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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 822 Session of 2019

INTRODUCED BY SCHWANK AND COSTA, AUGUST 7, 2019

REFERRED TO BANKING AND INSURANCE, AUGUST 7, 2019

AN ACT

Providing for the protection of consumers of health care coverage against surprise balance bills for emergency services and certain covered health care services.

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Section 506. Effective date.

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

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Health Insurance Surprise Balance Bill Protection Act.

Section 102. 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:

"Balance bill." A bill for a covered service provided to an insured that seeks to collect from the insured the difference between an out-of-network provider's fee for a covered service received by the insured from the out-of-network provider and the reimbursement received by the out-of-network provider from the insured's health care plan.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Confidential information." Nonpublic personal health information, trade secret or confidential proprietary information and copies thereof in the possession or control of the department, the Department of Health, the Department of State, the Office of Attorney General, any resolution organization assigned to a dispute under section 305 or other person, that is produced by, obtained by or disclosed to any of them in the course of a dispute resolution under this act.

"Confidential proprietary information." Commercial or financial information:

(1) that is privileged or confidential; and

(2) the disclosure of which would cause substantial harm to the competitive position of the person that submitted the information.

"Cost-sharing." A copayment, coinsurance, deductible or similar charge. The term does not include premiums, balance billing amounts or the cost of noncovered services.

"Covered service." A health care service reimbursable by an insurer pursuant to a health care plan.

"Department." The Insurance Department of the Commonwealth.

"Emergency medical services agency" or "EMS agency." As defined in 35 Pa.C.S. § 8103 (relating to definitions).

"Emergency service." A health care service provided to an insured after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in detrimental consequences to the health of the insured or, with respect to a pregnant woman, the health of the insured or her unborn child. The term includes:

(1) Emergency medical services, including emergency medical services as defined in 35 Pa.C.S. § 8103, rendered by an EMS agency.

(2) A health care service that a provider determines is necessary to evaluate and, if necessary, stabilize the condition of an insured so that the insured may be transported without suffering detrimental consequences or aggravating the insured's condition.

(3) If an insured is admitted, a health care service

rendered prior to transfer or discharge.

"Facility." A facility that provides a health care service, including:

(1) A general, special, psychiatric or rehabilitation hospital.

(2) An ambulatory surgical facility.

(3) A cancer treatment center.

(4) A birth center.

(5) An inpatient, outpatient or residential drug and alcohol treatment facility.

(6) A laboratory, diagnostic or other outpatient medical service or testing facility.

(7) A physician office or clinic.

"Health care plan." A package of coverage benefits with a particular cost-sharing structure, network and service area that is purchased through a health insurance policy.

"Health care practitioner." An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board. The term includes:

(1) A health service doctor, as that term is defined in 40 Pa.C.S. § 6302 (relating to definitions).

(2) An individual accredited or certified to provide behavioral health services.

(3) A practice group.

(4) A licensed individual to whom a facility has granted clinical privileges and who provides health care services to patients of the facility under the clinical privileges.

(5) A licensed individual who provides health care services to a patient, or in conjunction with services

provided to that patient in a facility.

"Health care service." The term includes the following:

(1) Categories of services:

(i) A covered treatment.

(ii) An admission.

(iii) A procedure.

(iv) Medical supplies and equipment.

(v) Other services prescribed or otherwise provided or proposed to be provided by a provider to an insured under a health care plan.

(2) Types of services:

(i) An emergency service.

(ii) A behavioral health care service.

(iii) A service provided in conjunction with the service sought by an insured in or from a provider, including, but not limited to, radiology, pathology, anesthesiology, neonatology, hospitalist services and diagnostic interpretation.

"Health information." Information or data, whether oral or recorded in any form or medium, created by or derived from a provider or an insured that relates to one or more of the following:

(1) The past, present or future physical, mental or behavioral health or condition of an individual.

(2) The provision of a health care service to an individual.

(3) Payment for the provision of a health care service to an individual.

"Health insurance policy." A policy, subscriber contract, certificate or plan issued by an insurer that provides medical

or health care coverage. The term does not include any of the following:

(1) An accident only policy.

(2) A credit only policy.

(3) A long-term care or disability income policy.

(4) A specified disease policy.

(5) A Medicare supplement policy.

(6) A TRICARE policy, including a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(7) A fixed indemnity policy.

