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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2507 Session of 1992

INTRODUCED BY LEE, CAWLEY, VROON, BUNT, GODSHALL, CESSAR, HERMAN, GANNON, TRELLO, S. H. SMITH AND RAYMOND, MARCH 17, 1992

REFERRED TO COMMITTEE ON INSURANCE, MARCH 17, 1992

AN ACT

Providing for State aid for medical insurance for needy individuals; establishing the Health Care Services Commission and conferring powers and duties upon it; conferring powers and duties upon the Insurance Department and the Department of Public Welfare; establishing the Health Insurance Fund and the Employer Health Incentive Fund and providing for their administration; and making a repeal.

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

Section 1. Short title.

This act shall be known and may be cited as the Equal Access to Health Services Act.

Section 2. Declaration of policy.

The General Assembly finds and declares as follows:

(1) Approximately 1,000,000 citizens of this Commonwealth have no health insurance or other coverage and lack the income and resources needed to obtain health services.

(2) Without health coverage, persons either go without treatment or eventually receive treatment through costly, inefficient, acute care.

(3) The Commonwealth's current medical assistance system results in privately insured patients subsidizing the treatment of medical assistance recipients, thereby driving up the cost of private health insurance and making it more and more difficult for medical assistance patients to find doctors who will treat them.

(4) The Commonwealth's current medical assistance system is structured so as to greatly inflate administrative costs and to inappropriately allocate the Commonwealth's limited

health care resources.

(5) It is the policy of this Commonwealth to guarantee basic health services for citizens near the poverty level and for high risk patients who are unable to secure affordable medical coverage in order to do all of the following:

(i) Provide access to health services for those in need.

(ii) Allocate existing health care resources in a fair, honest and equitable manner.

(iii) Reduce the cost of administering the medical assistance program.

(iv) Reduce or eliminate cost shifting.

(v) Promote the stability of the health service delivery system and the health, welfare and happiness of all the people of this Commonwealth.

Section 3. 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:

"Basic health policy." The Basic Health Services Insurance Policy established in section 10.

"Commission" The Health Services Commission established in section 4.

"Department." The Department of Public Welfare of the Commonwealth.

"Eligible claimant." An individual determined by the Department of Public Welfare under section 6 to be eligible for benefits under this act.

"Fund." The Health Insurance Fund established in section 9.

"Health services." Medical services currently being provided

to citizens of this Commonwealth. The term includes all of the following:

(1) Provider services and supplies.

(2) Outpatient services.

(3) Inpatient hospital services.

(4) Nursing home care.

(5) Home health care.

(6) Health promotion and disease prevention services.

"Incentive fund." The Employer Health Incentive Fund established in section 8.

"Income." As defined in section 303 of act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Independent actuary." The independent health insurance actuary hired by the Health Services Commission under section 4.

"Insured." An eligible claimant currently covered by a basic health policy.

"Insurer." An entity authorized to transact and transacting the business of health care or accident insurance in this Commonwealth.

"Listing." The Health Care Priority Listing under section 5.

"Policy." A policy of insurance issued by an insurer.

"Poverty level." The Poverty Level by Family Size of the United States Bureau of the Census.

Section 4. Commission.

(a) Establishment.--The Health Services Commission is established. The commission shall consist of 11 members appointed by the Governor with the consent of two-thirds of the members elected to the Senate:

(1) Four members must be physicians licensed to practice medicine in this Commonwealth who have clinical expertise in

the general areas of obstetrics, perinatal, pediatrics, adult medicine, geriatrics or public health.

(2) One member must be a public health nurse.

(3) One member must be a social services worker.

(4) Two members must be representatives of the health insurance industry.

(5) Two members must be consumers of health care.

(6) One member must be a certified public accountant.

(b) Term.--

(1) Members of the commission shall serve original terms as follows:

(i) Two members shall serve for two years.

(ii) Three members shall serve for three years.

(iii) Three members shall serve for four years.

(iv) Three members shall serve for five years.

(2) After the completion of the initial term under paragraph (1), each member of the commission shall serve for a term of four years.

(c) Compensation.--Members shall receive compensation for their services at rates set by the department and shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(d) Assistance.--The commission may establish subcommittees of its members and hire other medical, economic or health services advisers as necessary to assist the commission in the performance of its duties.

(e) Independent actuary.--The commission shall employ the services of an independent health insurance actuary in order to provide the report called for in section 5(d) and to determine the services to be included in each basic health services

insurance policy.

Section 5. Listing.

(a) Duty.--By the first Tuesday in January of each odd-numbered year, the commission shall report to the Governor and the General Assembly a list of health services ranked by priority, from the most worthy to the least worthy of State funding. This list shall be referred to as the Health Care Priority Listing.

