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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1355 Session of 2008

INTRODUCED BY HUGHES, COSTA, WASHINGTON, KITCHEN, STACK, C. WILLIAMS, FONTANA, STOUT, MUSTO, O'PAKE AND FUMO, APRIL 9, 2008

REFERRED TO BANKING AND INSURANCE, APRIL 9, 2008

AN ACT

Amending the act of March 20, 2002 (P.L.154, No.13), entitled "An act reforming the law on medical professional liability; providing for patient safety and reporting; establishing the Patient Safety Authority and the Patient Safety Trust Fund; abrogating regulations; providing for medical professional liability informed consent, damages, expert qualifications, limitations of actions and medical records; establishing the Interbranch Commission on Venue; providing for medical professional liability insurance; establishing the Medical Care Availability and Reduction of Error Fund; providing for medical professional liability claims; establishing the Joint Underwriting Association; regulating medical professional liability insurance; providing for medical licensure regulation; providing for administration; imposing penalties; and making repeals," establishing the Pennsylvania Access to Basic Care (PA ABC) Program Fund and the Pennsylvania Access to Basic Care (PA ABC) Program; providing for health care coverage for certain adults, individuals, employees and employers and for expiration of certain sections; and repealing provisions of the Tobacco Settlement Act.

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

Section 1. Chapter 7 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, is amended by adding a subchapter to read:

SUBCHAPTER E

PENNSYLVANIA ACCESS TO BASIC CARE

(PA ABC) PROGRAM FUND

Section 751. Establishment.

There is established within the State Treasury a special fund to be known as the Pennsylvania Access to Basic Care (PA ABC) Program Fund.

Section 752. Allocation.

Money in the Pennsylvania Access to Basic Care (PA ABC) Program Fund is hereby appropriated upon approval of the Governor for health care coverage and services under Chapter 13.

Section 2. The act is amended by adding a chapter to read:

CHAPTER 13

PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM

Section 1301. Scope.

This chapter relates to offering health care coverage to eligible adults, individuals, employees and employers.

Section 1302. 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:

"AdultBasic Program." The adult basic coverage insurance program established under section 1303 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

"Average annual wage." The total annual wages paid by an employer divided by the number of the employer's full-time equivalent employees.

"Behavioral health services." Mental health or substance abuse services.

"Children's health insurance program." The children's health care program established under Article XXIII of the act of May

17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Chronic disease management program." A program that allows a patient, with the support of a health care team, to play an active role in the patient's care and assures that there is an infrastructure to ensure compliance with established practice guidelines.

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

"Contractor." An insurer awarded a contract to provide health care services under this chapter. The term includes an entity and its subsidiary which is established under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Department." The Insurance Department of the Commonwealth.

"Eligible adult." An individual who is currently enrolled in the Adultbasic Program, is on the waiting list for that program on the effective date of this section or meets all of the following:

(1) Is at least 19 years of age but not more than 64 years of age.

(2) Legally resides within the United States.

(3) Has been domiciled in this Commonwealth for at least

90 days prior to application to the program.

(4) Is ineligible to receive continuous eligibility coverage under Title XIX or XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), except for benefits authorized under a waiver granted by the United States Department of Health and Human Services to implement the Pennsylvania Access to Basic Care (PA ABC) Program.

(5) Is ineligible for medical assistance or Medicare.

(6) Subject to the provisions of section 1305, has a household income that is no greater than 300% of the Federal poverty level at the time of application.

(7) Has not been covered by any health insurance plan or program for at least 180 days immediately preceding the date of application, except that the 180-day period shall not apply to an eligible adult who meets one of the following:

(i) is eligible to receive benefits under the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law;

(ii) was covered under a health insurance plan or program provided by an employer, but at the time of application is no longer covered because of a change in the individual's employment status and is ineligible to receive benefits under the Unemployment Compensation Law;

(iii) lost coverage as a result of divorce or separation from a covered individual, the death of a covered individual or a change in employment status of a covered individual; or

(iv) is transferring from another government-subsidized health program, including a transfer that occurs as a result of failure to meet income eligibility

requirements.

