COMMONWEALTH OF PENNSYLVANIA

LEGISLATIVE JOURNAL

WEDNESDAY, MARCH 12, 2008

SESSION OF 2008 192D OF THE GENERAL ASSEMBLY No. 19

HOUSE OF REPRESENTATIVES

The House convened at 9 a.m., e.d.t.

THE SPEAKER (DENNIS M. O'BRIEN) PRESIDING

PRAYER

The SPEAKER. The prayer will be offered by the Reverend Alexander Masluk, guest of the Speaker, from St. Martha Parish in northeast Philadelphia.

REV. ALEXANDER MASLUK, Guest Chaplain of the House of Representatives, offered the following prayer:

Let us remember the holy presence of God and adore His divine majesty:

Blessed are You, Lord God of all creation. All times and seasons are of Your making. All creation is subject to Your eternal and immutable law.

You alone are the source of all wisdom and all authority. As the earth prepares to embrace the spring, the season of new life and renewal of faith, a season of new beginnings and deepened hope, the season where Your providence and love are remembered and celebrated, we ask You to bless those entrusted with the responsibility to legislate and govern.

Fill them with Your all-embracing wisdom that they might respect the dignity of every person from the first moment of their being. Provide the good things to which all are entitled, and fashion a society which proclaims Your divine justice. Allow them to hear Your gentle voice in the depths of their hearts so that all their deliberations may be guided not by political expediency and polls nor the expectation of accolades or reelection, but by Your loving will for all people as expressed in Your holy Word.

As these servants of the people work ardently for true justice, may they be a sign of Your command that every burden should be lifted and every obstacle to true peace be removed until at last we all gather in the kingdom of Your glory, where You live and reign forever and ever. Amen.

PLEDGE OF ALLEGIANCE

(The Pledge of Allegiance was recited by members and visitors.)

STATEMENT BY SPEAKER

The SPEAKER. The Chair would like to thank Father Masluk for his spiritual message today and also recognize that he is the brother-in-law of the late Tom McCormac, Republican staffer, and Kathy McCormac, who is currently on the Republican staff.

Father, thank you very much.

The House will be at ease.

Members will report promptly to the floor. The House will be at ease.

The House will come to order.

JOURNAL APPROVAL POSTPONED

The SPEAKER. Without objection, approval of the Journal of Tuesday, March 11, 2008, will be postponed until printed. The Chair hears no objection.

LEAVES OF ABSENCE

The SPEAKER. The Chair turns to requests for leaves of absence.

The Chair recognizes the majority whip, who requests that Representative SHAPIRO from Montgomery County, Representative SIPTROTH from Monroe County, and Representative GERBER from Montgomery County be placed on leave for today. The Chair sees no objection. The leaves will be granted.

The Chair recognizes the minority whip, who requests that Representative ADOLPH from Delaware County and Representative TRUE of Lancaster County be placed on leave for the day. The Chair sees no objection. These leaves will be granted.

Members will report to the floor.

MASTER ROLL CALL

The SPEAKER. The Chair is about to take the master roll. Members will proceed to vote.

(Members proceeded to vote.)

LEAVE OF ABSENCE

The SPEAKER. The Chair returns to requests for leaves of absence.

The Chair recognizes the minority whip, who requests that Representative MARSICO be placed on leave. The Chair sees no objection. The leave will be granted.

MASTER ROLL CALL CONTINUED

The following roll call was recorded:

PRESENT–195

Argall	Freeman	Mantz	Rock
Baker	Gabig	Markosek	Roebuck
Barrar	Galloway	Marshall	Rohrer
Bastian	Geist	McCall	Ross
Bear	George	McGeehan	Rubley
Belfanti	Gergely	McI. Smith	Sabatina
Benninghoff	Gibbons	McIlhattan	Sainato
Bennington	Gillespie	Melio	Samuelson
Beyer	Gingrich	Mensch	Santoni
Biancucci	Godshall	Metcalfe	Saylor
Bishop	Goodman	Micozzie	Scavello
Blackwell	Grell	Millard	Schroder
Boback	Grucela	Miller	Seip
Boyd	Haluska	Milne	Shimkus
Brennan	Hanna	Moul	Smith, K.
Brooks	Harhai	Moyer	Smith, M.
Buxton	Harhart	Mundy	Smith, S.
Caltagirone	Harkins	Murt	Solobay
Cappelli	Harper	Mustio	Sonney
Carroll	Harris	Myers	Staback
Casorio	Helm	Nailor	Stairs
Causer	Hennessey	Nickol	Steil
Civera	Hess	O'Brien, M.	Stern
Clymer	Hickernell	O'Neill	Stevenson
Cohen	Hornaman	Oliver	Sturla
Conklin	Hutchinson	Pallone	Surra
Costa	James	Parker	Swanger
Cox	Josephs	Pashinski	Tangretti
Creighton	Kauffman	Payne	Taylor, R.
Cruz	Keller, M.	Payton	Thomas
Curry	Keller, W.	Peifer	Turzai
Cutler	Kenney	Perry	Vereb
Daley	Kessler	Perzel	Vitali
Dally	Killion	Petrarca	Vulakovich
DeLuca	King	Petri	Wagner
Denlinger	Kirkland	Petrone	Walko
DePasquale	Kortz	Phillips	Wansacz
Dermody	Kotik	Pickett	Waters
DeWeese	Kula	Preston	Watson
DiGirolamo	Leach	Pyle	Wheatley
Donatucci	Lentz	Quigley	White
Eachus	Levdansky	Quinn	Williams
Ellis	Longietti	Ramaley	Wojnaroski
Evans, D.	Mackereth	Rapp	Yewcic
Evans, J.	Maher	Raymond	Youngblood
Everett	Mahoney	Readshaw	Yudichak
Fabrizio	Major	Reed	
Fairchild	Manderino	Reichley	O'Brien, D.,
Fleck	Mann	Roae	Speaker
Frankel			

ADDITIONS–0

NOT VOTING–0

EXCUSED–8

Adolph	Hershey	Shapiro	Taylor, J.
Gerber	Marsico	Siptroth	True

LEAVES ADDED–7

Cappelli	Milne	Rubley	True
Lentz	Perzel	Tangretti	

LEAVES CANCELED–4

Gerber	Shapiro	Siptroth	True

The SPEAKER. A quorum being present, the House will proceed to conduct business.

HOUSE RESOLUTION INTRODUCED AND REFERRED

No. 631 By Representatives PALLONE, SOLOBAY, CASORIO, BELFANTI, BIANCUCCI, BRENNAN, DALEY, DENLINGER, DePASQUALE, EVERETT, FAIRCHILD, GEORGE, GINGRICH, GOODMAN, GRUCELA, HARHAI, HORNAMAN, KILLION, KING, KORTZ, KOTIK, LENTZ, LONGIETTI, MAHONEY, MARKOSEK, McCALL, McGEEHAN, McILVAINE SMITH, MICOZZIE, PAYNE, PETRARCA, PHILLIPS, RAMALEY, READSHAW, ROAE, RUBLEY, SAINATO, SIPTROTH, STABACK, WALKO, WOJNAROSKI, YOUNGBLOOD, YUDICHAK, MOYER, LEACH, MYERS, J. WHITE, SWANGER, R. STEVENSON, PETRONE, BOBACK, HARHART, K. SMITH, CONKLIN, VULAKOVICH, GIBBONS, FREEMAN and BROOKS

A Resolution memorializing the Congress of the United States to provide adequate funding to the nation's volunteer fire departments in the 2009 Federal Budget.

Referred to Committee on INTERGOVERNMENTAL AFFAIRS, March 12, 2008.

HOUSE BILLS INTRODUCED AND REFERRED

No. 2250 By Representatives LEVDANSKY, R. TAYLOR, CAPPELLI, SEIP, NICKOL, SANTONI, REED, FRANKEL, BOYD, STURLA, MANN, BELFANTI, CALTAGIRONE, DeLUCA, DePASQUALE, GEIST, HARHAI, HARKINS, HENNESSEY, HUTCHINSON, LONGIETTI, MARKOSEK, MUSTIO, PETRARCA, RAMALEY, READSHAW, REICHLEY, RUBLEY, SIPTROTH, SURRA, THOMAS, WALKO, YUDICHAK, YOUNGBLOOD, LEACH, GRUCELA, MYERS, McCALL, FREEMAN, HARPER and MOYER

An Act amending the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, further providing for the carryover of the research and development tax credit; and increasing the annual limitation on credits.

Referred to Committee on FINANCE, March 12, 2008.

No. 2347 By Representatives KESSLER, HANNA, SAYLOR, SHAPIRO, BELFANTI, BENNINGTON, BISHOP, BRENNAN, CALTAGIRONE, CLYMER, CREIGHTON, D. EVANS, EVERETT, FAIRCHILD, FRANKEL, FREEMAN, GALLOWAY, GEORGE, GOODMAN, HARHAI, HENNESSEY, JOSEPHS, KULA, LEACH, MAHONEY, MANDERINO, MANTZ, MARSHALL, McCALL, McILHATTAN, McILVAINE SMITH, MELIO, MOYER, MYERS, M. O'BRIEN, PETRONE, PRESTON, ROSS, SAMUELSON, SCHRODER, SEIP, SIPTROTH, K. SMITH, STURLA, J. TAYLOR, VITALI, WANSACZ, YOUNGBLOOD and FLECK

An Act amending Title 3 (Agriculture) of the Pennsylvania Consolidated Statutes, providing for an organic farming transition program; and establishing the Organic Agriculture Development Fund.

Referred to Committee on AGRICULTURE AND RURAL AFFAIRS, March 12, 2008.

No. 2348 By Representatives EACHUS, DeLUCA, CARROLL, COHEN, COSTA, CURRY, DePASQUALE, DERMODY, DeWEESE, D. EVANS, FRANKEL, KORTZ, KOTIK, KULA, MANDERINO, McCALL, MUNDY, PARKER, PASHINSKI, SIPTROTH, SURRA, WHEATLEY and YUDICHAK

An Act amending the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, further providing for medical professional liability insurance, for the Medical Care Availability and Reduction of Error Fund and for actuarial data; establishing the Pennsylvania Access to Basic Care (PA ABC) Program Fund and 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; establishing the Pennsylvania Access to Basic Care (PA ABC) Program; providing for Continuing Access with Relief for Employers (CARE) Grants, 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.

Referred to Committee on INSURANCE, March 12, 2008.

No. 2349 By Representatives METCALFE, BOYD, CLYMER, CREIGHTON, EVERETT, FLECK, GRELL, HUTCHINSON, KORTZ, MANTZ, MENSCH, PICKETT, PYLE, RAPP, R. STEVENSON, SWANGER and TURZAI

An Act amending the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law, further providing for employers' reserve accounts.

Referred to Committee on LABOR RELATIONS, March 12, 2008.

SENATE BILLS FOR CONCURRENCE

The clerk of the Senate, being introduced, presented the following bills for concurrence:

SB 483, PN 1611

Referred to Committee on COMMERCE, March 12, 2008.

SB 484, PN 1750

Referred to Committee on COMMERCE, March 12, 2008.

SB 485, PN 1751

Referred to Committee on COMMERCE, March 12, 2008.

SB 486, PN 1752

Referred to Committee on COMMERCE, March 12, 2008.

SB 487, PN 1753

Referred to Committee on COMMERCE, March 12, 2008.

SB 488, PN 1754

Referred to Committee on COMMERCE, March 12, 2008.

BILL REPORTED FROM COMMITTEE, CONSIDERED FIRST TIME, AND TABLED

HB 2302, PN 3404 (Amended) By Rep. TANGRETTI

An Act providing for assistance to agencies promoting tourism; authorizing the Department of Community and Economic Development to make grants and provide assistance to properly designated tourism promotion agencies and regional marketing partnerships; conferring powers and imposing duties on the governing bodies of certain political subdivisions; and repealing the Tourist Promotion Law.

TOURISM AND RECREATIONAL DEVELOPMENT.

SENATE MESSAGE

HOUSE BILL
CONCURRED IN BY SENATE

The clerk of the Senate, being introduced, returned **HB 363, PN 427,** with information that the Senate has passed the same without amendment.

BILL SIGNED BY SPEAKER

Bill numbered and entitled as follows having been prepared for presentation to the Governor, and the same being correct, the title was publicly read as follows:

HB 363, PN 427

An Act designating the bridge carrying State Route 30 over Main Street in North Huntingdon Township, Westmoreland County, as the Veterans Bridge.

Whereupon, the Speaker, in the presence of the House, signed the same.

GUESTS INTRODUCED

The SPEAKER. The Chair would like to welcome to the floor of the House, as the guests of Representative Mike Gerber, Representative Tom Murt, Representative Josh Shapiro, and Representative Rick Taylor, the students of Upper Dublin High School. They are in the balcony. Would you please stand and be recognized.

The House will be at ease.

The Chair would like to welcome to the floor of the House, as the guest of the Bucks County delegation, a good friend of the Speaker, Commissioner Jim Cawley from Bucks County. Would you please stand and be recognized.

STATEMENT BY MINORITY LEADER

The SPEAKER. For what purpose does the minority leader, Representative Smith, rise?

Mr. S. SMITH. Mr. Speaker, when we adjourned last evening, I had made a request of the majority leader as to whether or not we could have a caucus on the amendment that was part of this debate, or— I know there is no bill before us. But anyway, I had asked for a caucus, Mr. Speaker. Off the record I was told that the House Republicans could caucus at 8:30 this morning and that we would begin promptly at 9 o'clock.

Mr. Speaker, our caucus did as best we could, as many members could get there at 8:30 – we were there. I was on the floor, Mr. Speaker, at 9 o'clock, and I would like to note for the record, Mr. Speaker, that the majority leader showed up at 9:30.

Now, Mr. Speaker, if he wants to waste his time, that is his business, but I do not really appreciate him wasting our time. We are here, Mr. Speaker, to get things done, and if the majority leader wants to continue to dilly-dally around – yeah, yeah, and you guys know it, too; and you guys know it, too. Tell me you like the direction this place is going.

So, Mr. Speaker, quite frankly, quite honestly, Mr. Speaker, I would like to ask the majority leader if he would answer my question about whether the Republicans are going to have the 2 hours to caucus on this bill that their caucus spent yesterday, when they knew what was in the amendment before we did. Are we going to be afforded a chance to fully caucus on this?

The SPEAKER. The Chair recognizes the majority leader, Representative DeWeese.

Mr. DeWEESE. Mr. Speaker, I would like to call up SB 1137 and proceed with the votes.

CALENDAR

BILLS ON SECOND CONSIDERATION

The House proceeded to second consideration of **SB 1137, PN 1621,** entitled:

An Act amending the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, further providing for medical professional liability insurance, for the Medical Care Availability and Reduction of Error Fund and for actuarial data; providing for the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund; further providing for abatement program, for the Health Care Provider Retention Account and for expiration; and providing for expiration of certain sections.

On the question recurring,

Will the House agree to the bill on second consideration?

The SPEAKER. When we broke yesterday, for the information of the members, we were on the Perry amendment.

On the question recurring,

Will the House agree to the amendment?

The clerk read the following amendment No. **A04850:**

Amend Title, page 1, lines 19 and 20, by striking out "FOR PENNSYLVANIANS (MCAP) Reserve Fund" and inserting
and Reduction of Error (Mcare) Reserve Account

Amend Sec. 2, page 17, lines 13 through 30; page 18, lines 1 through 8, by striking out all of said lines on said pages and inserting

SUBCHAPTER E
MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR
(MCARE) RESERVE ACCOUNT

Section 751. Establishment.

There is established within the Medical Care Availability and Reduction of Error (Mcare) Fund a special account to be known as the Medical Care Availability and Reduction of Error (Mcare) Reserve Account.

Section 752. Purpose.

Money in the Medical Care Availability and Reduction of Error (Mcare) Reserve Account shall remain in the account for the sole purpose of reducing the unfunded liability of the fund.

Amend Sec. 4 (Sec. 1112), page 20, lines 7 through 15, by striking out all of said lines and inserting

(c.1) Transfers to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.–If the Secretary of the Budget makes a transfer from the account under subsection (c), the remaining funds in the account shall be transferred to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund. If the Secretary of the Budget does not make a transfer from the account under subsection (c), all of the funds in the account shall be transferred to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund

On the question recurring,

Will the House agree to the amendment?

The SPEAKER. The Chair recalls that the gentleman, Representative Perry, was on the floor being recognized for a second time. The Chair will return to Representative Perry for his remarks.

Mr. PERRY. Thank you, Mr. Speaker.

Just a point of clarification.

So if I am being recognized for my second time, does this mean that there are no other members that wish to speak on behalf – for or against – this amendment?

The SPEAKER. The Chair will ask the membership. It is the courtesy of the House to ask all members if they wish to speak on the Perry amendment before the Chair recognizes the prime sponsor. Is there anyone else seeking recognition?

Representative Perry.

Mr. PERRY. Thank you, Mr. Speaker.

Mr. Speaker, what I have in my hand basically is a bill, a bill that the taxpayers of the Commonwealth will have to pay, anywhere from $1.8 to $2.3 billion. We do not know exactly how much right now. It is called the unfunded liability.

Right now we have $504 million in an account to pay for that, a portion of that unfunded liability, a portion of that bill

that is sitting in the bills-payable box of our household, so to speak. Meanwhile, in our checking account, we have $504 million – we could help to pay for that. But instead what we are talking about here is spending that money on some new programs, while that $504 million is gone and we still have that $1.8 to $2.3 billion bill. Who runs their house that way? Who digs a hole and then says the way to fill the hole up is by digging it deeper? None of us do that. This is insanity, number one.

Number two, again, people do not have any faith in the government because we keep lying to them. This bill is, in part, paid for by the CAT Fund (Catastrophic Loss Trust Fund), the auto CAT Fund. If anybody has ever received a moving violation, they know what that is. It is a fund, and it was originally meant to pay for people that had a catastrophic loss. That liability has been paid a long time ago, yet we still collect the money. And at some point we said we are going to pay for this Mcare (Medical Care Availability and Reduction of Error Act) Fund. We shifted what we told the people they were paying their bill for, and now we are going to shift it again. We are not going to pay the bill; we are going to create a bunch of new programs, and we are going to owe $1.8 to $2.3 billion.

Now, we have been told in the House here that this omnibus amendment, A6103, is going to solve that problem. Mr. Speaker, I got a copy of the notes from that amendment. It does not solve the problem; it does not do anything. We lose $504 million and owe $2.3 billion – a brilliant strategy for success here in Pennsylvania.

Please, Mr. Speaker, do the right thing. Do not put this on the taxpayers. They have already paid plenty. They have already paid over and over again for this. Let us pay our bills. If we want new programs, let us let those new programs stand on their own merit.

I urge passage of this amendment. Thank you, Mr. Speaker.

The SPEAKER. Will the House agree to the amendment? Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

I rise to oppose amendment No. 4850.

