
THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 310 Session of
2019

INTRODUCED BY COSTA, FONTANA, FARNESE, L. WILLIAMS AND BROOKS,
FEBRUARY 26, 2019

REFERRED TO BANKING AND INSURANCE, FEBRUARY 26, 2019

AN ACT

1 Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An
2 act relating to health care; prescribing the powers and
3 duties of the Department of Health; establishing and
4 providing the powers and duties of the State Health
5 Coordinating Council, health systems agencies and Health Care
6 Policy Board in the Department of Health, and State Health
7 Facility Hearing Board in the Department of Justice;
8 providing for certification of need of health care providers
9 and prescribing penalties," in preliminary provisions,
10 further providing for definitions; providing for organization
11 and powers and duties of the Health Care Competition
12 Oversight Board; in licensing of health care facilities,
13 further providing for definitions, for licensure and for
14 issuance of license; in general provisions, repeals and
15 effective date, providing for confidentiality; and making
16 editorial changes.

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

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

22 Section 103. Definitions.

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

1 * * *

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

4 * * *

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

6 CHAPTER 3
7 ORGANIZATION AND POWERS AND DUTIES OF THE
8 HEALTH CARE [POLICY] COMPETITION OVERSIGHT BOARD

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

10 Section 301.1. Health Care Competition Oversight Board.

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

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

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

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

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

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

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

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

1 (8) Two representatives of commercial insurance
2 carriers.

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

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

8 (11) One representative of organized labor.

9 (12) One health care competition economist.

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

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

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

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

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

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

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

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

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

14 Section 301.2. Powers and duties of competition oversight
15 board.

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

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

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

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

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

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

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

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

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

15 Section 301.3. Review of activities.

16 The department shall prepare and publish on an annual basis a
17 report of the activities and recommendations of the competition
18 oversight board. The department's report shall be submitted to
19 the Health and Human Services Committee of the Senate, the
20 Banking and Insurance Committee of the Senate, the Health
21 Committee of the House of Representatives and the Insurance
22 Committee of the House of Representatives.

23 Section 301.4. Study of health care competition.

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

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

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

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

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

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

11 (6) The relationship between hospital consolidation and
12 quality.

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

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

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

19 (b) The Legislative Budget and Finance Committee shall make
20 a written report of its findings and recommendations to the
21 competition oversight board, the Health and Human Services
22 Committee of the Senate, the Banking and Insurance Committee of
23 the Senate, the Health Committee of the House of Representatives
24 and the Insurance Committee of the House of Representatives
25 within one year of the effective date of this section.

26 Section 301.5. Expiration.

27 Sections 301.1, 301.2, 301.3 and 301.4 shall expire November
28 30, 2022.

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

1 Section 802.1. Definitions.

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

5 * * *

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

12 * * *

13 "Health insurance carrier." An entity licensed in this
14 Commonwealth to issue health insurance, subscriber contracts,
15 certifications or plans that provide medical or health care
16 coverage by a health care facility or licensed health care
17 provider that is offered or governed under the act of May 17,
18 1921 (P.L.682, No.284), known as "The Insurance Company Law of
19 1921," including section 630 and Article XXIV thereof, or any of
20 the following:

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

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

26 (3) 40 Pa.C.S. Chs. 61 (relating to hospital plan
27 corporations) and 63 (relating to professional health
28 services plan corporations).

29 * * *

30 "Integrated delivery network." One or more entities with

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

3 (1) One or more hospitals, one or more physician
4 practices or one or more health care providers, or any
5 combination thereof, offering health care services.

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

11 * * *

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

14 Section 806. Licensure.

15 * * *

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

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

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

27 (i) prohibited from using contractual provisions and
28 engaging in business practices that impede the
29 availability of health care and that restrict access to
30 facilities based solely or in part on the type of

1 insurance coverage offered by a health insurance carrier;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Section 6. Section 808(a) of the act is amended and the
12 section is amended by adding subsections to read:

13 Section 808. Issuance of license.

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

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

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

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

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

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

30 (6) that, in the case of abortion facilities, such

1 facility is in compliance with the requirements of 18 Pa.C.S.
2 Ch. 32 (relating to abortion) and such regulations
3 promulgated thereunder[.]; and

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

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

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

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

17 * * *

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

29 (e) Survey.--The department or any of its surveyors may
30 conduct a survey under this section of any hospital operating as

1 part of an integrated delivery network as often as the
2 secretary, in the secretary's sole discretion, deems
3 appropriate.

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

14 Section 7. The act is amended by adding a section to read:
15 Section 902.2. Confidentiality.

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

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

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

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