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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 913 Session of 2017

INTRODUCED BY WARD, VULAKOVICH, BROWNE, YAW, STEFANO, KILLION AND MENSCH, OCTOBER 5, 2017

REFERRED TO BANKING AND INSURANCE, OCTOBER 5, 2017

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," in casualty insurance, providing
12 for prescription drug coverage; and providing for
13 Pennsylvania Health Care Payor Claims Database.

14 The General Assembly of the Commonwealth of Pennsylvania
15 hereby enacts as follows:
16 Section 1. The act of May 17, 1921 (P.L.682, No.284), known
17 as The Insurance Company Law of 1921, is amended by adding a
18 section to read:
19 Section 631.2. Prescription Drug Coverage.--(a) Whenever a
20 health insurance policy provides coverage for prescription drugs
21 which have been approved by the United States Food and Drug
22 Administration for general use, the policy shall not impose cost
23 sharing for a prescribed drug that exceeds the average of all

rebates and discounts negotiated among a health insurer, pharmacy benefit manager and drug manufacturer. To ensure compliance with this subsection, a health insurer shall report the aggregate amount of rebates which the health insurer has received from pharmacy benefit managers or drug manufacturers for the preceding calendar year in the health insurer's annual statement filed with the department.

(b) A health insurance policy that provides prescription drug benefits through a pharmacy benefit manager may not authorize any of the following actions:

(1) Requiring cost sharing for a covered prescription drug or device that exceeds the retail price of the drug or device.

(2) Requiring a copayment for a thirty-day supply of a covered drug that exceeds one-twelfth of the policy's annual out-of-pocket spending limit.

(3) Prohibiting a pharmacist or pharmacy from providing an insured individual information on the amount of the insured's cost share for the insured's prescription drug and compared to the current cash price. A pharmacy benefits manager may not penalize a pharmacy or a pharmacist for disclosing this information to an insured.

(4) Charging or collecting from an insured individual a copayment that exceeds the total submitted charges by the network pharmacy for which the pharmacy is paid.

(5) Charging or holding a pharmacist or pharmacy responsible for a fee relating to the adjudication of a claim.

(6) Recouping funds from a pharmacy in connection with claims for which the pharmacy has already been paid, unless the recoupment is otherwise permitted or required by law.

(7) Penalizing or retaliating against a pharmacist or

1 pharmacy for exercising rights.
2 (c) This section shall apply to those health insurance
3 policies issued or entered into or renewed on or after the
4 effective date of this section.
5 (d) As used in this section:
6 "Cost sharing" means the cost to an individual insured under
7 a health insurance policy according to a coverage limit,
8 copayment, coinsurance, deductible or other out-of-pocket
9 expense requirements imposed by the policy, contract or
10 agreement.
11 "Department" means the Insurance Department of the
12 Commonwealth.
13 "Health insurance policy" means:
14 (1) An individual or group health, sickness or accident
15 policy, or subscriber contract or certificate offered, issued or
16 renewed by an entity subject to one of the following:
17 (i) This act.
18 (ii) The act of December 29, 1972 (P.L.1701, No.364), known
19 as the "Health Maintenance Organization Act."
20 (iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan
21 corporations).
22 (iv) 40 Pa.C.S. Ch. 63 (relating to professional health
23 services plan corporations).
24 (2) The term does not include accident only, fixed
25 indemnity, limited benefit, credit, dental, vision, specified
26 disease, Medicare supplement, Civilian Health and Medical
27 Program of the Uniformed Services (CHAMPUS) supplement, long-
28 term care or disability income, workers' compensation or
29 automobile medical payment insurance.
30 Section 2. The act is amended by adding an article to read:

1 ARTICLE XXII

2 PENNSYLVANIA HEALTH CARE PAYOR CLAIMS DATABASE

3 Section 2201. Scope of article.

4 This article relates to the Pennsylvania Health Care Payor

5 Claims Database.

6 Section 2202. Legislative intent and purpose.

7 (a) Legislative intent.--The General Assembly finds that:

8 (1) The establishment of effective health care data

9 analysis and reporting initiatives is essential to improving

10 the quality and cost efficiency of health care, fostering

11 competition among health care providers and insurers and

12 increasing consumer choice regarding health care services in

13 this Commonwealth.

14 (2) Accurate and valuable health care data can best be

15 shown through actual claims paid by health care payors.

16 (b) Purpose.--To fulfill the legislative intent under

17 subsection (a), the department, in conjunction with the

18 Pennsylvania Health Care Cost Containment Council, shall

19 administer the health care data reporting initiatives

20 established under this article.

