The Saskatchewan Universal Health - Enabling Act

New Century Party - 2025

Part I - Interpretation and Purpose

1-1 Short Title

This Act may be cited as The Universal Health (Extended Benefits) Enabling Act.

1-2 Purpose

(1) The purposes of this Act are to:
(a) establish a universal, single-payer program that provides $0 point-of-care access to medically necessary extended health services for residents of Saskatchewan;
(b) ensure insured services are publicly administered, with direct billing to the public plan and no extra-billing;
(c) create arm's-length Benefit Councils to recommend coverage rules, clinical indications, fee guides, and formularies based on clinical evidence, equity, and prudent stewardship;
(d) finance extended benefits through a Universal Health Levy set within actuarial corridors by an independent rates body;
(e) provide transparent dashboards of access, quality, safety, cost, and equity; and
(f) express the Legislature's intent to amalgamate extended benefits with physician and hospital services into a single universal health service in Saskatchewan, on a timeline to be proposed to the Assembly under this Act.
(2) This Act binds the Crown.

1-3 Application and Relationship to Other Laws

(1) This Act governs extended health services and does not displace the existing public coverage of hospital and physician services funded from the General Revenue Fund, except as expressly provided.
(2) In the event of a conflict between this Act and any other enactment respecting payment for insured extended services, this Act prevails, except The Health Information Protection Act and The Saskatchewan Human Rights Code, which prevail in case of conflict.
(3) Nothing in this Act abrogates or derogates from the rights of Indigenous peoples, including treaty rights. Implementation that affects rights, lands, or waters must align with Free, Prior, and Informed Consent (FPIC).

1-4 Definitions

In this Act:

(a) “Agency” means the unit within the Ministry responsible for administering the Plan under this Act or a Crown prescribed by regulation.
(b) “Benefit Council” means a council established under Part II to recommend coverage, clinical indications, fee guides, and formularies for a Health Area.
(c) “Clinician” means a regulated health professional authorized to provide the service at issue.
(d) “Clinically necessary” or “medically necessary” means, subject to Council guidance, a service, drug, device, supply, or program that a treating clinician, applying reasonable clinical judgment and accepted standards, determines is required to prevent, diagnose, treat, manage, or palliate a disease, condition, injury, impairment, or its symptoms, or to maintain, restore, or improve functional capacity; services provided primarily for cosmetic or convenience purposes are not medically necessary.
(e) “Council Secretariat” means the administrative support unit for the Benefit Councils.
(f) “Health Area” means an extended-benefits domain prescribed by regulation, including Pharmacare, Dental Care, Vision Care, Hearing Care, Mental Health Care, Home and Community Care, and Long-Term Care/Assisted Living.
(g) “Insured service” means a medically necessary service within a Health Area for which payment is authorized under this Act or regulations.
(h) “Non-insured enhancement” means a service or upgrade outside medical necessity (including purely cosmetic services) for which private payment or insurance may be permitted.
(i) “Opt-in provider” means a clinic, facility, or practitioner who enrols to provide insured services and directs bills to the Plan in accordance with this Act.
(j) “Plan” means the Saskatchewan Universal Health Plan established under this Act to pay for insured services in the Health Areas.
(k) “Resident” means a person lawfully entitled to be or to remain in Canada who makes their home and is ordinarily present in Saskatchewan, excluding a tourist, transient, or visitor, as further prescribed.
(l) “Universal Health Levy” or “UHL” means the payroll-based levy established in Part IV for the purpose of financing the Plan.

1-5 Rights and Entitlements

(1) Every resident is entitled to access insured services within the Health Areas without charge at the point of use.
(2) An opt-in provider must direct bill the Plan for insured services and shall not charge or accept any payment or consideration from a resident or third party for an insured service, except as permitted for non-insured enhancements.
(3) No contract of private insurance may cover insured services; private insurance may cover non-insured enhancements as prescribed.

(4) Access shall be provided without discrimination, with measures to advance equity for rural/northern residents, persons with disabilities, newcomers, and Indigenous peoples, as prescribed.

1-6 Clinical Governance and Exceptions

(1) Determination of medical necessity rests with the treating clinician, subject to professional standards and any Council-issued clinical indications or guidelines.
(2) The Agency shall maintain an expedited exception pathway—a 10-day decision standard—for high-cost drugs, devices, or therapies; applicants may appeal to an Independent Clinical Review Panel within 15 days, as prescribed.

1-7 Public Administration and Accountability

(1) The Plan shall be publicly administered and operated on a non-profit basis.
(2) The Minister shall publish open dashboards displaying de-identified indicators of access, quality, safety, equity, utilization, and expenditure for each Health Area, with minimum content and update cadence prescribed by regulation.
(3) The Minister shall table annually, alongside the Budget, a 10-year actuarial and fiscal outlook for the Plan, including UHL revenue projections, expenditure by Health Area, and risk corridors.

