SUMMARY
PENNSYLANIA HEALTH CARE REFORM ACT
Chapters 72 through 75 of Title 40 of the Pennsylvania Consolidated Statutes

Chapter 72: *Affordability*

Section 7202 – "Cover All Pennsylvanians" or "CAP"

Establishes a basic health insurance program to help small low-wage employers provide health insurance to their employees and to make reasonably priced health insurance available to uninsured adult individuals.

CAP Fund established as restricted account**:**

- Deposits from general appropriations, federal government or other sources, deposits required under state law, fair share tax, upon implementation of CAP those funds dedicated to adultBasic, and any return on CAP funds.

Components:

- **Rates and premiums**:
  - Rates and premiums established annually by Insurance Commissioner and may vary by region.
  - Enrollee premiums may not be increased more than the average of the increase in the medical care component of the Consumer Price Index (to account for medical care inflation) and the increase in average wage for Commonwealth.
- **Basic coverage** determined by Department of Insurance and will include coverage for: preliminary and annual health assessments; emergency care; inpatient and outpatient care; prescription drugs, medical supplies and equipment; emergency dental care; maternity care; skilled nursing, home health and hospice care; chronic disease management; preventive and wellness care; and behavioral health services.
  - Commonwealth has option to provide any service (such as prescription drugs or behavioral health) directly and not through a CAP contract.
  - No pre-existing condition exclusion.
- **Total monthly premium** estimated to be an average of $280 for the first year, but may vary by region. (See below for maximum enrollee share.)

- **Assistance to small employers** (2 to 50 full-time equivalent employees) whose average wage is below the Commonwealth average wage (currently $40,000):
    - Total employee premiums will be discounted up to 30% ($84 less) provided the employer:
        - Has not offered health insurance to their employees for at least the 180 days leading up to enrollment;
        - Enrolls at least 75% of employees who work 20 hours or more per week;
        - Pays at least 65% of the discounted premium (roughly $130); and
        - Establishes program for employee to pay his premium share, together with any other CAP or Cover All Kids premiums, with pre-tax dollars.
    - Employers will sign up directly with a CAP contractor servicing their geographic area.
- **Available to all adult individual Pennsylvanians** through a CAP contractor servicing their geographic area provided the individual:
    - Has been a resident of the Commonwealth for at least 90 days prior to enrolling (unless the individual is a student, in which case the individual must meet the domiciliary requirements adopted by the State System of Higher Education);
    - Is not eligible for Medicare or Medicaid, except for benefits authorized under a waiver granted by the US DHHS to implement CAP; and
    - With a household income 200% of the Federal poverty level or less has been without insurance for 90 days immediately prior to enrollment (with certain exceptions); or
    - With a household income more than 200% of the Federal poverty level has been without insurance for 180 days immediately prior to enrollment (with certain exceptions).
- **Waiting periods inapplicable** for those transferring from adultBasic program or other public program, those who lose health coverage because of change in employment status, divorce, and similar circumstances.
- **Maximum enrollee premium** for those enrolled through their employer is estimated to be roughly $70 per month (due to discounted premium and requirement that employer pay at least 65%) and for those enrolled as individuals is estimated to be roughly $280 per month.

- **Subsidies for any low-income enrollee** with household income up to 300% of the Federal poverty level upon application to and approval from Department of Insurance.
    - Subsidies result in following estimated average enrollee premiums:
        - Households up to and including 100% federal poverty level, $10.
        - Households more than 100%, but not more than 200%, $40.
        - Households more than 200%, but not more than 300%, $60.
    - Enrollee must verify income every six months or upon change in income or family composition
- **Prevailing Wage Act limitations:**
    - Employees under prevailing wage act contracts have subsidy reduced dollar for dollar for every dollar received to pay for health benefits.
    - Employers under prevailing wage act contracts not entitled to premium discounts.
- **No entitlement established:**
    - Insurance Department has flexibility to freeze enrollment, establish waiting lists, modify or reduce benefits, modify or increase cost sharing, go forward with only part of program, or not go forward at all.
- **CAP Contractors:**
    - Blues must submit proposal for CAP contract; others have option.
    - At least 85% Medical loss ratio required.
    - Blues must provide CAP information to those enrolled in or considering Special Care products.
- **Penalties may be imposed** by Department of Insurance for those who enroll, then drop enrollment, then re-enroll.
- **Data matching** requires those insuring or covering individuals to submit identifying data so the Department of Insurance can cross check for duplicate or other insurance coverage availability.
- **Waivers and State Plan Amendment** – The Department of Public Welfare will apply for waivers from the Federal government and amend the State Plan as

necessary to allow for the implementation of CAP. The program will not begin until the Federal waivers have been approved.

