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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 335 Session of 2011

INTRODUCED BY TOMLINSON, ERICKSON, MENSCH, RAFFERTY, BOSCOLA AND SOLOBAY, JANUARY 28, 2011

REFERRED TO BANKING AND INSURANCE, JANUARY 28, 2011

AN ACT

Requiring health insurers to disclose fee schedules and all rules and algorithms relating thereto; requiring health insurers to provide full payment to physicians when more than one surgical procedure is performed on the patient by the same physician during one continuous operating procedure; and providing for causes of action and for penalties.

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 Fee Schedule Disclosure and Multiple Surgical Procedures Policy Act.

Section 2. Legislative findings.

The General Assembly finds that:

(1) A majority of physicians in this Commonwealth are reimbursed for their services to patients by third-party payors. In some cases, this contractual relationship between physician and insurer has existed for years without the physician receiving from the insurer a formal contract or an accurate or complete fee schedule detailing fees or the rules or algorithms that actually define the rates at which

physicians are compensated for the services they render to the payors' insureds.

(2) Most health care insurers in this Commonwealth refuse to fully and accurately disclose their fee schedules to participating physicians; therefore, doctors do not know and cannot find out what they will receive in compensation prior to performing a service.

(3) This insurer policy is manifestly unfair to physicians. It is a breach of the physicians' contracts and it facilitates further breaches of such contracts by making it impossible for physicians to enforce their right to full payment for services rendered.

(4) During the course of a single operative session, a surgeon may perform multiple surgical procedures on the patient. These multiple surgical procedures are separate and distinct operations as defined by the Current Procedure Terminology Coding System created by the American Medical Association and other professional medical societies.

(5) The Current Procedural Terminology (CPT) Coding System is utilized by all physicians to identify to payors the services rendered by physicians and that payors purport to adopt the same CPT Coding System in defining the services for which they compensate such physicians.

(6) However, contrary to the dictates of the CPT Coding System and without disclosing any such deviation to the physicians with whom they contract, a number of health care insurers in this Commonwealth compensate physicians as if the procedures performed in addition to the primary procedure were merely incidental to the primary procedure and therefore such payors will compensate the surgeon for only one

procedure.

(7) This insurer policy is inconsistent with the medical judgments upon which the CPT Coding System is based, it is not accurately disclosed to physicians, it is manifestly unfair to surgeons, it leads to a lack of access to quality health care services for patients, and it adds to the excess profits insurers take from the health care delivery system.

Section 3. Declaration of intent.

The General Assembly hereby declares that it is the policy of this Commonwealth that:

(1) Physicians should receive from health care insurers a complete and accurate schedule of the reimbursement fees, including any rules or algorithms utilized by the payors to determine the amount physicians will be compensated if more than one procedure is performed during a single treatment session.

(2) Insurers must comply with their contractual obligations and surgeons should be fairly and justly compensated for all surgical procedures they perform in a single operative session.

Section 4. 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:

"CPT." Current Procedural Terminology used by physicians as developed by the American Medical Association.

"Fee schedule." The generally applicable monetary allowance payable to a participating physician for services rendered as provided for by agreement between the participating physician and the insurer, including, but not limited to, a list of

Healthcare Common Procedural Coding System (HCPCS) Level I Codes, HCPCS Level II National Codes and HCPCS Level III Local Codes and the fees associated therein; and a delineation of the precise methodology used for determining the generally applicable monetary allowances, including, but not limited to, footnotes describing formulas, algorithms, rules and calculations associated with determination of the individual allowances.

"HCPCS." The Healthcare Common Procedural Coding System of the Health Care Financing Administration that provides a uniform method for health care providers and medical suppliers to report professional services, procedures, pharmaceuticals and supplies.

"HCPCS Level I CPT Codes." The descriptive terms and identifying codes used in reporting supplies and pharmaceuticals used by, and services and procedures performed by, participating physicians as listed in the CPT.

"HCPCS Level II National Codes." Descriptive terms and identifying codes used in reporting supplies and pharmaceuticals used by, and services and procedures performed by, participating physicians.

"HCPCS Level III Local Codes." Descriptive terms and identifying codes used in reporting supplies and pharmaceuticals used by, and services and procedures performed by, participating physicians which are assigned and maintained by Pennsylvania's Centers for Medicare and Medicaid Services carrier.

"Insurer." Any insurance company, association or exchange authorized to transact the business of insurance in this Commonwealth. This shall also include any entity operating under any of the following:

(1) Section 630 of the act of May 17, 1921 (P.L.682,

No.284), known as The Insurance Company Law of 1921.

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

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

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

(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(6) 40 Pa.C.S. Ch. 67 (relating to beneficial societies).

"Participating physician." An individual licensed under the laws of this Commonwealth to engage in the practice of medicine and surgery in all its branches within the scope of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or in the practice of osteopathic medicine within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, who by agreement provides services to an insurer's subscribers.

Section 5. Disclosure of fee schedules.

Within 30 days of the effective date of this section, insurers shall provide their participating physicians with a copy of their fee schedule, including all applicable rules and algorithms utilized by the insurer to determine the amount any such physician will be compensated for performing any single procedure and any group of procedures during a single treatment session, which are applicable on July 1, 2004, and annually thereafter. Insurers shall also provide participating physicians with updates to the fee schedule as modifications occur.

Section 6. Procedure for payment of multiple surgical

procedures.

When a participating physician performs more than one surgical procedure on the same patient and at the same operative session, insurers shall pay the participating physician the greater of the amount calculated on the basis of the applicable insurer fee schedule and:

(1) any rules, algorithms, codes or modifiers included therein, governing reimbursement for multiple surgical procedures; or

(2) the principles governing reimbursement for multiple surgical procedures set forth and established by the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services, including the rule mandating payment to the physician of:

(i) 100% of the generally applicable maximum monetary allowance for the procedure which has the highest monetary allowance.

(ii) 50% of the generally applicable maximum monetary allowance for the second through fifth procedures with the next highest values.

(iii) Such payment amount as is determined following submission of documentation and individual review for more than five surgical procedures.

Section 7. Contract provisions.

Any provision in any contract, insurer policy or fee schedule that is inconsistent with any provision of this act is hereby declared to be contrary to the public policy of the Commonwealth and is void and unenforceable.

Section 8. Violations.

An insurer violates:

(1) Section 5 if the insurer fails to provide a participating physician with a copy of the fee schedule and updates to the fee schedule in the time frame provided in section 5.

(2) Section 6 if the insurer fails to adhere to the policy for payment of multiple surgeries as set forth and established by the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

Section 9. Cause of action.

In addition to all statutory, common law and equitable causes of action which already exist, a participating physician shall have a private cause of action for any violation of any provision of this act to enforce the provisions of this act. A participating physician shall be entitled to recover from an insurer any legal fees and costs associated with any suit brought under this section.

Section 10. Termination of agreement.

In addition to other remedies provided in this act, a participating physician may terminate the physician's agreement with an insurer if the insurer violates the provisions of this act. The physician may continue to provide services to the insurer's insureds and shall receive compensation as an out-of-network provider.

Section 11. Penalties.

Violations of this act shall be considered violations of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, and are subject to the penalties and sanctions of section 2182 of The Insurance Company Law of 1921.

Section 20. Effective date.

This act shall take effect immediately.