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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1971 Session of 1985

INTRODUCED BY BARBER, MANDERINO, PISTELLA, COHEN, STEWART, LEVDANSKY, PETRONE, TRELLO, PRESTON, DAWIDA, McHALE, FREEMAN, WOZNIAK, CARN, JOSEPHS, KUKOVICH AND GRUITZA, DECEMBER 10, 1985

REFERRED TO COMMITTEE ON HEALTH AND WELFARE, DECEMBER 10, 1985

AN ACT

Providing for the creation of the Health Care Cost Containment Commission, for its powers and duties, for hospital cost containment through reporting requirements, for the collection and dissemination of data, for hospital efficiency guidelines, utilization controls, public accountability of health care costs, and for health care for the indigent; establishing the Indigent Care Pool and Indigent Care Fund; requiring certain contributions; and making an appropriation.

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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 Reform Act.

Section 2. Legislative finding and declaration.

The General Assembly finds that there exists in this Commonwealth a major crisis because of the continuing escalation of costs for health care services. Because of the continuing escalation of costs, an increasingly large number of Pennsylvania citizens have no, or severely limited, access to appropriate and timely health care. Increasing costs are also undermining the quality of health care services currently being provided. Further, the continuing escalation is negatively affecting the economy of this Commonwealth, is restricting new economic growth and is impeding the creation of new job opportunities in this Commonwealth.

The continuing escalation of health care costs is attributable to a number of interrelated causes, including:

(1) Inefficiency in the present configuration of health

care service systems and in their operation.

(2) The present system of health care cost payments by third parties.

(3) The increasing burden of indigent care which encourages cost shifting.

(4) The absence of a concentrated and continuous effort in all segments of the health care industry to contain health care costs.

Therefore, it is hereby declared to be the policy of the Commonwealth of Pennsylvania to promote health care cost containment by creating an independent autonomous commission to be known as the Health Care Cost Containment Commission.

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.

It is further the intent of this act to facilitate the continuing provision of quality, cost-effective health services throughout the Commonwealth by providing data and information to the purchasers and consumers of health care on both cost and quality of health care services, and to assure access to health care services by the establishment of an Indigent Care Fund.

Section 3. 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" or "rate." The amount to be billed by a hospital for specific goods or services provided to a patient.

"Commission." The Health Care Cost Containment Commission.

"Covered services." Any health care services or procedures connected with episodes of illness that require either inpatient hospital care or major ambulatory surgery, including any initial and followup outpatient services associated with the episode of illness before, during or after inpatient hospital care or major ambulatory surgical procedures. The term does not include ambulatory or routine outpatient services connected with episodes of illness that do not require hospitalization or major ambulatory surgery.

"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 service plan with a certificate of authority issued by the Insurance Department, including, but not limited to, hospital plan corporations as defined in 40 Pa.C.S. Ch. 61, and professional health services plan corporations as defined in 40 Pa.C.S. Ch. 63; 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 the Commonwealth; administrator of a self-insured or partially self-insured health or accident plan providing covered services in the Commonwealth; any health and welfare fund that provides health or accident benefits or insurance pertaining to covered

service in the Commonwealth; the Department of Public Welfare and any other payor for covered services in the Commonwealth other than individual.

"Health care facility." A general or special hospital, including tuberculosis and psychiatric hospitals, inpatient and outpatient rehabilitation facilities, skilled nursing facilities, kidney disease treatment centers, including freestanding hemodialysis units, intermediate care facilities and ambulatory surgical facilities, imaging centers, diagnostic centers, freestanding emergency rooms, surgical centers, ambulatory care facilities and hospices, both profit and nonprofit and including those operated by an agency of State or local government.

"Health care insurer." Any person, corporation, labor organization or other entity that pays for health care services provided to an individual under a program of health care benefits, including, but not limited to, an insurance company, association or exchange issuing health insurance policies in this Commonwealth; hospital plan corporation, as defined in 40 Pa.C.S. Ch. 61; health services plan corporation as defined in 40 Pa.C.S. Ch. 63; health maintenance organization; preferred provider organization; fraternal benefit societies; beneficial societies; third-party administrators; and entities self-funding a program of health care benefits.

"Health maintenance organization." 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.

"High variation medical procedure." A medical procedure for which patterns of incidence and frequency vary widely and the patterns of which cannot be explained by differences in the health of the population.

