HOUSE AMENDED

PRIOR PRINTER'S NOS. 364, 1287 PRINTER'S NO. 1908

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 373 Session of 2017

INTRODUCED BY EICHELBERGER, GREENLEAF, REGAN, RAFFERTY, COSTA, BROWNE, ARGALL, MENSCH, WARD, VOGEL, BOSCOLA, RESCHENTHALER, HUTCHINSON, SCAVELLO, KILLION, BROOKS, AUMENT, McGARRIGLE, STEFANO, ALLOWAY, BLAKE AND McILHINNEY, FEBRUARY 15, 2017

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, JUNE 21, 2018

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in uniform health insurance claim form, further providing for forms for health insurance claims.

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

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

Section 1202. Forms for Health Insurance Claims.--(a) Each health insurance claim form processed or otherwise used by an insurer, including those used by the Department of [Public

Welfare] Human Services for public health care coverage, shall be the uniform claim form developed by the department. The claim form shall be identical in form and content except as provided in subsection (c). The department shall, in consultation with the Department of [Public Welfare] Human Services, insurers and health care providers or their representatives, first consider the feasibility of utilizing the UB-82/HCFA-1450 and HCFA-1500 forms, or their successors, as a uniform claim form. If these forms are deemed to be unsatisfactory, the department shall, in consultation with the Department of [Public Welfare] Human Services, insurers and health care providers or their representatives, develop a uniform claim form for use by all insurers, the Department of [Public Welfare's] Human Services' public health care coverage program and health care providers. The uniform claim form shall contain blank spaces at appropriate places in the document for approved additional information requests under subsection (c).

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

(c) (1) Subject to the procedure contained in clause (2), an insurer may request that a claimant provide departmentally approved additional information which is not requested on the

uniform claim form.

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

~~(3) If, in a dental claim form, an insured specifically authorizes payment of benefits directly to an entity or person who provided dental services in accordance with the provisions of the policy, the insurer shall make the payment to the specific provider of the dental services. Insurance contracts issued 120 days after the effective date of this act may not prohibit, and claim forms issued after that date must provide an option for, the payment of benefits directly to the specified provider of the dental service. The insurer may require written attestation of the assignment of the payment. Payment to the specific provider of the dental services from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment of payment. The dental claim form shall clearly and conspicuously state whether the provider seeking authorization for direct payment from the insurer will bill the patient for any balance above the direct payment assigned to the provider. The insured may be required to pay any applicable copayments, coinsurances or deductibles at the time of service, however, the provider shall not require the insured to pay any other amount above the direct payment assigned to the provider at the point of service.~~ <--

(3) EXCEPT AS PROVIDED IN PARAGRAPH (4), A CHECK FOR PAYMENT <-- OF A CLAIM COVERED UNDER ANY DENTAL CARE INSURANCE POLICY ISSUED OR RENEWED ON OR AFTER THE EFFECTIVE DATE OF THIS PARAGRAPH FOR COVERED DENTAL CARE SERVICES PROVIDED BY A LICENSED DENTAL PROVIDER, WHERE THE DENTAL PROVIDER IS NOT A PARTICIPATING PROVIDER UNDER A CONTACT WITH A DENTAL INSURER, SHALL BE MADE OUT TO BOTH THE DENTAL PROVIDER AND THE INSURED. THE CHECKS SHALL BE SENT TO THE INSURED. AN OUT-OF-NETWORK DENTAL PROVIDER SHALL NOT REQUIRE THE INSURED TO PAY ANY AMOUNT ABOVE ANY APPLICABLE COPAYMENTS, COINSURANCES OR DEDUCTIBLES AT THE TIME OF SERVICE.

(4) DENTAL INSURANCE POLICIES ISSUED OR RENEWED ON OR AFTER THE EFFECTIVE DATE OF THIS PARAGRAPH, AND DENTAL CLAIMS FORMS UNDER THOSE POLICIES, SHALL ALLOW AN OUT-OF-NETWORK PROVIDER OF THE DENTAL SERVICE TO REQUEST THAT THE DENTAL INSURER'S PAYMENT BE MADE ONLY TO THE PROVIDER. WHERE THE INSURED, WITH WRITTEN ATTESTATION, AGREES TO THE ASSIGNMENT OF PAYMENT, THE PROVIDER SHALL NOT REQUIRE THE INSURED TO PAY AN AMOUNT IN EXCESS OF THE INSURER'S RATE FOR THE SAME SERVICE PERFORMED BY A NETWORK PROVIDER, EXCEPT FOR ANY APPLICABLE COPAYMENTS, COINSURANCES OR DEDUCTIBLES.

(5) NOTHING IN PARAGRAPH (3) OR (4) SHALL PRECLUDE A DENTAL INSURER AND AN OUT-OF-NETWORK DENTAL PROVIDER FROM AGREEING TO AN ALTERNATE PAYMENT ARRANGEMENT. THE PROVIDER SHALL NOT REQUIRE THE INSURED TO PAY AN AMOUNT IN EXCESS OF THE INSURER'S RATE, EXCEPT FOR ANY APPLICABLE COPAYMENTS, COINSURANCES OR DEDUCTIBLES.

(d) In the case of vision and dental claim forms and in the case of supplemental major medical claim forms, utilization of the uniform claim form shall be at the discretion of the

individual insurer.

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

~~(1) The costs and benefits associated with the direct reimbursement of nonparticipating providers by health insurance carriers under a valid assignment of benefits.~~

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

~~(3) The impact of requiring direct reimbursement of nonparticipating providers by health insurance carriers on a health insurance carrier's ability to maintain an adequate number of providers in their network. A report on the study shall be presented to the chairman and minority chairman of the Insurance Committee of the House of Representatives and the chairman and minority chairman of the Banking and Insurance Committee of the Senate no more than thirty six months after the effective date of this subsection.~~

Section 2. This act shall take effect in ~~60~~ 240 days. <--