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HOUSE DEMOCRATIC POLICY COMMITTEE
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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE ROUNDTABLE

Topic: House Bill 1688

West Laurel Hill Cemetery – Bala Cynwyd, PA

August 29, 2018

AGENDA

2:00 p.m. Welcome and Opening Remarks

2:10 p.m. Panelists:

- Mary Miller
  Human Resources Professional
- Wendell Potter
  Former Head of Corporate Communications for Health Insurance Company
- David Steil
  Founding Member of HealthCare4AllPA
- Sam Marshall
  President and CEO of Insurance Federation of Pennsylvania
- Robin Stelly
  Organizer for Pennsylvania Health Access Network
- Sara Atkins
  Consumer

3:20 p.m. Closing Remarks

Remarks, Robin Stelly, organizer with PA Health Access Network

Policy meeting re: HB1688

August 29, 2018

Thank you, Representative DeLissio for convening this hearing so that we can continue the discussion of the best way to ensure that Pennsylvanians can access quality, affordable healthcare. My name is Robin Stelly. I am the statewide organizer with the PA HEALTH ACCESS NETWORK. I work with consumers of our healthcare system to, among other things, help them to share their healthcare stories and experiences. We call the people who are navigating America's various healthcare programs "consumers" because, while they may be patients, they are not our patients. They are individuals who are doing their best to find the highest quality healthcare at prices they can afford. And, too often, they find that they can't afford what they need. They are locked out of care. Or they are taken advantage of by unscrupulous actors. We believe strongly in the need for robust consumer protections, such as the ones afforded to us through the Affordable Care Act. Protections against gender discrimination, against age discrimination, against being priced out of the market because of pre-existing conditions. Protections against lifetime limits and annual caps. Protections that allow consumers to access free preventative services, and more.

The American healthcare system is an inefficient patchwork of programs that costs too much, provides below average outcomes, and doesn't cover everyone. When it comes to the health and financial stability of healthcare consumers, a single payer system is the best alternative to our current hodgepodge of programs. We see this fact affirmed every day at PHAN where we work with people who access their care through Medicaid, which is a single payer system. Medicaid has the power to transform and save lives. We saw the transformative power of Medicaid when it allowed **Adrianne G.** in Philadelphia to be able to see the doctors who diagnosed her with Multiple Sclerosis. Before that diagnosis, she did not know what was causing her weakness, dizzy spells and inability to concentrate, but she knew that she could not work. With Medicaid there for her, she found out the news she did not want to hear but which she says saved her life. Now she is pursuing treatment and she is hopeful that she will be able to work again one day. We saw the transformative power of Medicaid when **Brian K.** used it to see the doctors who diagnosed his stage 4 colon cancer. During his treatment, he never stopped working at his retail job and today, because of Medicaid Expansion, Brian is cancer-free. And we see the transformative power of Medicaid as it helps families in every part of the state secure care for their medically fragile children. Because of Medicaid, **children** with conditions like Down Syndrome, Autism, diabetes, Trisomy 13, Noonans' Syndrome and more are able to get the care they need without their parents losing everything to medical bills. Medicaid is truly an American success story that saves lives and families every day.

Again, we are very grateful for this hearing, which continues us on the path to an efficient system of care that puts consumers and patients first. Undoubtedly, we still have a way to go before we reach that goal, but fortunately, there are immediate steps that Pennsylvania could take now to help us do three important things:

1. better understand healthcare in the commonwealth,
2. have better data with which we can develop a comprehensive single payer system,
3. address specific problems that a single-payer system would inherit if implemented within the current system.

The first step would help prepare the state for a single-payer system. The other three would help lower costs, which is critical to the future of healthcare regardless of what delivery system is in place.

1) All-Payer Claims Database: All-payer claims databases (APCDs) are large State databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers. APCD data are reported directly by insurers to States, usually as part of a State mandate. You can probably already see the value of such an instrument. Because in order to change the healthcare system in Pennsylvania, (or even to have our current systems work efficiently) we must understand the effects of the systems, but we lack the data we

need to do the necessary analysis. We simply don't understand regional differences or provider behavior. To help solve that problem, we need an All-Payer Claims Database. This would:

- Provide total care costs, prices, use and quality AND **results of care for different providers, treatments and populations**.
- Provide comprehensive data on spending flows that can **help to identify and eliminate waste** in the healthcare system.
- **Identify high-value providers** so that consumers can be steered to them and their provider colleagues can strive to emulate them.
- Enable policymakers to evaluate the effects of state reforms.

On the cost reduction side, there are three steps that could be taken immediately:

1) Increased transparency in prescription drug pricing, a move we hope will ultimately lead to lower prices.

2) Dental care should be brought into the fold of covered care. PHAN sees firsthand the problems people have accessing dental care within Medicaid and how that actually drives up use of the ER and overall costs. Simple dental conditions that could be fixed with routine procedures become more painful, more costly, and damaging to people's general health and livelihoods.

Evidence shows us the following:

- Untreated oral disease has cumulative consequences and is associated with dangerous and disabling health conditions including heart disease, stroke, diabetes, bacterial pneumonia, sepsis, preterm and low birth weight deliveries, and rheumatoid arthritis;
- In 2012, every 15 seconds someone visited a hospital emergency department for a dental condition, and averaged two visits per person with almost half receiving a prescription for an opioid analgesic;
- Since 2010, emergency department spending for dental-related conditions increased by more than 60%;
- Pennsylvania's Managed Care Organizations reported that from 2010 to 2016, hospital inpatient treatment for oral diseases, which costs nearly 10 times more than treatment in a dentist's office, more than doubled;
- The Surgeon General estimates that 1.9 work days are lost each year to acute dental conditions for every 100 persons, meaning for each 100,000 Medicaid beneficiaries in Pennsylvania, 1,900 work days are lost due to serious oral diseases; (2,892,070 poeple use MA in PA)
- More than 40% of low-income adults have at least one untreated infected or decayed tooth.