(8) A dental only policy.

(9) A vision only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

(12) Any other similar policy providing for limited benefits.

"In-network provider." A provider that contracts with an insurer to provide health care services to an insured under a health care plan.

"Insurance fraud." As defined in 18 Pa.C.S. § 4117 (relating to insurance fraud).

"Insured." A person on whose behalf an insurer is obligated to pay covered health care expense benefits or provide health care services under a health care plan. The term includes a policyholder, certificate holder, subscriber, member, dependent or other individual who is eligible to receive health care services through a health care plan. An authorized representative may act on behalf of an insured.

"Insurer." An entity licensed by the department with accident and health authority to issue a policy, subscriber contract, certificate or plan that provides medical or health care coverage offered or governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including section 630 and Article XXIV thereof.

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Network." The health care providers designated by an insurer to provide health care services to insureds in a health care plan.

"Nonpublic personal health information." Health information that:

(1) identifies an individual who is the subject of the information; or

(2) there is a reasonable basis to believe could be used to identify an individual.

"Out-of-network provider." A provider that does not contract with an insurer to provide health care services to an insured under the insured's health care plan.

"Practice group." Two or more health care practitioners, legally organized in a business form recognized by the Commonwealth, including a partnership, professional corporation, limited liability company formed to render health care services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity that satisfies one of the following

criteria:

(1) in which each practitioner who is a member of the group provides substantially the full range of services that the practitioner routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel;

(2) for which substantially all of the services of the practitioners who are members of the group are provided through the group and are billed in the name of the group practice, and amounts so received are treated as receipts of the group; or

(3) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group.

An entity that does not otherwise meet this definition shall be considered a practice group even if its shareholders, partners or owners of the practice group include single-practitioner professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual practitioners.

"Provider." An individual, facility, institution, organization or other person, whether for profit or nonprofit, whose primary purpose is to provide health care services and is licensed or otherwise authorized to practice in this Commonwealth. The term includes a facility and health care practitioner.

"Record custodian." The department, the Department of Health, the Department of State, a resolution organization assigned to a dispute under section 305 or other person who

possesses or controls confidential information.

"Resolution organization." A qualified independent third-party claim dispute resolution entity selected by and contracted with the department.

"Service area." The geographic area in which a health care plan is offered.

"Surprise bill." A balance bill as provided in section 301.

"Trade secret." Information that:

(1) Derives independent economic value, actual or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure or use.

(2) Is the subject of efforts that are reasonable under the circumstances to maintain secrecy of the information.

CHAPTER 3

BALANCE BILLING AND PAYMENT

Section 301. Applicability.

(a) General rule.--This act applies to a balance bill for one or more of the following:

(1) A covered emergency service provided to an insured by an out-of-network provider except that this act does not apply to a bill for an emergency medical service for which an emergency medical services agency may register with the Department of Health for direct reimbursement pursuant to section 635.7 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) A covered service provided to an insured by an out-of-network provider at an in-network facility, when the insured did not know the provider was an out-of-network provider or did not choose to receive the service from the

out-of-network provider, and having requested to receive the service from an in-network provider.

(3) A covered service provided to an insured by an out-of-network provider, in conjunction with a health care service for which the insured presented for care to an in-network provider, when the insured did not know the provider was an out-of-network provider or did not choose to receive the service from the out-of-network provider, and requested to receive the service from an in-network provider.

(b) Exceptions.--This act does not apply to:

(1) A balance bill for a health care service rendered by an out-of-network provider when an in-network provider is available and the insured has elected to receive the service from an out-of-network provider instead of from an in-network provider.

(2) A health care service for which an entity, other than an insurer under a health insurance policy, is responsible.

(c) Construction.--Nothing in this act shall be construed to prohibit an insurer from appropriately utilizing reasonable medical management techniques.

Section 302. In-network facility notice.

(a) Written disclosure required.--At the time an in-network facility schedules a health care service or seeks prior authorization from an insurer for the provision of a health care service to an insured that is expected to include the provision of a health care service by an out-of-network provider, but in any event not less than 10 business days prior to admission or date of service, the in-network facility shall provide the insured with an out-of-network service written disclosure.

(b) Contents of written disclosure.--The out-of-network service written disclosure shall include the following:

(1) A statement that one or more certain named out-of-network providers are expected to be called upon to render a health care service to the insured during the course of treatment.