Section 7203 – Fair Share Tax

Establishes a tax on all employers in the Commonwealth, including government employers and church organizations, to help pay for CAP.

Components:

- **Tax amount** for fiscal years 2007-2008 through 2009-2010 is 3% of wages paid by the employer, and, thereafter, tax is 3.5% of wages.
- **Start up credit** over the first five years will assist all employers, but especially small employers, in adjusting to the tax.
  - For any quarter of the fiscal year beginning July 2007, the credit will be $15,000.
  - For any quarter of the second fiscal year, the credit will be $12,000.
  - For any quarter of the third fiscal year, the credit will be $9,750.
  - For any quarter of the fourth fiscal year, the credit will be $7,700.
  - For any quarter of the fifth fiscal year, the credit will be $3,981.25.
  - There shall be no start up credit for any quarter after the fifth fiscal year.
- **Additional credit** available to employers equal to 3% of the wages paid by the employer for fiscal years 2007-2008 through 2009-2010 and 3.5% of the wages thereafter, as follows:
  - Employer must offer qualifying health care coverage to all employees working 30 hours or more per week.
  - Employees working less than 90 consecutive days not included in requirement.
  - Qualifying coverage will be determined by Departments of Labor and Industry and Insurance based on out-of-pocket cost to employee and level of participation in employer's plan.
- **Reports and tax payments:**
  - Each quarter, employers who have a preliminary tax liability after calculation of tax and subtraction of start-up credit must file a report with Department of Labor and Industry.

- Report will include certification on simple form to establish eligibility for additional credit based on offering of qualifying health care coverage.

- Those employers who have a net tax liability after subtracting both start-up and additional credits must pay the tax concurrent with filing of report.

- **Enforcement** similar to enforcement under unemployment compensation law.

Section 7204 – Small group and individual health insurance market reform.

Increases regulatory authority of Insurance Department over small group and individual health insurance plans to reduce premium volatility and requires standard plans so that small group employers and individuals can compare plans on price alone.

Insurer requirements:

- All insurers offering small group or individual health insurance plans must:
    - **Use modified community rating** in setting rates – taking into account only age, geographic region and family composition.
    - **Vary rates by a factor no greater than 33%** of the community rate, thereby achieving a 2 to 1 ratio between the highest rate and the lowest rate charged.
- Small group plans must maintain a **medical loss ratio of no less than 85%.**

Insurance Department Rate Review Authority:

- May take into account operational efficiency, use of best practices, failure to reduce costs due to health care acquired infections or ineffective chronic care management in approving rates.

- May take action against a small group insurer whose plan fails to meet the 85% medical loss requirement, including requiring repayment of premiums.

Standard plan requirements:

- Every insurer offering small group and individual plans must offer a standard plan that:
    - Includes the benefits offered under CAP excluding behavioral health benefits.
    - Does not contain any pre-existing condition exclusion.

- Provides for a behavioral health benefit, priced and sold as an addition to the standard plan.

- May provide for riders offering additional benefits provided such benefits are clearly distinguished from those offered in the standard plan, priced and sold separately from the standard plan, and not duplicative of benefits in the standard plan.

Section 7205 – Mandatory health care coverage for students

Requires all students enrolled full-time in baccalaureate and post-baccalaureate programs to have health care coverage that meets minimum requirements.

- **All insurers** must offer minimum benefit package for students established by Insurance Department as individual coverage and as group coverage through any institution offering baccalaureate and post-baccalaureate programs.

- **Every student** enrolled in a baccalaureate and post-baccalaureate program must present evidence of meeting minimum coverage requirement to institution.

