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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2215 Session of 2024

INTRODUCED BY MALAGARI, ORTITAY, HILL-EVANS, SANCHEZ, MUNROE, GUENST, KHAN, FREEMAN, DALEY, KINSEY, KENYATTA, GIRAL AND CURRY, APRIL 15, 2024

REFERRED TO COMMITTEE ON INSURANCE, APRIL 15, 2024

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, in regulation of insurers and related persons generally, providing for nondiscrimination by payers in health care benefit plans.

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

Section 1. Title 40 of the Pennsylvania Consolidated Statutes is amended by adding a chapter to read:

CHAPTER 46

NONDISCRIMINATION BY PAYERS

IN HEALTH CARE BENEFIT PLANS

Sec.

§ 4601. Definitions.

The following words and phrases when used in this chapter

shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Ambulatory surgical facility." The term shall have the same meaning as defined under section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Arbitrator." An independent and impartial third party accredited by a national or international organization that specializes in dispute management with subject matter expertise in health care.

"Baseball-style arbitration." A method by which an arbitrator selects either the figure submitted by the health care benefit plan or the figure submitted by the out-of-network facility.

"CPT." The Current Procedural Terminology 2024 code set as published by the American Medical Association.

"DRG." The Diagnosis Related Group classification system that uses patient discharge information to classify patients into clinically meaningful groups.

"Facility." A physician-owned hospital or physician-owned ambulatory surgical facility.

"Health care benefit plan." An insurance policy, contract or plan that provides health care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

"Health care payer." An individual or entity that is responsible for providing or paying for all or part of the cost of health care services covered by a health care benefit plan. The term includes, but is not limited to, an entity subject to at least one of the following:

(1) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan

corporations).

(2) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including either of the following:

(i) A preferred provider organization subject to section 630 of The Insurance Company Law of 1921.

(ii) A fraternal benefit society subject to Article XXIV of The Insurance Company Law of 1921.

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

(4) An agreement by a self-insured employer or self-insured multiple employer trust to provide health care benefits to employees and the employees' dependents.

"Highest in-network rate." The highest rate for a service or fee that is determined by identifying the contracted rates of all plans of a health care payer or administering entity, if applicable, or all coverage offered by the health care payer in the same individual marketplace rating area as defined by the department for the same or similar item or service that is provided by a facility in the same or similar specialty or facility type and provided in the geographic region in which the item or service is furnished.

"Hospital." The term shall have the same meaning as defined under section 802.1 of the Health Care Facilities Act.

"Out-of-network facility." A facility that has not contracted with a health care payer to provide health care services to insureds covered by a health care payer.

§ 4602. Discrimination against willing facility prohibited.

(a) General rule.--A health care payer shall reimburse a willing facility of health care services. A health care payer

shall not discriminate against a facility delivering health care services who:

(1) Agrees to accept either the health care payer's highest in-network rate or a baseball-style arbitration and obtains and maintains Center for Medicare and Medicaid Services accreditation status.

(2) Can perform the procedure at an earlier date than the nearest in-network facility.

(3) Meets at least one of the following quality metrics:

(i) A hospital facility achieves a Hospital Consumer Assessment of Healthcare Providers and Systems, or successor rating system, patient satisfaction survey rating of at least four stars.

(ii) An ambulatory surgical facility achieves an Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems, or successor rating system, patient satisfaction survey rating of at least four stars.

(4) Is owned, at least in part, by physicians practicing at the out-of-network facility and who are in-network with the health care payer.

(b) Arbitrator selection.--In determining whether the arbitrator shall select the amount submitted by the health care payer or the out-of-network facility for the health care service rendered at an out-of-network facility, the arbitrator shall select either the health care payer's or the facility's best and final proposal for a payment amount without change based on which of the amounts is most consistent with the criteria specified under subsection (c).

(c) Criteria.--The determination of the arbitrator in

selecting either the health care payer's or out-of-network facility's payment amount shall be based exclusively on the following:

(1) Whether there is a gross disparity between the out-of-network facility's proposal for a reasonable payment amount for the health care service or CPT or DRG code in dispute as compared to the payment received by the out-of-network facility for the same health care service, CPT or DRG code from other health care payers in which the out-of-network facility is under contract.

(2) Whether there is a gross disparity in the amount proposed by the health care payer to the out-of-network facility as compared to the amount paid by the health care payer to the out-of-network facility as compared to the amount paid to the other facilities in the same specialty for the same health care service or CPT or DRG code and in the same geographic area that is under contract with the health care payer.

(3) The level of training, education, experience, quality and outcome measurements of the out-of-network facility.

(4) Other relevant economic aspects of the health care payer and the out-of-network facility payments as adduced by either party in arbitration.

(5) The circumstances and complexity of the particular case, including the patient's medical history and the time and cost of the health care service.

(6) Any final judgment of an award rendered by the arbitrator between the health care payer and the out-of-network facility for the same health care service, CPT or DRG

code within the prior year.

(d) Bundling.--The parties in arbitration may bundle a single health care service type, CPT or DRG code in multiple cases between the same health care payer and the out-of-network facility.

(e) Fees.--The arbitration fees shall be paid by the losing party in the arbitration dispute, except if the arbitration dispute is resolved as a result of a negotiation between the parties after the initiation of the arbitration process, and the arbitration fees shall be shared equally by the parties.

§ 4603. Applicability.

(a) Construction.--This chapter shall not be construed to prohibit a health care payer from negotiating and paying rates higher than the health care payer's standard payment levels to one or more facilities.

(b) Application.--This chapter:

(1) Shall apply to health care benefit plans that compensate facilities on a fee-for-service basis, per diem or other nonrisk basis.

(2) May not apply to health care benefit plans regarding products that compensate facilities on a capitated basis or under which facilities accept significant financial risk in a formal arrangement approved by Federal or State authorities.

§ 4604. Retaliation prohibited.

It shall be unlawful for a health care payer to terminate, threaten or otherwise retaliate against an in-network physician with ownership of an out-of-network facility for exercising rights under this chapter.

Section 2. This act shall take effect in 60 days.