No. 1986-89

AN ACT

SB 293

Providing for the creation of the Health Care Cost Containment Council, for its powers and duties, for health care cost containment through the collection and dissemination of data, for public accountability of health care costs and for health care for the indigent; establishing the Indigent Care Program; 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 Containment 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 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 council to be known as the Health Care Cost Containment Council.

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.

Nothing in this act shall prohibit a purchaser from obtaining from its third-party insurer, carrier or administrator, nor relieve said third-party insurer, carrier or administrator from the obligation of providing, on terms consistent with past practices, data previously provided to a purchaser pursuant to any existing or future arrangement, agreement or understanding.

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 service facility." A facility licensed in this Commonwealth, not part of a hospital, which provides medical, diagnostic or surgical treatment to patients not requiring hospitalization, including ambulatory surgical facilities, ambulatory imaging or diagnostic centers, birthing centers, freestanding emergency rooms and any other facilities providing ambulatory care which charge a separate facility charge. This term does not include the offices of private physicians or dentists, whether for individual or group practices.

"Charge" or "rate." The amount billed by a provider for specific goods or services provided to a patient, prior to any adjustment for contractual allowances.

"Council." The Health Care Cost Containment Council.

"Covered services." Any health care services or procedures connected with episodes of illness that require either inpatient hospital care or major ambulatory service such as surgical, medical or major radiological procedures, including any initial and followup outpatient services associated with the episode of illness before, during or after inpatient hospital care or major

ambulatory service. The term does not include routine outpatient services connected with episodes of illness that do not require hospitalization or major ambulatory service.

"Data source." A hospital; ambulatory service 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 (relating to hospital plan corporations) and professional health services plan corporations as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations); commercial insurer with a certificate of authority issued by the Insurance Department providing health or accident insurance; self-insured employer providing health or accident coverage or benefits for employees employed in 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 for those covered services it purchases or provides through the medical assistance program under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, and any other payor for covered services in the Commonwealth other than an individual.

"Health care facility." A general or special hospital, including tuberculosis and psychiatric hospitals, kidney disease treatment centers, including freestanding hemodialysis units, and ambulatory service facilities as defined in this section, and hospices, both profit and nonprofit, and including those operated by an agency of State or local government.

"Health care insurer." Any person, corporation or other entity that offers administrative, indemnity or payment services for health care in exchange for a premium or service charge 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 (relating to hospital plan corporations); professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations); health maintenance organization; preferred provider organization; fraternal benefit societies; beneficial societies; and third-party administrators; but excluding employers, labor unions or health and welfare funds jointly or separately administered by employers or labor unions that purchase or self-fund a program of health care benefits for their employees or members and their dependents.

"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.

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

"Indigent care." The actual costs, as determined by the council, for the provision of appropriate 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.

"Major ambulatory service." Surgical or medical procedures, including diagnostic and therapeutic radiological procedures, commonly performed in hospitals or ambulatory service facilities, which are not of a type commonly performed or which cannot be safely performed in physicians' offices and which require special facilities such as operating rooms or suites or special equipment such as fluoroscopic equipment or computed tomographic scanners, or a postprocedure recovery room or short-term convalescent room.

"Medical procedure incidence variations." The variation in the incidence in the population of specific medical, surgical and radiological procedures in any given year, expressed as a deviation from the norm, as these terms are defined in the classical statistical definition of "variation," "incidence," "deviation" and "norm."

"Medically indigent" or "indigent." The status of a person as described in the definition of indigent care.

"Payment." The payments that providers actually accept for their services, exclusive of charity care, rather than the charges they bill.

"Payor." Any person or entity, including, but not limited to, health care insurers and purchasers, that make direct payments to providers for covered services.

"Physician." An individual licensed under the laws of this Commonwealth to practice medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

"Preferred provider organization." Any arrangement between a health care insurer 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 service facility or a physician.

"Provider quality." The extent to which a provider renders care that, within the capabilities of modern medicine, obtains for patients medically acceptable health outcomes and prognoses, adjusted for patient severity, and treats patients compassionately and responsively.

"Provider service effectiveness." The effectiveness of services rendered by a provider, determined by measurement of the medical outcome of patients grouped by severity receiving those services.

"Purchaser." All corporations, labor organizations and other entities that purchase benefits which provide covered services for their employees or members, either through a health care insurer or by means of a self-funded program of benefits, and a certified bargaining representative that represents a group or groups of employees for whom employers purchase a program of benefits which provide covered services, but excluding entities defined in this section as "health care insurers."

"Raw data" or "data." Data collected by the council under section 6 in the form initially received. No data shall be released by the council except as provided for in section 11.

"Severity." In any patient, the measureable degree of the potential for failure of one or more vital organs.

Section 4. Health Care Cost Containment Council.

(a) Establishment.—The General Assembly hereby establishes an independent council to be known as the Health Care Cost Containment Council.

(b) Composition.—The council shall consist of 21 voting members, composed of and appointed in accordance with the following:

(1) The Secretary of Health.

(2) The Secretary of Public Welfare.

(3) The Insurance Commissioner.