Mr. Speaker, as I said yesterday at the beginning of our discussion, the focus today is about finding solutions to cover Pennsylvanians who are uninsured. The amendment offered helps cover no additional people. As a matter of fact, it does not help to cover the 4400 people in Perry County who are currently on the adultBasic waiting list, and for that reason, I ask that we oppose the amendment.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–95

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Millard	Reichley
Bear	Gingrich	Miller	Roae
Benninghoff	Godshall	Milne	Rock
Beyer	Grell	Moul	Rohrer
Boback	Harhart	Moyer	Ross
Boyd	Harper	Murt	Rubley
Brooks	Harris	Mustio	Saylor
Cappelli	Helm	Nailor	Scavello
Causer	Hennessey	Nickol	Schroder
Civera	Hess	O'Neill	Smith, S.
Clymer	Hickernell	Pallone	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	Turzai
Ellis	Maher	Pickett	Vereb
Evans, J.	Major	Pyle	Vulakovich
Everett	Mantz	Quigley	Watson
Fairchild	Marshall	Quinn	

NAYS–100

Belfanti	Galloway	Mann	Shimkus
Bennington	George	Markosek	Smith, K.
Biancucci	Gergely	McCall	Smith, M.
Bishop	Gibbons	McGeehan	Solobay
Blackwell	Goodman	McI. Smith	Staback
Brennan	Grucela	Melio	Sturla
Buxton	Haluska	Micozzie	Surra
Caltagirone	Hanna	Mundy	Tangretti
Carroll	Harhai	Myers	Taylor, R.
Casorio	Harkins	O'Brien, M.	Thomas
Cohen	Hornaman	Oliver	Vitali
Conklin	James	Parker	Wagner
Costa	Josephs	Pashinski	Walko
Cruz	Keller, W.	Payton	Wansacz
Curry	Kessler	Petrarca	Waters
Daley	King	Petrone	Wheatley
DeLuca	Kirkland	Preston	White
DePasquale	Kortz	Ramaley	Williams
Dermody	Kotik	Readshaw	Wojnaroski
DeWeese	Kula	Roebuck	Yewcic
Donatucci	Leach	Sabatina	Youngblood
Eachus	Lentz	Sainato	Yudichak
Evans, D.	Levdansky	Samuelson	
Fabrizio	Longietti	Santoni	O'Brien, D., Speaker
Frankel	Mahoney	Seip	
Freeman	Manderino		

NOT VOTING–0

EXCUSED–8

Adolph	Hershey	Shapiro	Taylor, J.
Gerber	Marsico	Siptroth	True

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **REED** offered the following amendment No. **A04861:**

Amend Sec. 3, page 18, lines 18 and 19, by striking out "AND 2007" and inserting

[and], 2007 and 2008

Amend Sec. 7, page 20, line 30; page 21, lines 1 through 9, by striking out all of said lines on said pages

Amend Sec. 8, page 21, line 10, by striking out "8" and inserting

7

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Reed on the amendment.

Mr. REED. Thank you, Mr. Speaker.

This amendment would, quite simply, extend the Mcare abatement through the year 2008.

The SPEAKER. Will the House agree to the amendment? Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support the amendment offered by the gentleman from Indiana County. I believe it is a good amendment, and I would like to point out the fact that what transpired earlier, actually not this year but late last year, was something that I think members on both sides of the aisle have agreed was a problem, and that is the fact that we connected the Mcare issue and the extension of the abatement to the situation with the costs of health care in the Commonwealth.

That decision was actually made unilaterally by the administration. It was done in a fashion without any legislative input. And in fact, by coupling those two issues, many of us have used the term "put a gun to the head" of the physicians – that if they did not get behind and support the Governor's proposal for CAP (Cover All Pennsylvanians) and his entire health-care package that, in fact, he would eliminate their abatement of the Mcare assessments on doctors.

This amendment that is being proposed by the Representative from Indiana County takes that gun and puts it back in its holster. It says that these are two separate issues, and they should be dealt with in two separate fashions. It provides us the time to extend the abatement for physicians, keep those doctors practicing in Pennsylvania, fulfilling a commitment that this body made to them many years ago, and it also then would give us the time in a sane and a civil fashion to dialogue and actually work together to try and develop a bipartisan solution to the issue of the costs of health care.

We have made strides in trying to work together. Unfortunately, this false and erroneous deadline that the administration put out there of March 31 that has nothing to do with any sense of trying to solve this problem, that pressure that that has created – I think everybody has seen the tension that is in this body, even as of last night – would be eliminated by adopting the Reed amendment.

So, Mr. Speaker, I would just ask that you would consider to support the Reed amendment. It is the right thing to do. It is the right thing to keep doctors practicing in Pennsylvania. It is the right thing to do to keep our physicians and attract new physicians to Pennsylvania, and it is the right thing to do to take the pressure off of this false deadline that was created by the Governor putting a gun to the head of our physicians.

Frankly, Mr. Speaker, I do not believe that blackmail is the proper way to do government. I believe that we should have a civil dialogue about the situation, and we need to remove the gun from the head of the physicians.

Please support the Reed amendment. Thank you, Mr. Speaker.

The SPEAKER. Will the House agree to the amendment? On the question— Representative Eachus.

Representative Killion.

Mr. KILLION. Thank you, Mr. Speaker.

I rise to support the Reed amendment. And I just want to caution to those on the other side of the aisle or those on maybe even my side of the aisle that are contemplating voting later today on the gut-and-replace amendment, that this is the only amendment, this and some others that are going to be offered that may go away a little later, but these are the only amendments that will guarantee that our doctors get their Mcare abatement.

Anyone who thinks that gut-and-replace amendment that we will see later will ever become law is kidding themselves. They are giving themselves some cover so they can go home and say that they extended Mcare for their docs, and that is false. That will never become law. The only way we are going to keep our doctors in Pennsylvania and extend the Mcare abatement for our doctors and our hospitals is to pass the Reed amendment.

Vote "yes" on the Reed amendment. Thank you, Mr. Speaker.

The SPEAKER. Representative Scavello.

Mr. SCAVELLO. Thank you, Mr. Speaker.

I rise to support the Reed amendment. And from my standpoint – from a growing county where my population pretty much doubled in the last 15 years – the need to bring doctors to the Commonwealth, the need to keep doctors in the Commonwealth, especially in Monroe County, the Reed amendment will go a long way in helping us do that, and I urge the members to support the amendment. Thank you.

The SPEAKER. Representative Denlinger.

Mr. DENLINGER. Thank you, Mr. Speaker.

Would the maker of the amendment stand for brief interrogation?

The SPEAKER. Representative Reed indicates that he will stand for interrogation. The gentleman is in order and may proceed.

Mr. DENLINGER. Thank you, Mr. Speaker.

I am wondering if the maker would share with me his basic purpose in coming forward with this amendment, which I think is critically needed. What motivated you to come forward with this amendment?

Mr. REED. Thank you, Mr. Speaker.

I think in the end, when you look at the debate that we have held on the health-care issue for a little over a year now, many of us agree about the need to find a solution to folks across the Commonwealth who are unable to afford health-care coverage. And although we may disagree on the means of accomplishing that goal, I think we all do agree that that is a goal that we should be focused on, both within the Commonwealth of Pennsylvania and also across the nation.

So as we continue to debate that issue and find a way to make health care more affordable, we must also ensure that folks who do have health-care coverage and the folks that we do add to the health-care rolls will continue to have access to top-quality doctors right here within the Commonwealth. And what we do not need to do is to hold hostage our medical community while we try to debate the merits of a plan to cover the uninsured across the Commonwealth.

So this amendment, quite simply, would extend the Mcare abatement for an additional year to give us the time to work out a plan to cover uninsured Pennsylvanians in a reasonable manner that both our taxpayers can afford and will allow our medical community to continue to operate within this Commonwealth, so that when we do find a solution to our health-care dilemma, there will still be doctors within the Commonwealth to serve our citizens.

Mr. DENLINGER. So would it be fair to say that your feeling is that if your amendment does not go in, we could see a

real drop in access to quality medical care all across Pennsylvania?

Mr. REED. Well, I think the key is that what we do not want to do is get into a game of chicken with the medical community and see doctors leave in a great mass exodus of this State because they are fearful of being held hostage and seeing their premiums continue to rise and not being able to operate and serve their patients within the Commonwealth.

So this amendment, once again, it takes the gun away from their heads. It allows everybody to have a cooling-down period. We can engage in the debate that we need to engage in with the health-care issue within the Commonwealth without worrying about driving our doctors out of the State while we engage within that debate.

Mr. DENLINGER. Very good.

If I may speak on the amendment, Mr. Speaker?

The SPEAKER. The gentleman in order and may proceed.

Mr. DENLINGER. Thank you.

I believe that the maker—

The SPEAKER. If the Chair can request that the gentleman speak closer to the microphone. We are having difficulty hearing the speaker.

Mr. DENLINGER. Yes, sir. Will do.

I think the gentleman makes an excellent point, the maker of the amendment, as did the gentleman from Delaware County.

Ultimately, we do not want to have our docs become pawns in a battle over health care in Pennsylvania. The Mcare extension is critical. This amendment is critical. We do not want to see our doctors become part of the political tug-of-war between the Republican side of the aisle and the Democratic side. And we know that when this initiative, this health-care initiative of the Governor, moves over to the Senate side, it is by no means assured for passage.

And so for all the members here in the House, we do need to think carefully about the Reed amendment, because it is the only way to guarantee that Mcare abatement for all of our docs who are out there. So if you have doctors in your home community, this is your opportunity to stand with them to make sure they get the abatement that they so critically need and not put them in the middle, not make them be pawns in this political tug-of-war.

Thank you, Mr. Speaker.

The SPEAKER. Representative Cutler.

Mr. CUTLER. Thank you, Mr. Speaker.

I would like to speak on the amendment, Mr. Speaker.

The SPEAKER. The gentleman is in order and may proceed.

Mr. CUTLER. As many of you might remember, as I have shared before here on the floor, previously I worked at a hospital, so I have quite a few physicians whom I had worked with in a professional capacity previously, and this is a very important issue to them. My inbox has been flooded with e-mails, my mailbox has been flooded with letters, and my phone has been ringing off the hook with regard to how important the Mcare abatement is.

And to put it frankly, the doctors are very upset. They are upset that they are being told that somehow the Mcare abatement is now part of the Cover All Pennsylvanians initiative, and here is the reason why: CAP has some good parts and it has some bad parts. I think we can all agree on that. However, the reality is, they are two separate issues. They are two separate issues that deserve to be debated separately and fully. And what is happening, currently, is we are being told that we have to accept the proposal before us in order to extend the Mcare abatement, and that is wrong.

Mr. Speaker, it will not matter who has insurance in this Commonwealth if we do not have doctors to provide the health care that we all need, and this is health care that we will need, it is health care that our constituents will need, and it is health care that our children will need. It is unfortunate, Mr. Speaker, that the doctors are being held hostage in this debate because the ideas cannot stand on their own merit. It is unfortunate, Mr. Speaker, that the ideas cannot be debated separately.

The reality is, we have had several medical malpractice crises in the State, and as I worked in the health-care field it became apparent, and it was this: The insurance companies do not necessarily make money on providing medical malpractice insurance. They make money on what is called the float. They take the premiums, they invest it in the stock market, and then they go forward, and that is where they make their money. Mr. Speaker, it is no coincidence that every previous medical practice crisis happened after a horrible year in the stock market.

Mr. Speaker, I encourage my colleagues, look at what happened to the S&P (Standard & Poor's), to the Dow, and to the NASDAQ (National Association of Securities Dealers Automated Quotations) just since the beginning of the year. These indices are down 10, 15, 20 percent. Individual stocks and companies are going bankrupt. Our economy is in shambles.

Mr. Speaker, financially we have some problems, and, Mr. Speaker, on the horizon, mark my words, there will be an increase in medical malpractice premiums again. There will be an increase to the doctors. And do you know what is going to happen? That big bill is going to come due, and we are not going to have any money left in the fund because we had to borrow it for a different idea that is completely unrelated. It is a travesty that we would rob from the doctors and rob from the patients who need the health care to fund a completely different program.

Mr. Speaker, I urge support of this amendment proffered by my honorable colleague, and, Mr. Speaker, I sincerely hope that everyone will remember the patients and the doctors back in their district when it comes time for this, because remember, without doctors, there is no health care, and it does not matter who is covered under what plan, because where will we go to find the care? Thank you.

LEAVE OF ABSENCE CANCELED

The SPEAKER. The Chair recognizes the presence of Representative Gerber on the floor. His name will be added to the master roll.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER. The Chair recognizes Representative Petri.

Mr. PETRI. Thank you, Mr. Speaker.

I rise to support Representative Reed's amendment that we have before us. You know, I entered the House in 2002, and at that time we had a severe medical malpractice crisis. Many have argued that it is over. I do not believe it is over. I believe that it is still as serious as it was the day I entered the House, even with all the improvements and initiatives we passed.

This amendment ensures that the Mcare abatement continues. During the summer, on a bipartisan basis, we held a hearing in Bucks County on the proposed CAP plan, and specifically what we learned was that the reimbursement rates are so low that most doctors will not sign up for the plan.

During a recent Appropriations Committee hearing I asked the question of the Insurance Commissioner and the Budget Secretary, as to whether or not there would be a tie to the CAP plan in order to ensure that doctors had to make a choice. And here is their choice, Mr. Speaker. Their choice is to accept the plan which will not allow them to even cover the cost of their nurse. Let me say that again for those of you who are talking over on the other side of the aisle: This choice that you are presenting the doctors with is to sign up for a plan that will not allow them to pay the cost of their nurses. So on the one hand, you are asking them to lose money, and on the other hand, you are asking them to not be able to practice in Pennsylvania if they do not accept the terms of this overall proposal.

It is not fair. It is not right. One of the previous speakers said something that I thought was very, very important. Good ideas stand on their own merit. That is right. A good idea does not need to be tied to another idea. It does not have to be a sword of Damocles.

What we are now trying to do is a major reversal in policy. And what we are saying to doctors is, you will not continue to get your abatement unless you sign up for this plan, you enroll everyone who wants to participate, you sign up for CHIP (Children's Health Insurance Program), you enroll everyone who wants to participate, you place no restrictions – understand, you can place no restrictions on the number of enrollees.

If you happen to be a doctor who gets 10,000 enrollees, you are going to accept those, and you are going to lose money. It is not fair to any business person to make them an indentured servant, and that is what we are trying to do.

Support the Reed amendment.

The SPEAKER. Representative Rohrer.

Mr. ROHRER. Thank you, Mr. Speaker.

Mr. Speaker, we are clearly entering into a debate here of significant consequence. There is no one in this building, I do not believe, who is not concerned about the ability of our citizens to obtain health care.

There are also very few, if any, who are not concerned that they are not able to access quality health care. But, Mr. Speaker, the way we are starting out in this entire debate is wrong. And the refusal, at this juncture, to consider the import of this simple amendment on whether or not our medical providers, who have been saddled with back-breaking medical premiums for which this program here, Mcare rebate program, was put into place in the first aspect, was to deal with them.

Even that, understand, Mr. Speaker, we never solved the problem. This is only a Band-Aid. But now the Governor and those who are wanting to implement this broad-sweeping new program are wanting to rip off the Band-Aid that, literally, is the only thing that is keeping many thousands of our medical providers in this State right now and telling them, we will do even more harm to you.

Mr. Speaker, I have in my district and in my county – as well as many of you here have – many, many medical providers. Our specialists and our others who are paying this high premium dollar to insure their practices –because we have not fixed the whole issue of tort – they are barely hanging on.

We have already lost, in this State, thousands of our docs that we desperately need. We are not able to attract our new ones. We cannot get young docs to come to Pennsylvania. And part of it is, we are not giving them enough reimbursement to live, and then we whack them on the other side through heavy premiums, and then the one thing that we had held out there as a little bit of a Band-Aid for them, the Governor and those who are supporting this plan we are talking about today are willing to yank it away from them. Mr. Speaker, it is very, very important that people who are watching understand that this has nothing to do, or little to do, with providing better health care or better coverage for the citizens of this State.

This has everything to do with enacting a program for which somebody can take claim that they have done well for more people. In fact, it is not. We lose our medical providers, which this will do – I know, I have had dozens of medical providers who are critical in the providing of quality health care in this Commonwealth, not just in my county of Berks, but others across the State who have said, if this does not continue, if this rebate does not continue for 2007 – which, frankly, is already overdue to them, this payment – if it does not happen, it will be the straw that breaks the camel's back. They will leave.

Then what are we going to stand here and do? We can come up with the best program in the world for health care, promise anything to everybody. But if there is nobody to provide the care, what makes the sense?

Mr. Speaker, this amendment deals with the issue at hand and an obligation that was made to our providers in years past and last year. It ought not even be involved in this discussion. It ought to be separate, because it is separate. This is a failure to keep a commitment. This is a failure by this Governor to fulfill a commitment, a financial necessity, and in fact, is choosing to use political coercion and blackmail to cause the entire industry to fall under a plan that, frankly, has yet to be proven that it can work. Mr. Speaker, this amendment is critical. This amendment is simple. It simply fulfills an obligation that has already been entered into. And if we are going to talk about today, stepping into offering new obligations to new people, we certainly cannot start by abrogating a preexisting obligation. This is an obligation we need to meet. This amendment should be supported.

Thank you, Mr. Speaker.

The SPEAKER. Is there anyone seeking recognition before the Chair recognizes the prime sponsor of the amendment? Representative Reed for the second time— Or Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

I rise to oppose amendment No. 4861, and let me be clear why I oppose this amendment: This amendment extends the Mcare abatement for only 1 year. The plan that we will vote on later extends the Mcare abatement for 10. So for that reason, the plan that we will vote on is superior, and I oppose the amendment.

The SPEAKER. The Chair apologizes. The Chair did not see Representative Rapp seeking recognition. The lady is in order and may proceed.

Ms. RAPP. Thank you, Mr. Speaker.

I rise to support the Reed amendment. I represent two rural hospitals, and many of my constituents are served by another hospital in Erie County, another rural hospital in the town of Corry, in another Representative's district.

Mcare abatement is vital to rural hospitals. Our rural hospitals have a difficult time recruiting doctors as it is. As previous speakers have stated, it makes no sense to have a new program using the Mcare abatement fund if there are no doctors there to provide the service. We in rural Pennsylvania have a difficult time now recruiting doctors to our area, as well as the urban areas of Pennsylvania.

I urge my colleagues to support the Reed amendment.

The SPEAKER. Representative Reed.

Mr. REED. Thank you very much, Mr. Speaker.

I understand the gentleman from Luzerne County when he says that later on today we will have the opportunity to vote for other amendments that may extend the Mcare abatement longer than the year 2008. But that should not preclude us from the opportunity right now to extend the Mcare abatement for 1 year to ensure that, at this point, that our doctors across the Commonwealth of Pennsylvania will know, that they will be secure in the knowledge, that the Mcare abatement will continue to exist for another year.

Instead of being at the whim of the Governor – who did extend the initial Mcare abatement this year by 90 days and does still have the ability to continue that extension – by voting in favor of this amendment, we are ensuring that the Mcare abatement will continue to roll on until the end of 2008.

Other amendments that may be considered today may pass, they may fail. Why not take the opportunity right now to continue this abatement to ensure that as we continue the debate on finding ways to, at a reasonable price, offer health-care coverage to our uninsured Pennsylvanians, that when they do obtain health-care coverage that they know that they will have a top-quality medical doctor within their community, so that they and their family will rest assured, if they need medical attention, that doctor will be there – right there in their community – to provide health-care services to them.

So I would encourage folks to support this amendment, and then we will take other amendments as they come about today. But support this amendment and extend the Mcare abatement for 1 additional year to make sure that our top-quality doctors are able to stay within this State.

Thank you, Mr. Speaker.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, earlier in the debate on this amendment there was a reference to a potential future extension of the Mcare abatement for a 10-year period of time being addressed in a subsequent amendment that will, ultimately, be considered by this House. I just would like to remind the members that I do not believe there has been any dialogue or any agreement with the Senate that they are going to adopt the substance of that future amendment and in fact, we will not have an extension of the Mcare abatement.

The original intention of SB 1137 was to deal with the Mcare issue. It is a Senate bill. We know that they are interested in extending the abatement for a period of time to try and deal with this issue in a comprehensive fashion. Mr. Speaker, we have no assurances that by voting this amendment down that, in fact, the future amendment, even if it does pass this chamber, is going to even see the light of day when it gets across this building. So it is a very, very risky move on behalf of these members to assume the risk that they are going to take care of physicians by adopting a future amendment that there is no agreement with the Senate to even be willing to consider.

So because of that, Mr. Speaker, I encourage the members to put up the prudent vote and the safe vote and adopt Reed amendment. Thank you.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–96

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	Turzai
Ellis	Maher	Pickett	Vereb
Evans, J.	Major	Pyle	Vulakovich
Everett	Mantz	Quigley	Watson
Fairchild	Marshall	Quinn	Yewcic

NAYS–98

Belfanti	Freeman	Longietti	Santoni
Bennington	Galloway	Mahoney	Seip
Biancucci	George	Manderino	Shimkus
Bishop	Gerber	Mann	Smith, K.
Blackwell	Gergely	Markosek	Smith, M.
Brennan	Gibbons	McCall	Solobay
Buxton	Goodman	McGeehan	Staback
Caltagirone	Grucela	McI. Smith	Surra
Carroll	Haluska	Melio	Tangretti
Casorio	Hanna	Mundy	Taylor, R.
Cohen	Harhai	Myers	Thomas
Conklin	Harkins	O'Brien, M.	Vitali
Costa	Hornaman	Oliver	Wagner
Cruz	James	Parker	Walko
Curry	Josephs	Pashinski	Wansacz
Daley	Keller, W.	Payton	Waters
DeLuca	Kessler	Petrarca	Wheatley
DePasquale	King	Petrone	White
Dermody	Kirkland	Preston	Williams
DeWeese	Kortz	Ramaley	Wojnaroski
Donatucci	Kotik	Readshaw	Youngblood
Eachus	Kula	Roebuck	Yudichak
Evans, D.	Leach	Sabatina	
Fabrizio	Lentz	Sainato	O'Brien, D.,
Frankel	Levdansky	Samuelson	Speaker

NOT VOTING–2

Pallone	Sturla

EXCUSED–7

Adolph	Marsico	Siptroth	True
Hershey	Shapiro	Taylor, J.	