"Hospital." An institution, licensed in this Commonwealth, which is a general, tuberculosis, mental, chronic disease or other type of hospital, kidney disease treatment center, or ambulatory surgical facility, whether profit or nonprofit, and including those operated by an agency of State or local government.

"Indigent care." The actual costs, as determined by Medicare principles as established in the Federal Medicare Reimbursement Manual (HIN 15), for the provision of free health care, on an inpatient or outpatient basis given to individuals who cannot pay for their care because they are above the medical assistance eligibility levels, and have no health insurance or other financial resources which can cover their health care.

"Low-level variation procedure." Any procedure that is not considered a high variation medical procedure.

"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.

"Medically indigent." The status of a person who is a member of a family unit whose total income is less than two-thirds of the Statewide average weekly wage; whose gross assets, exclusive of the family home and one motor vehicle, do not exceed an

amount equal to two-thirds of the Statewide average annual wage; and who is ineligible for medical assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"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." Any 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 freestanding 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.

"Raw cost data." Any data collected by the commission that reflects actual charges by providers, actual payment accepted by providers, or discloses discounts or differentials between payments accepted by providers and their billed charges.

"Statewide average weekly wage." That amount determined annually by the Department of Labor and Industry under the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law.

Section 4. Pennsylvania Health Care Cost Containment

Commission.

(a) Establishment.--The General Assembly hereby establishes an independent and autonomous commission to be known as the Health Care Cost Containment Commission.

(b) Composition.--The commission shall consist of 15 voting members, composed of the following:

(1) The Secretary of Health.

(2) The Secretary of Public Welfare.

(3) The Insurance Commissioner.

(4) Two representatives of the business community who are purchasers of health care, neither of which is primarily involved in the provision of health care or health insurance, appointed by the Governor from a list of six qualified persons recommended by the Pennsylvania Chamber of Commerce.

(5) Two representatives of organized labor who are not primarily involved in providing health care or health care insurance, appointed by the Governor from a list of six qualified persons recommended by the Pennsylvania AFL-CIO.

(6) Two representatives of organized consumer organizations which are not primarily involved in the provision of health care or health care insurance; one of which shall be appointed by the Governor from a list of three qualified persons recommended by the Speaker of the House of Representatives, one of which shall be appointed by the Governor from a list of three qualified persons recommended by the President pro tempore of the Senate.

(7) One representative of hospitals appointed by the Governor from a list of three qualified hospital representatives recommended by Hospital Association of Pennsylvania.

(8) One representative of physicians appointed by the Governor from a list of three qualified physician representatives recommended jointly by the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Society.

(9) One representative of the Blue Cross and Blue Shield Plans in Pennsylvania, appointed by the Governor from a list of three qualified persons recommended jointly by the Blue Cross and Blue Shield Plans of Pennsylvania.

(10) One representative of commercial insurance carriers, appointed by the Governor from a list of three qualified persons recommended by the Insurance Federation of Pennsylvania, Inc.

(11) One representative of the nursing home industry, appointed by the Governor from a list of three qualified persons recommended jointly by the Pennsylvania Health Care Association and the Pennsylvania Association of Non-Profit Homes for the Aging.

(12) One representative of the HMO Industry appointed by the Governor from a list of three qualified persons recommended by the Association of Pennsylvania HMO's.

(c) Chairperson and vice chairperson.--The members shall annually elect, by a majority vote of the commissioners, a chairperson and a vice chairperson of the commission from among their members, except that the Secretary of Health, the Secretary of Public Welfare and the Insurance Commissioner shall not be eligible to become chairperson.

(d) Quorum.--Eight members shall constitute a quorum for the transaction of any business, unless a greater number is required by the bylaws, and the act by the majority of the members

present at any meeting in which there is a quorum shall be deemed to be the act of the commission.

(e) Meetings.--

(1) The commission shall meet at least once every two months, and may provide for special meetings as it deems necessary. Meeting dates shall be set by a majority vote of the members of the commission or by the call of the chairperson upon seven days' notice to all commission members.

(2) All meetings of the commission shall be publicly advertised and open to the public, except that the commission, through its bylaws, may provide for Executive Sessions of the commission which shall not be open to the public. No act of the commission shall be taken in an Executive Session.

(3) All action taken by the commission shall be taken in open public session, and action of the commission shall not be taken except upon the affirmative vote of a majority of the members of the commission during meetings at which a quorum is present.

(f) Bylaws.--The commission shall adopt bylaws, not inconsistent with this act, and may appoint or elect such officers or committees as it deems advisable.

