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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2128 Session of 2018

INTRODUCED BY CHRISTIANA, MILLARD AND WARD, MARCH 9, 2018

REFERRED TO COMMITTEE ON HEALTH, MARCH 9, 2018

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 licensing of health care facilities, further providing for definitions, for licensure and for issuance of license; and, in general provisions, repeals and effective date, providing for confidentiality.

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

Section 1. Section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities 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 this act 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 that include both of the following:

(1) One or more hospitals, one or more physician practices 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 or

offering other health care benefits and coverage to employers or individuals in this Commonwealth.

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Section 2. Section 806 of the act is amended by adding a subsection to read:

Section 806. Licensure.

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(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 an 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 services at reimbursement rates that are based upon sound actuarial data.

(3) Failure of a 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 the terms of the new contract.

(4) Failure of a newly affiliated hospital with an existing integrated delivery network or failure of a 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 the 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) The 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 shall 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 the contracts between hospitals operating as part of an integrated delivery network and the health

insurance carriers shall be provided to the department and the Insurance Department.

Section 3. Section 808(a) of the act 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, the facility:

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

(ii) does not place restrictive covenants in its

employment contracts that restrain a 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 a 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.--A hospital submitting an attestation statement in accordance with this section must keep the books, records, accounts, papers, documents and computer or other recordings relating to its methodology for developing reimbursement rates for every health insurance carrier in the manner and for the time periods that the department, in its discretion, may require in order that its authorized representatives may readily verify that no portion of a 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 a 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. The expenses incurred in and about the survey of a 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 the manner provided the secretary by regulation.

Section 4. The act is amended by adding a section to read:

Section 902.2. Confidentiality.

(a) Received materials.--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 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.--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 5. This act shall take effect in 90 days.