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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1638 Session of 2017

INTRODUCED BY ORTITAY, GROVE, A. HARRIS, PHILLIPS-HILL, KAUFFMAN, MENTZER, RADER, WHEELAND AND ZIMMERMAN, JUNE 29, 2017

REFERRED TO COMMITTEE ON HEALTH, JUNE 29, 2017

AN ACT

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," providing for patient-centered health care reform; and establishing the Keystone Care Fund.

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

Section 1. The act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code, is amended by adding an article to read:

ARTICLE IV-A

PATIENT-CENTERED HEALTH CARE REFORM

Section 401-A. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Account." The enrollee's personal responsibility and wellness account established under section 406-A.

"CHIP." The children's health care program under Article

XXIII-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Enrollee." An individual enrolled in the plan.

"Fund." The Keystone Care Fund established under section 415-A.

"Medicaid." The Federal program established under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

"Medicare." The Federal program established under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

"Plan." The Keystone Care Plan established under section 402-A to administer Medicaid programs.

"Preventive care services." Care that is provided to an individual to prevent disease, diagnose disease or promote good health.

Section 402-A. Establishment of plan.

(a) Waiver application.--Upon the effective date of this article, the secretary shall apply to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services for a waiver under section 1315 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1315) to establish the plan, to be known as the Keystone Care Plan.

(b) Purpose.--The plan shall focus on achieving the following goals:

(1) Improving health care outcomes for enrollees.

(2) Providing greater accountability and flexibility for enrollees regarding medical decisions.

(3) Providing incentives for enrollees to use preventive care services to improve health outcomes and curtail the use

of more costly medical treatment and procedures that become necessary in the absence of preventive care services.

(c) Standards and costs.--Following the grant of the waiver application under subsection (a) and implementation of the plan, the secretary shall ensure that:

(1) the plan meets the goals under subsection (b); and

(2) the total cost of administering the plan does not exceed the cost of administering the State plan under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) which was in effect prior to the plan for each of the immediately prior two fiscal years.

Section 403-A. Administration of plan.

(a) Coordination.--For the purpose of administering the plan, the department shall coordinate with the Insurance Department to provide oversight of the marketing practices of the plan.

(b) Promotion.--The department shall promote the plan and provide information to potential enrollees who live in medically underserved areas of this Commonwealth.

(c) Enrollment distribution.--To the extent possible, the department shall ensure that enrollment in the plan is distributed throughout this Commonwealth in proportion to the number of individuals who are eligible for participation in the plan.

(d) Standards.--The department shall establish standards for consumer protection regarding the plan, including, but not limited to, the following:

(1) Standards to ensure quality of care.

(2) A uniform process for enrollee grievances and appeals.

(3) Standardized reporting concerning provider performance, consumer experiences and costs.

(e) Participation.--A health care provider that provides care to an individual who received health insurance coverage under the State plan under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) which was in effect prior to the plan shall participate in the plan.

(f) Referrals.--The department may refer an individual to the Insurance Department for information regarding insurance coverage and other insurance services if the individual:

(1) has applied for health insurance coverage under the plan; and

(2) is at high risk of chronic disease.

Section 404-A. Applicability.

The following do not apply to the plan:

(1) Section 403.1.

(2) Section 436.

(3) Section 443.1.

(4) Section 443.2.

(5) Section 454.

(6) Section 455.

(7) Section 456.

(8) Section 457.

(9) Section 458.

(10) Section 460.

(11) Section 460.1.

(12) Article VIII-I.

Section 405-A. Coverage under plan.

(a) Options set by department.--To the extent that the department determines, the plan shall provide enrollees options

for the following:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management services.

(9) Home health services, including case management services.

(10) Urgent care center services.

(11) Preventive care services.

(12) Family planning services which:

(i) shall include contraceptives and sexually transmitted disease testing under Medicaid; and

(ii) shall not include abortion services or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(b) Components.--The plan shall:

(1) Offer coverage for dental services and vision services to enrollees. The following apply:

(i) Vision services offered by the plan must include services provided by an optometrist.

