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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2309 Session of 1998

INTRODUCED BY PESCI, BELARDI, READSHAW, LAUGHLIN, TRELLO, STURLA, CURRY, LUCYK, MANDERINO, JOSEPHS, ROSS, HALUSKA, ITKIN, OLASZ, YOUNGBLOOD, SERAFINI, MUNDY, DeLUCA, PETRARCA AND WASHINGTON, MARCH 11, 1998

REFERRED TO COMMITTEE ON INSURANCE, MARCH 11, 1998

AN ACT

Providing consumers and employers access to information regarding health insurance policies.

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

Section 1. Short title.

This act shall be known and may be cited as the Patients Fair Disclosure Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Health insurance policy." Except for specified disease policies, any group health insurance policy, contract or plan, or any individual policy, which provides medical coverage on an expense-incurred, service or prepaid basis. The term includes the following:

(1) A health insurance policy or contract issued by a

nonprofit corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations) or the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(2) A health service plan operating under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

Section 3. Disclosure of information.

(a) General rule.--Each subscriber to a health insurance policy, and upon request each prospective subscriber to a health insurance policy prior to enrollment, shall be supplied with written disclosure information which shall be incorporated into the member handbook and the subscriber contract or certificate containing at least the information in subsection (b). In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling.

(b) Information.--The information to be disclosed shall include at least the following:

(1) A description of health insurance policy coverage provisions; health care benefits, including the percentage of the premium charged by the issuer that is expended directly for patient care, the "loss ratio"; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered.

(2) A description of all prior authorization or other requirements for treatments and services.

(3) A description of utilization review policies and procedures used by the health maintenance organization, including the following:

(i) the circumstances under which utilization review will be undertaken;

(ii) the toll-free telephone number of the utilization review agent;

(iii) the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;

(iv) the right to reconsideration;

(v) the right to an appeal, including the expedited and standard appeals processes and the timeframes for such appeals;

(vi) the right to designate a representative;

(vii) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;

(viii) further appeal rights, if any;

(ix) summary information about the number and disposition of grievances and appeals in the most recent period for which complete and accurate information is available;

(x) the percentage of utilization review determinations made by the issuer that deny coverage for treatment and diagnostic services recommended by the treating health professional or provider; and

(xi) the percentage of such denials that are reversed on appeal.

(4) A description prepaid annually of the types of methodologies the health maintenance organization uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; financial arrangements and incentives between health care practitioners and the health maintenance organization that may limit the items and services furnished to an enrollee, restrict referral or treatment options or reduce a health care practitioner's income based wholly or partially on the number of referrals to specialists, diagnostic tests or other services provided to enrollees, or in any other way negatively affect the fiduciary responsibility of a health professional or provider to an enrollee; any incentive plan under which a health care provider assumes financial risk; other financial incentives for a health professional or provider to reduce health care consumption. Nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a health maintenance organization and a health care provider.

(5) An explanation of a subscriber's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a subscriber's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services provided within the health maintenance organization.

(6) An explanation of a subscriber's financial responsibility for payment when services are provided by a

health care provider who is not part of the health maintenance organization or by any provider without required authorization or when a procedure, treatment or service is not a covered health care benefit.

(7) A description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including the following:

(i) The right to file a grievance regarding any dispute between an enrollee and a health maintenance organization.

(ii) The right to file a grievance orally when the dispute is about referrals or covered benefits.

(iii) The toll-free telephone number which enrollees may use to file an oral grievance.

(iv) The timeframes and circumstances for expedited and standard grievances.

(v) The right to appeal a grievance determination and the procedures for filing such an appeal.

(vi) The timeframes and circumstances for expedited and standard appeals.

(vii) The right to designate a representative.

(viii) A notice that all disputes involving clinical decisions will be made by qualified clinical personnel.

(ix) A statement that all notices of determination will include information about the basis of the decision and further appeal rights, if any.

(x) Information about grievances and appeals, including, at a minimum:

(A) The total number of grievances filed.

(B) The number of grievances filed by issue of

dispute.

(C) The number of grievances resolved in favor of the enrollee and the number resolved in favor of the plan.

(D) The number of grievance decisions appealed.

(E) The number of appeals resolved in favor of the enrollee and the number resolved in favor of the plan.

(F) The number of enrollees who filed more than one grievance.

(8) A description of the procedure for providing care and coverage 24 hours a day for emergency services. The description shall include a definition of emergency services and notice that emergency services are not subject to prior approval and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the health maintenance organization's service area.

(9) A description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including the ratio of enrollees to participating health professionals and providers by category and type of health professional and provider and notice of how to determine whether a participating provider is accepting new patients.

(10) A description of the procedures for changing primary and specialty care providers within the health maintenance organization.

(11) Notice that an enrollee may obtain a referral to a health care provider outside of the health maintenance

organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral.

(12) Notice that an enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral.

(13) Notice that an enrollee with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the enrollee's medical care and the procedure for requesting and obtaining such a specialist.

(14) Notice that an enrollee with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained.

(15) A description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization.

(16) A description of how the health maintenance organization addresses the needs of non-English speaking enrollees.

(17) Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking

information or authorization.

(18) A listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, appropriate board certification.

Section 4. Effective date.

This act shall take effect in 120 days.