PRINTER'S NO. 1859

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1247 Session of 2014

INTRODUCED BY VULAKOVICH, COSTA, VANCE, FONTANA, HUGHES, KASUNIC, SMITH, SOLOBAY AND WOZNIAK, MARCH 21, 2014

REFERRED TO BANKING AND INSURANCE, MARCH 21, 2014

AN ACT

Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An act relating to health care; prescribing the powers and duties of the Department of Health; establishing and providing the powers and duties of the State Health Coordinating Council, health systems agencies and Health Care Policy Board in the Department of Health, and State Health Facility Hearing Board in the Department of Justice; providing for certification of need of health care providers and prescribing penalties," in preliminary provisions, further providing for definitions; providing for organization and powers and duties of the Health Care Competition Oversight Board; in licensing of health care facilities, further providing for definitions, for licensure and for issuance of license and providing for confidentiality; and making editorial changes.

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

Section 1. Section 103 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, is amended by adding a definition to read:

Section 103. Definitions.

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

* * *

"Competition oversight board." The Health Care Competition Oversight Board.

* * *

Section 2. Chapter 3 heading of the act is amended to read:

CHAPTER 3

ORGANIZATION AND POWERS AND DUTIES OF THE

HEALTH CARE [POLICY] COMPETITION OVERSIGHT BOARD

Section 3. The act is amended by adding sections to read:

Section 301.1. Health Care Competition Oversight Board.

(a) The Health Care Competition Oversight Board is established. The membership of the competition oversight board shall be as follows:

(1) The Secretary of Health, who shall serve ex officio and act as cochair.

(2) The Insurance Commissioner, who shall serve ex officio and act as cochair.

(3) The Attorney General, who shall serve ex officio.

(4) Two physicians, one of whom shall be from a physician practice organization operating as part of an integrated delivery network.

(5) Three representatives of hospitals, one of whom shall be from a hospital operating as part of an integrated delivery network.

(6) One person with demonstrated expertise in health care delivery, health care management at a senior level or health care finance and administration, including payment methodologies.

(7) One representative of a Blue Cross or Blue Shield plan.

(8) Two representatives of commercial insurance carriers.

(9) One person with demonstrated expertise in health care consumer advocacy.

(10) One person with demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration.

(11) One representative of organized labor.

(12) One health care competition economist.

(b) Thirteen members of the competition oversight board listed under subsection (a) shall be appointed by the Governor and confirmed by a majority vote of the Senate. The Governor shall make all appointments to the competition oversight board within 90 days of the effective date of this section and the operations of the competition oversight board shall begin immediately upon confirmation of the members. The secretary and Insurance Commissioner shall convene the first meeting within 30 days after the confirmation of the members.

(c) The terms of the competition oversight board shall be as follows:

(1) Of the members first appointed, four shall be appointed for a term of one year, four for a term of two years and five for a term of three years. Thereafter, appointments shall be made for a term of three years.

(2) A vacancy during a term shall be filled for the unexpired term in the same manner as the predecessor was appointed.

(3) No appointed member shall serve more than two full consecutive terms of three years.

(d) A simple majority of the members of the competition

oversight board shall constitute a quorum for the transaction of any business. No member may act or attend through a designee or proxy.

(e) All meetings of the competition oversight board shall be subject to the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law." The competition oversight board shall meet at least four times a year and may convene additional meetings as may be necessary.

(f) The members of the competition oversight board shall not receive any compensation for serving as members of the board, but shall be reimbursed at rates established by the executive board for necessary expenses incurred in the performance of their duties.

Section 301.2. Powers and duties of competition oversight board.

The competition oversight board shall exercise all powers necessary and appropriate to carry out its duties, including the following:

(1) Monitor the reform of the health care delivery and payment system in this Commonwealth with respect to cost, quality and accessibility and how consumers are impacted.

(2) Examine the changes occurring to institutional and structural arrangements through which health care is financed and delivered and its impact on consumers.

(3) Examine the health care marketplace and the proper role of competition, antitrust and consumer protection laws and regulations and how they relate to the provision of high-quality, cost-effective health care.

(4) Determine the current status and role of competition in health care and how competition can be enhanced to

increase consumer welfare and protect patient access to necessary health care services.

(5) Survey all Federal and state laws pertinent to health care competition and determine how current laws and regulations work to foster existing and potential competition in health care and how these laws impact consumers.