- The American Dental Association estimates that up to 79% of emergency department dental visits could be treated in a dental office at less than half the cost;
- 1 in 4 elderly Americans have little or no remaining teeth limiting their ability to eat nutritious foods;

PHAN is advocating for increased access to oral health coverage through Medicaid and reduction in the red tape encountered to access it.

3) Lastly, many of our neighbors in PA – particularly seniors, people with disabilities, and people with substance use or mental health disorders – need **us** to think more creatively about what allows them to stay healthy and participate in their communities beyond a doctor's care. PHAN will actively advocate for these creative solutions: Health isn't just about seeing a doctor, if you don't have a safe place to live, you can't stay healthy. As part of the Housing is Health campaign, PHAN is working to ensure that high-risk Pennsylvanians have safe housing, which is a cost-effective intervention that keeps people out of the hospital.

And so, in closing: While we continue on the path to a single-payer system that will contain costs and provide access to quality healthcare for all our citizens, we shouldn't forget that Pennsylvania families are currently suffering. We should take immediate action to fight some particular issues in order to improve things right now:

1. End practices – like surprise medical billing – that unfairly put the burden of healthcare costs on patients (principles attached).
2. Pursue state-based reforms that would stabilize the insurance market, like a state-based individual mandate, state-based reinsurance program, or stronger oversight in the rate-setting process.
3. Pursue state-level regulations to limit the use of short-term (and unregulated) health plans the Trump Administration is pushing in yet another attempt to sabotage the Affordable Care Act.
4. We can't forget that high-deductible plans on the rise. This hurts people's health and ability to live healthy, etc.

Supporting resources:

Cost & Quality Problems: Prescription Drug Costs
Altarum, Healthcare Value Hub
https://bit.ly/2LIfDYZ

Dental

The **My Teeth Matter campaign** is calling on the state of Pennsylvania to restore access to necessary dental care and to simplify the processes required to access needed services. The campaign is led by the Pennsylvania Health Access Network (PHAN) in partnership with ACHIEVA.

https://www.myteethmatter.org/

All-Payer Claims Database

Altarum, Healthcare Value Hub

https://bit.ly/1SQlVU7

Housing as Health

The Housing as Health campaign is a statewide coalition of physical and behavioral healthcare providers, social services, housing-related entities, faith and community groups, advocates, and people enrolled in Medicaid, working together so that:

Medicaid in Pennsylvania should cover more supportive housing services for more consumers with either a physical or behavioral health condition through a plan created with public input.

http://www.housingashealth.org/

Surprise Medical Billing

https://pahealthaccess.org/surprise-medical-bills/

Stabilizing the Individual Insurance Market

Bipartisan Policy Center

https://bit.ly/2omxqLV

Limiting the use of short-term plans

https://pahealthaccess.org/short-term-plans/

House Co-Sponsorship Memoranda

House of Representatives
Session of 2017 - 2018 Regular Session

MEMORANDUM

Posted: February 3, 2017 03:59 PM
From: Representative Pamela A. DeLissio
To: All House members
Subject: Pennsylvania Health Care Plan - Former HB1688

I am again introducing legislation to establish the Pennsylvania Health Care Plan.

Similar legislation has been introduced on at least 4 occasions in the House over the past 9 years.

This legislation sets out a blueprint of bold steps that will result in a healthier citizenry at a lower cost with no co-pays, deductibles or premiums or concern about networks and with the freedom and flexibility to choose their health care providers.

This legislation improves upon our current health care delivery system in many ways. First and foremost, it preserves the private practice of medicine and the right of patients to choose their healthcare providers.

Briefly, the Pennsylvania Health Care Plan is a system in which the Pennsylvania Health Care Agency administers a plan that ensures the cost effective delivery of covered services that range from catastrophic care to wellness and preventative care.

Health Care Providers would have autonomy over patient care.

The program will be supported by the savings realized from replacing today's less than efficient, often profit-oriented, multiple payer system with a streamlined Pennsylvania Health Care Trust Fund.

The Pennsylvania Health Care Trust Fund will be funded by a 10% employer tax paid on payroll and a 3% personal income tax.

Using our respective Caucuses as an example, we would save millions in health insurance costs if the caucuses were to pay an amount equal to 10% of payroll versus the premium payments currently made.

One benefit for Plan participants is knowing definitively their healthcare cost exposure for the year.

This is a complex topic and I will be hosting a number of informational sessions to answer questions and to get your input.

I have also attached a chart that depicts the organizational structure of the Plan and highlights how the Plan would function.

View Attachment

Introduced as HB1688

PRINTER'S NO. 2508

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1688 Session of 2017

INTRODUCED BY DeLISSIO, ROZZI, BULLOCK, HARKINS, THOMAS, FREEMAN, DONATUCCI, STURLA AND RABB, OCTOBER 2, 2017

REFERRED TO COMMITTEE ON HEALTH, OCTOBER 2, 2017

AN ACT

Providing for a Statewide comprehensive health care system; establishing the Pennsylvania Health Care Plan and providing for eligibility, services, coverages, subrogation, participating and nonparticipating providers, cost containment, quality assurance and for transitional support and training; establishing the Pennsylvania Health Care Board, the Pennsylvania Health Care Agency, the Office of Health Care Ombudsman and the Pennsylvania Health Care Trust Fund; and imposing a payroll tax and an additional personal income tax.

TABLE OF CONTENTS

The General Assembly of the Commonwealth of Pennsylvania

hereby enacts as follows:

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Pennsylvania Health Care Plan Act.

Section 102. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Advisory committee." The advisory committee under section 301(b).

"Agency." The Pennsylvania Health Care Agency established under section 321.

"Board." The Pennsylvania Health Care Board established under section 301.

"Executive director." The executive director of the Pennsylvania Health Care Agency.

"Fund." The Pennsylvania Health Care Trust Fund established under section 901.