(4) Six representatives of the business community, at least one of whom represents small business, who are purchasers of health care as defined in section 3, none of which is primarily involved in the provision of health care or health insurance, three of which shall be appointed by the President pro tempore of the Senate and three of which shall be appointed by the Speaker of the House of Representatives from a list of twelve qualified persons recommended by the Pennsylvania Chamber of Commerce. Three nominees shall be representatives of small business.

(5) Six representatives of organized labor, three of which shall be appointed by the President pro tempore of the Senate and three of which shall be appointed by the Speaker of the House of Representatives from a list of twelve qualified persons recommended by the Pennsylvania AFL-CIO.

(6) One representative of consumers who is not primarily involved in the provision of health care or health care insurance, appointed by the Governor from a list of three qualified persons recommended jointly by the Speaker of the House of Representatives and 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 the 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 health maintenance organizations, appointed by the Governor from a list of three qualified persons recommended by the Pennsylvania Association of Health Maintenance Organizations.

(12) In the case of each appointment to be made from a list supplied by a specified organization, it is incumbent upon that organization to consult with and provide a list which reflects the input of other equivalent organizations representing similar interests. Each appointing authority will have the discretion to request additions to the list originally submitted. Additional names will be provided not later than 15 days after such request. Appointments shall be made by the appointing authority no later than 90 days after receipt of the original list. If, for any reason, any specified organization supplying a list should cease to exist, then the respective appointing authority shall specify a new equivalent organization to fulfill the responsibilities of this act.

(c) Chairperson and vice chairperson.—The members shall annually elect, by a majority vote of the members, a chairperson and a vice chairperson of the council from among the business and labor representatives on the council.

(d) Quorum.—Eleven members, a majority of which in any combination shall be made up of representatives of business and labor, shall constitute a quorum for the transaction of any business, 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 council.

(e) Meetings.—All meetings of the council shall be advertised and conducted pursuant to the act of July 19, 1974 (P.L.486, No.175), referred to as the Public Agency Open Meeting Law, unless otherwise provided in this section.

(1) The council 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 council or by the call of the chairperson upon seven days' notice to all council members.

(2) All meetings of the council shall be publicly advertised, as provided for in this subsection, and shall be open to the public, except that the council, through its bylaws, may provide for executive sessions of the council on subjects permitted to be discussed in such sessions under the Public Agency Open Meeting Law. No act of the council shall be taken in an executive session.

(3) The council shall publish a schedule of its meetings in the Pennsylvania Bulletin and in at least four newspapers in general circulation in the Commonwealth. Such notice shall be published at least once in each calendar quarter and shall list the schedule of meetings of the council to be held

in the subsequent calendar quarter. Such notice shall specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public, except that no such notice shall be required for executive sessions of the council.

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

(f) Bylaws.—The council shall adopt bylaws, not inconsistent with this act, and may appoint such committees or elect such officers subordinate to those provided for in subsection (c) as it deems advisable.

(g) Compensation and expenses.—The members of the council shall not receive a salary or per diem allowance for serving as members of the council 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 council business.

(h) Terms of council 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 eighteen appointed council members shall each serve for a term of three years and shall continue to serve thereafter until their successor is appointed, except that, of the members first appointed:

(i) Two each of the representatives of business and organized labor and the representative of consumers shall serve for a term to expire on June 30 of the year following their appointment.

(ii) Two each of the representatives of business and organized labor and the representatives of the Blue Cross and Blue Shield plans of Pennsylvania and the commercial insurance carriers shall serve for a term to expire on June 30 of the second year following their appointment.

(iii) Two each of the representatives of business and organized labor and the representatives of hospitals, physicians and health maintenance organizations shall serve for a term to expire on June 30 of the third year following their appointment.

(2) No appointed member shall be eligible to serve more than two full consecutive terms of three years. Vacancies on the council shall be filled in the same manner in which they were originally designated under subsection (b), within 60 days of the vacancy, except that when vacancies occur among the representatives of business or organized labor, two nominations shall be submitted by the organization specified in subsection (b) for each vacancy on the council.

(3) A member may be removed for just cause by the appointing authority after recommendation by a vote of at least 14 members of the council.

(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, the President pro tempore of the Senate or the Speaker of the House of Representatives under subsection (b) shall submit said list.

(2) Within 90 days of the effective date of this act, the Governor, the President pro tempore of the Senate and the Speaker of the House of Representatives shall make all of the appointments called for in subsection (b), and the council shall begin operations immediately following these appointments.

(j) Subsequent appointments.—Submission of lists of recommended persons and appointments of council members for the second and succeeding terms shall be made in the same manner as prescribed in subsection (b), except that:

(1) Organizations required under subsection (b) to submit lists of recommended persons shall do so at least 60 days prior to expiration of the council members' terms.

(2) The officer required under subsection (b) to make appointments to the council shall make said appointments at least 30 days prior to expiration of the council members' terms, and the appointment shall become effective immediately upon expiration of the incumbent members' terms.

(k) Appointments of acting councilors.—Should any organization or individual fail to submit a list of recommended persons as required under subsection (b) within the time limits in subsection (i) or (j), the officer designated to make the appointment under subsection (b) shall appoint as many acting councilors as required under subsection (b) until such time as the list of recommended persons is submitted by the original organization as required in subsection (b).