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **REED** offered the following amendment No. **A04863:**

Amend Title, page 1, line 19, by striking out "FOR PENNSYLVANIANS (MCAP)" and inserting
and Reduction of Error (MCARE)
Amend Title, page 1, line 20, by inserting after "~~and~~"
and
Amend Title, page 1, lines 21 and 22, by striking out "expiration;" in line 21 and all of line 22 and inserting
expiration.
Amend Sec. 2, page 16, line 7, by striking out "A SUBCHAPTER" and inserting
subchapters
Amend Sec. 2, page 17, lines 13 through 30; page 18, lines 1 through 8, by striking out all of said lines on said pages and inserting

SUBCHAPTER E
MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR
(MCARE) RESERVE FUND

Section 751. Establishment.

There is established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.

Section 752. Allocation.

Money in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be allocated annually as follows:

(1) Fifty percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall remain in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund for the sole purpose of reducing the unfunded liability of the fund.

(2) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be transferred to the Patient Safety Trust Fund for use by the Department of Public Welfare for implementing section 407.

(3) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be transferred to the Medical Safety Automation Fund.

SUBCHAPTER F
MEDICAL SAFETY AUTOMATION FUND

Section 762. Medical Safety Automation Fund established.

There is established within the State Treasury a special fund to be known as the Medical Safety Automation Fund. No money in the Medical Safety Automation Fund shall be used until legislation is enacted for the purpose of providing medical safety automation system grants to health care providers under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, a group practice or a community-based health care provider.

Amend Sec. 3 (Sec. 1102), page 18, lines 18 and 19, by striking out "AND 2007" and inserting
[and], 2007 and 2008"
Amend Sec. 5 (Sec. 1115), page 20, line 26, by striking out "2011" and inserting
2009
Amend Sec. 7, page 20, line 30; page 21, lines 1 through 9, by striking out all of said lines on said pages
Amend Sec. 8, page 21, line 10, by striking out "8" and inserting
7

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Reed on the amendment.

Mr. REED. Thank you very much, Mr. Speaker.

To be short, this amendment would establish the Mcare Reserve Fund and allocate 50 percent of that fund to reduce unfunded medical liability, 25 percent of that fund to the Patient Safety Trust Fund, and another 25 percent to the Medical Safety Automation Fund.

The balance of the retention program would be used to pay down the unfunded liability. The retention program would expire in 2009, rather than 2011.

The SPEAKER. Will the House agree to the amendment?

Representative Eachus.

Mr. EACHUS. Mr. Speaker, I rise to oppose amendment 4863. Mr. Speaker, we have an amendment that deals with these concepts in a much more comprehensive and significant way. And that is why I rise to oppose the amendment.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Again, Mr. Speaker, I rise to support this Reed amendment. And I really do not want to be redundant, but I really do think it is important that we understand that the money that is in the Mcare Fund was put there and directed there by a specific tax that was passed by this General Assembly back, I believe it was in 2003, and it was put there to secure and maintain the physician retention program – to keep doctors practicing in Pennsylvania.

We have an unfunded liability. We have basically been taking that tax money and holding our own. We have been maintaining. We have not been paying down the unfunded liability. The amendment that the Representative from Luzerne County refers to, that talks about this in the future, is raiding that fund. It will take money away from that fund and direct it to new programs, untried programs, programs we have no idea whether or not they are going to be effective, and it is going to put at risk the solvency of the Mcare retention fund.

I do not believe that that is wise. I do not believe that that is prudent. More importantly, the tax revenue that is in that fund was put there specifically to retain physicians in Pennsylvania. This is really going back on a commitment and a promise that we made to the doctors in Pennsylvania many years ago and the patients of Pennsylvania.

We stood on the Capitol steps. We did this in a bipartisan fashion to say it is imperative that people have access to health care. This vote is actually limiting access to health care. This is going to, in effect, say to the people of Pennsylvania, we do not really care if there are doctors practicing in Pennsylvania.

You are going to be putting them at risk by the future hope that in some dreamworld that the Senate is actually going to take up the substance of a future amendment. Mr. Speaker, that is a risk that I do not believe that this body should take. And it is a risk that I do not believe is prudent for us to put the people of Pennsylvania into.

The Reed amendment goes even further than his last amendment. It securitizes, it documents, puts into statute, protecting the physicians of Pennsylvania from rampant lawsuit abuse. It is absolutely essential that we not go back on that commitment.

What kind of a statement does that make to people when we make a promise in 2003 and in 2008, we go, whoops, we changed our minds. That is the exact kind of governance that has put our State, really put our State back, and has put at risk the physicians of Pennsylvania.

Mr. Speaker, I highly encourage a "yes" vote on the Reed amendment.

The SPEAKER. Representative Killion.

Mr. KILLION. Thank you, Mr. Speaker.

I would also— I do not want to be redundant either, but I just feel the need to rise to support this Reed amendment. The gentleman from Luzerne County stated that they have a better amendment a little later, so obviously this is good, they feel they have a better amendment. But I think when they say that – I think we are going to hear that a lot today, that later today they will have a better amendment – I think they need to be honest. They should change and say we have a better amendment that will never become law.

Because that is the fact. Their amendment will not become law. If we want to do what we need to do to help the doctors in Pennsylvania, to keep them here in Pennsylvania, to take care of our kids, to take care of our grandchildren, we need to pass amendments like this, real amendments that can become law so that we can extend the Mcare abatement and uncouple it from CAP. It is just horribly wrong to put those two issues together. Let us separate them. Let us pass the Reed amendment.

Thank you, Mr. Speaker.

The SPEAKER. Representative Scavello.

Mr. SCAVELLO. Thank you, Mr. Speaker.

I rise, again, in support of the Reed amendment. And also without being redundant, I just want to echo the comments of the gentleman from Lancaster.

In regard to the— When we collect dollars for a specific purpose to help our doctors and we put the dollars away, it was a promise that we made to the doctors and to the citizens of our Commonwealth, that we would take care of them. And now here, all of a sudden, we are going to take those dollars and we are going to use them for something else. You know, it is almost like gas tax dollars, Mr. Speaker. We collect gas tax dollars for a specific purpose and we start funneling those dollars to other programs and then we do not have the money to fix our roads.

We are going to create the same problem here if we do not support this amendment. We are not going to have the dollars to take care of our doctors and to take care of the citizens of Pennsylvania that need it the most. Again, I rise to support the amendment. I urge all the members to support the amendment. Thank you, Mr. Speaker.

The SPEAKER. Is there any member seeking recognition on the amendment?

Representative Reed, for the second time.

Mr. REED. Thank you very much, Mr. Speaker.

I rise, obviously, in support of this amendment. And this amendment, in short, what it does is takes SB 1137 back to the original version of the bill that passed the Senate in a very bipartisan fashion with the vote of 44 to 2 this past fall. In the end, what we have are two separate problems that this body needs to take care of.

Number one is taking care of ensuring that our doctors are able to continue to operate and perform surgeries within this Commonwealth by extending the Mcare abatement. And number two is finding a solution to the problem of affordable and accessible health care for the uninsured across the Commonwealth.

Those two separate problems should not be lumped together. Those two separate problems should not be held hostage in favor of one or the other. We should decouple those two sets of problems from one another, and this amendment would seek to do that.

In returning SB 1137 to its original form, extending the Mcare abatement, and then we can come back and deal with the issue of covering the uninsured across the Commonwealth of Pennsylvania as the legislative process intended to work – by going through it with an original piece of legislation, going through public hearings on that legislation, through the committee process, through the House, through the Senate, and until the Governor's desk.

A change that big deserves to have full access to the entire legislative process. So I ask for support for this amendment. Let us decouple the two issues. Let us take care of our doctors today so that they can take care of our patients tomorrow. Thank you.

The SPEAKER. Will the House agree to the amendment?

LEAVE OF ABSENCE CANCELED

The SPEAKER. The Chair recognizes the presence of Representative Siptroth on the floor. His name will be added to the master roll.

CONSIDERATION OF SB 1137 CONTINUED

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–95

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	Turzai
Ellis	Maher	Pickett	Vereb
Evans, J.	Major	Pyle	Vulakovich
Everett	Mantz	Quigley	Watson
Fairchild	Marshall	Quinn	

NAYS–102

Belfanti	Galloway	Manderino	Shimkus
Bennington	George	Mann	Siptroth
Biancucci	Gerber	Markosek	Smith, K.
Bishop	Gergely	McCall	Smith, M.

Blackwell	Gibbons	McGeehan	Solobay
Brennan	Goodman	McI. Smith	Staback
Buxton	Grucela	Melio	Sturla
Caltagirone	Haluska	Mundy	Surra
Carroll	Hanna	Myers	Tangretti
Casorio	Harhai	O'Brien, M.	Taylor, R.
Cohen	Harkins	Oliver	Thomas
Conklin	Hornaman	Pallone	Vitali
Costa	James	Parker	Wagner
Cruz	Josephs	Pashinski	Walko
Curry	Keller, W.	Payton	Wansacz
Daley	Kessler	Petrarca	Waters
DeLuca	King	Petrone	Wheatley
DePasquale	Kirkland	Preston	White
Dermody	Kortz	Ramaley	Williams
DeWeese	Kotik	Readshaw	Wojnaroski
Donatucci	Kula	Roebuck	Yewcic
Eachus	Leach	Sabatina	Youngblood
Evans, D.	Lentz	Sainato	Yudichak
Fabrizio	Levdansky	Samuelson	
Frankel	Longietti	Santoni	O'Brien, D.,
Freeman	Mahoney	Seip	Speaker

NOT VOTING–0

EXCUSED–6

Adolph	Marsico	Taylor, J.	True
Hershey	Shapiro		

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **SCHRODER** offered the following amendment No. **A04889:**

Amend Sec. 3 (Sec. 1102), page 18, lines 18 and 19, by inserting a bracket before "AND" in line 18 and after "2007," in line 19 and inserting immediately thereafter

, 2007 and 2008,

Amend Sec. 3 (Sec. 1102), page 18, line 27, by inserting brackets before and after "and 2006" and inserting immediately thereafter

, 2006 and 2007

Amend Sec. 3 (Sec. 1102), page 18, line 27, by inserting brackets before and after "2007" and inserting immediately thereafter

2008

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Schroder on the amendment.

Mr. SCHRODER. Thank you, Mr. Speaker.

Mr. Speaker, may I just ask that we be at ease for one moment?

The SPEAKER. The House will be at ease.

AMENDMENT PASSED OVER TEMPORARILY

The SPEAKER. The gentleman is in order and may proceed.

Mr. SCHRODER. Mr. Speaker, I request that we go over this amendment temporarily while an issue is being looked at.

The SPEAKER. The amendment will go over temporarily. Would the gentleman like to go over his other amendment at this time as well, so he can deal with this amendment at hand?

Mr. SCHRODER. Yes, that would be appreciated. Thank you.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **REED** offered the following amendment No. **A04985:**

Amend Title, page 1, line 19, by striking out "FOR PENNSYLVANIANS (MCAP)" and inserting

and Reduction of Error (MCARE)

Amend Title, page 1, line 20, by inserting after "~~and~~"

and

Amend Title, page 1, lines 21 and 22, by striking out "expiration;" in line 21 and all of line 22 and inserting

expiration.

Amend Sec. 2, page 16, line 7, by striking out "A SUBCHAPTER" and inserting

subchapters

Amend Sec. 2, page 17, lines 13 through 30; page 18, lines 1 through 8, by striking out all of said lines on said pages and inserting

SUBCHAPTER E
MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR
(MCARE) RESERVE FUND

Section 751. Establishment.

There is established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.

Section 752. Allocation.

Money in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be allocated annually as follows:

(1) Fifty percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall remain in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund for the sole purpose of reducing the unfunded liability of the fund.

(2) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be transferred to the Patient Safety Trust Fund for use by the Department of Public Welfare for implementing section 407.

(3) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be transferred to the Medical Safety Automation Fund.

SUBCHAPTER F
MEDICAL SAFETY AUTOMATION FUND

Section 762. Medical Safety Automation Fund established.

There is established within the State Treasury a special fund to be known as the Medical Safety Automation Fund. No money in the Medical Safety Automation Fund shall be used until legislation is enacted for the purpose of providing medical safety automation system grants to health care providers under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, a group practice or a community-based health care provider.

Amend Sec. 3 (Sec. 1102), page 18, lines 18 and 19, by striking out "AND 2007" and inserting

[and], 2007 and 2008"

Amend Sec. 4 (Sec. 1112), page 20, line 11, by striking out "FOR PENNSYLVANIANS (MCAP)" and inserting

and Reduction of Error (Mcare)

Amend Sec. 4 (Sec. 1112), page 20, line 15, by striking out "FOR PENNSYLVANIANS (MCAP)" and inserting
and Reduction of Error (Mcare)
Amend Sec. 5 (Sec. 1115), page 20, line 26, by striking out "2011" and inserting
2009
Amend Sec. 7, page 20, line 30; page 21, lines 1 through 9, by striking out all of said lines on said pages
Amend Sec. 8, page 21, line 10, by striking out "8" and inserting
7

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Reed on the amendment.

Mr. REED. Thank you very much, Mr. Speaker.

This amendment is very similar to the previous amendment that I had offered. It would extend the Mcare abatement, allocate 50 percent of the fund to reduce unfunded medical liability, 25 percent to the Patient Safety Trust Fund, and 25 percent to the Medical Safety Automation Fund.

Now, once again, it returns SB 1137 to a very similar position as when it passed the Senate by a bipartisan vote of 44 to 2 this past fall. And in the end, the ultimate goal is to decouple the two separate issues, extending the Mcare abatement and Cover All Pennsylvanians – two very important issues that face the folks across the Commonwealth of Pennsylvania, and two issues that do deserve to be heard and evaluated in a very separate manner, without the outcome of one being based upon the outcome of the other.

So, Mr. Speaker, I would encourage a positive vote in support of this amendment.

The SPEAKER. Will the House agree to the amendment?

Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker. I was wondering if the gentleman from Luzerne County would stand for brief interrogation.

The SPEAKER. The gentleman, Representative Reed, indicates he will stand for interrogation.

Mr. BOYD. No.

The SPEAKER. Representative Eachus. The gentleman declines interrogation.

The gentleman is in order to make a comment.

Mr. BOYD. Okay. Thank you, Mr. Speaker.

Had the gentleman indulged my question, what I intended to ask was if he had any type of a commitment from the Senate to take up the omnibus amendment that he is so affectionate of talking about that we are going to deal with and fix this Mcare issue.

Because I am not able to ask him that question and get an answer, I am going to assume, again, that the answer is no, that there has been no agreement with the Senate. And so, we have one chance and one chance only to deal with the extension of the Mcare abatement and that issue, and that is by adopting one of these amendments that we have had drafted to SB 1137, as it is before us right now.

Representative Reed has done yeoman's work in trying to get that language over to the Senate so that we can get this to the Governor's desk and give him the opportunity to fulfill the commitment that we have made to the people of Pennsylvania, to the patients of Pennsylvania, that we are here to secure their access to quality health care.

And at this point, we do not know where we stand on that issue. The Governor has established an artificial deadline of March 31, where he has put a gun to the head of every doctor, every hospital, thus, every one of our constituents who is in need of medical care, he has put a gun to their head and said, if I do not get my Cover All Pennsylvanians, I will not extend the Mcare abatement assessment, the payment assessment to those physicians.

Again, I emphasize: We have one chance and one chance only to get something to the Senate that we know that the Senate will take up. This is Senator White's original language. I just want to make sure that everybody understands very clearly, by voting against this, you are putting at risk your patients in your districts.

Thank you, Mr. Speaker.

The SPEAKER. Will the House agree to the amendment?

Representative Watson.

Mrs. WATSON. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support the Reed amendment. A lot has been said here, and I think somebody needs to be speaking for the doctors and maybe for newer members we need to do a little bit of history. But indeed, we made a commitment to doctors – that because we had a climate that was not friendly to them with Mcare and liability, we were doing something for them. That is the abatement process. We have kept that promise. And one thing in politics and in government that should be clear is that to be a good government you keep the promises that you make or you do not make them to begin with. In any event, we made a promise.

This Reed amendment and, in fact, the bill in chief deal with the promise. It particularly works on giving the doctors the abatement that they still need – extending it, while we do other things. Quite frankly, we had that discussion when we created our own task force: Do we link it all together? Do we put it all together as one? We chose to go a different way that would allow every member then to have an individual vote on what they liked and what they did not. But, never, ever, were we going to link the doctors and hold them up to all of this and tie everything up and say, because of a couple bills that I wanted and ideas that are particularly mine, I was going to pull the doctors in because then you all will have to vote for it.

Mr. Speaker, that is not good government. That is not the way we should be doing business, and I say that respectfully to all of you. But having spent the last 9 months on this issue, I think I have the right to, in effect, do a little teaching, if you will. And that is what this is about – a little teaching.

Mr. Speaker, it is very important that the Mcare abatement go through and go through now. We have the Senate who sent us the bill and said they will go for it. I would also mention here, we are doing something else with the doctors in this. We are going to keep doctors. We know that 6 percent of the doctors who come from the fine medical schools throughout Pennsylvania, only 6 percent stay in Pennsylvania.

Mr. Speaker, for you who have a reasonable age and hope to live longer, if you look and do the curve of when the doctors currently practicing retire, and you reach that retirement age, we are not going to have doctors here. There are not doctors in the pipeline to replace the good doctors who still practice in Pennsylvania.

By paying down that unfunded liability, that is the recruitment tool that keeps doctors here. That is critically important to us. And third, what this does is it gets at also that

Medical Safety Automation Fund – very important for the doctors. We want them to stay. We want them to practice. And we want them to practice safely to the benefit of all their patients. For all those reasons, and for the sake of what I call a promise and good government, Mr. Speaker, I support the Reed amendment and would call on my colleagues to do the same.

Thank you, Mr. Speaker.

The SPEAKER. Representative Marguerite Quinn.

Ms. QUINN. Thank you, Mr. Speaker.

Before I start, may I ask for some order in the House?

The SPEAKER. The lady is correct. Members will please take their seats.

Ms. QUINN. Thank you.

I stand here in support of the Reed amendment, and I am going to ask the members' indulgence as I read a press release that was put out on June 26 of this year. June 26 I was proud to stand in the rotunda with my colleague, Josh Shapiro, from across the aisle, as he introduced a bill for loan forgiveness to doctors.

He introduced it while saying, while the percentage of resident physicians in Pennsylvania has increased over the last 10 years, the percentage of residents remaining in the State to practice after completing their training has decreased every year, the same period.

With the growing demand for health care in the Commonwealth, coupled with the large number of physicians retiring in the next decade, we are facing a crisis that needs to be addressed now. The shortage of doctors is especially acute with primary care doctors and those in obstetrics and gynecology, Shapiro said. Providing incentives for doctors to practice in Pennsylvania is vital to our health-care system.

Mr. Speaker, I submit that as I go through my district and knock on doors and meet people, and those doors are answered by expecting women, I look at those beautiful bellies and I say, where are you going to deliver? And I am appalled to hear that they are crossing the river to go into Princeton to find health-care providers. We are in a crisis, and it needs to be addressed.

I have a letter written to me by one of my physicians, and I will just – one sentence. Help, your friends at Buckingham Family Medicine are very worried that the loss of the Mcare abatement will shatter our plan to hire another physician to help care for the growing and aging population of Bucks County.