"Office." The Office of Health Care Ombudsman established under section 331(a).

"Ombudsman." The health care ombudsman appointed under section 331(b).

"Participant." An individual who is enrolled in the plan.

"Plan." The Pennsylvania Health Care Plan established under section 501.

"Quality of care panels." The Health Professional Quality Panel, Health Institution Quality Panel and Health Supplier Quality Panel under section 303.

CHAPTER 3

ADMINISTRATION OF PENNSYLVANIA HEALTH CARE PLAN

SUBCHAPTER A

PENNSYLVANIA HEALTH CARE BOARD

Section 301. Pennsylvania Health Care Board.

(a) Board established.--The Pennsylvania Health Care Board is established as an independent administrative board. The board shall be composed of the following members:

(1) A member appointed by the Governor who shall serve as chairperson of the board.

(2) Two members from geographically diverse areas of this Commonwealth who have frequent and direct contact with the health care system and are knowledgeable about health issues as follows:

(i) A caregiver of a child with a chronic illness or developmental disability.

(ii) An adult with a chronic illness, physical disability or mental illness.

(3) A physician.

(4) A dentist.

(5) An ophthalmologist or optometrist.

(6) A pharmacist.

(7) A hospital representative.

(8) A skilled nursing facility representative.

(9) An attorney with expertise in health care law and policy.

(10) A mental health care professional.

(11) A representative of a business with fewer than 50 employees.

(12) A representative of a business with more than 50

employees.

(13) An organized labor representative from the health sector.

(14) A public health professional.

(b) Advisory committee.--

(1) Except for the gubernatorial appointee, the members of the board shall be appointed by an advisory committee comprised of the following:

(i) The President pro tempore of the Senate or a designee.

(ii) The Minority Leader of the Senate or a designee.

(iii) The Speaker of the House of Representatives or a designee.

(iv) The Minority Leader of the House of Representatives or a designee.

(v) The Secretary of Health or a designee.

(vi) The Secretary of Aging or a designee.

(vii) The Secretary of Human Services or a designee.

(viii) The Insurance Commissioner or a designee.

(ix) The Secretary of Labor and Industry or a designee.

(2) All actions of the advisory committee shall be by majority vote of the members present. A quorum shall be at least one more than half the number of the advisory committee members. Vacancies shall not be counted when calculating the number needed for a quorum.

(3) The advisory committee shall elect a chair from among its members. The advisory committee shall meet upon the call of the chair of the advisory committee.

(4) Advisory committee members shall not receive a salary but shall be reimbursed for all necessary expenses incurred in the performance of their duties.

(c) Terms.--

(1) Except as set forth in paragraph (2), the terms of the members shall be four years from the date of appointment or until a successor has been appointed.

(2) Of the initial members appointed by the advisory committee:

(i) One-half of the members shall serve initial terms of four years.

(ii) One-half of the members shall serve initial terms of two years.

(iii) After the initial terms, individuals appointed by the advisory committee shall serve for a term of four years.

(d) Filling of vacancy.--Each vacancy on the board shall be filled for the unexpired term by appointment in like manner as in case of expiration of the term of a member of the board. A vacancy shall be filled by a representative from the same constituent group as the new member's predecessor.

(e) Board chairperson.--The Executive Board established by section 204 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929, shall determine the salary to be paid to the chairperson of the board. The chairperson of the board shall, when present, preside at all meetings and, if absent, a member designated by the chairperson shall preside.

(f) Expenses.--Members of the board who are appointed by the advisory committee shall be reimbursed only for necessary and actual expenses incurred in the performance of their duties.

(g) Meetings and conduct of business.--

(1) The chairperson of the board shall set the time, place and date for the initial meeting of the board. The initial meeting shall be scheduled not sooner than 30 days nor later than 90 days after the appointment of the chairperson. Subsequent meetings shall occur as determined by the board but not less than six times annually. The chairperson may call additional meetings.

(2) The board is subject to:

(i) The provisions of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(ii) The act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

(3) A board member shall be deemed to have abandoned office upon failure to attend at least 75% of the board meetings in one year, without excuse approved by resolution of the board.

(4) Decisions at meetings of the board shall be reached by majority vote of those present in person and those present by electronic or telephonic means which permit, at a minimum, audio-video communication. Participation in a meeting pursuant to this paragraph shall constitute presence at the meeting. Absentee or proxy voting shall not be allowed.

(h) Quorum.--A quorum for the conducting of business at meetings of the board shall be at least one more than half the number of the board members. Vacancies shall not be counted when calculating the number needed for a quorum.

(i) Prohibition.--No member of the board may hold any other salaried public office, either elected or appointed, during the member's tenure on the board.

Section 302. Duties of board.

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

(b) Specific duties.--The board shall:

(1) Implement statutory eligibility standards for health care benefits.

(2) Annually adopt a health care benefits package for participants of the plan.

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

(4) At least annually, review the appropriateness and sufficiency of reimbursements for health care services rendered and consider whether a charge is fair and reasonable for its metropolitan statistical area.

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

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

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

(8) Establish an enrollment system that will ensure that eligible residents are knowledgeable and aware of their rights to health care and are formally enrolled in the plan.

(9) Adopt bylaws for governing its operations.

(10) Report annually to the General Assembly and to the Governor, on or before the first day of October, on the following:

(i) The performance of the plan.

(ii) The fiscal condition of the plan.

(iii) Recommendations for statutory changes.

(iv) The receipt of payments from the Federal Government.

(v) Whether current year goals and priorities were met.

(vi) Future goals and priorities.

(11) Obtain appropriate liability and other forms of insurance to provide coverage for the plan, the board, the agency and their employees and agents.

(12) Provide for oversight of the agency by taking the following actions:

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

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

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

(iv) Supporting the development of an integrated health care database for health care planning and quality assurance.

(v) Implementing policies and developing mechanisms and incentives to maximize efficacy across language and cultural barriers.