Section 5. Powers and duties of the council.

(a) General powers.—The council shall exercise all powers necessary and appropriate to carry out its duties, including 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, and to engage professional consultants, as it deems necessary to the performance of its duties. Any consultants engaged by the council shall be selected in accordance with the provisions for contracting with vendors set forth in section 16.

(2) To fix the compensation of all employees and to prescribe their duties.

(3) To make and execute contracts and other instruments, including those for purchase of services and purchase or leasing of equipment and supplies, necessary or convenient to the exercise of the powers of the council. Any such contract shall be let only in accordance with the provision for contracting with vendors set forth in section 16.

(4) To conduct examinations and investigations, to conduct audits, pursuant to the provisions of subsection (c), and to hear testimony and take proof, under oath or affirmation, at public or private hearings, on any matter necessary to its duties.

(5) To do all things necessary to carry out its duties under the provisions of this act.

(b) Rules and regulations.—The council may, in a manner provided by law, promulgate rules and regulations necessary to carry out its duties under this act.

(c) Audit powers.—The council 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, pursuant to the following:

(1) Audits of information submitted by providers or health care insurers shall be performed on a sample and issue-specific basis, as needed by the council, and shall be coordinated, to the extent practicable, with audits performed by the Commonwealth. All health care insurers and providers are hereby required to make those books, records of accounts and any other data needed by the auditors available to the council at a convenient location within 30 days of a written notification by the council.

(2) Audits of information submitted by purchasers shall be performed on a sample basis, unless there exists reasonable cause to audit specific purchasers, but in no case shall the council have the power to audit financial statements of purchasers.

(3) All audits performed by the council shall be performed at the expense of the council.

(d) General duties and functions.—The council is hereby authorized to and shall perform the following duties and functions:

(1) Develop a computerized system for the collection, analysis and dissemination of data. The council may contract with a vendor who will provide such data processing services. The council shall assure that the system will be capable of processing all data required to be collected under this act. Any vendor selected by the council shall be selected in accordance with the provisions of section 16, and said vendor shall relinquish any and all proprietary rights or claims to the data base created as a result of implementation of the data processing system.

(2) Establish a Pennsylvania Uniform Claims and Billing Form for all data sources and all providers which shall be utilized and maintained by all data sources and all providers for all services covered under this act.

(3) Collect and disseminate data, as specified in section 6, and other information from data sources to which the council is entitled, prepared according to formats, time frames and confidentiality provisions as specified in sections 6 and 10, and by the council.

(4) Adopt and implement a methodology and collect and disseminate data reflecting provider quality and provider service effectiveness pursuant to section 6.

(5) Subject to the restrictions on access to raw data set forth in section 10, issue special reports and make available raw data as defined in section 3 to any purchaser requesting it. Sale by any recipient or exchange or publication by a recipient, other than a purchaser, of raw council data to other parties without the express written consent of, and under terms approved by, the council shall be unauthorized use of data pursuant to section 10(c).

(6) On a monthly basis, publish in the Pennsylvania Bulletin a list of all the raw data reports it has prepared under section 10(f) and a description of the data obtained through each computer-to-computer access it has provided under section 10(f) and of the names of the parties to whom the council provided the reports or the computer-to-computer access during the previous month.

(7) Promote competition in the health care and health insurance markets.

(8) Assure that the use of council data does not raise access barriers to care.

(9) Recommend a permanent indigent care program as specified in, and incorporating the results of the study required in, section 8.

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

(11) Adopt, within 180 days following commencement of its operations pursuant to section 4(i), as part of the Pennsylvania Uniform Claims and Billing Form for covered services pursuant to subsection (d)(2) and section 6(b), a standard billing form for all providers, which shall include, in addition to information required pursuant to section 6(c), such other information and explanations as the council deems necessary, and which itemizes all charges for services, equipment, supplies and medicine. Each provider shall be required to utilize said standard billing form for covered services within 90 days of adoption of said form by the council. Such itemized billings shall be written in language that is understandable to the average person and be presented to each patient upon discharge from a health care facility or provision of physician services or within a reasonable time thereafter.

(12) Conduct studies and publish reports thereon analyzing the effects that noninpatient, alternative health care delivery systems have on health care costs. These systems shall include, but not be limited to: HMO's; PPO's; primary health care facilities; home health care; attendant care; ambulatory service facilities; freestanding 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 submission and collection.

(a) Submission of data.—The council is hereby authorized to collect and data sources are hereby required to submit, upon request of the council, all data required in this section, according to uniform submission formats, coding systems and other technical specifications necessary to render the incoming data substantially valid, consistent, compatible and manageable using electronic data processing according to data submission schedules, such schedules to avoid, to the extent possible, submission of identical data

from more than one data source, established and promulgated by the council in regulations pursuant to its authority under section 5(b).

