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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1033 Session of 1975

INTRODUCED BY WOOD, FRAME, EWING, HOWARD AND MURRAY, SEPTEMBER 24, 1975

REFERRED TO INSURANCE, SEPTEMBER 24, 1975

AN ACT

Establishing a State catastrophic health insurance plan, providing for the certification of health benefits plans as qualified and the regulation of insurers and providers of health care services thereunder, and establishing a health resource development fund.

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

Section 1. Short Title.--This act shall be known and may be cited as the "Catastrophic Health Insurance Plan Act."

Section 2. Legislative Findings.--While the quality of health care in this Nation is currently among the highest in the world, comprehensive health care services are still not available to every citizen of this Commonwealth at reasonable cost. It is a public policy goal of this Commonwealth that each citizen of this Commonwealth should have access to quality health care at reasonable cost and available to him protection against the extraordinarily high costs of health care services which are determined to be catastrophic.

Promotion of the aforementioned goal requires that employers

should be encouraged to provide comprehensive health care coverage of the highest quality to their employees and their dependents and that all other persons be encouraged to obtain comprehensive health care coverage of the highest quality for themselves and their dependents.

Providers of health care services should be encouraged to make health care services of the highest quality readily available to every citizen of this Commonwealth at the most reasonable cost.

Individuals or other entities which provide for the prepayment and insurance of health care services should be encouraged to provide the most comprehensive health benefits plans possible to eligible persons at all income levels.

In order to achieve the aforementioned public policy goal, it is necessary for the Commonwealth to provide inducements for employers and other persons to obtain comprehensive health benefits plans, to provide financial protection for the extraordinary costs of health care services which are determined to be catastrophic, and to prescribe certain duties and responsibilities for insurers and providers of health care services with regard to forms, rates, premiums and reimbursement procedures; and that the purpose of this legislation is to provide a plan to achieve these ends.

Section 3. Definitions.--For the purposes of this act:

"Allowable income" means gross income, which a person shall compute by totaling his gains, losses, profits and income derived from salaries, wages or compensation for personal services, of whatever kind and in whatever form paid, or from professions, vocations, trades, businesses, commerce, sales or dealings in property of whatever nature, growing out of the

ownership or use of or interest in such property; also from interest, rent, royalties, dividends, securities, or the transactions of any business carried on for gain, or profits and income derived from any source whatsoever, including prizes and awards, other than those primarily in recognition of some achievement in the arts, sciences or public interest without active entry by the recipient and without the requirement that he render substantial future services as a condition, or gains or profits or income derived through estates or trusts by the beneficiaries thereof.

"Benefit" or "health benefit" means a health care service financed for a person by a third party such as an insurer or the Commonwealth.

"Commonwealth" means the Commonwealth of Pennsylvania.

"Cost of eligible health care services" means those costs, charges or rates of providers at levels which have been approved in a qualified program by the Secretary of Health, and which shall serve as the basis for the costs, rates, or charges for which the Commonwealth would be liable to pay pursuant to the provisions of this act.

"Eligible health care service" means a health care service which would be covered within the type of qualified program an eligible person would be expected to have by the Secretary of Health in order to incur the smallest personal resource payment applicable under this act, without regard to any limitations with respect to the number of days or time such service is provided, or the cost of such service.

"Eligible person" means a person who has established permanent residency in the Commonwealth for three months and who has legal responsibility for the payment of eligible health

costs incurred on his behalf or the behalf of persons for whom he is legally responsible. A person who has moved to the Commonwealth for the primary purpose of receiving benefits provided pursuant to this act shall not be considered to be a permanent resident unless such residency has been determined pursuant to a judicial order to be a permanent residency.

"Employee" means any person who has entered into the employment of, or works under contract of service or apprenticeship with, any employer. It shall not include a person who has been employed for less than 30 days by his employer, nor shall it include a person who works less than an average of 24 hours per week.

"Employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver or trustee thereof, or the legal representative of a deceased person, including the Commonwealth or any subdivision thereof, which has in its employ one or more individuals during any calendar year. The term "employer" shall refer only to an employer of persons employed within the Commonwealth.

"Health benefits plan" means any plan which provides health benefits for any eligible person.

