

**DRAFT – 2/05/07**

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, reforming the health care system providing for access to affordable health insurance coverage for previously uninsured individuals and for small businesses, ensuring that charitable healthcare institutions meet their community benefit requirements, strengthening Commonwealth oversight of health insurance rate increases, imposing certain duties on retail drug stores and hospitals to report price information, establishing the Pennsylvania Center for Health Careers and the Health Careers Leadership Council, removing barriers to individual health care providers from practicing to the full extent of their scope of practice, education and training, imposing certain patient safety obligations on hospitals and nursing homes, prohibiting smoking in areas open to the public, food service establishments and places of employment, providing for administration, imposing penalties and making repeals.

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

Section 1. Title 40 of the Pennsylvania Consolidated Statutes is amended by adding a part to read:

PART IV  
HEALTH CARE REFORM

Chapter 71  
General Provisions

§7101. Short Title. This part shall be known and may be cited as the Pennsylvania Health Care Reform Act.

§7102. Legislative Intent.

The General Assembly recognizes the following public policy purposes and declares that the following objectives of the Commonwealth are to be served by this act:

(1) Health care costs have been increasing twice as fast as average wages in the Commonwealth. Yet at the same time as health care costs are skyrocketing and nearly one million Pennsylvanians remain uninsured, the Commonwealth is paying billions of dollars each year in avoidable health care costs.

(2) The large number of uninsured workers in the Commonwealth has a negative impact on the Commonwealth's economy and productivity because insured workers are healthier, more productive and use fewer sick days. The Commonwealth should play a role in making health care coverage affordable for small businesses and for uninsured individuals.

(3) The health care crisis is of national concern, but it is possible to create a solution in Pennsylvania that drives down the cost of health care and improves the well-being of Pennsylvania's citizens by addressing three fundamental issues: affordability, access and quality.

(4) The Commonwealth has a clear interest in ensuring that Pennsylvania families and small employers can afford health insurance. In addition to the staggering human impact of inadequate health care, paying for the uninsured drives up the cost of health care for all insured Pennsylvanians. The extra charge in insurance premiums resulting from this amounts to over a billion dollars each year.

(5) Individual and small group health insurance rates are volatile. In order to ensure that affordable individual and small group health insurance is available, we must (a) contain health care coverage premium increases for small employers, (b) spread the risks, (c) ensure that affordable health care coverage is available to those who have lost their employer-based coverage (d) ensure that a substantial portion of the premiums for small employers are used to pay medical claims and (e) require justification for premium increases.

(6) The Commonwealth's not-for-profit hospitals receive tax and other benefits as a result of their classification as charitable institutions and, in return, are required to provide a substantial community benefit. However, there is currently no uniform method of assessing whether a hospital has met this obligation. Not-for-profit hospitals that enjoy these benefits must demonstrate how they are meeting their obligations to the community.

(7) With regard to quality and price, Pennsylvania's health care market should be as transparent as possible, so that all consumers will have the information they need to make informed decisions on where they can obtain the best quality health care at the best price.

(8) To expand access to quality health care, all health care professionals need to be able to practice to the fullest extent of their education, training and skills. Pennsylvania lags behind the rest of the nation in ensuring that nurses, nurse practitioners, physician assistants and other health care providers are permitted to play critical roles to support, coach and treat the patient – resulting in better outcomes for all Pennsylvanians. Barriers that limit licensed health care providers from performing up to

the fullest extent of their scope of practice, education and training in the Commonwealth should be eliminated.

(9) The unnecessary use of emergency room services in the Commonwealth affects both the outcome of patient care and the cost to the entire health care system. Access to clinics that can function as places where individuals go on a regular basis to receive health care should be expanded and Pennsylvanians should be educated about the appropriate use of emergency rooms and alternative sites of care.

(10) The primary goals of the Commonwealth's health care system must be the safety of its patients and the quality of health care services delivered. In order to further these goals and to continue to improve the safety of patients, hospital-acquired infections, which lead to thousands of unnecessary deaths each year and drive up health care costs, must be eliminated. Hospitals need to focus on infection and error trends in their facilities and adopt safe practices and quality management systems to reduce them. Not only individual health care providers, but administrators and boards of directors must be accountable for understanding the importance of patient safety in reducing risk, improving quality, and reducing the cost of health care.

(11) Breathing secondhand smoke is a significant health hazard for nonsmokers. It is in the best interests of the citizens of the Commonwealth to protect nonsmokers from involuntary exposure to secondhand tobacco smoke in indoor areas open to the public, food service establishments and places of employment. In addition, adults who smoke, are overweight, or inactive are at an increased risk of developing high blood pressure, type 2 diabetes, heart disease and some types of cancers and become an economic burden to all health care payers in the Commonwealth.

§7103. Definitions. The following words and phrases when used in this part shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Ambulatory surgical facility.” An entity licensed as an ambulatory surgical facility under the act of July 19, 1979 (P.L. 130, No. 48), known as the Health Care Facilities Act.

“Behavioral health.” Mental health or substance abuse conditions.

“Birth center.” An entity licensed as a birth center under the act of July 19, 1979 (P.L. 130 No. 48), known as the Health Care Facilities Act.

“CAP” or “Cover All Pennsylvanians.” The health insurance program established under section 7202.

“CAP Fund.” The restricted account established under section 202.

“Commonwealth Attorneys Act.” The act of October 15, 1980 (P.L.950, No.164).

“Commonwealth Documents Law.” The act of July 31, 1968 (P.L. 769, No.240).

“Employer.” Every individual, copartnership, association, corporation (domestic or foreign) or other entity, the legal representative, trustee in bankruptcy, receiver or trustee of any individual, copartnership, association or corporation or other entity, or the legal representative of a deceased person, who or which employs one or more individuals to perform services for remuneration for any period of time. The term includes individuals who are self-employed and includes the legislative, executive and judicial branches of the Commonwealth and any political subdivision.

“Fiscal year.” A 12 calendar month period commencing with July 1.

“Health Care Cost Containment Act.” The act of July 8, 1986 (P.L. 408, No. 89).

“Health care facility.” An ambulatory surgical facility, birth center, hospital, or nursing home.

“Health Care Facilities Act.” The act of July 19, 1979 (P.L. 130, No. 48).

“Health care provider.” A licensee; a health care facility; or an officer, employee or agent of any of them acting in the course and scope of employment.

“Hospital.” An entity licensed as an acute-care general hospital, a specialty hospital or rehabilitation hospital under the act of July 19, 1979 (P.L. 130, No. 48), known as the Health Care Facilities Act.

“Insurer.” A company or health insurance entity licensed in the Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under the act of May 17, 1921 (P.L. 682, No. 284), known as the Insurance Company Law of 1921, or any of the following:

(1) The act of December 29, 1972 (P.L. 1701, No. 364), known as the “Health Maintenance Organization Act.”

(2) The act of May 18, 1976 (P.L. 123, No. 54), known as the “Individual Accident and Sickness Insurance Minimum Standards Act.”

(3) 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations), or 63 (relating to professional health services plan corporations).

(4) Section 630 of the act of May 17, 1921 (P.L. 682, No. 284) (relating to preferred provider organizations).

“Licensee.” An individual who is licensed by the Department of State to provide professional health care services in the Commonwealth.

“MCARE.” The act of March 20, 2002 (P.L. 154, No. 13), known as The Medical Care Availability and Reduction of Error (MCARE) Act.

“Medical assistance.” The program of medical assistance established under the act of June 13, 1967 (P.L. 31, No. 21), known as the Public Welfare Code.

“Medicare.” The Federal program established under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. §1395 et seq.).

“Nursing home.” An entity licensed as a long-term care nursing facility under the act of July 19, 1979 (P.L. 130, No. 48), known as the Health Care Facilities Act.

“PHC4.” The Health Care Cost Containment Council established under the act of July 8, 1986 (P.L. 408, No. 89), known as the Health Care Cost Containment Act.

“Public Welfare Code.” The act of June 13, 1967 (P.L. 31, No. 21).

“Regulatory Review Act.” The act of June 25, 1982 (P.L.633, No.181).

“Tax Reform Code.” The act of March 4, 1971 (P.L. 6, No.2).

## Chapter 72 Affordability

§7201. Definitions. The following words and phrases, when used in this part, shall have the meanings given to them in this section unless the context clearly indicates otherwise.

“adultBasic.” The health investment insurance program established under chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

“Accident and Health Filing Reform Act.” The act of December 18, 1996 (P.L. 1066, No. 159).

“Average annual wage.” The total annual wages paid by an employer divided by the number of the employer’s employees.

“Basic benefit package.” The minimum health benefit insurance plan determined by the Insurance Commissioner under section 7202.

“Charitable institution.” A hospital that possesses an exemption from tax under Article II of the act of March 4, 1971 (P.L. 6, No.2), known as the Tax Reform Code of 1971 because it meets the criteria for being an institution of purely public charity as set forth in section 5 of the act of November 26, 1997 (P.L. 508, No. 55), known as the Institutions of Purely Public Charity Act.

“Chronic care model.” A model based on redesign of health care delivery so that patients, who are supported by a health care team, play an active role in their care, and there is an infrastructure to ensure compliance with established practice guidelines. The model includes the following six components:

(1) Self-Management: providing patients with chronic conditions support and information so they can effectively manage their health.

(2) Decision Support: ensuring that treatment decisions by health care providers are based on evidence-based medicine.

(3) Changing the Way Health Care is Provided: ensuring that the patients get the care needed by clarifying roles and tasks and ensuring that all who take care of patients have centralized, up-to-date information about the patient and that follow-up care is provided as a standard procedure.

(4) Clinical Information System: the Patient Registry is the clinical information system that is the foundation for successful integration of all the components of the model because it permits tracking of individual patients and a population of patients, helps guide the course of treatment, anticipate problems and track problems.

(5) Organization of Health Care: the entire organization must be engaged in the chronic care improvement effort.

(6) Supportive Community Programs: forming powerful alliances and partnerships with state, local, business, religious and other organizations to support or expand care for those with chronic disease.

“Chronic disease.” A disease that is long-lasting or recurrent, does not resolve spontaneously, and is rarely completely cured.

“Commissioner.” The Insurance Commissioner of the Commonwealth.

“Commonwealth average annual wage.” The average annual wage in the Commonwealth for a calendar year determined by the Department of Labor and Industry under section 404(e)(2) of the act of December 5, 1936 (2<sup>nd</sup> Sp.Sess., 1936 P.L. 2897, No.1), known as the Unemployment Compensation Law.

“Community benefit.” The community service requirement of an institution of purely public charity under the act of November 26, 1997 (P.L. 508, No. 55), known as the Institutions of Purely Public Charity Act.

“Community Health Reinvestment Agreement.” The Agreement on Community Health Reinvestment entered into February 2, 2005, by the Insurance Department and Capital Blue Cross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross, and published in the Pennsylvania Bulletin at 35 Pa.B. 4155 (July 23, 2005).

“Contractor.” A person with whom the Insurance Department has entered into a contract for the purposes of section 7202.

“Department.” The Insurance Department of the Commonwealth.

“Drug price registry.” The Pennsylvania Drug Retail Price Registry established by PHC4 under section 7209.

“Eligible employee enrollee.” An individual who is 19 years of age or older, is an employee of an eligible small low wage employer participant and has enrolled in the program established under section 7202.

“Eligible individual.” An individual who is 19 years of age or older, has been a resident of the Commonwealth at least 90 days prior to enrollment in the program established under section 7202, is ineligible for Medicare and who:

(1) is currently enrolled in the health investment insurance program established under chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, or is waitlisted for such program on the effective date of this section; or

(2) has a household income that is no greater than 200% of the Federal poverty level at the time of application and has not been covered by any health insurance plan or program for at least 90 days immediately preceding the date of application; or

(3) has a household income that is greater than 200% of the Federal poverty level and has not been covered by any health insurance plan or program during the 180 days immediately preceding the date of application.

