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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1968 Session of 1985

INTRODUCED BY DORR, PISTELLA, ARTY, CAWLEY, CLYMER, STABACK, GLADECK, GREENWOOD, SIRIANNI, LASHINGER, MILLER, SAURMAN, D. W. SNYDER AND E. Z. TAYLOR, DECEMBER 11, 1985

REFERRED TO COMMITTEE ON HEALTH AND WELFARE, DECEMBER 11, 1985

AN ACT

Providing for the furnishing of information on health care services, in terms of quality and cost; providing for an Uncompensated Medical Care Fund; creating the Pennsylvania Health Services Council in the Department of Health and providing for membership, procedures, powers and duties of the council; providing for enforcement; making an appropriation; and making a repeal.

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

Section 1. Short title.

This act shall be known and may be cited as the Health Care Cost Containment Act.

Section 2. Legislative findings.

Health care costs in Pennsylvania have become a critical problem for all segments of this Commonwealth's citizenry. Expenditures for health care have created a substantial burden on consumers, business and industry, labor and the Commonwealth. It is the purpose of this legislation to promote the public interest by encouraging the development of competitive health care services in which health care costs are contained and to assure that all citizens have reasonable access to quality health care.

Section 3. Legislative intent.

(a) Policy.--The intent of this act is to facilitate the continuing provision of quality, cost effective health services throughout this Commonwealth by providing data and information to the purchasers and consumers of health care on cost and quality of services and to assure access to services by the establishment of an Uncompensated Medical Care Fund.

(b) Status of data suppliers.--Persons or entities supplying

data and information on health care services to the council as required by this act, or receiving the data and information from the council in accordance with this act, are declared to be acting pursuant to State requirements embodied in this act, and it is intended that they be exempt from antitrust claims or actions grounded upon supply or receipt of the information.

Section 4. Definitions.

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

"Ambulatory surgical facility." A facility licensed in this Commonwealth, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This term does not include the offices of private physicians or dentists, whether for individual or group practices.

"Charge." The amount to be billed by a hospital for specific goods or services provided to a patient.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Council." The Pennsylvania Health Services Council.

"Data source." A hospital; ambulatory surgical facility; physician; health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act; hospital, medical or health services plan with a certificate of authority issued by the Insurance Department, including, but not limited to, 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) and 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations); commercial insurer with a certificate of authority issued by the Insurance Department providing health or

accident insurance; self-insured employer providing health or accident coverage or benefits for employees employed in this Commonwealth; administrator of a self-insured or partially self-insured health or accident plan providing covered services in this Commonwealth; any health and welfare fund that provides health or accident benefits or insurance pertaining to covered services in this Commonwealth; the Department of Public Welfare and any other payor for covered services in this Commonwealth other than an individual.

"Department." The Department of Health of the Commonwealth.

"Fund." The Uncompensated Medical Care Fund established under this act.

"Health care insurer." An insurance company as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) and 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations); a health maintenance organization; a preferred provider organization, and any other third party payor of medical bills regulated by the Insurance Department.

"Health maintenance organization" or "HMO." An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee, as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Hospital." An institution licensed in this Commonwealth which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnoses, treatment and care for injured, disabled or sick persons or rehabilitation services for such persons. The term includes psychiatric hospitals.

"Major ambulatory surgery." Surgical or medical procedures commonly performed on an inpatient basis in hospitals or ambulatory surgical facilities, which are not of a type commonly performed or which may be safely performed in physicians' offices, and which require a dedicated operating room or suite and generally require a postoperative recovery room or short-term convalescent room.

"Physician." An individual licensed under the laws of this Commonwealth to practice medicine and surgery within the scope of the act of July 20, 1974 (P.L.551, No.190), known as the Medical Practice Act of 1974, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

"Preferred provider organization" or "PPO." An arrangement between a health care insurer or purchaser and providers of health care services which specifies rates of payment to such providers which differ from their usual and customary charges to the general public and which encourage enrollees to receive health services from such providers.