"Eligible employee." An eligible adult or an employee who meets all the requirements of an eligible adult or employee at the time the eligible employer makes application to the program.

"Eligible employer." An employer that meets all of the following:

(1) Has at least two but not more than 50 full-time equivalent employees.

(2) Has not offered health care coverage through any plan or program during the 180 days immediately preceding the date of application for participation in the Pennsylvania Access to Basic Care (PA ABC) Program.

(3) Has not provided remuneration in any form to an employee for the purchase of health care coverage during the 180 days immediately preceding the date on which the employer applies for participation in the program.

(4) Pays an average annual wage that is less than 300% of the Federal poverty level for an individual.

"Employee." An individual who is employed for more than 20 hours in a single week and from whose wages an employer is required under the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.) to withhold Federal income tax.

"Employer." The term shall include:

(1) Any of the following who or which employs two but not more than 50 employees to perform services for remuneration:

(i) an individual, partnership, association, domestic or foreign corporation or other entity;

(ii) the legal representative, trustee in bankruptcy, receiver or trustee of any individual,

partnership, association or corporation or other entity; or

(iii) the legal representative of a deceased individual.

(2) An individual who is self-employed.

(3) The executive, legislative and judicial branches of the Commonwealth and any one of its political subdivisions.

"Fund." The Pennsylvania Access to Basic Care (PA ABC) Program Fund.

"Health benefit plan." An insurance coverage plan that provides the benefits set forth under section 1313. The term does not include any of the following:

(1) An accident-only policy.

(2) A credit-only policy.

(3) A long-term or disability income policy.

(4) A specified disease policy.

(5) A Medicare supplement policy.

(6) A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(7) A fixed indemnity policy.

(8) A dental-only policy.

(9) A vision-only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy pursuant to 75 Pa.C.S. (relating to vehicles).

(12) Such other similar policies providing for limited benefits.

"Health care coverage." A health benefit plan or other form of health care coverage that is approved by the Department of Community and Economic Development in consultation with the

Insurance Department. The term does not include coverage under the PA ABC program.

"Health maintenance organization" or "HMO." An entity organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Health savings account." An account established by an employer under section 1307 on behalf of an employee whose income is greater than 200% of the Federal poverty level.

"Hospital." An institution that has an organized medical staff engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill persons. The term includes a facility for the diagnosis and treatment of disorders within the scope of specific medical specialties. The term does not include a facility that cares exclusively for the mentally ill.

"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. § 6101 (relating to definitions).

"Individual." A natural person who meets all the requirements of an eligible adult but whose household income is greater than 300% of the Federal poverty level.

"Insurer." A company or health insurance entity licensed in this Commonwealth to issue an individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider and that is offered or governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as

The Insurance Company Law of 1921.

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

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

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

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

"Medical loss ratio." The ratio of paid medical claim costs to earned premiums.

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

"Offeror." An insurer that submits a bid or proposal under section 1311 in response to the department's procurement solicitation.

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

"Prescription drug." A controlled substance, other drug or device for medication dispensed by order of an appropriately licensed medical professional.

"Professional health services plan corporation." A not-for-profit corporation operating under the provisions of 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Program." The Pennsylvania Access to Basic Care (PA ABC) Program established under this chapter.

"Qualifying health care coverage." A health benefit plan or other form of health care coverage actuarially equivalent to the benefits in section 1313 and approved by the Insurance Department.

"Terminate." The term includes cancellation, nonrenewal and rescission.

"Unemployment Compensation Law." The act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law.

"Uninsured period." A continuous period of time of not less than 180 consecutive days immediately preceding application during which an adult has been without health care coverage in accordance with the requirements of this chapter.

Section 1303. Establishment of program.

The Pennsylvania Access to Basic Care (PA ABC) Program is established in the department.

Section 1304. Funding.

(a) Sources.--The following are the sources of money for the program:

(1) Money received from the Supplemental Assistance and Funding Account established under section 1112(a.1).

(2) Money received from the Federal Government or other sources.

(3) Money required to be deposited pursuant to other provisions of this chapter or any other law of this Commonwealth.