Provided, however, that an individual attending an institution of higher education in the Commonwealth shall be required to meet the domiciliary requirements of 22 Pa. Code Ch. 507 prior to enrollment in the program established under section 7202 and the uninsured periods required by paragraphs (2) and (3) shall not apply to an individual who: (i) is eligible to receive benefits pursuant to the act of December 5, 1936 (2<sup>nd</sup> Sp.Sess., 1936 P.L. 2897, No.1), known as the Unemployment Compensation Law; (ii) was covered under a health insurance plan or program but at the time of application is no longer employed and is ineligible to receive benefits pursuant to the Unemployment Compensation Law; (iii) lost coverage as a result of divorce or separation from a spouse or the death of a spouse; or (iv) is transferring from another government-subsidized health insurance program.

“Eligible individual enrollee.” An eligible individual who is enrolled in the program established under section 7202. The term does not include an eligible employee enrollee.

“Eligible small low wage employer.” An employer that meets all of the following:

(1) has at least two, but not more than 50 employees;

(2) has not offered health care insurance through any plan or program during the 180 days immediately preceding the date of application for participation in the program established under section 7202;

(3) the average annual wage paid by the employer is less than the Commonwealth average annual wage; and

(4) will enroll in the program established under section 7202 at least 75% of all of its employees who work 20 hours or more per week.

“Eligible small low wage employer participant.” An eligible small low wage employer who is participating in the program established under section 202.

“Employee.” Any individual from whose wages an employer is required under the Internal Revenue Code to withhold Federal income tax.

“Enrollee.” An eligible employee enrollee or an eligible individual enrollee, as the context may require.

“Fair share tax.” The tax imposed under section 7203.

“Health benefit plan.” Any individual or group health insurance policy, subscriber contract, certificate or plan which provides health or sickness and accident coverage which is offered by an insurer. The term shall not include any of the following:

- (1) accident only policy;
- (2) limited benefit policy;
- (3) credit only policy;
- (4) long-term or disability income policy;
- (5) specified disease policy;
- (6) Medicare supplement policy;
- (7) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement;
- (8) Fixed indemnity;
- (9) Dental only;
- (10) Vision only;
- (11) Workers' compensation policy; or
- (12) Automobile medical payment policy pursuant to Title 75 Pa.C.S.

“Hospital payment registry.” The Pennsylvania Hospital Payment Registry established by PHC4 under section 7209.

“Hospital plan corporation.” A not-for-profit corporation operating under the provisions of 40 Pa.C.S. chapter 61.

“Individual health benefit plan.” A health benefit plan offered to an individual.

“Institution of higher education.” A public or private two or four year college, university or post baccalaureate program.

“Institutions of Purely Public Charity Act.” The act of November 26, 1997 (P.L. 508, No. 55).

“Medical loss ratio.” The ratio of incurred medical claim costs to earned premiums.

“Offeror.” A hospital plan corporation, professional health service corporation or other insurer that submits a proposal in response to the Insurance Department’s solicitation of bids or proposals issued pursuant to section 7202.

“Outpatient procedure payment registry.” The Pennsylvania Outpatient Procedure Payment Registry established by PHC4 under section 7209.

“PACE.” The Pharmaceutical Assistance Contract for the Elderly established under the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law.

“Patient representative.” An individual designated to act as the patient’s health care agent or health care representative under 20 Pa.C.S. Ch. 54 (relating to health care) or who has informed the hospital that he will be financially responsible for the patient’s medical care.

“Preexisting condition.” A disease or physical condition for which medical advice or treatment has been recommended or received prior to the effective date of coverage.

“Prescription drug.” A controlled substance, other drug or device for medication dispensed by order of a health care provider with prescriptive authority under the laws of the Commonwealth.

“Prevailing Wage Act.” The act of August 15, 1961 (P.L. 987, No. 442).

“Professional health service corporation.” A not-for-profit corporation operating under the provision of 40 Pa.C.S. chapter 63.

“Qualifying health care coverage.” A health benefit plan or other form of health care coverage that qualifies an employer for the credit pursuant to section 7203.

“Small employer.” In connection with a group health plan with respect to a calendar year and a plan year, an employer who employs an average of at least two but not more than 50 employees on business days during the preceding calendar year and

who employs at least two such employees on the first day of the plan year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination whether an employer is a small employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year.

“Small group health benefit plan.” A health benefit plan offered to a small employer.

“Standard plan.” The health benefit package established by the Insurance Department in accordance with section 7204.

“Tobacco Settlement Act.” The act of June 26, 2001 (P.L.755, No.77).

“Unemployment Compensation Law.” The act of December 5, 1936 (2<sup>nd</sup> Sp.Sess., 1936 P.L. 2897, No.1).

“Wages.” All remuneration (including the cash value of mediums of payment other than cash) paid by an employer to all individuals for services performed in the Commonwealth (including amounts withheld from the individuals pay by the employer), except that the term “wages” shall not include the following:

(1) Remuneration for service performed by an individual who (i) has been and will continue to be free from control or direction over the performance of such services both under his contract of service and in fact; and (ii) as to such services such individual is customarily engaged in an independently established trade, occupation, profession or business. For purposes of subclause (ii), an individual is not customarily engaged in an independently established trade, occupation, profession or business with respect to services the individual performs unless all of the following apply:

(A) the individual possesses the tools, equipment and other assets necessary to perform the services independent of the entity for whom the services are performed;

(B) the individual’s arrangement with the entity for whom the services are performed is such that the individual may realize a profit or suffer a loss as a result of performing the services;

(C) the individual performs the services through a business that was established before the individual began to perform the services and in which the individual has a proprietary interest; and

(D) prior to performing the services, the individual (1) performed the same or similar services for another entity under circumstances where the requirements of subclause (i), determined without regard to this subclause (D), are satisfied, or (2) held himself out to the public as available to perform the same or similar services under such circumstances;

(2) Remuneration excluded from wages pursuant to the provisions of section 4(x) of the act of December 5, 1936 (2<sup>nd</sup> Sp.Sess., 1936 P.L. 2897, No.1), known as the Unemployment Compensation Law, other than the provisions of section 4(x)(1), except that this paragraph shall not exclude remuneration included in wages pursuant to section 4(x)(6) of the Unemployment Compensation Law.

§7202. Cover All Pennsylvanians health insurance program.

(a) Establishment of program.--The Cover All Pennsylvanians health insurance program is hereby established within the department. The purpose of the program is to assist certain small businesses to cover their uninsured employees and to provide access to affordable health insurance coverage for uninsured adult Pennsylvanians. The department shall administer the program pursuant to the provisions of this section.

(b) Establishment of CAP Fund.--There is established a restricted account in the General Fund, to be known as the CAP Fund. Money appropriated by the General Assembly, income earned on the money in the fund, money received from the Federal government or other sources, funds required to be deposited pursuant to other provisions of this part or any other law, funds received from the fair share tax described in section 203, and other revenues described in subsection (c) shall be deposited into the fund. The money in the fund is hereby appropriated, upon approval of the Governor, to be used exclusively for the implementation and administration of CAP.

(c) Revenues to be deposited into the CAP Fund.--For fiscal year 2007-2008 and thereafter, the following revenues shall be deposited into the CAP Fund:

(1) all funds appropriated for adultBasic under section 306(b)(1)(vi) of the Tobacco Settlement Act; and

(2) all funds required to be dedicated to adultBasic or any alternative program to benefit persons of low income under the Community Health Reinvestment Agreement within the respective service areas for each party to that agreement; provided, however, that such funds will only be used to defray the cost of the subsidies approved under subsection (d)(4).

(d) Premiums, discounts, and subsidies.—Premiums, discounts and subsidies shall be determined in accordance with this subsection.

(1) Premiums for CAP shall be established annually by the Commissioner, may vary by region and contractor and shall be based on actuarially sound and adequate review. The Commissioner shall forward notice of the premium amount to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin and the premium shall be implemented by contractors as soon as practicable following such publication but in no event later than 120 days following such publication. Premiums to be paid by eligible small low wage employer participants and enrollees under this section shall be increased at a rate no higher than the average of the change in the medical care component of the Consumer Price Index and the change in average wage for the Commonwealth of Pennsylvania as determined by the Department of Labor and Industry.

(2) The premium for eligible employee enrollees shall be discounted in an amount determined annually by the Commissioner. The premium discount shall not exceed 30%.

(i) An eligible small low wage employer participant shall pay at least 65% of the discounted premium for each employee enrolled. The employer shall have the option of paying more than 65% of the discounted premium for each employee.

(ii) An eligible employee enrollee not receiving a subsidy under paragraph (4) shall pay the balance of the discounted premium.

(iii) An eligible small low wage employer participant shall facilitate the payment, on a pre-tax basis, of that portion of the discounted premium to be paid by its eligible employee enrollees as well as any CAP premiums for dependents or, if applicable, premiums for the children's healthcare program established under the act of May 17, 1921 (P.L. 682, No. 284), known as the Insurance Company Law of 1921.

(3) The premiums for eligible individual enrollees not receiving subsidies under paragraph (4) shall be at the full premium level.

(4) An enrollee whose household income is at or below 300% of the Federal poverty level may apply to the department for a premium subsidy under the provisions of this paragraph.

(i) The department shall review and approve applications for subsidies under this subsection.

(ii) For the 2007-2008 fiscal year, subsidies shall be calculated to result in the following premium amounts based on household income:

(A) for an enrollee whose household income is not greater than 100% of the Federal poverty level, the monthly premium shall be \$10;

(B) for an enrollee whose household income is greater than 100% but not greater than 200% of the Federal poverty level, the monthly premium shall be \$40; and

(C) for an enrollee whose household income is greater than 200% but not greater than 300% of the Federal poverty level, the monthly premium shall be \$60.

(iii) For subsequent fiscal years, the Commissioner may establish different subsidy amounts and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(iv) Enrollees receiving subsidies pursuant to this paragraph shall verify their household income and household composition with the department every six months and shall notify the department in writing within 30 days upon any change in their household income or composition.

(5) Notwithstanding any other provision of this section to the contrary:

(i) an enrollee who is paid the prevailing wage while working on a public work as required by the Prevailing Wage Act, and who is otherwise entitled to a subsidy pursuant to paragraph (4), shall be subject to a reduction of the subsidy on a dollar-for-dollar basis for every dollar paid to him as part of the prevailing wage requirement that is allocable for use in the purchase of health care benefits; and

(ii) a small low wage employer participant that has a contract to perform work on a public work subject to the Prevailing Wage Act shall not be entitled to the premium discount provided under paragraph (2) during the term of the contract.

(6) The department shall freeze enrollment and establish waiting lists to assure that the Commonwealth's costs to implement and administer CAP do not exceed funds made available for the program. Nothing under this section shall

constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth.

(7) Notwithstanding any other law to the contrary, in the event it is more cost effective for the Commonwealth to purchase health care coverage from an enrollee's employer-based program than pay the Commonwealth's share of any subsidized premium, and that employer-based program meets or exceeds the basic benefit package, employer-based coverage may be purchased in place of enrollment in CAP by the Commonwealth paying the employee's share of the premium to the employer.

(f) Duties of the department. The department shall:

(1) Administer the CAP program on a Statewide basis.

(2) Solicit bids or proposals and award contracts for the basic benefit package through a competitive procurement in accordance with 62 Pa. C.S. (relating to procurement) and in accordance with subsection (g). The department may award contracts on a multiple award basis as described in 62 Pa.C.S. § 517 (relating to multiple awards).

(3) Impose reasonable cost sharing arrangements and encourage appropriate use by contractors of cost effective health care providers who will provide quality health care by establishing and adjusting co-payments to be incorporated into CAP by contractors. The department shall forward changes to co-payments to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. Such changes shall be implemented by contractors as soon as practicable following such publication, but in no event more than 120 days following such publication.

(4) Ensure that the eligibility of eligible small low wage employer participants and enrollees receiving subsidies are redetermined every six months.