(2) A statement that the named out-of-network provider may not have a contract with the insurer and is therefore considered to be an out-of-network provider.

(3) A statement that a health care service rendered by the named provider will be provided on an out-of-network basis.

(4) A description of the range of the charges for the out-of-network provider's health care service.

(5) Directions on how the insured may obtain from the insurer an identification of in-network providers who may render the health care service and how the insured may request and receive the health care service from an in-network provider.

(6) Notification that the insured may rely on the rights and remedies that may be available under this act or other Federal or State law, contact the insurer for additional assistance or agree to accept and pay the charges for the health care service by the out-of-network provider on an out-of-network basis.

Section 303. Hold harmless.

(a) Out-of-network providers and insurers.--

(1) An out-of-network provider that renders a health care service covered by this act to an insured may not surprise bill the insured for any amount in excess of the

cost-sharing amounts that would have been imposed if the health care service had been rendered by an in-network provider.

(2) The insurer shall furnish to the out-of-network provider upon request a statement of the applicable in-network provider cost-sharing amounts owed by the insured to the provider.

(3) The insured shall be responsible for no more than the cost-sharing amounts that would have been due if the health care service had been rendered by an in-network provider.

(b) Collections.--An out-of-network provider may not advance a surprise bill to collection.

(c) Assignment of benefits.--

(1) An out-of-network provider of a health care service covered by this act that does not surprise bill an insured shall be deemed to have received an assignment of benefits from the insured, and any reimbursement paid by the insurer shall be paid directly to the out-of-network provider.

(2) (i) If an insured receives a surprise bill, the insured may submit to the insurer a surprise bill form, as described in subsection (d), to declare the bill a surprise bill. Submission of the surprise bill form to the insurer by the insured shall effect an assignment of the insured's benefits to the out-of-network provider.

(ii) An insured who submits a surprise bill form to the insurer, except in the case of insurance fraud, shall be held harmless from all costs except the in-network provider cost-sharing amount that would otherwise have been due.

(d) Surprise bill form.--

(1) The department shall specify the content and format of a surprise bill form. A draft shall be published for a 30-day comment period prior to the final form being published. Publication shall be on the department's publicly accessible Internet website and in the Pennsylvania Bulletin. Substantive revisions of the form shall also be subject to the comment period and publication requirement. The form shall at least:

(i) Describe what is a surprise bill.

(ii) Describe the assignment of benefits effected by submission of the form.

(iii) Describe the hold harmless protection effected by submission of the form.

(iv) Explain the need to submit the form and the surprise bill to the insurer.

(v) Caution the insured regarding what is insurance fraud in the context of submitting the form, including that insurance fraud is punishable as a felony crime, may require payment of restitution and may subject a person who has committed insurance fraud to a civil action.

(2) The department shall make the surprise bill form available on the department's publicly accessible Internet website and in hard copy upon request.

(3) An insurer shall make available on the department's publicly accessible Internet website and include in the insured's health insurance policy form information on how to access and submit a surprise bill form.

(4) When an insured receives a health care service that may be subject to a surprise bill, each provider and insurer

associated with the health care service shall make a good faith effort to notify the insured of the protections afforded by this act, the surprise bill form and the means for submitting the surprise bill form to the insurer. The notification may include referencing the availability of the surprise bill form on a provider bill or an explanation of benefits, making the surprise bill form available on a publicly accessible Internet website and making the surprise bill form available to the insured in hard copy.

(e) Overpayment.--If the insured pays an out-of-network provider more than the in-network cost-sharing amount:

(1) The provider shall refund to the insured, within 30 business days of receipt of payment, any amount paid in excess of the in-network provider cost-sharing amount.

(2) If an out-of-network provider has not made a full refund of any amount paid in excess of the in-network provider cost-sharing amount to the insured within 30 business days of receipt of payment, interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30-business day period.

(3) A violation of this subsection shall be considered a violation of the act of December 17, 1968 (P.L.1224, No.387), known as the Unfair Trade Practices and Consumer Protection Law.

(f) Credit against maximum out-of-pocket cost-sharing amount.--An insurer shall count toward an insured's in-network provider deductible and maximum out-of-pocket cost-sharing amount each payment that an insured makes to satisfy a surprise balance bill subject to this act.

