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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 300

Session of 2007

INTRODUCED BY FERLO, FONTANA, WASHINGTON, KITCHEN AND HUGHES, MARCH 9, 2007

REFERRED TO BANKING AND INSURANCE, MARCH 9, 2007

AN ACT

Providing for a Statewide comprehensive health care system; establishing the Pennsylvania Health Care Plan and providing for eligibility, services, coverages, subrogation, participating providers, cost containment, reduction of errors, tort remedies, administrative remedies and procedures, attorney fees, quality assurance, nonparticipating providers, transitional support and training; and establishing the Pennsylvania Health Care Agency, the Employer Health Services Levy, the Individual Wellness Tax and the Pennsylvania Health Care Board and providing for their powers and duties.

WHEREAS, It is in the public interest to guarantee every resident of this Commonwealth timely access to health care, to assure a high quality of health services with adequate and stable reimbursement for health care providers, and to apportion rationally the costs of care;

WHEREAS, Health care providers and patients have lost confidence in the existing system for resolving claims of medical error and complications of treatment;

WHEREAS, The Commonwealth is dependent upon the volunteered services of citizen firefighters, search and rescue teams, and emergency medical technicians and there has been a substantial

loss of such volunteers as well as a general inability to recruit replacement volunteers;

WHEREAS, A commitment to age-appropriate health awareness, physical education, and first responder emergency training for children through primary and secondary schools will enhance the ability of our citizens to manage their health and the health and safety of their families and communities;

WHEREAS, Our Commonwealth must embrace a culture of wellness and illness prevention, rather than ever more expensive interventions and treatments;

WHEREAS, A fair and scientific assessment of environmental risks is key to identifying and abating such threats to the health and safety of Pennsylvanians;

WHEREAS, The number of avoidable hospital-acquired injuries and infections requires a renewed emphasis upon collection of reliable data with the objective of analyzing the cause of such events and developing and adopting effective protocols and procedures to reduce their frequency;

WHEREAS, At least one million Pennsylvanians have no health insurance at all and millions more have insurance that is inadequate for their needs or risk;

WHEREAS, Providing financing for injuries incurred in the course and scope of employment through workers' compensation insurance is an increasingly expensive and inefficient approach to managing the cost of industrial accident and disease and is further creating an increasing burden on Commonwealth employers;

WHEREAS, Unacceptable health access disparities exist in this Commonwealth by region, race, ethnicity, income and gender;

WHEREAS, The existing funding mechanism for health care in this Commonwealth is ill-suited to respond to a natural or man-

made catastrophe that could disrupt the availability of health care in the affected regions while at the same time demanding immediate flexibility in revenue sourcing to pay for the care of the injured and reconstruction of health care infrastructure;

WHEREAS, Current availability of and funding for substance abuse counseling and treatment is grossly inadequate to the need resulting in lost productivity, domestic violence, vehicular and workplace accidents and crime;

WHEREAS, Health care costs are a leading cause of personal bankruptcy and the use of credit cards as a last means of funding care for an individual or the individual's loved ones only adds to the cost of such care through higher interest rates associated with unsecured revolving credit;

WHEREAS, Pennsylvania spends significantly more per capita on health care than many other states, putting our Commonwealth and our businesses at a competitive disadvantage to other states and to all the foreign countries where governments provide universal health care;

WHEREAS, Unstable and unaffordable rate increases for health insurance are causing significant economic hardship for Commonwealth residents and their employers;

WHEREAS, The annual increases in the cost of private health insurance are leading more Pennsylvania employers to shift costs to workers or to discontinue insurance of employees and retirees altogether;

WHEREAS, The escalating cost of insuring public employees is increasing the taxpayer burden and preventing municipalities, school boards and the Commonwealth itself from investing in education, public works, human services, environmental protection and other projects needed for the public good;

WHEREAS, The Commonwealth has an inefficient concentration of diagnostic and treatment facilities in some communities while other areas are underserved;

WHEREAS, Technology exists to support a system of digital medical records that would substantially reduce administrative costs while also reducing medical errors and duplicative treatments or diagnostic procedures caused by unavailable or unreadable records and orders;

WHEREAS, The ever-increasing cost of prescription drugs is depriving our citizens of medications that save lives and prevent costly illness yet there currently exists no means whereby our Commonwealth can leverage the purchasing power of its 12,000,000 citizens to bargain for the same discounts enjoyed by nations of even smaller populations;

WHEREAS, Needed community hospitals, long-term care facilities, nursing homes and health care agencies within this Commonwealth are threatened with financial failure due to inadequate reimbursement for services and an increasing percentage of unreimbursed care;

WHEREAS, Historically efforts to control health care costs while maintaining the private health insurance market has invariably led to diminished access and quality in health care;

WHEREAS, An unsustainable and ever-increasing percentage of every Pennsylvania health care dollar goes to inefficient and redundant administrative systems, marketing and underwriting expenses;

WHEREAS, Through the adoption of a single-payer public health insurance system, Pennsylvania could cover all residents and better manage and control the future cost of health care;

WHEREAS, By simplifying administration, eliminating marketing

and underwriting expenses, achieving bulk purchase discounts on pharmaceuticals and medical equipment and reducing the use of emergency facilities for primary care, Pennsylvania could reallocate billions of dollars toward providing direct health care and improved quality and access;

WHEREAS, Too many of our citizens have lost their focus on the importance of a personal commitment to and responsibility for health as the most effective means of controlling health care costs; and

WHEREAS, Advances in medical technology are not available to all Pennsylvania residents who need them while at the same time some communities have an excess capacity of such technology resulting in inefficient application of resources;

THEREFORE, The Commonwealth of Pennsylvania hereby finds it necessary to enact this legislation.

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The General Assembly of the Commonwealth of Pennsylvania

hereby enacts as follows:

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Family and Business Health Care Security Act.

Section 102. 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:

"Agency." The Pennsylvania Health Care Agency established under this act.

"Board." The Pennsylvania Health Care Board established under this act.

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

"Executive director." The Executive Director of the Pennsylvania Health Care Board.

"Fund." The Pennsylvania Health Care Trust Fund established under this act.

"Individual Wellness Tax" or "IWT" The Individual Wellness Tax established under this act.

"Plan." The Pennsylvania Health Care Plan established under this act.

"Tax." The Employer Health Services Levy established under this act.