(vi) Establishing rules and procedures for

implementation and staffing of a no-fault compensation system for iatrogenic injuries or complications of care in cases where a patient's condition is made worse or an opportunity for cure or improvement is lost due to the health care or medication provided or appropriate care not provided by participating providers under the plan.

(vii) Establishing standards and criteria for the determination of appropriate transitional support and training in accordance with Chapter 11 for residents of this Commonwealth who are displaced from work.

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

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

(13) Establish the quality of care panels in accordance

with section 303.

(14) Establish a secure and centralized electronic health record system wherein a participant's entire health record can be readily and reliably accessed by authorized persons with the objective of eliminating the errors and expense associated with paper records and diagnostic films. The system shall ensure the privacy of all health records it contains.

(15) Establish, from the revenues received, a reserve fund sufficient to provide a continuation of services during periods of reduced or insufficient revenue due to economic conditions or unforeseen emergency major health care needs.

(16) Adopt rules of ethics and definitions of irreconcilable conflicts of interest that will determine under what circumstances members must recuse themselves from voting. The executive director and board members and their immediate families are prohibited from having any pecuniary interest in any business with a contract or in negotiation for a contract with the agency. For purposes of this paragraph, the term "immediate family member" includes a spouse, child, stepchild, parent, stepparent, grandparent, brother, stepbrother, sister, stepsister or like relative-in-law.

(17) Establish procedures to identify, investigate and resolve fraudulent practices in connection with the plan.

(18) Promulgate regulations and establish guidelines and standards necessary to implement this act.

Section 303. Quality of care panels.

(a) Establishment.--The following quality of care panels shall be established by the board upon recommendation of the

advisory committee:

(1) The Health Professional Quality Panel.

(2) The Health Institution Quality Panel.

(3) The Health Supplier Quality Panel.

(b) Composition.--The quality of care panels shall be comprised of persons who represent a cross section of the medical and provider community as follows:

(1) Appointments shall be made by the board upon recommendation of the advisory committee. The board shall appoint a board member to serve as a nonvoting member and chairperson of each quality of care panel.

(2) The Health Professional Quality Panel shall consist of one representative of each of the following constituencies:

(i) Primary care physicians.

(ii) Specialty care physicians.

(iii) Clinical psychologists.

(iv) Nurses.

(v) Social workers.

(vi) Midwives.

(vii) Nutritionists.

(viii) Pharmacists.

(ix) Optometrists.

(x) Podiatrists.

(xi) Hearing specialists.

(xii) Physical or occupational therapists.

(xiii) Dentists.

(xiv) Chiropractors.

(xv) Health educators.

(xvi) Acupuncturists.

(xvii) Consumers.

(3) The Health Institution Quality Panel shall consist of one representative of each of the following constituencies:

(i) Academic medical centers.

(ii) Community hospitals.

(iii) Rehabilitation centers.

(iv) Trauma systems.

(v) Convenient care centers.

(vi) Hospice program.

(vii) Substance abuse centers.

(viii) Home health care services.

(ix) Skilled nursing facilities.

(x) Birth centers.

(xi) Consumers.

(4) The Health Supplier Quality Panel shall consist of one representative of each of the following constituencies:

(i) Medical imaging facilities.

(ii) Medical laboratories.

(iii) Durable medical equipment suppliers.

(iv) Pharmaceutical suppliers.

(v) Medical suppliers other than durable medical equipment suppliers.

(vi) Electronic medical records.

(vii) Consumers.

(c) Consumer representatives.--Each consumer representative under subsection (b) must possess expertise in the area of health care of the quality of care panel to which the consumer representative is appointed.

(d) Duties.--Duties of the quality of care panels shall

include:

(1) Making recommendations to the board on the establishment of policy on medical issues, population-based public health issues, research priorities, scope of services, expansion of access to health care services and evaluation of the performance of the plan in order to provide high quality care for residents of this Commonwealth.

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

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

(4) Develop and recommend a schedule of reimbursement rates for covered medical services.

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

(6) Coordinating resources in order to minimize duplication among providers, institutions and suppliers.

(7) Evaluating research in order to recommend products or services.

(8) Presenting key recommendations in a report to the board on improving quality of care. The quality of care recommendations shall be presented in a formal report at every board meeting.

(e) Compensation.--Voting members of the quality of care panels shall be paid a per diem rate, established by the board, for attendance at meetings and further be reimbursed for actual and necessary expenses incurred in the performance of their

duties.

(f) Meetings.--The quality of care panels shall meet regularly as needed to create policies and recommendations to deliver cost-effective, evidence-based, quality health care to the residents of this Commonwealth.

(g) Staffing.--The board shall hire staff to work with the agency on the development of quality of care recommendations.

(h) Report to board.--The chair of each quality of care panel shall inform the board on progress or explain the lack of progress in implementing key recommendations of the quality of care panels.

SUBCHAPTER B

PENNSYLVANIA HEALTH CARE AGENCY

Section 321. Pennsylvania Health Care Agency.

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

(b) Executive director.--The executive director of the agency shall be appointed by and shall serve at the pleasure of the board. The executive director shall be the chief administrator of the plan and is responsible for the implementation of the plan. The executive director shall oversee the operation of the agency and the agency's performance of any duties assigned by the board.

(c) Salary of executive director.--The salary of the executive director shall not exceed the statutory salary of the Governor. The executive director may not hold any other salaried public office, either elected or appointed, during the executive director's tenure with the agency.

(d) Personnel and employees.--The board shall employ and fix the compensation of agency personnel. The employment of personnel by the board is subject to the civil service laws of this Commonwealth.

SUBCHAPTER C

OFFICE OF HEALTH CARE OMBUDSMAN

Section 331. Office of Health Care Ombudsman.

(a) Establishment.--The Office of Health Care Ombudsman is established to represent the interests of plan participants and prospective participants.