(b) Pennsylvania Uniform Claims and Billing Form.—The council shall adopt, within 180 days of the commencement of its operations pursuant to section 4(i), a Pennsylvania Uniform Claims and Billing Form format. The council shall furnish said claims and billing form format to all data sources, and said claims and billing form shall be utilized and maintained by all data sources for all services covered by this act. The Pennsylvania Uniform Claims and Billing Form shall consist of the Uniform Hospital Billing Form UB-82/HCFA-1450, and the HCFA-1500, or their 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).

(c) Data elements.—For each covered service performed in Pennsylvania, the council 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 council-specified standard code and date;

(9) up to three secondary procedures by council-specified standard codes and dates;

(10) uniform health care facility identifier, continuous across episodes, patients and providers;

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

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

(13) total charges of health care facility, 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 council;

(14) actual payments to health care facility, segregated, if available, according to the categories specified in paragraph (13);

(15) charges of each physician or professional rendering service relating to an incident of hospitalization or treatment in an ambulatory service facility;

(16) actual payments to each physician or professional rendering service pursuant to paragraph (15);

(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) provider service effectiveness and provider quality pursuant to section 5(d)(4) and subsection (d).

(d) Provider quality and provider service effectiveness data elements.—In carrying out its duty to collect data on provider quality and provider service effectiveness under section 5(d)(4) and subsection (c)(21), the council shall define a methodology to measure provider service effectiveness which may include additional data elements to be specified by the council sufficient to carry out its responsibilities under section 5(d)(4). The council may adopt a nationally recognized methodology of quantifying and collecting data on provider quality and provider service effectiveness until such time as the council has the capability of developing its own methodology and standard data elements. The council shall include in the Pennsylvania Uniform Claims and Billing Form a field consisting of the data elements required pursuant to subsection (c)(21) to provide information on each provision of covered services sufficient to permit analysis of provider quality and provider service effectiveness within 180 days of commencement of its operations pursuant to section 4.

(e) Reserve field utilization and addition or deletion of data elements.—The council shall include in the Pennsylvania Uniform Claims and Billing Form a reserve field. The council may utilize the reserve field by adding other data elements beyond those required to carry out its responsibilities under section 5(d)(3) and (4) and subsections (c) and (d), or the council may delete data elements from the Pennsylvania Uniform Claims and Billing Form only by a majority vote of the council and only pursuant to the following procedure:

(1) The council shall obtain a cost-benefit analysis of the proposed addition or deletion which shall include the cost to data sources of any proposed additions.

(2) The council shall publish notice of the proposed addition or deletion, along with a copy or summary of the cost-benefit analysis, in the Pennsylvania Bulletin, and such notice shall include provision for a 60-day comment period.

(3) The council may hold additional hearings or request such other reports as it deems necessary and shall consider the comments received during the 60-day comment period and any additional information gained through such hearings or other reports in making a final determination on the proposed addition or deletion.

(f) Other data required to be submitted.—Providers are hereby required to submit and the council is hereby authorized to collect, in accordance with submission dates and schedules established by the council, the following additional data, provided such data is not available to the council from public records:

(1) Audited annual financial reports of all hospitals and ambulatory service facilities providing covered services as defined in section 3.

(2) The Medicare cost report (OMB Form 2552 or equivalent Federal form), or the AG-12 form for Medical Assistance or successor forms, whether completed or partially completed, and including the settled Medicare cost report and the certified AG-12 form.

(3) Additional data, including, but not limited to, data which can be used to provide at least the following information:

(i) the incidence of medical and surgical procedures in the population for individual providers;

(ii) physicians who provide covered services and accept medical assistance patients;

(iii) physicians who provide covered services and accept Medicare assignment as full payment;

(iv) status of licensure and accreditation of hospitals and ambulatory service facilities;

(v) mortality rates for specified diagnoses and treatments, grouped by severity, for individual providers;

(vi) rates of infection for specified diagnoses and treatments, grouped by severity, for individual providers;

(vii) morbidity rates for specified diagnoses and treatments, grouped by severity, for individual providers;

(viii) readmission rates for specified diagnoses and treatments, grouped by severity, for individual providers; and

(ix) rate of incidence of postdischarge professional care for selected diagnoses and procedures, grouped by severity, for individual providers.

(4) Any other data the council requires to carry out its responsibilities pursuant to section 5(d).

(g) Allowance for clarification or dissents.—The council shall maintain a file of written statements submitted by data sources who wish to provide an explanation of data that they feel might be misleading or misinterpreted. The council shall provide access to such file to any person and shall, where practical, in its reports and data files indicate the availability of such statements. When the council agrees with such statements, it shall correct the appropriate data and comments in its data files and subsequent reports.

(h) Availability of data.—Nothing in this act shall prohibit a purchaser from obtaining from its health care insurer, nor relieve said health care insurer from the obligation of providing said purchaser, on terms consistent with past practices, data previously provided or additional data not currently provided to said purchaser by said health care insurer pursuant to any existing or future arrangement, agreement or understanding.

Section 7. Data dissemination and publication.