1-8 Transparency, Integrity, and Enforcement (General)

(1) The Agency may conduct audits and inspections, compel records, and issue compliance orders to enforce the prohibitions on extra-billing and duplicate insurance for insured services.
(2) Administrative Monetary Penalties (AMPs), repayment, suspension, and debarment for repeat non-compliance may be imposed as prescribed by regulation.
(3) Providers are entitled to timely dispute resolution, with written reasons, within periods prescribed by regulation.

1-9 Amalgamation Duty (Future Integration)

(1) Within 24 months of this Part coming into force, the Minister shall table in the Assembly a roadmap for amalgamating extended benefits under this Act with physician and hospital services into a single Universal Health Service for Saskatchewan, including legislative options, fiscal impacts, and timelines.
(2) The roadmap must be developed with stakeholder consultation, including Indigenous governing bodies under FPIC.

1-10 Regulation-Making (General)

The Lieutenant Governor in Council may make regulations respecting any matter necessary to carry out this Part, including: further definitions; residency evidence; dashboard indicators; the composition and operations of the Independent Clinical Review Panel; inspection and AMP procedures; and transition provisions.

Part II - Universal Coverage

2-1 Plan and Entitlement

(1) A program to be known as the Saskatchewan Universal Health Plan (the "Plan") is established to fund insured services within the Health Areas for $0 at point of care.
(2) Every resident is entitled to insured services under this Part, subject only to eligibility verification prescribed by regulation.
(3) Insured services shall be publicly administered and directly billed to the Plan by opt-in providers; extra-billing and balance-billing for insured services are prohibited.
(4) Private insurance shall not cover insured services; private insurance may cover non-insured enhancements as prescribed.

2-2 Health Areas (Scope of Coverage)

(1) The following Health Areas are established and may be expanded by regulation:
(a) Pharmacare;
(b) Dental Care;
(c) Vision Care;
(d) Hearing Care;
(e) Mental Health Care;
(f) Home and Community Care; and
(g) Long-Term Care and Assisted Living.
(2) The Lieutenant Governor in Council may prescribe sub-areas, program streams, inclusion/exclusion lists, clinical indications, and phased roll-in schedules.

2-3 Medical Necessity and Clinical Exceptions

(1) A service is medically necessary where the treating clinician, applying reasonable clinical judgment and accepted standards, determines it is required to prevent, diagnose,

treat, manage, or palliate a condition, injury, impairment, or its symptoms, or to maintain, restore, or improve functional capacity, subject to Council guidance under section 2-5.
(2) The Agency shall operate an expedited exception pathway for high-cost drugs, devices, or therapies with a 10-day decision standard; reasons must be provided in writing.
(3) An applicant may appeal to an Independent Clinical Review Panel within the period and on the grounds prescribed by regulation.

2-4 Benefit Councils – Establishment

(1) For each Health Area, there shall be a Benefit Council.
(2) A Council Secretariat shall support all Benefit Councils.
(3) Councils are arm's-length advisory bodies whose recommendations shall be adopted by the Minister unless returned with written reasons within 45 days for further review; reasons shall be published.

2-5 Benefit Councils – Functions

Each Benefit Council shall, for its Health Area:
(a) recommend coverage rules, clinical indications, and fee guides or remuneration models for insured services;
(b) recommend and maintain formularies or device lists, including generic-first and biosimilar-to-reference switching policies with clinical exceptions (Pharmacare);
(c) set access targets (e.g., wait-time, attachment) and equity objectives (e.g., rural/northern, disability, Indigenous access);
(d) recommend data standards and quality/safety indicators for dashboards;
(e) advise on scope-of-practice alignment and task-sharing; and
(f) conduct periodic reviews and horizon scanning for new evidence and technologies.

2-6 Benefit Councils – Composition and Integrity

(1) Membership shall include: practising clinicians relevant to the Health Area; patient/public representatives; health economics and quality/safety expertise; and at least one Indigenous-appointed member, all as prescribed.
(2) Councils shall adopt conflict-of-interest and industry-interaction policies (including disclosure and recusal) and publish minutes, rationales, and voting records, subject to privacy law.
(3) Members shall not accept honoraria, gifts, or other consideration from vendors of products under active review, as prescribed.

2-7 Provider Participation and Direct Billing

(1) A provider may opt in to deliver insured services by enrolling with the Agency and agreeing to direct billing, data/reporting standards, audits, and Council guidance.
(2) An opt-in provider shall not charge or accept any payment from a resident for an insured service other than prescribed missed-appointment or non-clinical administrative fees.
(3) Contracts, fee schedules, and service codes shall be published or made available in accordance with regulation.

2-8 Payment Models and Fee Guides

(1) Payment models may include fee-for-service, capitation, sessional/salaried, bundled payments, or hybrids, as recommended by Councils and prescribed by regulation.
(2) Fee guides and remuneration shall be reviewed at least annually and align with access, quality, safety, and equity objectives.