(b) Health care ombudsman.--The office shall be headed by the health care ombudsman, who shall be appointed by the board upon recommendation of the advisory committee. The ombudsman shall serve at the pleasure of the board until a successor is appointed and qualified. The ombudsman shall be a person who by reason of training, experience and attainment is qualified to represent the interest of participants and prospective participants. The ombudsman shall devote full time to the office.

(c) Employment restrictions.--No individual who serves as an ombudsman shall, while serving in the position, engage in any business, vocation or other employment, or have other interests, that conflict with the official responsibilities of the ombudsman during the tenure of the appointment.

(d) Political office restrictions.--Any individual who is

appointed to the position of ombudsman shall not seek election nor accept appointment to any political office during the tenure as ombudsman.

(e) Staff.--The ombudsman shall appoint attorneys and additional clerical, technical and professional staff as may be appropriate and may contract for additional services as shall be necessary for the performance of the functions of the office. No employee shall, while employed by the office, engage in any business, vocation or other employment, or have other interests, that conflict with the official responsibilities of the employee.

(f) Compensation.--The compensation of the ombudsman and the attorneys and clerical, technical and professional staff of the office shall be set by the Executive Board established by section 204 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

(g) Role of agency.--The agency shall have administrative responsibilities for the office only and shall not be responsible, in any manner, for the policies, procedures or other substantive matters developed by the office in carrying out its duties to represent the plan participants and prospective participants.

Section 332. Duties of office.

(a) Duties of office.--In addition to any other duties prescribed by this act, the office shall respond to questions, complaints and problems related to implementation of the plan. The office shall respond to an issue related to implementation of the plan by acting directly or through one or more contractors. The initial response of the office shall occur within 24 hours following the office's notification of an issue.

The office shall work with agency staff to provide information when questions are presented and to identify permanent or temporary resolutions to complaints and problems.

(b) Report.--The ombudsman shall prepare a report for each board meeting summarizing major issues presented to the office and recommendations for their resolution by the board.

Section 333. Funding of office.

The operating costs and expenses of the office shall be paid from the money deposited in the fund.

SUBCHAPTER D

(Reserved)

SUBCHAPTER E

(Reserved)

SUBCHAPTER F

IMMUNITY

Section 371. Immunity.

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

CHAPTER 5

PENNSYLVANIA HEALTH CARE PLAN

Section 501. Establishment of plan.

(a) Establishment of plan.--The Pennsylvania Health Care Plan is established and shall be administered by the agency under the direction of the board.

(b) Coverage.--The plan shall provide health care coverage for residents of this Commonwealth in accordance with this act.

The agency shall work simultaneously to:

(1) Control health care costs.

(2) Achieve measurable improvement in health care outcomes.

(3) Promote a culture of health awareness.

(4) Develop an integrated health care database to support health care planning and quality assurance.

(c) Implementation.--The board shall implement the plan within one year of the effective date of this section.

Section 502. Universal health care access eligibility.

(a) Eligibility.--The following individuals may enroll as participants in the plan:

(1) A resident of this Commonwealth who files a Pennsylvania individual income tax return and any dependent of the resident.

(2) Students from out-of-State who are attending school in this Commonwealth and file a Pennsylvania individual income tax return.

(3) Part-year residents who file a Pennsylvania individual income tax return.

(b) Determination of residency status.--The agency shall establish rules for use in making residency determinations. To the extent applicable, the agency shall determine residency using the rules of the Department of Revenue in its administration of personal income taxes.

(c) Demonstration of eligibility.--The board shall establish standards and a simple procedure for use in demonstrating proof of eligibility.

(d) Enrollment.--Enrollment in the plan shall be established by the board, and participants shall be provided with smart

technology cards with appropriate proof of identity technology and privacy protection.

(e) Outreach to eligible residents.--Residents of this Commonwealth who are unable to file or pay their taxes because of physical or mental disabilities may obtain assistance through county assistance offices and other agencies identified by the board.

(f) Waiver.--If a waiver is not granted from the medical assistance or Medicare program operated under Title XVIII or XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), the medical assistance or Medicare program for which a waiver is not granted shall act as the primary insurer for those eligible for such coverage, and the plan shall serve as the secondary or supplemental plan of health insurance coverage. Until such time as a waiver is granted, the plan shall not pay for services for persons otherwise eligible for the same health care benefits under the medical assistance or Medicare program.

(g) Veterans.--The plan shall serve as the secondary or supplemental plan of health insurance coverage for military veterans except where reasonable and timely access, as defined by the board, is denied or unavailable through the Department of Veterans Affairs, in which instance the plan shall be the primary insurer and shall seek reasonable reimbursement from the Department of Veterans Affairs for the services provided to veterans.

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

(i) Reimbursement.--The plan shall reimburse providers practicing outside of this Commonwealth at plan rates. Services provided to a participant outside this Commonwealth by other than a participating provider shall be reimbursed to the participant or to the provider at plan rates.

(j) Presumption of eligibility.--An individual who arrives at a health care facility unconscious or otherwise unable to document eligibility for coverage due to the individual's medical condition shall be presumed to be eligible, and emergency care shall be provided without delay occasioned by issues of ability to pay.

(k) Rules.--The board shall adopt rules ensuring that a participating provider who renders humanitarian emergency care, urgent care or prevention or treatment for a communicable disease or prenatal and delivery care within this Commonwealth to a noneligible recipient shall be reimbursed by the plan for the care provided. The rules shall reasonably limit the frequency of reimbursement to protect the fiscal integrity of the plan. The agency shall secure reimbursement for the costs paid for the care provided from any appropriate third-party funding source or from the individual to whom the services were rendered.

Section 503. Covered services.

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

(1) All medically necessary inpatient and outpatient care and treatment, both for primary and specialty care. Medically necessary care and treatment shall be approved by the quality of care panels and provided by licensed health

care providers.

(2) Emergency services.

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

(4) Rehabilitation services, including speech, occupational, physical and evidence-based alternative therapy.