(g) Compensation and expenses.--The members of the commission shall not receive a salary or per diem for serving as members of the commission but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. Said expenses may include reimbursement of travel and living expenses while engaged in commission business.

(h) Terms of commission members.--

(1) The terms of the Secretary of Health, the Secretary of Public Welfare and the Insurance Commissioner shall be concurrent with their holding of public office. The terms of the 12 commission members appointed by the Governor shall be three years, except that of the members first appointed:

(i) One each of the representatives of business, organized labor, consumers and the representatives of the Blue Cross and Blue Shield Plans shall serve for a term of not more than one year, to expire on June 30 of the year following their appointment.

(ii) Each of the representatives of hospitals, nursing homes, physicians and the commercial insurance carriers shall serve for a term of not more than two years, to expire on June 30 of the second year following their appointment.

(iii) One each of the representatives of business, organized labor, consumers and the representative of the HMO Industry shall serve a term of not more than three years, to expire on June 30 of the third year following appointment.

(2) No appointed member shall be eligible to serve more than two consecutive terms. Vacancies on the commission shall be filled in the same manner in which they were originally designated under subsection (b), within 60 days of the vacancy.

(i) Commencement of operations.--

(1) Within 60 days after the effective date of this act, each organization or individual required to submit a list of recommended persons to the Governor under subsection (b), shall submit said list to the Governor.

(2) Within 90 days of the effective date of this act, the Governor shall make all of the appointments called for in subsection (b), and the commission shall begin operations immediately following these appointments.

(3) Should any organization or individual fail to submit a list of recommended persons required under subsection (b) within the required time outlined in paragraph (1), the Governor shall appoint an acting commissioner until such time as the list of recommended persons is submitted to the Governor by the original organization or individual as required in subsection (b).

Section 5. Powers and duties of the commission.

(a) General powers.--The commission shall exercise all powers necessary or appropriate to carry out this act, including, but not limited to, the following:

(1) To employ an executive director, legal counsel, investigators, and other staff necessary to comply with the provisions of this act and regulations promulgated thereunder, subject to the provisions of the act of August 5, 1941 (P.L.752, No.286), known as the Civil Service Act, and to engage professional consultants, as it deems necessary to the performance of its duties.

(2) To fix the compensation of all employees, consistent with the standards established by the Executive Board of the Commonwealth, and to prescribe their duties.

(3) To make and execute contracts and other instruments, including those for purchase or leasing of equipment and supplies, necessary or convenient to the exercise of the powers of the commission.

(4) To conduct examinations, investigations and audits

and to hear testimony and take proof, under oath or affirmations, at public or private hearings, on any matter material to its duties.

(5) Do all things necessary to carry out its responsibilities under the provisions of this act.

(b) Rules and regulations.--The commission may, in a manner provided by law, promulgate rules and regulations necessary to carry out this act.

(c) Audit powers.--The commission shall have the right to independently audit all information required to be submitted by data sources as needed to corroborate the accuracy of the submitted data. Audits shall be performed on a sample and issue-specific basis, as needed by the commission, and shall be coordinated, to the extent practicable, with audits performed by the Commonwealth. All data sources are hereby required to make all books, records of accounts and any other data needed by the auditors available to the commission at a convenient location within 30 days of a written notification by the commission.

(d) General duties and functions.--The commission shall, at a minimum, perform the following duties and functions:

(1) Develop a computerized system for the collection, analysis and dissemination of data. The commission may contract with a vendor who will provide such data processing services. The commission shall assure that system be capable of processing all data collection required under this act.

(2) 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.

(3) Collect and disseminate data and other information from data sources to which the commission is entitled,

prepared according to formats, time frames and confidentiality provisions as specified in sections 6, 7, 13 and 15, or by the commission.