CHAPTER 3

ADMINISTRATION AND OVERSIGHT OF THE PENNSYLVANIA HEALTH CARE PLAN

SUBCHAPTER A

PENNSYLVANIA HEALTH CARE BOARD

Section 301. Organization.

(a) Composition.--The Pennsylvania Health Care Board shall be composed of 11 voting members and shall be chaired by the executive director.

(b) Appointments.--

(1) The executive director shall be appointed by the Governor. The members of the board shall be appointed by the Governor, the President pro tempore of the Senate, and the Speaker of the House of Representatives who collectively shall make appointments of members from individuals representative of each of the following constituencies:

(i) Hospitals.

(ii) Organized labor, private sector.

(iii) Consumers.

(iv) Business.

(v) Agriculture.

(vi) Physicians.

(vii) Public sector employees.

(viii) Nurses.

(ix) Pharmacists.

(x) Long-term care facilities.

(xi) Social workers.

(2) The Governor shall initially appoint the executive director, who shall serve as chair of the board, appointments of the members shall thereafter be made in a rotating fashion beginning with the President pro tempore of the Senate, then the Speaker of the House of Representatives and then the Governor, with each in turn making an appointment from a constituency category not previously filled.

(c) Terms of members.--Each member appointed or reappointed

under this section shall hold office for three years, starting on the first day of the first month following the member's appointment. A serving member of the board shall continue to serve following the expiration of the member's term until a successor takes office or a period of 90 days has elapsed, whichever occurs first.

(d) Midterm vacancies.--Midterm vacancies shall be filled by the same appointer and the individual appointed to fill a vacancy occurring prior to the expiration of the term for which a member is appointed shall hold office for the remainder of the predecessor's term.

(e) Compensation, benefits and expenses.--The executive director and members of the board shall receive an annual salary, benefits and expense reimbursement established by the board, to be paid from the trust. The initial board shall establish its own compensation. No increase or decrease in salary or benefits adopted by the board for the executive director or members shall become effective within the same three-year term.

(f) Meetings.--

(1) The executive director shall set the time, place and date for the initial and subsequent meetings of the board and shall preside over its meetings. The initial meeting shall be set not sooner than 50 nor later than 100 days after the appointment of the executive director. Subsequent meetings shall occur at least monthly thereafter.

(2) All meetings of the board are open to the public unless questions of patient confidentiality arise. The board may go into closed executive session with regard to issues related to confidential patient information.

(g) Quorum.--Two-thirds of the appointed members of the board shall constitute a quorum for the conducting of business at meetings of the board. Decisions at ordinary meetings of the board shall be reached by majority vote of those actually present or, in the event of emergency meeting, those also present by electronic or telephonic means. Where there is a tie vote, the executive director shall be granted an additional vote to break the tie.

(h) Ethics.--The executive director, the members and their immediate families are prohibited from having any pecuniary interest in any business with a contract or in negotiation for a contract with the agency. The board shall also adopt rules of ethics and definitions of irreconcilable conflicts of interest that will determine under what circumstances members must recuse themselves from voting.

(i) Prohibitions.--No member of the board, except for the executive director, who shall receive no additional salary or benefits by virtue of serving on the board, shall hold any other salaried Commonwealth public position, either elected or appointed, during the member's tenure on the board.

Section 302. Duties of board.

(a) General duties.--The board is responsible for directing the agency in the performance of all duties, the exercise of all powers, and the assumption and discharge of all functions vested in the agency. The board shall adopt and publish its rules and procedures in the Pennsylvania Bulletin no later than 180 days after the first meeting of the board.

(b) Specific duties.--The duties and functions of the board include, but are not limited to, the following:

(1) Implementing statutory eligibility standards for

benefits.

(2) Annually adopting a benefits package for participants of the plan.

(3) Acting directly or through one or more contractors as the single payer administrator for all claims for health care services made under the plan.

(4) At least annually reviewing the appropriateness and sufficiency of reimbursements.

(5) Providing for timely payments to participating providers through a structure that is well organized and that eliminates unnecessary administrative costs.

(6) Implementing standardized claims and reporting methods for use by the plan.

(7) Developing a system of centralized electronic claims and payments accounting.

(8) Establishing an enrollment system that will ensure that those who travel frequently and cannot read or speak English are aware of their right to health care and are formally enrolled in the plan.

(9) Reporting annually to the General Assembly and to the Governor, on or before the first day of October, on the performance of the plan, the fiscal condition of the plan, recommendations for statutory changes, the receipt of payments from the Federal Government, whether current year goals and priorities were met, future goals and priorities, and major new technology or prescription drugs that may affect the cost of the health care services provided by the plan.

(10) Administering the revenues of the trust.

(11) Obtaining appropriate liability and other forms of

insurance to provide coverage for the plan, the board, the agency and their employees and agents.

(12) Establishing, appointing and funding appropriate staff, office space, equipment, training and administrative support for the agency throughout this Commonwealth, all to be paid from the trust.

(13) Administering aspects of the agency by taking actions that include, but are not limited to, the following:

(i) Establishing standards and criteria for the allocation of operating funds.

(ii) Meeting regularly to review the performance of the agency and to adopt and revise its policies.

(iii) Establishing goals for the health care system established pursuant to the plan in measurable terms.

(iv) Establishing Statewide health care databases to support health care services planning.

(v) Implementing policies and developing mechanisms and incentives to assure culturally and linguistically sensitive care.

(vi) Establishing rules and procedures for implementation and staffing of a no-fault compensation system for iatrogenic injuries or complications of care whereby a patient's condition is made worse or an opportunity for cure or improvement is lost due to the health care or medications provided or appropriate care not provided by participating providers under the plan.

(vii) Establishing standards and criteria for the determination of appropriate transitional support and training for residents of this Commonwealth who are displaced from work during the first two years of the

implementation of the plan.

(viii) Evaluating the state of the art in proven technical innovations, medications and procedures and adopting policies to expedite the rapid introduction thereof in this Commonwealth.

(ix) Establishing methods for the recovery of costs for health care services provided pursuant to the plan to a beneficiary who is also covered under the terms of a policy of insurance, a health benefit plan or other collateral source available to the participant under which the participant has a right of action for compensation. Receipt of health care services pursuant to the plan shall be deemed an assignment by the participant of any right to payment for services from any such policy, plan or other source. The other source of health care benefits shall pay to the trust all amounts it is obligated to pay to, or on behalf of, the participant for covered health care services. The board may commence any action necessary to recover the amounts due.

