

MODEL LANGUAGE FOR CHOICE OF HEALTH CARE PROFESSIONAL

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Section 1. Definitions.

- A. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- B. “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.
- C. “Group health plan” means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection J, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- D. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- (3) “Health benefit plan” does not include:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;

- (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- E. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: This definition applies to individual health professionals, not “corporate persons.”

- F. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- G. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person’s responsibility for copayments, coinsurance or deductibles.
- H. (1) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.
- (2) For purposes of this subsection, a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.
- I. “Managed care plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.
- J. “Medical care” means amounts paid for:
- (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

- (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
- (3) Insurance covering medical care referred to in paragraphs (1) and (2).
- K. “Network” means the group of participating health care professionals providing services to a managed care plan.
- L. “Participant” has the meaning given for such term under section 3(7) of ERISA.
- M. “Participating health care professional” means a health care professional who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.
- N. “Primary care health care professional” means a health care professional designated by a covered person to supervise, coordinate or provide initial care or continuing care to the covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.
- O. “Subscriber” means, in the case of an individual health insurance contract, the person in whose name the contract is issued.

Section 2. Applicability and Scope.

- A. Except as provided in subsection B, these sections apply to any health carrier providing coverage under an individual or group health benefit plan.
- B. (1) These sections do not apply to grandfathered plan coverage.
- (2) For purposes of this subsection, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

Section 3. Choice of Health Care Professional.

- A. (1) If a health carrier offering group or individual health insurance coverage requires or provides for the designation by a covered person of a participating primary health care professional, the health carrier shall permit each covered person to:
 - (a) Designate any participating primary care health care professional who is available to accept the covered person; and
 - (b) For a child, designate any participating physician who specializes in pediatrics as the child’s primary care health care professional and is available to accept the child.
- (2) The provisions of paragraph (1)(b) shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.
- B. (1) If a health carrier provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:
 - (a) Shall not require any person’s, including a primary care health care professional’s, prior authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and
 - (b) Shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to subparagraph (a) of this paragraph,

by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

- (2) (a) The health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier.
- (b) For purposes of paragraph (1)(a), a health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other than a physician, who is authorized under State law to provide obstetrical or gynecological care.
- (3) The provisions of paragraph (1)(a) shall not be construed to:
 - (a) Waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or
 - (b) Preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

Section 4. Notice Requirements

- A. A health carrier shall provide notice to covered persons of the terms and conditions of the plan related to the designation of a participating health care professional provided in section 3 and of a covered person's rights with respect to those provisions.
- B. (1) In the case of group health insurance coverage, the notice described in subsection A shall be included whenever the health carrier provides a participant with a summary plan description or other similar description of benefits under the health benefit plan.
- (2) In the case of individual health insurance coverage, the notice described in subsection A shall be included whenever the health carrier provides a primary subscriber with a policy, certificate or contract of health insurance.
- (3) A health carrier may use the model language in Appendix A to satisfy the requirements of this subsection.

Drafting Note: States that do not adopt Appendix A may instead provide a reference to 45 CFR § 147.138(a)(4)(iii) for the model language.

Appendix A - Choice of Health Care Professional Model Notice Language

- For health carriers that require or allow for the designation of primary care health care professionals by participants, beneficiaries or enrollees, insert:

[Name of health carrier] generally [requires/allows] the designation of a primary care health care professional. You have the right to designate any primary care health care professional who participates in our network and who is available to accept you or your family members. [If the health carrier designates a primary care health care professional automatically, insert: Until you make this designation, [name of health carrier] designates one for you.] For information on how to select a primary care health care professional, and for a list of participating primary care health care professionals, contact the [health carrier] at [insert contact information].

- For health carriers that require or allow for the designation of a primary care health care professional for a child, add:

For children, you may designate a pediatrician as the primary care health care professional.

- For health carriers that provide coverage for obstetric or gynecological care and require the designation by a participant, beneficiary or enrollee of a primary care health care professional, add:

You do not need prior authorization from [name of health carrier] or from any other person, including a primary care health care professional, in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [health carrier] at [insert contact information].