(ii) The plan shall pay at least 50% of the premium cost of coverage for dental services and vision services.

(iii) An enrollee who receives coverage for dental services and vision services shall pay an amount determined by the department for the coverage. The amount

shall not be less than 1% nor more than 5% of the enrollee's annual household income.

(iv) Payment required under this subsection shall be in addition to the payment required under the plan into the account.

(2) Comply with coverage requirements that apply to an accident and health insurance policy issued in this Commonwealth.

(3) Not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

Section 406-A. Personal responsibility and wellness account.

(a) Establishment.--As part of the enrollment in the plan, an enrollee shall establish an account, to be known as a personal responsibility and wellness account, into which money may be deposited for the enrollee's expenses under the plan.

(b) Source of deposits.--Deposits into an account on behalf of an enrollee shall only be made by the following:

(1) The enrollee.

(2) An employer of the enrollee.

(3) The Commonwealth.

(c) Minimum funding amount.--The minimum funding amount for an account shall be as specified under section 407-A.

(d) Purpose.--An account shall be used to pay the enrollee's deductibles for health care services provided under the plan.

(e) Deposit procedure.--A person under subsection (b) may make deposits into an account as follows:

(1) At the request of an enrollee, an enrollee's

employer shall withhold or cause to be withheld from the enrollee's wages or salary, after taxes are deducted from the wages or salary, contributions to the account, which shall be distributed equally throughout the calendar year. Submission of the enrollee's contributions to the account shall be made through the department, which shall immediately deposit the money in the account or otherwise credit the account and provide the enrollee with notification of the deposit or credit.

(2) An enrollee may submit a contribution to the account through the department, which shall immediately deposit the money into the account or otherwise credit the account and provide the enrollee with notification of the deposit or credit.

(3) As determined by the department.

(f) Employer payments.--An enrollee's employer may make required payments to an account from funds not payable by the employer to the enrollee. The amount of the payments shall not exceed 50% of the enrollee's required payment to the account.

Section 407-A. Contributions into account.

(a) Commencement.--An individual becomes an enrollee upon an initial payment into the account.

(b) Limitation.--An enrollee's required payment to the plan may not exceed 1/12 of the annual payment required under this section.

(c) Application.--To participate in the plan, an individual shall apply for the plan on a form prescribed by the department. The department may develop and allow a joint application for a household.

(d) Amounts.--Following approval by the department for an

individual to participate in the plan, the individual as enrollee shall contribute into the account the lesser of the following as determined by the department:

(1) One thousand one hundred dollars per year, less any amounts paid by the enrollee under Medicaid, Medicare or CHIP. The Commonwealth shall contribute to the account the difference between the amount paid by the enrollee and $1,100 if the enrollee's payment is less than $1,100 per year.

(2) Not more than the following applicable percentage of the enrollee's annual household income per year, less any amounts paid by the enrollee under Medicaid, Medicare or CHIP as determined by the department:

(i) two percent of the enrollee's annual household income per year if the enrollee's annual household income is at or below 100% of the Federal poverty limit;

(ii) three percent of the enrollee's annual household income per year if the enrollee's annual household income is above 100% of the Federal poverty level and is at or below 125% of the Federal poverty limit;

(iii) four percent of the enrollee's annual household income per year if the enrollee's annual household income is above 125% of the Federal poverty level and is at or below 150% of the Federal poverty limit; or

(iv) five percent of the enrollee's annual household income per year if the enrollee's annual household income is above 150% of the Federal poverty limit and is at or below 200% of the Federal poverty limit.

(e) Termination for nonpayment.--If an enrollee's required

payment to the account is not made within 60 days after the required payment date, the enrollee may be terminated from participation in the plan. The following shall apply:

(1) The enrollee must receive written notice before being terminated from the plan.

(2) After an individual is terminated from the plan, the individual may not reapply to participate in the plan for 12 months.

Section 408-A. Incentives for using preventive services.