(14) Recruiting the Health Advisory Panel of seven members made up of a cross section of the medical and provider community. The members of the advisory panel shall be paid a per diem rate, established by the board, for attendance at meetings and further be reimbursed for actual and necessary expenses incurred in the performance of their duties, which shall include:

(i) Advising the board on the establishment of policy on medical issues, population-based public health issues, research priorities, scope of services, expansion of access to health care services and evaluation of the

performance of the plan.

(ii) Investigating proposals for innovative approaches to the promotion of health, the prevention of disease and injury, patient education, research and health care delivery.

(iii) Advising the board on the establishment of standards and criteria to evaluate requests from health care facilities for capital improvements.

(iv) Evaluating and advising the board on requests from providers, or their representatives, for adjustments to reimbursements.

(15) Establishing a secure and centralized electronic health record system wherein a beneficiary's entire health record can be readily and reliably accessed by authorized persons with the objective of eliminating the errors and expense associated with paper records and diagnostic films.

SUBCHAPTER B

PENNSYLVANIA HEALTH CARE AGENCY

Section 321. Pennsylvania Health Care Agency.

(a) Establishment of agency.--There is hereby established the Pennsylvania Health Care Agency. The agency shall administer the plan and is the sole agency authorized to accept applicable grants-in-aid from the Federal Government and State government. It shall use such funds in order to secure full compliance with provisions of Federal and State law and to carry out the purposes established under this act. All grants-in-aid accepted by the agency shall be deposited into the Pennsylvania Health Care Trust Fund established under this act, together with other revenues raised within this Commonwealth to fund the plan.

(b) Appointment of executive director.--The executive

director of the agency shall be appointed by the Governor for a term of three years and is the chief administrator of the plan.

(c) Personnel and employees.--The board shall employ and fix the compensation of agency personnel as needed by the agency to properly discharge the agency's duties. The employment of personnel by the board is subject to the civil service laws of this Commonwealth. The board shall employ personnel including, but not limited to, the following leadership positions, all of whom will report to the executive director of the agency:

(1) Administrator for planning, research and development.

(2) Administrator for finance.

(3) Administrator for quality assurance.

(4) Administrator for consumer affairs and health education.

(5) Administrator of health claims.

(6) Administrator for volunteer services.

(7) Administrator for provider coordination.

(8) Administrator for law.

(9) Administrator of transition services until the termination of this position on December 31, 2013.

(10) Beneficiary advocate.

Section 322. Executive director duties.

The executive director shall oversee the operation of the agency and the agency's performance of any duties assigned by the board.

Section 323. Administrator for planning, research and development.

The executive director of the agency shall determine the duties of the administrator of planning, research and

development. Those duties shall include, but not be limited to, the following:

(1) Establishing policy on medical issues, population-based public health issues, research priorities, scope of services, the expansion of participants' access to health care services and the evaluation of the performance of the plan.

(2) Investigating proposals for innovative approaches for the promotion of health, the prevention of disease and injury, patient education, research and the delivery of health care services.

(3) Establishing standards and criteria for evaluating applications from health care facilities for capital improvements.

(4) Evaluating environmental risks and coordinating agency policy with other governmental and nongovernmental entities committed to assuring health by reducing environmental hazards.

Section 324. Administrator for consumer affairs and health education.

The executive director of the agency shall determine the duties of the administrator for consumer affairs and health education. Those duties shall include, but not be limited to, the following:

(1) Developing educational and informational guides for consumers that describe consumer rights and responsibilities and that inform consumers of effective ways to exercise consumer rights to obtain health care services. The guides shall be easy to read and understand and available in English and in other languages. The agency shall make the guide

available to the public through public outreach and educational programs and through the Internet website of the agency.

(2) Establishing a toll-free telephone number to receive questions and complaints regarding the agency and the agency's services. The agency's Internet website shall provide complaint forms and instructions online.

(3) Examining suggestions from the public.

(4) Making recommendations for improvements to the board.

(5) Examining the extent to which individual health care facilities in a region meet the needs of the community in which they are located.

(6) Receiving, investigating and responding to all consumer complaints about any aspect of the plan and, where appropriate, referring the results of all investigations of questioned care to the appropriate provider or health care facility licensing board or, in cases of possible violation of law, to a law enforcement agency.

(7) Publishing an annual report for the public, the Governor and the General Assembly that contains a Statewide evaluation of the agency.

(8) Holding public hearings in each congressional district, at least annually, for public input.

Section 325. Administrator for quality assurance.

The executive director of the agency shall determine the duties of the administrator of quality assurance. Those duties shall include, but not be limited to, the following:

(1) Studying and reporting on the efficacy of health care treatments and medications for particular conditions.

(2) Identifying causes of medical errors and devising procedures to reduce their frequency.

(3) Establishing an evidence-based formulary.

(4) Identifying treatments and medications that are unsafe or have no proven value.

(5) Establishing a process for soliciting information on medical standards from providers and consumers for purposes of this section.

(6) Independently reviewing all claims submitted to the administrator of health claims to determine if correctable errors have occurred or whether there are patterns of errors or complications which require closer investigation, evaluation and correction, and then to assure all such appropriate measures are recommended in writing to the executive director.

Section 326. Administrator for finance.

The executive director of the agency shall determine the duties of the administrator of finance. Those duties shall include, but not be limited to, the following:

(1) Administering the trust.

(2) Making payments to participating providers within five business days of submission and to other providers within 30 days of submission.

(3) Developing a system of simplified, secure and centralized electronic claims and payments employing the best technology with assured backup and catastrophe recovery contingencies and facilities.

(4) Communicating to the State Treasurer when funds are needed from the trust for the operation of the plan.

(5) Developing information systems for utilization

review.

(6) Investigating and recommending for appropriate civil and/or criminal prosecution possible provider or consumer fraud.

Section 327. Administrator for claims.

The executive director of the agency shall determine the duties of the administrator of claims. Those duties shall include, but not be limited to, the following:

(1) Establishing a system of administrative procedures, health claim hearing officers and appeal panel for the processing of patient claims.

(2) Supervising the health claims hearing officers to assure swift and fair processing of claims.