"Provider." A hospital, an ambulatory surgical facility, a medical clinic, a free standing medical treatment facility such as a birthing center, emergency facility, dialysis unit, imaging facility or a physician.

"Purchaser." All payors for covered services other than individuals.

"Rate." The amount to be billed by a hospital for specific goods or services provided to a patient.

"Secretary." The Secretary of the Department of Health of the Commonwealth.

"Uncompensated care." Any uncollected charges, reduced to

actual allowable costs, associated with the provision of free care, delivered to persons deemed medically indigent.

Section 5. Pennsylvania Health Services Council.

(a) Establishment.--The General Assembly establishes the Pennsylvania Health Services Council in the department to insure that quality health care is available to all citizens in this Commonwealth and that health care costs are contained and controlled.

(b) Composition.--The council shall consist of 15 members, who shall be appointed by the Governor. Council members shall have recognized expertise in health care cost containment. There shall be three representatives of Pennsylvania businesses, at least one of whom shall represent large business and at least one of whom shall represent small business none of which are involved primarily in the provision of health care or insurance. There shall be three representatives of organized labor who are not primarily involved in the provision of health care or health insurance. There shall be one representative of hospitals, one representative of physicians, one representative of the Pennsylvania Blue Cross and Pennsylvania Blue Shield plans in this Commonwealth, one representatives of commercial insurance carriers, one representative of health maintenance organizations and one consumer representative. The Secretary of Health, the Secretary of Welfare and the Insurance Commissioner shall each serve concurrent with their terms of office and be voting members of the council.

(c) Terms of council members.--Except for the Secretary of Health and the Secretary of Welfare and the Insurance Commissioner, each council member shall serve for three years. Of the members first designated, four members shall be

designated to serve for one year, four members for two years and four members for three years. Members may be reappointed to serve one subsequent term and may only be removed for good cause.

(d) Organization.--Within 60 days following the appointment of a quorum of the council, the secretary shall convene an organization meeting of the council.

(e) Chairman.--The Secretary of Health shall chair the council.

(f) Meetings.--The council shall meet at least quarterly at such times and places determined by the chairman.

(g) Compensation.--Council members shall receive reimbursement for reasonable expenses incurred while on official council business.

(h) Quorum.--A majority of the members of the council shall constitute a quorum.

(i) Staff.--The department shall provide the staff which the council determines is necessary to carry out the business of the council subject to annual appropriations from the General Assembly.

(j) Computerized data processing system.--The council shall develop the format and parameters for a computerized system for the collection, analysis and dissemination of data. The council shall contract with one or more qualified vendors to assist in developing the system and the data processing or other services required in such system.

Section 6. Powers and duties of the council.

The council shall have the following powers and duties:

(1) To establish a Pennsylvania Uniform Claims Form for all data sources which shall be utilized and maintained by

all data sources for all services covered by this act.

(2) To collect and disseminate to the public such data and other information on costs and quality of covered services as the council determines necessary to accomplish the purposes of this act according to formats, time frames and patient confidentiality provisions specified by the council. For purposes of this subsection, the term "covered services" means health care services rendered in connection with episodes of illness requiring either inpatient care or major ambulatory surgery, including initial and follow-up outpatient services associated with the episode before, between or after hospital stays or major ambulatory surgical procedures in an ambulatory surgical facility. Ambulatory services unconnected with an episode of illness requiring hospitalization or major ambulatory surgery are not included in the meaning of the term "covered services."

(3) To establish, operate and monitor regional uncompensated care fund pools.

(4) To establish hospitalization utilization review guidelines, audit utilization review programs and certify compliance with these guidelines.

(5) To make annual reports to the General Assembly on the rate of increase of the cost of health care in this Commonwealth, the effectiveness of the council in carrying out the legislative intent of the act and make recommendations on the need for further health care cost containment legislation. The council shall also make annual reports to the General Assembly on the quality of health care and access to health care for all citizens of this Commonwealth.

