverse determination through the preauthorization process and the appeal has resulted in a continued adverse determination either based on lack of medical necessity or an administrative defect, the insured, the insured's health care provider or a designee on behalf of either the insured or the insured's health care provider or a designee may file a consumer complaint with the Insurance Department. The complaint shall be adjudicated without unnecessary delay and a determination issued by the Insurance Department with appropriate sanctions, if applicable, pursuant to the authority given to the Insurance Department.

(g) To the extent that an insured, an insured's health care provider or a designee on behalf of either the insured or the insured's health care provider or a designee files a consumer complaint with the department or the Office of Attorney General pursuant to their authority to receive such complaints, a copy of the complaint filed with either the department or the Office of Attorney General shall be forwarded to the Insurance Department and the copy shall serve as a new consumer complaint to be adjudicated pursuant to the terms of this section and all other applicable law.

(h) Nothing in this section shall be construed to preclude an insured or an insured's designee the ability to file a separate consumer complaint with the Insurance Department for failure to comply with the requirements of this act as it applies to preauthorization processes or denial of health insurance coverage generally.

Section 2195. Access Requirements in Service Areas.--If a patient's safe discharge is delayed for any reason, including lack of available posthospitalization services, including, but not limited to, skilled nursing facilities, home health services and postacute rehabilitation, the managed care plan shall reimburse the hospital for each subsequent date of service at the greater of the contracted rate with the managed care plan for the current level of care and service or the full diagnostic related group payment divided by the mean length of stay for the particular diagnostic related group.

Section 2196. Uniform Preauthorization Form.--(a) Within three (3) months of the effective date of this section, the Insurance Department shall convene a panel to develop a uniform preauthorization form that all health care providers in this

Commonwealth shall use to request preauthorization and that all health insurers shall accept as sufficient to request preauthorization of health care services.

(b) The panel shall consist of not fewer than ten (10) persons. Equal representation shall be afforded to the physician, health care facility, employer, health insurer and consumer protection communities within this Commonwealth.

(c) Within one (1) year of the effective date of this section, the panel shall conclude development of the uniform preauthorization form and the Insurance Department shall make the uniform preauthorization form available to health care providers in this Commonwealth and utilization review entities and agents.

Section 2197. Preauthorization Exemptions.--A health care service that has been provided following approval through the preauthorization procedures provided by the insurer or which have been disclosed as not subject to preauthorization procedures shall not be subject to retrospective review or concurrent review based on medical necessity related to the preauthorization.

Section 2198. Data Collection and Reporting.--(a) The Insurance Department shall maintain and collect data on the number of appeals filed by enrollees, enrollee designees and health care providers with utilization review entities.

(b) The Insurance Department shall, on an annual basis, publish a report made accessible on the department's publicly accessible Internet website and serve a copy of the report on the Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives that identifies the following data elements by place and type of

service:

(1) The total number of appeals filed against utilization review entities.

(2) The number and percentage of appeals filed against each utilization review entity.

(3) The total number of appeals found in favor of utilization review entities.

(4) The number and percentage of appeals found in favor of each managed care plan.

(5) The total number of appeals found in favor of the enrollee, designee or health care provider.

(6) The number and percentage of appeals found in favor of the enrollee, designee or health care provider against each managed care plan.

(c) The Insurance Department shall evaluate, monitor and track health plan statistics per the information gathered in subsection (a) and investigate negative trends and outliers and shall facilitate meetings between health care providers and managed care plans to discuss and resolve disputes.

Section 12. Nothing in this act shall be construed to preclude an insurer from developing a program exempting a health care provider from preauthorization protocols.

Section 13. This act shall take effect in 60 days.