(4) Define a methodology to collect and disseminate data reflecting quality and efficiency of medical care pursuant to section 6(c)(21) and (d). In carrying out its duty, the commission shall collect data which can assess quality of and access to health care, including, but not limited to:

(i) the incidents of high variation medical practice patterns on a diagnostic basis, by procedure and hospital;

(ii) overall occupancy;

(iii) occupancy by service;

(iv) number of procedures performed in relation to minimum standards for those selected procedures;

(v) location of services for all procedures reasonably performed on an outpatient basis;

(vi) percentage of physicians on staff accepting medical assistance patients;

(vii) percentage of physicians on staff accepting Medicare assignment as full payment;

(viii) status of hospital with regard to trauma, capacity and other specified emergency health care services;

(ix) status or classification of emergency department according to a national standard chosen by the commission;

(x) status of licensure and Joint Accreditation of Hospitals inspections;

(xi) twenty, thirty and forty minute geographic

access zones;

(xii) mortality rates for specified diagnoses and treatments;

(xiii) rates of infection;

(xiv) the quality index, as established by the commission and the change in quality index;

(xv) morbidity rates;

(xvi) incidence of use of specified procedures by diagnosis;

(xvii) correlations between volume of procedures and prices charged, average payments accepted and quality outcomes;

(xviii) readmission rates;

(xiv) rate of incidence for post discharge professional care; and

(xx) average length of stay.

The commission shall be prohibited from releasing any raw cost data or issuing any reports or studies that are not adjusted to reflect quality and efficiency data.

(5) Establish utilization review guidelines as specified in section 8 and certify compliance with these guidelines.

(6) Promote competition in the health care and health insurance markets without raising access barriers to care.

(7) Establish, operate and monitor a Statewide Indigent Care Pool as specified in section 9.

(8) Establish capital cost containment guidelines and review for final approval of certain certificate of need applications, as specified in section 10.

(9) To make annual reports to the General Assembly on the rate of increase in the cost of health care in the

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

(10) To approve hospital billing forms that itemize all charges for services, equipment, supplies and medicine. Each hospital shall submit their billing form to the commission for approval. Such itemized billings shall be written in language that is understandable to the average person and be presented to each patient upon discharge from the hospital or within a reasonable time thereafter.

(11) To conduct studies and publish reports thereon analyzing the effects that noninpatient, 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. These reports shall be submitted to the General Assembly and shall be made available to the public.

Section 6. Data collection.

(a) Submission of data.--The commission is hereby authorized to require data sources to submit data, according to uniform submission formats, coding system and other technical specifications necessary to render the incoming data substantially valid, consistent, compatible and manageable using electronic data processing methods.

(b) Pennsylvania Uniform Claims Form.--The commission shall furnish a Pennsylvania Uniform Claims Form format to all data sources which shall be utilized and maintained by all data sources for all services covered by this act. The Pennsylvania Uniform Claims Form shall consist of the Uniform Hospital Billing Form UB-82/HCFA-1450, or its successors, as developed by the National Uniform Billing Committee, with additional fields as necessary to provide all of the data set forth in subsections (c) and (d). Any reserve field available to accommodate additional data after inclusion of subsection (c) data elements may be utilized to accommodate only additional data designated in accordance with subsection (d). Additional fields necessary for the collection of data required under subsections (c) or (d) shall be added in the manner provided for in subsection (e).

(c) Data elements.--For each covered service performed in Pennsylvania, the commission shall be required to collect the following data elements:

(1) uniform patient identifier, continuous across multiple episodes and providers;

(2) patient date of birth;

(3) patient sex;

(4) patient ZIP Code number;

(5) date of admission;

(6) date of discharge;

(7) principal and up to four secondary diagnoses by standard code;

(8) principal procedure by commission specified standard code and date;

(9) up to three secondary procedures by commission specified standard codes and dates.

(10) uniform hospital or facility identifier, continuous across episodes, patients and providers;

(11) uniform identifier of admitting physician, by unique physician identification number established by the commission, continuous across episodes, patients and providers;

(12) uniform identifier of consulting physicians, by unique physician identification number established by the commission, continuous across episodes, patients and providers;

(13) Total charges of providers, segregated into major categories, including, but not limited to, room and board, radiology, laboratory, operating room, drugs, medical supplies and other goods and services according to guidelines specified by the commission;

(14) Actual payments to hospital or facility;

(15) charges of each physician rendering service relating to an incident of hospitalization or treatment in a freestanding short procedure care unit;

(16) actual payments to each physician or professional rendering service;

(17) uniform identifier of primary payor;

(18) ZIP Code number of facility where health care service is rendered;

(19) uniform identifier for payor group contract number;

(20) patient discharge status; and

(21) quality and efficiency of medical care pursuant to sections 5(d)(4) and 6(d).

All raw cost data required under this section shall be submitted by data sources after being adjusted by stratifying variables.

The commission shall determine appropriate formulas which each data source shall use in adjusting raw cost data submitted to the commission. The stratifying variables for which the commission shall provide appropriate formulas for raw cost data adjustment shall include, but not be limited to, indigent care load; percent of minority patients; direct and indirect teaching costs; case mix; geographic location as a proxy for wage differentials; and sole-community provider status.