I do not know if I have a lot of people listening here, but I think that these are words that we all hear through our district and for that reason, I rise to support the Reed amendment.

Thank you, Mr. Speaker.

The SPEAKER. Representative Cutler.

Mr. CUTLER. Thank you, Mr. Speaker.

I was wondering if the maker of the future amendment, 6103, would just stand for a brief question.

The SPEAKER. The gentleman declines.

Mr. CUTLER. That is a shame because we heard how great his amendment was, and I happen to note, Mr. Speaker—

The SPEAKER. The Chair will caution members. The only issue is not future amendments. Members have to confine their interrogation and their remarks to the amendment at hand.

PARLIAMENTARY INQUIRY

Mr. CUTLER. Mr. Speaker, it is, in fact, related and here is why. I have a point of parliamentary inquiry then.

The SPEAKER. The Chair allows latitude to individual members if they bring their remarks around to the issue at hand.

Mr. CUTLER. Well, the issue at hand, Mr. Speaker, is the cost of this amendment as compared to the cost of the amendment—

The SPEAKER. The gentleman is in order.

Mr. CUTLER. I was wondering if there is a fiscal note with regards to 6103 that is available for our review.

The SPEAKER. That is an appropriate inquiry at the time the amendment is before the House.

Mr. CUTLER. Mr. Speaker, thank you.

I appreciate the answer. I guess my confusion is this, Mr. Speaker: We are being asked to, essentially, buy something on blind faith. We are being told that there is a better amendment – a more comprehensive amendment –but one that we do not know what the cost is.

We do not know what the cost of the amendment is, and we cannot make an intelligent decision regarding whether or not this amendment, as offered by Representative Reed, is better than the one that will be offered in the future. And here is the reason why: We know the cost of Representative Reed's amendment. We know the dollars that are allocated, and we are using existing money.

Mr. Speaker, I, for one, will not buy a pig in a poke just on the future of a better promise. I have got a good amendment before me. I think that we should vote it. The maker of the amendment has taken great thought and deliberation in taking and allocating the money to support good programs. Good programs, Mr. Speaker, that I believe will work and get to the real nature of the problem and that is increased liability here in the State.

Mr. Speaker, providing insurance to other people, while a good and noble deed, does nothing – hear me, please – does nothing to help decrease the status of liability in this State. And that is the real nature of the Mcare Fund and what it should do.

Mr. Speaker, it is a real shame that we cannot get an apples-to-apples comparison and lack of a fiscal note to compare the two amendments. But for me, and I will encourage all of my colleagues to do this, take the good one that we have before us rather than a promise we are not sure that can be kept in the future.

The SPEAKER. Is Representative Turzai seeking recognition?

PARLIAMENTARY INQUIRY

The SPEAKER. The Chair recognizes Representative Boyd for the second time.

Mr. BOYD. Brief parliamentary inquiry, Mr. Speaker.

The SPEAKER. The gentleman will state his point of parliamentary inquiry.

Mr. BOYD. I have heard reference – maybe I missed it with the noise – that it was inappropriate to refer to the future, potential future, amendment while we are discussing this amendment?

The SPEAKER. The gentleman is incorrect. To interrogate a member on that amendment is inappropriate. To reference that amendment and bring your argument back to the amendment at hand is in order.

Mr. BOYD. Okay. Thank you, Mr. Speaker.

The SPEAKER. Representative Dally.

Is there anyone seeking recognition before the Chair recognizes the prime sponsor of the amendment?

Representative Reed, for the second time.

Mr. REED. Thank you very much, Mr. Speaker.

Once again, I would encourage the members to support this amendment. Return SB 1137 to its original format, where it passed the Senate by a bipartisan vote of 44 to 2. This is a bill that we know that the Senate will take up because we put it back into its original format. Let us keep our commitment to the doctors, who keep their commitment to our patients across the Commonwealth on a daily basis. Let us get this issue behind us, and let us get on to the real issue of debating on how to make our entire health-care system more accessible and more affordable to all Pennsylvanians across the Commonwealth of Pennsylvania.

Thank you, Mr. Speaker.

On the question recurring,

Will the House agree to the amendment?

The following roll call was recorded:

YEAS–95

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	Turzai
Ellis	Maher	Pickett	Vereb
Evans, J.	Major	Pyle	Vulakovich
Everett	Mantz	Quigley	Watson
Fairchild	Marshall	Quinn	

NAYS–102

Belfanti	Galloway	Manderino	Shimkus
Bennington	George	Mann	Siptroth
Biancucci	Gerber	Markosek	Smith, K.
Bishop	Gergely	McCall	Smith, M.
Blackwell	Gibbons	McGeehan	Solobay
Brennan	Goodman	McI. Smith	Staback
Buxton	Grucela	Melio	Sturla
Caltagirone	Haluska	Mundy	Surra
Carroll	Hanna	Myers	Tangretti
Casorio	Harhai	O'Brien, M.	Taylor, R.
Cohen	Harkins	Oliver	Thomas
Conklin	Hornaman	Pallone	Vitali
Costa	James	Parker	Wagner
Cruz	Josephs	Pashinski	Walko
Curry	Keller, W.	Payton	Wansacz
Daley	Kessler	Petrarca	Waters
DeLuca	King	Petrone	Wheatley
DePasquale	Kirkland	Preston	White
Dermody	Kortz	Ramaley	Williams
DeWeese	Kotik	Readshaw	Wojnaroski
Donatucci	Kula	Roebuck	Yewcic
Eachus	Leach	Sabatina	Youngblood
Evans, D.	Lentz	Sainato	Yudichak
Fabrizio	Levdansky	Samuelson	
Frankel	Longietti	Santoni	O'Brien, D.,
Freeman	Mahoney	Seip	Speaker

NOT VOTING–0

EXCUSED–6

Adolph	Marsico	Taylor, J.	True
Hershey	Shapiro		

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

LEAVE OF ABSENCE CANCELED

The SPEAKER. The Chair recognizes the presence of Representative Shapiro on the floor. His name will be added to the master roll.

CONSIDERATION OF SB 1137 CONTINUED

On the question recurring,

Will the House agree to the bill on second consideration?

The SPEAKER. The Chair recognizes Representative Schroder for amendment A04889.

Mr. SCHRODER. Mr. Speaker, that amendment is being redrafted due to a drafting error, and I believe the other side of the aisle is aware of that. I would request, again, that we go over it temporarily.

The SPEAKER. The Chair thanks the gentleman.

On the question recurring,

Will the House agree to the bill on second consideration?

Mr. **TURZAI** offered the following amendment No. **A05079:**

Amend Title, page 1, lines 18 through 22, by striking out all of said lines and inserting

data, for abatement program, for eligibility, for procedure; providing for the Health Care Provider Retention Reserve Account; further providing for expiration; and making a transfer.

Amend Sec. 1 (Sec. 711), page 3, line 18, by inserting a bracket before "Unless"

Amend Sec. 1 (Sec. 711), page 3, line 20, by inserting a bracket after "for" and inserting immediately thereafter

For

Amend Sec. 1 (Sec. 711), page 3, line 23, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 3, line 26, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 3, line 29, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 5, line 4, by striking out "paragraphs (3) and" and inserting

paragraph

Amend Sec. 1 (Sec. 711), page 5, line 5, by striking out "$500,000 and shall be set" and inserting

$750,000 and shall be set by the commissioner

Amend Sec. 1 (Sec. 712), page 8, line 18, by striking out "or (4)"

Amend Sec. 1 (Sec. 712), page 8, line 22, by striking out the bracket before "$250,000"

Amend Sec. 1 (Sec. 712), page 8, line 29, by inserting a bracket before "zero]"

Amend Sec. 1 (Sec. 712), page 9, line 4, by striking out "711(d)(3) and (4)" and inserting

711(d)(4)

Amend Sec. 1 (Sec. 712), page 10, line 5, by inserting a bracket before "(e)"

Amend Sec. 1 (Sec. 712), page 11, line 14, by inserting a bracket after "(m)."

Amend Sec. 3 (Sec. 1102), page 18, line 17, by inserting a bracket before "for"

Amend Sec. 3 (Sec. 1102), page 18, line 21, by inserting a bracket after "2005" and inserting immediately thereafter

until the liability of the fund under section 712(c)(2)(iii) is zero

Amend Bill, page 19, lines 5 through 30; page 20, lines 1 through 30, page 21, lines 1 through 10, by striking out all of said lines on said pages and inserting

Section 5. The act is amended by adding a section to read:

Section 1114.1. Health Care Provider Retention Reserve Account.

(a) Establishment.–There is established within the General Fund a special account to be known as the Health Care Provider Retention Reserve Account. The funds in the account shall only be used for the purpose of reducing unfunded liability under Chapter 7.

(b) Transfer.–Notwithstanding any other provision of this act, the Secretary of the Budget shall, as of December 31, 2007, transfer all funds in the account into the Health Care Provider Retention Reserve Account.

Section 6. This act shall take effect as follows:

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

(i) The repeal of section 712(e) of the act.

(ii) The amendment of section 1102(a) of the act.

(iii) The addition of section 1114.1 of the act.

(2) The remainder of this act shall take effect immediately.

On the question,

Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Turzai on the amendment.

Mr. TURZAI. Thank you very much, Mr. Speaker.

I think it is important for the legislature and for members of the listening audience to understand that Senator White had sent over a bill that addressed Mcare, and I think a lot of people may not have a sense as to what Mcare is about and how it came to be. And this will explain the amendment that I have, with respect to the original bill.

In the Mcare Fund, it is funded by three particular revenue sources: One is from the auto CAT surcharge off of fees that you, the public, pay with respect to automobiles; second, part of the cigarette tax; and third, moneys paid in by physicians.

Now, that money is used with respect to Mcare. It is used to pay, particularly, for high-risk specialty physicians, part of the, really, outrageous medical malpractice liability amounts that they have to pay. And why is that? I mean, so what is the underlying issue here? It is because we have a legal system that has not been reformed. And as a result of the fact that we are a State that has not done any legal reforms, we have significant medical malpractice premiums. And it is not limited to the health-care arena, but it is certainly a place where it has its most significant impact.

So instead of getting to the underlying problems of how we reduce lawsuit abuse reform and change the legal system to reduce risk and to bring predictability and accountability, we ended up doing this Mcare Fund, which replaced a former thing called the CAT Fund (Medical Professional Liability Catastrophe Loss Fund). And essentially, the Commonwealth is, at least in part, in the business of providing insurance under this Mcare Fund.

Now, the number one goal here would be to reform the legal system to eliminate lawsuit abuse and to get the State out of the business of helping insurance, but we have never made those legal reforms. So we have this Mcare Fund, and what has happened, as some of my prior colleagues have stated, is we have less health-care providers staying in Pennsylvania or coming to Pennsylvania.

We have got fine medical schools, fine residency programs, but many of those people leave. So we have this Mcare Fund, and what has happened is, in committee, the opposing party hijacked it and put in an amendment that gutted what Senator White wanted to do with those Mcare funds. What many of the amendments, including the one that I am putting on the table, are designed to do is to ultimately ensure the stability of the Mcare Fund and ultimately eliminate it and get us out of the business of insurance.

My amendment takes a step in that direction. It cannot fully happen if we do not do true tort reform or lawsuit abuse reform. That has got to be a significant component part of it, too. But the amendment that I have in front of you is an amendment that takes moneys from this Mcare Fund, which you the taxpayers are paying for, it takes those existing moneys and it uses it to pay off what is called the unfunded liability, the unfunded liability, of the Mcare Fund for the risk that is out there for, primarily, our specialty doctors.

And if we want to get out of that business— That is what that money was designed to do, but, unfortunately, given the Democratic amendment, it hijacks that money and diverts it for other purposes instead of for its original purpose.

Mr. Speaker, with respect to all of the discussion about health care and health-care costs, that, absolutely, is an important discussion that has to happen, and I applaud my colleagues Scott Boyd and Kathy Watson and the task force for taking it head on.

But in the end, who is providing the quality health care that we want? And if you do not have people here to provide that quality health care, then the fact of the matter is, there is no health care. And we have to take care of this Mcare Fund. We have got to make sure that it stays stable, and we have to make sure that, ultimately, we phase out that unfunded liability. And by phasing out the unfunded liability, we get the government out of the business – get out of the business – of providing insurance for anybody.

I am hoping that we are going to do lawsuit abuse reform as part of this. This amendment, essentially, says take those Mcare moneys and use it to pay off the unfunded liability of the Mcare, and then get the State out of the business of providing this type

of medical malpractice insurance. And that is really, ultimately, what needs to happen.

We need to shore up this fund for X period of years, and then get out of the business, get out of the business of providing this insurance. And I am hoping that we are going to couple that with the lawsuit abuse reform measures. Now, I will tell you this, the opposition saw a pot of money – because there is a reserve of about $500 million – and this administration, any chance they get to see a pot of money that they can get their hands on, they want to grab and divert it from its original purpose. That original purpose was reached by a bipartisan compromise of Republicans and Democrats. Everybody was on board with that, but because there is an excess fund, they want to take it and divert it and hijack it, just as the other speakers have said, and get rid of what our original purpose was.

Let us stick to the original purpose. Let us shore up the fund. Let us finally pay off this unfunded liability, and then let us get out of this business. To be honest with you, we would not even need to be in the business if we would have done lawsuit abuse reform like the majority of States in the United States have done.

We have not done it. That is why we are doing Band-Aid approaches like this, and I think it is time that we face, just really face the facts. I would ask your support for this particular amendment. I, again, applaud my colleagues for taking on the issue of making sure that there is quality health care for as many Pennsylvanians as possible, but this issue is about the Mcare Fund and what we do with those moneys.

Thank you very, very much, Mr. Speaker, and I ask for an affirmative vote.

The SPEAKER. Will the House agree to the amendment?

Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

I oppose amendment No. 5079. I have to tell you that my focus in this – and I realize we are dealing with a lot of variables today in these amendments – my focus is making sure that the uninsured get covered. In Allegheny County alone, there are 6,085 people on the adultBasic waiting list, and I want to make sure that we keep the focus on reducing that waiting list. We have dealt with this issue in a comprehensive way within the amendment we will take up later, and for that reason I oppose the amendment.

On the question recurring,

Will the House agree to the amendment?

The following roll call was recorded:

YEAS–95

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	Turzai
Ellis	Maher	Pickett	Vereb
Evans, J.	Major	Pyle	Vulakovich
Everett	Mantz	Quigley	Watson
Fairchild	Marshall	Quinn	

NAYS–103

Belfanti	George	Mann	Shimkus
Bennington	Gerber	Markosek	Siptroth
Biancucci	Gergely	McCall	Smith, K.
Bishop	Gibbons	McGeehan	Smith, M.
Blackwell	Goodman	McI. Smith	Solobay
Brennan	Grucela	Melio	Staback
Buxton	Haluska	Mundy	Sturla
Caltagirone	Hanna	Myers	Surra
Carroll	Harhai	O'Brien, M.	Tangretti
Casorio	Harkins	Oliver	Taylor, R.
Cohen	Hornaman	Pallone	Thomas
Conklin	James	Parker	Vitali
Costa	Josephs	Pashinski	Wagner
Cruz	Keller, W.	Payton	Walko
Curry	Kessler	Petrarca	Wansacz
Daley	King	Petrone	Waters
DeLuca	Kirkland	Preston	Wheatley
DePasquale	Kortz	Ramaley	White
Dermody	Kotik	Readshaw	Williams
DeWeese	Kula	Roebuck	Wojnaroski
Donatucci	Leach	Sabatina	Yewcic
Eachus	Lentz	Sainato	Youngblood
Evans, D.	Levdansky	Samuelson	Yudichak
Fabrizio	Longietti	Santoni	
Frankel	Mahoney	Seip	O'Brien, D.,
Freeman	Manderino	Shapiro	Speaker
Galloway			

NOT VOTING–0

EXCUSED–5

Adolph	Marsico	Taylor, J.	True
Hershey			

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

LEGISLATIVE FELLOWS INTRODUCED

The SPEAKER. May I have the attention of the House. The Legislative Fellowship Program, sponsored by the House of Representatives through the Bipartisan Management Committee and the Office of the Chief Clerk, has 14 students from 7 different schools participating in this spring's 2008 semester program, which runs for 13 weeks. It is the largest class ever in this program.

Legislative fellows are assigned to either a committee chairman or a leadership office. The final requirement necessary to complete the fellowship is that each intern must create, research, and present an original piece of legislation, complete with oral defense before an audience of friends, professors, House staff, and members.

The final presentations are scheduled for April 11 and April 18, and hopefully many of you will attend. Just for your

information, to date, almost 300 students have successfully completed this program, and many of them are currently working here in the House, in the Senate, and in the Governor's Office.

We welcome to the hall of the House today the 14 fellows that began their internship in January. They are seated in the rear of the House. First, and as I call your name will you please stand, Paula Barbush, a student originally from Brazil, attending Penn State Harrisburg, assigned to the Office of the Majority Whip under Representative McCall, and supervised by Nikki Jones. Would you please recognize Paula Barbush.

Rachel Bungo, a student from Williamstown, Pennsylvania, attending Penn State Harrisburg. She was assigned to the Environmental Resources and Energy Committee under Representative George, and supervised by Tom Kuhn. Would you please stand and be recognized.

Michael Dixon, a student originally from the United Kingdom, attending West Chester University, assigned to the Finance Committee under Representative Levdansky, and supervised by Bob Kassoway. Would you please stand and be recognized.

Joshua Hoffman, a student from Schaefferstown, Pennsylvania, attending Elizabethtown College, assigned to the Policy Committee under Representative Turzai, supervised by Krystjan Callahan. Would you please stand and be recognized.

Elaine Jurek, a student from Newville, Pennsylvania, attending Penn State Harrisburg, assigned to the Veterans Affairs and Emergency Preparedness Committee under Representative Fairchild, supervised by Rick O'Leary. Would you please stand and be recognized.

Amy Kennedy, a student from Foxboro, Massachusetts, attending Messiah College, assigned to the Education Committee under Representative Roebuck, and supervised by Chris Wakeley. Would you please stand and be recognized.

Holly Lehman, a student from Harrisburg, Pennsylvania, attending Penn State Harrisburg, assigned to the Agriculture and Rural Affairs Committee under Representative Hershey, and she is supervised by Kerry Golden. Would you please stand and be recognized.

Jun Li, a student from Syosset, New York, attending the University of Pennsylvania, assigned to the Urban Affairs Committee under Representative John Taylor, supervised by Christine Goldbeck. Would you please stand and be recognized.

Jesseca Myers, a student from Thompsontown, Pennsylvania, attending Mansfield University, assigned to the Finance Committee under Representative Nickol, and supervised by Andrew Ritter. Would you please stand and be recognized.

Robert Orth, a student from Ashland, Pennsylvania, attending Lebanon Valley College, assigned to the Consumer Affairs Committee under Representative Preston, and supervised by Gail Davis. Would you please stand and be recognized.

Vanessa Scalavino, a student from Shippensburg, Pennsylvania, attending Elizabethtown College, assigned to the Insurance Committee under Representative DeLuca, and supervised by Rick Speese. Would you please stand and be recognized.

Nicole Stettler, a student from Willow Street, Pennsylvania, attending Penn State Harrisburg, assigned to the Office of the Caucus Chairman under Representative Cohen, and supervised by Mike Cassidy. She is not here, but please acknowledge her accomplishment, as well.

Kate Tussey, a student from Perkiomenville, Pennsylvania, assigned to the Health and Human Services Committee under Representative Kenney, supervised by Melanie Brown. Would you please stand and be recognized.

Megan Zimmerman, a student from Palmyra, Pennsylvania, assigned to the Aging and Older Adult Services Committee under Representative Hennessey, supervised by Sharon Schwartz. Would you please stand and be recognized.

Also seated in the back with the interns is the legislative fellowship coordinator, Ray Whittaker. We thank you for all your efforts.

Ladies and gentlemen of the House, all the members, all the interns in the back, please stand, and we thank you for your service.

CONSIDERATION OF SB 1137 CONTINUED

On the question recurring,

Will the House agree to the bill on second consideration?

Mr. **TURZAI** offered the following amendment No. **A05080:**

Amend Title, page 1, lines 18 through 22, by striking out all of said lines and inserting

data, for abatement program, for eligibility, for procedure; providing for the Health Care Provider Retention Reserve Account; further providing for expiration; and making a transfer.