(6) To audit information submitted by data sources to corroborate accuracy. The audits will be performed on a sample basis, unless there is reasonable cause to audit specific data sources which shall be at the expense of the council.

(7) To establish and maintain a list of physicians licensed in this Commonwealth, who shall be available, at the request of treating physicians, to render second opinions regarding the necessity of performing additional medical tests or procedures on the patients of the said primary treating physicians, for the purpose of limiting causes of action as provided in section 14.

(8) To approve hospital forms that itemize all charges for services, equipment, supplies and medicine in language understandable to the average person. Such itemized billings shall be presented to each patient upon discharge from the hospital.

(9) To conduct studies and publish reports thereon analyzing the effects that non-inpatient, alternative health care delivery systems have on health care cost. These systems shall include, but not be limited to, HMO's, PPO's, primary health care facilities, home health care, attendant care, ambulatory surgical facilities, free standing emergency centers, birthing centers and hospice care.

(10) To conduct studies and publish reports thereon analyzing the impact of augmented preventive services on health care cost. These services shall include, but not be limited to, prenatal care, hypertension screening, cancer screening, drug and alcohol programs, occupational and environmental disease detection and prevention.

Section 7. Duties of data sources and purchasers.

Data sources and purchasers shall cooperate with the council in carrying out its purpose, as set forth in this act. All reports submitted by data sources and providers shall be filed under oath. Hospitals and ambulatory surgical facilities must publish biannually, in a format determined by the council, a price list for facility services and procedures. The biannual publication shall be in a local newspaper with broad general circulation and shall be published during the last week in January and the last week of July of each year. It shall be unlawful for a provider to accept as payment a rate or charge which is higher than that stated in its publicly available schedule of rates and charges unless the provider publishes, in a manner similar to the required annual publication, an amendment to its price list prior to instituting the higher rate or charge. Providers that are not required to publish in a local newspaper shall notify the council of a rate or charge increase and may not accept as payment a rate or charge which is higher than rates or charges filed with the council.

Section 8. Access to data.

The information and data received by the council shall be utilized to benefit the public. The council shall make determinations on requests for information in favor of access except that the council shall be required to maintain the confidentiality of individual patients. Release of facility-specific data, coded physician information and all other information collected by the council is intended by this act.

Section 9. Specific data reports.

The council shall publish, at least annually, information which will stimulate increased competition in the pricing of

health care services which will aid consumers, employers and other purchasers to make informed choices in purchasing health care. The council may charge a user fee for specific information. The council must conduct periodic reviews of its user fee structure to assure that all segments of the public have appropriate, reasonable access to the council's information.

Section 10. Uncompensated medical care.

(a) Fund.--An Uncompensated Medical Care Fund is established to insure that medically indigent persons who are not eligible for medical assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, have reasonable access to necessary inpatient hospital care.

(b) Funding.--Within 30 days following the end of each of its fiscal years, which begins after the effective date of this act, each hospital and each ambulatory surgical center, free standing emergency treatment facility, birthing center, dialysis unit and imaging center in this Commonwealth shall contribute to the fund 1% of its gross operating revenue including all revenue available for the operations of the hospital and available for the benefit of its interests for the fiscal year. Within 30 days following the end of each of its fiscal years which begins after the effective date of this act, each health care insurer in this Commonwealth shall contribute 0.6% of its gross health care and accident insurance revenues for the fiscal year to the fund. Moneys in the fund shall be held in a separate account in the State Treasury.

(c) Administration.--The council shall administer the fund and all moneys in the fund are hereby appropriated to the council on a continuing basis to carry out the purposes of this

section.

(d) Credits.--The council may establish a system of credits which will exempt hospitals from contributing wholly or in part, to the fund if a hospital establishes that it has provided an established level of uncompensated care.