(5) In consultation with appropriate Commonwealth agencies, conduct monitoring and oversight of contracts entered into with contractors.

(6) In consultation with appropriate Commonwealth agencies, monitor, review and evaluate the adequacy, accessibility, and availability of services delivered to enrollees.

(7) In consultation with appropriate Commonwealth agencies, establish and coordinate the development, implementation, and supervision of an outreach plan to ensure that all those who may be eligible have access to CAP. The plan shall include provisions for reaching special populations, including nonwhite and non-

English-speaking persons and persons with disabilities; for reaching different geographic areas, including rural and inner-city areas; and for assuring that special efforts are coordinated within the overall outreach activities throughout the Commonwealth.

(8) For individual enrollees and upon their request, facilitate the payment of premiums for CAP and dependents covered under CAP or, if applicable, for the children's healthcare program established under the act of May 17, 1921 (P.L. 682, No. 284), known as the Insurance Company Law of 1921, on a pre-tax basis.

(g) Awarding of contracts.

(1) Each professional health service corporation and hospital plan corporation or their subsidiaries or affiliates doing business in this Commonwealth shall submit a bid or proposal to the department to carry out the purposes of this section in the area serviced by such corporation. All other insurers may submit a bid or proposal to the department to carry out the purposes of this section.

(2) The department shall review and score the bids or proposals on the basis of all of the requirements for the CAP program. The department may include such other criteria in the solicitation and in the scoring and selection of the bids or proposals that the department, in the exercise of its administrative duties under this section, deems necessary; provided, however, that the department shall:

(i) Select, to the greatest extent practicable, offerors that contract with health care providers to provide health care services on a cost-effective basis. The department shall select offerors that use appropriate cost-management methods that will enable the program to provide coverage to the maximum number of enrollees.

(ii) Select, to the greatest extent practicable, only offerors that comply with all procedures relating to coordination of benefits as required by the department and the Department of Public Welfare.

(3) Contracts may be for an initial term of up to five years, with options to extend for five one-year periods.

(h) Rates and Charges.--

(1) The medical loss ratio for a contract shall be no less than 85%.

(2) No enrollee shall be charged a fee by any person as a requirement for enrolling in CAP.

(h) Participation by eligible small low wage employers.--An eligible small low wage employer seeking to participate in the CAP program shall select and contact a contractor that services its geographic area from a list of CAP contractors posted on the department's CAP website or otherwise obtained from the department upon request. The employer shall adequately inform employees of the opportunity to enroll in the program and the process for enrollment required by the contractor. Enrollees shall comply with the application and other enrollment requirements of the contractor and shall pay all required premiums.

(j) Termination of employment.--Eligible employee enrollees who are terminated from employment shall be eligible to continue participating in the CAP program provided they continue to meet the requirements of an eligible individual enrollee and pay any increased premiums that may be required.

(k) Enrollment by eligible individuals.--An eligible individual seeking to purchase insurance through CAP shall:

(1) Select and contact a contractor that services his geographic area from a list of CAP contractors posted on the department's CAP website or otherwise obtained from the department upon request.

(2) Comply with the application and other enrollment requirements of the contractor.

(3) Pay the required premiums directly to the contractor.

(l) Basic benefit package.—

(1) The basic benefit package to be offered under CAP shall be of such scope and duration as the department shall determine, which shall provide for preliminary and annual health assessments; emergency care; limited inpatient and outpatient care; prescription drugs; emergency dental care; maternity care; limited skilled nursing, home health and hospice care; chronic disease management; diabetic supplies and equipment; preventive and wellness care; and limited inpatient and outpatient behavioral health care.

(2) The Commonwealth may elect to provide any benefit directly through its own program or contractor.

(3) Enrollment in CAP shall not be prohibited based upon a preexisting condition nor shall a CAP benefit plan exclude a diagnosis or treatment for the condition based upon its preexistence.

(m) Data matching.—

(1) In order to ensure that the Commonwealth does not pay more than its share of premiums under the CAP program for any one enrollee, all insurers providing health care coverage to individuals residing in the Commonwealth shall report to the department in writing on a monthly basis the names and other identifying information of all individuals they insure.

(2) The department shall use the information obtained in paragraph (1) to determine whether any portion of an enrollee's premium is being paid from any other source. If a determination is made that an enrollee's premium is being paid from another source, the department shall not make any additional payments to the insurer for such enrollee.

(3) If any payment has been made to an insurer by the department for an enrollee for whom any portion of the premium paid by the department is being paid from another source, the insurer shall reimburse the department the amount of any such excess payment or payments.

(4) To the maximum extent permitted by law, and notwithstanding any policy or plan provision to the contrary, a claim by the department for reimbursement under paragraph (3) shall be deemed timely filed with the insurer if it is filed within three years following the date of payment.

(5) The department is authorized to enter into agreements with insurers for the purpose of carrying out the provisions of this subsection. The agreements shall provide for the electronic exchange of data between the parties at a mutually agreed upon frequency, but no less than once every two months, and may also allow for payment of a fee by the department to the insurer.

(6) The department, in cooperation with the Department of Public Welfare, shall determine that no other insurance coverage is available to the enrollee through an alimony agreement or an employment-related or other group basis. If such insurance coverage is available, the department shall re-evaluate the enrollee's eligibility under this section.

(n) Information to be provided for insurers.—A hospital plan corporation or a professional health services corporation shall provide a person in the Commonwealth who has applied for insurance through its Special Care product with written information about the existence of CAP, the benefits it covers and the cost to the person to purchase CAP in plain language so that the person applying for insurance through Special Care can compare the costs and benefits of it and CAP. Insurers shall develop written materials that comply with the provisions of this subsection and submit

them to the department for review. Only materials approved by the department may be provided to applicants for any Special Care product offered in the Commonwealth.

(o) Regulations.--The department may promulgate regulations for the implementation and administration of this section.

(p) Federal waivers.--The Department of Public Welfare, in cooperation with the department, shall apply for all applicable waivers from the Federal government and shall amend the State Plan as deemed necessary to carry out the provisions of this part. When the Department of Public Welfare receives approval of such waivers, it shall so notify the department and shall transmit notice of the approval fact to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin. The department shall be authorized to change the premium and co-payment amounts payable under subsection (d) in order for the CAP program to meet Federal requirements.

(q) Federal funds.—Notwithstanding any other provision of law, the Department of Public Welfare, in cooperation with the department, shall take any action as may be necessary to ensure the receipt of Federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq. for services provided under this part, and to qualify for available Federal financial participation under said title.

#### §7203. Fair share tax.--

(a) Imposition of tax.--In order to help fund the Commonwealth's cost of implementing and administering CAP, each employer in the Commonwealth shall pay a fair share tax equal to three percent of the wages paid by the employer.

(b) Credits against tax.—

(1) In order to give employers an opportunity to plan in advance for the payment of the fair share tax, for fiscal years 2007-2008 through 2011-2012, the amount of the tax an employer is otherwise required to pay may be reduced by the amount of the credit determined under this paragraph. For fiscal year 2007-2008, the amount of the credit shall be \$60,000. Prior to the commencement of each subsequent fiscal year, the Department of Revenue shall determine the amount of the credit for that fiscal year and forward such determination to the Department of Labor and Industry. The Department of Labor and Industry shall forward a notice of the determination to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(2) Recognizing that some employers voluntarily provide health care benefits to their employees, relieving the Commonwealth's taxpayers of the burden of paying for health care for otherwise uninsured individuals, every employer that offers qualifying health care coverage to each of its employees who work 30 hours per week or

more following no more than 90 days of continued employment during any fiscal year shall be entitled to an annual credit against the fair share tax in an amount equal to three percent of the employer's wages. The Department of Labor and Industry, in consultation with the department, shall determine whether the employer's offer shall be considered as qualifying health care coverage based on the premium and out-of-pocket costs to the employee and the level of employee participation. In the case of multiple plans offered by the same employer, the determination shall be based on the cost to the lowest wage employees of the employer and the relative participation of those employees.

(3) The total amount of the credits under this subsection shall not exceed the amount of fair share tax imposed under subsection (a) for the year the credit is granted.

(4) The credits under this subsection may not be carried back or carried forward to other years, refunded, assigned or sold.

(c) Reports by employers.

(1) If an employer's liability for fair share tax for a calendar quarter, determined without regard to subsection (b)(2), exceeds the amount of credit available to the employer pursuant to subsection (b)(1) for that calendar quarter, the employer shall file a report with the Department of Labor and Industry for that calendar quarter. The report shall be due by the last day of the month immediately following the calendar quarter. The report shall be made in a manner prescribed by the Department of Labor and Industry and shall contain all information required by the Department of Labor and Industry, including the following:

(i) The amount of wages paid by the employer during the calendar quarter.

(ii) The number of hours worked by each employee in the calendar quarter.

(iii) A certification that the employer did or did not satisfy the requirements for the credit under subsection (b)(2) throughout the calendar quarter.

(2) Each employer shall file any other reports required by the Department of Labor and Industry in the administration of this section, which shall be made in the manner prescribed by the Department of Labor and Industry and contain all information required by the Department of Labor and Industry.

(d) Payment of tax.--Concurrently with each report required under subsection (c), the employer shall pay to the Department of Labor and Industry the amount of fair share tax imposed under this section for the period covered by the report.

(e) Penalties.--Any employer who does not make and file the periodic report required by subsection (c)(1) in the manner prescribed by the Department of Labor and Industry on or before the date such report is required to be filed shall pay a penalty. The amount of the penalty shall be ten percent (10%) of the amount of fair share tax due for the period; provided, however, that such penalty shall be not less than fifty dollars (\$50) or more than five thousand dollars (\$5,000). All penalties collected under this subsection shall be deposited into the CAP Fund.

(f) Interest.-- Fair share taxes unpaid on the date on which they are due and payable shall bear interest at one-twelfth (1/12) of the annual rate determined by the Secretary of Revenue under section 806 of the act of April 9, 1929 (P.L.343, No.176), known as "The Fiscal Code," per month or fraction of a month, or at the rate of three quarters of one per centum (0.75%) per month or fraction of a month, whichever is greater, from the date they become due until paid. All interest collected under this subsection shall be deposited into the CAP Fund.

(g) Refunds.-- If any employer applies for refund or credit of any amount paid as fair share tax, interest or penalties, and the Department of Labor and Industry determines that such amount, or any portion thereof, was erroneously collected, the Department of Labor and Industry may at its discretion either allow a credit, without interest, in connection with subsequent fair share tax payments or shall refund from the CAP Fund, without interest, the amount erroneously paid. No refund or credit shall be allowed with respect to a payment as fair share tax, interest or penalties, unless the employer files an application on or before, whichever of the following dates shall be the later:

(1) one year from the date on which such payment was made,  
or

(2) four years from the reporting due date of the reporting period with respect to which such payment was made.

For a like cause and within the same period, a refund may be made or a credit allowed on the initiative of the Department of Labor and Industry.

(h) Collections and enforcement.

(1) Records maintained by employers pursuant to section 206(a) of the Unemployment Compensation Law and corresponding regulations shall be open to inspection by the Department of Labor and Industry for purposes of this section to the same extent that they are open to inspection for purposes of the Unemployment Compensation Law.

(2) The provisions of sections 304(a)-(d), 305(c), 308.1, 309 and 309.2 of the Unemployment Compensation Law are incorporated into this section and shall be applicable to the fair share tax, interest and penalties. References in such provisions of the Unemployment Compensation Law to contributions shall be deemed to be references to the fair share tax for purposes of this section.