(3) Reviewing all appeals from the determinations of the health claims hearing officers, and then advising the executive director who shall then make the final agency determination.

(4) Supervising follow-up oversight of awarded claims to determine when or if adjustments to the awarded compensation is appropriate given improvement in the awardee's condition and if so to initiate appropriate review procedures before the health claims hearing officers.

Section 328. Administrator for volunteer services.

The executive director of the agency shall determine the duties of the administrator for volunteer services. Those duties shall include, but not be limited to, the following:

(1) Coordinating with the State Treasurer to establish procedures necessary to implement the volunteer tax rebate provisions of this act.

(2) Investigating the status of volunteerism in this

Commonwealth in firefighting, search and rescue, emergency response and otherwise as it pertains to the health of Pennsylvanians and the means by which citizens can be encouraged to volunteer.

(3) Developing programs to encourage blood and organ donation in this Commonwealth.

(4) Making recommendations to the executive director and the board for programs and initiatives that will best support and encourage health-related volunteerism in this Commonwealth.

Section 329. Administrator for provider coordination.

The executive director of the agency shall determine the duties of the administrator for provider coordination. Those duties shall include, but not be limited to, all of the following:

(1) Processing all applications for participating provider status.

(2) Assisting participating providers in their efforts to meet the qualification requirements established by the board.

(3) Establishing an inquiry office to assist participating providers with regard to proper submission of requests for reimbursements.

Section 330. Administrator for law.

The executive director of the agency shall determine the duties of the administrator for law. Those duties shall include, but not be limited to, the following:

(1) Establishing, supervising and maintaining a team of legal professionals as necessary to support all of the legal representation needs of the agency.

(2) Defending the interests of the plan before the health claims hearing officers and before the courts against nonmeritorious claims.

(3) Representing the board in disciplinary actions against participating providers.

(4) Serving as the principal ethics officer for the agency.

Section 331. Administrator for transition services.

The executive director of the agency shall determine the duties of the administrator of transition services. Those duties shall include, but not be limited to, the following:

(1) Establishing procedures for identifying Pennsylvanians whose livelihood will be detrimentally affected by the passage of this act.

(2) Establishing procedures to most efficiently and effectively transition such persons into positions with the agency where appropriate or to other health-related fields where the passage of this act will create an immediate need for qualified employees.

(3) Reporting to the administrator of finance with respect to the financial requirements to support the eligible displaced citizens and to assist in the filing for transitional wage replacement benefits approved by the board.

(4) Planning for the discontinuance of this division of the board on December 31, 2013.

Section 332. Administrator for beneficiary advocate.

The executive director of the agency shall determine the duties of the beneficiary advocate. Those duties shall include, but not be limited to, the following:

(1) Establishment of a readily accessible beneficiary

telephone and Internet website resource in instances where they are having difficulties securing necessary care through the plan. This office shall make immediate inquiries to ascertain the nature of the difficulties and to resolve the beneficiary's problem.

(2) Where a beneficiary seeks specialized care from outside this Commonwealth and from other than a participating provider, the beneficiary advocate shall assist in the proper application for an extension of benefits on behalf of the beneficiary.

(3) Management of death claim dependent trusts.

SUBCHAPTER C

(Reserved)

SUBCHAPTER D

(Reserved)

SUBCHAPTER E

(Reserved)

SUBCHAPTER F

IMMUNITY

Section 371. Immunity.

In the absence of fraud or bad faith, the advisory panel, the board and agency and their respective members and employees shall incur no liability in relation to the performance of their duties and responsibilities under this act. The Commonwealth shall incur no liability in relation to the implementation and operation of the plan.

CHAPTER 5

PENNSYLVANIA HEALTH CARE PLAN

Section 501. General provisions.

(a) Establishment of plan.--There is hereby established the

Pennsylvania Health Care Plan that shall be administered by the independent Pennsylvania Health Care Agency under the direction of the Pennsylvania Health Care Board.

(b) Coverage.--The plan shall provide health care coverage for all citizens of this Commonwealth and for certain eligible visitors. The agency shall work simultaneously to control health care costs, achieve measurable improvement in health care outcomes, promote a culture of health awareness, increase satisfaction with the health care system, adopt an optional no-fault administrative system to fairly compensate those whose conditions are made worse by the treatments they receive or through failures to receive appropriate care, implement policies that strengthen and improve culturally sensitive care, and develop an integrated health care database to support health care planning and quality assurance.

(c) Reforms.--The board shall implement the reforms adopted by the General Assembly hereby on January 1, 2010.

Section 502. Universal health care access eligibility.

(a) Eligibility.--All Pennsylvania citizens, including documented aliens, full-time out-of-State students attending school in this Commonwealth, homeless persons and migrant agricultural workers and their accompanying families are eligible beneficiaries under the plan. The board shall establish standards and a simple procedure to demonstrate proof of eligibility.

(b) Enrollment.--Enrollment in the plan shall be automatic and beneficiaries shall be provided with access cards with appropriate proof of identity technology and privacy protection. Individuals covered under a collective bargaining agreement that provides health benefits at least as extensive as the plan, as

certified by the executive director, shall not be eligible for plan benefits.

(c) Waivers.--If waivers are not obtained from the medical assistance and/or Medicare programs operated under Title XVIII or XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), the medical assistance and Medicare nonwaived programs shall act as the primary insurers for those eligible for such coverage, and the plan shall serve as the secondary or supplemental plan of health coverage. Until such time as waivers are obtained, the plan will not pay for services for persons otherwise eligible for the same benefits under Medicare or Medicaid. The plan shall also be secondary to benefits provided to military veterans except where reasonable and timely access, as defined by the board, is denied or unavailable through the United States Veterans' Administration, in which instance the plan will be primary and will seek reasonable reimbursement from the United States Veterans' Administration for the services provided to veterans.

(d) Priority of plans.--A plan of employee health coverage provided by an out-of-State employer to a Pennsylvania resident working outside of this Commonwealth shall serve as the employee's primary plan of health coverage, and the plan shall serve as the employee's secondary plan of health coverage.

(e) Reimbursement.--The plan shall reimburse participating providers practicing outside of this Commonwealth at plan rates, or reasonable locally prevailing rate, for health care services rendered to a beneficiary while the beneficiary is out of this Commonwealth. Services provided to a beneficiary out of this Commonwealth by other than a participating provider shall be reimbursed to the beneficiary or to the provider at a fair and

reasonable rate for that location.