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

(6) Hospice care.

(7) Prescription drugs and prescribed medical nutrition.

(8) Vision care, aids and equipment.

(9) Hearing care, hearing aids and equipment.

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

(11) Medical supplies and prescribed medical equipment.

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

(13) Dental care.

(14) Home health care services.

(15) Chiropractic.

(16) Complementary and alternative modalities that have been shown by the National Institute of Health's Division of Complementary and Alternative Medicine to be safe and effective for possible inclusion as covered benefits.

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

(c) Copayments, deductibles and other charges.--Participants are not subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the

package and shall not be directly billed nor balance billed by participating providers for covered benefits provided to the participant. If a participant has directly paid for nonemergency services of a nonparticipating provider, the participant may submit a claim for reimbursement from the plan for the amount the plan would have paid a participating provider for the same service. If emergency services are rendered by a nonparticipating provider, the participant shall receive reimbursement of the full amount paid to the nonparticipating provider, not to exceed the amount the plan would have paid a participating provider for the same service.

(d) Exclusions of coverage.--

(1) The board may remove or exclude procedures and treatments, equipment and prescription drugs from the plan benefit package that the Food and Drug Administration or a quality of care panel finds, on the basis of medical evidence, unsafe or that add no therapeutic value.

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

(e) Participant choice.--Participants shall normally be granted freedom to choose participating providers, including specialists, without preapprovals or referrals. However, the board shall adopt procedures to restrict the freedom to choose for those individuals who engage in patterns of wasteful or abusive self-referrals to specialists. A specialist who provides

primary care to a self-referred participant shall be reimbursed at the board-approved primary care rate established for the service in that community.

(f) Practice patterns.--Practice patterns of participating providers shall be monitored. Practice patterns that reflect overutilization or underutilization shall be reviewed. The board may set policies addressing overutilization or underutilization after reviewing practice patterns and recommendations from the quality of care panels.

(g) Service.--No participating provider shall be compelled to offer any particular service so long as the refusal is consistent with the provider's practice.

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

(i) Appeals.--A participant may appeal a decision relating to covered services under the plan to the ombudsman.

Section 504. Supplemental health insurance coverage.

Subject to the regulations of the Insurance Commissioner and all applicable laws, private health insurers shall be authorized to offer coverage supplemental to the health benefits package approved and provided under the plan.

Section 505. Duplicate coverage.

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

Section 506. Subrogation.

The agency has no right of subrogation against a participant's third-party claims for harm or losses not covered under this act. A participant has no right to claim against a third-party tortfeasor for the services provided or available to the participant under this act. In all personal injury actions accruing and prosecuted by a participant after the participant's enrollment in the plan, the presiding judge shall advise any jury that all health care expenses have been or will be paid under the plan, and, therefore, no claim for past or future health care benefits is pending before the court.

Section 507. Eligible participating providers and availability of services.

(a) General rule.--Health care providers licensed, registered or certified to practice and licensed health care facilities are eligible to become a participating provider in the plan in which instance they shall enjoy the rights and have the duties as set forth in the plan as provided under this section or as adopted by the board in accordance with this act. Nonparticipating providers shall not enjoy the rights nor bear the duties of participating providers.

(b) Required notice.--

(1) In advance of initially providing services to a participant, nonparticipating providers shall advise the participant at the time the appointment is made that the person or entity is a nonparticipating provider and that the recipient of the service initially will be personally responsible for the entire cost of the service and ultimately responsible for the cost in excess of any reimbursement approved by the board for participating providers.

(2) A form signed by the participant acknowledging that the provider has disclosed to the participant whether the provider participates or does not participate in the plan and who is responsible for the cost of care shall be deemed sufficient notice.

(3) Failure to make the required disclosure is deemed a fraud on the participant and shall entitle the participant to a refund from the provider equal to 200% of the amount paid to the nonparticipating provider in excess of the board-approved reimbursement for the services rendered, plus all reasonable fees for collection. The burden of proof that the disclosure was made shall be on the nonparticipating provider.

(c) Plan by board.--The board shall assess the number of primary care and specialty providers needed to supply adequate health care services in this Commonwealth generally and in all geographic areas and shall develop a plan to meet that need. The board shall develop financial incentives for participating providers in order to maintain and increase access to health care services in underserved areas of this Commonwealth.

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

The plan shall review fee schedules and may offer reimbursement mechanisms, including capitation, salary and bonuses.

(e) Adjustments to reimbursements.--Participating providers shall have the right individually or collectively to petition the board for adjustments to reimbursements believed to be too low. Petitions shall be initially evaluated by the agency, with input from the Health Professional Quality Panel. The agency shall submit a report to the chairperson of the board within 30 days. Following receipt of the report, the chairperson shall submit a recommendation to the board for action at the next scheduled board meeting. Participating providers who remain dissatisfied after the board has ruled may appeal the board's determination to Commonwealth Court, which shall review the action of the board on an abuse of discretion standard.

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

(g) Health care delivery models.--The board, with the assistance of the quality of care panels, shall review best practices in delivering high quality care. Those wellness practices that can be adopted shall be funded with an increasing emphasis on prevention and community-based care in order to reduce the need for hospitalization and skilled nursing facility care in the future.

(h) Performance reports.--The board, with the assistance of the quality of care panels, shall define performance criteria and goals for the plan and shall make a written report to the General Assembly at least annually on the plan's performance. Reports shall be made publicly available with the goal of total

transparency and open self-analysis as a defining quality of the agency. The board shall establish a system to monitor the quality of health care and patient and provider satisfaction and to adopt a system to devise improvements and efficiencies to the provision of health care services.

(i) Data reporting.--Participating providers shall, in a prompt and timely manner, provide information to the agency in the form and manner requested by the agency.

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

Section 508. Rational cost containment.