(a) Public reports.—Subject to the restrictions on access to council data set forth in section 10 and utilizing the data collected under section 6 as well as other data, records and matters of record available to it, the council shall prepare and issue reports to the General Assembly and to the general public, according to the following provisions:

(1) The council shall, for every provider within the Commonwealth and within appropriate regions and subregions within the Commonwealth and for those inpatient and outpatient services which, when ranked by order of frequency, account for at least 65% of all covered services and which, when ranked by order of total payments, account for at least 65% of total payments, prepare and issue quarterly reports that at least provide information on the following:

(i) Comparisons among all providers of payments received, charges, population-based admission or incidence rates, and provider service effectiveness, such comparisons to be grouped according to diagnosis and severity, and to identify each provider by name and type or specialty.

(ii) Comparisons among all providers, except physicians, of inpatient and outpatient charges and payments for room and board, ancillary services, drugs, equipment and supplies and total services, such comparisons to be grouped according to provider quality and provider service effectiveness and according to diagnosis and severity, and to identify each health care facility by name and type.

(iii) Until and unless a methodology to measure provider quality and provider service effectiveness pursuant to sections 5(d)(4) and 6(c) and (d) is available to the council, comparisons among all providers, grouped according to diagnosis, procedure and severity, which identify facilities by name and type and physicians by name and specialty, of charges and payments received, readmission rates, mortality rates, morbidity rates and infection rates. Following adoption of the methodology specified in sections 5(d)(4) and 6(c) and (d), the council may, at its discretion, discontinue publication of this component of the report.

(iv) The incidence rate of selected medical or surgical procedures, the provider service effectiveness and the payments received for those providers, identified by the name and type or specialty, for which these elements vary significantly from the norms for all providers.

(2) In preparing its reports under paragraph (1), the council shall ensure that factors which have the effect of either reducing provider revenue or increasing provider costs, and other factors beyond a provider's control which reduce provider competitiveness in the market place, are explained in the reports. It shall also ensure that any clarifications and dissents submitted by individual providers under section 6(g) are noted in any reports that include release of data on that individual provider.

(3) The council shall, for all providers within the Commonwealth and within appropriate regions and subregions within the Commonwealth, prepare and issue quarterly reports that at least provide information on the following:

(i) The number of physicians, by speciality, on the staff of each hospital or ambulatory service facility and those physicians on the staff that accept Medicare assignment as full payment and that accept Medical Assistance patients.

(ii) The status of hospitals respecting accreditation and licensure.

(4) The council shall publish all reports required in this section in the Pennsylvania Bulletin and shall publish, in at least one newspaper of general circulation in each subregion within the Commonwealth, reports on the providers in that subregion and subregions adjacent to it. In addition, the council shall advertise the availability of these reports and the charge for duplication in the Pennsylvania Bulletin and in at least one newspaper of general circulation in each subregion within the Commonwealth at least once in each calendar quarter.

(b) Raw data reports and computer access to council data.—The council shall provide special reports derived from raw data and a means for computer-to-computer access to its raw data to any purchaser, pursuant to section 10(f). The council shall provide such reports and computer-to-computer access, at its discretion, to other parties, pursuant to section 10(g). The council shall provide these special reports and computer-to-computer access in as timely a fashion as the council's responsibilities to publish the public reports required in this section will allow. Any such provision of special reports or computer-to-computer access by the council shall be made only subject to the restrictions on access to raw data set forth in section 10(b) and only after payment for costs of preparation or duplication pursuant to section 10(f) or (g).

Section 8. Health care for the medically indigent.

(a) Declaration of policy.—The General Assembly finds that every person in this Commonwealth should receive timely and appropriate health care services from any provider operating in this Commonwealth; that, as a continuing condition of licensure, each provider should offer and provide medically necessary, lifesaving and emergency health care services to every person in this Commonwealth, regardless of financial status or ability to pay; and that health care facilities may transfer patients only in instances where the facility lacks the staff or facilities to properly render definitive treatment.

(b) Indigent Care Program.—To reduce the undue burden on the several providers that disproportionately treat medically indigent people on an uncompensated basis, to contain the long-term costs generated by untreated or delayed treatment of illness and disease and to determine the most appropriate means of treating and financing the treatment of medically indigent persons, there is hereby created an Indigent Care Program. To fulfill its duties and responsibilities respecting the Indigent Care Program, the council is authorized and directed to:

(1) Study the medically indigent population, the magnitude of uncompensated care for the medically indigent, the degree of access to and the result of any lack of access by the medically indigent to appropriate care, the types of providers and the settings in which they provide indigent care and the cost of the provision of that care pursuant to subsection (c).

(2) Determine, from the study required in paragraph (1), a definition of the medically indigent population and the most appropriate method for the delivery of timely and appropriate health care services to the medically indigent.

(3) Develop a plan for an ongoing program of indigent care to provide those services determined to be required pursuant to paragraph (2) in accordance with the conditions and requirements set forth in subsection (d).