(d) Quality and efficiency data elements.--In carrying out its duty to collect data on quality and efficiency of medical care under sections 5(d)(4) and 6(c)(21), the commission shall define a methodology to measure quality and efficiency of medical care which may include additional data elements to be specified by the commission sufficient to carry out its responsibilities under sections 5(d)(4), 6, 7, 13 and 15. The commission may adopt a nationally recognized methodology of quantifying and collecting data on quality and efficiency until such time as the commission has the capability of developing its own methodology and standard data elements. The commission shall add to the available existing reserve field of the Pennsylvania Uniform Claims Form data elements providing information on each episode of illness sufficient to permit analysis of the quality and efficiency of medical services rendered in the manner provided in subsection (e).

(e) Reserve field additions and other data elements.--The commission may increase the reserve field of the Pennsylvania Uniform Claims Form and additional data elements may be added to or deleted from the Pennsylvania Uniform Claims Form only by a majority vote of the commission, and only pursuant to the following procedure:

(1) Commission staff shall prepare a cost-benefit analysis of the proposed addition or deletion which shall include the cost to data sources of any proposed additions.

(2) The commission shall circulate notice of the proposed addition or deletion, along with a copy of the cost-benefit analysis, among data sources and provide for a 60-day comment period.

(3) The commission may hold additional hearings or request such other reports as it deems necessary to make a final determination on the proposed addition or deletion.

Section 7. Data dissemination and publication.

Subject to the confidentiality provisions and raw cost data limitations contained in sections 5, 6 and 13, the commission shall issue publications which shall include:

(1) Publication. The commission shall utilize the data provided under section 6, as well as other data, records and matters of record available to it, to develop and publish periodic reports on:

(i) Comparable practice patterns among individual hospitals or according to appropriate regions or subregions within this Commonwealth, concerning population based admission rates, total lengths of stay and preoperation and postoperation lengths of stay.

(ii) Comparisons among individual hospitals, or appropriate regions or subregions, of room and board charges, ancillary charges, total hospital stay charges and charges for inpatient versus outpatient procedures.

(iii) Statewide, regional or subregional comparisons between and among the types and frequencies of hospitalizations and treatments, adjusted for severity

and stage of illness.

(2) High variation procedures. The commission shall issue an annual report identifying those providers where the existence of high variation medical procedures indicate excessive utilization of the health services they provide. The commission shall make a copy of the report available to the appropriate licensing authorities for action consistent with the purposes of this act. Physicians shall be identified by their medical license number only.

Section 8. Utilization review.

(a) Review guidelines.--The commission is hereby instructed to establish utilization review guidelines to govern utilization review activities in and by providers. All providers shall establish or be part of a utilization review program which meet these guidelines. The guidelines shall require such programs to include, but not be limited to, the following:

(1) Preadmission testing for all elective admissions except for those with demonstrably low variation.

(2) Utilization review for all hospital admissions, except for those with demonstrably low variation which shall include the following:

(i) preadmission review for all elective admissions;

(ii) review of all emergency admissions within 48 hours thereof;

(iii) concurrent review for all inpatient admissions;

(iv) retrospective review for all inpatient admissions; and

(v) discharge planning review.

(3) Mandatory second surgical opinions for all elective

surgery identified as a high variation medical procedure.

(b) Reports.--The commission shall require all health care insurers to report to the commission and to their subscribers on an annual basis on savings generated through their utilization review programs and on the accuracy of their bills.

(c) Departmental utilization review standards.--The commission shall require the Department of Public Welfare to maintain the utilization review standards set forth in this section, for its medical assistance program.

(d) Guideline review.--The commission shall review all proposed guidelines on utilization review prior to their final publication in the Pennsylvania Bulletin.

(e) Liability to health care provider.--No patient or health care insurer shall be liable to a hospital or any other health care provider for health care services finally adjudged unnecessary by the utilization review program promulgated hereunder, provided the patient has acted in good faith. Once a cost has been disallowed, the provider may not rebill that charge to another patient or payor.

Section 9. Health care for the medically indigent.

(a) Right to health care.--Every person in this Commonwealth shall have the right to receive timely and appropriate health care services from any hospital operating in this Commonwealth. As a continuing condition of licensure, each hospital shall offer and provide its full range of health care services to every person in this Commonwealth regardless of financial status or ability to pay. Hospitals may transfer patients only in instances where the hospital lacks the staff or facilities to properly render definitive treatment.