"Health care services" means those medical, professional, and paraprofessional services provided to a person to prevent disease, to maintain health, to detect disease and disability in early stages, to diagnose and treat illness, and to rehabilitate a person to his fullest capacities.

"Health maintenance organization" means an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of an agreed upon set of

comprehensive health care services for a voluntarily enrolled group of persons in a geographic area and is reimbursed through a prenegotiated and fixed periodic payment made by or on behalf of each person or family enrolled in the plan.

"Insurer" means all persons offering or insuring health care services on a prepaid basis including, but not limited to, persons authorized to transact health insurance in this Commonwealth, hospital service corporations, medical service corporations or any other person whose primary function is to provide diagnostic, therapeutic or preventive health care services to a defined population on the basis of a periodic premium. It shall include all persons providing health benefits coverage for employees on a self-insurance basis.

"Maternity benefits" means those benefits rendered for normal obstetrical care, regardless of the marital status of the woman. It shall include benefits for the completion of obstetrics, prenatal care, care of the newborn infant, labor, delivery and puerperal care. The term shall include benefits for normal deliveries or for any complications of pregnancy which do not result in the delivery of a viable fetus.

"Medicare" means Part A. and Part B. of the United States Social Security Act, Title XVIII, as amended (42 U.S.C. sections 1394, et seq.).

"Personal resource payment" means the amount an eligible person is obligated to pay from his allowable income for eligible health care services which are not otherwise reimbursable under a health benefits plan unless such person is covered under the provisions of section 8.

"Physician" means any person duly licensed to practice medicine and surgery pursuant to the provisions of the act of

July 20, 1974 (P.L.551, No.190), known as the "Medical Practice Act of 1974."

"Provider" means any physician, hospital, or other person which is licensed or otherwise authorized in this Commonwealth to furnish health care services.

"Qualified program" means any health benefit plan which has been certified as qualified by the Secretary of Health pursuant to this act.

"United States" means the Government of the United States of America or any of its instrumentalities.

Section 4. Eligibility.--Each eligible person shall be entitled to reimbursement from the Commonwealth for the costs of eligible health care services which are determined to be catastrophic under the conditions and limitations established by and in accordance with this act and rules and regulations promulgated pursuant thereto. The Secretary of Health shall prescribe by regulation the form and manner for application for such reimbursement.

Section 5. Costs.--(a) The Commonwealth shall pay for the costs of eligible health care services of an eligible person when such costs are determined to be catastrophic. The costs of eligible health care services shall be determined to be catastrophic when such costs incurred by an eligible person exceed the amount of his applicable personal resource payment as determined pursuant to section 6.

(b) Any person who becomes eligible for payment for the costs of eligible health care services determined to be catastrophic shall remain eligible for such coverage during the calendar year in which he becomes so entitled and during the following calendar year if such person incurs an obligation

during such following calendar year for the payment of costs of eligible health care services which are at least equal to 25% of the amount of such person's personal resource payment during the preceding year of catastrophic coverage. Said amount shall then be an eligible cost for catastrophic coverage during such following calendar year.

(c) Costs of eligible health care services incurred on and after October 1 of any calendar year shall be construed as costs incurred in the following year.

Section 6. Personal Resource Payment Computation.--(a) To be eligible for payment by the Commonwealth of the costs of eligible health care services of a catastrophic nature, an eligible person must have incurred an obligation to make the applicable personal resource payment computed pursuant to this section. Such payment shall not be a cost payable by the Commonwealth pursuant to section 5.

(b) The applicable personal resource payment shall be determined on a calendar year basis and shall not include the payments made to meet the deductible of a major medical plan or the premium costs of a health benefits plan. It shall include the coinsurance payments made under a major medical plan.

(c) The applicable personal resource payment applies to the obligation for payment of the costs for eligible health care services that are not covered under any health benefit plan, except for health maintenance organization plans.

(d) The applicable personal resource payments shall be determined in relation to the extent of coverage for health benefits, if any, to which an eligible person is otherwise entitled.

(e) The applicable personal resource payment of an eligible

person:

(1) Who has a qualified program shall be an amount equal to $500 or to 10% of his allowable income, whichever amount is greater.