- **Every institution** offering baccalaureate and post-baccalaureate programs must make health care coverage, including CAP, available to its full time students.

  - An institution may satisfy the requirement by providing on-campus coverage through clinics and other facilities, which coverage is approved by the Insurance Department and provides for hospital admissions and emergency services throughout the Commonwealth.

- **Every institution** offering baccalaureate and post-baccalaureate programs must certify to the Insurance Department that all requirements of this Section have been met.

Section 7206 – Optional coverage for children up to age 30.

Requires insurers to allow parents to continue to cover their children under their health insurance plan until the child reaches the age of 30.

- Insurers must offer extended coverage option, even where child has previously been insured under different plan.

- The child must be unmarried, have no dependents, be a resident of the Commonwealth or a full-time student in the Commonwealth, and have no other health insurance coverage.

- Any increase in premium for such extended coverage shall be paid by the parent and not passed on to any employer.

Section 7207 – Hospital community benefit requirements.

Establishes mechanism for measuring hospital community benefit obligation.

Requirements:

- **Community needs assessment** -- By January 1, 2008, every hospital operating as a charitable institution must conduct a community needs assessment to identify those unmet health needs, particularly for vulnerable populations, which:
  - Includes a process for involving community groups; and
  - Is updated every three years.
- **Community Benefits Report** – By April 15 of every year, every hospital operating as a charitable institution must file a report with the Department of Health, which:
  - Details the calculations **establishing the dollar value of the aggregate community benefits** that the hospital is required to provide under the criterion it selects to qualify as a charitable institution under the Institutions of Purely Public Charities Act.
  - Details a **description and the dollar value of each community benefit the hospital has provided** to meet the needs identified in the assessment.
    - For this purpose, the calculation of uncompensated goods and services set forth in the Institutions of Purely Public Charities Act is further **limited as follows**:
      - The **cost of uncompensated services is calculated based on the Medicare reimbursement** for such services, not the charge or cost report data.
      - Volunteer assistance does not include services rendered to the hospital.
      - **Bad debt, efforts to increase market share, professional education, and the like are excluded** from uncompensated goods and services.
  - Is **published** on the hospital website and made available upon request.
- **Audits** – The Department of Health has authority to audit and disallow claims for uncompensated goods or services that do not comply with the requirements.

- **Penalties** – A hospital shall pay the difference in dollar value between its community benefit obligation and the benefits it has actually provided.

- **Uncompensated Care Payment** – A hospital shall be eligible for uncompensated care payments under the Tobacco Settlement Act only if the dollar value of the community benefits it provides exceeds its obligation.

Section 7208 – Uniform admission, fair billing, and collection.

Establishes requirements for hospital admission, fair billing, and collection policies.

Admissions:

- Policies must be based on sound medical practice, written in clear and understandable language, and based on the urgency of the patient's medical condition and the risk to the patient of going without medical care.

- Hospitals must help uninsured patients apply for enrollment in CAP, medical assistance or CHIP.

- Hospitals must provide for referral and transfer of patients to other facilities if the hospital does not accept the patient's insurance or the hospital does not provide the services that the patient needs.

Billing:

- Hospitals must provide itemized bills and complete explanation of charges.

- Hospitals must provide financial counseling and assistance in enrolling in public programs or obtaining other financial help.

- No deposit shall be required where there is a reasonable expectation that the person will qualify for insurance coverage.

- Hospitals must establish timely and effective billing complaint resolution process.

- No uninsured or self-pay patient shall be required to pay more than the Medicare reimbursement rate for any service.

- Hospitals shall not require any patient to enter into any third party credit arrangement.

Collection:

- Hospitals must work to establish reasonable payment plans for payment for services.

- Hospitals shall take legal action only where there is evidence that the individual has the financial means to pay.

- No collection activity shall force foreclosure of an individual's primary residence.

- Hospitals shall require collection agencies to follow the same requirements.

<u>Section 7209</u> – Transparency of price and quality information.

Establishes three price registries to be maintained by the Health Care Cost Containment Council (PHC4) so that consumers can make more informed choices for the delivery of health care services.

