AMENDMENTS TO HOUSE BILL NO. 1013

Sponsor: SENATOR WHITE

Printer's No. 1709

Amend Bill, page 1, lines 12 and 13, by striking out "FOR DEFINITIONS AND"

Amend Bill, page 1, line 13, by inserting after "services" and providing for quality eye care for insured Pennsylvanians

Amend Bill, page 1, lines 19 through 21; page 2, lines 1 through 22; by striking out all of said lines on said pages and inserting

Section 1. Section 2116 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

Amend Bill, page 2, line 29, by inserting a bracket before "The"

Amend Bill, page 3, line 1, by inserting after "emergency."

] The managed care plan shall pay all reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all copayments, coinsurances or deductibles.

Amend Bill, page 3, lines 12 through 24, by striking out all of said lines and inserting

(b) For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103 (relating to definitions), that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.

(c) For emergency services provided to medical assistance participants, the following provisions shall apply:

(1) The provisions of subsection (b) shall apply to the same services provided to medical assistance participants under Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code.

(2) Payment for the services shall be in accordance with the current managed care contracted rates.

(3) Sufficient funds shall be appropriated each fiscal year for payment of the services.

(d) The provisions of subsection (b) shall apply to all group and individual major medical health insurance policies issued by a licensed health insurer.

Section 2. The act is amended by adding an article to read:

ARTICLE XXVII

QUALITY EYE CARE FOR INSURED PENNSYLVANIANS

Section 2701. Short title of article.

This article shall be known and may be cited as the Quality Eye Care for Insured Pennsylvanians Act.

Section 2702. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Covered vision care." Vision services and materials for which reimbursement is available under a health insurance policy, regardless of whether the reimbursement is contractually limited by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation or alternative benefit payment.

"Department." The Insurance Department of the Commonwealth.

"Health insurance policy." An individual or group health insurance policy, subscriber contract, certificate or plan issued by or through an insurer that provides covered vision care. The term does not include accident only, fixed indemnity, limited benefit, credit, dental, specified disease, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

"Health 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 and is offered or governed under any of the following:

(1) Section 630, Article XXIV or other provision of this act.

(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).

(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Insured." An individual on whose behalf a health insurer is obligated to pay for vision care under a health insurance

policy.

"Materials." Ophthalmic devices, including, but not limited to, lenses, devices containing lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coating, contact lenses and prosthetic devices to correct, relieve or treat defects or abnormal conditions of the human eye or its adnexa associated with the delivery of vision care.

"Noncovered services." Vision care that is not covered but for which a discount may be provided under the terms of a health insurance policy.

"Vision care." A provision of eye care services, materials or both.

"Vision care provider." A licensed doctor of optometry practicing under the authority of the act of June 6, 1980 (P.L.197, No.57), known as the Optometric Practice and Licensure Act, or a licensed physician who has also completed a residency in ophthalmology.

"Vision care supplier." A person or entity that creates, promotes, sells, provides, advertises or administers vision care supplies, including an optical laboratory. The term includes persons or entities affiliated with a health insurer.

Section 2703. Vision care provider and vision care supplier selection.

A health insurance policy shall allow an insured who receives vision care from an in-network vision care provider to select an out-of-network vision care supplier for related vision care on the recommendation or referral of the in-network vision care provider, provided that the in-network vision care provider gives to the insured, prior to recommending, referring, prescribing or ordering any vision care from the out-of-network vision care supplier, written notice that:

(1) The out-of-network vision care supplier is not an in-network vision care supplier.

(2) The insured has the option of selecting an in-network vision care supplier.

(3) The insured may have different financial obligations depending on whether the vision care supplier is in-network or out-of-network.

Section 2704. Discount access.

A health insurance policy that has a discount program for noncovered services shall permit an insured who receives vision care from an in-network vision care provider to receive a noncovered service from the in-network vision care provider at a nondiscounted rate, provided that the vision care provider gives to the insured, prior to receipt of the noncovered service, written disclosure that the vision care provider does not participate in the insured's discount program.

Section 2705. Enforcement.

(a) Scope.--The department may investigate and enforce the provisions of this article only insofar as the actions or inactions being investigated relate to coverage under a health

insurance policy.

(b) Insurance Commissioner power.--Upon satisfactory evidence of a violation of this article by any insurer or other person within the scope of the department's investigative and enforcement authority under subsection (a), the Insurance Commissioner may, in the Insurance Commissioner's discretion, pursue any of the following actions:

(1) Suspend, revoke or refuse to renew the license of the offending person.

(2) Enter a cease and desist order.

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

(4) Impose a civil penalty of not more than $10,000 for each action in willful violation of this article.

(c) Limitation.--Penalties imposed under this article shall not exceed $500,000 in the aggregate during a calender year.

(d) Violations by optometrists and opthalmologists.--A violation of this article by an optometrist shall constitute unprofessional conduct under the act of June 6, 1980 (P.L.197, No.57), known as the Optometric Practice and Licensure Act. A violation of this article by an ophthalmologist shall constitute unprofessional conduct under the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

Section 2706. Regulations.

The department may promulgate regulations as may be necessary or appropriate to implement this article.

Section 2707. Applicability.

This article shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Federal Government or the department, this article shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Federal Government or the department, this article shall apply to any policy issued or renewed on or after 180 days after the effective date of this section.

Section 3. The amendment of section 2116 of the act shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Federal Government or the Insurance Department, this section shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Federal Government or the Insurance Department, this section shall apply to any policy issued or renewed on or after 180 days

after the effective date of this section.

Amend Bill, page 3, line 25, by striking out "3" and inserting

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