(2) Who has a program that would have otherwise been qualified, except for a qualified major medical health benefits plan, shall be an amount equal to $1,250 or to 25% of his allowable income, whichever amount is greater.

(3) Who has a plan or plan of health benefits which is not a qualified program shall be an amount equal to the difference between costs covered by his plan or plans of coverage and costs covered by a qualified program, or an amount which does not exceed $5,000 or 50% of his allocable income, whichever is greater.

(4) Who has medicare coverage and a qualified supplemental program shall be an amount equal to $500.

(5) Who has medicare coverage and does not have a qualified supplemental program shall be an amount equal to $1,000.

(6) Who is not otherwise entitled to coverage under any other health benefits plan shall be an amount equal to either $5,000 or to 50% of his allowable income, whichever amount is greater.

Section 7. Exclusions from Income Computation.--All services and charges therefor within any of the following classifications are excluded from the financial protection provided pursuant to section 5 and shall not be included as applicable personal resource payments pursuant to section 6:

(1) Benefits provided pursuant to the laws of the United States including, but not limited to military service-connected disabilities, health care services provided for employees of the

Armed Forces of the United States, health care services financed for the benefit of persons over 65 years of age and for persons with insufficient income and assets to purchase benefits pursuant to the laws of the United States, and health care services which may be financed in the future on behalf of all citizens by the United States.

(2) Care which is primarily for custodial or domiciliary purposes.

(3) Cosmetic surgery, dentistry, optometry, and chiropractic unless prescribed by a physician as medically necessary for treatment of a condition resulting from an injury, illness or disability.

(4) Corrective appliances and artificial aids including, but not limited to, hearing aids, dental appliances and dentures, and corrective lenses and eyeglasses, unless such appliances and aids are prescribed by a physician as medically necessary for the purpose of rehabilitation.

(5) Drugs and medication not requiring prescriptions.

(6) Outpatient psychiatric care in excess of 50% of the cost incurred for such eligible health care services as may be incurred in a calendar year.

(7) Services delivered in facilities which have not been certified by the Secretary of Health as qualified to provide such services.

(8) Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any workmen's compensation law, temporary disability benefits law, occupational disease law or similar legislation, whether or not the covered person claims or

receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages.

(9) Any benefits which are covered or payable under any health, accident or other insurance policy including any benefits payable under the act of July 19, 1974 (P.L.489, No.176), known as the "Pennsylvania No-fault Motor Vehicle Insurance Act," any other private or governmental health benefit system, or through any similar third party liability.

Section 8. Employer Responsibility.--(a) Each employer shall, in accordance with regulations promulgated by the Commissioner of Insurance in consultation with the Secretary of Health, offer the opportunity for his employees to enroll in any available qualified health maintenance organization on the same absolute dollar cost-sharing terms which may be provided for other health benefits plans made available for employee enrollment.

(b) The fair value of services rendered by a health maintenance organization to a subscriber after such subscriber has exhausted the services provided by the health maintenance organization's qualified program shall be recognized as costs for eligible health care services which may be included by the subscriber in computing his applicable personal resource payment pursuant to section 6.

Section 9. Qualification of Plans, Notice; Certification.--(a) Upon application by an insurer for certification of a health benefits plan or plans as a qualified program for the purposes of this act, the Secretary of Health, after consultation with the Commissioner of Insurance, shall make a determination within 90 days as to whether the applicant's plan or plans are qualified, and shall publish in the Pennsylvania Bulletin and

the major newspapers of the Commonwealth on a semiannual basis thereafter a notice that such plan or plans are qualified.

(b) A program may be certified for a period of two years, if, at least:

(1) It meets the minimum standards of this act.

(2) Its insurer meets the duties established by this act and the laws of the Commonwealth.

(3) It provides benefits which are approximately equal in scope and in actuarial value to the benefits described in section 10.