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

(b) Capital investments.--

(1) Capital investments of $1,000,000 or more require the approval of the board. If a facility, an individual acting on behalf of a facility or any other purchaser obtains by lease or comparable arrangement any facility or part of a facility, or any equipment for a facility, the market value of which would have been a capital expenditure, the lease or arrangement shall be considered a capital expenditure for

purposes of this section.

(2) For purposes of this subsection, the term "capital investments" includes the costs of studies, surveys, design plans and working drawing specifications and other activities essential to planning and execution of capital investment. The term includes capital investments that change the bed capacity of a health care facility by more than 10% over a 24-month period or that add a new service or license category.

(c) Study.--An entity that intends to make capital investments or acquisitions shall prepare a business case for making each investment and acquisition. It shall include the full-life-cycle costs of the investment or acquisition, an environmental impact report that meets existing State standards and a demonstration of how the investment or acquisition meets the health care needs of the population it is intended to serve. Acquisitions may include acquisitions of land, operational property or administrative office space.

(d) Deemed approval.--Capital investment programs submitted for approval shall be deemed approved by the board if not disapproved by the board within 60 days from the date the submissions are received by the chairperson of the board. A 60-day extension may apply if the board requires additional information.

(e) Recommendations.--Recommendations of the Health Care Cost Containment Council and other public and private authoritative bodies as shall be identified from time to time by the board shall be received by the chairperson of the board and submitted to the board with the chairperson's recommendation regarding implementation of the recommended reforms. The board

shall receive input from all interested parties and then shall vote upon the recommendations within 60 days. If procedural or protocol reforms are adopted, participating providers shall be required to implement the designated best practices within the next 60 days.

(f) Appeal.--A decision of the board may be appealed through a uniform dispute resolution process that has been established by unanimous approval of the board.

(g) Required investments.--The board, with the recommendations of the Health Institution Quality Panel, may adopt programs to assist participating providers in making capital investments responsive to best practice recommendations.

CHAPTER 9

PENNSYLVANIA HEALTH CARE TRUST FUND

Section 901. Pennsylvania Health Care Trust Fund.

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

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

Section 902. Agency budget.

The agency budget shall comprise the cost of the agency, services and benefits provided, administration, data gathering, planning and other activities and revenues of the fund. The board shall limit administrative costs, excluding start-up

costs, to 5% of the agency budget. The board shall annually evaluate methods to reduce administrative costs and publicly report the results of that evaluation.

Section 903. Funding sources.

Revenues of the fund shall be obtained from the following sources:

(1) Funds obtained through Federal health care programs.

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

(3) Receipts from the tax under section 904.

(4) Receipts from the tax imposed under section 905.

Section 904. Payroll tax.

(a) Imposition.--Beginning July 1 of the calendar year following the effective date of this section, a tax of 10% is imposed on payroll amounts generated as a result of an employer conducting business activity within this Commonwealth. For purposes of the payroll tax imposed under this section, the business activity shall be directly attributable to activity within this Commonwealth. For purposes of computation of the payroll tax, the payroll amount attributable to the Commonwealth shall be determined by applying an apportionment factor to total payroll expense based on that portion of payroll expense which the total number of days an employee, partner, member, shareholder or other individual works within this Commonwealth bears to the total number of days the employee or person works outside of this Commonwealth.

(b) Business activity.--For purposes of the payroll tax assessed pursuant to this section, an employer is conducting business within this Commonwealth if the employer engages, hires, employs or contracts with one or more individuals as

employees and, in addition, the employer does at least one of the following:

(1) Maintains a fixed place of business within this Commonwealth.

(2) Owns or leases real property within this Commonwealth for purposes of a business.

(3) Maintains a stock of tangible personal property in this Commonwealth for sale in the ordinary course of a business.

(4) Conducts continuous solicitation within this Commonwealth related to a business.

(5) Utilizes the highways of this Commonwealth in connection with the operation of a business other than transportation through this Commonwealth.

(c) Reports.--All employers in this Commonwealth shall file returns and make payments as required by the Department of Revenue. An employer making a return shall certify the correctness of the return. The Department of Revenue may audit, examine or inspect the books, records or accounts of all employers subject to the tax imposed under this section.

(d) Regulations.--The Department of Revenue may promulgate regulations necessary to implement this section.

(e) Deposit in fund.--All taxes, additions and penalties collected pursuant to this section shall be transmitted to the State Treasurer for deposit into the fund and used exclusively for the purposes of this act.

(f) Offset prohibited.--An employer shall not offset the amount of tax paid pursuant to this section by reducing compensation or benefits paid to employees.

(g) Enforcement.--The Department of Revenue shall proceed to

recover taxes due and unpaid under this section in accordance with the applicable processes, remedies and procedures for the collection of taxes provided by the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

(h) Construction.--This section shall not be construed to limit the Department of Revenue from recovering delinquent taxes by any other means provided by law.

(i) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Employer." All persons conducting business activity within this Commonwealth, including a governmental entity.

"Payroll amounts." All amounts paid by an employer as salaries, wages, commissions, bonuses, net earnings and incentive payments, whether based on profits or otherwise, fees and similar remuneration for services rendered, whether directly or through an agent and whether in cash, in property or the right to receive property.

Section 905. Additional personal income tax imposed.

(a) Personal income tax.--Beginning July 1 of the calendar year following the effective date of this section, there is imposed an additional tax upon each class of income as defined in Article III of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The tax shall be calculated, collected and paid over to the Commonwealth in the same manner as provided in Article III of the Tax Reform Code of 1971.

(b) Rate.--The tax imposed by subsection (a) shall be at the rate of 3%.

(c) Deposit of tax proceeds.--The Department of Revenue shall deposit taxes collected under this section in the fund.

The amount shall be the sum of the taxes collected under this section and Article III of the Tax Reform Code of 1971 multiplied by a fraction equal to the rate of tax under this section divided by the sum of the rate of tax under this section and the rate of tax under section 302 of the Tax Reform Code of 1971.