Registries:

- The drug retail price registry updated monthly will include the prices of the 150 most frequently prescribed prescription drugs and their generic equivalents gathered from pharmacies in the Commonwealth.

- The hospital payment registry updated annually will include information regarding the payments received by hospitals for the 150 most frequent admission diagnoses and the 150 most frequently dispensed drugs.

- The outpatient procedure payment registry updated annually will include information regarding the payments received by ambulatory surgery facilities and imaging centers for the 50 most frequent outpatient procedures.

Consumer access:

- Registries will provide links to other programs, be in clear language, and contain information in a format that allows consumers to make comparisons among providers.

- Information on registries may be combined with other information to provide information on quality as well as price.

- Registries shall be searchable and allow consumers to access comparative information by zip code.

Chapter 73: *Accessibility*

<u>Section 7302</u> – Pennsylvania Center for Health Careers

Formally establishes the Center to develop strategies to address the Commonwealth's short and long-term health care workforce needs.

- Governed by the Health Careers Leadership Council composed of the Secretaries of Labor and Industry, State, Health and Public Welfare, four members of the General Assembly and public members appointed by the Governor in consultation with the Workforce Investment Board.

- Center shall, among other activities, assess workforce needs, focus on recruitment and retention of health care workers at all levels, research best practices, and develop recruitment tools to increase diversity.

Section 7303 – Health care provider practice.

Expands access to health care providers by eliminating barriers to practice to the fullest extent permitted by the provider's scope of practice and expanding the scope of practice in certain cases.

General rule:

- Allows Certified Registered Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants, Nurse Midwives and Independent Dental Hygienist Practitioners to take medical histories, perform physical or mental examinations and to provide acute illness or minor injury care or management of chronic diseases in the same manner as physicians and dentists, so long as those activities fall within their specialty certification and scope of practice.

- Requires these providers to maintain an appropriate level of malpractice insurance coverage.

Collaborative or written agreements:

- Lifts limitation on how many CRNP's and PA's a physician may supervise under a collaborative or written agreement at the same time.

- Prohibits unreasonable restrictions in collaborative or written agreements.

- Requires the Bureau of Professional and Occupational Affairs in the Department of State to establish a complaint review process with respect to collaborative and written agreements, including mediation requirements.

Elimination of barriers to practice:

- Certified Registered Nurse Practitioner's will be given additional authority to order various types of services and equipment and to perform and sign various types of evaluations and assessments.

- Nurse Midwives will be given prescriptive authority.

- Clinical Nurse Specialists (a type of Advanced Nurse Practitioner) will receive title protection.

- Dental hygienists will be permitted to perform additional functions and administer local anesthesia so long as they obtain a permit and receive certain training.

- The "Independent Hygiene Practitioner" is established as an identified provider who can perform the functions of a dental hygienist at specified sites without the supervision of a dentist.

- The places where pharmacists are permitted to manage drug therapy is expanded to include academic health centers and group practice settings where the pharmacist is an integral member of the clinical team and has access to the patient's medical records.

- Certified Registered Nurse Anesthetist's are given greater autonomy to practice in collaboration with and not under the supervision of an anesthesiologist.

Insurer requirements to increase access:

- Insurers are required to include the following classes of providers in all provider networks:

    - Certified registered nurse practitioners, physician's assistants, clinical nurse specialists practicing in primary care, and nurse midwives; and

    - Urgent care, convenient care, nurse managed care, and federally qualified health centers if they are geographically available.

- Insurers must establish a credentialing process to insure an adequate provider network, which process shall be submitted for approval to the Department of Health.

- Insurers are required to pay rates sufficient to assure the availability and adequacy of the provider network, taking into account the need for fiscal restraint.

- Insurers are required to provide financial incentives for primary care providers offering extended hours in the evenings and on weekends, which permit patients to walk-in or receive a same-day appointment.

- Insurers are required to pay providers who deliver primary care as primary care providers and reasonable rates for delivering specialty care.

- Insurers are prohibited from excluding children with behavioral health needs from coverage.

Section 7304 – Hospice licensure.