(i) False statements and representations; other offenses

(1) Any employer (whether or not liable for the payment of fair share taxes under this subsection) or any officer or agent of such employer or any other person who does any of the following commits a summary offense and shall, upon conviction, be sentenced to pay a fine of not less than one hundred dollars nor more than fifteen hundred dollars or to imprisonment for not longer than thirty days, or both:

(i) makes a false statement or representation knowing it to be false, or who knowingly fails to disclose a material fact to avoid becoming or remaining subject hereto, or to avoid or reduce any fair share tax or other payment required from an employer under this subsection;

(ii) willfully fails or refuses to make fair share tax or other payment required hereunder;

(iii) willfully fails or refuses to produce or permit the inspection or copying of records as required hereunder; or

(iv) willfully fails or refuses to furnish any report required by paragraph (3) or the rules or regulations of the Department of Labor and Industry.

(2) The number of offenses under paragraph (1) shall be determined as follows:

(i) Each false statement or representation or failure to disclose a material fact shall constitute a separate offense under paragraph (1)(i).

(ii) Each day of failure or refusal shall constitute a separate offense under paragraph (1)(ii), (iii) and (iv).

(iii) Each report required by subsection (c) or the rules or regulations of the Department of Labor and Industry shall be the basis of a separate offense under paragraph (1)(iv).

(3) In addition to any other sanction, any employer, officer, agent or other person convicted under this section for willful failure or refusal to make a payment shall be ordered to make restitution of the unpaid amounts, including interest and penalty from the date the payment was due through the date of payment.

(4) For purposes of this paragraph, the term "willfully" shall have the meaning applicable to the term "willfully" under 18 Pa.C.S. § 302 (relating to general requirements of culpability).

(j) Powers and duties of the Department of Labor and Industry.--It shall be the duty of the Department of Labor and Industry to administer and enforce this section. It shall have power and authority to adopt, amend, and rescind such rules, regulations, and guidance, require such reports from employers, employees, and any other person deemed by the Department of Labor and Industry to be affected by this section, make such investigations, and take such other action as it deems necessary or suitable. Such rules, regulations and guidance shall not be inconsistent with the provisions of this section. In the discharge of the duties imposed by this section, the Secretary of the Department of Labor and Industry and any agent duly authorized in writing by him shall have the power to administer oaths and affirmations, take depositions, and certify to official acts. The Department of Labor and Industry shall have the power to issue subpoenas to compel the attendance of witnesses and the production of books, papers, correspondence, memoranda and other records deemed necessary in the administration of this section.

#### §7204. Health insurance rate increases; Standard plan.

(a) Applicability.—This section applies to all small group health benefit plans and individual health benefit plans issued, made effective, delivered or renewed in the Commonwealth after the effective date of this section.

(b) Premium rates.--

(1) All insurers shall establish community rates for plans subject to this section and shall file such rates with the department as required by law. For purposes of this section, an insurer's "community rate" shall refer to a rating

methodology that is based on the experience of all risks covered by that plan without regard to health status, occupation or any other factor. An insurer may adjust its community rate for the following:

- (i) age;
- (ii) geographic region as approved by the department;
- (iii) family composition.

(2) An insurer shall apply all risk adjustment factors under subparagraphs (i), (ii) and (iii) of paragraph (1) consistently with respect to all plans subject to this section.

(3) An insurer shall not charge a rate that is more than 33% above or below the community rate, as adjusted as permitted under paragraph (1).

(4) An insurer shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles. Rates shall not be excessive, inadequate, or unfairly discriminatory.

(c) Additional Rate Review.--

(1) In conjunction with and in addition to the standards set forth in the Accident and Health Filing Reform Act and all other applicable statutory and regulatory requirements, the department may disapprove a rate filing based upon the following:

- (i) The rate is not actuarially sound.
- (ii) The increase is requested because the insurer has not operated efficiently or has factored in experience that conflicts with recognized best practices in the health care industry.
- (iii) The increase is requested because the insurer has incurred costs of additional care due to avoidable hospital-acquired infections and avoidable hospitalizations due to ineffective chronic care management, after data for such incidents has become available to, and can be analyzed by, the insurer and the department.
- (iv) For small group health plans, the medical loss ratio is less than 85%.

(2) In the event a small group health benefit plan has a medical loss ratio of less than 85%, the department may, in addition to any other remedies available under law, require the insurer to refund the difference to policyholders on a pro rata basis as soon as practicable following receipt of notice from the department of such requirement but in no event later than 120 days following receipt of such notice. The department shall establish procedures for the circumstances under which such refunds will be required.

(3) The filing and review procedures set forth in the Accident and Health Filing Reform Act shall apply to any filing conducted pursuant to this section.

(d) Standard plan required.--

(1) An insurer shall not offer a plan that does not meet the minimum benefits specified in the standard plan developed by the department in accordance with the following criteria:

(i) Plans offered by an insurer on an expense-incurred basis shall be actuarially equivalent to at least the minimum benefits required to be offered under the standard plan.

(ii) The standard plan shall at least include all of the benefits of the basic benefit package except that it shall not include coverage for drug and alcohol treatment and mental health care services.

(iii) The standard plan shall not contain pre-existing condition exclusion.

(2) The standard plan may include options for deductible and cost-sharing provisions if the department determines that such provisions:

(i) dissuade consumers from seeking unnecessary services;

(ii) balance the effect of cost-sharing in reducing premiums and in effecting utilization of appropriate services; and

(iii) limit the total cost-sharing that may be incurred by an individual in a year.

(3) Each individual in the Commonwealth who applies to an insurer for enrollment in a plan offered by the insurer shall be accepted as an enrollee.

(4) The department shall forward a notice of the elements of the standard plan to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. Insurers subject to the provisions of this section shall be required to begin offering the standard plan as soon as practicable following such publication but in no event later than 120 days following such publication.

(e) Optional additional coverage.

(1) An insurer may offer benefits in addition to those in the standard plan if the additional benefits:

(i) are offered and priced separately from benefits specified in the standard plan;

(ii) do not have the effect of duplicating any of the benefits in the standard plan; and

(iii) are clearly specified as enhancements to the standard plan.

(2) Each benefit offered in addition to the standard plan that increases health care choices or lowers the cost-sharing arrangement is subject to all of the provisions of this section applicable to the standard plan.

(3) The department may prohibit an insurer from offering an additional benefit under this section if the department finds that the additional benefit will be sold in conjunction with the insurer's standard plan in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this section or other state law.

(f) Regulations.--The department may promulgate regulations necessary for the implementation and administration of this section.

§7205. Health insurance coverage for full-time students.

(a) Minimum health benefit package.--Within 90 days following the effective date of this section, the Commissioner shall establish a minimum health benefit package for full-time students enrolled in public or private baccalaureate and post baccalaureate programs in Pennsylvania and transmit a description of the package to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. As soon as practicable after the date of publication of the package, but in no event later than 120 days following such publication, all insurers shall offer the package. The Commissioner

may make revisions to the minimum health benefit package periodically, but no more than one time per 12 month period. Each such revision shall be implemented by insurers as soon as practicable following publication of the revision in the Pennsylvania Bulletin but in no event later than 120 days following such publication.

(b) Mandatory coverage.--

(1) Every full-time student enrolled in a public or private baccalaureate or post baccalaureate program in Pennsylvania shall maintain health insurance coverage which provides the minimum benefit package established in this section. The coverage shall be maintained throughout the period of the student's enrollment.

(2) Every student required to meet the mandatory coverage in this section shall present evidence of such coverage to the institution at least annually, in a manner prescribed by the institution.

(3) Every public or private college or university or post baccalaureate program in Pennsylvania shall make available health insurance coverage, including CAP for those who are eligible under section 7202, on a group or individual basis for purchase by students who are required to maintain the coverage pursuant to this section.

(4) Notwithstanding the foregoing, the requirements of this section may be satisfied if the baccalaureate or post baccalaureate program provides on-campus student health care coverage equivalent to the minimum benefit package through its own clinics and health care facilities and receives approval from the department that such equivalent coverage meets the minimum benefit package.

(c) Every public or private baccalaureate or post baccalaureate program in Pennsylvania shall certify to the department at least annually that the requirements of this section have been met for all periods of the preceding year.

(d) The department may impose a fine of up to \$500 per day for each day that a public or private baccalaureate or post baccalaureate program fails to meet any of its obligations in this section. The fine shall be due within 30 days following receipt by the institution of notice of the violation. Funds collected under this subsection shall be deposited into the CAP Fund.

§7206. Health insurance coverage for certain children of insured parents.

(a) Option to cover certain children.--An insurer that issues, delivers, executes, or renews health care insurance in the Commonwealth, under which coverage

of a child terminates at a specified age, shall, at the option of the child's parent or guardian, provide coverage to a child of the insured beyond that specified age, up through the age of 29, provided that the child:

- (1) is not married;
- (2) has no dependents;
- (3) is a resident of the Commonwealth or is enrolled as a full-time student at an institution of higher education in the Commonwealth; and
- (4) is not covered by another health insurance policy.

(b) Exercise of option.--An insured may exercise the option provided by subsection (a) at any time during the term of the policy by notice to the insurer.

(c) Employer contribution.—Employers shall not be required to contribute to any increased premium charged by the insurer for the exercise of the option provided by subsection (a), but such contributions may be agreed to by the employer.

#### §7207. Hospital community benefit requirements.

(a) Community needs assessment.--

(1) Hospitals operating as charitable institutions shall by January 1, 2008, either alone, in conjunction with other health care providers, or through other organizational arrangements, complete a community needs assessment in accordance with guidelines established by the Department of Health whereby the hospital identifies, for its primary service area as determined by the hospital, unmet needs to improve or maintain health status in the community, particularly with respect to those vulnerable populations exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for public health programs.

(2) The hospital shall conduct its community needs assessment by including a process for consulting with community groups and local government officials in identifying and prioritizing community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangements. The community needs assessment shall be updated at least once every three years.

(b) Community benefits report.--

(1) On or before April 1, 2008, and every calendar year thereafter, the hospital shall prepare a community benefits report containing the following information with respect to the immediately preceding calendar year:

(i) the specific criterion under section 5(d)(1) of the Institutions of Purely Public Charity Act that the hospital asserts qualifies it as providing benefits to the community and the calculation of the dollar amount that criterion requires the hospital to meet; and

(ii) a description and value of the uncompensated goods or services that the hospital has provided to address the specific community needs identified in the community needs assessment.

(2) The amount attributed to uncompensated goods or services as set forth in the Institutions of Purely Public Charity Act for the purposes of this report shall be further limited as follows:

(i) The full cost of uncompensated health care services shall be calculated as the Medicare reimbursement the hospital receives for those services.

(ii) The reasonable value of volunteer assistance donated by individuals who are employed or otherwise affiliated with the provision of health care services by the hospital shall only include community services or programs related to the mission of the hospital, but which are not provided in or by the hospital.

(ii) The term uncompensated goods or services shall not include the following:

(A) Bad debt;

(B) Health screening, health education classes, or other programs either designed to increase market share or for which a fee is charged or a referral to the hospital is made;

(C) Programs provided as an employee benefit;

(D) Use of facility space to hold meetings for community groups;

(E) Expenses for in-service training, continuing education, orientation, mentoring, or joint appointments.

(c) Filing and publication.—The hospital shall file its report on or before April 15 of each calendar year with the Department of Health and shall publish its community needs assessment and annual report on its hospital website and make them available to any member of the community upon request.

(d) Audit.—The Department of Health shall have authority to audit the hospital's community benefit report at any time and disallow any amount claimed for uncompensated goods and services that does not comply with this section. A hospital shall retain records documenting the calculations contained in its community benefit report for a period of 3 years following issuance of the report.

(e) Fines.—

(1) A hospital that reports an amount of uncompensated goods and services under subsection (b)(1)(ii) that is lower than the amount it is required to provide under subsection (b)(1)(i), shall pay the difference to the Department of Health within 60 days following receipt of written notice from the Department of Health that the same is due.

(2) A false or misleading statement contained in a hospital's community benefit report or a failure to comply with the provisions of this section shall subject the hospital to a fine of \$1,000 per day to be imposed and collected by the Department of Health.

(3) The fines imposed by paragraphs (1) and (2) shall be in addition to any other fine or other penalty that may be imposed upon a hospital under the Institutions of Purely Public Charity Act.