(a) List of health care services.--The department shall provide to each enrollee a list of health care services that qualify as preventive care services for the age, gender and preexisting conditions of the enrollee. The department shall consult with the Centers for Disease Control and Prevention for a list of recommended preventive care services.

(b) Amount.--At no cost to an enrollee, the plan shall provide payment for not more than $500 of qualifying preventive care services per year for the enrollee. Additional preventive care services covered under the plan and received by the enrollee during the year shall be subject to the deductible and payment requirements of the plan.

Section 409-A. Coverage limitations.

The plan shall have the following per enrollee coverage limitations:

(1) An annual individual maximum coverage limitation of $300,000.

(2) A lifetime individual maximum coverage limitation of $1,000,000.

Section 410-A. Funding requirements for plan.

(a) Limitations.--The following requirements shall apply to

money appropriated by the General Assembly for the plan:

(1) At least 85% of the appropriated money shall be used for payments regarding health care services.

(2) The secretary shall determine the amount necessary for the following:

(i) Administrative costs associated with implementing this article.

(ii) Profits due to an insurer or a health maintenance organization under a contract with the department to provide health insurance coverage under the plan. The amount determined under this subparagraph shall not exceed 15% of the appropriated money.

(b) Status of plan.--Nothing in this article shall be construed to classify the plan as an entitlement program. The maximum enrollment of enrollees shall be dependent on money appropriated for the plan.

Section 411-A. Eligibility for enrollment in plan.

(a) Eligible individuals.--Subject to subsection (c), an individual is eligible to become an enrollee if the individual:

(1) is 18 years of age or older but less than 65 years of age;

(2) is a citizen of the United States;

(3) has resided in this Commonwealth for at least 12 months;

(4) has an annual household income of less than 200% of the Federal poverty limit;

(5) is not eligible for health insurance coverage through the individual's employer; and

(6) has not had health insurance coverage for at least six months.

(b) Ineligible individuals.--An individual is not eligible to become an enrollee if the individual:

(1) participates in Medicare; or

(2) is eligible for Medicaid as a person with a disability.

(c) Approval by Federal Government.--The eligibility requirements under subsection (a) are subject to approval for Federal financial participation by the United States Department of Health and Human Services as part of the waiver under section 1315 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1315 et seq.).

(d) Eligibility period.--

(1) An individual who is approved as an enrollee shall be eligible for a 12-month plan period.

(2) An enrollee may not be refused renewal to participate in the plan based solely on the reason that the plan has reached the plan's maximum enrollment.

(e) Renewal.--If an enrollee chooses to renew participation in the plan, the enrollee shall complete a renewal application and any necessary documentation and submit the application and documentation to the department on a form prescribed by the department.

(f) Nonrenewal.--If an enrollee chooses not to renew participation in the plan, the enrollee may allow the enrollment to lapse but may not reapply to participate in the plan for at least 12 months after the date that the enrollee's participation has lapsed.

Section 412-A. Money in account.

(a) Money in account upon renewal.--If an enrollee renews participation in the plan at the end of the enrollee's 12-month

period, money remaining in the account shall remain in the account and count against the enrollee's payments for the subsequent plan period. If, during the plan period, the enrollee did not receive all qualified preventive services recommended under this article, the State's contribution to the account may not be used to reduce the enrollee's payments for the subsequent plan period.

(b) Refund.--If an enrollee does not renew participation in the plan, is no longer eligible for the plan or is terminated from the plan for nonpayment of a required payment, the department shall, not more than 60 days after the last date of the enrollee's participation in the plan, refund to the enrollee the amount of money remaining in the account as determined by the department and subject to the following:

(1) For an enrollee who does not renew participation or who is no longer eligible for the plan, the refund to the enrollee shall be the amount of money in the account personally deposited by the enrollee divided by the amount of money in the account deposited from all other sources, with that quotient then multiplied by the total amount of money remaining in the account.

(2) For an enrollee who was terminated from the plan for nonpayment of a required payment, the refund to the enrollee shall be the amount determined under paragraph (1) multiplied by 0.75.