(c) Study.—The council shall conduct a study pursuant to subsection (b)(1), conduct public hearings and take testimony, and thereafter report to the Governor and the General Assembly the results of that study and the results of those public hearings and its recommendations for an ongoing program to finance and deliver care to the medically indigent within 18 months of commencement of the council's operations. The council may contract with an independent vendor to conduct this study in accordance with the provisions for selecting vendors in section 16. The study shall include, but not be limited to, the following:

(1) the number and characteristics of the medically indigent population, including such factors as income, employment status, health status, patterns of health care utilization, type of health care needed and utilized, eligibility for health care insurance, distribution of this population on a geographic basis and by age, sex and racial or linguistic characteristics, and the changes in these characteristics, including the following:

(i) the needs and problems of indigent persons in urban areas;

(ii) the needs and problems of indigent persons in rural areas;

(iii) the needs and problems of indigent persons who are members of racial or linguistic minorities;

(iv) the needs and problems of indigent persons in areas of high unemployment; and

(v) the needs and problems of the underinsured;

(2) the degree of and any change in access of this population to sources of health care, including hospitals, physicians and other providers;

(3) the distribution and means of financing indigent care between and among providers, insurers, government, purchasers and consumers, and the effect of that distribution on each;

(4) the major types of care rendered to the indigent, the setting in which each type of care is rendered and the need for additional care of each type by the indigent;

(5) the likely impact of the current competitive environment, the impact of the provision of care by for-profit provider entities and the effects of cost containment in the Commonwealth on the access to, availability of and financing of needed care for the indigent, including the impact on providers which provide a disproportionate amount of care to the indigent;

(6) the distribution of delivered care and actual cost to render such care by provider, region and subregion;

(7) the provision of care to the indigent through improvements in the primary health care system, including the management of needed hospital care by primary care providers;

(8) innovative means to finance indigent care through such mechanisms as assigned-claims insurance programs, prepaid or capitated delivery

programs, contributions to a pool, donations of professional services or a combination of these or other methods;

(9) reduction in the dependence of indigent persons on hospital services through improvements in preventive health measures; and

(10) the extent to which the proposed Permanent Indigent Care Program required under subsection (d) can be used in conjunction with the medically needy program of Medicaid, through such mechanisms as alterations in eligibility requirements and purchasing methods based upon price and quality of care under the Medical Assistance Program.

(d) Establishing the Permanent Indigent Care Program.—On or before July 1, 1988, the council shall provide to the Governor and the General Assembly a plan, based upon its determination made pursuant to subsection (b)(2), for an ongoing program for the delivery and financing of care to medically indigent persons in the Commonwealth, as defined by the council pursuant to subsection (b)(3). Said plan shall be submitted to the Governor and to the General Assembly for their review. In developing its plan, the council shall be required to address the recommendations developed pursuant to subsection (c). Within 120 days of the submission of the council's plan, the General Assembly shall:

(1) enact the plan as submitted;

(2) modify and enact the plan; or

(3) enact a substitute indigent care program.

Section 9. Mandated health benefits.

In relation to current law or proposed legislation, the council 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 information on the proposed mandated health benefit pursuant to the following:

(1) The General Assembly hereby declares that proposals for mandated health benefits or mandated health insurance coverage should be accompanied by adequate, independently certified documentation defining the social and financial impact and medical efficacy of the proposal. To that end the council, upon receipt of such requests, is hereby authorized and directed to contract with individuals, pursuant to the selection procedures for vendors set forth in section 16, who will constitute a Mandated Benefits Review Panel to review mandated benefits proposals and provide independently certified documentation, as provided for in this section.

(2) The panel shall consist of three senior researchers, each of whom shall be a recognized expert, one in health research, one in biostatistics and one in economics research.

(3) The Mandated Benefits Review Panel shall have the following duties and responsibilities:

(i) To review documentation submitted by persons proposing or opposing mandated benefits within 90 days of submission of said documentation to the panel.

(ii) To report to the council, pursuant to its review in subparagraph (i), the following:

(A) Whether or not the documentation is complete as defined in paragraph (4).

(B) Whether or not the research cited in the documentation meets professional standards.

(C) Whether or not all relevant research respecting the proposed mandated benefit has been cited in the documentation.

(D) Whether or not the conclusions and interpretations in the documentation are consistent with the data submitted.

(4) To provide the Mandated Benefits Review Panel with sufficient information to carry out its duties and responsibilities pursuant to paragraph (3), persons proposing or opposing legislation mandating benefits coverage should submit documentation to the council, pursuant to the procedure established in paragraph (5), which demonstrates the following:

(i) The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth.

(ii) The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.

(iii) The demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit.

(iv) All relevant findings bearing on the social impact of the lack of the proposed benefit.

(v) Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.

(vi) Where the proposed benefit would mandate coverage of an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.

(vii) The results of any other relevant research.

(viii) Evidence of the financial impact of the proposed legislation, including at least:

(A) The extent to which the proposed benefit would increase or decrease cost for treatment or service.

(B) The extent to which similar mandated benefits in other states have affected charges, costs and payments for services.

(C) The extent to which the proposed benefit would increase the appropriate use of the treatment or service.

(D) The impact of the proposed benefit on administrative expenses of health care insurers.

(E) The impact of the proposed benefits on benefits costs of purchasers.

(F) The impact of the proposed benefits on the total cost of health care within the Commonwealth.

(5) The procedure for review of documentation is as follows:

(i) Any person wishing to submit information on proposed legislation mandating insurance benefits for review by the panel should submit the documentation specified in paragraph (4) to the council.

