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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2401 Session of 2012

INTRODUCED BY BOYD, AUMENT, CLYMER, CUTLER, EVERETT, HARHART, KILLION AND WATSON, MAY 21, 2012

REFERRED TO COMMITTEE ON INSURANCE, MAY 21, 2012

AN ACT

Establishing the Commonwealth Health Insurance Interchange.

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 Commonwealth Health Insurance Interchange Act (CHIIA).

Section 2. 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 care." A health insurance plan, available to individuals and small employers, as set forth in this act.

"Department." The Insurance Department of the Commonwealth.

"Health care payment." An amount established by the employer to contribute to the employee's health benefits.

"Health insurer." A company or health insurance entity licensed in this Commonwealth to issue any individual or group

health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or 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 December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

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

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Health plan." A plan, other than basic care, as provided for in this act. The term shall not include any of the following:

(1) An accident-only policy.

(2) A credit-only policy.

(3) A long-term care or disability income policy.

(4) A specified-disease policy.

(5) A Medicare supplemental policy.

(6) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplemental policy.

(7) A fixed-indemnity policy.

(8) A dental-only policy.

(9) A vision-only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

(12) A short-term medical insurance policy for an eligible individual who is temporarily without health insurance, such as an individual between jobs, a student or a new employee waiting for coverage to begin.

(13) Medical assistance.

(14) The Children's Health Insurance Program established under Article XXIII of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Act of 1921.

(15) Other limited benefit plans as recognized by the department as exempted from this act.

"Interchange." The Commonwealth Health Insurance Interchange Act (CHIIA).

"Licensed health insurance producer." An entity licensed under Article VI-A of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

"Medical service fee." An amount charged to the patient by a health care provider for services rendered.

"Rate band." A limit on the amount that insurers may vary premiums based on health status.

"Small employer." An employer that employed an average of not more than 50 employees during the preceding calendar year, as defined in section 301 of the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act, under the definition of "small group."

Section 3. Commonwealth Health Insurance Interchange Act.

(a) Establishment.--The Commonwealth Health Insurance Interchange (CHIIA) is established within the department.

(b) Function.--The interchange shall:

(1) Facilitate the purchase and sale of basic care as provided for in this act.

(2) Meet the requirements of this act and any regulations implemented under this act.

(c) Contracts.--The interchange may facilitate a contract with an eligible third party for any of its functions described in this act.

(d) Information.--The interchange shall enter into information-sharing agreements with Federal and State agencies to carry out its responsibilities under this act, provided that such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all Federal and State regulations.

Section 4. General requirements.

(a) Website.--The interchange shall maintain an Internet website through which individuals and small employers may do all of the following:

(1) Obtain information on basic care as provided for in this act.

(2) Do various premium comparisons of basic care in a particular zip code.

(3) Complete a preliminary application for enrollment in basic care.

(4) Provide for the purchase of basic care by the applicant.

(b) Updates.--The website shall be updated at least monthly.

(c) Contact information.--The interchange shall provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(d) Links for research.--The interchange shall provide links to health insurance companies so individuals and small employers may chose which company they want to research. This link shall

provide a health insurance company insurance producer locator by zip code so that the consumer using the interchange site is connected to a licensed health insurance producer who may sell, solicit and negotiate placement of basic care and other health care plans. Nothing in this section shall restrict a consumer from enrolling in the interchange through any health insurance company or a licensed health insurance producer that is authorized by the department to participate in the interchange or that is entitled to receive compensation from the health insurance company chosen to issue the policy.

(e) Other links.--The interchange shall provide linkage to other interactive Internet systems including portals providing access to medical assistance and the Children's Health Insurance Program eligibility. It shall also provide a link to department health insurance consumer educational materials and supply a form where eligible individuals and small employers may make an inquiry or register a complaint or concern.

(f) Applications.--The interchange shall develop a uniform application with health insurance companies for use by individuals and small employers.

(g) Expanded coverage.--Every licensed health insurance company may offer additional coverages to provide broader benefits. An individual or small employer shall be charged for any additional coverages added to basic care by endorsement.

(h) Changes in premiums.--A change in the premium shall only be effective for basic care on the annual renewal date for that policy or for new policies purchased after the effective date of the rate change period. Every insurer offering basic care shall develop a base rate for department approval; this base rate shall not be excessive, inadequate or unfairly discriminatory.

(i) Limits on increases and decreases.--A proposed rate band premium adjustment to the base rate for basic care shall increase no more than 20% or decrease no more than 15% from the current approved base rate. The insurer may not, without prior approval of the department, use rating characteristics when determining a rate band premium adjustment for basic care other than:

(1) Age of each applicant.

(2) Tobacco use.

(3) The geographic area/zip code for the applicant's residency.

(j) Preexisting condition.--

(1) A preexisting condition shall not be considered by the insurer when an eligible individual or small employer initially enrolls in or renews basic care coverage.

(2) However, if basic care lapses or is terminated, reenrollment in basic care shall consider preexisting conditions for rating purposes according to the rules of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

Section 5. Payments to employees for the purchase of basic care.