(b) Indigent Care Pool.--To reduce the undue burden on the

several hospitals that disproportionately treat medically indigent people on a compensated basis, and to contain the long-term costs generated by untreated or delayed treatment of illness and disease, there is hereby created an Indigent Care Pool, to be contributed to by charges assessed by the commission on health care providers and health care insurers, to help fund the delivery of timely and appropriate inpatient, outpatient and preventative health care services to the medically indigent. The commission shall administer the collection of all moneys in the Indigent Care Pool and all moneys collected by the commission shall be deposited and held in a separate account in the State Treasury which is hereby established and which shall be known as the Indigent Care Fund (herein referred to as the "fund"). The fund shall be administered by the commission and all moneys in the fund are hereby appropriated to the commission on a continuing basis to carry out the purposes of this section.

(c) Contributions to Indigent Care Fund.--Within 30 days following the end of its fiscal year, each provider, except physicians, in this Commonwealth shall contribute to the Indigent Care Pool 1% of its gross operating revenue for the past fiscal year, subject to the credit provided in subsection (d)(1). In addition, within 30 days following the end of its fiscal year, every health care insurer in this Commonwealth shall contribute 0.6% of its gross health care and accident premiums for the past fiscal year, subject to the credit provided in subsection (d)(2).

(d) Credits.--

(1) Providers which expend more than 3% of their gross operating budget on providing health care to the medically indigent shall be entitled to the following credit against

the contribution required in subsection (c). For every dollar of indigent care provided to the medically indigent by a provider, in excess of 3% of its budget, the provider shall receive a credit of $1 toward its contribution to the Indigent Care Pool.

(2) Health care insurers which make health care coverage available to individuals on a nongroup basis and which provide for at least one period in each calendar year when any or all such individuals may obtain health care coverage without regard to health status or medical underwriting shall be entitled to the following credit against the contribution required in subsection (c). For every dollar in losses incurred in providing such coverage in excess of 100% of the premium or subscription income earned on such coverage, the insurer or service plan corporation shall receive a credit of $1 toward its contribution to the Indigent Care Pool.

(e) Distribution.--The commission shall administer distribution of all moneys in the Indigent Care Pool. Distribution of moneys from the fund shall be made to providers upon application as provided in subsection (f). The commission shall establish a formula for distribution of funds back to providers on the basis of their relative indigent care burden. The commission shall review the providers total financial resources when reviewing an application for distribution from the fund, including the affiliated or related corporations and endowment or other trust fund moneys available to the provider. Providers shall be required to use funds received from the fund to meet their indigent care needs and shall be expected to reduce charges consistent with the level of funds received unless otherwise authorized by the commission. The commission

may require further financial disclosure by providers, as a condition of approval of any provider application.

(f) Application.--The commission shall establish an application form to be used by providers seeking distributions from the fund. Such application form shall include such instruction as the commission deems necessary and reasonable in carrying out its responsibilities under subsection (e). Providers may submit applications for reimbursement from the fund on a quarterly basis. The first application may be submitted six months after the fund has been established.

(g) Eligibility.--Before a provider can be eligible to receive any funds from the fund, it must provide the commission with appropriate certification that for the past fiscal year, it has met all of its obligations under the Hill-Burton Act (60 Stat. 1040, 42 U.S.C. 291 et seq.) and under this act.

(h) Rules and regulations.--The commission shall promulgate such rules and regulations as are necessary to carry out this section.

(i) Determination of eligibility.--The provider shall be responsible for determination and verification of eligibility of each recipient of care.

(j) Reimbursement limit.--Reimbursements to providers shall be limited to the aggregate level of funding which will be available from the fund for the care of the medically indigent.

(k) Signed application.--Every provider 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 provider.

(l) Inpatient limitation.--The commission shall not reimburse inpatient services which can be performed less

expensively in an accessible outpatient setting.

(m) Other available funds.--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.

(n) Preadmission deposit prohibited.--No provider may require a preadmission deposit from any medically indigent patients or medical assistance patients as a condition for offering any of its health care services. Further, a provider may transfer medically indigent patients or medical assistance patients only in instances where the provider lacks the staff or facilities to properly render definitive medical treatment.

(o) Penalty.--Providers who violate subsection (n) shall be ineligible for payment from the fund, and shall be subject to the loss of their license.