(4) All funds collected under this subsection, as well as any fines or penalties collected from hospitals under the Institutions of Purely Public Charity Act shall be deposited into the CAP Fund.

(f) Uncompensated care program.—Notwithstanding the provisions of Chapter 11 of the Tobacco Settlement Act to the contrary, a hospital subject to the provisions of this section shall only be entitled to apply for payment from the Hospital Uncompensated Care Program established under that Chapter equal to the amount by which the amount of uncompensated goods and services reported under the provisions of subsection (b)(1)(ii) exceeds the amount it is required to provide under subsection (b)(1)(i).

§7208. Uniform admission and fair billing and collection practices.

(a) Admission criteria. A hospital shall be subject to the following with respect to its admission criteria:

(1) A hospital may not deny admission, and a health care provider may not refuse to provide services, for reasons not based on sound medical practice to individuals seeking medical services requiring admission to the hospital. Admission policies and protocols shall be in plain language and available upon request. Admissions shall be prioritized on the basis of urgency of the medical condition and the risk to the individual of going without medical care.

(2) No individual shall be denied necessary medical services from a hospital based on race, color, religion, gender, disability, sexual orientation, national origin, or source of payment.

(3) A hospital shall facilitate the completion of an application for enrollment in CAP and, if applicable, the children's healthcare program established under the act of May 17, 1921 (P.L. 682, No. 284), known as the Insurance Company Law of 1921, by any uninsured individual who presents at the hospital for admission or emergency services. The hospital shall deliver the completed application or applications by facsimile or other expeditious means to a contractor providing coverage for the individual's county of residence.

(4) When a hospital cannot provide the specific medical services required by a patient, the hospital shall make appropriate arrangements for transferring the patient to another hospital or other source of health care that can provide the required medical services.

(5) A hospital is not required to provide services or make a referral that is contrary to its stated ethical policy in accordance with the act of December 9, 2002 (P.L. 1701, No. 214), known as the Religious Freedom Protection Act; provided, however, that such hospital shall provide express notice to its patients of its policies regarding those health care services.

(b) Billing policies. A hospital shall be subject to the following with respect to its billing policies:

(1) A hospital shall provide to the patient or the patient representative upon request an itemized bill and an explanation of all charges in plain language.

(2) Prior to admission or as soon as practicable thereafter, the hospital shall inform the patient or the patient representative if the hospital, its staff, contractors, or subcontractors will not accept the patient's third party payment.

(3) A hospital shall provide the patient, or the patient's representative, with information and counseling on the availability of known financial resources for his health care and assist the patient or patient's representative in enrolling in public programs including CAP for which the patient may be eligible and in securing such other financial resources as may be available.

(4) A deposit shall not be required by a hospital where there is a reasonable expectation that the individual will qualify for CAP, Medicare, medical assistance, other government programs, or a private insurance program that will cover the services to be provided at the hospital.

(5) A hospital shall establish a process for receiving and reviewing billing complaints that includes a requirement that hospital staff address them in a specified, timely manner and shall notify the patient or patient's representative of the complaint process upon admission to and at discharge from the hospital.

(6) In no event shall uninsured patients or self-pay patients be compelled to pay more than the Medicare reimbursement rate for the services provided.

(c) Collection policies. A hospital shall be subject to the following with respect to its collection policies:

(1) It shall work with each patient to establish a reasonable payment plan.

(2) It shall only take legal action when there is evidence that the patient or responsible party has income and/or assets to meet the financial obligation.

(3) It shall not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill.

(4) It shall require that any collections agency engaged by the hospital follow the requirements of this subsection.

§7209. Transparency in price and quality for consumers.

(a) The Pennsylvania drug retail price registry.

(1) PHC4 shall establish and maintain a registry to be known as the “Pennsylvania drug retail price registry” for the purpose of making retail price information for the 150 most frequently prescribed prescription drugs, together with their generic equivalents where applicable, in the Commonwealth readily available to consumers.

(i) The drug price registry shall include the information submitted to PHC4 under this subsection, shall include the name and address of each pharmacy providing the information and shall be organized by zip code.

(ii) The drug price registry shall be updated monthly by PHC4 and shall be posted on PHC4’s internet website in a format that is conducive to review and comparison by consumers of prescription drug retail prices charged by pharmacies in each zip code within the Commonwealth. It shall include a toll-free telephone number maintained by PHC4 that consumers may call to obtain reprints of the registry.

(iii) The website shall be designed so that the consumer may download and print the displayed information and shall include the following:

(A) internet web links to other government resources that provide information relating to the regulation of prescription drugs and state and federal health care coverage and pharmaceutical assistance programs;

(B) an advisory statement alerting consumers of the need to tell their health care practitioner and pharmacist about all the medications they may be taking and to ask them how to avoid harmful interactions between those drugs, if any; and

(C) clearly understandable language that is designed to assist consumers in understanding the content of, and how to access, the information made available on the website pursuant to this subsection.

(2) Within 30 days following the effective date of this section, the director of PACE shall determine and submit to the Pennsylvania Bulletin for publication a list of the 150 most frequently prescribed prescription drugs in the Commonwealth and their generic equivalents and the unit amount to be used for price reporting purposes. The list shall be updated by the director of PACE annually thereafter and each such update shall be submitted to the Pennsylvania Bulletin for publication.

(3) Every pharmacy selling pharmaceuticals at retail in the Commonwealth shall submit to PHC4 for inclusion in the drug price registry, on the 10<sup>th</sup> day of each calendar month beginning with the first calendar month following publication of the list described in paragraph 2, its prior monthly retail prices for each drug on the list and its generic equivalent, together with the amount of the dispensing fee. In addition, each such pharmacy shall make the list and its prices available to its customers at the pharmacy retail site upon request.

(i) Each pharmacy retail site shall post a sign that notifies customers of the availability of its price list in a conspicuous location that is either at or adjacent to the place where prescriptions are presented for compounding and dispensing, in the customer waiting area, or in the area where prescribed drugs are delivered.

(ii) The provisions of this paragraph shall not be construed to prevent a pharmacy from changing its current retail price at any time, provided that the listed price is updated at least weekly to reflect the new retail price at the pharmacy retail site.

(4) The State Board of Pharmacy may impose a fine of up to \$1,000 per day for each day that a pharmacy fails to comply with any of the provisions of this paragraph. A separate fine may be imposed for each failure to comply. All fines shall be due 30 days from receipt of notice of each such failure. Funds collected pursuant to this paragraph shall be deposited into the CAP Fund.

(b) The Pennsylvania hospital payment registry.

(1) PHC4 shall also establish and maintain a registry to be known as the “Pennsylvania hospital payment registry” for the purpose of making readily available to consumers information regarding the payments received by hospitals for the 150 most frequent admission diagnoses and the 150 most frequently dispensed drugs.

(i) The hospital payment registry shall include the information submitted to PHC4 under this subsection, shall include the name and address of each hospital providing the information and shall be organized by zip code.

(ii) The hospital payment registry shall be updated annually by PHC4 and shall be posted on PHC4’s internet website in a format that is conducive to review and comparison by consumers of reimbursement data from hospitals in each zip code of the Commonwealth. It shall include a toll-free telephone number maintained by PHC4 that consumers may call to obtain reprints of the registry.

(iii) The website shall be designed so that the consumer may download and print the displayed information and shall include the following:

(A) internet web links to other government resources that provide information relating to the regulation of hospitals and health insurance; and

(B) clearly understandable language that is designed to assist consumers in understanding the content of, and how to access, the information made available on the website pursuant to this subsection.

(iv) The information on the hospital payment registry may be combined with other data collected by PHC4 and posted on PHC4's internet website to provide comparative information useful to consumers selecting a hospital for medical care.

(2) Within 90 days following the effective date of this section and on or before January 31 of each year thereafter, all hospitals shall submit to PHC4 for inclusion in the hospital payment registry all of the following:

(i) the 150 most frequent admission diagnoses and the 150 most frequently dispensed drugs (both prescription and non-prescription) in the hospital during the preceding year;

(ii) the amount an individual enrolled in a high deductible health plan with a health savings account is required to pay for the diagnoses and drugs described in subparagraph (i);

(iii) the average payment the hospital has negotiated with third party payers for the diagnoses and drugs described in subparagraph (i); and

(iv) the amount an uninsured patient is charged for the diagnoses and drugs described in subparagraph (i).

(3) A hospital shall make the list and payments received available to its patients at the hospital site upon request. The hospital shall post a sign that notifies patients of the availability of the list at or adjacent to the place where patients are admitted to the hospital and at the place where patients receive financial counseling.

(c) The Pennsylvania outpatient procedure payment registry.

(1) PHC4 shall also establish and maintain a registry to be known as the "Pennsylvania outpatient procedure payment registry" for the purpose of

making readily available to consumers information regarding the payments received by ambulatory surgery facilities and imaging centers for the 50 most frequent outpatient procedures.

(i) The outpatient procedure payment registry shall include the information submitted to PHC4 under this subsection, shall include the name and address of each outpatient facility providing the information and shall be organized by zip code.

(ii) The outpatient procedure payment registry shall be updated annually by PHC4 and shall be posted on PHC4's internet website in a format that is conducive to review and comparison by consumers of reimbursement data from outpatient facilities in each zip code of the Commonwealth. It shall include a toll-free telephone number maintained by PHC4 that consumers may call to obtain reprints of the registry.

(iii) The website shall be designed so that the consumer may download and print the displayed information and shall include the following:

(A) internet web links to other government resources that provide information relating to the regulation of outpatient facilities and health insurance; and

(B) clearly understandable language that is designed to assist consumers in understanding the content of, and how to access, the information made available on the website pursuant to this subsection.

(iv) The information on the outpatient procedure payment registry may be combined with other data collected by PHC4 and posted on PHC4's internet website to provide comparative information useful to consumers selecting a provider of medical care.

(2) Within 90 days following the effective date of this section and on or before January 31 of each year thereafter, all ambulatory surgery facilities and all imaging centers shall submit to PHC4 for inclusion in the outpatient procedure payment registry the 50 most frequent procedures performed at the ambulatory surgery facility or imaging center during the preceding year, the charge for each such procedure and the average third party reimbursement for each such procedure.

(3) PHC4, in consultation with the Department of Health, may determine that the same information should be obtained from other health care providers that primarily perform outpatient procedures other than for primary or chronic care and, 90 days following publication of notice in the Pennsylvania Bulletin, those health care

providers shall submit to PHC4 for inclusion in the outpatient procedure payment registry the information set forth in paragraph (2).

(d) Guidelines.--PHC4 may adopt guidelines to effectuate the purposes of this section.

(e) Enforcement.--In addition to any other remedy available, PHC4 may impose a civil penalty of up to \$500 per day for each failure of a facility to provide PHC4 the information required under this section. All fines collected under this subsection shall be deposited in the CAP Fund.

### Chapter 73 Accessibility

§7301. Definitions. The following words and phrases, when used in this part, shall have the meanings given to them in this section unless the context clearly indicates otherwise.

“Center.” The Pennsylvania Center for Health Careers established under section 7302.

“Certified registered nurse anesthetist” or “CRNA.” A registered nurse certified by the State Board of Nursing to administer anesthesia and who meets the requirements of section 7303(j).

“Clinical nurse specialist” or “CNS.” An individual who is licensed by the State Board of Nursing and holds

(1) a graduate degree, master’s degree, doctoral degree, or a post-master’s certificate from an educational program that is recognized by the State Board of Nursing or a national nursing accrediting body accepted by the board and that prepares graduates to practice as a CNS; and

(2) a national certification as a CNS in a designated specialty or in an area pertinent to the designated specialty or meets equivalence requirements as specified in regulations of the State Board of Nursing when there is no certification examination available in the CNS specialty area.

“CODA.” American Dental Association’s Commission on Dental Accreditation

“Collaborative or written agreement.” An agreement between a physician and a health care provider that is not a physician where such an agreement has been required under law for the health care provider to provide health care services.