(f) Presumption of eligibility.--Any individual who arrives at a health care facility unconscious or otherwise unable due to their mental or physical condition to document eligibility for coverage shall be presumed to be eligible, and emergency care shall be provided without delay occasioned over issues of ability to pay.

(g) Rules.--The board shall adopt rules assuring that any participating provider who renders humanitarian emergency or urgent care within this Commonwealth to a not actually eligible recipient shall nevertheless be reimbursed for such care from the plan subject to such rules as will reasonably limit the frequency of such events to protect the fiscal integrity of the plan. It shall be the agency's responsibility to secure reimbursement for the costs paid for such care from any appropriate third party funding source, or from the individual to whom the services were rendered.

Section 503. Covered services.

(a) Benefits package.--The board shall establish a single health benefits package within the plan that shall include, but not be limited to, all of the following:

(1) Inpatient and outpatient care, both primary and secondary.

(2) Emergency services.

(3) Emergency and other medically necessary transport to covered health services.

(4) Rehabilitation services, including speech, occupational and physical therapy.

(5) Inpatient and outpatient mental health services and substance abuse treatment.

(6) Hospice care.

(7) Prescription drugs and prescribed medical nutrition.

(8) Vision care, aids and equipment.

(9) Hearing care, hearing aids and equipment.

(10) Diagnostic medical tests, including laboratory tests and imaging procedures.

(11) Medical supplies and prescribed medical equipment.

(12) Immunizations, preventive care, health maintenance care and screening.

(13) Dental care.

(14) Home health care services.

(15) Chiropractic and massage therapy.

(16) Long-term care for those unable to care for themselves independently and including assisted and skilled care.

(b) Exclusions for preexisting conditions.--The plan shall not exclude or limit coverage due to preexisting conditions.

(c) Copayments, deductibles, etc.--Beneficiaries of the plan are not subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package and shall not be directly billed nor balance billed by participating providers for covered benefits provided to the beneficiary. Where a beneficiary has directly paid for nonemergency services of a nonparticipating provider, the beneficiary may submit a claim for reimbursement from the plan for the amount the plan would have paid a participating provider for the same service. Where emergency services are rendered by a nonparticipating provider, the beneficiary shall receive reimbursement of the full amount paid to such nonparticipating provider not to exceed 125% of the amount the plan would have

paid a participating provider for the same service.

(d) Exclusions of coverage.--The board shall remove or exclude procedures and treatments, equipment and prescription drugs from the plan benefit package that the board finds unsafe or that add no therapeutic value.

(e) The board shall exclude coverage for any surgical, orthodontic or other procedure or drug that the board determines was or will be provided primarily for cosmetic purposes unless required to correct a congenital defect, to restore or correct disfigurements resulting from injury or disease or that is certified to be medically necessary by a qualified, licensed provider.

(f) Choice by beneficiary.--Beneficiaries shall normally be granted free choice of the participating providers, including specialists, without preapprovals or referrals. However, the board shall adopt procedures to restrict such free choice for those individuals who engage in patterns of wasteful or abusive self-referrals to specialists. Specialists who provide primary care to a self-referred beneficiary will be reimbursed at the board-approved primary care rate established for the service in that community.

(g) Service.--No participating provider shall be compelled to offer any particular service so long as the refusal is general, consistent and not discriminatory.

(h) Discrimination.--The plan and participating providers shall not discriminate on the basis of race, ethnicity, national origin, gender, age, religion, sexual orientation, health status, mental or physical disability, employment status, veteran status or occupation.

Section 504. Excess and collective bargaining agreement health

insurance coverage.

Subject to the regulations of the Insurance Commissioner and all applicable laws, private health insurers shall be authorized to offer coverage supplemental to the package approved and provided automatically under this act. Private insurers shall also be authorized to offer programs to support the health care terms of a collective bargaining agreement provided that such benefits are at least as comprehensive as those provided under the plan.

Section 505. Duplicate coverage.

The agency is subrogated to and shall be deemed an assignee of all rights of a beneficiary who has received duplicate health care benefits, or who has a right to such benefits, under any other policy or contract of health care or under any government program.

Section 506. Subrogation.

(a) General rule.--The agency shall have no right of subrogation against a beneficiary's third-party claims for harm or losses not covered under this act. Nor shall any beneficiary under this act have a claim against a third-party tortfeasor for the services provided or available to the beneficiary under this act. In all personal injury actions accruing and prosecuted by a beneficiary on or after January 1, 2010, the presiding judge shall advise any jury that all health care expenses have been or will be paid under the plan, and, therefore, no claim for past or future health care benefits is pending before the court.

(b) Exception.--The exception to the general rule of no subrogation shall be that the agency retains its equitable right to subrogation to the recovery, including the recovery for noneconomic damages, of those persons opting out of the no-fault

administrative remedies adopted herein and who successfully prosecute to verdict or settlement a claim for health care professional or institutional negligence. The agency's right to subrogation shall be absolute and shall not be subject to reduction for attorney fees or costs of litigation.

Section 507. Eligible participating providers and availability of services.

(a) General rule.--All licensed health care providers and facilities are eligible to become a participating provider in the plan in which instance they shall enjoy the rights and have the duties as set forth in the plan as stated in this section or as adopted by the board from time to time. Nonparticipating providers shall not enjoy the rights nor bear the duties of participating providers.

(b) Required notice.--In advance of initially providing services to a beneficiary, nonparticipating providers shall advise the beneficiary at the time the appointment is made that the person or entity is a nonparticipating provider and that the recipient of the service will be initially personally responsible for the entire cost of the service and ultimately responsible for the cost in excess of the reimbursement approved by the board for participating providers. Failure to make such financial disclosure will be deemed a fraud on the beneficiary and entitle the beneficiary to a refund equal to 200% of the amount paid to the nonparticipating provider in excess of the board-approved reimbursement for the services rendered, plus all reasonable fees for collection. The burden of proof that such disclosure was made shall be on the nonparticipating provider.

(c) Plan by board.--The board shall assess the number of primary and specialty providers needed to supply adequate health

care services in this Commonwealth generally and in all geographic areas and shall develop a plan to meet that need. The board shall develop financial incentives for participating providers in order to maintain and increase access to health care services in underserved areas of this Commonwealth.