Section 10. Qualification of Certain Plans Presumed.--Any plan or combination of plans which provides the following benefits or their actuarial equivalent may be deemed to be a qualified program for the purposes of this act:

(1) Hospital services:

(i) One hundred twenty days of inpatient care in short-term general hospitals, or 45 days in a specialized hospital, including the full cost of a semi-private room accommodation; all meals and dietary services, including such special meals which an attending physician may prescribe; general nursing care, and intensive care; services by voluntary or paid hospital employees, interns, other physicians in training, or by a contractor with the hospital for rendering hospital services; use of operating, cystoscopic, delivery, recovery, emergency and treatment rooms, including their respective facilities and equipment; all drugs, medicine and medications used in and supplied by the hospital, including those which, at the time prescribed, are in commercial production and are commercially available to the hospital; all medical and surgical supplies including, but not limited to, therapeutic solutions,

anesthetics, oxygen, serums, vaccines, intravenous preparations, visualizing dyes, dressings, bandages and casts, whether of plaster or other material composition; diagnostic surgical procedures and diagnostic tests including, but not limited to, angiocardiography, aortography, arthrogram, basal metabolism, bronchoscopy, cardiac catheterization, cerebral arteriography, electrocardiograms, electroencephalograms, esophagoscopy, gastroscopy, pneumoencephalography, pulmonary function, thorascopy, ventriculography and insulin and shock therapy; diagnostic and therapeutic X-ray, radium, radon and radioactive isotope therapy and chemotherapy; renal and hemodialysis; blood derivatives and substitutes, plasma, and charges for administration, typing and cross-matching, but not charges for whole blood, and including the use of blood transfusion equipment and facilities; cardiac pacemakers, including batteries, electrodes and replacements, and inhalation and oxygen therapy, speech and hearing therapy, occupational therapy, and physical therapy including, but not limited to, physiotherapy, electrotherapy, and hydrotherapy.

(ii) Coverage of all costs and charges for treatments, use of equipment, and administration of such treatments and equipment by hospital personnel for the performance of all such hospital services as defined in paragraph (1)(i).

(iii) Coverage of all necessary services as defined in paragraph (1)(i) and (ii) for the inpatient maternity care, including pregnancy, childbirth, care related to pregnancy or childbirth and any disease, injury or condition in connection therewith or incident thereto, except that an insured or subscriber may be liable for the first $100 of cost of such services, after which the qualified plan shall pay the balance.

(iv) The full cost of outpatient care from a hospital, if it is for: an accidental injury occurring not more than 72 hours after a poisoning or traumatic accident; a cardiac pacemaker followup examination; the removal of implanted orthopedic hardware; the application of casts, whether of plaster or other material; any of the diagnostic surgical procedures and diagnostic tests set forth in paragraph (1)(i); renal and hemodialysis; services rendered in connection with blood transfusions or paracenteses or both; and the use of an operating room for an operation involving a cutting procedure, use of general anesthesia, or reduction of a fracture or dislocation.

(v) The full cost of outpatient radiological services including, but not limited to, diagnostic X-ray, radiotherapy and diagnostic and therapeutic radioisotopic services.

(vi) The full cost of all hospital services, both inpatient and outpatient, for those services as defined in paragraph (1)(i) and (ii) if such services are made necessary by accidental injuries, or if the patient is admitted for the extraction of one or more bony impacted teeth, treatment of malignancy of the mouth, or oral surgery.

(2) Physician's charges for the following services:

(i) surgical services, consisting of cutting, cauterizing or other operative procedures requiring the use of surgical instruments or the reduction of fractures and dislocations, including routine pre and postoperative care, provided in a hospital, hospital outpatient department, physician's office, or the patient's home;

(ii) services of an assisting physician in connection with such an operative procedure when the nature of such procedure is

such that an assisting physician is medically necessary;

(iii) services of a physician-anesthetist if anesthesia is administered by a physician other than the surgeon or assisting surgeon;

(iv) diagnostic services as listed below, whether performed in a physician's office, approved and licensed medical laboratory or in a hospital, when required for the diagnosis of any condition due to illness or injury:

(A) diagnostic X-ray, radium, radon and radioisotopic examination;

(B) electroencephalograms, basal metabolism tests and electrocardiograms;

(C) such diagnostic surgical procedures and diagnostic tests as set forth in paragraph (1)(i);

(D) laboratory tests, including pathological examinations; and

(E) radiation treatments by X-ray, radium, external radiation or radioactive isotopes;

(v) physicians' visits to care for a bed patient in a short-term general hospital up to 120 days per period of illness, or for 45 days per period of illness in specialized hospitals, except for routine preoperative and postoperative physical examinations;