(e) Distribution.--The council shall equitably distribute the fund on a regional basis to provide financial relief to hospitals that provide uncompensated health care to medically indigent persons. The council shall review the hospital's total financial resources when reviewing an application for relief from the fund, including the resources of affiliated or related corporations and endowment or other trust funds.

(f) Application.--Hospitals may submit applications for reimbursement from the fund on a quarterly basis. The first application may be submitted six months after the hospital has contributed to the fund or satisfied through a system of credits, that it has provided an established level of uncompensated care.

(g) Eligibility.--Any hospital applying for distribution from the fund shall be required to file and comply with a credit and collection policy that is acceptable to the council. The hospital must also provide appropriate certification that it has met all obligations under the Hill-Burton Act (60 Stat. 1040, 42 U.S.C. 291 et seq.) and under this act for the prior fiscal year.

(h) Rulemaking.--The council shall promulgate such rules as are necessary to continue said program.

(i) Determination of eligibility.--The hospital shall be responsible for determination and verification of eligibility of each recipient of care. The hospital shall use and enforce an

ability-to-pay scale currently approved by the council or a copayment schedule currently approved by the council before applying for reimbursement pursuant to this act.

(j) Deadline.--By July 1, 1988, relative reimbursement to hospitals shall reflect inpatient hospital services rendered to the medically indigent in different regions of this Commonwealth on a geographic basis. The council shall divide this Commonwealth into regions for the purpose of the administration of the fund on a geographic basis. To the extent possible, the boundaries of the regions shall be coterminous with county boundaries, and, where possible, a region shall consist of one or more entire counties or city and counties. The council may make changes in the boundaries of the regions when deemed necessary or appropriate.

(k) Limit on reimbursements.--Reimbursements to hospitals shall be limited to the aggregate level of funding which will be available from the fund for the care of the medically indigent. Hospitals shall be reimbursed at a level not to exceed costs as determined by Medicare and Medicaid cost reports.

(l) Application for indigency determination.--Every hospital shall require that a medically indigent person who is to be considered eligible for assistance under this act shall submit a signed application therefor to the hospital.

(m) Authorization by applicant.--By signing the application, the medically indigent person specifically authorizes the council to obtain records pertaining to eligibility from a financial institution, as defined in or from any insurance company or from any wage and employment data available from the Department of Labor and Industry.

(n) Penalty for nonuse of alternative services.--The

department shall not reimburse inpatient services which can be performed less expensively in an accessible outpatient setting.

(o) Certain persons noneligible.--Hospital services to a person who is employed but does not choose to participate in a group medical insurance plan offered through his place of employment shall not be eligible for reimbursement pursuant to this act.

(p) Priority of payment sources.--All other means of payment shall be exhausted before funds are utilized for reimbursement under this act. The fund shall be the payor of last resort.

(q) Transfer of indigent patients.--Hospitals may only transfer medically indigent patients, or medical assistance patients in instances where the hospital lacks the staff or facilities to properly render definitive treatment. The council shall develop specific sanctions for those facilities who engage in such practices.

Section 11. Utilization review.

The council is hereby instructed to establish utilization review guidelines to govern utilization review activities in and by providers. All providers must establish utilization review programs which meet these guidelines. The guidelines shall require such programs to offer preadmission certification and concurrent review. Any third party insurer or purchaser electing not to use the provider utilization review program must certify to the council that it is subjecting its inpatient admissions to a utilization review program which meets the guidelines established by the council. Such alternative utilization review programs may be conducted by the third party insurer or purchaser or by a utilization review organization under contract to the third party insurer or purchaser. Providers shall make

all data necessary for review activities available to the third party insurer or purchaser or their agents in a timely and satisfactory manner. In establishing its utilization review guidelines, the council shall consider and utilize, to the extent possible, existing utilization review requirements of State and Federal agencies and private certification organizations.

Section 12. Preferred provider organizations.