(b) Criteria.--In considering the prioritization to be given to each health service, the commission shall determine which health services are of most benefit to citizens of this Commonwealth. The commission may take into consideration the cost of the service to be provided versus the benefit to be gained, as well as other factors necessary to ensure the most equitable, humane and fair method of distributing public health care resources. The commission may differentiate services according to the patient's likelihood of recovery and probable postrecovery physical and mental condition.

(c) Public input.--The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions. After determining the criteria to be utilized in determining the priority of health services, the commission shall conduct public hearings throughout this Commonwealth to obtain information regarding each of the health services to be prioritized. The commission shall solicit testimony and information from a broad range of interested parties, including advocates for seniors; handicapped persons; mental health services consumers; low-income citizens; and providers of health care, including physicians, dentists, oral

surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(d) Report.--The listing shall be accompanied by a report of the independent actuary determining the cost of health insurance necessary to cover each of the health services in the listing.

Section 6. Eligibility.

(a) Determination.--The department shall establish regulations to determine eligible claimants. The regulations shall ensure all of the following:

(1) The following individuals are eligible claimants:

(i) Individuals whose family income is equal to or less than 133% of the poverty level.

(ii) Individuals who cannot obtain insurance for less than an excessive percentage their income. For purposes of this subparagraph, the department shall establish, for all levels of income, a maximum percentage of income which is not excessive.

(2) Employees covered under their employer's health insurance plan shall not be eligible claimants.

(b) Projections.--The department shall furnish the commission with its projections regarding the number of claimants in each established eligibility category.

Section 7. Copayment formula.

The department shall establish regulations setting forth a copayment amount, which each eligible claimant shall be required to pay when purchasing health insurance. The regulations shall ensure all of the following:

(1) No eligible claimant's copayment percentage shall be so high that a fiscally prudent person could not afford to pay it.

(2) All eligible claimants shall be required to pay some percentage of their basic medical insurance policy cost.

(3) The copayment percentages shall be established on a sliding scale under which eligible claimants earning more money shall be required to pay a greater percentage of their basic health policy costs.

Section 8. Incentive fund.

(a) Establishment.--The Employer Health Incentive Fund is established. The source of the incentive fund shall be contributions from employers. The department shall promulgate regulations on contributions under the following guidelines:

(1) Employers shall only be required to contribute for employees whose income is less than 300% of the poverty level.

(2) The contribution rate shall be established as a percentage of wages for the employee for whom contribution is made.

(3) The contribution rate shall not be so high as to significantly discourage an employer from hiring an individual if the employer elects not to insure the individual. The contribution rate shall not exceed 3% of the wages of the employee for whom contribution is made.

(b) Tax credit.--The department shall promulgate regulations providing a tax credit from the incentive fund for employers who provide health insurance to their employees. The department shall follow the following criteria in promulgating regulations under this subsection:

(1) The tax credit shall be based upon a percentage of the actual expense of providing health insurance to the employee for whom the contribution under subsection (a) is

made.

(2) The tax credit shall only be offered to employers whose health insurance plans cover all the health services provided for in the basic health policy.

(3) The amount of the tax credits under this subsection should, to the greatest extent possible, equal the amount of the contributions under subsection (a). If the amount of tax credits under this subsection exceeds the contributions under subsection (a), the department may transfer money from the fund to the incentive fund. No money may be transferred from the incentive fund to the fund.

(c) Balancing.--In order to balance the incentive fund, regulations under subsections (a) and (b) shall provide for automatic changes in the contribution rate and the amount of tax credit if the incentive fund is in danger of depletion.

Section 9. Fund.

(a) Establishment.--The Health Insurance Fund is established. The fund is a separate fund in the General Fund.

(b) Source.--The source of the fund shall be annual appropriations. In order to safeguard against possible fund shortfalls, the department may direct the independent actuary to allow for a surplus beyond coverage of basic health policies in the report under section 5(d).

(c) Administration.--

(1) The department shall promulgate regulations to administer the fund.

(2) The purpose of the actuarial study under section 5(d) is to insure that the aggregate expenditures by the department for coverage of health services under this act shall not exceed the money appropriated to the fund. If the

fund is depleted and no supplemental appropriation is provided, the department may not make any payments under this act. If this paragraph applies, section 13(b) shall not apply.

(3) If the fund is depleted or in danger of depletion, the department may not set reimbursement limits for health services.

Section 10. Basic health policy.

(a) Establishment.--Within one month of the enactment of the general appropriation act, the independent actuary shall set forth the health services which will be covered by the Basic Health Services Insurance Policy. The independent actuary shall determine what services can be provided under the basic health policy by utilizing the following figures:

(1) The amount of money appropriated to the fund program under section 9.

(2) The copayment formula established under section 7.

(3) The anticipated number of eligible claimants supplied to the commission by the department.

