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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1356 Session of 2008

INTRODUCED BY COSTA, HUGHES, FONTANA, STOUT, WASHINGTON, KASUNIC, MUSTO, STACK, O'PAKE, KITCHEN, C. WILLIAMS 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," further providing for medical professional liability insurance, for the Medical Care Availability and Reduction of Error Fund and for actuarial data; establishing the Continuing Access with Relief for Employers (CARE) Fund; further defining "health care provider"; further providing for the Health Care Provider Retention Program; establishing the Supplemental Assistance and Funding Account; further providing for expiration of the Health Care Provider Retention Program; and providing for Continuing Access with Relief for Employers (CARE) Grants.

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

Section 1. Section 711(d) and (g) of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability

and Reduction of Error (Mcare) Act, are amended to read:

Section 711. Medical professional liability insurance.

* * *

(d) Basic coverage limits.--A health care provider shall insure or self-insure medical professional liability in accordance with the following:

(1) For policies issued or renewed in the calendar year 2002, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a health care provider who conducts more than 50% of its health care business or practice within this Commonwealth and that is not a hospital.

(ii) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a health care provider who conducts 50% or less of its health care business or practice within this Commonwealth.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

(2) For policies issued or renewed in the calendar years 2003[, 2004 and 2005] <u>through 2008</u>, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

[(3) Unless the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, for policies issued or renewed in calendar year 2006 and each year thereafter subject to paragraph (4), the basic insurance coverage shall be:

(i) $750,000 per occurrence or claim and $2,250,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $750,000 per occurrence or claim and $3,750,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (2); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.

(4) Unless the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, for policies issued or renewed three years after the increase in coverage limits required by paragraph (3) and for each year thereafter, the basic insurance coverage shall be:

(i) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a participating

health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (3); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.]

(5) For policies issued or renewed in calendar year 2009, the basic insurance coverage shall be:

(i) $550,000 per occurrence or claim and $1,650,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $550,000 per occurrence or claim and $2,700,000 per annual aggregate for a hospital.

(6) For policies issued or renewed in calendar years 2010 and thereafter:

(i) The basic insurance coverage for a participating health care provider that is not a hospital shall increase by $50,000 per occurrence or claim and $150,000

per annual aggregate per year until such time as the basic insurance coverage required shall be $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate.

(ii) The basic insurance coverage for a nonparticipating health care provider shall be $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate.

(iii) The basic insurance coverage for a hospital shall increase by $50,000 per occurrence or claim and $200,000 per annual aggregate until such time as the basic insurance coverage requirement shall be $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate per year.

(7) Basic insurance coverage amounts shall be exclusive of a deductible or any other contribution from the health care provider.

* * *

(g) Basic insurance liability.--

(1) An insurer providing medical professional liability insurance shall not be liable for payment of a claim against a health care provider for any loss or damages awarded in a medical professional liability action in excess of the basic insurance coverage required by subsection (d) unless the health care provider's medical professional liability insurance policy or self-insurance plan provides for a higher limit.

(2) If a claim exceeds the limits of a participating health care provider's basic insurance coverage or self-insurance plan, the fund shall be responsible for payment of the claim against the participating health care provider up

to the fund liability limits. The fund shall not be responsible if a claimant has waived collection of any portion of the applicable basic insurance coverage limit.

(3) If the health care provider has more than one basic insurance coverage policy with more than one insurer applicable to a claim, the fund shall be liable when the policy with the highest limit has been tendered to the fund.

* * *

Section 2. Section 712(c), (d), (e), (i), (j) and (m) of the act are amended and the section is amended by adding a subsection to read:

Section 712. Medical Care Availability and Reduction of Error Fund.

* * *

(c) Fund liability limits.--

(1) For calendar year 2002, the limit of liability of the fund created in section 701(d) of the former Health Care Services Malpractice Act for each health care provider that conducts more than 50% of its health care business or practice within this Commonwealth and for each hospital shall be $700,000 for each occurrence and $2,100,000 per annual aggregate.