(6) Make recommendations for modifications to existing laws or regulations or for the creation of new laws or regulations to achieve effective competition policy in this Commonwealth that at its core protects patient access to necessary health care services.

(7) Consult with the Federal Trade Commission and the Antitrust Division of the Department of Justice, as appropriate.

Section 301.3. Review of activities.

The department shall prepare and publish on an annual basis a report of the activities and recommendations of the competition oversight board. The department's report shall be submitted to the Public Health and Welfare Committee of the Senate, the Banking and Insurance Committee of the Senate, the Health Committee of the House of Representatives and the Insurance Committee of the House of Representatives.

Section 301.4. Study of health care competition.

(a) The Legislative Budget and Finance Committee, in consultation with health care experts and specialists, shall conduct a study relative to certain issues related to health care competition in this Commonwealth, which examines and identifies all of the following:

(1) The impact of hospital mergers on prices, costs, quality of care and competition.

(2) The impact of hospital-physician consolidation on prices, costs, quality of care and competition.

(3) The impact of health insurer consolidation on prices, costs, quality of care and competition.

(4) The correlation between health care price growth and market concentration, both hospital market concentration and health insurer market concentration.

(5) A retrospective examination of the impact of hospital mergers on prices paid to hospitals by health insurers.

(6) The relationship between hospital consolidation and quality.

(7) The relationship between hospital-physician consolidation and quality.

(8) An assessment of the hospital market concentration levels in this Commonwealth.

(9) An assessment of the health insurance market concentration levels in this Commonwealth.

(b) The Legislative Budget and Finance Committee shall make a written report of its findings and recommendations to the competition oversight board, the Public Health and Welfare Committee of the Senate, the Banking and Insurance Committee of the Senate, the Health Committee of the House of Representatives and the Insurance Committee of the House of Representatives within one year of the effective date of this section.

Section 301.5. Expiration.

Sections 301.1, 301.2, 301.3 and 301.4 shall expire June 30, 2017.

Section 4. Section 802.1 of the act is amended by adding definitions to read:

Section 802.1. Definitions.

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

* * *

"Default provider agreement." An agreement between a hospital that is part of an integrated delivery network and a willing health insurance carrier to provide health care services, which agreement is imposed upon the parties in the event that they fail to enter into a mutually agreeable contract.

* * *

"Health insurance carrier." An entity licensed in this Commonwealth to issue health insurance, subscriber contracts, certifications or plans that provide medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including section 630 and Article XXIV thereof, or any of the following:

(1) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(2) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."

(3) 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

* * *

"Integrated delivery network." One or more entities with

common ownership, operation or control, which include both of the following:

(1) One or more hospitals, one or more physician practices and/or one or more health care providers offering health care services.

(2) One or more entities operating as a health insurance carrier offering health insurance, administering health benefits, operating a health maintenance organization and/or offering other health care benefits and coverage to employers and/or individuals in this Commonwealth.

* * *

Section 5. Section 806 of the act is amended by adding a subsection to read:

Section 806. Licensure.

* * *

(j) Hospitals operating as part of an integrated delivery network.--

(1) In addition to complying with the standards and regulations promulgated under this section, hospitals operating as part of an integrated delivery network or any entity directly or indirectly owned, operated or controlled as part of these entities shall contract with any health insurance carrier that is willing to enter into a contract.

(2) When contracting with health insurance carriers, hospitals operating as part of an integrated delivery network shall be:

(i) prohibited from using contractual provisions and engaging in business practices that impede the availability of health care and that restrict access to facilities based solely on the type of insurance coverage

offered by a health insurance carrier;

(ii) prohibited from incorporating contractual provisions that limit or preclude the use of tiered networks by health insurance carriers;

(iii) prohibited from using any portion of the reimbursement rate to subsidize a health insurance carrier operating as part of the same integrated delivery network;

(iv) prohibited from incorporating a termination provision with a health insurance carrier for reasons other than a willful breach of contract; and

(v) permitted to contract for its services at reimbursement rates that are based upon sound actuarial data.

(3) Failure of any hospital operating as part of an integrated delivery network and a willing health insurance carrier to maintain a mutually agreeable contract shall result in the parties entering into a default provider agreement while they submit to mandatory binding arbitration. The default provider agreement shall set forth payment terms, while all other contractual terms of the previously executed contract shall remain in effect until the arbitration process is completed. The arbitrator shall set all terms of the new contract.