Amend Sec. 1 (Sec. 711), page 3, line 18, by inserting a bracket before "Unless"

Amend Sec. 1 (Sec. 711), page 3, line 20, by inserting a bracket after "for" and inserting immediately thereafter

For

Amend Sec. 1 (Sec. 711), page 3, line 23, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 3, line 26, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 3, line 29, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 5, line 4, by striking out "paragraphs (3) and" and inserting

paragraph

Amend Sec. 1 (Sec. 711), page 5, line 5, by striking out "$500,000 and shall be set" and inserting

$750,000 and shall be set by the commissioner

Amend Sec. 1 (Sec. 712), page 8, line 18, by striking out "or (4)"

Amend Sec. 1 (Sec. 712), page 8, line 22, by striking out the bracket before "$250,000"

Amend Sec. 1 (Sec. 712), page 8, line 29, by inserting a bracket before "zero]"

Amend Sec. 1 (Sec. 712), page 9, line 4, by striking out "711(d)(3) and (4)" and inserting

711(d)(4)

Amend Sec. 1 (Sec. 712), page 10, line 5, by inserting a bracket before "(e)"

Amend Sec. 1 (Sec. 712), page 11, line 14, by inserting a bracket after "(m)."

Amend Sec. 1 (Sec. 712), page 14, line 4, by inserting a bracket before"(m)"

Amend Sec. 1 (Sec. 712), page 14, line 14, by inserting a bracket after "Fund."

Amend Sec. 3 (Sec. 1102), page 18, line 17, by inserting a bracket before "for"

Amend Sec. 3 (Sec. 1102), page 18, line 21, by inserting a bracket after "2005" and inserting immediately thereafter

until the liability of the fund under section 712(c)(2)(iii) is zero

Amend Bill, page 19, lines 5 through 30; page 20, lines 1 through 30, page 21, lines 1 through 10, by striking out all of said lines on said pages and inserting

Section 4. The act is amended by adding a section to read:

Section 1114.1. Health Care Provider Retention Reserve Account.

Section 4. The act is amended by adding a section to read:

Section 1114.1. Health Care Provider Retention Reserve Account.

(a) Establishment.–There is established within the General Fund a special account to be known as the Health Care Provider Retention Reserve Account. The funds in the account shall only be used for the purpose of reducing unfunded liability under Chapter 7.

(b) Transfer.–Notwithstanding any other provision of this act, the Secretary of the Budget shall, as of December 31, 2007, transfer all funds in the account into the Health Care Provider Retention Reserve Account.

Section 5. All surcharges levied under 75 Pa.C.S. § 6506(a) shall be transferred to the Hazardous Sites Cleanup Fund on and after the effective date of this section.

Section 6. This act shall take effect as follows:

(1) Section 5 of this act shall take effect December 31, 2007, or immediately, whichever is later.

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

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

(ii) The amendment of section 1102(a) of the act.

(iii) The addition of section 1114.1 of the act.

(3) The remainder of this act shall take effect immediately.

On the question,

Will the House agree to the amendment?

AMENDMENT WITHDRAWN

The SPEAKER. The Chair recognizes Representative Turzai on the amendment.

Mr. TURZAI. Mr. Speaker, we withdrew that amendment.

The SPEAKER. The Chair thanks the gentleman.

The House will be at ease.

The House will come to order.

GUESTS INTRODUCED

The SPEAKER. If I could have the members' attention, we have a very special guest today. As the guests of Representative Mike Carroll, we have Dave and Lorin Halliwell of Tobyhanna Township, Monroe County. Dave is an Operation Iraqi Freedom vet, and he is in the balcony. Would you please join the Chair in welcoming our hero to the floor of the House.

CONSIDERATION OF SB 1137 CONTINUED

On the question recurring,

Will the House agree to the bill on second consideration?

Mr. **SCHRODER** offered the following amendment No. **A06043:**

Amend Title, page 1, line 22, by inserting after "FOR"

health insurance continuation and for

Amend Sec. 1 (Sec. 712), page 10, lines 2 through 4, by striking out all of said lines

Amend Sec. 2 (Sec. 752), page 17, line 21, by striking out "(A) ANNUAL ALLOCATION.–"

Amend Sec. 2 (Sec. 752), page 17, lines 23 through 30; page 18, lines 1 through 8, by striking out "ANNUALLY AS FOLLOWS:" in line 24, all of lines 23 through 30, page 17, all of lines 1 through 8, page 18 and inserting

for continuation of health insurance under section 5103.2. The annual allocation under this section shall not exceed $42,000,000.

Amend Bill, page 20, by inserting between lines 26 and 27

Section 5.1. The act is amended by adding a section to read:

Section 5103.2. Health insurance continuation.

(a) Eligibility.–A person collecting unemployment benefits shall be eligible for a rebate of 50% of the cost of any health care insurance premium the person paid during the period during which the person collects unemployment benefits.

(b) Allocation.–Funds allocated under section 752 shall be used by the Insurance Department to provide rebates under subsection (a).

(c) Regulations.–The Insurance Department shall promulgate regulations to effectuate this section.

Amend Sec. 7, page 20, line 30; page 21, lines 1 through 9, by striking out all of said lines on said pages

Amend Sec. 8, page 21, line 10, by striking out "8" and inserting

7

On the question,

Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Schroder on the amendment.

Mr. SCHRODER. Thank you, Mr. Speaker.

Mr. Speaker, this amendment takes a different approach from what we have been talking about so far in our other amendments today.

Mr. Speaker, the way I look at this is if we are going to go after Mcare and raid its so-called surplus funds and, in essence, break faith with the medical community that has been depending on these funds, perhaps later on in another amendment – which we are really not allowed to ask questions on at this point, so we really do not know for sure – but be that as it may, if we are going to do all this, I suggest we go about it a little differently than either expanding or creating a State-run health-care program.

Mr. Speaker, what this amendment would do is it would allow payments to be made to individuals who are unemployed so that they can pay for 50 percent of their COBRA (Consolidated Omnibus Budget Reconciliation Act) insurance continuation. Mr. Speaker, I think we would go a long way to addressing the problem of people who are uninsured if we look at these people who are in transition; in other words, between jobs, unemployed. It is really the most frequent concern that I hear in my district about people who need health care. It is so difficult for them to be able to afford their COBRA payments in order to continue on with their health care until they land that next job, until they find that next job.

So, Mr. Speaker, I think this approach would go a long way in helping those people in transition, people who are truly in

need, to continue their health-care insurance for both themselves and their families. I think we should give this concept serious consideration today, and I would ask for your consideration of the amendment.

Thank you.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I just briefly rise to support the Schroder amendment.

One of the things that as a member of the Insurance Committee and being a participant in hearings all over the State, one of the things that we discovered in listening to people talk about the Governor's health-care plan was that the uninsured are not a homogeneous group of people. They are very, very different people, but by and large what we found is that many of them are uninsured for a very brief period of time. They are, in fact, transitional. They are, in fact, between jobs.

One of the concerns that we received in hearing testimony about Cover All Pennsylvanians – which we are going to consider later today, Mr. Speaker – is the fact that it is a broad-sweeping, one-size-fits-all plan that really does not target who truly the uninsured are. In fact, there are statistics from the Insurance Department that we will refer to later, but are quite substantial and significant, in that of the uninsured, 50 percent are between the ages of 18 and 34.

The key to this, Mr. Speaker, and for the ladies and gentlemen of the House, is that the Schroder proposal goes directly to attacking one of the key elements of the problem with those who do not have health insurance. And that is what we should be about trying to solve, and we should be about doing it, Mr. Speaker, in such a way that really utilizes the limited number of taxpayer dollars in the most efficient way possible.

Mr. Schroder has proffered an idea that gets at the heart of a group of people who we know need help and does it with a limited number of taxpayer dollars so that we will not be facing the uncertainty of whether or not we receive Federal Medicaid dollars down the road, the uncertainty of whether or not we are going to get our colleagues across the building to embrace the Governor's tax increases. It will not be reliant upon unknowns, but it is reliant on a revenue stream that we already know exists is available and will, in fact, Mr. Speaker, really get to the heart of one of the key groups that we know is currently uninsured. If that is what we are about, if we are concerned about people who do not have health insurance, you have to embrace the Schroder concept. It gets at those people who have lost their jobs and cannot afford COBRA. They are the poster children, Mr. Speaker, of the folks who are looking to get health insurance.

Based on that, I want to commend Mr. Schroder. It is a great idea. It is outside the box. It is innovative thinking, and I would encourage all the members on both sides of the aisle who care about getting health insurance to the uninsured to embrace the Schroder amendment.

Thank you, Mr. Speaker.

The SPEAKER. Is there anyone seeking recognition before the Chair recognizes the prime sponsor of the amendment?

Representative Schroder, for the second time.

Mr. SCHRODER. Thank you, Mr. Speaker.

I think the comments of Representative Boyd – I would echo them. I think he is absolutely correct, and I would ask for a "yes" vote on the amendment.

Thank you.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–94

Argall	Gabig	Mensch	Rapp
Baker	Geist	Metcalfe	Raymond
Barrar	Gillespie	Micozzie	Reed
Bastian	Gingrich	Millard	Reichley
Bear	Godshall	Miller	Roae
Benninghoff	Grell	Milne	Rock
Boback	Harhart	Moul	Rohrer
Boyd	Harper	Moyer	Ross
Brooks	Harris	Murt	Rubley
Cappelli	Helm	Mustio	Saylor
Causer	Hennessey	Nailor	Scavello
Civera	Hess	Nickol	Schroder
Clymer	Hickernell	O'Neill	Smith, S.
Cox	Hutchinson	Payne	Sonney
Creighton	Kauffman	Peifer	Stairs
Cutler	Keller, M.	Perry	Steil
Dally	Kenney	Perzel	Stern
Denlinger	Killion	Petri	Stevenson
DiGirolamo	Mackereth	Phillips	Swanger
Ellis	Maher	Pickett	Turzai
Evans, J.	Major	Pyle	Vereb
Everett	Mantz	Quigley	Vulakovich
Fairchild	Marshall	Quinn	Watson
Fleck	McIlhattan		

NAYS–104

Belfanti	Galloway	Mann	Shimkus
Bennington	George	Markosek	Siptroth
Beyer	Gerber	McCall	Smith, K.
Biancucci	Gergely	McGeehan	Smith, M.
Bishop	Gibbons	McI. Smith	Solobay
Blackwell	Goodman	Melio	Staback
Brennan	Grucela	Mundy	Sturla
Buxton	Haluska	Myers	Surra
Caltagirone	Hanna	O'Brien, M.	Tangretti
Carroll	Harhai	Oliver	Taylor, R.
Casorio	Harkins	Pallone	Thomas
Cohen	Hornaman	Parker	Vitali
Conklin	James	Pashinski	Wagner
Costa	Josephs	Payton	Walko
Cruz	Keller, W.	Petrarca	Wansacz
Curry	Kessler	Petrone	Waters
Daley	King	Preston	Wheatley
DeLuca	Kirkland	Ramaley	White
DePasquale	Kortz	Readshaw	Williams
Dermody	Kotik	Roebuck	Wojnaroski
DeWeese	Kula	Sabatina	Yewcic
Donatucci	Leach	Sainato	Youngblood
Eachus	Lentz	Samuelson	Yudichak
Evans, D.	Levdansky	Santoni	
Fabrizio	Longietti	Seip	O'Brien, D., Speaker
Frankel	Mahoney	Shapiro	
Freeman	Manderino		

NOT VOTING–0

EXCUSED–5

Adolph	Marsico	Taylor, J.	True
Hershey			

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mrs. **WATSON** offered the following amendment No. **A06050:**

Amend Title, page 2, line 2, by striking out all of said line and inserting

procedure, for certificate of retention, for the Health Care Provider Retention Account and for expiration and providing for the Health Care Provider Retention Reserve Account; providing for small business health savings tax account tax credits, for disease management tax credits, for healthy living and wellness tax incentives, for community-based health provider assistance and for health care comparison; and making a transfer.

Amend Bill, page 2, lines 9 through 30; pages 3 through 12, lines 1 through 30; page 13, lines 1 through 27, by striking out all of said lines on said pages and inserting

Section 1. Sections 711(d) and 712(c), (e) and (m) 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], 2005, 2006 and 2007, 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] For policies issued or renewed in calendar year [2006 and each year thereafter subject to paragraph (4)] 2008, the basic insurance coverage shall be:

(i) [$750,000] $550,000 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] $550,000 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] For policies issued or renewed [three years after the increase in coverage limits required by paragraph (3)] in calendar year 2009 and for each year thereafter, the basic insurance coverage shall be:

(i) [$1,000,000] $600,000 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] $600,000 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 2010 and each year thereafter, the commissioner shall increase the required per occurrence or claim basic insurance coverage by $50,000 increments for a participating health care provider that is not a hospital and for a hospital until such time as the required per occurrence or claim basic insurance coverage is $750,000.

(6) For policies issued or renewed in the calendar year immediately following the calendar year in which the required per occurrence or claim basic insurance coverage is $750,000 and 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.

* * *

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 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), (4)

or (5) 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.] $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a health care provider except a hospital or $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate for a hospital, minus the amount required for basic insurance coverage under section 711(d)(3) or (4) or the amount the commissioner determines as the required basic insurance coverage under section 711(d)(5), as appropriate.

(iii) If the basic insurance coverage requirement is increased in accordance with section [711(d)(4)] 711(d)(6) 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.

* * *

[(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).]

* * *

(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,] 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 of Error Fund. These funds shall be used to reduce surcharges and assessments [in accordance with subsection (e). Beginning January 1, 2014, and each year thereafter, the surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the General Fund] levied under this section.

* * *

Section 1.1. The act is amended by adding a section to read:

Section 762. Medical Safety Automation Fund established.

There is established within the State Treasury a special fund to be known as the Medical Safety Automation Fund. No money in the Medical Safety Automation Fund shall be used until legislation is enacted for the purpose of providing medical safety automation system grants to health care providers under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, a group practice or a community-based health care provider.

Section 2. The definition of "account" 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:

"Account." The Health Care Stabilization and Provider Retention Account established in section 1112.

* * *

Section 3. 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] and each year thereafter until the liability of the fund under section 712(c)(2)(iii) is zero, 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.–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).

Section 4. Sections 1104, 1105 and 1112 of the act, added December 22, 2005 (P.L.458, No.88), are amended to read:

Section 1104. Procedure.

(a) Application.–A health care provider may apply to the Insurance Department for an abatement of the assessment imposed for the previous calendar year specified on the application. The application must be submitted by the second Monday of February of the calendar year specified on the application and shall be on the form required by the Insurance Department. The department shall require that the application contain all of the following supporting information:

(1) A statement of the applicant's field of practice, including any specialty.

(2) Except for physicians enrolled in an approved residency or fellowship program, a signed certificate of retention.

(3) A signed certification that the health care provider is an eligible applicant under section 1103 for the program.

(4) Such other information as the Insurance Department may require.

(a.1) Electronically filed application.–A hospital may submit an electronic application on behalf of all health care providers when the hospital is responsible for payment of the health care provider's assessment under this act and the hospital has received prior written approval from the Insurance Department.

(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 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.

(2) The Insurance Department shall notify the Department of Public Welfare that the applicant has self-certified as eligible for a 50% abatement of the imposed assessment 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.

(3) Notwithstanding paragraph (2), upon the required basic insurance coverage being increased under section 711(d)(3), (4) or (5), the Insurance Department shall annually increase the abatement each applicant is entitled to claim under paragraph (2) by 10%.

(c) Refund.–If a health care provider paid the assessment for the calendar year prior to applying for an abatement under subsection (a), the health care provider may, in addition to the completed application required by subsection (a), submit a request for a refund. The request shall be submitted on the form required by the Insurance Department. If the Insurance Department grants the health care provider an abatement of the assessment for the calendar year in accordance with subsection (b), the Insurance Department shall either refund to the health care provider the portion of the assessment which was abated or issue a credit to the health care provider's professional liability insurer.

Section 1105. Certificate of retention.

(a) Certificate.–The Insurance Department shall prepare a certificate of retention form. The form shall require a health care provider seeking an abatement under the program to attest that the health care provider will continue to provide health care services in this Commonwealth for at least one full calendar year following the year for which an abatement was received pursuant to this chapter.

(a.1) Hospital responsibility.–When a hospital has submitted an application on behalf of a health care provider, the hospital shall be responsible for ensuring compliance with the certificate of retention and shall indemnify the health care provider retention account for each health care provider who fails to continue to provide medical services within this Commonwealth for the year following receipt of the abatement.

(b) Repayment.–

(1) Except as provided in paragraph (2), if a health care provider receives an abatement but, prior to the end of the retention period, ceases providing health care services in this Commonwealth, the health care provider shall repay to the Commonwealth 100% of the abatement received plus administrative and legal costs, if applicable. A health care provider subject to this paragraph shall provide written notice to the Insurance Department within 60 days of the date of cessation of health care services.

(2) Paragraph (1) shall not apply to a health care provider who is any of the following:

(i) A health care provider who is enrolled in an approved residency or fellowship program.

(ii) A health care provider who dies prior to the end of the retention period.

(iii) A health care provider who is disabled and unable to practice prior to the end of the retention period.

(iv) A health care provider who is called to active military duty prior to the end of the retention period.

(v) A health care provider who retires and who is at least 70 years of age prior to the end of the retention period.

(c) Tax.–An amount owed the Commonwealth under subsection (b) shall be considered a tax under section 1401 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code. The Department of Revenue shall provide assistance to the Insurance Department in any collection effort. Any amount collected under this chapter, including administrative and legal costs, shall be deposited into the [Health Care Provider Retention Account] account.

(d) Failure to pay.–The Insurance Department shall notify the appropriate licensing board of any failure to pay an amount required of a licensee under this section. Upon such notification, the licensing board shall suspend or revoke the license of the licensee.

Section 1112. Health Care Stabilization and Provider Retention Account.

(a) Fund established.–There is established within the General Fund a special account to be known as the Health Care Stabilization and Provider Retention Account. Funds in the account shall be subject to an annual appropriation by the General Assembly [to the Department of Public Welfare. The Department of Public Welfare shall administer funds appropriated under this section].

(a.1) Abatement program appropriations.–Funds appropriated to the Department of Public Welfare for the abatement program shall be administered by the Department of Public Welfare consistent with its duties under section 201(1) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(a.2) Health care stabilization appropriations.–Money in the account shall be allocated annually by the Secretary of the Budget as follows:

(1) Seventy-five million dollars shall be transferred to be used for the small business health savings tax account tax credit established under Chapter 13.

(2) Five million dollars shall be transferred to be used for the disease management tax credit established under Chapter 15.

(3) Five million dollars shall be transferred to be used for the healthy living and wellness tax incentives established under Chapter 17.

(4) Five million dollars shall be transferred to the Health Care Cost Containment Council to be used in accordance with Chapter 21.

(5) Fifteen million dollars shall be transferred to the Patient Safety Trust Fund for use by the Department of Public Welfare for implementing section 407.

(6) Twenty-two million dollars shall be transferred to the Low Income Health Care Access Fund to increase service in accordance with Chapter 19.

(7) Ten million dollars shall be transferred to the Medical Safety Automation Fund.

[(b) Transfers from Mcare Fund.–By December 31 of each year, the Secretary of the Budget may transfer from the Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712(a) to the account an amount equal to the difference between the amount deposited under section 712(m) and the amount granted as discounts under section 712(e)(2) for that calendar year.]

(c) [Transfers] Abatement transfers from account.–The Secretary of the Budget [may] shall annually transfer from the account to the Medical Care Availability and Reduction of Error (Mcare) Fund an amount [up] equal to the aggregate amount of abatements granted by the Insurance Department under section 1104(b)[.], minus the sum of the amount deposited in the fund under section 712(m) and any payments of the assessment levied under section 712(d).

(d) Other deposits.–The Department of Public Welfare may deposit any other funds received by the department which it deems appropriate in the account.

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

Section 5. Section 1115 of the act, amended October 27, 2006 (P.L.1198, No.128), is repealed:

[Section 1115. Expiration.

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

Section 6. The act is amended by adding a section to read:

Section 1116. Health Care Provider Retention Reserve Account.