(2) The limit of liability of the fund for each participating health care provider shall be [as follows:

(i) For] for calendar year 2003 and each year thereafter, the limit of liability of the fund shall be $500,000 for each occurrence and $1,500,000 per annual aggregate.

[(ii) If the basic insurance coverage requirement is increased in accordance with section 711(d)(3) and,

notwithstanding subparagraph (i), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund shall be $250,000 for each occurrence and $750,000 per annual aggregate.

(iii) If the basic insurance coverage requirement is increased in accordance with section 711(d)(4) and, notwithstanding subparagraphs (i) and (ii), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund shall be zero.]

(3) The limit of liability of the fund for each participating health care provider shall be:

(i) For calendar years 2003 through 2008, $500,000 for each occurrence and $1,500,000 per annual aggregate.

(ii) For calendar year 2009, $450,000 per occurrence or claim and $1,350,000 per annual aggregate.

(iii) For calendar years 2010 and thereafter, the limit of liability shall decrease by $50,000 per occurrence or claim and $150,000 per annual aggregate per year until such time as the fund limit of liability shall be zero dollars per occurrence or claim and zero dollars per annual aggregate.

(d) Assessments.--

(1) For calendar [year 2003 and for each year thereafter,] years 2003 through 2017, the fund shall be funded by an assessment on each participating health care provider. Assessments shall be levied by the department on or after January 1 of each year. The assessment shall be based on the prevailing primary premium for each participating

health care provider and shall, in the aggregate, produce an amount sufficient to do all of the following:

(i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.

(ii) Pay expenses of the fund incurred during the preceding claims period.

(iii) Pay principal and interest on moneys transferred into the fund in accordance with section 713(c).

(iv) Provide a reserve that shall be 10% of the sum of subparagraphs (i), (ii) and (iii).

(2) The department shall notify all basic insurance coverage insurers and self-insured participating health care providers of the assessment by November 1 for the succeeding calendar year.

(3) Any appeal of the assessment shall be filed with the department.

[(e) Discount on surcharges and assessments.--

(1) For calendar year 2002, the department shall discount the aggregate surcharge imposed under section 701(e)(1) of the Health Care Services Malpractice Act by 5% of the aggregate surcharge imposed under that section for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were surcharged as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the

aggregate discount shall be granted equally to all participating health care providers.

(iii) The department shall issue a credit to a participating health care provider who, prior to the effective date of this section, has paid the surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to the effective date of this section.

(2) For calendar years 2003 and 2004, the department shall discount the aggregate assessment imposed under subsection (d) for each calendar year by 10% of the aggregate surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were assessed as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(3) For calendar years 2005 and thereafter, if the basic insurance coverage requirement is increased in accordance with section 711(d)(3) or (4), the department may discount the aggregate assessment imposed under subsection (d) by an amount not to exceed the aggregate sum to be deposited in the fund in accordance with subsection (m).]

* * *

(i) Change in basic insurance coverage.--If a participating

health care provider changes the term of its medical professional liability insurance coverage, the assessment shall be calculated on an annual basis and shall reflect the assessment percentages in effect for the period over which the policies are in effect. A policy period less than 12 months may result in a prorated reduction in the Mcare annual aggregate limit.

(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on [or before] December 31 or the last business day of the year following the August 31 on which they became final.

* * *

(m) Supplemental funding.--Notwithstanding the provisions of 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary, beginning January 1, 2004, [and for a period of nine calendar years thereafter,] through June 30, 2018, all surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system shall be remitted to the Commonwealth for deposit in the Medical Care Availability and [Restriction] Reduction of Error Fund. These funds shall be used to reduce surcharges and assessments in accordance with subsection (e). Beginning [January 1, 2014] July 1, 2018, and each year thereafter, the surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the [General Fund.] Health Care Provider Retention Account.

* * *

(o) Coverage of claims in relation to payment of certain late assessments.--

(1) All basic insurance coverage insurers, self-insured participating health care providers and risk retention groups

shall bill, collect and remit the assessment to the department within 60 days of the inception or renewal date of the primary professional liability policy.

