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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 480 Session of 2011

INTRODUCED BY MATZIE, BARBIN, V. BROWN, D. COSTA, CALTAGIRONE, DeLUCA, GEORGE, HALUSKA, HORNAMAN, KORTZ, KOTIK, KULA, LONGIETTI, MANN, MUNDY, M. O'BRIEN, PASHINSKI, STURLA AND DAVIS, FEBRUARY 16, 2011

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 16, 2011

AN ACT

Providing for health care provider choice; and imposing penalties.

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

Section 1. Short title.

This act shall be know and may be cited as the Health Care Professional Choice 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:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Covered person." A policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

"Department." The Insurance Department of the Commonwealth.

"Grandfathered plan coverage." Coverage provided by a health

carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with Federal regulations.

"Group health insurance coverage." Health insurance coverage offered in connection with a group health plan.

"Group health plan." An employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829) to the extent that the plan provides medical care and includes items and services paid for as medical care to current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

"Health benefit plan."

(1) A policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. The term includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, except as otherwise exempted under this definition.

(2) The term does not include:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) The term does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Other similar, limited benefits specified in Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996.

(4) The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(5) The term does not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1882(g)(1)).

(ii) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

(iii) Similar supplemental coverage provided to coverage under a group health plan.

"Health care professional." A physician, certified nurse midwife, dentist, podiatrist, nurse, nurse practitioner, chiropractor or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

"Health carrier." A company or health insurance entity licensed in this Commonwealth to offer or issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is governed under this act or any of the following:

(1) Article XXIV of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan

corporations) or Ch. 63 (relating to professional health services plan corporations).

"Health maintenance organization." An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee.

"Individual health insurance coverage." Health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance. A health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.

"Managed care plan." A health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

"Medical care." Amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

(2) Transportation primarily for and essential to medical care under paragraph (1).

(3) Insurance covering medical care under paragraphs (1) and (2).

"Network." The group of participating health care

professionals providing services to a managed care plan.

"Participant." As defined in section 3(7) of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

"Participating health care professional." A health care professional who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

"Primary care health care professional." A health care professional designated by a covered person to supervise, coordinate or provide initial care or continuing care to the covered person, who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Subscriber." In the case of an individual health insurance contract, the person in whose name the contract is issued.

Section 3. Choice of health care professional.

(a) Designation.--

(1) If a health carrier offering group or individual health insurance coverage requires or provides for the designation by a covered person of a participating primary health care professional, the health carrier shall permit each covered person to:

(i) Designate any participating primary care health care professional who is available to accept the covered person.

(ii) For a child, designate any participating physician who specializes in pediatrics as the child's

primary care health care professional and is available to accept the child.

(2) The provisions of paragraph (1)(ii) shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

(b) Obstetrical or gynecological care.--

(1) If a health carrier provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:

(i) Shall not require any person's, including a primary care health care professional's, prior authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(ii) Shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, under subparagraph (i).

(2) (i) The health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier.

(ii) For purposes of paragraph (1)(i), a health care professional who specializes in obstetrics or gynecology

means any individual, including an individual other than a physician, who is authorized under State law to provide obstetrical or gynecological care.

(3) The provisions of paragraph (1)(i) shall not be construed to:

(i) Waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care.

(ii) Preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

Section 4. Notice.

(a) Requirement.--A health carrier shall provide notice to covered persons of the terms and conditions of the plan related to the designation of a participating health care professional provided under section 3 and of a covered person's rights with respect to those provisions.

(b) Form.--

(1) In the case of group health insurance coverage, the notice shall be developed by the department using the notice developed by the National Association of Insurance Commissioners described under the appendix A of the National Association of Insurance Commissioners model law entitled "Choice of Health Care Professionals Notice" and shall be included whenever the health carrier provides a participant with a summary plan description or other similar description of benefits under the health benefit plan.

(2) In the case of individual health insurance coverage,

the notice described shall be developed by the department using the notice developed by the National Association of Insurance Commissioners described in the appendix of the model law entitled "Choice of Health Professionals Notice" and shall be included whenever the health carrier provides a primary subscriber with a policy, certificate or contract of health insurance.

Section 5. Enforcement.

(a) Penalties and remedies.--Upon a determination by hearing that this act has been violated, the commissioner may pursue one or more of the following courses of action:

(1) Issue an order requiring the person in violation to cease and desist from engaging in the violation.

(2) Suspend or revoke or refuse to issue or renew the certificate or license of the person in violation.

(3) Impose a civil penalty of not more than $5,000 for each violation.

(4) Impose any other penalty or remedy deemed appropriate by the commissioner, including restitution.

(b) Other remedies.--The enforcement remedies imposed under this section shall be in addition to any other remedies or penalties that may be imposed by statute. Violations of this article are deemed and defined by the commissioner to be an unfair method of competition and an unfair or deceptive act or practice under the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

Section 6. Applicability.

(a) Applicability.--Except as provided under subsection (b), this act shall apply to a health carrier providing coverage under an individual or group health benefit plan.

(b) Exception.--This act shall not apply to grandfathered plan coverage.

Section 7. Regulations.

The department shall promulgate regulations necessary to implement this act.

Section 20. Effective date.

This act shall take effect in 60 days.