“Council.” The Health Careers Leadership Council established under section 7302.

“CRNP.” A certified registered nurse practitioner.

“Debridement.” The removal of dental calculus from teeth.

“Department.” The Department of Labor and Industry of the Commonwealth.

“Expanded primary care.” The provision of primary and urgent care during evenings and weekends on a walk-in basis.

“General supervision.” Supervision by a dentist who has authorized dental hygiene services for a patient to be administered in accordance with the dentist’s diagnosis and treatment plan without the dentist being present, including being present in the treatment location.

“Health care worker.” An employee, independent contractor, licensee or other individual authorized to provide health care services in a health care facility or who is engaged in public health activities.

“Independent dental hygiene practitioner.” A dental hygienist who performs educational, preventative, therapeutic and intra-oral procedures which the hygienist is educated to perform and which require the hygienist’s professional competence and skill but which do not require the professional competence and skill of a dentist without the authorization, assignment or examination of a dentist, and who is certified by the State Board of Dentistry as having satisfied the requirements of section 7303(h).

“Local Anesthesia.” A drug administered by injection in the mouth to temporarily eliminate or diminish the sensation of pain during routine dental care.

“PA.” A physician’s assistant.

“Primary care provider.” A licensee who is a physician, physician assistant, certified registered nurse practitioner, nurse midwife or any group practice consisting of some or all of the foregoing.

“Radiologic procedure.” A medical or dental procedure, such as an x ray, that uses radiation or other sources to create images useful in diagnosis.

“Secretary.” The Secretary of the Department of Labor and Industry.

“Soft tissue curettage.” The removal of soft tissue in the mouth with a curette.

§7302. Pennsylvania Center for Health Careers.

(a) Establishment.--The Pennsylvania Center for Health Careers is hereby established within the department. The center will provide a focused direction and purpose for the development of strategies to address the Commonwealth’s short and long term health care workforce challenges to ensure the quality and supply of such workforce by:

- (1) increasing the capacity of nursing education in the Commonwealth;
- (2) retaining health care workers;
- (3) increasing diversity of health care workers;
- (4) responding to the demand for critical allied health professionals; and
- (5) addressing the needs of direct care workers.

(b) Powers and duties.--The center shall have the following powers and duties:

- (1) Determine the health care workforce needs of the Commonwealth through research, outreach and study.
- (2) Research best practices in addressing similar workforce needs in other states.
- (3) Assess the effectiveness of the initiatives, programs and projects the center undertakes.
- (4) Assist and implement the initiatives and strategies of the council.
- (5) Develop recruitment and workplace tools that assist health care facilities to increase the diversity of their workforce and promote the delivery of culturally competent care.

(c) Leadership council.--The center shall be governed by the Health Careers Leadership Council which shall consist of the following members:

(1) The secretary, the Secretary of State, the Secretary of Health, the Secretary of Public Welfare, or their designees.

(2) Four members of the General Assembly:

(i) Two members of the Senate, one appointed by the President pro tempore of the Senate and one appointed by the Minority Leader of the Senate.

(ii) Two members of the House of Representatives, one appointed by the Speaker of the House of Representatives and one appointed by the Minority Leader of the House of Representatives.

(3) Additional members that are representatives of health care related professionals and organizations, including employers, employees and educators, in such number as may be determined by the Governor and to be appointed by the Governor in consultation with the Pennsylvania Workforce Investment Board created by the act of December 18, 2001, (P.L. 949, No. 114), known as the Workforce Development Act.

(4) Members of the council shall serve at the pleasure of their respective appointing authorities. Members shall not receive compensation for their service as members of the council, but shall be reimbursed for reasonable and necessary expenses in the performance of their duties in accordance with Commonwealth policy with the approval of the secretary.

(5) The Governor shall designate a member or members of the council to serve as chair or co-chairs.

(6) The council shall have the following powers and duties:

(i) Determine the organization, procedures and priorities of the center.

(ii) Develop initiatives, programs and projects for the center to address the health care workforce needs of the Commonwealth.

(iii) Apply for grants and seek other revenue sources, including General Fund appropriations through the department's budget.

(iv) Do all other acts necessary to carry out the purposes and policies of this section.

(d) Administration.—The department shall provide administrative support to the council. The center shall use and have access to any information, services, functions and other resources in the possession of Commonwealth agencies deemed necessary to the fulfillment of its responsibilities under this section.

§7303. Health care provider practice.

(a) General rule.—Notwithstanding the provision of other law or regulation, CRNPs, CNSs, PAs, and nurse midwives may provide acute illness or minor injury care or management of chronic diseases within the scope of their respective practices as determined by the applicable state licensing board.

(b) Medical Malpractice.-- A CRNP, CNS or PA whose specialty certification is in primary care shall maintain a level of malpractice coverage required by law of a primary care physician.

(c) Collaborative and written agreements.--

(1) There shall be no limit to the number of CRNPs with prescriptive authority or PAs a physician supervises or has primary responsibility for under a collaborative or written agreement at any given time.

(2) Collaborative and written agreements shall not unreasonably restrict any primary care provider's ability to practice to the fullest extent of his clinical education and experience.

(3) The State Board of Medicine shall establish a complaint review process whereby any health care provider required to have a collaborative or written agreement with a physician may complain to the board with respect to (i) the unwillingness of physicians to enter into an agreement or (ii) any unduly restrictive provisions contained in an agreement. The process shall ensure that peers of the complaining provider are included in any review process and include other safeguards to prevent bias in outcome. The board shall promulgate regulations establishing the process in conjunction with the State Board of Nursing no later than 12 months after the effective date of this section.

(4) The provisions of 49 Pa. Code §18.57 and §21.287 are abrogated to the extent such provision restricts the number of CRNPs a physician may supervise at any time. The provisions of 49 Pa. Code §18.152(b)(2) are abrogated to the

extent such provision restricts the number of PAs for which a physician may have primary responsibility.

(d) Certified registered nurse practitioners.—Except as limited by the scope of his specialty certification:

(1) A CRNP shall not be limited in prescribing any drug including a controlled substance on Schedules II through V nor shall there be any limit on the number of refills or dosages except as may be provided under federal law; provided, however that the CRNP shall use his own Drug Enforcement Administration number and not that of any collaborating physician in writing the prescription.

(2) In addition to existing authority, a CRNP shall also have the authority to do all of the following:

- (i) order home health and hospice care;
- (ii) order durable medical equipment;
- (iii) issue oral orders under the same conditions and in the same facilities as physicians are permitted to do;
- (iv) perform and sign workers' compensation physicals;
- (v) perform physical therapy and dietitian referrals;
- (vi) order respiratory or occupational therapy;
- (vii) perform disability assessments for the program providing Temporary Assistance to Needy Families;
- (viii) perform methadone treatment and psychiatric evaluations;
- (ix) perform and sign cosmetology license physicals;
- (x) issue home schooling certifications; and
- (xi) make commitments under the act of July 9, 1976 (P.L. 817, No. 143), known as the Mental Health Procedures Act.

(e) Nurse midwives.--A nurse midwife may prescribe drugs associates with obstetrical and gynecologic practice if the midwife:

(1) has successfully completed at least forty-five (45) hours of coursework specific to advanced pharmacology at a level above that required by a professional nursing education program; and

(2) acts in accordance with regulations promulgated by the State Board of Medicine, which shall not unreasonably restrict the midwife's independent practice.

(f) Clinical nurse specialists.--Any person who holds a license to practice professional nursing in this Commonwealth who meets the requirements to be a CNS shall have the right to use the title Clinical Nurse Specialist and the abbreviation CNS. No other person shall have that right.

(g) Dental hygienists.—

(1) Classifications developed by the American Society of Anesthesiologists shall not be a factor in determining the level of supervision required by dental hygienists. The supervising dentist and the dental hygienist shall determine the appropriate level of supervision for each patient based on the patient's health and history.

(2) In addition to existing authority, a dental hygienist may perform the following in any setting under the general supervision of a dentist:

(i) radiologic procedures;

(ii) debridement; and

(iii) soft tissue curettage.

(3) A dental hygienist may administer local anesthesia under the following conditions:

(i) The dental hygienist has applied for and received a permit from the State Board of Dentistry and paid any required permit fee; and

(ii) The dental hygienist holds a current license in good standing, is certified in basic life support, and has provided the Board documentation evidencing one of the following:

(A) Graduation within the 5 years immediately preceding the filing of the application from a dental hygiene school accredited by CODA,

which included the successful completion of a course in the administration of local anesthesia.

(B) Successful completion within the 5 years immediately preceding the filing of the application of a course consisting of a minimum of 30 hours of instruction in the administration of local anesthesia sponsored by an education program accredited by CODA.

(C) Possession of a current license or permit issued by the proper licensing authority of another state, territory, or district, or by Canada, where the dental hygienist is authorized under the laws of that jurisdiction to administer local anesthesia; provided that the dental hygienist has been actively engaged in the administration of local anesthesia within the 5 years immediately preceding the filing of the application; and that the applicable jurisdiction required, as a condition of receiving the license or permit, that the dental hygienist complete a course in the administration of local anesthesia accredited by CODA or its Canadian counterpart.

(4) In addition to other locations set forth in law, a dental hygienist may provide dental services in free clinics.

(h) Independent dental hygiene practitioners.--

(1) An independent dental hygiene practitioner must be certified by the State Board of Dentistry upon meeting the following criteria:

(i) completion of 1,800 hours of practice under the supervision of a dentist; and.

(ii) purchase of a malpractice policy in an amount determined to be adequate by the board.

(2) Following certification by the State Board of Dentistry under paragraph (1), an independent dental hygiene practitioner may:

(i) perform any procedure a dental hygienist may perform without supervision of a dentist;

(ii) order and administer fluoride treatments and products, to include fluoride varnish, home fluoride treatment and other such fluoride containing products as may be necessary to prevent dental caries; and

(iii) order dental equipment.

(3) An independent dental hygiene practitioner shall limit his professional practice to the following practice sites:

- (i) Schools.
- (ii) Correctional facilities.
- (iii) Health care facilities
- (iv) "Personal care homes" as defined in section 1001 of the Public Welfare Code.
- (v) "Domiciliary care" as defined in section 2202-A of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.
- (vi) An "older adult daily living center" as defined in section 2 of the act of July 11, 1990 (P.L.499, No.118), known as the Older Adult Daily Living Centers Licensing Act.
- (vii) A "facility" as defined in section 3 of the act of June 18, 1984 (P.L.391, No.82), known as the Continuing-Care Provider Registration and Disclosure Act.
- (viii) A public or private institution under the jurisdiction of a Federal, State or local agency.
- (ix) Day care centers as defined in articles IX and X of the Public Welfare Code.
- (x) Facilities operating Head Start programs established by the Omnibus Budget and Reconciliation Act of 1981 (Public Law 97-35, 95 Stat. 357).
- (xi) Free clinics.
- (xii) Other institutions the State Board of Dentistry deems appropriate.

(i) Pharmacists.—In addition to the activities authorized by the act of September 27, 1961 (P.L. 1700, No. 699), known as the Pharmacy Act, pharmacists may manage drug therapy in any integrated health setting such as academic health centers, and group practice settings where the pharmacist is an integral member of the interdisciplinary clinical team and has access to the patient's medical record. In such

practice settings, the pharmacist shall follow the same protocols and procedures as that required for drug therapy management in institutions as defined in the Pharmacy Act.

(j) Certified registered nurse anesthetists.—The State Board of Nursing shall certify a registered nurse as a CRNA if the nurse satisfies the requirements established by this subsection and any regulations promulgated by the board. The certification of a nurse under this subsection shall expire on the same date as the nurse's license expires.

(1) A registered nurse must satisfy, and shall be certified by the State Board of Nursing upon meeting the following criteria:

(i) completion of the educational program of a school for nurse anesthetists accredited by an accrediting agency recognized by the board; and

(ii) receipt of certification as a certified registered nurse anesthetist by a board-recognized national certification organization.