(vi) consultation services, where medically necessary in the opinion of the attending physician, at the rate of one consultation per specialty per period of illness;

(vii) obstetrical delivery services, consisting of services rendered incident to pregnancy or childbirth, or for any diseases or injuries or conditions in connection therewith or incident thereto, including, but not limited to, pre- and

postnatal care;

(viii) newborn baby care, when the examination and care is provided by a physician other than the physician making the delivery or administering anesthesia related to the delivery;

(ix) emergency accident services performed by a physician within 72 hours of a traumatic or poisoning accident; and

(x) dental surgical services, if such services are made necessary by an accidental injury and are rendered during the hospitalization immediately following such an injury, or if for the extraction of one or more bony impacted teeth or for treatment of malignancy of the mouth.

(3) To supplement the protection provided by paragraph (1)(i) and (ii), the following additional major medical coverages shall be required as a condition for a program being certified as qualified:

(i) Up to $100,000 in coverage for an eligible person and $100,000 in coverage for each covered dependent for the payment of eligible health care services, and such coverage may include a limit on such coverage during any one calendar year of $25,000.

(ii) The restoration of any amount charged against the maximum coverage limit of an eligible person at the annual rate of $4,000 or the amount necessary to restore such coverage to its maximum limit, whichever is less.

(iii) Coverage for at least 80% of the first $2,000, and for 100% above $2,000, of the costs of eligible health care services after the insured or subscriber has paid an annual deductible of $100 or two $100 deductibles per family for covered services.

(iv) Coverage for the following services:

(A) health care services described in paragraph

(1)(i) and (ii) to the extent such services are not covered by any other part of a qualified program or any other health benefits plan;

(B) physicians' services, including home and office visits;

(C) professional ambulance services locally to or from a hospital for inpatients, or to a hospital accident room following an accident;

(D) drugs and medications which require a written prescription;

(E) rental or purchase, whichever costs less, of wheelchairs and other durable equipment used for medical treatment exclusively;

(F) out-of-hospital speech therapy and physical therapy;

(G) multiphasic screening examinations;

(H) orthopedic braces, prosthetic appliances including, but not limited to, artificial limbs and eyes, including replacement, repair or adjustment;

(I) full-time or visiting nurse services by a registered nurse or licensed practical nurse when ordered by an attending physician, who deems such nurse services medically necessary, up to maximum charges of $750 per year; and

(J) Services for diagnosis and treatment of mental and nervous disorders provided, however, that an insured shall be required to make a 50% copayment, and that the payment of the insurer shall in no event exceed $1,000 in a case involving outpatient psychiatric treatment.

(4) Any plan or combination of plans which provides benefits

to persons over the age of 65 years may be deemed to be a qualified supplemental program for the purposes of this act if such plan or combination of plans is designed to supplement medicare and provide the following coverages:

(i) the full cost of the hospital deductible and copayment of Part A of medicare;

(ii) the full costs of the physicians' deductible and copayment amounts of Part B of medicare;

(iii) payments of amounts equivalent to Parts A and B of medicare for services rendered outside the United States;

(iv) hospital outpatient treatment for accidents and medical emergencies; and

(v) X-ray and other diagnostic tests conducted in the hospital's outpatient department or in the doctor's office.

(5) Disapproval of any health benefits plan for certification as a qualified program shall be subject to review and a hearing in accordance with the procedure for contested cases prescribed in the act of April 9, 1929 (P.L.177, No.175), known as "The Administrative Code of 1929."

Section 11. Duties of Health Care Providers.--(a) It shall be the duty of providers of health care services:

(1) to provide health care services to any person in need of such services without regard to the person's race, sex, religion, age, medical condition, occupational status or marital status; and

(2) to provide health care services to insurers and other persons at costs, charges or rates which are reasonable, equitable and nondiscriminatory.

(b) On the basis of the duties required by this act and on the basis of other existing legal requirements with respect to

providers of health care services, the Secretary of Health shall provide by regulation for the certification of providers as eligible for reimbursements under qualified programs and under this act. Any providers not meeting the duties prescribed by subsection (a) or violating any regulations promulgated pursuant to this section may, after a hearing upon ten days' notice, be denied such certification or have such certification revoked by the Secretary of Health for a period not to exceed one year. No provider lacking such certification shall be entitled to reimbursements under qualified programs or from the Commonwealth pursuant to this act.