Section 304. Direct dispute resolution.

(a) Construction.--Nothing in this act shall be construed to:

(1) Prevent an insurer and an out-of-network provider from mutually agreeing to a payment amount for a health care service covered by this act outside of the mechanism provided in this section.

(2) Prevent an insurer from addressing the availability and use of in-network providers in the insurer's contracts with in-network provider facilities and in-network providers that make referrals to other providers.

(b) Payment for health care service.--If an insurer receives a surprise bill form and bill from an insured or if an out-of-network provider submits to an insurer a bill for a health care service covered by this act:

(1) The insurer shall pay, in accordance with the prompt payment requirements under section 2166 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, the out-of-network provider amount due under the health insurance policy or as required by Federal law.

(2) Payment under paragraph (1) shall be made directly to the provider according to the assignment of benefits provision under section 303(c).

(3) The insurer and provider may reach agreement as to an additional amount to be paid for the provider's health care services, payment of which, in addition to the applicable in-network provider cost-sharing amount owed by the insured, shall constitute payment in full to the provider for the health care service rendered.

(4) If the provider and insurer do not reach agreement on a payment amount, either through the negotiation process

specified in this subsection or otherwise, within 60 calendar days after the insurer receives the bill for the health care service, either party may submit the dispute for formal dispute resolution under this section. Either party may aggregate claims from the provider to the insurer that are submitted for formal dispute resolution to include all claims pertaining to an insured from a single encounter.

Section 305. Arbitrated dispute resolution.

(a) Process established.--

(1) (i) An independent dispute resolution process for the purpose of arbitrating disputes between an insurer and a provider for payment for an out-of-network service covered by this act is established. Private negotiations are permitted.

(ii) Nothing in this section shall be construed to preclude the parties from reaching a resolution of their dispute before the arbitrator issues a final award.

(2) (i) The dispute resolution process shall use the American Arbitration Association or, if the American Arbitration Association ceases to exist or ceases to be qualified or becomes unable to perform arbitrations in connection with section 304, a similarly qualified organization specified by the department, as the resolution organization.

(ii) Except as otherwise provided in this section, the arbitration shall follow the desk/telephonic track procedures of the American Arbitration Association Healthcare Payor Provider Arbitration Rules and Mediation Procedures, with fees calculated under the Standard Fee Schedule and based on the monetary amount in dispute

between the out-of-network provider's initial bill and the insurer's initial out-of-network payment.

(3) An arbitrator appointed to administer a dispute shall be impartial and independent of the parties and shall perform the arbitrator's duties with diligence and in good faith.

(4) If either an insurer or an out-of-network provider submits the dispute for resolution, the other party shall also participate in the process as provided in this section.

(5) The award obtained through the resolution process shall be binding on both parties and not appealable. The award shall be binding on the insurer and provider for any disputes between them involving the same claim code stated in the demand for arbitration for a period of one year from the date of the award.

(6) A payment made by an insurer to a provider under an award obtained through the resolution process specified in this section, in addition to the applicable cost-sharing owed by the insured who received the health care service that is the subject of the resolution process, shall constitute payment in full for the health care service rendered.

(b) Binding resolution process.--

(1) The party initiating the process shall file a demand for arbitration, and the applicable administrative filing fee, with the resolution organization and simultaneously send a copy of the demand to the department and the other party. The initiating party shall include on the demand the claim code, claim amount and complete contact information for both parties and shall transmit the demand in accordance with the resolution organization's procedures.

(2) Within 14 calendar days after notice of the filing of the demand is sent by the resolution organization, the parties named in the demand shall each submit their best and final offer for the amount in dispute with supporting documents to each other and the resolution organization.

(3) An arbitrator shall be selected in accordance with the process established by the resolution organization, subject to the following:

(i) During the 14-calendar-day period after the notice of filing is sent, the parties may negotiate a settlement. If a settlement is reached, both parties shall advise in writing the resolution organization and the department.

(ii) If, during the 14-calendar-day period, the parties do not notify in writing the resolution organization that a settlement was reached, an arbitrator shall be appointed in accordance with the procedures of the resolution organization.

(iii) Upon appointment of the arbitrator, the resolution organization shall require the parties to deposit sums of money as the resolution organization deems necessary to cover the expense of arbitration, including the arbitrator's fees, if any, render an accounting to the parties and return any unexpended balance at the conclusion of the case. The deposit for arbitrator's fees shall be split evenly between the parties.

