

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 564 Session of 2019

INTRODUCED BY SAYLOR, RYAN, BARRAR, JAMES, READSHAW, BERNSTINE, MURT, ROTHMAN, MILLARD, McNEILL, B. MILLER, LAWRENCE, WHEELAND, ZIMMERMAN, KAUFFMAN, GOODMAN, CIRESI, JONES, HILL-EVANS, MENTZER, BOBACK, DUSH, DIAMOND, EVERETT, NEILSON, MALONEY, KORTZ, FRITZ, HAHN, STAATS, RADER, GLEIM AND HARKINS, FEBRUARY 28, 2019

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, JUNE 27, 2019

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," in uniform health insurance claim <--
12 form, further providing for forms for health insurance
13 claims. QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION, <--
14 FURTHER PROVIDING FOR PROMPT PAYMENT OF CLAIMS.

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

17 Section 1. Section ~~1202~~ 2166 of the act of May 17, 1921 <--
18 (P.L.682, No.284), known as The Insurance Company Law of 1921,
19 is amended to read:

20 Section ~~1202. Forms for Health Insurance Claims.~~ (a) Each <--
21 health insurance claim form processed or otherwise used by an

1 insurer, including those used by the Department of [~~Public~~  
2 ~~Welfare~~] ~~Human Services~~ for public health care coverage, shall  
3 be the uniform claim form developed by the department. The claim  
4 form shall be identical in form and content except as provided  
5 in subsection (c). The department shall, in consultation with  
6 the Department of [~~Public Welfare~~] ~~Human Services~~, insurers and  
7 health care providers or their representatives, first consider  
8 the feasibility of utilizing the UB-82/HCFR 1450 and HCFR 1500  
9 forms, or their successors, as a uniform claim form. If these  
10 forms are deemed to be unsatisfactory, the department shall, in  
11 consultation with the Department of [~~Public Welfare~~] ~~Human~~  
12 ~~Services~~, insurers and health care providers or their  
13 representatives, develop a uniform claim form for use by all  
14 insurers, the Department of [~~Public Welfare's~~] ~~Human Services'~~  
15 public health care coverage program and health care providers.  
16 The uniform claim form shall contain blank spaces at appropriate  
17 places in the document for approved additional information  
18 requests under subsection (c).

19 (b) ~~The feasibility study and subsequent development of the~~  
20 ~~uniform claim form shall be complete within one hundred eighty~~  
21 ~~(180) days of the effective date of this article. All insurers,~~  
22 ~~the Department of [~~Public Welfare's~~] ~~Human Services'~~ public~~  
23 ~~health care coverage program and health care providers shall be~~  
24 ~~required to use the uniform claim form within one hundred twenty~~  
25 ~~(120) days after the uniform claim form is developed. The~~  
26 ~~department may consider a request from the Department of [~~Public~~~~  
27 ~~Welfare~~] ~~Human Services~~ for an extension in meeting the  
28 implementation schedule of this section.

29 (c) (1) ~~Subject to the procedure contained in clause (2),~~  
30 ~~an insurer may request that a claimant provide departmentally~~

1 ~~approved additional information which is not requested on the~~  
2 ~~uniform claim form.~~

3 ~~(2) An insurer may request departmental approval of~~  
4 ~~additional information requests to be printed in the blank~~  
5 ~~spaces on the uniform claim form, and on subsequent pages if~~  
6 ~~necessary, by submitting a written request to the department.~~  
7 ~~Such a request shall be deemed approved by the department if not~~  
8 ~~disapproved within sixty (60) days after receipt of the request.~~  
9 ~~A disapproval shall be subject to the procedures under 2 Pa.C.S.~~  
10 ~~(relating to administrative law and procedure).~~