2-9 Pharmacare (Scope)

(1) The Plan shall fund medically necessary prescription drugs, vaccines, supplies, and listed devices as set out on a Saskatchewan Formulary maintained on Council advice.
(2) Policies shall include generic-first, biosimilar-first with clinical exception pathways, therapeutic substitution where appropriate, and provisions for rare-disease and oncology drugs.
(3) Province-wide e-prescribing and real-time eligibility/claims shall be implemented as prescribed.
(4) Dispensing fees, professional services, and pharmacy remuneration shall be set by regulation on Council advice.
(5) The Minister may establish pooled procurement or bulk-buying arrangements and preferred-product agreements, subject to transparency rules.

2-10 Dental Care (Scope)

(1) The Plan shall fund medically necessary preventive, basic, and major restorative dental services, including diagnostics, hygiene, fillings, endodontics, periodontics, prosthodontics, oral surgery, and medically necessary sedation/anesthesia, as prescribed.
(2) Orthodontics shall be covered where medically necessary per Council clinical criteria (e.g., functional impairment, airway), with prior-authorization timelines prescribed.
(3) A provincial dental fee guide and clinic enrolment terms shall be prescribed on Council advice.

2-11 Vision Care (Scope)

(1) The Plan shall fund eye examinations and medically necessary vision services, lenses, and devices; frame and lens allowances, replacement cycles, and low-vision device criteria shall be prescribed on Council advice.
(2) Medically necessary ocular procedures (excluding purely elective cosmetic procedures) shall be covered as prescribed.

2-12 Hearing Care (Scope)

(1) The Plan shall fund audiology assessments, medically necessary hearing aids and assistive devices (with replacement intervals), fitting/verification, repairs, and pediatric/complex programs, as prescribed.
(2) Coverage for cochlear implants and other implantable devices shall include surgery, devices, processors, mapping, and follow-up per clinical criteria.

2-13 Mental Health Care (Parity)

(1) Mental health services shall have parity of esteem with physical health.
(2) The Plan shall fund publicly delivered or contracted psychotherapy/psychological services under stepped-care models, community mental-health clinics, crisis services, and addictions/harm-reduction (including OAT).
(3) Coverage may include TMS and other evidence-based modalities; treatment-resistant pathways (e.g., ketamine, psychedelic-assisted therapy) may be funded under clinical protocols, as prescribed.

2-14 Home and Community Care (Scope)

(1) The Plan shall fund home nursing, rehabilitation, personal support, respite, palliative/hospice care, and paramedicine treat-and-refer, as prescribed.
(2) Virtual care shall be funded as a complement to in-person services, with modality standards prescribed.

2-15 Long-Term Care and Assisted Living (Scope)

(1) The Plan shall fund the care components of long-term care and assisted living as prescribed; accommodation and hospitality charges may be regulated separately.
(2) The Minister may prescribe minimum staffing, quality standards, inspections, public reporting, and transition policies to public or not-for-profit operations.

2-16 Access, Attachment, and Rural/Northern Equity

(1) The Minister may prescribe a right to attachment to a primary care home within a defined period and require Community Health Centres or other models to achieve it.
(2) The Plan may fund travel and accommodation supports for residents who must travel for insured services, with eligibility and scales prescribed.
(3) Indigenous-governed or community-controlled services may opt in under culturally grounded agreements aligned with FPIC.

2-17 Data, Quality, and Dashboards

(1) Opt-in providers shall submit minimum datasets on access, activity, outcomes, safety, and equity metrics as prescribed.
(2) The Minister shall publish open dashboards by Health Area, with update cadence, suppression, and privacy safeguards prescribed.

2-18 Integrity, Audits, and Remedies

(1) The Agency may conduct audits, require records, and perform site inspections to verify eligibility, billing, quality, and safety.
(2) Where extra-billing, duplicate insurance, or misuse occurs, the Agency may order repayment, impose AMPs, suspend enrolment, or debar, subject to reconsideration and appeal as prescribed.
(3) Provider payment disputes and clinical-exception appeals shall be resolved within timelines prescribed, with written reasons.

2-19 Transition

(1) The Lieutenant Governor in Council may phase in Health Areas or cohorts by regulation to ensure continuity of care.
(2) Existing private plans may operate only to the extent they cover non-insured enhancements; transitional provisions, including premium-credit schedules under the Universal Health Levy, may be prescribed.
(3) The Agency shall implement provider onboarding and beneficiary education prior to each phase-in.

2-20 Coordination with Other Parts

(1) The Agency shall coordinate with:
(a) Saskatchewan Jobs (SaskJobs) for health-workforce placement and training vouchers;
(b) the Saskatchewan Century Corps (SCC) for care-sector trainees and reservists; and

(c) the Saskatchewan Manufacturing Corporation (SMC) and procurement entities for pooled purchasing and device standards, where appropriate.
(2) Arrangements must respect privacy and data-sharing safeguards.

2-21 Regulations (Part II)

The Lieutenant Governor in Council may make regulations for the purposes of this Part, including:
(a) prescribing detailed coverage, indications, exclusions, and phase-in schedules for each Health Area;
(b) establishing the composition, appointment, operations, and integrity policies of Benefit Councils and the Independent Clinical Review Panel;
(c) prescribing payment models, fee guides, service codes, and enrolment agreements;
(d) prescribing formulary rules, substitution policies, prior-authorization timelines, and dispensing/remuneration frameworks;
(e) prescribing access targets, equity measures, data standards, dashboard indicators, and publication cadences;
(f) prescribing integrity measures, audits, AMPs, repayment, suspension, debarment, and appeals; and
(g) any matter necessary to carry out this Part.