(d) Reimbursements.--Reimbursements shall be determined by the board in such a fashion as to assure that a participating provider receives compensation for services that fairly and fully reflect the skill, training, operating overhead included in the costs of providing the service, capital costs of facilities and equipment, cost of consumables and the expense of safely discarding medical waste, plus a reasonable profit sufficient to encourage talented individuals to enter the field and for investors to make capital available for the construction of state-of-the-art health care facilities in this Commonwealth.

(e) Adjustments to reimbursements.--Participating providers shall have the right alone or collectively to petition the board for adjustments to reimbursements believed to be too low. Such petitions shall be initially evaluated by the administrator of provider services, with input from the Health Advisory Panel, who shall submit a report to the executive director within 30 days. The executive director will then submit a recommendation to the board for action at the next scheduled board meeting. Participating providers who remain dissatisfied after the board has ruled may appeal the board's determination to the Court of Common Pleas of Dauphin County, which shall review the action of the board on an abuse of discretion standard.

(f) Evaluation of access to care.--The board annually shall evaluate access to trauma care, diagnostic imaging technology, emergency transport and other vital urgent care requirements and

shall establish measures to assure beneficiaries have equitable and ready access to such resources regardless of where in this Commonwealth they may be.

(g) Performance reports.--The board, with the assistance of the Health Advisory Panel and the administrator of quality assurance, shall define performance criteria and goals for the plan and shall make a written report to the General Assembly at least annually on the plan's performance. All such reports, including the survey results obtained, shall be made publicly available with the goal of total transparency and open self-analysis as a defining quality of the agency. The board shall establish a system to monitor the quality of health care and patient and provider satisfaction and to adopt a system to devise improvements and efficiencies to the provision of health care services.

(h) Data reporting.--All participating providers shall provide data to the agency promptly upon the request of the executive director.

(i) Coordination of services.--The board shall coordinate the provision of health care services with any other Commonwealth and local agencies that provide health care services directly to their charges or residents.

Section 508. Rational cost containment.

(a) Approval of expenditures.--As part of its cost containment mission, the board shall screen and approve or disapprove private or public expenditures for new health care facilities and other capital investments that may lead to redundant and inefficient health care provider capacity. Procedures shall be adopted for this purpose with an emphasis upon efficiency and a fair and open consideration of all

applications.

(b) Capital investments.--All capital investments valued at one million dollars or greater, including the costs of studies, surveys, design plans and working drawing specifications, and other activities essential to planning and execution of capital investment and all capital investments that change the bed capacity of a health care facility by more than 10% over a 24-month period or that add a new service or license category shall require the approval of the board. When a facility, an individual acting on behalf of a facility or any other purchaser obtains by lease or comparable arrangement any facility or part of a facility, or any equipment for a facility, the market value of which would have been a capital expenditure, the lease or arrangement shall be considered a capital expenditure for purposes of this section.

(c) Deemed approval.--Capital investment programs submitted for approval shall be deemed approved unless specifically rejected by the board within 60 days from the date the submissions are received by the executive director.

(d) Recommendations.--Recommendations of the Pennsylvania Heath Cost Containment Council, Pittsburgh Regional Health Care Initiative and such other public and private authoritative bodies as shall be identified from time to time by the board shall be received by the executive director and submitted to the board with the executive director's recommendation regarding implementation of the recommended reforms. The board shall receive input from all interested parties and then shall vote upon all such recommendations within 60 days. Where procedural or protocol reforms are adopted, participating providers will be required to implement such designated best practices within the

next 60 days.

(e) Required investments.--If mandated reforms require the acquisition of additional equipment, participating providers shall make such investments within one year, and, upon application, the board shall provide financing for such mandated equipment on reasonable terms.

(f) Sanctions.--Participating providers refusing to adopt recommended reforms shall, after a reasonable opportunity to be heard, be subject to such sanctions as the board shall deem appropriate and necessary up to and including the suspension or permanent decertification of the provider.

CHAPTER 7

NO-FAULT ADMINISTRATIVE REMEDIES

Section 701. Rationalization of remedies for errors and complications.

A primary objective of the board shall be to reduce the frequency of medical errors and complications and to establish a no-fault administrative procedure for fair and expeditious compensation to those who suffer injuries or complications relating to their care.

Section 702. Voluntary waiver of tort remedies and choice to retain tort remedies.

Beneficiaries under the plan shall be conclusively deemed to have voluntarily waived all other common law and statutory tort remedies against any participating provider for alleged professional negligence, error of judgment or failure to secure informed consent. Beneficiaries under the plan not willing to waive such common law and statutory remedies may opt out of the no-fault administrative remedies set forth in this act at any time prior to the events complained of. Nonparticipating

providers shall not fall within the protections of the waiver of tort remedies.

Section 703. No-fault administrative remedies for those not opting out.

(a) Compensation.--In exchange for the waiver of their traditional tort remedies, beneficiaries who suffer a new injury or complication directly related to the care provided by, or medications or treatments prescribed by a participating provider shall be entitled to expedited compensation without proof of professional negligence or error of judgment. Where the application for compensation does not arise from a new injury or complication but rather asserts a failure of a participating provider to properly intervene, and thus mitigate the natural progress of a disease or injury, proof of a departure from the standard of care must be demonstrated by a preponderance of the credible evidence for the claimant to qualify for compensation. Out-of-state patients seeking care in Pennsylvania from a participating provider shall, prior to treatment unless unconscious or other circumstances prevent it, be provided with a form approved by the board on which the patient can opt in or opt out of the no-fault administrative remedies. Where no election is made, the patient shall be conclusively presumed to have chosen to participate in the no-fault administrative remedies should the occasion arise.

(b) Other compensation.--In further exchange for the waiver of their traditional tort remedies, beneficiaries not opting out of the no-fault administrative remedies and who assert that they did not give their informed consent to an invasive procedure or treatment, but who have not suffered a new injury or complication thereby, shall be entitled to compensation upon

proof of the failure of the participating provider, or the provider's representative, to provide at least the level of information required for the procedure at issue pursuant to guidelines adopted by the board.

(c) Award of damages.--Eligible claimants not opting out of the no-fault administrative remedies shall be entitled to awards to be determined by the health claims hearing officers as follows:

(1) For past and/or continuing lost earning capacity, up to a maximum of $5,000 per month.