(a) Establishment.–There is established within the General Fund a special account to be known as the Health Care Provider Retention Reserve Account. The funds in the account shall only be used for the purpose of reducing unfunded liability under Chapter 7.

(b) Transfer.–Notwithstanding any other provision of this act, the Secretary of the Budget shall, as of December 31, 2007, transfer all funds in the account into the Health Care Provider Retention Reserve Account.

Section 6.1. The act is amended by adding chapters to read:

CHAPTER 13

SMALL BUSINESS HEALTH SAVINGS ACCOUNT TAX CREDIT

Section 1301. Scope.

This chapter relates to small business health savings account tax credit.

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:

"Department." The Department of Revenue of the Commonwealth.

"Employee" or "employees." An individual or group of individuals employed by a small business. The term shall also include a sole proprietor.

"Health insurance policy." An individual or group health, sickness or accident policy or subscriber contract or certificate issued by an entity subject to any one 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).

"Health Savings Account." As defined in section 223(d) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(d)).

"Pass-through entity." Any of the following:

(1) A partnership, limited partnership, limited liability company, business trust or other unincorporated entity that for Federal income tax purposes is taxable as a partnership.

(2) A Pennsylvania S corporation.

"Qualified high deductible health plan." A health insurance policy that would qualify as a high deductible health plan under section 223(c)(2) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(c)(2)).

"Qualified tax liability." The liability for taxes imposed 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. The term shall include the liability for taxes imposed under Article III of the Tax Reform Code of 1971 on an owner of a pass-through entity.

"Secretary." The Secretary of Revenue of the Commonwealth.

"Small business." An employer who, on at least 50% of its working days during the taxable year, employed fewer than 100 employees.

"Tax credit." The small business health savings account tax credit.

"Taxpayer." A small business subject to tax 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. The term includes:

(1) the partner, shareholder, owner or member of a pass-through entity; or

(2) a sole proprietor.

Section 1303. Credit for Health Savings Account contributions.

(a) Application.–A taxpayer who purchases and provides a qualified high deductible health insurance policy to employees and makes a contribution to a health savings account on behalf of employees in a taxable year may apply for a tax credit as provided in this chapter. By September 15, a taxpayer must submit an application to the department for the aggregate contribution made by the taxpayer to employee health savings accounts in the taxable year that ended in the prior calendar year.

(b) Computation.–A taxpayer who qualifies under subsection (a) shall receive a tax credit for the taxable year in accordance with the following:

(1) Fifty percent of the aggregate contribution made by the taxpayer to employee health savings accounts when the contribution is provided for the benefit of employees, spouses and dependents for the taxable year.

(2) Twenty-five percent of the aggregate contribution made by the taxpayer to employee health savings accounts when the contribution is provided solely for the benefit of an employee.

(c) Notification.–By December 15 of the calendar year following the close of the taxable year during which the contribution to employee health savings accounts was made, the department shall notify the taxpayer of the amount of the taxpayer's tax credit approved by the department.

Section 1304. Limitation on credits.

(a) Limit.–The total amount of credits approved by the department shall not exceed $30,000,000 in any fiscal year.

(b) Calculation.–If the total amount of small business health savings account tax credits applied for by all taxpayers exceeds the amount allocated for those credits, then the small business health savings account tax credit to be received by each applicant shall be the product of the allocated amount multiplied by the quotient of the small business health savings account tax credit applied for by the applicant divided by the total of all small business health savings account credits applied for by all applicants, the algebraic equivalent of which is:

taxpayer's small business health savings account tax credit ' amount allocated for those credits X (small business health savings account tax credit applied for by the applicant/total of all small business health savings account tax credits applied for by all applicants).

Section 1305. Carryover, carryback, refund and assignment of credit.

(a) Carryover.–If the taxpayer cannot use the entire amount of the tax credit for the taxable year in which the tax credit is first approved, then the excess may be carried over to succeeding taxable years and used as a credit against the qualified tax liability of the taxpayer for those taxable years. Each time that the tax credit is carried over to a succeeding taxable year, it is to be reduced by the amount that was used as a credit during the immediately preceding taxable year. The tax credit may be carried over and applied to succeeding taxable years for no more than 15 taxable years following the first taxable year for which the taxpayer was entitled to claim the credit.

(b) Application of credit.–A tax credit approved by the department for monetary contributions made to employee health savings accounts in a taxable year first shall be applied against the taxpayer's qualified tax liability for the current taxable year as of the

date on which the credit was approved before the tax credit is applied against any tax liability under subsection (a).

(c) Prohibition.–A taxpayer is not entitled to assign, carry back or obtain a refund of an unused tax credit.

Section 1306. Shareholder, owner or member pass-through.

(a) Shareholder's calculation.–If a Pennsylvania S corporation does not have an eligible tax liability against which the tax credit may be applied, a shareholder of the Pennsylvania S corporation is entitled to a tax credit equal to the tax credit determined for the Pennsylvania S corporation for the taxable year multiplied by the percentage of the Pennsylvania S corporation's distributive income to which the shareholder is entitled.

(b) Owner or member calculation.–If a pass-through entity other than a Pennsylvania S corporation does not have an eligible tax liability against which the tax credit may be applied, an owner or member of the pass-through entity is entitled to a tax credit equal to the tax credit determined for the pass-through entity for the taxable year multiplied by the percentage of the pass-through entity's distributive income to which the owner or member is entitled.

(c) Application; restrictions.–The credit provided under subsection (a) or (b) is in addition to any tax credit to which a shareholder, owner or member of a pass-through entity is otherwise entitled under this chapter. However, a pass-through entity and a shareholder, owner or member of a pass-through entity may not claim a credit under this chapter for the same contributions made to employee health savings accounts.

Section 1307. Report to General Assembly.

The secretary shall submit an annual report to the General Assembly indicating the effectiveness of the credit provided by this chapter no later than March 15 following the year in which the credits were approved. The report shall include the names of all taxpayers utilizing the credit as of the date of the report and the amount of credits approved and utilized by each taxpayer. Notwithstanding any law providing for the confidentiality of tax records, the information contained in the report shall be public information. The report may also include any recommendations for changes in the calculation or administration of the credit.

Section 1308. Regulations.

The secretary shall promulgate regulations necessary for the implementation and administration of this chapter.

CHAPTER 15

DISEASE MANAGEMENT TAX CREDIT

Section 1501. Scope.

This chapter relates to disease management insurance policy tax credits.

Section 1502. 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:

"Department." The Department of Revenue of the Commonwealth.

"Disease management insurance policy." A group or individual health insurance policy that includes a disease management program.

"Disease management program." A set of interventions designed to improve the health of individuals, especially those with certain ailments or diseases. A disease management program may include:

(1) Identifying patients and matching the intervention with need.

(2) Support for adherence to evidence-based medical practice guidelines, including providing medical treatment guidelines to physicians and other providers, and providing support services to assist the physician in monitoring the patient.

(3) Services designed to enhance patient management and adherence to an individualized treatment plan, including patient education, monitoring and reminders, and behavior modification programs aimed at encouraging lifestyle changes.

(4) Routine reporting and feedback loops, including communication with patient, physician, health plan and ancillary providers, and practice profiling.

(5) Collection and analysis of process and outcome measures.

"Pass-through entity." Any of the following:

(1) A partnership, limited partnership, limited liability company, business trust or other unincorporated entity that for Federal income tax purposes is taxable as a partnership.

(2) A Pennsylvania S corporation.

"Primary contractor." A person licensed to conduct business in this Commonwealth that develops, implements or monitors disease management programs.

"Qualified tax liability." The liability for taxes imposed under Article III (relating to personal income tax), IV (relating to corporate net income tax) or VI (relating to capital stock franchise tax) of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The term includes the liability for taxes imposed under Article III of the Tax Reform Code of 1971 on a sole proprietor, partner, shareholder, owner or member of a pass-through entity.

"Secretary." The Secretary of Revenue of the Commonwealth.

"Service provider." A person licensed to conduct business in this Commonwealth that is selected by the primary contractor to provide disease management programs.

"Small business." A taxpayer with fewer than 50 employees.

"Tax credit." The disease management insurance policy tax credit authorized under this chapter.

"Taxpayer." An entity subject to tax under Article III (relating to personal income tax), IV (relating to corporate net income tax) or VI (relating to capital stock franchise tax) of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The term includes:

(1) the partner, shareholder, owner or member of a pass-through entity that receives a tax credit; or

(2) a sole proprietor.

Section 1503. Credit for disease management insurance policies.

(a) Application.–

(1) A taxpayer who purchases and provides a disease management insurance policy to employees in a taxable year may apply for a tax credit as provided in this chapter. By September 15, a taxpayer must submit an application to the department for premiums paid in the taxable year that ended in the prior calendar year.

(2) A taxpayer with 50 or more employees who purchases and provides a disease management insurance policy to employees in a taxable year may apply for a tax credit as provided in this chapter. By September 15, a taxpayer must submit an application to the department for premiums paid in the taxable year that ended in the prior calendar year.

(b) Tax credit.–A taxpayer qualified under subsection (a)(1) shall receive a tax credit for the taxable year in the amount of $500 for each employee of the taxpayer covered by a disease management insurance policy. A taxpayer qualified under subsection (a)(2) shall receive a tax credit for the taxable year in an amount equal to 50% of the cost to the taxpayer for providing health care coverage for employees, contingent on proof the purchased coverage utilizes disease management protocols.

(c) Notification of credit.–By December 15 of the calendar year following the close of the taxable year, the department shall notify the taxpayer of the amount of the taxpayer's tax credit approved by the department.

Section 1504. Certification requirement.

(a) Application.–In order to qualify for the tax credit, a taxpayer, in conjunction with the Department of Labor and Industry and the Insurance Department, shall make application for the certification of the disease management program purchased as part of the disease management insurance policy. The Insurance Department shall develop the certification criteria.

(b) Reapplying.–In the subsequent tax year, a taxpayer reapplying for the tax credit must provide verification to the Department of Labor and Industry and the Insurance Department that the disease management program meets the certification requirements and continues to be purchased by the taxpayer.

Section 1505. Carryover, carryback, refund and assignment of credit.

(a) General rule.–If the taxpayer cannot use the entire amount of the tax credit for the taxable year in which the tax credit is first approved because the amount of the tax credit exceeds the tax liability of the taxpayer for the year in which the tax credit under section 1503 (relating to credit for disease management insurance policies) is to be applied, the excess may be carried over to succeeding taxable years and used as a credit against the qualified tax liability of the taxpayer for those taxable years. Each time the tax credit is carried over to a succeeding taxable year, it shall be reduced by the amount that was used as a credit during the immediately preceding taxable year. The tax credit may be carried over and applied to succeeding taxable years for no more than 15 taxable years following the first taxable year for which the taxpayer was entitled to claim the credit.

(b) Application of tax credit.–A tax credit approved by the department for premiums incurred in a taxable year shall first be applied against the taxpayer's qualified tax liability for the current taxable year as of the date on which the credit was approved before the tax credit may be applied against any tax liability under subsection (a).

(c) Unused tax credit.–A taxpayer is not entitled to assign, carry back or obtain a refund of an unused tax credit.

Section 1506. Time limitations.

A taxpayer is not entitled to a tax credit for health insurance premiums providing for disease management programs incurred in taxable years ending after December 31, 2010.

Section 1507. Limitation on credits.

(a) Allocation for small businesses.–Forty percent of available funds shall be allocated exclusively for small businesses. However, if the total amounts allocated to either the group of applicants exclusive of small businesses or the group of small business applicants is not approved in any fiscal year, the unused portion will become available for use by other qualifying taxpayers.

(b) Proration of tax credits.–

(1) If the total amount of tax credits applied for by all taxpayers, exclusive of small businesses, exceeds the amount allocated for those credits, the tax credit to be received by each applicant shall be prorated by the department among all applicants, exclusive of small businesses, who have qualified for the credit.

(2) If the total amount of tax credits applied for by all small businesses exceeds the amount allocated for those credits, the tax credit to be received by each small business applicant shall be prorated by the department among all small business applicants who have qualified for the credit.

Section 1508. Shareholder, owner or member pass-through.

(a) Pennsylvania S corporations.–If a Pennsylvania S corporation does not have an eligible tax liability against which the tax credit may be applied, a shareholder of the Pennsylvania S corporation is entitled to a tax credit equal to the tax credit determined for the Pennsylvania S corporation for the taxable year multiplied by the percentage of the Pennsylvania S corporation's distributive income to which the shareholder is entitled.

(b) Pass-through entities.–If a pass-through entity other than a Pennsylvania S corporation does not have an eligible tax liability against which the tax credit may be applied, an owner or member of the pass-through entity is entitled to a tax credit equal to the tax credit determined for the pass-through entity for the taxable year multiplied by the percentage of the pass-through entity's distributive income to which the owner or member is entitled.

(c) Entitlement.–The credit provided under subsection (a) or (b) is in addition to any tax credit to which a shareholder, owner or member of a pass-through entity is otherwise entitled under this chapter. However, a pass-through entity and a shareholder, owner or member of a pass-through entity may not claim a credit under this chapter for the same premium or employee.

Section 1509. Accountability.

(a) Review procedures.–Any taxpayer that receives a tax credit under this chapter shall be subject to a performance review by the Department of Labor and Industry, in conjunction with the Insurance Department. As appropriate, the performance review shall be based upon information submitted to the department that includes the following:

(1) The contractor's or service provider's strategic goals and objectives for disease management programs.

(2) The contractor's or service provider's annual performance plan setting forth how these strategic goals and objectives are to be achieved and the specific methodology for evaluating results, along with any proposed methods for improvement.

(3) The contractor's or service provider's annual performance report setting forth the specific results in achieving its strategic goals and objectives for disease management, including any changes in the health of participants in the disease management program.

(4) The progress made in achieving expected program priorities and goals.

(5) Any other information deemed necessary by the department.

(b) Penalty.–If a performance review indicates that a primary contractor or a service provider failed to comply with contract requirements or meet performance goals, taxpayers may be subject to a reduction in or ineligibility for future tax credit funding under this chapter.

Section 1510. Report to General Assembly.

(a) Submission of report.–The secretary shall submit an annual report indicating the effectiveness of the credit provided by this chapter no later than March 15 following the year in which the credits were approved to the Governor, the chairmen and the minority chairmen of the Public Health and Welfare Committee and the Appropriations Committee of the Senate and the chairmen and minority chairmen of the Health and Human Services Committee and the Appropriations Committee of the House of Representatives.

(b) Contents.–The report shall include the names of all taxpayers utilizing the credit as of the date of the report and the amount of credits approved and utilized by each taxpayer.

(c) Public information.–Notwithstanding any law providing for the confidentiality of tax records, the information contained in the report shall be public information.

(d) Recommendations.–The report may also include any recommendations for changes in the calculation or administration of the credit.

Section 1511. Termination.

The department shall not approve a tax credit under this chapter for taxable years ending after December 31, 2010.

Section 1512. Regulations.

The secretary shall promulgate regulations necessary for the implementation and administration of this chapter.

CHAPTER 17

HEALTHY LIVING AND WELLNESS TAX INCENTIVES

Section 1701. Scope.

This chapter relates to tax incentives for wellness services and healthy living equipment and products.

Section 1702. 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:

"Annual limitation." $2,500.

"Annual personal income tax return." The return required to be filed under section 330 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Code." The act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Department." The Department of Revenue of the Commonwealth.

"Healthy living product." Exercise equipment used in a residential property, nutritional supplements purchased by a taxpayer, a membership to a gym, exercise facility or a similar facility, the cost of a class or a course providing for the instruction of a physical activity, including martial arts, sports, dance or similar activities.

"Qualified expense." The cost incurred for the purchase at the sale at retail or use of a healthy living product or a wellness service.

"Tax credit." The healthy living and wellness tax credit.

"Taxable income." The term shall have the same meaning as given to it in section 301 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Taxpayer." The term shall have the same meaning as given to it in section 301 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Wellness service." Pregnancy care, fitness centers, weight management, nicotine cessation, stress management and other similar services.

Section 1703. Healthy living and wellness tax credit.

(a) Application.–A taxpayer may apply on the annual personal income tax return for a tax credit for qualified expenses as provided under this chapter.

(b) Department duties.–The following apply:

(1) The department shall provide a form by which a taxpayer may apply for the tax credit.

(2) The department shall make the form available with the annual personal income tax return.

(3) The department shall not grant a tax credit for a qualified expense that was not incurred by the taxpayer.

(4) The department shall prescribe a method by which a taxpayer may apply for the tax credit, including making available a method by which a taxpayer may claim and provide proof of qualified expenses when applying for the tax credit.

(5) The department shall grant a tax credit to a taxpayer who satisfies the requirements of this section.

(c) Computation.–A taxpayer who applies under subsection (a) shall be eligible to receive a tax credit for the taxable year equal to the amount of qualified expenses incurred by the taxpayer.

(d) Limitations.–The following apply:

(1) The amount of a tax credit awarded to a taxpayer under this section shall not exceed the annual limitation.

(2) A taxpayer shall be ineligible for a tax credit if the taxpayer is not up to date with all tax payments for tax liabilities prior to the tax year for which a taxpayer is applying for a tax credit.

(3) The amount of a tax credit awarded to a taxpayer under this section shall not result in taxable income being less than zero.

Section 1704. Sales and use tax exclusion.

In addition to the exclusions from tax provided for under section 204 of the code, the sale at retail or use of healthy living products and wellness services shall not be subject to the tax imposed under Article II of the code.

Section 1705. Construction.

To the extent necessary, a term used in this chapter that is not defined in section 1702 shall carry the same meaning given to it under Article II or III of the code unless the context clearly indicates otherwise.

Section 1706. Regulations.

The department shall promulgate rules and regulations as necessary for effectuating the provisions of this chapter.

Section 1707. Applicability.

This chapter shall apply to taxable years beginning after June 30, 2008.

CHAPTER 19

COMMUNITY-BASED HEALTH PROVIDER ASSISTANCE

Section 1901. Scope of chapter.

This chapter relates to community-based health provider assistance.

Section 1902. 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:

"Community-based health care provider." Any of the following nonprofit health care centers which provide primary health care services:

(1) A federally qualified health center as defined under section 1905(1)(2)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396d(1)(2)(B)).

(2) A rural health clinic as defined under section 1861(aa)(2)) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(aa)(2)), certified by Medicare.

(3) A freestanding hospital clinic serving a federally designated health care professional shortage area.

(4) A free or partial-pay health clinic which provides services by volunteer medical providers.

"Department." The Department of Health of the Commonwealth.

"Health care provider." A health care facility or health care practitioner as defined in the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, a group practice or a community-based health care provider.

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

"Program." The Community-Based Health Provider Assistance Program.

"Uncompensated care." The cost of reasonable and medically necessary care provided to individuals unable or unwilling to pay for services provided by a community-based health provider.

Section 1903. Program.

(a) Program established.–The Community-Based Health Provider Assistance Program is established to provide grants to community-based health providers to:

(1) Improve the access to and quality of health care in this Commonwealth.

(2) Assist in covering the reasonable costs of providing health care services, outreach and care management opportunities to persons eligible to receive health care services from or through community-based health providers.

(3) Improve access to medically necessary preventive, curative and palliative physical, dental and behavioral health care services offered by and through community-based health providers, while reducing unnecessary or duplicative services.

(4) Reduce the unnecessary utilization of emergency health care services by supporting the development and provision of effective alternatives offered by or through community-based health providers.

(5) Improve the availability of quality health care services offered by or through community-based health providers for expectant mothers, women who have recently given birth and their children.

(6) Promote the use of chronic care and disease management protocols offered by or through community-based health providers in an effort to optimize both individual health outcomes and the use of health care resources.

(b) Administration.–The program shall be administered by the department and shall be funded by annual transfers to the Low Income Health Care Access Fund to support community-based health providers' provision of health care.

(c) Department responsibilities.–The department shall have the following powers and duties:

(1) Administer the program.

(2) Within 90 days of the effective date of this section, develop and provide an application form consistent with this chapter.

(3) Determine the eligibility of community-based health providers for the assistance provided under this chapter, based upon its consideration of revenue and cost data and other information provided by community health providers, as well as such other information as the department determines to be appropriate to reflect the financial condition and needs of such centers and the Commonwealth.