(2) All basic insurance coverage insurers, self-insured participating health care providers and risk retention groups shall be subject to the following:

(i) For assessments remitted to the department in excess of 60 days after the inception or renewal date of the primary policy, the basic insurance coverage insurer, self-insured participating health care provider or risk retention group shall pay to the department a penalty equal to 10% per annum of each untimely assessment accruing from the 61st day after the inception or renewal date of the primary policy until the remittance is received by the department.

(ii) In addition to the provisions of subparagraph (i), if the department finds that there has been a pattern or practice of not complying with this section, the basic insurance coverage insurer, self-insured participating health care provider or risk retention group shall be subject to the penalties and process set forth in the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

(iii) If the basic insurance coverage insurer, self-insurer or risk retention group receives the assessment from a health care provider, professional corporation or professional association with less than 30 days to make the remittance timely as provided under this subsection, the basic insurance coverage insurer, self-insurer or risk retention group remittance period shall be extended

by 30 days from the date of receipt upon providing reasonable evidence to the department regarding the date of receipt and shall not be subject to the penalties provided for under this section.

(iv) If the basic insurance coverage insurer, self-insurer or risk retention group receives an assessment after 60 days of the inception or renewal date of the primary professional liability policy and remits the assessment within 30 days from the date of receipt, the basic insurance coverage insurer, self-insurer or risk retention group shall not be subject to the penalties provided for under this section. Remittances to the department beyond the 30-day period shall be subject to the penalties provided for under this section.

(v) (A) A health care provider or professional corporation, professional association or partnership shall be provided coverage from the inception or renewal date of the primary professional liability policy if the billed assessment is paid to the basic insurance coverage insurer, self-insurer or risk retention group within 60 days of the inception or renewal date of the primary professional liability policy.

(B) A health care provider or professional corporation, professional association or partnership that fails to pay the billed assessment to its basic insurance coverage insurer, self-insurer or risk retention group within 60 days of policy inception or renewal and before receiving notice of a claim shall not have coverage for that claim.

(C) If a health care provider or professional corporation, professional association or partnership is billed by the basic insurance coverage insurer, self-insurer or risk retention group later than 30 days after the policy inception or renewal date and the health care provider or professional corporation, professional association or partnership pays the basic insurance coverage insurer, self-insurer or risk retention group within 30 days from the date of receipt of the bill and the basic insurance coverage insurer, self-insurer or risk retention group carrier remits the assessment to the department within 30 days from the date of receipt, the health care provider shall be provided coverage as of the inception or renewal date of the primary policy. Coverage shall also be provided to the health care provider or professional corporation, professional association or partnership for all professional liability claims made after payment of the assessment.

(vi) Except as to provisions in conflict with this section, nothing in this section shall be construed to affect existing regulations saved by section 5107(a), and all existing regulations shall remain in full force and effect.

Section 3. Section 745 of the act is repealed:

[Section 745. Actuarial data.

(a) Initial study.--The following shall apply:

(1) No later than April 1, 2005, each insurer providing medical professional liability insurance in this Commonwealth

shall file loss data as required by the commissioner. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) By July 1, 2005, the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.

(b) Additional study.--The following shall apply:

(1) Three years following the increase of the basic insurance coverage requirement in accordance with section 711(d)(3), each insurer providing medical professional liability insurance in this Commonwealth shall file loss data with the commissioner upon request. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) Three months following the request made under paragraph (1), the commissioner shall conduct a study regarding the availability of additional basic insurance

coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.]

Section 4. Chapter 7 of the act is amended by adding subchapters to read:

SUBCHAPTER E

(RESERVED)

SUBCHAPTER F

CONTINUING ACCESS WITH RELIEF FOR EMPLOYERS (CARE) FUND

Section 761. Establishment.

There is established within the State Treasury a special fund to be known as the Continuing Access with Relief for Employers (CARE) Fund.

Section 762. Allocation.