Part III - Service Delivery

3-1 Service Delivery System

(1) Insured services under the Plan shall be delivered through:
(a) public operators, including the Saskatchewan Health Authority or successor;
(b) Community Health Centres (CHCs) and Mobile CHCs established under this Part;
(c) opt-in providers and clinics contracted to the Plan; and
(d) Indigenous-governed and community-controlled services operating under agreements consistent with section 3-5.
(2) The Minister shall ensure reasonable geographic access to each Health Area prescribed in Part II.
(3) Delivery models and service maps may be phased by regulation.

3-2 Community Health Centres (CHCs)

(1) The Minister may establish CHCs as publicly operated or contracted, team-based primary and community care hubs providing, at minimum, primary care, mental health/addictions, preventive oral health, chronic disease management, and navigation.

(2) CHCs shall operate with salaried or sessional inter-professional teams (e.g., family physician/NP, nurse, mental health clinician, dental hygienist, dietitian, rehab as needed) and may integrate onsite pharmacy and diagnostics.
(3) CHCs shall offer evening and weekend hours and coordinate after-hours coverage.
(4) Mobile CHCs may be established to serve rural, northern, and remote communities; staffing stipends, travel/per diem, and safety standards shall be prescribed.
(5) Each CHC shall be assigned a catchment and may accept out-of-catchment patients where capacity allows.

3-3 Right to Attachment and Access Standards

(1) The Minister may, by regulation, set a right to attachment to a primary care home within a prescribed period and require CHCs and contracted primary care clinics to meet the standard.
(2) Access standards (e.g., same-day/next-day, urgent/episodic, chronic follow-up) shall be prescribed on Benefit Council advice.
(3) The Agency may direct temporary surge resources to sites falling below standards.

3-4 Opt-In Providers and Clinics (Enrolment & Contracts)

(1) A provider or clinic may deliver insured services by enrolling with the Agency and entering a service agreement that requires:
(a) direct billing, no extra-billing or balance-billing;
(b) compliance with payment models, fee guides, service codes, and audits;
(c) submission of minimum clinical and administrative datasets;
(d) adherence to access, equity, safety, and quality standards; and
(e) cooperation with navigation, referral, and continuity-of-care protocols.
(2) Agreements may specify salaried, capitation, sessional, bundled, fee-for-service, or hybrid remuneration, consistent with Part II.
(3) The Agency may suspend, vary, or terminate agreements for cause, subject to reconsideration and appeal as prescribed.

3-5 Indigenous-Governed and Community-Controlled Services

(1) Where services are delivered by Indigenous-governed or community-controlled entities, delivery shall occur under co-developed agreements that respect FPIC, uphold cultural safety, and align with Plan requirements adapted to community context.
(2) Reporting, funding, and accountability shall be co-designed and may differ from mainstream models where agreed.

3-6 Mental Health & Addictions Delivery

(1) The Minister shall ensure a stepped-care continuum including walk-in and scheduled counselling, intensive outpatient, crisis, OAT, and specialty services, with parity to physical health access standards.
(2) Evidence-based modalities (including TMS and prescribed treatment-resistant protocols) shall be provided through CHCs and contracted providers as scoped by Part II.
(3) Harm-reduction services may be publicly operated or contracted, with standards and clinical protocols prescribed.

3-7 Dental Delivery

(1) Dental clinics may enrol to provide insured services under the provincial dental fee guide with direct billing to the Plan.
(2) Public oral-health programs (preventive, school-based, LTC outreach) may be operated by CHCs or the public operator as prescribed.

3-8 Vision & Hearing Delivery

(1) Optometry/ophthalmology and audiology providers may enrol to deliver insured assessments, devices, and procedures per Part II.
(2) Device fitting, verification, replacement cycles, and pediatric/complex supports shall be delivered through enrolled clinics or CHCs as prescribed.

3-9 Home & Community Care, Paramedicine

(1) The public operator shall expand home nursing, rehab, personal support, respite, palliative, and paramedic treat-and-refer programs.
(2) Contracted agencies may deliver components under standardized contracts, training, and quality requirements.

3-10 Long-Term Care and Assisted Living

(1) The Minister may set minimum staffing ratios, skill mix, and clinical governance standards; inspection results shall be published as prescribed.
(2) Transition of facilities to public or not-for-profit operation may be implemented by regulation, with continuity-of-care protections.

3-11 Virtual Care and After-Hours

(1) Virtual care is a public option complementing in-person services; all enrolled primary-care clinics and CHCs shall offer virtual access within prescribed parameters.
(2) Virtual standards shall address licensure, identity verification, modality appropriateness, documentation, continuity, and data residency.
(3) The Minister shall ensure after-hours clinical coverage and advice lines, integrated with CHCs and urgent-care pathways.