A small employer may, in lieu of providing health care coverage, provide an employee with a health care payment for the purpose of paying all or a portion of the basic care that is independently purchased by an employee. This payment shall not be considered compensation for the employee as defined under section 301 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

Section 6. Funding.

The General Assembly shall appropriate funds for startup costs to implement the interchange. Within 60 days of the effective date of this act, the department shall determine a cost estimate to administer the interchange.

Section 7. Basic care.

(a) Required offering.--An insurer licensed in this Commonwealth to sell health insurance and has at least 1% of the health insurance market Statewide shall offer basic care.

(b) Service fee.--All eligible benefits may be subject to a medical service fee. A medical service fee shall not exceed 10% of the health care provider's approved fee schedule, as provided for in section 8. The additional medical service fee shall be limited to $1,000 maximum per health care provider per calendar year and shall be paid to the provider rendering services.

(c) Benefits.--Basic care benefits include all of the following:

(1) Twenty-one days of inpatient surgical and medical coverage per policy year.

(2) Eight office visits for primary health care services.

(3) Surgery and anesthesia.

(4) Emergency accident and medical treatment.

(5) Diagnostic services up to $2,500 for each policy year.

(6) Chemotherapy and radiation treatment.

(7) Maternity care.

(8) Newborn care up to 31 days following birth.

(9) Prescription drugs as provided for in a formulary of commonly dispensed medications covered under basic care to be established by the department with assistance from the

Department of Health.

Section 8. Health care provider fee schedule.

(a) General fees.--Except as provided for in section 7(b), a health care provider or institution providing treatment, accommodations, products or services to a patient for a benefit covered by basic care shall not require, request or accept payment for treatment, accommodations, products or services in excess of any of the following:

(1) One hundred twenty percent of the prevailing charge at the 75th percentile.

(2) One hundred twenty percent of the applicable fee schedule, the recommended fee or the inflation index charge.

(3) One hundred twenty percent 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 provider's usual and customary charge, whichever is less.

(b) Calculating payments.--The reimbursement allowances applicable in this Commonwealth under the Medicare program are an appropriate basis for the department and health care insurers to calculate payment for treatments, accommodations, products or services.

(c) Subsequent fee schedules.--Future changes or additions to Medicare allowances are applicable under this section.

(d) Unreasonable fees.--If the department determines that an allowance under the Medicare program is not reasonable, the Insurance Commissioner may adopt a different allowance by regulation, which allowance shall be applied against the percentage limitation in this subsection.

(e) Other charges.--If a prevailing charge, fee schedule, recommended fee, inflation index charge or DRG payment has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed 80% of the provider's usual and customary charge.

(f) Emergency treatment.--If acute care is provided in an acute care facility to a patient with an immediately life-threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under 35 Pa.C.S. § 8107 (relating to Pennsylvania Trauma Systems Foundation) or to a major burn injury patient by a burn facility which meets all the service standards of the American Burn Association, the amount of payment may not exceed the usual and customary charge.

(g) Billing.--Providers subject to this section may not bill the insured directly but must bill the insurer for a determination of the amount payable.

Section 9. Advisory committee.

(a) Establishment.--An advisory committee is formed to assist in overseeing the provisions of this act.

(b) Members.--The advisory committee shall be comprised of the following members:

(1) The Insurance Commissioner or a department designee who will serve as chairperson.

(2) Two members of the Senate appointed by the President pro tempore, one of whom shall be a member of the minority party.

(3) Two members of the House of Representatives appointed by the Speaker, one of whom shall be a member of

the minority party.

(4) Two representatives of hospitals selected by the Governor from a list of five individuals supplied by an association whose membership consists primarily of hospitals.

(5) Two primary health care practitioners selected by the Governor from a list of five individuals supplied by an association whose membership consists of medical care practitioners.

(6) One individual appointed by the Governor and employed by a for-profit insurance carrier licensed to provide health insurance from a list supplied by an association whose membership consists of for-profit insurers.

(7) One individual employed by a nonprofit health insurer appointed by the Governor.

(8) Two members of the general public appointed by the Governor.

(9) Two insurance producers licensed to sell health insurance in this Commonwealth appointed by the Governor from a list of five individuals submitted by an association whose members consist of insurance producers licensed to sell health insurance.

(10) One actuary who is not an employee of this Commonwealth appointed by the department.

(c) Legislative terms.--Legislative members shall serve so long as they remain in office.

(d) Other terms.--All other members of the advisory committee shall serve for a two-year term, not to exceed two terms.

(e) Compensation.--No member of the advisory committee shall be eligible to receive financial reimbursement, except for

travel.

(f) Duties.--The advisory committee shall have the following responsibilities:

(1) Assist the Insurance Commissioner in preparing the interchange annual report as specified in subsection (g).

(2) Provide expertise to the Insurance Commissioner.

(3) Assist the department in reviewing the Internet website for accuracy and clarity in communication to individuals and small employers.

(g) Report.--A report shall be submitted to the General Assembly by March 1 of each calendar year, to include a summary of the previous year's interchange data.

Section 10. Effective date.

This act shall take effect in 180 days.