(4) Upon implementation of the program:

(i) Only those funds appropriated for health

investment insurance under section 306(b)(1)(vi) of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, and designated for the AdultBasic Program.

(ii) Money currently required to be dedicated to the AdultBasic Program or any alternative program to benefit persons of low income under the Community Health Reinvestment Agreement within the respective service areas for each party to that agreement. Money under this subparagraph shall be used only to defray the cost of the program and subsidies approved under sections 1305 and 1306.

(5) Any moneys derived from whatever sources and designated specifically to fund the program.

(6) Return on investments in the fund.

Section 1305. Purchase by eligible adults and individuals.

(a) Eligible adults.--An eligible adult or individual who seeks to purchase coverage under the program must:

(1) Submit an application to the department or its contractor.

(2) Pay to the department or its contractor the amount of the premium specified.

(3) Be responsible for any required copayments for health care services rendered under the health benefit plan in section 1313 subject to Federal waiver requirements.

(4) Notify the department or its contractor of any change in the eligible adult's or individual's household income.

(b) Monthly premiums.--Except to the extent that changes may be necessary to meet Federal requirements under section 1317 or

to encourage eligible employer participation, subsidies for the 2008-2009 fiscal year and each fiscal year thereafter shall result in the following premium amount based on household income for a health benefit plan:

(1) For an eligible adult whose household income is not greater than 150% of the Federal poverty level, no monthly premium.

(2) For an eligible adult whose household income is greater than 150% but not greater than 175% of the Federal poverty level, a monthly premium of $40.

(3) For an eligible adult whose household income is greater than 175% but not greater than 200% of the Federal poverty level, a monthly premium of $50.

(4) For an eligible adult whose household income is greater than 200%, a monthly premium may be established based upon Federal requirements and in accordance with Federal waivers, if applicable, by the commissioner.

(c) Other eligible adults.--An eligible adult whose household income is greater than 200% but less than 300% of the Federal poverty level may purchase under the program either the benefit package under section 1313 or other qualifying health care coverage at the per-member, per-month premium cost.

(d) Individuals.--An individual may purchase the benefit package under section 1313 at the per-member, per-month premium cost as long as the individual demonstrates, on an annual basis and in a manner determined by the department, either one of the following:

(1) The individual is unable to afford individual or group coverage because that coverage would exceed 10% of the individual's household income or because the total cost of

coverage for the individual is 150% of the premium cost established under this section for that service area.

(2) The individual has been refused coverage by an insurer because the individual or a member of that individual's immediate family has a preexisting condition and coverage is not available to the individual.

(e) Establishing premiums.--For each fiscal year beginning after June 30, 2009, the department may adjust the premium amounts under subsection (b) to reflect changes in the cost of medical services and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(f) Purchase of health benefit plan.--An eligible adult's or individual's payment to the department or its contractor under subsection (b) shall be used to purchase the benefit health plan established under section 1313 and must be remitted in a timely manner.

(g) Subsidy.--Funding for the program shall be used by the department to pay the difference between the total monthly cost of the health benefit plan and the eligible adult's premium. Subsidization of the health benefit plan is contingent upon the amount of the funding for the program and is limited to eligible adults in compliance with this section.

Section 1306. Participation by eligible employers and eligible employees.

(a) Eligible employers.--An eligible employer that seeks to participate in the program shall:

(1) Offer to all eligible employees the opportunity to participate in the program and enroll at least one-half of the eligible employees.

(2) Comply with the application process established by the department or its contractor.

(3) Remit to the department or its contractor any premium amounts required under subsections (c) and (d).

(4) Allow health insurance premiums to be paid by eligible employees on a pretax basis and inform its employees of the availability of such program.

(5) Notify the department or its contractor of any change in the eligible employee's income.

(b) Eligible employees.--An eligible employee who seeks to participate with an eligible employer under the program must:

(1) Submit an application by an eligible employer to the department or its contractor.

(2) Be responsible for any required copayments for health care services rendered under the health benefit plan in section 1313.

(c) Premiums for employers.--

(1) In addition to remitting the eligible employee portion under subsections (a) and (d), an eligible employer shall pay the employer share of the total monthly cost for each participating employee to the department or its contractor each month.