21 Section 2203. Definitions.

22 The following words and phrases when used in this article

23 shall have the meanings given to them in this section unless the

24 context clearly indicates otherwise:

25 "Department." The Insurance Department of the Commonwealth.

26 "Health care insurer." As follows:

27 (1) A person, corporation or other entity that offers

28 administrative, indemnity or payment services for health care

29 in exchange for a premium or service charge under a program

30 of health care benefits, including, but not limited to, any

of the following:

(i) An insurance company, association or exchange issuing health insurance policies in this Commonwealth governed by this act.

(ii) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(iii) A professional health service corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(iv) A health maintenance organization governed by the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(v) A third-party administrator governed by Article X of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

(2) The term does not include employers, labor unions or health and welfare funds jointly or separately administered by employers or labor unions that purchase or self-fund a program of health care benefits for their employees or members and their dependents.

"Payor." A person or an entity, including, but not limited to, health care insurers and purchasers, that make direct payments to providers for covered services.

"Purchaser." As follows:

(1) Any of the following:

(i) A corporation, a labor organization or another entity that purchases benefits which provide covered services for its employees or members, either through a health care insurer or by means of a self-funded program of benefits.

(ii) A certified bargaining representative that represents a group or groups of employees for whom an employer purchases a program of benefits which provides covered services.

(2) The term does not include a health care insurer.

Section 2204. Database.

(a) Establishment.--The Pennsylvania Health Care Payor Claims Database is established to:

(1) facilitate data driven, evidence-based improvements in access, quality and cost of health care; and

(2) promote and improve health through the understanding of health care expenditure patterns and operation and performance of the health care system.

(b) Collection of data.--In coordination with the Pennsylvania Health Care Cost Containment Council, the department shall collect paid claims data for covered benefits pursuant to a health care payor claims data submission manual as described in subsection (c).

(c) Manual.--The following shall apply regarding a health care payor claims data submission manual:

(1) The manual shall define the data elements needed to establish and maintain a health care payor claims database for all claims paid on behalf of patients receiving health care in this Commonwealth.

(2) A health care payor shall comply with the manual to submit data.

(3) The manual shall use and build upon existing data collection standards and methods.

(4) For each claim, including each medical, dental and pharmacy claim, the manual shall include, but not be limited

to, the following data elements identified in the manual to further the intent of this article:

(i) Additional patient and provider identifiers.

(ii) Patient demographic information.

(iii) Data necessary to identify the date and time of service and the location and type of provider and facility, such as a hospital, office or clinic.

(iv) Data describing the nature of health care services provided to the patient, including diagnosis codes.

(v) Other data relating to health care costs, prices and utilization.

(d) Reporting.--

(1) The Health Care Cost Containment Council may not require a health care insurer to report on data elements that are not reported to nationally recognized accrediting organizations or in quarterly or annual reports submitted to the department, the Department of Health or the Department of Human Services.

(2) The department may not require reporting by health care insurers in different formats than are required for reporting to nationally recognized accrediting organizations or in quarterly or annual reports submitted to the department, the Department of Health or the Department of Human Services.

(3) The department may adopt the quality findings as reported to nationally recognized accrediting organizations. Additional quality data elements must be defined and released for public comment prior to use.

(e) Availability of data.--Nothing in this article shall

prohibit a purchaser from obtaining from its health care insurer, nor relieve the health care insurer from the obligation of providing to the purchaser, on terms consistent with past practices, data previously provided or additional data not currently provided to the purchaser by the health care insurer pursuant to an existing or a future arrangement, agreement or understanding.

Section 2205. Special studies and reports.

A Commonwealth agency, the Senate or the House of Representatives may direct the department to publish, or contract for publication, a special study, including, but not limited to, a special study on diseases and the cost of health care related to particular diseases in this Commonwealth. A special study published under this subsection shall become a public document.

Section 2206. Enforcement and penalty.

(a) Compliance enforcement.--The department shall have standing to bring an action in law or equity to enforce compliance with any provision of this article or any requirement or appropriate request of the department made under this article. The Attorney General shall bring an enforcement action in aid of the department in a court of common pleas at the request of the department and in the name of the Commonwealth.

(b) Penalty.--

(1) A person who fails to supply data under this article may be assessed a civil penalty not to exceed $1,000 for each day the data is not submitted.

(2) A person who knowingly submits inaccurate data under this article commits a misdemeanor of the third degree and shall, upon conviction, be sentenced to pay a fine of $1,000

1 or to imprisonment for not more than one year, or both.

2 Section 3. This act shall take effect in 60 days.