SENATE AMENDED

PRIOR PRINTER'S NO. 1075 PRINTER'S NO. 3569

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 991 Session of 1993

INTRODUCED BY GODSHALL, COY, SEMMEL, ARMSTRONG, FLICK, BUNT, GORDNER, MELIO, TOMLINSON, SAURMAN, STERN, BELARDI AND MICOZZIE, MARCH 25, 1993

SENATOR HOLL, BANKING AND INSURANCE, IN SENATE, AS AMENDED, APRIL 19, 1994

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," further providing for preferred provider organizations.

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

Section 1. Section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, added June 11, 1986 (P.L.226, No.64), is amended to read:

Section 630. Preferred Provider Organizations.--Upon compliance with the provisions of this act and notwithstanding any other provision of law to the contrary, the General Assembly hereby affirms the right of any health care insurer, fraternal

benefit society or purchaser to:

(a) Enter into agreements with providers or physicians relating to health care services which may be rendered to persons for whom the insurer or purchaser is providing health care coverage, including agreements relating to the amounts to be charged by the provider or physician for services rendered.

(b) Issue or administer policies or subscriber contracts in this Commonwealth which include incentives for the covered person to use the services of a provider who has entered into an agreement with the insurer or purchaser.

(c) Issue or administer policies or subscriber contracts in this Commonwealth that provide for reimbursement for services only if the services have been rendered by a provider or physician who has entered into an agreement with the insurer or purchaser.

(d) The Insurance Commissioner shall determine that:

(1) A preferred provider organization which assumes financial risk is licensed as an insurer OR FRATERNAL BENEFIT SOCIETY in this Commonwealth, has adequate working capital and reserves, or is governed and regulated under the provisions of the Employee Retirement Income Security Act of 1974, referred to as ERISA (Public Law 93-406, 88 Stat. 829), and has filed a certificate to that effect with the Insurance Commissioner. <——

(2) Enrollee literature adequately discloses provisions, limitations and conditions of benefits available or that the preferred provider organization is governed and regulated under the provisions of ERISA and has filed a certificate to that effect with the Insurance Commissioner.

(e) The Insurance Commissioner, in consultation with the Secretary of Health, shall determine that arrangements and

provisions for preferred provider organizations which assume financial risk which may lead to undertreatment or poor quality care are adequately addressed by quality and utilization controls and by a formal grievance system, unless the Insurance Commissioner makes a prior determination that the preferred provider organization is governed by and regulated under the provisions of the Employee Retirement Income Security Act and has filed a certificate to that effect with the Insurance Commissioner.

(f) No preferred provider organization which assumes financial risk may commence operations until it has reported to the Insurance Commissioner and the Secretary of Health such information as the Insurance Commissioner and the Secretary of Health require in accordance with the duties required in this section. If, after sixty days, either the Insurance Commissioner or the Secretary of Health has not informed the preferred provider organization of deficiencies, the preferred provider organization may commence operations unless and until such time as the Insurance Commissioner or the Secretary of Health has identified significant deficiencies and such deficiencies have not subsequently been corrected within sixty days of notification.

(g) Any disapproval or order to cease operations issued in accordance with this section shall be subject to appeal in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

(H) FRATERNAL BENEFIT SOCIETIES OPERATING UNDER SUBSECTIONS (A), (B) AND (C) SHALL BE SUBJECT TO SECTIONS 616 THROUGH 632. <—

Section 2. This act shall take effect in 60 days.