(2) A registered nurse who is enrolled in an educational program of a school for nurse anesthetists accredited by an accrediting agency recognized by the State Board of Nursing may, during such enrollment, administer anesthesia under the direction of the chief or director of anesthesia services, an anesthesiologist or a CRNA.

(3) A registered nurse who has obtained the education required by this subsection, but who has not yet obtained certification as a CRNA may administer anesthesia under the direction of the chief or director of anesthesia services, an anesthesiologist or a CRNA until the announcement of results of the first examination taken for certification for which the registered nurse is eligible. If the registered nurse fails to take, or fails to pass, that examination, the registered nurse shall immediately cease practicing as a nurse anesthetist; provided, however, that the registered nurse may appeal to the State Board of Nursing for authority to continue practicing as a nurse anesthetist if, due to extenuating circumstances, the registered nurse is unable to take the examination in a time period specified by the board following completion of the required education.

(4) A CRNA shall be subject to all of the following:

(i) A CRNA shall administer anesthesia in cooperation with a physician, dentist or podiatrist. For purposes of this section, "cooperation" shall mean a process in which the CRNA and the physician, dentist or podiatrist work together with each contributing an area of expertise at the individual and respective level of education and training of the CRNA and the physician, dentist or podiatrist.

(ii) A CRNA's performance shall be under the overall direction of the chief or director of anesthesia services; provided, however, that in situations or health care facilities where anesthesia services are not mandatory, the CRNA's performance shall be under the overall direction of the physician, dentist or podiatrist responsible for the patient's care.

(iii) When the operating/anesthesia team consists entirely of non-physicians, an anesthesiologist or consulting physician of the CRNA's choice shall be available to the CRNA by physical presence or electronic communication.

(5) Nothing in this subsection shall be construed to prohibit the continued practice of CRNAs who were authorized to practice in this Commonwealth on the effective date of this subsection.

(k) Health insurers.--An insurer issuing health insurance coverage within the Commonwealth is:

(1) required to include the following classes of health care providers in every provider network:

(i) CRNPs, PAs, CNSs and nurse midwives; and

(ii) urgent care, convenient care, nurse managed care or federally qualified health centers where they are geographically available to provide services to those insured by the insurer.

(2) required to credential individual health care providers based on the individual's clinical experience, education, and licensure status;

(3) required to pay health care providers incentives for provided expanded primary care;

(4) required to pay a primary care provider and CRNA directly for services provided unless the provider or CRNA notifies the insurer otherwise; and

(5) required to pay health care providers reasonable rates for health care services that are within their scope of practice to provide;

(6) prohibited from excluding minor children with behavioral health conditions from coverage or excluding from covered services behavioral therapy services for minor children.

The Insurance Commissioner may modify the list in paragraph (1) from time to time by publication of a notice in the Pennsylvania Bulletin.

## Chapter 74 Quality of Care; Healthy Lifestyles

§7401. Definitions. The following words and phrases, when used in this part, shall have the meanings given to them in this section unless the context clearly indicates otherwise.

“Authority.” The Patient Safety Authority established under the act of March 20, 2002 (P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act.

“Bar.” Any area, including outdoor seating areas, devoted to the sale and service of alcoholic beverages for on-premises consumption and where the service of food is only incidental to the consumption of such beverages.

“Consumer Price Index.” The consumer price index for all Urban Consumers (CPI-U) for the Pennsylvania, New Jersey, Delaware and Maryland area, for the most recent 12-month period for which figures have been officially reported by the United States Department of Labor, Bureau of Labor Statistics immediately prior to the subject date.

“Department.” The Department of Health of the Commonwealth.

“Food service establishment.” Any area, including outdoor seating areas, or portion thereof in which the business is the sale of food for on-premises consumption.

“Health care acquired infection.” An infection acquired in a health care facility.

“Impaired professional program.” The program established under the act of December 20, 1985 (P.L. 457, No. 112), known as the Medical Practice Act of 1985.

“Patient safety report.” The Patient Safety and Quality Improvement Report required under section 7402.

“Places of employment.” Any indoor area or portion thereof under the control of an employer in which employees of the employer perform services, and shall include offices, school grounds, retail stores, banquet facilities, theaters, food stores, banks, financial institutions, factories, warehouses, employee cafeterias, lounges, auditoriums, gymnasiums, restrooms, elevators, hallways, museums, libraries, bowling establishments,

employee medical facilities, rooms or areas containing photocopying equipment or other office equipment used in common, and company vehicles.

“Retail tobacco business.” A sole proprietorship, limited liability company, corporation, partnership or other enterprise in which the primary activity is the retail sale of tobacco products and accessories, and in which the sale of other products is merely incidental.

“Safe practices.” The set of standards endorsed by the National Quality Forum that should be used by health care providers to reduce the risk of harm to patients.

“School grounds.” Any building, structure and surrounding outdoor grounds contained within a public or private pre-school, nursery school, elementary or secondary school’s legally defined property boundaries and any vehicles used to transport children or school personnel.

“Smoking.” The burning of a lighted cigar, cigarette, pipe or any other matter or substance which contains tobacco.

§7402. Patient safety.

(a) Electronic surveillance of health care acquired infections.

(1) By September 1, 2008 all hospitals will use a uniform electronic surveillance system to report health care acquired infections to PHC4. The system shall provide for:

(i) Extraction of existing electronic clinical data from hospital systems on an ongoing basis;

(ii) Translation of non-standardized laboratory data into uniform information that can be analyzed on a population-wide basis;

(iii) Clinical support, educational tools and training to ensure that information provided under this paragraph will lead to change; and

(iv) Clinical improvement measurement and the structure to provide ongoing positive and negative feedback to hospital staff who implement change.

(2) Within thirty (30) days following the effective date of this section, PHC4 shall identify and certify a specific system or systems that meet the criteria described in paragraph (1) and shall forward them to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(b) Reporting emergency services.--PHC4, in consultation with the department, shall determine the manner and scope of reporting to PHC4 that hospitals shall undertake with respect to individuals presenting at hospitals for emergency services. PHC4 shall forward requirements concerning the reporting, including the date such reporting is to commence, to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin and there after compliance with such requirements shall be a condition of licensure for hospitals.

(c) Reporting by nursing homes.--Nursing homes shall report to PHC4 the same infections and in the same manner that hospitals are required to report to PHC4 under the Health Care Cost Containment Act. Such reporting shall begin within 30 days following the effective date of this section. For purposes of this section, nursing homes shall be additional data sources as defined in the Health Care Cost Containment Act and covered services, also as defined in that act, shall include those services provided by nursing homes.

(d) Analysis of nursing home data by Patient Safety Authority.

(1) At the request of the department but no less frequently than once per year, the authority shall analyze data without patient identifying information reported to the department by nursing homes with respect to events compromising patient safety as required by 28 Pa.Code § 51.3.

(2) The authority shall conduct such analyses as it determines are appropriate to provide information to nursing homes which can be used to improve patient safety and quality of care.

(3) The authority shall provide nursing homes with patient safety advisories issued by the authority and permit any nursing home administrator to attend any patient safety training program it offers.

(4) Nursing homes shall pay the department a surcharge on their licensing fees to provide sufficient revenues to the authority for its responsibilities under this section. The department shall determine the proportionate share to be paid by each nursing home on a per-bed basis within 60 days following the effective date of this section.

(i) The total surcharge for all nursing homes shall not exceed \$1,000,000 in fiscal year 2007-08, and shall be increased by the Consumer Price Index in each succeeding fiscal year. All surcharges shall be paid by the end of each fiscal year.

(ii) The department shall transfer the total surcharges collected to the Patient Safety Trust Fund established under section 305 of MCARE within 30 days of receipt.

(iii) In the event that the Patient Safety Trust Fund is discontinued or the authority is dissolved, any balance of the surcharges paid by nursing homes remaining in the Patient Safety Trust Fund, after deducting administrative costs of liquidation, shall be returned to the nursing homes in proportion to their financial contributions to the Patient Safety Trust Fund in the preceding licensing period

(iv) If, after 30 days' notice, a nursing home fails to pay a surcharge levied by the department under this subsection, the department may assess an administrative penalty of \$1,000 per day until the surcharge is paid. Such penalty shall be imposed from the date of the notice and deposited into the CAP Fund.

(e) E-prescribing.

(1) Within 60 days following the effective date of this section, every health care facility shall develop a full and complete implementation plan with specific goals, key performance indicators and timelines in order to meet the following requirements:

(i) Commencing September 1, 2008, every health care facility shall provide easy and timely access to an e-prescribing system for all of its staff, employees, or contractors who have prescriptive authority in the Commonwealth and who write prescriptions for patients of the health care facility in order to allow them to write prescriptions electronically and check for potentially harmful drug interactions.

(ii) Thereafter, the health care facility shall certify to the department on its application for license or license renewal that it provides access for all staff, employees, and contractors with prescriptive authority to an e-prescribing system and requires its use.

(2) Within 60 days following the effective date of this section, the State Board of Medicine shall determine the date after which it will require every physician, as a condition to licensure, to use an e-prescribing system to write prescriptions electronically and check for potentially harmful drug interactions and forward a notice of such date to the Legislative Reference Bureau for publication in the

Pennsylvania Bulletin. Effective as of that date, the State Board of Medicine shall have the authority to require every physician to certify on his application for license or license renewal that he has access to and uses an e-prescribing system.

(3) (i) Any false or misleading statement on a certification by a health care facility shall subject the health care facility to a fine of \$5,000 per instance, which fine shall be imposed and collected by the department and deposited into the CAP Fund.

(ii) Any false or misleading statement on a certification by a physician shall subject the physician to a fine of \$5,000 per instance, which fine shall be imposed and collected by the State Board of Medicine and deposited into the CAP Fund.

(4) Notwithstanding any provision of law or regulation, oral orders for medication or treatment shall be issued or accepted only in emergency circumstances when no alternative method is available.

(5) Up to \$25,000,000 of the funds appropriated by the General Assembly for the Machinery and Equipment Loan Fund established under 12 Pa.C.S. Ch. 29 shall be made available for grants to health care facilities to assist in acquiring the systems described in this subsection. Grants shall not exceed 50% of hospital's costs, which shall be approved by the Department of Community and Economic Development. The Department of Community and Economic Development shall develop criteria for evaluating applications for grants that considers the fiscal condition of the hospital, the ability of the hospital to implement the technology, and the potential savings through avoided costs and reduced errors. The criteria shall be forwarded by the Department of Community and Economic Development to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(f) Health care facilities annual report.

(1) Every hospital shall, on or before April 1 of each calendar year, submit to the department a Patient Safety and Quality Improvement Report for each facility that it operates. The patient safety report shall cover the prior calendar year and shall contain at least the following information:

(i) Three year trends in the rates of health care acquired infections, medication errors, readmissions and procedure complications, failures to rescue, and falls.

(ii) The recommendations of the authority and approved by the department pursuant to section 301 of MCARE that have been implemented at the hospital.

(iii) The specific safe practices that each hospital facility will adopt and implement during the next calendar year to reduce health care acquired infections, medication errors, readmissions and procedure complications, failures to rescue, and falls.

(iv) Beginning with the second report submitted under this subsection, and with each report submitted thereafter, the progress of implementation of safe practices adopted during the previous calendar year, whether the hospital will continue any such practice, and the reason the hospital will discontinue any safe practice previously adopted.

(v) The hospital's plan to implement facility-wide and data-driven error-reduction or quality improvement programs that the hospital intends to adopt and implement at each hospital facility, including, but not limited to Computer Physician Order Entry systems, medication bar coding, and programs to identify and correct systemic causes of error and achieve reliable quality outcomes.

(2) Submission of the report shall be a condition of licensure.

(3) The department may use information reported to it under paragraph (1) for the purposes of providing information to consumers and developing performance and quality standards and best practices and shall cooperate with PHC4 in making such information available on a single consumer accessible internet website that may be used by consumers for comparative purposes to determine where they wish to receive health care.