11 ~~(3) If, in a dental claim form, an insured specifically~~  
12 ~~authorizes payment of benefits directly to an entity or person~~  
13 ~~who provided dental services in accordance with the provisions~~  
14 ~~of the policy, the insurer shall make the payment to the~~  
15 ~~specific provider of the dental services. The insurance contract~~  
16 ~~may not prohibit, and claim forms must provide an option for,~~  
17 ~~the payment of benefits directly to the specified provider of~~  
18 ~~the dental service. The insurer may require written attestation~~  
19 ~~of the assignment of the payment. Payment to the specific~~  
20 ~~provider of the dental services from the insurer may not be more~~  
21 ~~than the amount that the insurer would otherwise have paid~~  
22 ~~without the assignment of payment.~~

23 ~~(d) In the case of vision and dental claim forms and in the~~  
24 ~~case of supplemental major medical claim forms, utilization of~~  
25 ~~the uniform claim form shall be at the discretion of the~~  
26 ~~individual insurer.~~

27 ~~(e) (1) The Legislative Budget and Finance Committee shall~~  
28 ~~conduct a study to examine all of the following:~~

29 ~~(i) The costs and benefits associated with the direct~~  
30 ~~reimbursement of nonparticipating providers by health insurance~~

1 ~~carriers under a valid agreement of benefits.~~

2 ~~(ii) The impact on consumers of prohibiting health insurance~~  
3 ~~carriers from refusing to accept a valid assignment of benefits.~~

4 ~~(iii) The impact of requiring direct reimbursement of~~  
5 ~~nonparticipating providers by health insurance carriers on a~~  
6 ~~health insurance carrier's ability to maintain an adequate~~  
7 ~~number of providers in the health insurance carrier's network.~~

8 ~~(2) A report on the study under clause (1) shall be~~  
9 ~~presented to the chairperson and minority chairperson of the~~  
10 ~~Banking and Insurance Committee of the Senate and the~~  
11 ~~chairperson and minority chairperson of the Insurance Committee~~  
12 ~~of the House of Representatives no later than thirty six (36)~~  
13 ~~months after the effective date of this subsection.~~

14 SECTION 2166. PROMPT PAYMENT OF CLAIMS.--(A) A LICENSED <--  
15 INSURER OR A MANAGED CARE PLAN SHALL PAY A CLEAN CLAIM SUBMITTED  
16 BY A PARTICIPATING HEALTH CARE PROVIDER OR NONPARTICIPATING  
17 HEALTH CARE PROVIDER WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF  
18 THE CLEAN CLAIM.

19 (B) IF A LICENSED INSURER OR A MANAGED CARE PLAN FAILS TO  
20 REMIT THE PAYMENT AS PROVIDED UNDER SUBSECTION (A), INTEREST AT  
21 TEN PER CENTUM (10%) PER ANNUM SHALL BE ADDED TO THE AMOUNT OWED  
22 ON THE CLEAN CLAIM. INTEREST SHALL BE CALCULATED BEGINNING THE  
23 DAY AFTER THE REQUIRED PAYMENT DATE AND ENDING ON THE DATE THE  
24 CLAIM IS PAID. THE LICENSED INSURER OR MANAGED CARE PLAN SHALL  
25 NOT BE REQUIRED TO PAY ANY INTEREST CALCULATED TO BE LESS THAN  
26 TWO (\$2) DOLLARS.

27 (C) FOR PURPOSES OF THIS SECTION, A CLAIM SHALL BE DEEMED TO  
28 BE PAID WHEN A LICENSED INSURER OR MANAGED CARE PLAN:

29 (1) MAILS A CHECK TO THE PARTICIPATING HEALTH CARE PROVIDER  
30 OR NONPARTICIPATING HEALTH CARE PROVIDER; OR

1       (2) MAKES AN ELECTRONIC TRANSFER OF FUNDS TO THE  
2 PARTICIPATING HEALTH CARE PROVIDER OR NONPARTICIPATING HEALTH  
3 CARE PROVIDER.

4       Section 2. This act shall take effect in 60 days.