Money in the Continuing Access with Relief for Employers (CARE) Fund is hereby appropriated on a continuing basis to the Department of Community and Economic Development and shall be dedicated to assisting certain employers that currently offer and maintain health care coverage for their employees in compliance with the requirements under section 1308.

Section 5. The definition of "health care provider" in section 1101 of the act, added December 22, 2005 (P.L.458, No.88), is amended to read:

Section 1101. Definitions.

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

* * *

"Health care provider." [An individual who is all of the following:

(1) A physician, licensed podiatrist, certified nurse midwife or nursing home.

(2) A participating health care provider as defined in section 702.] Any of the following:

(1) A nursing home or birth center that is a participating health care provider as defined in section 702.

(2) An individual who is a physician, licensed podiatrist or certified nurse midwife.

* * *

Section 6. Section 1102 of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read:

Section 1102. Abatement program.

(a) Establishment.--There is hereby established within the Insurance Department a program to be known as the Health Care Provider Retention Program. The Insurance Department, in conjunction with the Department of Public Welfare, shall administer the program. The program shall provide assistance in the form of assessment abatements to health care providers for calendar years [2003, 2004, 2005, 2006 and 2007] beginning 2003 and ending 2017, except that licensed podiatrists shall not be

eligible for calendar years 2003 and 2004, and nursing homes shall not be eligible for calendar years 2003, 2004 and 2005.

(b) Other [abatement.--] abatements.--

(1) Emergency physicians not employed full time by a trauma center or working under an exclusive contract with a trauma center shall retain eligibility for an abatement pursuant to section 1104(b)(2) for calendar years 2003, 2004, 2005 and 2006. Commencing in calendar year 2007, these emergency physicians shall be eligible for an abatement pursuant to section 1104(b)(1).

(2) Birth centers shall retain eligibility for abatement pursuant to section 1104(b)(2) for calendar years 2003, 2004, 2005, 2006 and 2007. Commencing in calendar year 2008, birth centers shall be eligible for abatement pursuant to section 1104(b)(1).

Section 7. Section 1103 of the act, added December 22, 2005 (P.L.458, No.88), is amended by adding paragraphs to read:

Section 1103. Eligibility.

A health care provider shall not be eligible for [assessment] abatement under the program if any of the following apply:

* * *

(6) The health care provider has refused to be an active provider in the Pennsylvania Access to Basic Care (PA ABC) Program in the health care provider's service area.

(7) The active health care provider is an active provider in the Pennsylvania Access to Basic Care (PA ABC) Program and places restrictions on benefits for patients enrolled in that program.

(8) The health care provider has refused to be an active provider in the children's health insurance 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.

(9) The active health care provider is an active provider in the children's health insurance program and places restrictions on benefits for patients enrolled in the children's health insurance program.

(10) The Department of Revenue has determined that the health care provider has not filed all required State tax reports and returns for all applicable taxable years or has not paid any balance of State tax due as determined at settlement, assessment or determination by the Department of Revenue that are not subject to a timely perfected administrative or judicial appeal or subject to a duly authorized deferred payment plan as of the date of application. Notwithstanding the provisions of section 353(f) of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, the Department of Revenue shall supply the Insurance Department with information concerning the status of delinquent taxes owed by a health care provider for purposes of this paragraph.

(11) (i) The health care provider has not attended at least one Commonwealth-sponsored independent drug information service session, either in person or by videoconference.

(ii) This paragraph does not apply if the Commonwealth has not made a Commonwealth-sponsored independent drug information service session available to the health care provider prior to the date that the health care provider's application is submitted under

section 1104.

Section 8. Section 1104(b) of the act, added December 22, 2005 (P.L.458, No.88), is amended to read:

Section 1104. Procedure.