Requires the Department of Health to promulgate regulations for licensure of residential hospices, including small facilities (22 or fewer beds) and children's hospices or hospices with units for children.

Chapter 74: *Quality*

Section 7402 – Patient safety requirements.

Establishes requirements for health care providers to eliminate health care acquired infections, reduce medical errors, and improve patient safety and quality outcomes.

Reporting requirements:

- All hospitals are required to use a uniform electronic surveillance system identified and certified by PHC4 to report health care acquired infections to PHC4.
- Hospitals are also required to report emergency department data to PHC4 with respect to individuals presenting at hospitals for emergency services.
- Nursing homes are required to report to PHC4 information on health care acquired infections similar to that reported by hospitals.

Nursing home data analysis by Patient Safety Authority:

- The Patient Safety Authority will analyze data already being reported by nursing homes to the Department of Health to improve patient safety and the quality of care.
    - Nursing homes will receive patient safety advisories published by the Authority and nursing home staff will be eligible for patient safety training conducted by the Authority.
    - Nursing homes are required to pay a surcharge to help fund the Authority's activities of $1 million in the aggregate, pro rated on a per bed basis.

Health information technology:

- Health care facilities are required to develop a plan for implementing e-prescribing systems in their facilities so that every health care provider with prescriptive authority has access to and uses such systems by September 1, 2008.
- The State Board of Medicine is required to set a date by which every licensed physician in the Commonwealth must have access to and use an e-prescribing system to write prescriptions electronically and check for potentially harmful drug

interactions. As of those dates, access to and use of those systems will be a condition of licensure for health facilities and physicians. Grant funds of $25,000,000 will be made available to assist hospitals in acquiring the necessary systems.

Reduction of infections and errors:

- Hospitals are required to submit an annual report to:
  - Identify three-year trends in reducing health care acquired infections, medication errors, readmissions and procedure complications, failures to rescue, and falls.
  - Specify which safe practices as endorsed by the National Quality Forum the hospital has adopted.
  - Specify its plans for adopting and implementing facility-wide and data-driven error-reduction or quality improvement programs.
- Hospitals and nursing homes are required to adopt universal screening of patients, residents and staff for MRSA (methicillin-resistant staphylococcus aureus) and to isolate and take other necessary actions to prevent the spread of MRSA to other inpatients, residents and staff in the event of a positive culture.
- The Department of Health is required to establish standardized best practices for eliminating health care acquired infections and reducing medical errors and a date by which health care facilities shall adopt those practices. It shall be a condition to licensure that health care facilities adopt the standardized best practices and demonstrate that a reduction in health care acquired infections and medical errors has occurred.

Patient safety training:

- Patient safety training is required for top administrators and board members of hospitals as well as top clinical personnel. Similar training is required of nursing home administrators and directors of nursing.
- The State Board of Medicine is not permitted to approve for accreditation any graduate medical education program that does not require at least 6 hours of training focused on eliminating health care acquired infections, preventing medical errors and integrating safe practices.
- The State Board of Medicine is given authority to defer disciplinary or corrective action in the event a clinical needs assessment program is developed and approved by the Board through which a person licensed by the Board may be referred for a clinical skills assessment and undertake a subsequent plan to improve clinical skills or otherwise address any clinical skills deficiencies.

Section 7403 – Statewide smoking ban.

Bans smoking in public places and places of employment across the Commonwealth.

- Excepted from the ban are the following:
    - Private homes and automobiles.
    - Hotel rooms.
    - Retail tobacco businesses.
    - Certain cigar bars in existence on or before December 31, 2005.
- Violators of the ban will be subject to a civil penalty of not less than $250 for the first offense, $500 for the second offense and $1,000 for each subsequent offense. In addition, a court may order immediate compliance.
- County boards of health will be tasked with enforcing the ban. If a county does not have a board of health, the county will be required to designate an "enforcement officer" within 30 days of passage of the bill for this purpose.

Miscellaneous Provisions

Chapter 75 includes miscellaneous provisions relating to the promulgation of regulations by Commonwealth agencies, enforcement by the Insurance Department against violations of provisions of the bill by a licensee of the Department, necessary repeals and severability.