Section 10. Capital cost containment and certificate of need review.

(a) Certificate of need.--The commission shall require all health care facilities, as defined in this act, to acquire a certificate of need or an amended certificate of need from the Department of Health for any capital expenditure which would require a certificate of need under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(b) Review.--Notwithstanding Chapter 7 of the Health Care Facilities Act, the commission shall review for final approval or disapproval all certificate of need or amended certificate of need applications that are approved by the Department of Health under the Health Care Facilities Act. Final review and formal commission action shall take place within 60 days following the date the Department of Health issues its approval under the Health Care Facilities Act.

Section 11. Augmented preventive services.

(a) Studies, reports, etc.--The commission shall conduct studies and publish reports thereon analyzing the effects which specific augmented preventive services would have on health care cost containment. Such reports shall be issued and delivered by September 30 of each year to the Governor, to the Chairman of the Senate Appropriations Committee and to the Chairman of the House Appropriations Committee, so that these reports may be considered in the development of the budget for the Commonwealth. Each report shall contain the recommendation by the commission as to whether the augmented preventive service can be provided to sufficient numbers of the population of this Commonwealth on a cost-effective basis.

(b) Augmented preventive services.--Augmented preventive services include, but are not limited to, prenatal care; hypertension screening and treatments; cancer screening; early detection and intervention in child developmental delays; diabetes education; accident prevention; alcohol and drug control or cessation for abusers; hemophilia treatment; expanded ambulatory services; program to aid elderly people in independent living; weight control; cessation of smoking; occupational disease election and prevention; and environmental disease detection and prevention. Augmented preventive services may be targeted for different age, sex or other medically relevant population groups.

Section 12. Preferred provider organizations.

(a) Rights of health care provider or purchaser.--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 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 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 who has entered into an agreement with the insurer or purchaser.

(b) Duties of the commission.--Prior to the commencement of operations of any preferred provider organization, the commission shall determine and certify that:

(1) Any preferred provider organization which assumes financial risk is either licensed as an insurer in this Commonwealth or has adequate working capital and reserves.

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

(3) 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.

(c) Filing requirements.--No preferred provider organization which assumes financial risk may commence operations until it

has reported to the commission such information as the commission requires in accordance with the duties required in section 12(d). Preferred provider organizations may not exclude from participation, or otherwise penalize, any health care provider in compliance with this act unless the commission finds that such exclusion would not lead to substantially diminished access to health care in the appropriate region or subregion. The commission shall promulgate regulations which will prohibit market segmentation and unreasonable profiteering in the health care industry.

(d) Notification of deficiencies.--If, after 60 days, the commission has not informed the preferred provider organization of deficiencies, the preferred provider organization may commence operations unless and until such time as the commission has identified significant deficiencies and such deficiencies have not subsequently been corrected within 60 days of notification.

(e) Appeal procedure.--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 law and procedure).

(f) Continued operation of provider organization.--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 under subsection (b), and may continued to operate subject to the terms of this section.

Section 13. Access to commission data.

(a) Public access and limitations.--The information and data

received by the commission shall be utilized by the commission for the benefit of the public. Subject to the specific limitations set forth in this section, the commission shall make determinations on requests for information in favor of access.

(b) Limitations on access.--Unless specifically provided for in this act, neither the commission nor any contracting system vendor shall release and no data source, person, member of the public or other user of any data of the commission shall gain access to:

(1) any data of the commission which could reasonably be excepted to reveal the identity of an individual patient;

(2) any data of the commission relating to provider effective prices or actual payments to any identified provider made by any person other than the person requesting access to the data;

(3) any data disclosing discounts or differentials between payments accepted by providers for services and their billed charges obtained by identified purchasers from identified providers unless comparable data on all other purchaser data sources is also released and the commission determines that the release of such information is not prejudicial or inequitable to any individual purchaser or provider or group thereof. In making such determination the commission shall consider that it is primarily concerned with the analysis and dissemination of provider effective prices, not with discounts;

(4) any raw data of the commission, except as permitted in section 17;

(5) any data which would identify costs of health care in the absence of equivalent data on the same provider or

population which identifies quality and efficiency as contained in section 5(d)(4) or section 6(c) and (d); or

(6) any data which would be used to exclude or limit health insurance coverage of populations which require a high volume of services or high cost services to protect their health.