Section 12. Prior Approval by Insurance Commissioner.--(a) No health benefits plan shall be certified as a qualified program by the Secretary of Health until the contracts, agreements, policies, certificates, endorsements, riders or other documents, hereinafter referred to as "forms," for use with such plan, and the rates and premiums to be charged therefor have been filed with and approved by the Commissioner of Insurance. Such approval shall be based upon compliance with minimum standards for form and premiums for health benefits plans established by regulations promulgated by the Commissioner of Insurance.

(b) Such minimum standards shall be designed to carry out the following purposes:

(1) the provision of health benefits at rates and premiums which are reasonable and nondiscriminatory to insureds and subscribers, and adequate for the safety and soundness of insurers;

(2) the reasonable standardization and simplification of coverages to facilitate consumer understanding and comparisons;

(3) the elimination of provisions which may be misleading or unreasonably confusing in connection with the purchase of such coverages or with the settlement of claims;

(4) the elimination of deceptive practices in connection with the sale of such coverages;

(5) the elimination of provisions which may be contrary to the health needs of the public;

(6) the availability of qualified plans to persons residing in the Commonwealth who apply therefor regardless of age, sex, race, religion, occupational status, marital status, or medical condition;

(7) the promotion of efficient management of health care services within the Commonwealth;

(8) the elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof; and

(9) the addition of coverages, the sale of which is required by the public interest to protect the health of persons residing in the Commonwealth.

(c) Disapproval of any form or rate or premium by the Commissioner of Insurance shall be subject to review and a hearing in accordance with the procedure for contested cases prescribed in the act of April 9, 1929 (P.L.177, No.175), known as "The Administrative Code of 1929."

Section 13. Insurance and Reinsurance Agreements.--(a) To facilitate the offering of health benefits plans which meet the requirements for certification as qualified programs, insurers may enter into agreements to form reinsurance facilities to share the profits and losses resulting from such plans. No such agreement shall be effective unless it complies with the

regulations promulgated by the Commissioner of Insurance for the establishment and operation of such reinsurance facilities and has been approved by the commissioner.

(b) If the commissioner finds that the number of health benefits plans certified as qualified programs are insufficient to adequately serve the health care needs of the public, he may require all insurers authorized to write health insurance in this Commonwealth, as a condition of their authority to continue to transact such insurance, to be members of a reinsurance facility in accordance with the regulations promulgated by the commissioner for such facilities.

Section 14. Suspension or Revocation of Certified Plans.--(a) The Secretary of Health may suspend or revoke the certification of a health benefits plan as a qualified program if:

(1) Its insurer violates any provision of this act or any rule or regulation promulgated pursuant thereto.

(2) The plan is modified in any respect without the approval of the commissioner.

(3) Any form or rate or premium is modified without the approval of the Commissioner of Insurance.

(4) Reimbursement is made to any provider not certified as eligible for such reimbursement.

(5) The plan is implemented in any way which is contrary to or not consistent with its provisions as certified.

(b) Prior to any such suspension or revocation the insurer of the plan or any other interested party shall be entitled to a review of the matter and a hearing in accordance with the procedure for contested cases prescribed in the act of April 9, 1929 (P.L.177, No.175), known as "The Administrative Code of

1929."

Section 15. Health Resources Development Fund.--(a) There is hereby established in the Department of Health the health resources development fund to be administered by the Secretary of Health in accordance with the provisions and for the purposes hereinafter prescribed. Such fund shall consist of moneys as may be appropriated by the Legislature or received from insurers or other persons and may be expended by the commissioner as hereinafter provided.

(b) Moneys in such fund may be expended by contract, loan or grant, to maintain, expand, and improve health facilities, health care services, and health education in this Commonwealth. Such purposes shall include the following: construction or modernization of health facilities, the education or training of persons who would be qualified to provide professional health care services, the meeting of start-up costs of new forms of health delivery systems, such as health maintenance organizations, the provision of benefits for persons lacking adequate insured coverage, and the development and implementation of experiments in lower costs or to improve the quality, availability, and accessibility of health services.