(2) In addition to remitting the eligible employee portion under paragraph (1), an eligible employer's premium payment to the department or its contractor shall be at least 50% of the total monthly cost for each eligible employee but not less than $150.

(d) Premiums for eligible employees.--The premium for eligible employees shall be the same as the premium required to be paid by eligible adults under section 1305(b).

(e) Purchase by certain eligible employees.--An eligible employee whose household income is greater than 200% but less than 300% of the Federal poverty level may purchase either the benefit package under section 1313 or other qualifying health care coverage under section 1307 at the per-member, per-month premium cost minus any amount remitted by the employer under subsection (c).

(f) Publishing premium amounts.--For each fiscal year beginning after June 30, 2009, the department may establish different premium amounts for eligible employees and eligible employers as required under this section and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(g) Purchase of coverage.--A premium payment made by an eligible employer to the department or its contractor shall be used to purchase the health benefit plan and must be remitted in a timely manner.

(h) Alternative coverage.--

(1) Notwithstanding any other provision of law to the contrary, employer-based coverage may, in the commissioner's sole discretion, be purchased in place of participation in the program or may be purchased in conjunction with any portion of the program provided outside the scope of the program contracts by the Commonwealth paying the employee's share of the premium to the employer if it is more cost effective for the Commonwealth to purchase health care coverage from an employee's employer-based program than to pay the Commonwealth's share of a subsidized premium.

(2) This section shall apply to any employer-based program, whether individual or family, such that if the

Commonwealth's share for the employee plus its share for any spouse under the program or children under the children's health insurance program is greater than the employee's premium share for family coverage under the employer-based program, the Commonwealth may choose to pay the latter alone or in combination with providing any benefit the Commonwealth does not provide through its program contracts.

(i) Termination of employment.--An eligible employee who is terminated from employment shall be eligible to continue participating in the program if the eligible employee continues to meet the requirements as an eligible adult and pays any increased premium required.

Section 1307. Health savings accounts.

The department shall approve the establishment of health savings accounts that are actuarially equivalent to the benefits in section 1313 for employees who enroll in the program. Health savings accounts established under the program shall meet the requirements as defined in section 223(d) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(d)).

Section 1308. (Reserved).

Section 1309. Program requirements.

(a) Rates.--Rates for the program shall be approved annually by the department and may vary by region and contractor. Rates shall be based on an actuarially sound and adequate review.

(b) Annual premiums review.--Premiums for the program shall be established annually by the department.

(c) Use of funding.--Funding shall be used by the department to pay the difference between the total monthly cost of the health benefit plan and the premium payments by the eligible employee, the eligible employer or the eligible adult.

(d) Monthly increases.--With respect to a continuous period of eligibility for an eligible employer to apply for participation in the program and in addition to the requirements of section 1306(d), an eligible employer shall be subject to a 1% increase in the base premium for each month after the latter of the following:

(1) twelve months from the date of the effective date of this section; or

(2) twelve months from the date the eligible employer files for a Federal or State tax identification number.

(e) Funding contingency for subsidization.--Subsidization of premiums paid under sections 1305 and 1306 is contingent upon the amount of the funding available to the program, the Federal poverty levels approved by the Federal waiver or State plan amendments granted under section 1317 and is limited to eligible adults and eligible employees who are in compliance with the requirements under this chapter.

(f) Limit on subsidy.--At no time shall the subsidy paid by the Commonwealth from funds other than Federal moneys for the premium of eligible employees be more than 40% of the total cost of the health benefit plan purchased in each region or with each contractor.

Section 1310. Duties of department.

The department has the following duties:

(1) Administer the program on a Statewide basis.

(2) Solicit bids or proposals and award contracts as follows:

(i) The department shall solicit bids or proposals and award contracts for the benefit package under section 1313 through a competitive procurement process in

accordance with 62 Pa.C.S. (relating to procurement) and subsection (g). The department may award contracts on a multiple-award basis as described in 62 Pa.C.S. § 517 (relating to multiple awards).