Upon compliance with the provisions of this act and notwithstanding any other provision of law to the contrary, the General Assembly hereby affirms the right of any health care insurer or purchaser to:

(1) Enter into agreements with providers or physicians relating to health care services which may be rendered to persons for whom the insurer or purchaser is providing health care coverage, including agreements relating to the amounts to be charged by the provider or physician for services rendered.

(2) Issue or administer policies or subscriber contracts in this Commonwealth which include incentives for the covered person to use the services of a provider who has entered into an agreement with the insurer or purchaser.

(3) Issue or administer policies or subscriber contracts in this Commonwealth that provide for reimbursement for services only if the services have been rendered by a provider or physician who has entered into an agreement with the insurer or purchaser.

(4) The commissioner shall determine that:

(i) Any preferred provider organization which assumes financial risk is either licensed as an insurer

in this Commonwealth or has adequate working capital and reserves.

(ii) Enrollee literature adequately discloses provisions, limitations and conditions of benefits available.

(5) The secretary shall determine that arrangements and provisions for preferred provider organizations which assume financial risk which may lead to undertreatment or poor quality care are adequately addressed by quality and utilization controls and by a formal grievance system.

(6) No preferred provider organization which assume financial risk may commence operations until it has reported to the commissioner and the secretary such information as the commissioner and the secretary require in accordance with the duties required in paragraphs (4) and (5) of this section. If, after 60 days, either the commission or the secretary has not informed the preferred provider organization of deficiencies, the preferred provider organization may commence operations unless and until such time as the commissioner or the secretary has identified significant deficiencies and such deficiencies have not subsequently been corrected within 60 days of notification.

(7) Any disapproval or order to cease operations issued in accordance with this section shall be subject to appeal in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative agency law and procedure).

(8) This act shall not apply to any preferred provider organization organized, established and maintained solely by an employer for the exclusive benefit of its employees and

their dependents.

(9) Within 120 days of the effective date of this act, any preferred provider organization which assumes financial risk currently operating on the effective date shall file the information required by the commissioner and the secretary under paragraphs (4) and (5) and may continue to operate subject to the terms of this section.

Section 13. Compliance enforcement.

The council shall have standing to bring an action at law or in equity through private counsel in any court of common pleas to enforce compliance with any provision of this act or any requirement or appropriate request of the council made pursuant to this act. In addition, the Attorney General is authorized and shall bring any such enforcement action in aid of the council in any court of common pleas at the request of the council in the name of the Commonwealth.

Section 14. Defensive medicine limitation.

If, during diagnosis and treatment, a patient's treating physician determines that additional tests or procedures are not medically necessary to the proper diagnosis or treatment of the patient and that obtaining a second opinion to verify this opinion is cost effective, the treating physician may select from the list of physicians established by the council, a physician to render a second opinion. The treating physician may request a determination from the selected physician as to whether additional tests or procedures are medically necessary for the proper diagnosis and treatment of the patient. If the physician rendering the second opinion concurs that such additional tests or procedures are not medically necessary for the proper diagnosis and treatment of the patient, no person

shall be permitted to maintain an action against either the treating physician or the physician rendering the second opinion for the failure to perform additional tests or procedures or for making a determination that such additional tests or procedures were not medically necessary.

Section 15. Mandated health benefits.

In relation to current proposed legislation, the council shall provide the appropriate committee chairman in the Senate and in the House of Representatives with a cost-benefit analysis of any proposed mandated health insurance benefit.

Section 16. Appropriation.

The sum of $600,000 is hereby appropriated to the Department of Health for the operation of the Pennsylvania Health Services Council to carry out the purposes of this act.

Section 17. Repeals.

The provisions of 40 Pa.C.S. § 6124 (relating to rates and contracts) are repealed.

Section 18. Expiration.

This act shall expire six years from its effective date unless extended by statute.

Section 19. Effective date.

This act shall take effect in 60 days.