PRINTER'S NO. 771

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 685 Session of 2007

INTRODUCED BY LENTZ, MELIO, SHAPIRO, SCAVELLO, BARRAR, BELFANTI, BISHOP, CALTAGIRONE, CAPPELLI, CURRY, GEORGE, GOODMAN, HENNESSEY, HORNAMAN, KING, KIRKLAND, KORTZ, LEACH, M. O'BRIEN, PALLONE, PAYTON, REICHLEY, SABATINA, McILVAINE SMITH, SOLOBAY, WALKO AND WHEATLEY, MARCH 9, 2007

REFERRED TO COMMITTEE ON INSURANCE, MARCH 9, 2007

AN ACT

Providing for fair medical bill payments to certain health care providers and institutions for care, treatments and services covered under health insurance policies.

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 Fair Reimbursement for Health Care Providers Act.

Section 2. Findings.

The General Assembly of the Commonwealth of Pennsylvania finds that:

(1) Many health care providers and institutions in this Commonwealth receive reimbursements even less than Medicare rates for services they provide for covered care.

(2) Health care providers and institutions are currently undercompensated for treatments and services properly covered under health insurance policies.

(3) Health care providers and institutions are currently required or asked to enter into reimbursement agreements with health care insurers that provide for inadequate reimbursement.

(4) The continuing low reimbursement rates to these providers threaten the health, safety and welfare of the citizens of this Commonwealth because health care providers and institutions may leave this Commonwealth or close down if the low reimbursements continue.

(5) Fair reimbursements must be established for health care providers and institutions for services provided to individuals for care, treatments and services covered under health insurance policies.

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:

"Health insurance policy." An individual or group health insurance policy, contract or plan that provides medical, mental, dental, optical, psychological or health care coverage by a health care facility or licensed health care provider on an expense incurred, service or prepaid basis offered by or is governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) The act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

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

(4) The act of May 18, 1976 (P.L.123, No.54), known as

the Individual Accident and Sickness Insurance Minimum Standards Act.

(5) A nonprofit corporation subject to 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

"Insurer." An entity that insures an individual or group health insurance policy, contract or plan described under a health insurance policy.

Section 4. Fair reimbursements for health care providers and institutions.

(a) Rates.--

(1) Subject to subsection (b), a health insurance policy that provides coverage to an individual and is effective, delivered, issued, executed or renewed in this Commonwealth on or after the effective date of this section shall provide payment to any health care provider or institution providing any care covered under a health insurance policy for all care including treatment, accommodation, products or services to a covered individual for treatments at a minimum, the lesser of:

(i) 110% of the applicable fee schedule, the recommended fee or the inflation index charts; or

(ii) 100% of the diagnostic-related groups (DRG) payment;

whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program and its regulations for comparable services at the time the services were rendered or at the provider's usual and customary charge.

(2) The fair payment under a health insurance policy for

all care including treatment, accommodation, products or services to a covered individual treatments rendered in this Commonwealth by a physician in one of the four highest rate classes of medical malpractice premiums shall be paid, at a minimum, the lesser of:

(i) 125% of the applicable fee schedule, the recommended fee or the inflation index charts; or

(ii) 125% of the diagnostic-related groups (DRG) payment;

whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services at the time the services were rendered, or the providers' usual and customary charge.

(b) Medicare allowance modifications.--

(1) The General Assembly finds that the reimbursement allowance applicable in this Commonwealth under the Medicare program is an appropriate basis to calculate payments for care including treatments, accommodations, products or services for care and treatment.

(2) Future changes or additions to the Medicare allowances shall apply to this section. If the Insurance Commissioner determines that an allowance under Medicare is not reasonable, the Insurance Commissioner may adopt a different allowance by regulation, which allowance shall be applied against a percentage limitation in this section.

(3) If a prevailing charge, fee schedule, recommended fee, inflation index charge or DRG payment is not being calculated under the Medicare program for a particular treatment, accommodation, product or service, the

reimbursement may not be less than 80% of the provider's usual and customary charge.

(4) If acute care is provided in an acute care facility to a patient with immediate life-threatening or urgent injury by a Level I or Level II trauma center, accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L.164, No.45), known as the Emergency Medical Services Act, or to a major burn injury patient by a burn facility which meets all of the service standards of the American Burn Association, the reimbursement may not be less than the usual or customary charge while the patient is still at an immediate life-threatening or urgent injury level.

Section 5. Direct billing to insureds prohibited.

No high risk provider or high risk institution subject to this act may:

(1) Bill an insured directly, but must bill the insurer for determination of the amount payable.

(2) If receiving fair payments under this act, bill or otherwise attempt to collect from an insured the difference between the provider's or institution's full charge and the fair amount paid by the insurer, unless required by a copayment under the health insurance policy.

Section 6. Repeals.

All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 7. Effective date.

This act shall take effect immediately.