(c) Public inspection of records.--All reports prepared by the commission shall be public records, and shall be available to the public for a reasonable fee, not to exceed the cost of duplication. The commission shall, on a monthly basis, prepare, post in its offices, and make available to interested parties, a list of all special studies and reports requested or published, as well as the dates they will be available for public inspection and duplication.

(d) Unauthorized use of data.--Any person who knowingly releases commission data violating the patient confidentiality, actual payments, discount data or raw data safeguards set forth in this section to an unauthorized person commits a misdemeanor of the second degree and, upon conviction, shall be sentenced to pay a fine of $5,000, or to undergo imprisonment for not more than two years, or to both. An unauthorized person who knowingly receives or possesses such data commits a misdemeanor of the second degree.

(e) Unauthorized access to data.--Should any person inadvertently or by commission error gain access to data that violates the safeguards set forth in this section, the data must immediately be returned, without duplication, to the commission with proper notification.

Section 14. Mandated health benefits.

In relation to current law or proposed legislation the

commission shall, upon the request of the appropriate committee chairman in the Senate and in the House of Representatives, or upon the request of the Secretary of Health, provide a cost-benefit analysis of the proposed mandated health insurance benefit. As part of its cost-benefit analysis of existing or proposed mandated health insurance benefits, the commission shall advise of the existence of the least costly health delivery system for the services in question.

Section 15. Special studies and reports.

(a) Special studies.--The commission shall have authority to publish special studies under contract with private organizations or public agencies, but such studies shall be derived only from data available to the commission at the time the studies are requested. The commission shall develop and implement safeguards to maintain individual patient confidentiality, individual payment confidentiality and confidentiality of discount data or differentials between payments accepted by providers for services and their billed charges, and all other access and raw data limitations provided for in sections 5, 6 and 13 shall be maintained. Any special study undertaken by the commission under contract shall become public documents as provided for in section 13(a)(2).

(b) Special reports.--

(1) The commission shall study and make a report, within 18 months from the effective date of this act, on the special medical needs of:

(i) Senior citizens, particularly low-income senior citizens, senior citizens who are members of minority groups and senior citizens residing in low-income urban or rural areas.

(ii) Low-income rural and urban areas.

(iii) Minority communities.

(iv) Women.

(v) Children.

(vi) Workers.

(vii) Veterans.

The report shall include information on the current availability of services to these targeted parts of the population, and whether access to such services has increased or decreased over the past ten years, and specific recommendations for the improvement of their primary care and health delivery systems, including disease prevention and comprehensive health care services. The commission shall also study and report on the effects of using prepaid, capitated or HMO health delivery systems as ways to promote the delivery of primary health care services to the underserved segments of the population enumerated above.

(2) The commission shall study and report on the short and long-term fiscal and programmatic impact on the health care consumer of changes in ownership of hospitals from nonprofit to profit, whether through purchase, merger or the like.

Section 16. Compliance enforcement.

The commission shall have standing to bring an action in 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 commission made pursuant to this act. In addition, the Attorney General is authorized and shall bring any such enforcement action in aid of the commission in any court of common pleas at the request of

the commission in the name of the Commonwealth.

Section 17. Research and demonstration projects.

(a) Project assistance by commission.--The commission shall actively encourage research and demonstrations to design and test improved methods of assessing provider quality and efficiency. To that end, provided that no data submission requirements in a mandated demonstration may exceed the current reserve field on the Pennsylvania Uniform Claims Form, the commission may:

(1) Authorize contractors engaged in health services research approved by the commission to have access to the commission's raw data files, providing such entities assume any contractual obligations imposed by the commission to assure patient identity confidentiality.

(2) Place data sources participating in research and demonstrations on different data submission requirements from other data sources in this Commonwealth.

(3) Require data source participation in research and demonstration projects when this is the only testing method the commission determines is promising.

(b) State-owned hospitals.--The commission shall research and develop hospital quality, efficiency and cost containment procedures, techniques and models and shall test these procedures, techniques and models at various hospitals owned by the Commonwealth. The State-owned hospitals shall cooperate with the commission and shall fairly test the commission's hospital efficiency and cost containment procedures, techniques and models provided that such testing does not endanger patient health.

Section 18. Appropriation.

The sum of $2,250,000, or as much thereof as may be necessary, is hereby appropriated to the Health Care Cost Containment Commission for the fiscal year July 1, 1985, to June 30, 1986, to carry out the provisions of this act.

Section 19. Effective date.

This act shall take effect in 60 days.