3-12 Patient Navigation and Single Front Door

(1) The Agency shall operate a Single Front Door (phone, web, mobile) for eligibility, attachment requests, way-finding, and complaints.
(2) Navigation shall prioritize Tier groups prescribed in regulation (e.g., rural/northern, Indigenous, disability, newcomers) and coordinate travel supports under section 2-16.

3-13 Digital Health Infrastructure

(1) The Agency shall establish or designate a provincial digital health platform supporting: client registry, e-prescribing, claims, referrals, bookings, interoperable EMR/EHR, and dashboards.
(2) Interoperability and information-blocking rules shall be prescribed; vendors must meet open standards and performance SLAs.
(3) No automated tool shall be the sole basis of an adverse eligibility or coverage decision; residents are entitled to human review and explanation.
(4) Privacy, security, and data residency standards shall be prescribed; consent models shall respect Indigenous data sovereignty where applicable.

3-14 Quality, Safety, and Clinical Governance

(1) The Agency shall set quality and safety standards per Benefit Council advice and require participation in incident reporting, morbidity/mortality review, and continuous improvement.
(2) Professional licensing remains with statutory colleges; nothing in this Act authorizes licensure.
(3) The Agency may conduct quality audits, issue improvement directives, and link remuneration to quality indicators as prescribed.

3-15 Procurement and Supply

(1) The Minister may establish pooled procurement of drugs, devices, and clinical supplies; CHCs and enrolled providers shall use preferred products where clinically appropriate.
(2) Contracts shall include ethical sourcing and environmental criteria where feasible.

3-16 Workforce Integration

(1) The Agency shall coordinate with SaskJobs (Part IV) and the SCC (Part V) to recruit, train, place, and retain health workers, including clinical placements and return-of-service pathways.
(2) The Minister may, by regulation, recognize team-based scope-of-practice protocols and task-sharing consistent with college standards and patient safety.

3-17 Equity, Language, and Accessibility

(1) Delivery shall include interpretation, disability accommodations, and culturally safe care.
(2) Regulations may set accessibility standards for facilities, digital services, and communications.
(3) The Minister may prescribe language-access obligations and incentives for services provided in Indigenous languages and French.

3-18 Emergency and Surge Preparedness

(1) The public operator and CHCs shall maintain surge plans for outbreaks, wildfires, floods, heat events, and other emergencies.
(2) The Agency may activate SCC reservists and temporary funding to maintain access standards during declared events.

3-19 Transparency and Reporting

(1) Operators and enrolled providers shall supply data for public dashboards (access, wait times, outcomes, equity) with update cadence and suppression rules prescribed.
(2) The Agency shall publish service maps, CHC hours, and performance indicators.

3-20 Remedies, Audits, and AMPs

(1) The Agency may conduct compliance audits and site inspections.
(2) Where obligations are breached (e.g., extra-billing, data non-submission, safety deficiencies), the Agency may order repayment, impose AMPs, place providers on remedial action plans, or suspend/debar; reconsideration and appeal shall be prescribed.

(3) Nothing in this section limits actions by professional colleges or other authorities.

3-21 Transition

(1) The Lieutenant Governor in Council may designate pilot regions and staged roll-in of CHCs and delivery contracts.
(2) Existing public programs may continue until integrated; the Minister may issue transition directives to ensure continuity of care.
(3) Legacy private plan direct-pay arrangements for insured services shall sunset as prescribed in coordination with Part IV.

3-22 Regulations (Part III)

The Lieutenant Governor in Council may make regulations:
(a) establishing CHCs/Mobile CHCs, catchments, hours, and service bundles;
(b) prescribing enrolment terms, payment models, and contract forms for providers/clinics;
(c) setting access/attachment standards and surge rules;
(d) prescribing digital-health standards, interoperability, privacy/security, and algorithmic safeguards;
(e) prescribing quality/safety indicators, incident reporting, and improvement directives;
(f) prescribing procurement and preferred-product frameworks;
(g) prescribing Indigenous-governed service agreements and data sovereignty protocols;
(h) prescribing AMPs, audit powers, remedial actions, reconsideration, and appeals; and
(i) generally for carrying out the purposes of this Part.

Part IV - Single Pay and Universal Health Levy

4-1 Definitions (Part IV)

In this Part:
(a) “Agency” means the agency designated under Part I to administer the Plan;
(b) “employee” and “employer” have the meanings prescribed by regulation and include, for this Part, dependent contractors and any other prescribed work relationships;
(c) “remuneration” means employment income reported on T4/T4A (including taxable benefits) and any prescribed equivalents; it does not include dividends or capital gains unless prescribed for anti-avoidance;
(d) “self-employed person” means a person with net business income reported for provincial income-tax purposes;
(e) “Universal Health Levy” or “UHL” means the payroll levy established by this Part;

(f) “insured service” means a service, drug, device, supply, or benefit covered under Part II and regulations.

