

## Government Relations Update – November 5, 2019

### Pennsylvania Issues

#### Legislation

- **SB 857**: Telemedicine. As previously reported, on September 19, 2019, Senator Elder Vogel (R–Lawrence) reintroduced legislation to define key components of telemedicine, set telemedicine licensing requirements and require that insurers pay for telemedicine services if they cover the same service provided in person. Senators Bob Mench (R–Bucks), Lisa Baker (R–Pike), John Yudichak (D–Carbon, Luzerne) and David Argall (R–Schuylkill) serve as co-sponsors of the bill. On October 29, 2019, the Senate Banking and Insurance Committee amended the legislation to remove the payment parity provision and instead require payment at a rate negotiated between the insurer and the provider for telemedicine services if the service is otherwise covered in person. The amended bill was passed by the Senate on October 30, 2019, and it was referred to the House Insurance Committee. The Hospital and Healthsystem Association of Pennsylvania (HAP) supports the bill, since the expanded use of telemedicine will assist with physician shortages in rural communities. HAP and the Pennsylvania Medical Society have advocated for payment parity for telemedicine services, but payers have successfully opposed those provisions. The bill passed the Senate last year, but the House failed to consider it.
- **HB 1862**: Balance Billing. On October 25, 2019, Representative Tina Pickett (R–Sullivan) introduced legislation to address balance billing of insureds by out-of-network providers. The bill would require an insurer to pay an out-of-network provider at the “commercially reasonable rate” for services, unless the parties have a contract for out-of-network services or otherwise agree on a rate. The “commercially reasonable rate” would mean the median in-network contracted rate that the insurer would pay to an in-network provider in the geographic region where the service is provided. Any controversy or claim relating to the determination of the commercially reasonable rate would be settled by arbitration administered by the American Arbitration Association under its Healthcare Payor Provider Arbitration Rules using expedited desk/telephonic track procedures.

The Pennsylvania Medical Society opposes the bill as introduced and supports two proposed amendments. The first proposed amendment, introduced by Representative Aaron Kaufer (R–Luzerne), would determine the “commercially reasonable rate” based on “all reasonably necessary costs associated with the services provided.” Representative Greg Rothman (R–Cumberland) proposed the second amendment, which includes specific language for arbitrators to consider when making a decision on the appropriate payment, as well as a provision requiring the losing party to pay for the costs of the arbitration. On October 29, 2019, the legislation was assigned to the House Insurance Committee. HAP and St. Luke’s are reviewing the bill and the proposed amendments and are developing an advocacy plan.

- **SB 841**: Pennsylvania Health Care Cost Containment Council. On September 3, 2019, Senator Scott Martin (R–Lancaster) introduced legislation to remove the requirement for periodic reauthorizations for the Pennsylvania Health Care Cost Containment Council (PHC4). PHC4 was established in 1986 as an independent agency tasked with collecting and disseminating health care cost data. It has been reauthorized multiple times, with slight modifications. In addition to removing the requirement for periodic authorizations, the bill would add a member of the Senate and the House to the Council and permit members of the Council to attend meetings remotely. The bill was passed by the Senate on October 30, 2019, and it has been referred to the House Health Committee. HAP supports the legislation.
- **SB 351**: Assault on Healthcare Workers. On March 4, 2019, Senator Judy Ward (R–Blair) introduced legislation to change the classification for assault on a health care practitioner while in the performance of duty where there is bodily injury from a misdemeanor of the second degree to a felony of the second degree. The legislation passed the Senate on October 28, 2019, and it was referred to the House Judiciary Committee. HAP supports the legislation.

## Miscellaneous

- **Proposed Expansion of Pennsylvania Antitrust Rules:** In late August, the Pennsylvania Office of Attorney General (OAG) submitted proposed regulations to the Pennsylvania Independent Regulatory Review Commission (IRRC) that would allow the OAG to expand its antitrust enforcement authority. The proposed regulations would create a definition of “unfair market trade practices” with an expanded list of illegal acts, all of them antitrust violations, subject to enforcement by the OAG and private parties. The scope of the list extends far beyond the limited list of unfair methods of competition currently included by statute in the Pennsylvania Unfair Trade Practices and Consumer Protection Law (UTPCPL).

HAP submitted a comment letter on September 30, 2019 arguing that the OAG is attempting to achieve, by regulation, what the Pennsylvania General Assembly has repeatedly voted against over a 50-year period. Since the enactment of the UTPCPL in 1968, state lawmakers defeated 26 legislative attempts to extend the provisions of the UTPCPL to include additional types of antitrust violations. HAP also stressed that the OAG has the authority to bring an action to block a hospital merger on the ground that the merger is anticompetitive. Because there is no state antitrust statute, the OAG asserts that it has been limited in other antitrust enforcement actions it could bring against hospitals.

If approved, these new regulations would give the OAG and private parties the power to challenge activities beyond mergers that have been subject to enforcement by federal antitrust enforcement authorities. The Pennsylvania Chamber of Commerce, the Insurance Federation of Pennsylvania and the Coalition for Civil Justice Reform have joined HAP in arguing that the proposed rule impermissibly expands the OAG’s powers under existing law. The OAG has two years to submit final form regulations for review by the IRRC and legislative standing committees. HAP plans to monitor these regulations and take steps to ensure that any regulations do not unlawfully and impermissibly expand the power of the OAG.

## Federal Issues

### Miscellaneous

- **Modernizing and Clarifying the Federal Fraud and Abuse Rules:** On October 9, 2019, the Office of the Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) issued two proposed rules to modify the Federal fraud and abuse rules in an effort to incentivize providers to better coordinate and collaborate care for patients. Notably, the proposed rules would allow incentives from providers to patients as incentives to manage their care. Given the overlap between the Stark Law and the Anti-Kickback Statute (AKS), OIG and CMS coordinated the release of these proposed rules. The OIG’s proposed rule, however, creates its proposed safe harbors for value-based arrangements that are more restrictive than the CMS proposed safe harbors. The OIG explicitly recognized this difference, noting that the intent was to create a back-stop to any fraud and abuse issues that may arise. So, while these rules are intended to be read together, the differences between the two rules are likely to limit the agencies’ efforts to provide a cohesive set of regulations.

The rule proposed by the OIG to modify the AKS would: (1) introduce new safe harbors to protect the exchange of money and in-kind remuneration between parties to value-based arrangements; (2) protect the donation of cybersecurity technologies and services related to those technologies; (3) modify the existing safe harbor for electronic health records to reflect changes to requirements for interoperability; (4) expand the “personal services” safe harbor for outcomes-based payments; (5) expand the recently created safe harbor for local transportation to allow for the transportation of discharged patients and increase the mileage limits for rural areas; and (6) expand permitted beneficiary inducements to telehealth technologies provided to in-home dialysis patients. Among other changes, the rule proposed by CMS would modify the Stark Law to permit providers to pay up to \$3500 to a physician for participating in certain value based arrangements. Comments to each proposed rule are due in early December. St. Luke’s will continue to monitor the progress of the rules and their impact on our current and planned activities.