(ii) (A) In order to effectuate the program promptly upon receipt of all applicable waivers and approvals from the Federal Government, the department may amend such contracts as currently exist to provide benefits under either the program or the Public Welfare Code, or may otherwise procure services outside of the competitive procurement process of 62 Pa.C.S.

(B) This subparagraph shall expire at such time as there are effective contracts awarded under this section in every county of this Commonwealth, but not later than 18 months after the effective date of this section.

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

(4) In consultation with other appropriate Commonwealth agencies, conduct monitoring and oversight of contracts

entered into with contractors.

(5) In consultation with other appropriate Commonwealth agencies, monitor, review and evaluate the adequacy, accessibility and availability of services delivered to eligible adults, individuals or eligible employees.

(6) In consultation with other appropriate Commonwealth agencies, establish and coordinate the development, implementation and supervision of an outreach plan to ensure that all those who may be eligible are aware of the program. The outreach plan shall include provisions for:

(i) Reaching special populations, including nonwhite and non-English speaking individuals and individuals with disabilities.

(ii) Reaching different geographic areas, including rural and inner-city areas.

(iii) Assuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

(iv) Allowing for the acceptance of applications at county assistance offices operated by the Department of Public Welfare.

(7) At the request of an eligible adult, individual, eligible employee or eligible employer, facilitate the payment on a pretax basis of premiums:

(i) for the program and dependents covered under the program; or

(ii) if applicable, for the children's health insurance program.

(8) Establish penalties for eligible adults, individuals, eligible employees or eligible employers who

enroll in the program, drop enrollment and subsequently re-enroll for the purpose of avoiding the ongoing payment of premiums. The commissioner shall forward notice of these penalties to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(9) Coordinate with the Department of Public Welfare in the implementation of this chapter and may designate the Department of Public Welfare to perform any duties that are appropriate under this chapter.

Section 1311. Submission of proposals and award of contracts.

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

(b) Review and scoring of bids or proposals.--The department shall review and score the bids or proposals on the basis of all the requirements for the program. The department may include other criteria in the solicitation and in the scoring and selection of the bids or proposals that the department, in the exercise of its duties under section 1310, deems necessary. The department shall do all of the following:

(1) Select, to the greatest extent practicable, offerors that contract with health care providers to provide health care services on a cost-effective basis. The department shall select offerors that use appropriate cost-management methods, including the chronic care and prevention measures, which

will enable the program to provide coverage to the maximum number of enrollees.

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

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

(d) Duties of contractors.--A contractor that contracts with the department to provide a health benefit plan to eligible adults or eligible employees:

(1) Shall process claims for the coverage.

(2) Shall reimburse providers at a reimbursement rate of:

(i) (A) not less than 105% of the Federal Medicare reimbursement rate for the service provided by a provider under section 1104(B)(1);

(B) not less than 90% of the Federal Medicare reimbursement rate for the service provided by a provider under section 1104(B)(2); or

(ii) (A) at a rate of 90% of the Medicaid reimbursement rate for an inpatient service; and

(B) at a rate of 100% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate, except as provided in section 1213(b).

(3) May not deny coverage to an eligible adult or eligible employee who has been approved by the department to participate in the program.

Section 1312. Rates and charges.

(a) Medical loss ratio.--The medical loss ratio for a contract shall be not less than 85%.

(b) Limitation on fees.--No eligible adult or eligible employee shall be charged a fee, other than those specified in this chapter, as a requirement for participating in the program.

Section 1313. Health benefit plan.

(a) Benefits.--The health benefit plan to be offered under the program shall be of the scope and duration as the department determines and shall provide for all of the following, which may be as limited or unlimited as the department may determine:

(1) Preliminary and annual health assessments.

(2) Emergency care.

(3) Inpatient and outpatient care.

(4) Prescription drugs, medical supplies and equipment.

(5) Emergency dental care.

(6) Maternity care.

(7) Skilled nursing.

(8) Home health and hospice care.

(9) Chronic disease management.

(10) Preventive and wellness care.

(11) Inpatient and outpatient behavioral health services.

(b) Commonwealth election.--The Commonwealth may elect to provide any benefit independently and outside the scope of the program contracts.