(2) For noneconomic harm, defined as past and/or continuing pain, suffering, disfigurement and/or inconvenience, up to a maximum of $5,000 per month.

(3) For a failure of informed consent, either alone or in conjunction with an award for past and or continuing lost earning capacity and/or noneconomic harm, a maximum single lump-sum payment of $10,000.

(4) For death, and in addition to the lost earning capacity and noneconomic harm endured prior to death, up to a maximum of $10,000 per month for 120 months to be placed in trust for the benefit of the decedent's dependents. The trust shall be managed by the office of the beneficiary advocate under guidelines adopted by the board.

(d) Adjustments of limits.--The board shall adjust the limits of compensation annually to account for inflation, and all awards for continuing lost earning capacity and/or noneconomic damages shall be adjusted annually at the same rate of inflation as determined by the board.

(e) Payment from trust.--The cost of all such compensation shall be paid from the trust. No participating provider shall be

held financially responsible for any portion of the compensation award nor shall participating providers be required to fund the cost of such awards collectively through any assessment or premium.

Section 704. Administrative claims procedures.

(a) Application for compensation.--The board shall adopt simplified procedures for the submission of applications for no-fault compensation under this act to the administrator of health claims. The procedures shall provide for the expeditious handling and approval of any clearly qualifying claims. Where fact-finding is required in whole or in part, such claims shall be presented expeditiously to a health claims hearing officer for findings. Administrative appeals to the executive director shall be permitted, and, where a claimant has been denied compensation or contests the sufficiency of the award, claimant shall have an appeal to the Court of Common Pleas of Dauphin County which will consider the adequacy of the compensation on a de novo basis with the power to increase or decrease the amount awarded administratively. However, such court shall not have the power to award compensation in excess of the limits established by this act.

(b) Attorney fees.--Where on appeal to the Court of Common Pleas of Dauphin County a denied claim is approved or an administrative award is increased by at least 25%, the court shall also award a reasonable attorney fee of no more than 20% and all reasonable litigation expenses including the cost of expert witnesses and exhibits.

(c) Adjustment of awards.--The board shall further adopt procedures whereby awards granted under this section for continuing harms shall be subject to increase, not to exceed the

limits, or decrease upon a showing of a material change in the claimant's condition. Continuing benefits shall be contingent upon the reasonable cooperation of the claimant with respect to the rehabilitation and mitigation of the claimant's injury.

(d) Administrative procedure.--The board shall adopt administrative procedure to review appeals of participating providers with respect to denials or adjustment of reimbursement which appeals must be filed within 90 days of the notice of a denied or adjusted reimbursement.

Section 705. Beneficiary right to counsel.

(a) Choice of counsel.--Beneficiaries seeking to file a claim for no-fault compensation under this act shall have the right to be represented by legal counsel of their choice.

(b) Fee agreement.--Any contingent fee agreement entered into between a beneficiary claimant and their legal counsel shall be limited as follows:

(1) Five percent where the claim is administratively approved without a hearing.

(2) Ten percent where the claim proceeds to a hearing.

(3) Twenty percent where the claim is resolved after appeal.

Section 706. Quality assurance follow-up to claims.

(a) Investigations.--All claims of error, complication or failure of informed consent shall simultaneously be submitted for analysis and quality assurance investigation through the office of the administrator for quality assurance. The beneficiary submitting the claim shall be advised of the progress of the inquiry and invited to present such information or testimony as they deem necessary to the full and fair consideration of the matters reported. Beneficiaries may attend

and/or be represented during this process by counsel of their choosing at their own expense or may request the assistance at no cost of a qualified advocate from the office of the administrator of consumer affairs.

(b) Representation of providers.--Participating providers who are the subject of an inquiry initiated by a beneficiary application for compensation may attend and/or be represented by counsel of their choosing at their own expense or may request the assistance at no cost of a qualified advocate from the office of the administrator for provider coordination.

(c) Reports.--At the conclusion of the inquiry, the administrator of quality assurance shall submit a report and recommendations to the executive director who shall then take such action as they deem necessary under the circumstances to avoid a recurrence of any avoidable errors. A copy of the recommendations shall be provided to the beneficiary who initiated the claim and also to the participating provider involved in the inquiry. The report will be forwarded to appropriate licensing authorities for further action.

Section 707. Surviving tort claims against participating providers.

(a) Optional remedies.--Otherwise eligible persons who have opted out of the no-fault administrative remedies of the plan shall retain their right to pursue traditional tort remedies against participating providers through the courts of this Commonwealth and, where jurisdictional requirements are satisfied, through the courts of the United States.

(b) Legal counsel.--In all such cases participating providers shall have the right to legal counsel of their choice the reasonable cost of which shall be paid by the plan as will

the reasonable cost of experts and other trial expenses. In the event of a final award in favor of the persons filing the claim, the plan shall further provide primary indemnification of up to three million dollars per claim and six million dollars per annual aggregate claims per participating provider.

(c) Excess liability coverage.--In the event the private insurance market does not make excess coverage available to participating providers at reasonable cost, the board shall recommend to the General Assembly the establishment of an excess liability insurance pool sponsored by the Commonwealth and financed with premiums to be paid by those participating providers who seek additional protection above and beyond the protection provided in subsection (b).

Section 708. Claims against nonparticipating providers.

Health care providers opting out of the plan shall be responsible for the cost of their legal defense and shall be further responsible to the patient and/or the plan for any settlement or award, if any. Where the plan has paid for health care-related costs arising from an alleged failure of due care by a nonparticipating provider and where the injured party has otherwise been made whole, the plan shall be subrogated to the claim to the extent of the medical expenses incurred or that have been found will be incurred.

Section 709. Parallel no-fault compensation for beneficiaries injured by nonparticipating providers.

Beneficiaries who have not opted out of the no-fault administrative remedies pursuant to section 702, and who believe they have been harmed by the negligence of a nonparticipating provider, may elect, alone or in addition to pursuing traditional tort claims against the nonparticipating providers,

to submit a claim under section 704, in which instance the plan shall be subrogated to and/or credited with the beneficiary's recovery, net of reasonable attorney fees and expenses, from the nonparticipating provider to the extent of economic, noneconomic and/or failure of informed consent benefits paid to such beneficiaries.