4-2 Single Payer; $0 Point of Care

(1) Insured services are delivered on a single-payer basis: residents present a valid health card and owe $0 at the point of care.
(2) Direct billing: Enrolled providers shall bill the Plan directly and shall not charge or accept any additional payment for insured services.
(3) Extra-billing & balance-billing prohibited. Any such charge is void and repayable to the resident.

4-3 Enforcement of Single Payer

(1) Where extra-billing or balance-billing occurs, the Agency may order:
(a) repayment to the resident;
(b) administrative monetary penalties (AMPs) prescribed by regulation;
(c) holdbacks, remedial action plans, suspension, or debarment from the Plan.
(2) Decisions are subject to reconsideration and appeal as prescribed.
(3) The Agency shall maintain a public non-compliance register.

4-4 Prohibition on Duplicative Private Insurance

(1) No contract of private insurance shall cover insured services under this Act, except for prescribed non-insured enhancements (e.g., cosmetic services, elective amenities).
(2) A contravening contract is unenforceable to that extent.
(3) Regulations may establish transition rules for existing contracts.

4-5 Enrolment, Claims & Payment Integrity

(1) Providers/clinics shall enrol with the Agency and agree to claims, data, audit, and quality requirements.
(2) The Agency shall publish payment timelines, clean-claim definitions, dispute pathways, and interest on late public payments.
(3) The Agency may conduct post-payment review, audits, and recover overpayments with interest; good-faith errors may be resolved via corrective education and repayment plans as prescribed.

4-6 Establishment of the Universal Health Levy (UHL)

(1) A Universal Health Levy is imposed to fund insured services.
(2) Components:
(a) an employer levy on remuneration paid by employers to employees;
(b) an employee levy on remuneration received by employees;
(c) a self-employed levy equivalent to the employee levy on net business income.
(3) The UHL is in addition to other taxes and contributions.
(4) The UHL shall be administered by the Minister of Finance or prescribed authority, in coordination with the Agency.

4-7 Base, Withholding & Remittance

(1) Employers shall withhold and remit the employee levy and remit the employer levy on the prescribed schedule.
(2) Self-employed persons shall make instalments and year-end reconciliation as prescribed.
(3) Multiple-employer and interprovincial employment rules, small-remitter rules, and seasonal rules shall be prescribed.
(4) Anti-avoidance: Where arrangements have the effect of avoiding the levy (including misclassification), the Minister may recharacterize remuneration and assess the levy, interest, and AMPs.

4-8 Initial Rate Architecture & Corridor

(1) Rate corridor: On Benefit Council and actuarial advice, regulations shall set and may adjust rates within an actuarial corridor of:
(a) employee levy 2.0%–3.5% of remuneration;
(b) employer levy 2.5%–5.5% of remuneration.
(2) Regulations shall prescribe progressive bands and thresholds, which may include:
(a) employee: an exclusion band on the first portion of annual remuneration; a higher marginal rate above a prescribed high-income threshold;
(b) employer: a small-payroll relief band; higher marginal rates above a prescribed large-payroll threshold.
(3) Self-employed contribute at the employee rate on net business income.
(4) Outside the corridor, Cabinet may adjust only on the basis of a published independent actuarial report tabled annually.

Note (policy intent, to guide regulation): The initial regulation is expected to reflect the schedule described in public materials (e.g., employee 2.5% after the first $25,000; 3.5% above $200,000; employer 2.5% after $200,000 payroll; 5% above $5,000,000), subject to Benefit Council and actuarial confirmation.

4-9 Two-Year Transition Credit for Existing Private Plans

(1) For 24 months after this Part comes into force, employers and employees may receive a credit against UHL liabilities equal to verified, pre-existing spending on private extended health/dental plans, up to regulatory caps.
(2) Credits apply only to policies in force on the prescribed cut-off date; renewals or expansions beyond baseline are ineligible unless prescribed.
(3) Credits may be claimed only upon submission of audited proof and are subject to clawback for misrepresentation.
(4) Credits sunset at the end of month 24.

4-10 Anti-Clawback & Wage Protection

(1) An employer shall not reduce wages or other compensation, or require employee payments, to offset the employer's UHL.
(2) Any such agreement is void; the Agency may order restitution and impose AMPs.
(3) Retaliation for asserting rights under this section is prohibited.

4-11 Collections, Interest, Penalties & Director Liability

(1) Late or under-remitted UHL is subject to interest and AMPs prescribed by regulation.
(2) Corporate directors may be jointly and severally liable for unremitted UHL in circumstances similar to payroll source-deduction regimes.
(3) The Minister may issue assessments, garnishments, liens, and set-off against provincial payments, as prescribed.

4-12 Universal Health Fund; Use of Proceeds

(1) A Universal Health Fund is established as a special purpose account into which all UHL receipts are deposited.
(2) Monies in the Fund may be used only for:
(a) payment for insured services;
(b) administration of the Plan and this Act;
(c) maintaining a stability reserve within an actuarially advised target range.
(3) Investment and reserve policies shall be approved on actuarial advice and published.

4-13 Forecasting, Transparency & Public Dashboards

(1) The Minister shall table an annual 10-year actuarial forecast of UHL revenues, expenditures by Health Area, and reserve status.