(ii) The council shall, within 30 days of receipt of the documentation:

(A) Publish in the Pennsylvania Bulletin notice of receipt of the documentation, a description of the proposed legislation, provision for a period of 60 days for public comment and the time and place at which any person may examine the documentation.

(B) Submit copies of the documentation to the Secretary of Health and the Insurance Commissioner, who shall review and submit comments to the council on the proposed legislation within 30 days.

(C) Submit copies of the documentation to the panel, which shall review the documentation and issue their findings, pursuant to paragraph (3), within 90 days.

(iii) Upon receipt of the comments of the Secretary of Health and the Insurance Commissioner and of the findings of the panel, pursuant to subparagraph (ii), but no later than 120 days following the publication required in subparagraph (ii), the council shall submit said comments and findings, together with its recommendations respecting the proposed legislation, to the Governor, the President pro tempore of the Senate, the Speaker of the House of Representatives, the Secretary of Health, the Insurance Commissioner and the person who submitted the information pursuant to subparagraph (i).

Section 10. Access to council data.

(a) Public access.—The information and data received by the council shall be utilized by the council for the benefit of the public. Subject to the specific limitations set forth in this section, the council shall make determinations on requests for information in favor of access.

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

(1) Any raw data of the council that does not simultaneously disclose payment, as well as provider quality and provider service effectiveness pursuant to sections 5(d)(4) and 6(d) or 7(a)(1)(iii).

(2) Any raw data of the council which could reasonably be expected to reveal the identity of an individual patient.

(3) Any raw data of the council which could reasonably be expected to reveal the identity of any purchaser, as defined in section 3, other than a purchaser requesting data on its own group or an entity entitled to said purchaser's data pursuant to subsection (f).

(4) Any raw data of the council relating to actual payments to any identified provider made by any purchaser, except that this provision shall not apply to access by a purchaser requesting data on the group for which it purchases or otherwise provides covered services or to access to that same data by an entity entitled to the purchaser's data pursuant to subsection (f).

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

(c) Unauthorized use of data.—Any person who knowingly releases council 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 first degree and shall, upon conviction, be sentenced to pay a fine of $10,000 or to imprisonment for not more than five years, or both. An unauthorized person who knowingly receives or possesses such data commits a misdemeanor of the first degree.

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

(e) Public access to records.—All public reports prepared by the council shall be public records and shall be available to the public for a reasonable fee, not to exceed the cost of duplication.

(f) Access to raw council data by purchasers.—Pursuant to sections 5(d)(5) and 7(b) and subject to the limitations on access set forth in subsection (b), the council shall provide access to its raw data to purchasers in accordance with the following procedure:

(1) Special reports derived from raw data of the council shall be provided by the council to any purchaser requesting such reports.

(2) A means to enable computer-to-computer access by any purchaser to raw data of the council as defined in section 3 shall be developed, adopted and implemented by the council, and the council shall provide such access to its raw data to any purchaser upon request.

(3) In the event that any employer obtains from the council, pursuant to paragraph (1) or (2), data pertaining to its employees and their dependents for whom said employer purchases or otherwise provides covered services as defined in section 3 and who are represented by a certified collective bargaining representative, said collective bargaining representative shall be entitled to that same data, after payment of fees as specified in paragraph (4). Likewise, should a certified collective bargaining representative obtain from the council, pursuant to paragraph (1) or (2), data pertaining to its members and their dependents who are employed by and for

whom covered services are purchased or otherwise provided by any employer, said employer shall be entitled to that same data, after payment of fees as specified in paragraph (4).

(4) In providing for access to its raw data, the council shall charge the purchasers which originally obtained such access a fee sufficient to cover its costs to prepare and provide special reports requested pursuant to paragraph (1) or to provide computer-to-computer access to its raw data requested pursuant to paragraph (2). Should a second or subsequent party or parties request this same information pursuant to paragraph (3), the council shall charge said party a fee sufficient to cover only the costs of duplicating the original access.

(g) Access to raw council data by other parties.—Subject to the limitations on access to raw council data set forth in subsection (b), the council may, at its discretion, provide special reports derived from its raw data or computer-to-computer access to parties other than purchasers. The council shall publish regulations that set forth the criteria and the procedure it shall use in making determinations on such access, pursuant to the powers vested in the council in section 4. In providing such access, the council shall charge the party requesting the access a fee sufficient to cover its costs of providing such access.

Section 11. Special studies and reports.

(a) Special studies.—The Department of Health may publish or contract for publication of special studies. Any special study so published shall become a public document.

(b) Special reports.—

(1) The Department of Health may study and issue a report on the special medical needs, demographic characteristics, access or lack thereof to health care services and need for financing of health care services 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 urban or rural areas.

(iii) Minority communities.

(iv) Women.

(v) Children.

(vi) Unemployed workers.

(vii) Veterans.

The reports 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 department may 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 department may study and report on the short-term 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. The department may also study and report on factors which have the effect of either reducing provider revenue or increasing provider cost, and other factors beyond a provider's control which reduce provider competitiveness in the marketplace, are explained in the reports.