* * *

(b) Review.--Upon receipt of a completed application, the Insurance Department shall review the applicant's information and grant the applicable abatement of the assessment for the previous calendar year specified on the application in accordance with all of the following:

(1) The Insurance Department shall notify the Department of Public Welfare that the applicant has self-certified as eligible and was not disqualified for an abatement under section 1103(6), (7), (8), (9), (10) and (11) for a 100% abatement of the imposed assessment if the health care provider was assessed under section 712(d) as:

(i) a physician who is assessed as a member of one of the four highest rate classes of the prevailing primary premium;

(ii) an emergency physician;

(iii) a physician who routinely provides obstetrical services in rural areas as designated by the Insurance Department; [or]

(iv) a certified nurse midwife[.]; or

(v) a birth center.

(2) The Insurance Department shall notify the Department of Public Welfare that the applicant has self-certified as eligible and was not disqualified for an abatement under section 1103(6), (7), (8), (9), (10) and (11) for a 50% abatement of the imposed assessment in calendar years 2008

through 2012, a 56.5% abatement in calendar year 2013, a 63.5% abatement in calendar year 2014, a 70% abatement in calendar year 2015, a 78% abatement in calendar year 2016, an 88% abatement in calendar year 2017 and a 100% abatement in calendar year 2018 if the health care provider was assessed under section 712(d) as:

(i) a physician but is a physician who does not qualify for abatement under paragraph (1);

(ii) a licensed podiatrist; [or]

(iii) a nursing home[.]; or

(iv) a birth center.

* * *

Section 9. Section 1112(c) and (e) of the act, added December 22, 2005 (P.L.458, No.88), are amended and the section is amended by adding subsections to read:

Section 1112. Health Care Provider Retention Account.

* * *

(a.1) Supplemental Assistance and Funding Account.--There is established within the Health Care Provider Retention Account a special account to be known as the Supplemental Assistance and Funding Account. Funds in this account shall be used annually to supplement the funding of the Pennsylvania Access to Basic Care (PA ABC) Program.

* * *

(c) Transfers from account.--

(1) The Secretary of the Budget may annually transfer from the account to the Medical Care Availability and Reduction of Error (Mcare) Fund an amount up to the aggregate amount of abatements granted by the Insurance Department under section 1104(b).

(2) In addition to the transfers specified in paragraph (1), the Secretary of the Budget may also transfer funds from the account to the Medical Care Availability and Reduction of Error (Mcare) Fund for the purpose of paying claims and operating expenses coming due after January 1, 2018.

(3) The Secretary of the Budget may transfer funds from the account to the Pennsylvania Access to Basic Care (PA ABC) Program Fund.

(4) The Secretary of the Budget shall annually transfer from the account to the Continuing Access Relief for Employers (CARE) Fund an amount at least equal to the amount deposited under section 712(m).

(c.1) Transfers from the Supplemental Assistance and Funding Account.--The Secretary of the Budget shall annually transfer funds from the Supplemental Assistance and Funding Account established under subsection (a.1) to the Pennsylvania Access to Basic Care (PA ABC) Program Fund.

* * *

[(e) Administration assistance.--The Insurance Department shall provide assistance to the Department of Public Welfare in administering the account.]

Section 10. Section 1115 of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read:

Section 1115. Expiration.

The Health Care Provider Retention Program established under this chapter shall expire December 31, [2008] 2018.

Section 11. The act is amended by adding a chapter to read:

CHAPTER 13

RESERVED

Section 1301. (Reserved).

Section 1302. (Reserved).

Section 1303. (Reserved).

Section 1304. (Reserved).

Section 1305. (Reserved).

Section 1306. (Reserved).

Section 1307. (Reserved).

Section 1308. Continuing Access with Relief for Employers (CARE) grants.

(a) General rule.--A Continuing Access with Relief for Employers (CARE) grant shall be provided to employers that meet the requirements of this section.

(b) Eligibility.--An employer is eligible to receive a CARE grant if that employer meets the following:

(1) has maintained coverage for at least 12 consecutive months prior to the effective date of this act; or

(2) (i) has maintained coverage for at least 12 consecutive months prior to applying for the CARE grant;

(ii) has incurred a health care expense in this Commonwealth; and

(iii) has a tax liability for the year in which application is made for the CARE grant.