(4) After the arbitrator is appointed, the resolution organization shall transmit to the arbitrator the parties' previously submitted best and final offers with supporting

documents.

(5) In making an award under this subsection, the arbitrator may consider:

(i) The level of training, education and experience of the provider.

(ii) The provider's usual charge for comparable health care services provided in-network and out-of-network with respect to any health care plan.

(iii) The insurer's usual payment for comparable health care services provided in-network and out-of-network in the service area.

(iv) The payment for comparable health care services provided in the service area by a recognized standard, including Medicare or a median index.

(v) The availability of the health care service for the insured from in-network providers.

(vi) The propensity of the provider to be included in networks and the propensity of the insurer to include providers in networks.

(vii) Payments made in prior surprise bill disputes between the provider and the insurer.

(viii) The circumstances and complexity of the particular case, including the time and place of the health care service.

(ix) Any final award between the insurer and provider for the same claim code from a period of one year prior.

(6) The arbitrator's award shall be one of the two amounts submitted by the parties as their best and final offers and shall be binding on both parties.

(7) The arbitrator shall issue a final binding award in writing. The award shall include the final offers from each party and the claim code, and shall be issued within 30 days after the arbitrator has received the parties' best and final offer and supporting documents. Electronic copies of the final award shall be provided to both parties and the department.

(c) Cost allocations.--

(1) In the final award, the arbitrator shall apportion the administrative fees, arbitrator compensation and expenses to the nonprevailing party.

(2) A party that fails to pay all amounts due to the other party within 30 days of receiving the final award shall:

(i) Pay interest to the prevailing party, calculated and paid in accordance with section 2166 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(ii) Be subject to a penalty of $100 per day until all payments are made in full.

(d) Resolution organization records.--A resolution organization shall comply with the following:

(1) Maintain for 18 months after a case is closed, by calendar year, all in an easily accessible and retrievable format, the following:

(i) The written demand filed by the initiating party establishing the date the resolution organization receives a request for dispute resolution.

(ii) Complete materials received from both parties.

(iii) The award.

(iv) The date the award was communicated to the parties.

(2) Document measures taken to appropriately safeguard the confidentiality of the records and prevent unauthorized use and disclosures under applicable Federal and State law.

(3) Report annually to the department in the aggregate:

(i) The total number of demands for arbitrations received under this section.

(ii) The total number of arbitrations concluded.

(iii) The breakdown of disposition for arbitrations concluded, including arbitrations withdrawn due to settlement and the awards made.

(4) Protect from disclosure, except as provided in section 502, information specifically identifying the insured who received the health care services that were the subject of an arbitration decision. This information shall be protected and remain confidential in compliance with all applicable Federal and State laws and regulations and shall be confidential as nonpublic personal health information.

(5) Report immediately to the department a change in its status which would cause it to cease performing or being qualified to perform arbitrations under this act.

CHAPTER 5

MISCELLANEOUS PROVISIONS

Section 501. Communications to consumers.

(a) Departmental notice.--The department shall provide a notice on its publicly accessible Internet website containing information for consumers of health care coverage relating to the protections provided by this act and information regarding the process by which consumers may report and file complaints

with the department or another appropriate regulatory agency relating to surprise bills.

(b) Provider communications.--

(1) A provider that provides health care services and a facility in which health care services are rendered to patients covered by a health care plan who may not be covered at in-network provider rates shall post a sign containing the following information in a prominent place or an appropriate written or electronic communication.

(i) The rights of insureds under this act.

(ii) The identification of the department as the proper Commonwealth agency to receive complaints relating to surprise balance bills prohibited under this act.

(iii) Contact information for the department.

(2) The department may specify the form and content of the notice required under paragraph (1).

(3) A communication detailing the cost of a health care service covered by this act shall clearly state that an insured will only be responsible for payment of the applicable cost-sharing amounts under the insured's health care plan.

(c) Insurer communications.--

(1) An insurer shall provide a written notice to an insured of the protections provided to insureds under this act. The notice shall include information regarding how an insured may contact the department to report and dispute a surprise balance bill. The insurer shall:

(i) Post the notice on its publicly accessible Internet website and make it available upon request within 90 days of the effective date of this section.

