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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1508 Session of 1997

INTRODUCED BY WALKO, VEON, SURRA, THOMAS, MANDERINO, GEORGE, BELARDI, SATHER, MUNDY, ROONEY, HALUSKA, McCALL, CAPPABIANCA, YOUNGBLOOD, CASORIO, BLAUM, CURRY, ITKIN, BEBKO-JONES, SHANER, MELIO, OLASZ, LAUGHLIN, DeLUCA, SCRIMENTI, PRESTON, JOSEPHS, MIHALICH, PETRARCA, BOSCOLA, WASHINGTON, GIGLIOTTI, STEELMAN, TRICH, A. H. WILLIAMS AND M. COHEN, MAY 14, 1997

REFERRED TO COMMITTEE ON INSURANCE, MAY 14, 1997

AN ACT

Amending the act of December 29, 1972 (P.L.1701, No.364), entitled "An act providing for the establishment of nonprofit corporations having the purpose of establishing, maintaining and operating a health service plan; providing for supervision and certain regulations by the Insurance Department and the Department of Health; giving the Insurance Commissioner and the Secretary of Health certain powers and duties; exempting the nonprofit corporations from certain taxes and providing penalties," further providing for definitions; providing for a managed care consumer advocate program; and making editorial changes.

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

Section 1. Sections 1 and 2 of the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, amended December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 1. Short Title.--This act shall be known and may be cited as the "[Health Maintenance Organization] <u>Managed Care Plan</u> Act."

Section 2. Purpose.--The purpose of this act is to permit and encourage the formation and regulation of [health maintenance organizations] managed care plans and to authorize the Secretary of Health to provide technical advice and assistance to corporations desiring to establish, operate and maintain [a health maintenance organization] managed care plans to the end that increased competition and consumer choice offered by diverse [health maintenance organizations] managed care plans can constructively serve to advance the purposes of quality assurance, cost-effectiveness and access.

Section 2. The definition of "direct provider" in section 3 of the act, amended December 19, 1980 (P.L.1300, No.234), is amended and the section is amended by adding definitions to read:

Section 3. Definitions.--As used in this act:

* * *

"Department" means the Department of Health of the Commonwealth.

"Direct provider" means an individual who is a direct provider of health care services under a benefit plan of a [health maintenance organization] managed care plan or an individual whose primary current activity is the administration of health facilities in which such care is provided. An individual shall not be considered a direct provider of health care solely because the individual is a member of the governing body of a health-related organization.

"Enrollee" or "subscriber" means a person covered by a health insurance policy or managed care plan including a person who is covered as an eligible dependent of another person.

* * *

"Managed care plan" or "plan" means a system pursuant to which health care, related equipment or services are provided for members or subscribers whose access to other health care must be approved by a primary care practitioner selected by or for such member or subscriber from a panel of participating practitioners. The term includes, but is not limited to, health maintenance organizations and preferred provider organizations.

"Preferred provider organization" means a health care benefit arrangement designed to supply services at a reasonable cost through incentives for enrollees to use designated health care providers, and in which:

(1) patients pay more to use services rendered by health care providers who are not part of the organization's network; and

(2) health care providers expect to benefit through increased patient volume and prompt payment, in return for the health care providers' agreement to abide by a fee schedule and follow utilization management procedures.

* * *

Section 3. Sections 4, 5.1, 6.1, 7, 8 and 9 of the act, amended or added December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 4. Services Which Shall be Provided.--(a) Any law to the contrary notwithstanding, any corporation may establish, maintain and operate a [health maintenance organization] managed care plan upon receipt of a certificate of authority to do so in accordance with this act.

(b) Such [health maintenance organizations] managed care plans shall:

(1) Provide either directly or through arrangements with

others, basic health services to individuals enrolled;

(2) Provide either directly or through arrangements with other persons, corporations, institutions, associations or entities, basic health services; and

(3) Provide physicians' services (i) directly through physicians who are employes of such organization, (ii) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis or (iii) under similar arrangements which are found by the secretary to provide adequate financial incentives for the provision of quality and cost-effective care.