(d) Rules and regulations.--The rules and regulations of the Department of Revenue promulgated under Article III of the Tax Reform Code of 1971, or any other act, shall be applicable to the tax imposed by this section to the extent that they are applicable.

(e) Construction.--The tax imposed by this section shall be in addition to any tax imposed under Article III of the Tax Reform Code of 1971 or section 321(c) of the act of June 27, 2006 (1st Sp.Sess., P.L.1873, No.1), known as the Taxpayer Relief Act. The provisions of Article III of the Tax Reform Code of 1971 shall apply to the tax imposed by this section.

CHAPTER 11

TRANSITIONAL SUPPORT

Section 1101. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Displaced employee." A resident of this Commonwealth employed by a health care insurer or other health-care-related business who loses employment within the first two years following implementation of the plan as a direct result of the implementation of the plan.

Section 1102. Transitional support and training for displaced employees.

(a) Agency duties.--The agency shall:

(1) Identify displaced employees.

(2) Determine the amount of monthly wages that each displaced employee has lost due to the plan's implementation.

(3) Attempt to position the displaced employees in comparable positions of employment or assist in the retraining and placement of the displaced employees elsewhere.

(b) Coordination of services.--The agency shall fully coordinate activity with public and private services that are available or actually participating in providing employment-related assistance.

(c) Appeals.--Displaced employees who are dissatisfied with the level of assistance they are receiving may appeal to the ombudsman. A determination by the ombudsman shall be final and not subject to appeal.

CHAPTER 45

MISCELLANEOUS PROVISIONS

Section 4501. Effective date.

This act shall take effect immediately.

Office of the Ombudsman

- Independent of the Agency
- Handle all complaints not resolved through the Agency resolution process
- Make recommendations to the Board

Pennsylvania Health Care Board

- Chairperson appointed by the Governor
- Board comprised of 15 members total – 14 appointed by the Advisory Committee
- Chairperson salary will be set by **Executive Board**
- Board shall:
  - Governance and oversight of the Agency, Trust Fund, Quality of Care Panels and Ombudsman
  - Appoint members for the Quality of Care Panels
  - Set Plan policy
  - Oversee Plan administration
  - Adopt the benefits package for the Plan
  - Ensure sufficiency of Plan revenues
  - Work with Legislature to establish and maintain statutory authority

Advisory Committee

Shall be comprised of:

- President Pro Tempore of the Senate or designee
- Minority Leader of the Senate or designee
- Speaker of House of Representatives or designee
- Minority Leader of House or Representatives or designee
- Secretary of Health or designee
- Secretary of Aging or designee
- Secretary of Human Services or designee
- Insurance Commissioner or designee
- Secretary of Labor and Industry or designee

Responsibilities:

- Appoint 14 members of the Board
- Recommend to the Board candidates for the Quality of Care Panels
- Recommend candidates for Ombudsman

PA Health Care Agency

- Executive Director appointed by the Board
- Adopt the Health Care Plan standards and regulations
  - Adopt standards and regulations
  - Ensure compliance of member eligibility
  - Recommend covered services
  - Implement services reimbursement rates
  - Certify eligibility of licensed healthcare practitioners under the Plan
  - Ensure timely reimbursement to licensed healthcare practitioners
  - Establish process for revision of services and reimbursement rate
  - Ongoing review of technology and protocols
  - Make recommendations to the Board for revisions to Plan Policy
  - Ensure compliance of licensed healthcare practitioners with Plan Policy and standards
- Administer all operations of the Plan on day to day basis
  - Receive from licensed healthcare practitioners invoices for services
  - Reimburse licensed healthcare practitioners for services
  - Audit compliance of services to Plan standards
  - Establish a dispute resolution process
  - Maintain and staff Plan member services customer support

Quality of Care Panels

- Established under the authority of the Board
- A Board member will serve as Chair of the Panel
- Panels shall consist of:
  - Health Professional Panel
  - Health Institution Panel
  - Health Supplier Panel
- Responsible for development of policy recommendations to the Board
- Staffed as required to provide documentation and evidenced based health care recommendations to the Board
- Work continually with the PA Health Care Agency to adopt and revise Plan standards and regulations

Pennsylvania Health Care Trust Fund

- Established within the State Treasury
- All money collected and received by the Plan shall be transmitted to the State Treasurer for deposit into the fund and used exclusively to finance the Plan
- The State Treasurer may invest the principal and interest earned by the fund
- The PA Health Care Agency budget shall comprise the cost of the agency, covered services, Quality of Care Panels, Office of the Ombudsman, PA Health Care Board and PA Health Care Trust Fund
- Responsible for managing tax receipts and disbursements
- Work with Dept. of Revenue to ensure collection of taxes provided under the Plan
- Develop appropriate financial reports of the status of the trust fund
- Project sufficiency of Plan revenues compared to expenditures
- Personal Income tax of 3% (no co-pays – no deductibles – no premiums)*
- Employer payment of 10% of payroll tax

* A resident of PA that files a PA income tax return and any dependent of the resident is eligible to enroll in the Plan

Helpful Information and Links

Definitions of Universal Health Care:
"Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." – World Health Organization (WHO)

Definition of Single Payer Health Care:
"Single-payer national health insurance, also known as "Medicare for all," is a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands." – Physicians for a National Health Program (PNHP)

"Universal Coverage Is Not "Single Payer" Healthcare"
By: Dan Munro
Forbes, December 8, 2013
https://www.forbes.com/sites/danmunro/2013/12/08/universal-coverage-is-not-single-payer-healthcare/#2e5662d036ee

"A Brief History: Universal Health Care Efforts in the US"
By: Physicians for a National Health Program (PNHP)
http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us

"Fix It: Healthcare at the Tipping Point" – A Film
https://www.youtube.com/watch?v=KS-olhBvEkc

The Legislation: HB1688 – http://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2015&sInd=0&body=H&type=B&bn=1688