(ii) Include the notice with an explanation of benefits for claims submitted beginning not more than 90 days after the effective date of this section.

(2) The department may by notice specify the form and content of the notice required under paragraph (1).

(3) A communication detailing the cost of a health care service covered by this act shall clearly state that an insured will only be responsible for payment of the applicable cost-sharing amounts under the insured's health care plan.

Section 502. Records and confidentiality.

(a) General rule.--A record custodian may not disclose confidential information. A record containing confidential information shall be:

(1) Confidential and privileged.

(2) Not subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

(3) Not subject to subpoena.

(4) Not subject to discovery nor admissible as evidence in a private civil action.

(b) Exceptions.--A record custodian may disclose confidential information to the department, the Department of Health, the Department of State, a resolution organization or the Office of Attorney General to facilitate the fulfillment of a duty or obligation under this act. A duty or obligation that requires the use of confidential information includes:

(1) Arbitration of a disputed claim.

(2) Resolution of a consumer complaint.

(3) Investigation and enforcement of an alleged violation of this act.

(c) Departmental analysis and disclosure of confidential information.--Nothing in this act shall be construed to prevent the department from using confidential information for internal analysis or from disclosing aggregated confidential information in a way that the identity of the subject of the information cannot be ascertained.

(d) No waiver of privilege or confidentiality.--The sharing of confidential information with or by the department, the Department of Health, the Department of State, a resolution organization or the Office of Attorney General as authorized by this act shall not constitute a waiver of an applicable privilege or claim of confidentiality.

Section 503. Enforcement.

(a) General authority.--

(1) The department, the Department of Health, the Department of State and the Office of Attorney General shall have authority to enforce this act and may investigate potential violations of this act based upon information received from insureds, insurers, providers and other sources in order to ensure compliance with this act.

(2) Nothing in this act shall be construed to limit the ability of the department, the Department of Health, the Department of State or the Office of Attorney General from using information received under this act in the course of their regulatory duties under any other law.

(3) Except as otherwise specified, fines collected under this act shall be deposited in the General Fund.

(b) Departmental authority.--

(1) Upon satisfactory evidence of a violation of this act by an insurer, the commissioner may impose any of the

penalties under section 5 of the act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act.

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

(3) Upon receipt or discovery of evidence of a potential violation of this act by a provider, the department may refer the matter to the Department of Health, the Department of State or the Office of Attorney General, as may be appropriate.

(c) Department of State.--

(1) A violation of a provision of this act by a health care practitioner shall constitute unprofessional conduct and subject the health care practitioner to disciplinary action under the applicable provisions of the professional licensure statute under which the health care practitioner is licensed.

(2) Penalties collected under this section shall be deposited in the fund specified in the professional licensure statute under which the disciplinary action is taken.

(d) Department of Health.--

(1) A violation of a provision of section 302, 303(d)(4) or 501(b) by an EMS agency shall constitute a violation of and may be subject to the penalties under 35 Pa.C.S. § 8156 (relating to penalties).

(2) A violation of a provision of section 302, 303(d)(4) or 501(b) by a facility shall constitute a violation of and may be subject to the penalties under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(3) Penalties collected under this section shall be deposited in the General Fund.

(e) Office of Attorney General.--A violation of this act shall be deemed a violation of and may be subject to the penalties under the act of December 17, 1968 (P.L.1224, No.387), known as the Unfair Trade Practices and Consumer Protection Law.

(f) Administrative practice and procedure.--The administrative provisions of this section shall be subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). A party against whom penalties are assessed in an administrative action may appeal to the Commonwealth Court as provided in 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(g) Remedies cumulative.--The enforcement remedies imposed under this section are in addition to any other remedies or penalties that may be imposed under any other applicable statute.

(h) Duplicative penalties prohibited.--Two or more authorities may not impose a penalty on the same insurer or provider for the same violation. An authority that imposes a penalty under this act will notify the department of the imposition of the penalty.

Section 504. Private cause of action.

Nothing in this act shall be construed to create or imply a private cause of action for a violation of this act other than

as permitted under the act of December 17, 1968 (P.L.1224, No.387), known as the Unfair Trade Practices and Consumer Protection Law.

Section 505. Regulations.

The department, the Department of Health and the Department of State may each promulgate regulations as may be necessary and appropriate to implement this act.

Section 506. Effective date.

This act shall take effect in six months.