Section 5.1. Certificate of Authority.--(a) Every application for a certificate of authority under this act shall be made to the commissioner and secretary in writing and shall be in such form and contain such information as the regulations of the Departments of Insurance and Health may require.

(b) A certificate of authority shall be jointly issued by order of the commissioner and secretary when:

(1) The secretary has found and determined that the applicant:

(i) has demonstrated the potential ability to assure both availability and accessibility of adequate personnel and facilities in a manner enhancing availability, accessibility and continuity of services;

(ii) has arrangements for an ongoing quality of health care assurance program; and

(iii) has appropriate mechanisms whereby the [health maintenance organization] managed care plan will effectively provide or arrange for the provision of basic health care services on a prepaid basis; and

(2) The commissioner has found and determined that the applicant has a reasonable plan to operate the [health maintenance organization] managed care plan in a financially sound manner and is reasonably expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) The adequacy of working capital and funding sources.

(ii) Arrangements for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the [health maintenance organization] managed care plan.

(iii) Any agreement with providers of health care services whereby they assume financial risk for the provision of services to subscribers.

(iv) Any deposit of cash, or guaranty or maintenance or minimum restricted reserves which the commissioner, by regulation, may adopt to assure that the obligations to subscribers will be performed.

(c) Within ninety days of receipt of a completed application for a certificate of authority, the commissioner and secretary shall jointly either:

(1) approve the application and issue a certificate of authority; or

(2) disapprove the application [specifying] and specify in writing the reasons for such disapproval. Any disapproval of an

application may be appealed in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

Section 6.1. Foreign [Health Maintenance Organizations] Managed Care Plans.--(a) A [health maintenance organization] managed care plan approved and regulated under the laws of another state may be authorized by issuance of a certificate of authority to operate or do business in this Commonwealth by satisfying the commissioner and the secretary that it is fully and legally organized under the laws of [its] the other state, and that it complies with all requirements for [health maintenance organizations] managed care plans organized within the Commonwealth.

(b) The commissioner and the secretary may waive or modify the provisions of this act under which they have the authority to act if they determine that the same are not appropriate to a particular [health maintenance organization] managed care plan of another state, that such waiver or modification will be consistent with the purposes and provisions of this act, and that it will not result in unfair discrimination in favor of the [health maintenance organization] managed care plan of another state.

(c) The commissioner and the secretary are hereby authorized and directed to develop with other states reciprocal licensing agreements concerning the licensure of [health maintenance organizations] managed care plans which permit the commissioner and the secretary to accept audits, inspections and reviews of agencies from other states to determine whether [health maintenance organizations] managed care plans licensed in other states meet Commonwealth requirements.

Section 7. Board of Directors.--A corporation receiving a certificate of authority to operate a [health maintenance organization] managed care plan under the provisions of this act shall be organized in such a manner that assures that at least one-third of the membership of the board of directors of the [health maintenance organization] managed care plan will be subscribers of the [organization] plan. The board of directors shall be elected in the manner stated in the corporation's charter or bylaws.

Section 8. Contracts with Practitioners, Hospitals, Insurance Companies, Etc.--(a) Contracts enabling [the] a corporation to provide the services authorized under section 4 of this act made with hospitals and practitioners of medical, dental and related services shall be filed with the secretary. The secretary shall have power to require immediate renegotiation of such contracts whenever he determines that they provide for excessive payments, or that they fail to include reasonable incentives for cost control, or that they otherwise substantially and unreasonably contribute to escalation of the costs of providing health care services to subscribers, or that they are otherwise inconsistent with the purposes of this act.

(b) A [health maintenance organization] managed care plan may reasonably contract with any individual, partnership, association, corporation or organization for the performance on its behalf of other necessary functions including, but not limited to, marketing, enrollment, and administration, and may contract with an insurance company authorized to do an accident and health business in this State or a hospital plan corporation or a professional health service corporation for the provision of insurance or indemnity or reimbursement against the cost of

health care services provided by the [health maintenance organization] managed care plan as it deems to be necessary. Such contracts shall be filed with the commissioner.