(2) The Agency shall publish monthly dashboards showing UHL revenue, payment outflows, and key access/outcome metrics, with privacy safeguards.

4-14 Interprovincial & Reciprocity Rules

(1) Regulations may provide for reciprocity and credits to avoid double-levying where employment or residence spans jurisdictions.
(2) The Minister may enter agreements with other governments to coordinate collection and coverage portability.

4-15 Small Employer Relief & Exemptions

(1) Regulations may establish relief bands for small payrolls, non-profits, or other prescribed classes, provided Plan sustainability is maintained.
(2) Any class exemption or relief shall be transparent, time-limited or reviewable, and included in annual actuarial reporting.

4-16 Appeals (Levy)

(1) Employers, employees, or self-employed persons may appeal assessments, penalties, or denial of credits within prescribed timelines to the designated appeals body.
(2) Payment pending appeal shall follow rules prescribed by regulation.

4-17 Transition; Alignment with Coverage Roll-In

(1) The Lieutenant Governor in Council may stage the effective date of the UHL to align with phased roll-in of insured services under Part II and delivery capacity under Part III.
(2) The ban on duplicative private insurance for a given Health Area shall take effect when that Health Area is designated as insured under Part II and corresponding delivery arrangements are in place.
(3) The Agency shall publish a transition schedule no less than 90 days before each phase.

4-18 Regulations (Part IV)

The Lieutenant Governor in Council may make regulations:
(a) prescribing levy rates, bands, thresholds, reliefs, and phase-in schedules within the corridor;
(b) defining remuneration, employee/employer/self-employed status, attribution and anti-avoidance rules;
(c) governing withholding, remittance, instalments, reconciliation, interest and AMPs;

(d) establishing the two-year transition credit eligibility, verification, caps, and clawbacks;
(e) prescribing the form/content of provider enrolment, claims, audits, integrity rules, repayment and AMPs;
(f) prescribing enforcement tools, director liability conditions, and appeals;
(g) establishing and governing the Universal Health Fund, reserve policy, and reporting;
(h) providing reciprocity and inter-jurisdictional credits; and
(i) generally, for carrying out the purposes of this Part.

Part V - Recruitment

5-1 Definitions (Part V)

In this Part:
(a) “Agency” means the agency designated under Part I to administer the Plan;
(b) “Authority” means the provincial health authority or successor body responsible for service delivery;
(c) “Priority occupation” means a regulated or unregulated health role designated by regulation;
(d) “Priority region” means a rural, northern, remote, or otherwise designated region under regulation;
(e) “Return-of-Service Scholarship (ROS)” means a scholarship or bursary granted under this Part in exchange for a service commitment in Saskatchewan;
(f) “Practice-Ready Assessment (PRA)” means an assessment and supervised practice pathway for internationally educated/experienced professionals prescribed by regulation;
(g) “Team-based practice (TBP)” means an interdisciplinary, salaried or alternative payment team model (including CHCs under Part III) recognized by the Minister;
(h) “Training seat” includes funded positions in degree, diploma, certificate, residency, internship, and clinical placement programs.

5-2 Purpose

The purpose of this Part is to ensure Saskatchewan has a sufficient, well-distributed, and culturally safe health workforce by:
(a) expanding education and clinical training capacity;
(b) recruiting domestically and internationally in accordance with ethical recruitment standards;
(c) accelerating recognition of credentials and supervised practice pathways;
(d) supporting retention through incentives, housing/childcare supports, and healthy work design; and
(e) prioritizing rural/northern, Indigenous, and high-need communities.

5-3 Provincial Health Workforce Strategy

(1) The Minister shall publish, at least annually, a Provincial Health Workforce Strategy that sets:
(a) target numbers by priority occupation and region;
(b) seat expansion, clinical placement, and preceptor targets;
(c) recruitment, PRA cohort sizes, and timelines;
(d) retention and wellness actions; and
(e) equity targets, including Indigenous workforce participation.
(2) The Strategy shall be developed with the Authority, educational institutions, regulatory colleges, unions, Indigenous governing bodies, and patient representatives.

5-4 Seat Expansion & Clinical Training Capacity

(1) The Minister may fund training seat expansions in Saskatchewan universities, colleges, and approved providers for priority occupations.
(2) The Minister may fund clinical placements and preceptor stipends, simulation labs, and rural training hubs.
(3) Institutions receiving funds shall meet placement, geography, and equity distribution requirements as prescribed.

5-5 Return-of-Service Scholarships & Bursaries

(1) The Minister may grant ROS scholarships/bursaries covering tuition, fees, and prescribed expenses for learners in priority occupations.
(2) Service terms, designated worksites/regions, bonus incentives for extended service, hardship waivers, and liquidated damages for default shall be set by regulation.
(3) ROS appointees are eligible for relocation, onboarding, and housing/childcare supports under 5-10.