(c) Application.--Beginning July 1, 2009, and for each year thereafter, an employer seeking to receive a CARE grant shall submit an application to the department containing, at a minimum, the following information:

(1) A statement of the aggregate health care expense made by the employer to provide coverage during the previous 12 consecutive months to employees.

(2) The names, addresses and Social Security numbers of the employees provided health care coverage under paragraph

(1) and whether that health care coverage is for the employee or the employee and the employee's spouse and/or dependents.

(3) The names and addresses of the insurance carriers or underwriters that received payment from the employer for the health care coverage provided under paragraph (2).

(d) Computation.--An employer who qualifies under subsection (b) shall receive a grant limited to actual employer health care expenses paid for the previous 12 consecutive months in accordance with the following:

(1) No greater than 25% of the employer's health care expense to maintain health care coverage for the employee.

(2) No greater than 50% of the employer's health care expense to maintain health care coverage for the employee, the employee's spouse and/or dependents.

(3) The total amount of paragraphs (1) and (2) shall not exceed the tax liability owed by the employer for the year application is made for the CARE grant.

(4) If no tax liability is owed by the employer then the employer may not apply for a CARE grant.

(e) Duties of department.--The department has the following duties:

(1) Administer the program.

(2) In consultation with other appropriate Commonwealth agencies:

(i) Develop an application for the collection of information that is consistent with the requirements of this section and that contains any other information that may be necessary to award CARE grants.

(ii) Develop a process to determine the validity of information collected by the department from the

application with information filed by the employer, the employee or insurers with any other agency. This process shall include guaranteeing confidentiality of employer and employee information that is consistent with Federal and State laws.

(f) Coordination.--The department shall coordinate with other departments in the implementation of this section.

(g) Limitation on grants.--The total amount of grants approved by the department shall not exceed the amount of funding designated under section 762. Any application filed by an employer when funding is not available shall not be considered and cannot be carried forward for consideration in any succeeding fiscal year.

(h) Lapse.--Funds not used by the department for CARE grants at the end of the fiscal year shall lapse back to the Health Care Provider Retention Account and be designated to the PA ABC Program.

(i) Report to General Assembly.--The department shall submit an annual report to the General Assembly indicating the effectiveness of the program provided under this section no later than March 15, 2010. The report shall include the names of all the employers that received a CARE grant as of the date of the report and the amount of each CARE grant approved. The report may also include any recommendations for changes in the calculation or administration of the CARE grant.

(j) Sunset.--This section shall sunset January 1, 2018.

(k) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"CARE grant." A Continuing Access with Relief for Employers

(CARE) grant provided by the Department of Community and Economic Development.

"Coverage." Health care coverage that is maintained by an employer for an employee, the employee's spouse and/or dependents for 12 consecutive months.

"Department." The Department of Community and Economic Development of the Commonwealth.

"Employee." An individual who meets the following:

(1) 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.

(2) Is at least 19 years of age but no older than 64 years of age.

(3) Legally resides within the United States.

(4) Has been domiciled in this Commonwealth for at least 90 days prior to enrollment.

(5) Has a household income that is no greater than 300% of the Federal poverty level at the time of application.

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

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

(2) Pays an average annual wage that is not greater than 300% of the Federal poverty limit for an individual.

"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 care expense." A payment made by an employer to

maintain health care coverage for an employee, the employee's spouse and/or dependents.

"Program." The Continuing Access with Relief for Employers (CARE) Grant Program established under this section.

"Tax liability." Liability under Article III, IV or VI of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

Section 12. 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 13. The amendment of section 712(e) of the act shall apply retroactively to December 31, 2007.

Section 14. This act shall take effect as follows:

(1) The following provisions shall take effect July 1, 2008, or immediately, whichever is later:

(i) The amendment of section 712(e) and (m) of the act.

(ii) The amendment of the definition of "health care provider" in section 1101 of the act.

(iii) The amendment of section 1112 of the act.

(iv) Section 12 of this act.

(2) The remainder of this act shall take effect upon publication of the notice specified under section 12 of this act.