Section 9. Right to Serve or Benefits When Outside the State.--If a subscriber entitled to services provided by the corporation necessarily incurs expenses for such services while outside the service area, the [health maintenance organization] managed care plan to which the person is a subscriber may, in its discretion and if satisfied both as to the necessity for such services and that it was such as the subscriber would have been entitled to under similar circumstances in the service area, reimburse the subscriber or pay on his behalf all or part of the reasonable expenses incurred for such services. Such decision for reimbursement shall be subject to review by the commissioner at the request of a subscriber.

Section 4. The act is amended by adding a section to read:

Section 9.1. Managed Care Consumer Advocate Program.--(a) A managed care consumer advocate program shall be established within the department to perform the following functions on behalf of enrollees of managed care plans:

(1) Assist consumers in receiving a timely response from managed care plan representatives.

(2) Assist consumers by providing information, referral and assistance to individuals about means of obtaining health coverage and services appropriate to the consumers' needs.

(3) Educate and train consumers in the use of available resources concerning managed care plans.

(4) Assist enrollees to understand their rights and responsibilities under their managed care plan. This clause includes accessing appropriate levels of care and specialty

providers.

(5) Identify, investigate and resolve enrollee complaints about health care services and assist enrollees with filing complaints and appeals.

(6) Advocate policies and programs that protect consumer interests and rights under managed care plans.

(7) Prepare an annual consumer satisfaction survey for distribution to the public.

(b) The consumer advocate shall be accessible through a toll-free telephone number and shall ensure that individuals receive timely responses to their inquiries.

(c) The consumer advocate shall be immune from civil liability for good faith performance of official duties.

(d) Each managed care plan shall advise enrollees of the role of the consumer advocate and how to contact the consumer advocate.

(e) The consumer advocate shall report to the General Assembly on the types of assistance, provided by category and frequency of assistance provided by each managed care plan.

Section 5. Section 10 of the act, amended December 19, 1980 (P.L.1300, No.234) and repealed in part December 18, 1996 (P.L.1066, No.159), is amended to read:

Section 10. Supervision.--(a) Except as otherwise provided in this act, a [health maintenance organization] managed care plan operating under the provisions of this act shall not be subject to the laws of this State now in force relating to insurance corporations engaged in the business of insurance nor to any law hereafter enacted relating to the business of insurance unless such law specifically and in exact terms applies to such [health maintenance organization] plan. For a

[health maintenance organization] managed care plan established, operated and maintained by a corporation, this exemption shall apply only to the operations and subscribers of the [health maintenance organization] plan.

(b) All [health maintenance organizations] managed care plans shall be subject to the following insurance laws:

(1) The act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

(2) Any rehabilitation, liquidation or conservation of a [health maintenance organization] managed care plan shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies.

(c) (1) All rates charged subscribers or groups of subscribers by a [health maintenance organization] managed care plan and the form and content of all contracts between a [health maintenance organization] plan and its subscribers or groups of subscribers, all rates of payment to hospitals made by a [health maintenance organization] plan pursuant to contracts provided for in this act, budgeted acquisition costs in connection with the solicitation of subscribers, and the certificates issued by a [health maintenance organization] plan representing its agreements with subscribers shall, at all times, be on file with the commissioner and be deemed approved unless explicitly rejected within sixty days of filing.

(2) Filings under this subsection shall be [made] submitted to the commissioner in such form, and shall set forth such information as the commissioner may require to carry out the

provisions of this act. Any disapproval of a filing by the commissioner may be appealed in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

(d) Solicitors or agents compensated directly or indirectly by any corporation subject to the provisions of this act shall meet such prerequisites as the commissioner by regulation shall require.

(e) A [health maintenance organization] managed care plan shall establish and maintain a grievance resolution system satisfactory to the secretary, whereby the complaints of its subscribers may be acted upon promptly and satisfactorily.

(f) If a [health maintenance organization] managed care plan offers eye care which is within the scope of the practice of optometry, it shall make optometric care available to its subscribers, and shall make the same reimbursement whether the service is provided by an optometrist or a physician.

Section 6. Sections 11, 12, 13, 15, 16 and 17 of the act, amended December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 11. Reports and Examinations.--(a) (1) [The] A corporation that has a certificate of authority under section 4 of this act shall, on or before the first of March of every year, file with the commissioner a statement verified by at least two of the principal officers of the corporation summarizing its financial activities during the calendar or fiscal year immediately preceding, and showing its financial condition at the close of business on December 31 of that year, or the corporation's fiscal year. [Such] The statement shall be in such form and shall contain such matter as the commissioner

prescribes.