CHAPTER 9

PENNSYLVANIA HEALTH CARE TRUST FUND

Section 901. Pennsylvania Health Care Trust Fund.

(a) Establishment.--The Pennsylvania Health Care Trust Fund is hereby established within the State Treasury. All moneys collected and received by the plan shall be transmitted to the State Treasurer for deposit into the fund, to be used exclusively to finance the plan.

(b) State Treasurer.--The State Treasurer may invest the principal and interest earned by the fund in any manner authorized under law for the investment of Commonwealth moneys. Any revenue or interest earned from the investments shall be credited to the fund.

(c) Administrator of finance.--The administrator of finance of the agency shall notify the board when the monthly expenditures or anticipated future expenditures of the plan appear to be in excess of the anticipated future revenues for the same period. The board shall implement appropriate measures upon such notification. Such measures shall include the adjustment of the Wellness Tax as necessary to ensure the solvency of the trust.

Section 902. Rolling budget process.

(a) Estimated annual budget.--The board shall prepare and recommend to the General Assembly an estimated annual budget for

health care, which budget specifies an estimated requirement for health care provided under this act. The budget shall include all of the following components:

(1) A system budget covering all expenditures for the agency.

(2) A capital investment budget.

(3) A purchasing budget.

(4) A research and innovation budget.

(b) Budget projections.--In preparing the budget, the board shall consider anticipated increased expenditures and savings, including, but not limited to, projected increases in expenditures due to improved access for underserved populations and improved reimbursement for primary care, projected administrative savings under the single-payer mechanism, projected savings in prescription drug expenditures under competitive bidding and a single buyer, and projected savings due to provision of primary care rather than emergency room treatment.

(c) Rolling budget.--The board shall operate on a rolling budget whereby it will anticipate its funding needs 90 days in advance and shall seek adjustments from the General Assembly to The Employer Health Services Levy and/or The Individual Wellness Tax to assure solvency of the plan and to avoid unnecessary cash surpluses in the trust.

Section 903. Limitation on administrative expense.

The system budget referred to in this chapter shall comprise the cost of the agency, services and benefits provided, administration, data gathering, planning and other activities and revenues deposited with the system account of the trust. The board shall limit administrative costs to 5% of the agency

budget and shall annually evaluate methods to reduce administrative costs and publicly report the results of that evaluation.

Section 904. Funding sources.

Funding of the plan shall be obtained from the following dedicated sources:

(1) Funds obtained from existing or future Federal health care programs.

(2) Funds from dedicated sources specified by the General Assembly.

(3) Receipts from the tax of 10% of gross payroll, including self-employment profits. One percent of the tax shall become effective the date that shall be the first day of a calendar month no less than 32 days after the effective date of this act, and the tax shall become fully effective November 1, 2008. Employers who are part of a collective bargaining agreement whereby the health care benefits are no less generous than those provided under the plan shall be excused from paying 90% of the tax.

(4) Receipts from the Individual Wellness Tax of 3% of personal earned, passive, pension and investment income. One-half of one percent of the Individual Wellness Tax shall become effective the date that shall be the first day of a calendar month no less than 32 days after the effective date of this act, and the IWC tax shall become fully effective November 1, 2008. Employees who are part of a collective bargaining agreement whereby the health care benefits are no less generous than those provided under the plan shall be excused from paying 90% of the Individual Wellness Tax.

(5) In the event the General Assembly has not responded

to a request by the board for an increase in funding in anticipation of projected expenses, the board is hereby authorized to order a temporary increase, for no more than 90 days, in the Employer Health Services Tax and/or the Individual Wellness Tax of no more than 250 basis points each to respond to a threatened insolvency of the plan.

CHAPTER 11

TRANSITIONAL SUPPORT AND TRAINING FOR DISPLACED WORKERS

Section 1101. Transitional support and training for displaced workers.

(a) Determination of administrator.--The administrator of transition services shall determine which citizens of this Commonwealth employed by a health care insurer, health insuring corporation or other health care-related business have lost their employment as a result of the implementation and operation of the plan. The administrator also shall determine the amount of monthly wages that the individual has lost due to the plan's implementation. The department shall attempt to position these displaced workers in comparable positions of employment or assist in the retraining and placement of such displaced employees elsewhere.

(b) Information.--The administrator of transition services shall forward the information on the amount of monthly wages lost by Commonwealth residents due to the implementation of the plan to the board. The board shall determine the amount of compensation required to assure income maintenance and training that each displaced worker shall receive on a case-by-case basis and shall submit a claim to the trust for payment. A displaced worker, however, shall not receive compensation or training assistance from the trust in excess of $5,000 per month for two

years. Compensation paid to the displaced worker under this section shall serve as a supplement to any compensation the worker receives from any other source including unemployment insurance.

(c) Coordination of services.--The administrator of transition services shall fully coordinate activity with public and private services also available or actually participating in the assistance to the affected individuals.

(d) Appeals.--Persons dissatisfied with the level of assistance they are receiving may appeal to the office of the executive director whose determination shall be final and not subject to appeal.

CHAPTER 13

VOLUNTEER EMERGENCY RESPONDER NETWORK

Section 1301. Preservation of volunteer emergency responder network.

Because this Commonwealth is dependent upon the volunteered services of firefighters, emergency medical technicians and search and rescue workers, the board is further charged with administering a Commonwealth income tax credit program for such volunteers.

Section 1302. Eligibility certification.

Annually, in January, administrators of volunteer firefighting and rescue departments, emergency medical technicians and paramedics stations and similar volunteer emergency entities shall certify the identity of Commonwealth residents providing active services during the prior calendar year.

Section 1303. Eligibility criteria.

Active status shall require a minimum of 200 hours of service

during the preceding year and response to no less than 50% of the emergency calls during at least three of the four calendar quarters.

Section 1304. Amount of tax credit.

Each volunteer certified as active shall be granted a credit equal to $1,000 toward their State income tax obligation under Article III of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. Any eligible volunteer who does not incur $1,000 in annual State income tax liability shall nevertheless be eligible for a refund equal to the amount the credit exceeds that volunteer's tax obligation.

Section 1305. Reimbursement of Department of Revenue.

The State Treasury shall be reimbursed the value of such volunteer credits from the fund.

CHAPTER 15

MISCELLANEOUS PROVISIONS

Section 1501. Effective date.

This act shall take effect immediately.