(c) Enrollment.--Enrollment in the program may not be prohibited based upon a preexisting condition, nor may a program health benefit plan exclude a diagnosis or treatment for a condition based upon its preexistence.

(d) Copayments.--The department may establish a copayment for any of the services provided in the health benefit plan as long as the copayment meets any Federal requirements under section 1317. The department shall forward notice of the copayment amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

Section 1314. Data matching.

(a) Covered individuals.--All entities providing health insurance or health care coverage within this Commonwealth shall, not less frequently than once every month, provide the names, identifying information and any additional information on coverage and benefits as the department may specify for all eligible adults, individuals or eligible employees for whom the entities provide insurance or coverage.

(b) Use of information.--

(1) The department shall use information obtained in subsection (a) to determine whether any portion of an eligible adult's, individual's, eligible employee's or eligible employer's premium is being paid from any other source and to determine whether another entity has primary liability for any health care claims paid under any program administered by the department.

(2) If a determination is made that an eligible adult's, individual's, eligible employee's or eligible employer's premium is being paid from another source, the department may not make any additional payments to the insurer for the eligible adult, individual, eligible employee or eligible employer.

(c) Excess payment.--If a payment has been made to an insurer by the department for an eligible adult, individual,

eligible employee or eligible employer for whom any portion of the premium paid by the department is being paid from another source, the insurer shall reimburse the department the amount of any excess payment or payments.

(d) Reimbursement.--The department may seek reimbursement from an entity that provides health insurance or health care coverage that is primary to the coverage provided under any program administered by the department.

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

(f) Agreements.--The department may enter into agreements with entities that provide health insurance and health care coverage for the purpose of carrying out the provisions of this section. The agreements shall provide for the electronic exchange of data between the parties at a mutually agreed upon frequency, but not less than monthly, and may also allow for payment of a fee by the department to the entity providing health insurance or health care coverage.

(g) Other coverage.--

(1) The department shall determine whether any other health care coverage is available to an eligible adult, eligible employee or eligible employer through an alimony agreement or an employment-related or other group basis.

(2) If other health care coverage is available, the department shall reevaluate the enrollee's eligibility under this chapter.

(h) Penalty.--

(1) The department may impose a penalty of up to $1,000 per violation on any insurer that fails to comply with the obligations imposed by this chapter.

(2) All moneys collected under this subsection shall be deposited into the fund.

Section 1315. Entitlements and claims.

Nothing in this chapter shall be construed as an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth. The Department of Public Welfare, in conjunction with the department, shall establish a waiting list and State plan amendments and revisions to Federal waivers as are necessary to ensure that expenditures in the program do not exceed available funding.

Section 1316. Regulations.

The department may promulgate regulations for the implementation and administration of this chapter.

Section 1317. Federal waivers.

(1) The Department of Public Welfare, in cooperation with the department, shall apply for all applicable waivers from the Federal Government and shall seek approval to amend the State plan as necessary to carry out the provisions of this chapter.

(2) If the Department of Public Welfare receives approval of a waiver or approval of a State plan amendment as required by this section, it shall notify the department and transmit notice of the waiver or State plan amendment approvals to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(3) The department may change the benefits under section

1313 and the premium and copayment amounts payable under sections 1305 and 1306 and eligibility requirements in order for the program to meet Federal requirements.

Section 1318. Federal funds.

Notwithstanding any other provision of law, the Department of Public Welfare, in cooperation with the department, shall take any action necessary to do all of the following:

(1) Ensure the receipt of Federal financial participation under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) for coverage and for services provided under this chapter.

(2) Qualify for available Federal financial participation under Title XIX of the Social Security Act.

Section 3. The Insurance Department shall publish a notice in the Pennsylvania Bulletin when a law is enacted that provides for or designates at least $120,000,000 for the Supplemental Assistance and Funding Account.

Section 4. Repeals are as follows:

(1) The General Assembly declares that the repeal under paragraph (2) is necessary to effectuate this act.

(2) Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

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

Section 5. This act shall take effect as follows:

(1) Section 3 of this act shall take effect July 1, 2008, or immediately, whichever is later.

(2) The remainder of this act shall take effect upon publication of the notice specified under section 3 of this act.