(4) Failure of any newly affiliated hospital with an existing integrated delivery network or failure of any hospital operating as part of a newly formed integrated delivery network and a willing health insurance carrier to enter into a mutually agreeable contract within 90 days of the affiliation or formation shall result in the parties

submitting to mandatory binding arbitration to establish a contract. The arbitrator shall set all terms of the new contract.

(5) A mutually agreeable arbitrator shall be chosen by the parties from the American Arbitration Association's National Healthcare Panel of arbitrators experienced in handling payor-provider disputes.

(6) All costs associated with the arbitration shall be split equally between the parties.

(7) The arbitrator shall conduct the arbitration pursuant to the American Arbitration Association's Healthcare Payor Provider Arbitration Rules.

(8) Contract terms and conditions shall be established as follows:

(i) Each party shall submit best and final contract terms to the arbitrator.

(ii) The arbitrator may request the production of documents, data and other information.

(iii) Payment terms and all other contractual provisions shall be set by the arbitrator.

(9) The default provider agreement shall remain in effect until the hospital operating as part of an integrated delivery network and a willing health insurance carrier complete the arbitration process.

(10) Payment terms under the default provider agreement will be set according to an amount equal to the greatest of the following three possible amounts:

(i) The amount the health insurance carrier negotiated with other in-network hospitals for the same service.

(ii) The amount calculated by the same method the health insurance carrier uses to determine payments for out-of-network services, such as the usual, customary and reasonable charge.

(iii) The amount that would be paid under Medicare for the same services.

(11) Copies of all contracts between hospitals operating as part of an integrated delivery network and all health insurance carriers shall be provided to the department and the Insurance Department.

Section 6. Section 808(a) of the act, amended December 22, 2011 (P.L.563, No.122), is amended and the section is amended by adding subsections to read:

Section 808. Issuance of license.

(a) Standards.--The department shall issue a license to a health care provider when it is satisfied that the following standards have been met:

(1) that the health care provider is a responsible person;

(2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered;

(3) that the health care facility provides safe and efficient services which are adequate for the care, treatment and comfort of the patients or residents of such facility;

(4) that there is substantial compliance with the rules and regulations adopted by the department pursuant to this act;

(5) that a certificate of need has been issued if one is necessary; [and]

(6) that, in the case of abortion facilities, such facility is in compliance with the requirements of 18 Pa.C.S. Ch. 32 (relating to abortion) and such regulations promulgated thereunder[.]; and

(7) that, in the case of a hospital operating as part of an integrated delivery network, such facility:

(i) has contracts with all willing health insurance carriers;

(ii) does not place restrictive covenants in its employment contracts that restrain any health care practitioner from engaging in his lawful profession; and

(iii) has submitted an attestation statement to the department and the Insurance Department certifying that no portion of any reimbursement rate with a health insurance carrier is subsidizing the health insurance carrier operating as part of the same integrated delivery network.

* * *

(d) Methodology records.--Every hospital submitting an attestation statement in accordance with this section must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its methodology for developing reimbursement rates for every health insurance carrier in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify that no portion of any reimbursement rate is subsidizing the health insurance carrier operating as part of the same integrated delivery network.

(e) Survey.--The department or any of its surveyors may

conduct a survey under this section of any hospital operating as part of an integrated delivery network as often as the secretary, in his sole discretion, deems appropriate.

(f) Survey expenses.--When conducting a survey under this section, the department may retain attorneys, independent actuaries, independent certified public accountants or other professionals and specialists as surveyors. All expenses incurred in and about the survey of any hospital, including compensation of department or Insurance Department employees assisting in the survey and any other professionals or specialists retained in accordance with this section shall be charged to and paid by the hospital surveyed in such a manner as the secretary shall by regulation provide.

Section 7. The act is amended by adding a section to read:

Section 902.2. Confidentiality.

(a) Received materials.--Any insurance contracts, documents, materials or information received by the department or Insurance Department from a hospital for the purpose of compliance with this act and any regulations developed pursuant to this act shall be confidential.

(b) Access.--The department may use the information under section 806 and any regulations developed pursuant to this act for the sole purpose of a licensure or corrective action against a health care facility.

(c) Right-to-know requests.--Any insurance contracts, documents, materials or information made confidential under this act shall not be subject to requests under the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

Section 8. This act shall take effect in 90 days.