(2) The financial affairs and status of [every such corporation] each corporation that has a certificate of authority under section 4 of this act shall be examined by the commissioner or [his] the commissioner's agents not less frequently than once in every three years [and for]. For this purpose, the commissioner and [his] the commissioner's agents shall be entitled to:

(i) the aid and cooperation of the officers and employes of the corporation [and shall have convenient];

(ii) access to all books, records, papers, and documents that relate to the financial affairs of the corporation[. They shall have authority to]; and

(iii) examine under oath or affirmation the officers, agents, employes and subscribers for the health services of the corporation, and all other persons having or having had substantial part in the work of the corporation in relation to its affairs, transactions and financial condition.

(3) The [Insurance Commissioner] commissioner may at any time, without making such examination, call on any such corporation for a written report authenticated by at least two of its principal officers concerning the financial affairs and status of the corporation.

(b) A corporation that has a certificate of authority under section 4 of this act shall maintain its financial records in such manner that the revenues and expenses associated with the establishment, maintenance and operation of its prepaid health care delivery system under this act are identifiable and distinct from other activities it may engage in which are not directly related to the establishment, maintenance and operation

of its prepaid health care delivery system under this act.

(c) The secretary or [his] the secretary's agents shall have free access to all the books, records, papers and documents that relate to the business of the corporation, other than financial.

Section 12. Contracts to Provide Medical Care.--A [health maintenance organization] managed care plan established pursuant to this act may receive and accept from governmental or private agencies payments covering all or part of the cost of subscriptions to provide its services, facilities, appliances, medicines or supplies.

Section 13. Exemption from Taxation.--Every [health maintenance organization] managed care plan established, maintained and operated by a corporation not-for-profit is hereby declared to be a charitable and benevolent institution and all its income, funds, investments and property shall be exempt from all taxation of the State or its political subdivisions.

Section 15. Penalty.--(a) The commissioner and secretary may suspend or revoke any certificate of authority issued to a [health maintenance organization] managed care plan under this act, or, in their discretion, impose a penalty of not more than one thousand dollars ($1,000) for each and every unlawful act committed, if they find that any of the following conditions exist:

(1) that the [health maintenance organization] managed care plan is providing inadequate or poor quality care, thereby creating a threat to the health and safety of its subscribers;

(2) that the [health maintenance organization] managed care plan is unable to fulfill its contractual obligations to its subscribers;

(3) that the [health maintenance organization] managed care plan or any person on its behalf has advertised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner; or

(4) that the [health maintenance organization] managed care plan has otherwise failed to substantially comply with this act.

(b) Before the commissioner or secretary, whichever is appropriate, shall take any action as above set forth, [he] the commissioner or secretary shall give written notice to the [health maintenance organization,] managed care plan accused of violating the law, stating specifically the nature of [such] the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing of the matter shall be held. Hearing procedure and appeals from decisions of the commissioner or secretary shall be as provided in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

Section 16. Exclusions.--[Certificates] No certificates of authority shall [not] be required of:

(1) [Health maintenance organizations] Managed care plans offered by employers for the exclusive enrollment of their own employes, or by unions for the sole use of their members.

(2) Any plan, program or service offered by an employer for the prevention of disease among his employes.

Section 17. Effect of Act on Other Plans.--(a) Any requirements or privileges granted under this act shall apply exclusively to that portion of business or activities which reasonably relates to the establishment, maintenance and operation of a [health maintenance organization] managed care plan pursuant to the provisions of this act.

(b) [Any health maintenance organization program] A managed care plan approved by the commissioner or secretary and operating under the provisions of 40 Pa.C.S. Ch.61 (relating to hospital plan corporations) or 40 Pa.C.S. Ch.63 (relating to professional health services plan corporations) or under any statute superseded by either of such statutes, prior to the effective date of this act, may continue to operate under the provisions of such authority or successor provisions, if any.

Section 7. This act shall take effect in 60 days.