(b) Criteria.--In determining the health services which will be covered by every basic health policy, the independent actuary shall include services in the order in which they are prioritized on the listing.

(c) Notice.--After determining the coverage to be provided under the basic health policy, the independent actuary shall notify the commission and the department of its findings. The department shall submit the findings to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(d) Subsequent legislation.--If, after publication of the

notice under subsection (b), the General Assembly appropriates additional money to the fund, the independent actuary will have 30 days from that date to determine what additional services can then be provided under the basic health policy.

Section 11. Insurers.

(a) General rule.--Insurers are encouraged to make available health insurance coverage identical to that in a basic health policy. However, nothing in this act shall be construed so as to require insurers to offer such coverage.

(b) Provisions.--It is the intent of this act to allow insurers some flexibility in fashioning basic health policies. Accordingly, the Insurance Department shall promulgate regulations setting forth provisions which shall be allowed in such policies, including deductibles, preferred providers and other cost saving provisions.

(c) Term.--The initial basic health policies shall begin after October 31, 1992. Except for special circumstances recognized in regulations of the Insurance Department, renewals of basic health policies shall be for one-year periods starting on November 1, 1993.

(d) Approval.--Before offering a basic health policy, an insurer must submit the policy to the Insurance Department for approval. If the Insurance Department approves the basic health policy or fails to disapprove it within 30 days of submittal, the basic health policy may be offered for sale to eligible claimants.

(e) Additional coverage.--Nothing in this act shall be construed to prohibit or discourage eligible claimants from purchasing, at their own expense, additional health insurance coverage beyond what is required to be in a basic health policy.

Section 12. Purchase of insurance.

(a) Application.--Upon application for a basic health policy by an eligible claimant, the insurer shall provide the eligible claimant with a copy of its policy.

(b) Department.--An eligible claimant shall submit the policy under subsection (a) to the department. The following shall apply:

(1) If the department determines the policy premium to be reasonable and determines the policy's coverages to be substantially similar to those required in a basic health policy, the difference between the policy premium and the eligible claimant's determined copayment shall be paid to the insurer from the fund.

(2) If the department determines the policy premium to be unreasonable or determines the policy's coverages to be not substantially similar to those required in a basic health policy, the department shall assist the eligible claimant in obtaining insurance coverage with an insurer company with which the Commonwealth contracts to provide basic health policies. The difference between the policy premium and the eligible claimant's determined copayment shall be paid to the insurer from the fund.

Section 13. Failure to insure.

(a) General rule.--If an eligible claimant who has not purchased insurance is in need of health services covered under a basic health policy, the department shall pay for the services from the fund.

(b) Recovery from eligible claimant.--If payment is made under subsection (a), the department shall take the following actions:

(1) Impose an administrative penalty upon the eligible claimant an amount equal to the lesser of:

(i) the amount of the eligible claimant's copayment had the eligible claimant purchased a basic health policy; or

(ii) the actual cost of the health services obtained.

(2) Require the eligible claimant to purchase a basic health policy. For a policy under this paragraph, the eligible claimant's copayment shall be 50% higher than that required by regulation under section 7. The department may seek, in the court of common pleas of the judicial district in which the eligible claimant resides, attachment of wages to effect the purchase under this paragraph. This paragraph shall not be extended to require renewals of the basic health policy. Upon purchase of a renewal of the basic health policy, the eligible claimant shall receive a credit toward the copayment required in an amount equal to the 50% addition to copayment under this paragraph.

Section 14. Employer obligations.

Employers with more than one employee who do not provide medical insurance shall contribute to the incentive fund and shall provide notice to their employees of all of the following:

(1) The existence of this act.

(2) The medical assistance available under this act and location of the nearest office of the department where additional information can be obtained.

(3) The possible financial penalties for failure to obtain health insurance under this act.

(4) Any employee group health insurance plan in which

the employee may be eligible to participate.

Section 15. Construction.

(a) Other acts.--Nothing in this act shall be construed to deny benefits to individuals provided for under any other statute.

(b) Competition.--Nothing in this act shall be construed to discourage or prohibit insurers from competing in the free marketplace to offer the lowest rates possible for basic health policies and other insurance.

Section 16. Immunity.

An insurer or health care provider shall not be subject to criminal or civil liability or professional disciplinary action for failing to provide a service which the General Assembly has not funded or has eliminated from its funding under this act.

Section 17. Applicability.

Any provision of this act which is dependent upon the department securing Federal approval shall not apply until that approval is secured.

Section 18. Repeal.

Subdivision (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, is repealed.

Section 19. Effective date.

This act shall take effect as follows:

(1) Sections 6(a), 7, 8, 9(c)(1) and 11(b) and this section shall take effect immediately.

(2) The remainder of this act shall take effect in 180 days.