(c) Moneys provided by loan shall be disbursed for periods not exceeding 25 years and at an annual rate of interest not exceeding 5%.

(d) Moneys may be made available for scholarships for education in any health care profession or occupation on the condition that for each year of educational cost provided by the fund the recipient is required to serve in any public service employment related to health care services which is deemed acceptable by the commissioner.

(e) Moneys disbursed from the fund shall be for purposes in conformance with Commonwealth plans for comprehensive health, health services, manpower and land use, as approved by the Governor.

(f) The Secretary of Health shall establish criteria for eligible capital projects and eligible education and training projects which are consistent with the comprehensive health, manpower and land use plans approved by the Governor.

Section 16. Allocation of Funds to Health Resources Development.--(a) Notwithstanding any provision of its articles of incorporation, bylaws, or other enabling documents or laws to the contrary, an insurer is hereby authorized to allocate sums of money, derived from the collections of premiums, to the health resources development fund.

(b) Notwithstanding any provision of its articles of incorporation, bylaws, or other enabling documents or law to the contrary, an insurer is further authorized to expend on an annual basis a sum of moneys equal to not more than 5% of its previous year's premium income for a project approved by the Secretary of Health. The secretary is authorized to approve projects which are in conformance with purposes of section 15 and with the criteria established pursuant thereto.

Section 17. Additional Power and Duties for the Secretary of Health and Insurance Commission.--(a) In order to carry out his functions, powers and duties and the duty of the Commonwealth to pay for the costs of eligible health care services of eligible persons which are determined to be catastrophic under this act, the Secretary of Health is authorized:

(1) to enter into contracts with insurers to underwrite on an insurance basis such Commonwealth duty, or to act as a fiscal

agent for the Commonwealth to carry out such duty, or for any other purpose reasonably related to such duty;

(2) to establish procedures for payment of benefits to eligible persons, which shall include provisions for time limits for filing claims, review of claims and the approval or disapproval thereof, hearings for appeal of disapproval of claims, and any other procedural matters as may be necessary to provide for the prompt, efficient and equitable handling of claims for such benefits; and

(3) to promulgate any rule or regulation he deems necessary to effectuate the purposes of this act.

(b) The Commissioner of Insurance is authorized to promulgate any rule or regulation he deems necessary to carry out his functions, powers and duties under this act.

Section 18. State or Federal Agreements.--The Insurance Commissioner and the Secretary of Health, subject to the approval of the Governor, are authorized to enter into agreement with appropriate officials of a sister state or of the United States to carry out any of their duties under this act.

Section 19. Report Required.--(a) The Secretary of Health shall provide for a health cost report to be made not later than 180 days after enactment of this act to the Governor and the Legislature on the legislative and administrative steps required:

(1) to provide for more comprehensive protection against the costs of health care services for persons not covered by a health benefits plan;

(2) to control the rising cost of health care services;

(3) to provide for more efficient administration of health care services by the Commonwealth;

(4) to establish more efficient and uniform rate setting processes for the Commonwealth's purchase of health care services and goods;

(5) to reduce out-of-pocket costs of health care services to persons residing in the Commonwealth;

(6) to establish a uniform reporting system for providers for the cost of health care services; and

(7) to respond to such other changes in health care financing, planning, and regulation as may be required in the Commonwealth in the event of the passage of a national health insurance act.

(b) In preparing such report, the commissioner shall consult with and seek the advice and assistance of the State Treasurer, the Commissioner of Insurance, the Secretary of Public Welfare, the Secretary of Labor and Industry and the Directors of the Workmen's Compensation Bureau, the Secretary of Education, representatives of insurers and providers, and representatives of employer and employee organizations.

Section 20. Annual Reports Required.--The Secretary of Health shall make an annual report to the Governor and the Legislature not later than January 30 of each year outlining in specific detail the health conditions of the people of the Commonwealth, the level of health care services available to the people of the Commonwealth, the amount of funds spent in the previous year by public and private agencies and consumers for health care services, and unmet health needs of the people of the Commonwealth, the amounts of moneys disbursed for the entitlements established under this act, and the amounts of moneys which may be needed according to actuarial estimates to meet those entitlements in the following two years.

Section 21. Effective Date.--This act shall take effect 180 days following enactment.