(4) Establish a process to allocate funding as provided under this chapter, to determine the optimal use of funds and to reallocate funds if acceptable requests for funding within a particular category are not received.

(5) Calculate and make payments to qualified community health providers from the funds deposited in the Low Income Health Care Access Fund.

(6) Provide an annual report to the chairman and minority chairman of the Public Health and Welfare Committee of the Senate and the chairman and minority chairman of the Health and Human Services Committee of the House of Representatives describing the operation of the program and detailing grants made, the names and addresses of the community-based health providers receiving grants and such other information as may be determined by the department to be necessary or desirable.

(7) Audit grants awarded under this chapter to ensure that funds have been used in accordance with the terms and standards adopted by the department.

(8) Provide ongoing assessment of the benefits and costs of the assistance provided under this chapter.

(d) Other funding sources.–The Commonwealth is authorized and directed to seek Federal matching funds under medical assistance, as well as grants and funding from other sources, to supplement amounts made available under this chapter to the extent permitted by law.

(e) Limitations on payments by department.–Payments made under this chapter in a fiscal year shall not exceed the amount of funds available in the Low Income Health Care Access Fund for the program and any payment under this chapter shall not constitute an entitlement from the Commonwealth or a claim on any other funds of the Commonwealth.

(f) Report.–Each community-based health provider receiving a grant under this chapter shall report at least annually to the department, as specified by the department, and shall include all of the following:

(1) The efforts undertaken to improve access to and the delivery and management of health care services.

(2) The reduction of unnecessary and duplicative health care services.

(3) The improvements in overall health indicators and in utilization of health care services, with particular emphasis on indicators including an assessment of:

(i) The establishment of relationships between providers and individuals directed toward funding medical homes for such persons, as well as the provision of preventive and chronic care management services.

(ii) The care of expectant mothers.

(iii) Postpartum care of mothers.

(iv) The care of newborn children and infants.

(4) An accounting of the expenditure of funds from the grant and all funds received from other sources.

Section 1904. Grants to community-based health providers.

(a) Allocation of funds.–The department shall provide grant assistance to community health providers on the basis of the process established in this section, subject to reallocation as provided under subsection (f).

(b) Method of awarding grants.–The department shall develop a methodology to determine grant amounts to be awarded under this chapter, based upon community need for the services to be supported by funding provided to community-based health providers. It is the intent of the General Assembly that during the first three years of the program the department shall use its best efforts to make grants as follows, subject to reallocation as provided under subsection (f):

(1) Twelve million dollars for expansion of current community-based health providers or development of new community-based health providers.

(2) Five million dollars for improvements in prenatal, obstetrics, postpartum and newborn care provided by or through community-based health providers.

(3) Five million dollars for services intended to reduce unnecessary emergency room utilization and to expand capacity and services offered by or through existing community-based health providers.

(c) Additional information.–In addition to the application, the applicant shall provide:

(1) A feasibility study of the proposed uses of funds to be provided under the grant.

(2) A business or financial plan that describes the long-term sustainability, financial cost to the applicant and the proposed benefits of the work to be accomplished pursuant to the grant.

(3) A strategic plan and schedule for the development and implementation of the work to be accomplished under the grant.

(d) Limitation.–The amount of a grant to any specific community-based health care provider under this program shall not exceed $2,000,000 and shall be for a term of not more than five years.

(e) Reallocation.–The department shall reallocate funds among the categories provided under subsection (b) if sufficient requests are not received by the department that comply with this chapter or the requirements of the department.

Section 1905. Low Income Health Care Access Fund.

(a) Restricted account established.–There is established a restricted account in the Mcare Fund, to be known as the Low Income Health Care Access Fund.

(b) Funding.–The Low Income Health Care Access Fund shall be funded by:

(1) Appropriations to the Low Income Health Care Access Fund.

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

(3) Money required to be deposited in the Low Income Health Care Access Fund pursuant to other provisions of this chapter or any other law.

(4) Return on money in the Low Income Health Care Access Fund, net of investment costs.

(c) Nonlapse.–The money in the Low Income Health Care Access Fund is continuously appropriated to the Low Income Health Care Access Fund and shall not lapse at the end of any fiscal year.

CHAPTER 21

HEALTH CARE COMPARISON

Section 2101. 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:

"Adult basic." The health investment insurance program established under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

"Ambulatory service facility." A facility licensed in this Commonwealth, not part of a hospital, which provides medical, diagnostic or surgical treatment to patients not requiring hospitalization, including ambulatory surgical facilities, ambulatory imaging or diagnostic centers, birthing centers, freestanding emergency rooms and any other facilities providing ambulatory care which charge

a separate facility charge. Physician's offices and offices of other licensed health care providers, whether in group or individual practices, shall be considered ambulatory service facilities for the purposes of this act.

"Children's Health Insurance Program" or "CHIP." The 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.

"Council." The Health Care Cost Containment Council.

"Covered services." Any health care services or procedures connected with episodes of illness that require either inpatient hospital care or major ambulatory service such as surgical, medical or major radiological procedures, including any initial and follow-up outpatient services associated with the episode of illness before, during or after inpatient hospital care or major ambulatory service. The term includes routine outpatient services connected with episodes of illness that do not require hospitalization or major ambulatory service, including all office visits to physicians, chiropractors and other data sources including other licensed health care providers.

"Data source." A hospital; ambulatory service facility; physician; audiologist; birthing center; chiropractor; dentist; doctor of medicine; mental health professional including psychologists; nurse practitioner; optometrist; osteopath; physical therapist; podiatrist; speech pathologist or other licensed health care provider; health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act; hospital, medical or health service plan with a certificate of authority issued by the Insurance Department, including, but not limited to, hospital plan corporations as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) and professional health services plan corporations as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations); commercial insurer with a certificate of authority issued by the Insurance Department providing health or accident insurance; self-insured employer providing health or accident coverage or benefits for employees employed in the Commonwealth; administrator of a self-insured or partially self-insured health or accident plan providing covered services in the Commonwealth; any health and welfare fund that provides health or accident benefits or insurance pertaining to covered service in the Commonwealth; the Department of Public Welfare for those covered services it purchases or provides through the medical assistance program under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, and any other payor for covered services in the Commonwealth other than an individual. This term shall also include physicians.

"Health care facility." A general or special hospital, including tuberculosis and psychiatric hospitals, kidney disease treatment centers, including freestanding hemodialysis units, birthing centers, offices of physicians, chiropractors and other data sources including other licensed health care providers, and ambulatory service facilities as defined in this section, and hospices, both profit and nonprofit, and including those operated by an agency of State or local government.

"Licensee." An individual who is a data source and is licensed or certified by the Commonwealth of Pennsylvania to provide a covered service in a hospital, an office or other health care facility in this Commonwealth.

"Medical assistance." Medical treatment which is subsidized or completely paid for by the Commonwealth under Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medicare." The program established under Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C. § 1395 et seq.).

"Other licensed health care provider." Any of the following:

(1) a licensee;

(2) a health care facility; or

(3) an officer, employee or entity of a licensee or health care facility acting in the course and scope of employment.

"Physician." An individual licensed under the laws of this Commonwealth to practice medicine or surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985. The term includes other licensed health care providers.

"Provider." A hospital, an ambulatory service facility or a physician or a data source, a birthing center or other licensed health care provider.

"Work group." The data abstraction and technology work group established by the council under section 6(a.1) of the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

Section 2102. Powers and duties of council.

The council is hereby authorized to and shall compile and establish an Internet database for the general public showing physician charge comparisons for common services and treatments.

Section 2103. Data submission and collection.

(a) Abstraction and technology work group.–

(1) The work group shall develop a system of data collection and analysis on physician charges for common services and treatments working with council staff and outside third-party venders as needed and authorized by the council. The analysis shall provide a methodology for developing a charge comparison Internet search capability showing most commonly utilized medical services and treatments.

(2) The work group will, as part of its analysis, examine physician charge comparison systems used in other states as an addendum to its report identifying which components of those other state systems are applicable or appropriate to Pennsylvania. This analysis of other states shall include descriptions as to how the physician charge data is collected and shall include a recommendation to the council, as to the most efficient, cost-effective and least intrusive way to determine the physician charge comparisons for common utilized services and treatments. The work group recommendation to the council shall contain comparison by common physician service or treatment and geographic location of the physician searchable by county.

(3) This physician charge comparison shall also contain data on reimbursement rates for adult basic, CHIP, Medicaid, medical assistance, Medicare and insurer reimbursement rates by insurer.

(4) The work group shall report its recommendations to the council no later than 180 days after the effective date of this section. The physician charge comparison described in this paragraph shall be available to consumers beginning January 1, 2009, or sooner.

(b) Data elements.–For each covered service performed in Pennsylvania, the council shall be required to collect charges from physicians for commonly utilized treatments as approved by the council in accordance with subsection(a)(4).

Section 7. Section 1211 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, is repealed insofar as it is inconsistent with the provisions of this act.

Section 8. All surcharges levied under 75 Pa.C.S. § 6506(a) shall be transferred to the Hazardous Sites Cleanup Fund on and after the effective date of this section.

Section 9. This act shall take effect as follows:

(1) Section 8 of this act shall take effect December 31, 2007, or immediately, whichever is later.

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

(i) The repeal of section 712(e) of the act.

(ii) The amendment of the definition of "account" in section 1101 of the act.

(iii) The amendment of section 1102(a) of the act.

(iv) The amendment of section 1105 of the act.

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

(vi) The addition of section 1116 of the act.

(vii) The addition of Chapter 13 of the act.

(viii) The addition of Chapter 15 of the act.
(ix) The addition of Chapter 17 of the act.
(x) The addition of Chapter 19 of the act.
(3) The remainder of this act shall take effect immediately.

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Watson on the amendment.

Mrs. WATSON. Thank you, Mr. Speaker.

Amendment A06050, briefly then I assume someone wants a description of the amendment. It will provide for the Mcare abatement. This does this in 6 years, phasing it out; doctors increasing increments in their pay of $50,000. It provides tax credits for small businesses. It provides for wellness programs, disease management, and credits for that. It also includes money to fight the hospital-acquired or health-care acquired infections, and there is funding in there for that. And particularly, this includes then what you would term "community-based health-provider assistance." We know that it is funding money and providing money to the federally qualified health centers so that they can extend hours, take care of more people, and by their own discussion, they believe they will increase then usage by 80,000 folks who are currently uninsured and would have then a medical home across the State.

That, basically, is what the amendment does. You will see that what it is is a compilation of some of the bills that we put out individually as freestanding bills last December, at the beginning of December, and we think that at least some of these should be amended into this legislation since no one else is bringing them up.

Thank you.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, first of all, I just want to commend Representative Watson. As I think many people in the chamber know, we have worked together in a task force to look at the issue of health care and worked, really, with members on both sides of the aisle to try and develop a package of legislation that looks at this issue in, really, what I would define as a targeted fashion, identifying who the uninsured are, who needs help in Pennsylvania, and developing a plan that really focuses on consumer-driven health care and the consumer-driven health delivery system.

Mr. Speaker, when we look at the issue of escalating health-care costs, the uninsured are clearly a part of the discussion. They are clearly a part of what we need to reach out to and try and help. Representative Schroder had an idea that we just considered that would have taken a huge bite out of those who were uninsured. Unfortunately, our colleagues across the aisle did not embrace that idea.

But beyond that discussion, Mr. Speaker, we have got to get to the crux of the issue, and the crux of the issue is that the cost of health care is continuing to escalate out of control for everybody. The reason that we have more people without health insurance is because the cost of insurance and the cost of health care is rising for everybody. And what our package does, and what the Watson amendment does, is really embody tools that will keep businesses and keep employers in the marketplace of providing health insurance.

As government continues to escalate government programs and government expands their role in this marketplace, what it does is it puts more and more pressure on the private sector to do two things: one, get out of the business. We are just going to stop providing health benefits. Mr. Speaker, I am a small employer. I know from which I speak on this issue. I have endured increasing health insurance premiums. As government competes and gets in that marketplace, it is very easy for employers to just say, I am not going to do this anymore. Go see Ed Rendell; go see Todd Eachus; go see Scott Boyd. They are going to provide your health insurance for you. I am out of the marketplace. We are tremendously concerned that we are not doing more to keep private employers in the business of providing benefits for their employees. The Watson plan does that. It embodies some of the tools that will keep those market forces in play.

It also, as I said, does not ignore the uninsured. There are tools in our package that will go after expanding the use of federally qualified health centers. There are other provisions that we have that will help drive costs down for everybody, the transparency piece. There are a number of things that we have worked together across the aisle with some of our colleagues in the Insurance Committee and also some members of the administration, and we were making tremendous strides, Mr. Speaker, when those discussions ceased.

I am encouraging members to support this plan, kind of as a sign of faith that those negotiations would continue to go forward.

Additionally, it is important for the members to understand, while they would have the ability to vote for a health-care plan, they are also voting for the plan, Mr. Speaker, the plan that, in fact, deals with the Mcare unfunded liability, extends the abatement. This is the program that the physicians, Medical Society, and the Hospital Association had basically signed off and said they were okay with. We do not know what is in future amendments and what will be coming down the road. We know that what is in this plan has been agreed to. It has been agreed to by the providers. It deals with the unfunded liability. It extends the abatement. It secures our doctors and physicians.

Mr. Speaker, this is a good alternative, and I encourage the members to give this a serious look and ask them to vote for this amendment.

Thank you, Mr. Speaker.

The SPEAKER. Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

I rise to oppose amendment 6050 for one clear reason: This amendment does not eliminate and open one spot on the waiting list. There is not one additional person on the adultBasic waiting list that gets coverage with this amendment. Let us not lose our focus today. This is about covering Pennsylvanians with affordable health care. This amendment falls short. Please oppose the amendment.

The SPEAKER. Representative Cutler.

Mr. CUTLER. Thank you, Mr. Speaker.

I would just like to follow up those last remarks, if I may, and I am going to go back to a point that I stated earlier with regards to the waiting list for the insurance in this State. The reality is this: That list for insurance will only continue to grow if we do not have doctors in the State that can practice medicine.

Again, we cannot discuss the merits of the amendment. We cannot debate the amendment. We do not even know what the

future amendment might cost. But this one is in front of us, and it has several very good points in it that I would like to highlight, the unfunded liability that is in the future.

Mr. Speaker, I have already gotten letters and e-mails and calls about the difficulty in recruiting physicians because they will have to pay this future liability. We are now robbing that fund, not paying off the liability, and I have had physicians tell me they will not come here because they have got 20 years of potential payments ahead of them for a problem or a liability issue that they did not create.

You want to talk about a crisis in recruiting physicians, that is it; that is the reality. We will not have physicians in this State, and the other problem, Mr. Speaker, that the honorable lady has brought forward is also a very good one. Our package, as proposed, deals with the health-care costs for everyone – everyone who is currently self-paying, everyone who is paying insurance, everyone involved. If we can lower the cost, that increases access, and with better access, we all have access to health care.

Mr. Speaker, with this future amendment, as promised, if it does not address these issues, then we have got major problems. We have got problems with physicians who will not be here to practice. We have got problems with growing insurance lists, and, Mr. Speaker, we cannot keep robbing Peter to pay Paul. This reminds me of the scams that I see set up outside of Lincoln Financial when I go there to watch the Eagles. They have got these cards set up, and they will swap them around and ask you to pick a winner, and they never tell you, obviously, which one it is because they make money that way.

Mr. Speaker, this is no different than a card swap. All they are doing is taking money from one fund, moving it to another, and then we will have to worry about the financial crisis in the future and we will not have to answer that problem today, because here is the problem, Mr. Speaker: Too many of these plans are politically motivated to get votes today and we will pay the bill tomorrow, and that has got to stop.

The SPEAKER. Is there anyone seeking recognition before the Chair recognizes the prime sponsor of the amendment?

Representative Watson, for the second time.

Mrs. WATSON. Thank you, Mr. Speaker.

I think I should answer first the gentleman from Luzerne's comment about there is not anything here for uninsured. Actually, the way we did our original package, each piece of it was a separate entity; it was a separate bill, and so this amendment reflects some of those. We understand it does not reflect all. If it were my choice in how we would follow the process, we would go each thing individually. We would not bind Mcare abatement to a bunch of other issues. We would handle them separately so that members would have an opportunity and have the chance to really think what they were doing.

You will also note in this amendment, Mr. Speaker, I tried to be very careful that everything could be paid for. Again, going back to the way I view government is that you do not make a promise that you cannot keep, and so we do that here, Mr. Speaker. I think when we get to things like disease management with the chronic care, I think when we work on health-care acquired infections, we have good things in here. Certainly the federally qualified health centers – I might add there is not one in Bucks County, so it obviously did not affect my constituents – but it is a wonderful thing for Pennsylvanians across this State by expanding that program and allowing more people to have a primary medical home. We do a lot there.

If we get some of our other amendments in, we will be happy to do what the gentleman wants and we will do a retool of adultBasic, but let us deal with what is here in this amendment and then move forward. I did not start that process. I just have to follow it, what the majority leader said last night.

Thank you, Mr. Speaker.

The SPEAKER. Representative Boyd, for the second time.

Mr. BOYD. Thank you, Mr. Speaker.

My apologies to the prime sponsor; I know it is tradition for them to go last, but I was checking on some statistics before I came back to the microphone.

Mr. Speaker, a prior— One of my colleagues across the aisle made a comment that let us not lose sight of the objective. Mr. Speaker, I do not believe that this amendment loses sight of the objective at all. I think the objective is the cost of health care in Pennsylvania is skyrocketing, it is spiraling, and it is getting out of control for businesses to continue to pay health insurance premiums. This is the only amendment – please listen – this is the only amendment that addresses those issues. It is the only amendment that will get at the cost of health care, the core of what the problem is in Pennsylvania.

Ninety-two percent, Mr. Speaker, 92 percent of Pennsylvanians have health insurance. We rank well above just about every other State in the nation, currently, in the delivery of health insurance to our populations. If we do not get our arms around the cost, we will begin to lose that focus, and we will drift. We will begin to see more people uninsured.

And, Mr. Speaker, in every piece of testimony that we heard in the insurance committees that I went through, what happens when the government gets involved, there are artificially low reimbursement rates to providers – Medicaid, 80 percent of what the charge is; Medicare, 30 percent of what the charges are; Medicaid, 20 percent of charges; Medicare, 30 percent of charges. Ask any hospital CFO (chief financial officer). Do you make or lose money on that? They say they lose money. How do you do that? They shift the cost, Mr. Speaker, to the private sector. As we expand government programs, Mr. Speaker, the private sector pays more, costs go up, and they get out of the marketplace of providing health insurance.

The only amendment that you or any of us will consider today that gets at the core problem of the cost of health care is the Watson amendment. This is the vote, Mr. Speaker. If you care about the ever-escalating cost of health care in Pennsylvania, you will vote "yes" on this amendment. If you do not, you will vote "no." I cannot say it any clearer than that, Mr. Speaker. This amendment is at the core of what the problem is in the health delivery system in Pennsylvania.

Thank you, Mr. Speaker.

The SPEAKER. Representative Smith.

Mr. S. SMITH. Thank you, Mr. Speaker.

Mr. Speaker, the previous speaker I think made the important points, but I would just like to reiterate them just a little wee bit. I will not be too long.

When you look at the overall health insurance system in Pennsylvania, yes, there is a group of people that are uninsured that are somewhere between the welfare-type systems and the private-sector insurance programs that our employers provide for us, and we do want to expand insurance opportunities – affordable insurance opportunities – to that group of people that are currently uninsured. The plan that the House Democrats will

propose to this floor later today may address some of those people, but it ignores the 90 percent that currently have insurers; it ignores that group. This amendment, Mr. Speaker, recognizes the fact that employers cannot continue to provide insurance at the rate things are going, putting more people into the uninsured.

The fact is, Mr. Speaker, this amendment does control those costs; it does make it more affordable; it does help our employers continue to provide the insurance plans for employees that absorb that middle, absorb that group in the middle. That is the direction we need to go, Mr. Speaker. If we do not, if we simply ignore it and say, well, we are just going to create this expanded ABC-type program that the Democrat member's amendment would do, if that is all we are going to do, more employers are going to stop providing insurance. You are going to just shift the crowd that is not insured currently; you are just going to shift it. You need to address this from a comprehensive fashion.