Section 413-A. Use of emergency services for nonemergency care.

(a) General rule.--Except as provided in subsection (b) and to the appeal procedures to the department, an enrollee may be held liable under the plan for receiving nonemergency services in an emergency room setting, including prohibiting the enrollee

from using funds in the account to pay for the nonemergency services.

(b) Exception.--An enrollee may not be prohibited from using money in the account to pay for nonemergency services provided in an emergency room setting for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent individual who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

Section 414-A. Processing claims under plan.

(a) Reimbursement and coverage.--An insurer or a health maintenance organization that contracts with the department to provide health insurance coverage, dental coverage or vision coverage to an enrollee shall be responsible for the claim processing for the enrollee's coverage and:

(1) shall reimburse providers at a reimbursement rate of not less than the Medicare reimbursement rate for the service provided or at a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(2) may not deny coverage to an enrollee, unless the enrollee has met the coverage limitations described in this article.

(b) Cultural competency standards.--An insurer or a health

maintenance organization that contracts with the department to provide health insurance coverage under the plan shall incorporate cultural competency standards established by the department. The standards must include standards for non-English-speaking individuals, minority individuals and individuals with disabilities.

(c) Coverage for specific individuals.--An insurer or a health maintenance organization that contracts with the department to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the department to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six months; and

(2) either:

(i) meets the eligibility requirements for participation in the plan but is not enrolled because the plan has reached maximum enrollment; or

(ii) does not meet the eligibility requirements for participation in the plan.

(d) Underwriting and rating practices.--The insurance underwriting and rating practices applied to health insurance coverage offered under subsection (c) shall not be different from underwriting and rating practices used for the health insurance coverage provided under the plan. Standard individual or small group insurance underwriting and rating practices may be applied to the health insurance coverage.

(e) Prohibition.--The Commonwealth may not appropriate or otherwise provide money for health insurance coverage received

under this section.

Section 415-A. Keystone Care Fund.

(a) Establishment.--A restricted account is established in the Treasury Department to be known as the Keystone Care Fund.

(b) Purposes.--The fund shall:

(1) Administer the plan.

(2) Provide copayments, preventive care services and premiums for enrollees.

(c) Administration.--The secretary shall administer the fund.

(d) Expenses.--The expenses of administering the fund shall be paid from encumbered funds of the department.

(e) Composition.--The fund shall consist of the following:

(1) Tax revenue specified by the General Assembly.

(2) Other funds transferred or designated by the General Assembly to be part of the fund.

(3) Federal funds available for the purposes of the fund.

(4) Gifts or donations to the fund.

(5) Money appropriated by the General Assembly to administer the plan.

(f) Investments.--The State Treasurer shall:

(1) Invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested.

(2) Provide semiannual updates on investments regarding the fund to the following:

(i) The Secretary of the Budget.

(ii) The secretary.

(iii) The chairperson and minority chairperson of

the Appropriations Committee of the Senate.

(iv) The chairperson and minority chairperson of the Appropriations Committee of the House of Representatives.

(g) Appropriation requirement.--An appropriation must be made before money from the fund is available for use.

(h) No reversion.--Money in the fund shall not revert to the General Fund at the end of a fiscal year.

(i) Restrictions.--Money may not be transferred, assigned or otherwise removed from the fund by or for any department, agency, board, commission, authority, office or other entity of the Commonwealth without prior authorization from the General Assembly.

Section 416-A. Limitations on department.

The department may not operate the plan in a manner that would obligate the Commonwealth to financial participation beyond the level of State appropriations authorized for the plan by the General Assembly.

Section 417-A. Implementation of plan.

(a) Rules and regulations.--The department shall promulgate rules and regulations necessary to implement this article.

(b) Denial by Federal Government.--A denial of a waiver under section 402-A or a denial of Federal financial participation that applies to a provision of this article does not prohibit the department from implementing any other provision of this article that:

(1) is approved for Federal financial participation; or

(2) does not require Federal approval or Federal financial participation.

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