5-6 Practice-Ready Assessment & Supervised Practice

(1) The Minister shall establish PRA pathways for internationally educated or out-of-province professionals in priority occupations, with cohorts and timelines prescribed.
(2) PRA shall include credential verification, language/competency assessment, paid supervised practice, and accelerated transition to full licensure where standards are met.
(3) The Minister may fund assessors, preceptors, bridging coursework, and exam fees; participants shall receive stipends as prescribed.

(4) PRA shall comply with the WHO Global Code of Practice on the International Recruitment of Health Personnel.

5-7 Licensing Acceleration & Scope-of-Practice Alignment

(1) The Minister may enter agreements with regulatory colleges to:
(a) set service standards for application processing and recognition of substantially equivalent credentials;
(b) enable provisional or supervised licenses during PRA; and
(c) recognize out-of-province credentials via mobility agreements.
(2) The Minister may convene a Scopes-of-Practice Modernization Table (with colleges, unions, educators, the Authority, and Indigenous partners) to recommend regulatory changes under Part III enabling:
(a) NP-led primary care; pharmacist prescribing within protocols; paramedic treat-and-refer; expanded dental hygiene in CHCs; and other TBP enablers.
(3) Colleges receiving funds under this Part shall publish processing times and outcomes.

5-8 Recruitment Programs & Centralized Supports

(1) The Minister shall establish a Central Recruitment Service to coordinate domestic and international campaigns, candidate concierge services, licensing navigation, and placement to TBP/CHCs.
(2) The Service shall maintain a locum/relief pool to support rural/northern sites, maternity/parental leaves, and burnout prevention.

5-9 Retention, Wellness & Practice Design

(1) The Minister may fund retention packages for priority occupations and regions, including: CPD allowances, mentorship, sabbaticals, and TBP transition supports.
(2) The Authority and funded clinics shall implement safe scheduling, relief coverage, and right-to-disconnect policies consistent with Part II.
(3) The Minister may fund workforce housing, childcare stipends, and spousal employment supports in priority regions as prescribed.

5-10 Incentives: Signing, Relocation, Rural/Northern

(1) The Minister may provide signing bonuses, relocation grants, rural/northern stipends, and housing/childcare supports to recruits in priority occupations/regions, with amounts, duration, stacking rules, and clawbacks prescribed.
(2) Incentives may be front-loaded with retention tranches (e.g., 6/12/24 months).

(3) Incentives are recoverable where service terms are not fulfilled, subject to prescribed hardship waivers.

5-11 Integration with CHCs and Team-Based Practice

(1) The Authority shall prioritize staffing of Community Health Centres (CHCs) and other TBP models under Part III using recruits and PRA graduates.
(2) Funded teams shall meet evening/weekend access standards and interdisciplinary composition targets as prescribed.

5-12 SCC Integration (Care & Community Corps)

(1) The Agency and Authority shall coordinate with the Saskatchewan Century Corps (SCC) for pipeline roles (e.g., CCAs, ECEs, community health workers), clinical placements, and educator/preceptor payments.
(2) Hours completed in SCC pipelines may count toward relevant credentials/registrations where recognized by regulators.

5-13 Indigenous Workforce & Northern Pathways

(1) The Minister shall maintain an Indigenous Health Workforce Pathways program, co-designed with Indigenous governing bodies, to support entry, bridging, scholarships, Elders-in-residence, and culturally grounded supervision.
(2) The Authority shall prioritize train-in-place models in northern and remote communities and provide Indigenous language differentials where prescribed.

5-14 Data, Dashboards & Workforce Registry

(1) The Minister shall establish a Workforce Registry (with privacy safeguards) to track vacancies, time-to-fill, PRA throughput, retention, burnout indicators, and distribution by region/discipline.
(2) Quarterly public dashboards shall report progress against the Workforce Strategy.

5-15 Funding & Agreements

(1) Money required for this Part shall be paid out of monies appropriated by the Legislature; the Minister may establish special-purpose accounts for scholarships and PRA.
(2) The Minister may enter agreements with educational institutions, regulatory colleges, the Authority, Indigenous governing bodies, unions, and employers to implement this Part.
(3) Federal and interprovincial cost-sharing may be pursued.

5-16 Regulations (Part V)

The Lieutenant Governor in Council may make regulations:
(a) designating priority occupations and priority regions;
(b) setting targets, seat expansions, preceptor stipends, and training-hub standards;
(c) governing ROS eligibility, amounts, service terms, bonuses, defaults, and waivers;
(d) establishing PRA eligibility, assessment components, supervised practice terms, stipends, and cohort sizes;
(e) prescribing incentive types, amounts, stacking/clawback rules, and hardship exemptions;
(f) defining reporting requirements for colleges and funded entities;
(g) prescribing data, privacy, and registry parameters; and
(h) generally, for carrying out the purposes and provisions of this Part.

5-17 Transition & Commencement

(1) Within 120 days of this Part coming into force, the Minister shall publish the first Provincial Health Workforce Strategy and open applications for the initial ROS round and PRA cohorts.
(2) Within 180 days, the Minister shall finalize agreements for seat expansion and clinical placements.
(3) This Part comes into force on proclamation.