Section 12. Enforcement; penalty.

(a) Compliance enforcement.—The council 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, except section 11, or any requirement or appropriate request of the council made pursuant to this act. In addition, the Attorney General is authorized and shall bring any such enforcement action in aid of the council in any court of common pleas at the request of the council in the name of the Commonwealth.

(b) Penalty.—Any person who fails to supply data pursuant to section 6 commits a misdemeanor of the first degree and shall, upon conviction, be sentenced to pay a fine of $10,000 or to imprisonment for not more than five years, or both.

Section 13. Research and demonstration projects.

The council shall actively encourage research and demonstrations to design and test improved methods of assessing provider quality, provider service effectiveness 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 and Billing Form, the council may:

(1) Authorize contractors engaged in health services research selected by the council, pursuant to the provisions of section 16, to have access to the council's raw data files, providing such entities assume any contractual obligations imposed by the council 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 council determines is promising.

Section 14. Grievances and grievance procedures.

(a) Procedures and requirements.—Pursuant to its powers to publish regulations under section 5(b) and with the requirements of this section, the council is hereby authorized and directed to establish procedures and requirements for the filing, hearing and adjudication of grievances against the council of any data source. Such procedures and requirements shall be published in the Pennsylvania Bulletin pursuant to law.

(b) Claims; hearings.—Grievance claims of any data source shall be submitted to the council or to a third party designated by the council, and the

council or the designated third party shall convene a hearing, if requested, and adjudicate the grievance.

Section 15. Antitrust provisions.

Persons or entities required to submit data or information under this act or receiving data or information from the council in accordance with this act are declared to be acting pursuant to State requirements embodied in this act and shall be exempt from antitrust claims or actions grounded upon submission or receipt of such data or information.

Section 16. Contracts with vendors.

Any contract with any vendor for purchase of services or for purchase or lease of supplies and equipment related to the council's powers and duties shall be let only after a public bidding process and only in accordance with the following provisions, and no contract shall be let by the council that does not conform to these provisions:

(1) The council shall prepare specifications fully describing the services to be rendered or equipment or supplies to be provided by a vendor and shall make these specifications available for inspection by any person at the council's offices during normal working hours and at such other places and such other times as the council deems advisable.

(2) The council shall publish notice of invitations to bid in the Pennsylvania Bulletin. The council shall also publish such notice in at least four newspapers in general circulation in the Commonwealth on at least three occasions at intervals of not less than three days. Said notice shall include at least the following:

(i) The deadline for submission of bids by prospective vendors, which shall be no sooner than 30 days following the latest publication of the notice as prescribed in this paragraph.

(ii) The locations, dates and times during which prospective vendors can examine the specifications required in paragraph (1).

(iii) The date, time and place of the meeting or meetings of the council at which bids will be opened and accepted.

(iv) A statement to the effect that any person is eligible to bid.

(3) Bids shall be accepted as follows:

(i) No council member who is affiliated in any way with any bidder shall vote on the awarding of any contract for which said bidder has submitted a bid, and any council member who has an affiliation with a bidder shall state the nature of the affiliation prior to any vote of the council.

(ii) Bids shall be accepted and such acceptance shall be announced only at a public meeting of the council as defined in section 4(e), and no bids shall be accepted at an executive session of the council.

(iii) The council may require that a certified check, in an amount determined by the council, accompany every bid, and, when so required, no bid shall be accepted unless so accompanied.

(4) In order to prevent any party from deliberately underbidding contracts in order to gain or prevent access to council data, the council may award any contract at its discretion, regardless of the amount of the bid, pursuant to the following:

(i) Any bid accepted must reasonably reflect the actual cost of services provided.

(ii) Any vendor so selected by the council shall be found by the council to be of such character and such integrity as to assure, to the maximum extent possible, adherence to all the provisions of this act in the provision of contracted services.

(iii) The council may require the selected vendor to furnish, within 20 days after the contract has been awarded, a bond with suitable and reasonable requirements guaranteeing the services to be performed with sufficient surety in an amount determined by the council, and upon failure to furnish such bond within the time specified, the previous award shall be void.

Section 17. Appropriations.

(a) General appropriation.—The sum of $1,850,000, or as much thereof as may be necessary, is hereby appropriated to the Health Care Cost Containment Council for the fiscal year July 1, 1986, to June 30, 1987, to carry out all the provisions of this act required of the council.

(b) Study on indigent care.—The sum of $400,000, or as much thereof as may be necessary, is hereby appropriated to the Health Care Cost Containment Council to carry out the study on indigent care required by section 8.

(c) Reallocation upon receipt of other funds.—Should other funds become available to the council for the purpose of the study on indigent care required by section 8, the council may reallocate a portion of the $400,000 appropriation established in subsection (b) for the purpose of subsection (a).

Section 18. Severability.

The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Section 19. Sunset.

This act shall expire December 31, 1992, unless reestablished prior to that date in accordance with the act of December 22, 1981 (P.L.508, No.142), known as the Sunset Act.

Section 20. Effective date.

This act shall take effect immediately.

APPROVED—The 8th day of July, A. D. 1986.

DICK THORNBURGH