(g) Standards to reduce health care acquired infections and medical errors.--

(1) The department shall establish by regulation:

(i) standardized best practices for health care facilities to adopt to eliminate health care acquired infections and medical errors and to maintain patient safety; and

(ii) a date by which health care facilities shall adopt such standards as a condition of licensure.

(2) Thereafter, the department shall not issue or renew a license to a health care facility that fails to adopt the standardized best practices and demonstrate that it has reduced health care acquired infections and medical errors.

(h) Patient safety training

(1) As a condition of receiving a license from the department under the Health Care Facilities Act, and as a condition of continued licensure thereunder:

(i) each hospital shall ensure that every licensee providing clinical services in the hospital, every Chief Executive Officer, Chief Financial Officer, and Chief Medical Officer, and every officer and director of the hospital Board of Directors receives at least 6 hours of in-person and monitored training in patient safety and continuous quality improvement every two years; and

(ii) each nursing home shall ensure that its nursing home administrator and Director of Nursing receives at least 6 hours of in-person and monitored training in patient safety and continuous quality improvement every two years.

(2) Hospitals and nursing homes currently licensed will have 12 months following the effective date of this section to comply with this subsection. Hospitals and nursing homes applying for a license for the first time following the effective date of this section shall certify to the department that the persons described in paragraph (1)(i) and (ii) have completed the requisite training within the preceding 12 month period as a condition to being licensed.

(3) The department shall issue guidelines with respect to the particular types of patient safety education classes that will be acceptable. Such training shall emphasize the integrated nature of patient safety and continuous quality improvement.

(4) Documentation of training shall be maintained as part of the records of the hospital or nursing home.

(5) The training requirements of this subsection are not to be construed as in addition to any continuing education requirements imposed by a state licensing board.

(6) For the fiscal year 2008-2009 and thereafter, the State Board of Medicine shall not approve for accreditation any graduate medical education

program in the Commonwealth that does not require a minimum of 6 hours of patient safety training.

(h) Clinical skills assessments.--In the event that a program similar to the impaired professional program becomes available in the Commonwealth through which a licensee may be referred for a clinical skills assessment and undertake a subsequent plan to improve clinical skills or otherwise address any clinical skills deficiencies, the State Board of Medicine shall evaluate such program and determine whether to approve its use by licensees of the board. If approved, the board shall have the authority to defer disciplinary or corrective action provided that the licensee enters into an agreement with the board to undergo the assessment and continues to completion with a plan acceptable to the board to address any deficiency.

(i) Enforcement.--In addition to any other remedy available, PHC4 may impose a civil penalty of up to \$500 per day for each failure of a facility to provide PHC4 the information required under this section. All fines collected under this subsection shall be deposited in the CAP Fund.

#### §7403. Smoking restrictions.

(a) Restrictions.--Smoking shall not be permitted and no person shall smoke in the following indoor areas:

- (1) places of employment;
- (2) bars;
- (3) food service establishments;
- (4) enclosed indoor areas open to the public;
- (5) means of mass transportation, including subways, underground subway stations, and when occupied by passengers, buses (including school buses), vans, taxicabs and limousines;
- (6) ticketing, boarding and waiting areas in public transportation terminals;
- (7) any public or private facility that houses or treats children and youth, including youth detention centers and group homes except for private homes;

(8) any facility that provides child care services, provided that such services provided in a private home are excluded from this paragraph when children enrolled in such day care are not present;

(9) public and private colleges, universities and other educational and vocational institutions;

(10) health care facilities where individuals reside; provided, however, that the provisions of this section shall not prohibit smoking by patients in separate enclosed rooms of residential health care facilities, adult care facilities, community mental health residences or facilities where day treatment programs are provided, which are designated as smoking rooms for patients of such facilities or programs;

(11) commercial establishments used for the purpose of carrying on or exercising any trade, profession, vocation or charitable activity;

(12) indoor arenas;

(13) zoos;

(14) facilities where bingo, as defined in the act of July 10, 1981 (P.L. 214, No. 67), known as the Bingo Law, is played; and

(15) licensed facilities, as defined in 4 Pa.C.S. § 1103 (relating to definitions), or any other similar type of facility authorized under state law.

(b) “Smoking” or “No Smoking” signs, or the international “No Smoking” symbol, which consists of a pictorial representation of a burning cigarette in a circle with a bar across it, shall be prominently posted and properly maintained where smoking is regulated by this section, by the owner, operator, manager or other person having control of such area. The owner, operator or manager of a hotel or motel that chooses to develop and implement a smoking policy for rooms rented to guests shall post a notice at the reception area of the establishment as to the availability, upon request, of rooms in which no smoking is allowed.

(c) Exceptions.--The provisions of this section shall not apply to:

(1) private homes, private residences and private automobiles;

(2) a hotel or motel room rented to one or more guests;

(3) retail tobacco businesses; or

(4) cigar bars that, in the calendar year ending December 31, 2005, generated ten percent or more of their total annual gross income from the on-site sale of tobacco products and the rental of on-site humidors, not including any sales from vending machines.

(d) Relationship to other laws.--Smoking may not be permitted where prohibited by any other law, rule, or regulation of any Commonwealth agency or any political subdivision. Nothing in this section shall be construed to restrict the power of any political subdivision to adopt and enforce additional local laws, ordinances, or regulations which comply with at least the minimum applicable standards set forth in this section.

(e) Prohibited acts.--It shall be unlawful

(1) for any person that owns, manages, operates or otherwise controls the use of an area in which smoking is prohibited or restricted pursuant to this section to fail to comply with the provisions of this section; provided that it shall be an affirmative defense that during the relevant time period actual control of the area was not exercised by such person, but rather by a lessee, a sublessee or any other person. To establish an affirmative defense, the owner, manager, operator or person who controls the area shall submit an affidavit and may submit any other relevant proof indicating that such person did not exercise actual control of the area during the relevant time period. Such affidavit and other proof shall be sent by certified mail to the appropriate enforcement officer within 30 days of receipt by such person of a notice of violation;

(2) for an employer whose place of employment is subject to this section to fail to comply with the provisions of this section; provided that it shall be an affirmative defense that the employer has made a good faith effort to ensure that employees comply with the provisions of this section; or

(3) for any individual to smoke in any area where smoking is prohibited or restricted under this section.

For purposes of this section, the term “enforcement officer” shall mean the board of health of a county or, in the absence of one, an officer of a county designated for such purpose by resolution of the governing body of the county adopted within 30 days following the effective date of this section. Any such designation shall be filed with the department within 30 days after adoption and shall be effective 30 days after it is filed with the department. The enforcement officer shall have sole jurisdiction to enforce the provisions of this section on a county-wide basis pursuant to guidelines developed and published by the department. Any person who desires to register a complaint under this section may do so with the appropriate enforcement officer.

(f) Penalty for unlawful conduct.—

(1) If the enforcement officer determines that a violation of subsection (e) has occurred, the enforcement officer may impose 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 of competent jurisdiction may order immediate compliance with the provisions of this section.

(2) The enforcement officer, subsequent to any appeal having been finally determined, may bring an action to recover the civil penalty provided in paragraph (1) in any court of competent jurisdiction. A civil penalty recovered under the provisions of this section shall be recovered by and in the name of the county board of health or the county for whom the enforcement officer has been designated.

Chapter 75  
Miscellaneous Provisions

§7501. Regulations.

(a) Regulations promulgated under this part.—Except as may be otherwise provided in this part, the promulgation of regulations under this part by Commonwealth agencies given the discretion or authority to promulgate regulations shall, until 3 years from the effective date of this section be exempt from the following:

- (1) The Commonwealth Documents Law.
- (2) The Commonwealth Attorneys Act.
- (3) The Regulatory Review Act.

(b) Other regulations.—If, in the determination of the head of any Commonwealth agency given the discretion or authority to promulgate regulations, a regulation or a change to a regulation is needed for purposes of the safety of patients in the Commonwealth, the agency shall have the authority to promulgate such regulation or such change to a regulation as a final-omitted regulation as that term is defined in the Regulatory Review Act.

§7502. Enforcement.

(a) Determination of violation.--Upon a determination that a person licensed by the Insurance Department has violated any provision of this part, the Insurance Commissioner may pursue one or more of the following courses of action:

(1) Issue an order requiring the person to cease and desist from engaging in such violation.

(2) Suspend or revoke or refuse to issue or renew the certificate or license of the offending party or parties.

(3) Impose a civil penalty of up to \$5,000 for each violation.

(4) Impose any other penalty or pursue any other remedy deemed appropriate by the Insurance Commissioner, including restitution.

(b) Other remedies.--The enforcement remedies imposed under this section are in addition to any other remedies or penalties that may be imposed by any other applicable statute, including the act of July 22, 1974 (P.L. 589, No. 205), known as the Unfair Insurance Practices Act. Violations by any person of this part are deemed and defined by the Insurance Commissioner to be an unfair method of competition and an unfair or deceptive act of practice pursuant to the Unfair Insurance Practices Act.

(c) No private cause of action.--Nothing herein shall be construed as to create or imply a private cause of action for violation of this part.

#### §7503. Severability.

(a) General rule.—The provisions of this part are severable. If any provision of this part or its application to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this part which can be given effect without the invalid provision or application.

(b) Limitation.—If the provisions of section 203 relating to the determination by the Department of Labor and Industry or any other Commonwealth agency whether an employer is entitled to a credit against the fair share tax under section 203(b)(2) is found to be invalid by any court, section 203(b) shall thereafter be deemed to provide that an employer offering any health insurance benefits to its employees shall be entitled to the credit against the fair share tax described in such section.

#### Section 2. Repeals.--Repeals are as follows:

(1) The General Assembly declares as follows:

(i) The repeal under paragraph (2) is necessary to effectuate the provisions of 40 Pa.C.S. §7202.

(ii) The repeal under paragraph (3) is necessary to effectuate the provisions of 40 Pa.C.S. §7204.

(iii) The repeal under paragraph (4) is necessary to effectuate the provisions of 40 Pa.C.S. §§7209 and 7402.

(iv) The repeals under paragraph (5) are necessary to effectuate the provisions of 40 Pa.C.S. §7303.

(2) Chapter 13 of the act of June 26, 2001 (P.L. 755., No. 77), known as the Tobacco Settlement Act, is absolutely repealed, except to the extent necessary to allow the funds appropriated under section 306(b)(1)(vi) of the Tobacco Settlement Act for the program established in Chapter 13 of such act to be deposited in the CAP Fund pursuant to 40 Pa.C.S. §7202. This repeal shall be contingent upon the federal approval required by 40 Pa.C.S. §7202(p).

(3) Sections 3(e)(4) and (5) of the act of December 18, 1996 (P.L. 1066, No. 159), known as the Accident and Health Filing Reform Act, are repealed absolutely.

(4) The first sentence of Section 19 of the act of July 8, 1986 (P.L. 408, No. 89), known as the Health Care Cost Containment Act is absolutely repealed. The report required by that section to be written by the Legislative Budget and Finance Committee shall go forward except for the need for reauthorization of the Health Care Cost Containment Council.

(5) The last sentence of section 8.3(b) and section 8.4 of the act of May 22, 1951 (P.L. 317, No. 69), known as the Professional Nursing Law, and the last sentence of section 13(e) of the act of December 20, 1985 (P.L. 457, No. 112), known as the Medical Practice Act of 1985, are absolutely repealed.

(6) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 3 Effective dates. This act shall take effect as follows:

(a) 40 Pa.C.S. §7202 shall take effect 30 days after the date of publication of the notice required under section 7202(p).

(b) The following provisions shall take effect in 30 days:

(1) 40 Pa.C.S. §7203.

- (2) 40 Pa.C.S. §7205.
- (3) 40 Pa.C.S. §7303.
- (c) The remainder of this act shall take effect immediately.