Secondly, Mr. Speaker, this amendment deals with the end of the Mcare issue in a fiscally sound manner, in a responsible manner. There is approximately a $450 million surplus that we would propose be used to pay for all of the claims. Those are people that would sue doctors and legitimately win their claim against a doctor or hospital or provider. When the Mcare Fund is phased out, and we have differing plans on how that phaseout timeline would be, not drastically different in some respects, but where the big difference is, is that the House Democrat amendment is basically saying, we will put a little money aside for the end of the day, what is referred to around the building as the tail, the tail of the Mcare. Once the Mcare program is phased out, there are still a lot of people who are due money, that are owed money, under that government-run insurance program known as Mcare. If we do not set aside money for that, you are basically just saying, 10 years from now you are going to have this huge liability and you are going to be back fighting this same problem again.

This amendment, Mr. Speaker, addresses that in a much more comprehensive way. Even the way we propose to put that money aside, the surplus aside to pay for that tail arguably might not cover it all, but it will certainly put us in much, much better stead to address that problem.

So if you want to ignore that over the phaseout years of Mcare that there are going to be claims that will need to be paid for years after that – because they come in years after the actual action took place – if you want to ignore that problem, then vote against this amendment and for the House Democrat's amendment. It is fundamentally ignoring that issue, Mr. Speaker. It fundamentally ignores it.

Secondly, Mr. Speaker, this amendment clearly addresses the problem of uninsured as much as the House Democrat amendment does, but the difference is it does not start off with a wish and a prayer that a Federal waiver might be approved one day, and it does not start off with a huge, huge additional investment in General Fund tax dollars that will be part of this coming budget year. So if you want to go that route, you are looking at real tax increases and you are looking at the simple fact that you do not know if the Federal waiver is going to be even afforded the Commonwealth a year or two from now, and you have ignored the fact that the Mcare Fund, when it is phased out, is going to have a significant liability.

And many of you who have been here for a while remember the old CAT Fund. The auto CAT Fund is still part of the funding stream of this whole Mcare world and where we are going with both of the approaches that the House Republicans versus the House Democrats have put forth. But I think some of you who have been around here for a while remember the auto CAT Fund and how it came about and how for years – it has been gone; the CAT Fund has been gone for a long time – but we have been paying it off for several years thereafter. That is why that auto CAT Fund money was still there. It took years to pay it off. You are going to put yourself in the same position with the Mcare Fund as we did, whatever, 20 years ago with the auto CAT Fund. It sounded like a good idea at the time, but when you got to the end of the day, there was a huge, huge unfunded liability that needed to be addressed.

So, Mr. Speaker, there is no perfect plan here, I will admit. But this amendment— And there would be some supplements to this amendment, this does not encompass everything that we could possibly do. It is not our entire plan rolled into this. This amendment does address the problem of the uninsured as good as you can do, and it does do it in a fiscally responsible way, and it does take into account that somewhere down the road this Commonwealth is going to owe a huge amount of money to people who have legitimately been awarded damages under the Mcare insurance fund.

I urge the members to support the amendment. Thank you, Mr. Speaker.

The SPEAKER. Representative Cutler, for the second time.

Mr. CUTLER. Thank you, Mr. Speaker.

I, like my colleague before me, actually had pulled some additional facts that I would like to share with the General Assembly. We have been told here this morning that our plan, in the variety of amendments that we have offered, does not cover any additional uninsured people, and I take offense to that because here is why: Our plan, as a comprehensive package, addresses every piece of the problem that is before us. We address the rising cost of health care by allowing consumers to have more of a say in consumer-driven health care, and as I said before, the first time I spoke, cost is the driving factor here in the State with why people cannot get insurance. People cannot afford health insurance because the insurance premiums keep going up because health-care costs keep going up, and if we do not do anything to address that, it will not matter because everybody will end up on the State plan that, quite frankly, I do not think that we can afford.

Our plan addresses the issue of overutilization, the fact that many of the people currently on State plans go right to the emergency room to have their issues taken care of. They do not have family doctors. The reason they do not have family doctors is because State reimbursement is so poor that some physicians do not participate, and now we have engaged in some kind of blackmail, telling physicians, you cannot have your Mcare Fund unless you agree to all of these ancillary and unrelated issues going forward.

More importantly, the consumers do not have to pay for any of the care they go for. We are offering a Cadillac model to people that do not pay anything into it. We have people who are on the State system that get better coverage for some issues than people who work. Mr. Speaker, that is not fair.

It is proven again and again that dollar-one coverage, when people do not have any skin in the game, when they do not have any financial say in their health care, tend to overutilize the system. We do not need to look any further than our neighbor to the north, Canada, or across the sea to Great Britain, where they

have long waiting lines because people are encouraged to go into those systems for each and every ailment.

Mr. Speaker, I would like to pull some facts that I had pulled off the Internet and share them here, and these are directly from the testimony that was heard and given in part and repeated by the Governor. Approximately 800,000 people in the State need insurance. That is a very mobile group, if you will. It tends to change over time. Mr. Speaker, some of those people tend to be uninsured because they choose to be so.

I have a large contingency in my area that is Amish. They self-insure. So they self-pay and they go about it that way, and that is okay. That is their choice. They are allowed to do that. But, Mr. Speaker, this plan as proposed would cover approximately only 200,000 of those people over a period of 5 years. Mr. Speaker, at what cost, at what cost will we cover an additional 200,000 people over 5 years? Our plan starts today. It is not 5 years from now, and better than that, it just does not affect 200,000 people. It affects everyone in the State by getting costs under control.

Mr. Speaker, we only have to look to the north to see Massachusetts in a failed health-care system run by the State. They are already $160 million in the hole – $160 million.

Mr. Speaker, this plan that we have before us has a $120 million startup fee in it – $120 million before we even start covering anyone. It makes me question, Mr. Speaker, before we even get to the questionable funding streams, we have to commit $120 million to start this plan up. Who here would buy a home and put down a down payment without knowing what the end cost is going to be? I do not think any of our constituents would do it, and I do not think we should. We need to know the cost of this plan. We need to understand how it is going to be implemented and we need to understand, beyond a shadow of a doubt, how many people it is going to cover; 200,000 people out of the State, at what cost?

Mr. Speaker, our plan addresses everyone in the State, everyone from low-income to those who have insurance to those who self-pay. Mr. Speaker, that is the better plan for Pennsylvania. That is where we need to go. We need to decrease overutilization. We need to increase consumer choice. We need to make people make smart financial decisions so that they can better manage their health care, Mr. Speaker. That is what this is about, and our plan does that and it does it from day one, not at some point in the future and at some unknown cost.

Thank you.

The SPEAKER. Representative Clymer.

Mr. CLYMER. Thank you, Mr. Speaker.

I have some observations I would like to share with the members. Mr. Speaker, before I became a legislator, I had worked at the Lankenau Hospital down in Philadelphia for 13 years, and I want to talk about the specialists, the doctors that could be at risk if under another plan that we are not aware of. All the providers, that is the doctors, the specialists, have to come on board in order to get payment. That could be a problem, because if a specialist decides that he does not like this Cover All Pennsylvanians program that we may be looking at sometime later this afternoon, here are the consequences. In my legislative district, I have two hospitals – Grandview Hospital and St. Luke's Quakertown Hospital. The majority of physicians are surgeons.

Let us take a look at these specialists: They spend 4 years in college, 4 years in medical school, 1 year in an internship, and anywhere from 2 to 5 years in residency, depending on their specialty. And, Mr. Speaker, when they go into surgery, there is with them, usually, an anesthesiologist, two other surgeons, and three nurses. So they have this team, this wonderful team that is able to be effective in doing the operation and bringing good health to that patient. In addition to that, the more operations a specialist does, he reduces lawsuits because he or she has become proficient at their particular specialty. In addition to that, you have doctors who are able that if you have – we will take neurosurgeons – a team of them that work at a hospital and they can cover that hospital 24/7, you do not have to worry about 12 hours of the day where you do not have that specialist there. That is what we are looking at, just not names saying a specialist, but someone who is going to provide very important medical treatment to Pennsylvanians. So we have to be absolutely certain that we are not playing games here, where we think that they are going to stay simply because they are now here in Pennsylvania.

Someone said earlier in the debate about hospitals not having all the specialists they need, and that is absolutely correct. We are in a semicrisis where doctors, if they feel that there is too much bureaucratic effort being placed on them to do a job that they feel they know how to do and they are out of the decisionmaking process as to what clients they are going to treat, they could go up and leave.

And I just want to mention how important it is that we maintain our specialists. We cannot go out and train someone in 6 months who is going to be an orthopedist or OB-GYN (obstetrician-gynecologist). It takes years to train these men and women to become the specialists they are, not 6 months, not 8 months, and throw them into the medical tent and say, you know, you are here, start treating these patients.

So unless the other side can give us absolute assurance, 100-percent assurance that there is not going to be a negative direction in health care in Pennsylvania, then we need to vote for the Watson amendment.

In addition, Mr. Speaker, we all know that health care is a thriving industry, because we have such great teaching hospitals in the city of Philadelphia. Philadelphia itself is a bedrock of wonderful hospital and medical treatment, with renowned physicians. If they would decide to leave, it would be a disaster for the patients of Pennsylvania and for the city of Philadelphia and Pittsburgh and anyplace, including my district, where I just mentioned I have two hospitals.

Let us do the right thing. Let us be careful and prudent and make sure that we are going to have these specialists with us for many years to come, and vote for the Watson amendment.

Thank you, Mr. Speaker.

The SPEAKER. Representative Sturla.

Mr. STURLA. Thank you, Mr. Speaker.

I will try and be brief. I think we can all agree on both sides of the aisle that health care is a critical issue here in Pennsylvania, and for quite a number of years now, I have heard the gloom-and-doom predictions of the other side of the aisle that if we just did not do things their way, things were going to come to an end here in Pennsylvania for providing health care to citizens as we know it.

And yet what we have seen as a result of the policies that we have developed, we have seen the Mcare costs go down for physicians in Pennsylvania. We have seen the Governor promote a health-care plan for children in Pennsylvania that has covered all children in Pennsylvania. We have seen great strides

in terms of what we have been doing. We have stemmed the tide of what was supposedly a drain of doctors out of the State. We now have malpractice insurance rates going down, not just leveling off, but going down. We were told all those things would not happen, and now we are hearing more gloom and doom.

But I just wanted to provide one factual piece of information; it is not based on anybody's testimony, it is not based on anybody's opinion, it is not based on anything other than facts. In 2004 in the State of Pennsylvania –and I say this as the chair of the Professional Licensure Committee – there were 40,832 doctors licensed in the State of Pennsylvania; 40,832 physicians licensed in the State of Pennsylvania in the year 2004. Move forward to the year 2008. There are now 49,798 physicians licensed in the State of Pennsylvania. Now, I am not sure how that is doctors fleeing when you get another 8,966 more than there were 4 years ago. I am not sure how they are somehow fleeing the State and not giving care to our citizens in Pennsylvania. The last time I checked, the population in the State of Pennsylvania did not go up over the last 4 years. We just have a lot of Pennsylvanians that must be becoming doctors in the State of Pennsylvania. So those are the facts. They are not the opinions; they are the facts.

Thank you, Mr. Speaker.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–95

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	Turzai
Ellis	Maher	Pickett	Vereb
Evans, J.	Major	Pyle	Vulakovich
Everett	Mantz	Quigley	Watson
Fairchild	Marshall	Quinn	

NAYS–103

Belfanti	George	Mann	Shimkus
Bennington	Gerber	Markosek	Siptroth
Biancucci	Gergely	McCall	Smith, K.
Bishop	Gibbons	McGeehan	Smith, M.
Blackwell	Goodman	McI. Smith	Solobay
Brennan	Grucela	Melio	Staback
Buxton	Haluska	Mundy	Sturla
Caltagirone	Hanna	Myers	Surra
Carroll	Harhai	O'Brien, M.	Tangretti
Casorio	Harkins	Oliver	Taylor, R.
Cohen	Hornaman	Pallone	Thomas
Conklin	James	Parker	Vitali
Costa	Josephs	Pashinski	Wagner
Cruz	Keller, W.	Payton	Walko
Curry	Kessler	Petrarca	Wansacz
Daley	King	Petrone	Waters
DeLuca	Kirkland	Preston	Wheatley
DePasquale	Kortz	Ramaley	White
Dermody	Kotik	Readshaw	Williams
DeWeese	Kula	Roebuck	Wojnaroski
Donatucci	Leach	Sabatina	Yewcic
Eachus	Lentz	Sainato	Youngblood
Evans, D.	Levdansky	Samuelson	Yudichak
Fabrizio	Longietti	Santoni	
Frankel	Mahoney	Seip	O'Brien, D., Speaker
Freeman	Manderino	Shapiro	
Galloway			

NOT VOTING–0

EXCUSED–5

Adolph	Marsico	Taylor, J.	True
Hershey			

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mrs. **WATSON** offered the following amendment No. **A06052:**

Amend Title, page 1, line 15, by inserting after "repeals," "
providing for amendments relating to the State Plan for Medical Assistance;

Amend Bill, page 1, lines 25 and 26; page 2, line 1, by striking out all of said lines on said pages and inserting

Section 1. 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 section to read:

Section 106. State Plan for Medical Assistance.

(a) Scope.–This section applies to any provision of this act which:

(1) is added after December 31, 2007; and

(2) expands or reforms the adult basic program through a repeal of Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

(b) Effectiveness.–A provision subject to subsection (a) shall not take effect until publication of a notice in the Pennsylvania Bulletin stating that the Department of Public Welfare has received Federal waiver or approval to amend the State Plan for Medical Assistance.

(c) Expiration.–A provision subject to subsection (a) shall expire upon publication of a notice in the Pennsylvania Bulletin stating that the waiver or approval under subsection (b) has:

(1) expired;

(2) been modified; or

(3) been revoked.

Section 1.1. Sections 711, 712 and 745 of the act are amended to read:

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Watson on the amendment.

The House will be at ease for a moment.

The House will come to order.

Representative Watson is recognized and may proceed.

Mrs. WATSON. Thank you, Mr. Speaker.

This is amendment A06052 – short, sweet, to the point – really a product for me to do this amendment of listening to the Appropriations hearing when the Office of Health Care Reform testified, and that would be not knowing exactly what would be in the plan that the gentleman from Luzerne is offering.

One thing that came clear that night, I guess about a week or two ago, was the idea that whatever would be done would be conditional upon a waiver, a waiver that has never been gotten before from the Federal government, a waiver that they were simply starting to negotiate and do not know if they will be able to get, and yet the bulk of the money that would fund the program would come from the Federal government.

Mr. Speaker, I liken this to depending on the kindness of strangers. Call me pessimistic, but I do not think that is a safe bet and certainly not with the Federal government, when the history has been to reduce costs for them and shift them to States, Pennsylvania included.

And so, Mr. Speaker, in the interest of being fair, in the interest, Mr. Speaker, of not promising something and then either never delivering it or delivering it for a year or two and taking it away, this has in it then the clause that indeed it does not start, the clock does not really start and everything will not take effect until for sure we get the money, the money from the Federal government is there.

It also has a second point to it. If at some point in the future – it protects us – if in the future the Federal government were to take the waiver away, reduce the funding, do whatever it is that they tend to be doing, we would then revert back to the benefits that adultBasic had offered, again, trying to keep some people to have the care, and also, Mr. Speaker, not making a promise we do not keep, being fiscally responsible, which I think we would all want to do at the same time, and I will end by saying, and not depending on the kindness of strangers.

Thank you, Mr. Speaker.

The SPEAKER. Representative Ross.

Mr. ROSS. Thank you, Mr. Speaker.

I am particularly worried about the securing of this waiver. I have heard Secretary Leavitt, in particular, mention that they were very concerned about these waivers and felt that they had gotten out of control and that they were looking to reel them back in. Those are the waivers that have already been granted. We are talking now about a new, additional waiver and we are counting on it. It is not wise for us to count on this waiver to fund this program, which people are going to rely on, and not have a backup plan and an alternative.

I think that before we go any further, we should make sure that we do not commit to a program that we cannot reliably expect to have funded.

Thank you.

The SPEAKER. Is there any member seeking recognition?

Representative Boyd.

Mr. BOYD. Mr. Speaker, I was wondering if we could be at ease just a second, please.

The SPEAKER. The House will be at ease.

(Conference held.)

The SPEAKER. The House will come to order.

FILMING PERMISSION

The SPEAKER. The Chair wishes to advise members he has given permission to Jason Minick of the Associated Press to take still photographs of Representative Manderino for the next 10 minutes.

LEAVE OF ABSENCE CANCELED

The SPEAKER. The Chair recognizes the presence of Representative True on the floor. Her name will be added to the master roll.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER. The House will come to order.

AMENDMENT WITHDRAWN

The SPEAKER. The Chair recognizes Representative Watson.

Mrs. WATSON. Thank you, Mr. Speaker.

After a lengthy consultation and some discussion, I have decided to withdraw this amendment. So indeed we will withdraw 6052.

Thank you, Mr. Speaker.

The SPEAKER. The Chair thanks the lady.

On the question recurring,

Will the House agree to the bill on second consideration?

Mr. **KILLION** offered the following amendment No. **A06114:**

Amend Title, page 1, line 21, by inserting after "expiration;" providing for LifeLine health insurance;

Amend Bill, page 20, by inserting between lines 26 and 27

Section 5.1. The act is amended by adding a chapter to read:

CHAPTER 43

LIFELINE HEALTH INSURANCE

Section 4301. Scope of chapter.

This chapter relates to LifeLine health insurance.

Section 4302. Statement of purpose.

The General Assembly recognizes the need for individuals and employers in this Commonwealth to have the opportunity to acquire affordable health benefit plans that provide appropriate and affordable coverage. The General Assembly seeks to increase the availability of coverage by specifying health benefit plans which certain insurers shall offer and also to require the Insurance Department to take steps to facilitate the availability of information relating to the plans and their terms, conditions and premiums through electronic and other media.

Section 4303. 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:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Dependent child." A natural or adopted child of a qualified individual. The term includes a stepchild who resides in a qualified individual's household if the qualified individual has assumed the financial responsibility for the child and another parent is not legally responsible for the support and medical expenses of the child.

"Eligible dependent." A spouse of a qualified individual and a dependent child who is under 19 years of age.

"Health benefit plan." An individual or group health insurance policy, subscriber contract, certificate or plan which provides health or sickness and accident coverage which is offered by an insurer. The term does not include any of the following:

(1) An accident only policy.

(2) A limited benefit policy.

(3) A credit only policy.

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

(5) A specified disease policy.

(6) A Medicare supplement policy.

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

(8) A fixed indemnity policy.

(9) A dental only policy.

(10) A vision only policy.

(11) A workers' compensation policy.

(12) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

"High deductible health plan." A health insurance policy that would qualify as a high deductible health plan under section 223(c)(2) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(c)(2)).

"Insurer." A company or health insurance entity licensed in this Commonwealth to issue any 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 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).

"Licensee." An individual who is licensed by the Department of State to provide professional health care services in this Commonwealth.

"LifeLine health plan." A health benefit plan that offers the following, subject to the provisions of section 4304:

(1) Twenty-one days of inpatient hospital surgical and medical coverage per policy year.

(2) Coverage for four office visits for primary health care services for covered services rendered by a licensee, subject to a copayment for each visit of $10 for treatment of injury or illness.

(3) Coverage for surgery and anesthesia.

(4) Coverage for emergency accident and medical treatment.

(5) Coverage for diagnostic services up to $1,000 per policy year.

(6) Coverage for chemotherapy and radiation treatment.

(7) Coverage for maternity care.

(8) Coverage for newborn care for up to 31 days following birth.

"Participating insurer." An insurer that offers health benefit plans to groups or individuals and which has health benefit plans in force covering in the aggregate at least 100,000 qualified individuals in this Commonwealth.

"Standard health benefit plan." The LifeLine health plan and any high deductible health plan offered by participating insurers to individuals and employers.

Section 4304. Offering of standard health benefit plans.

(a) Offering of plans.–All participating insurers shall offer the standard benefit plans specified under this chapter to individuals and to employers for the benefit of individuals employed by them.

(b) Inclusion in coverage.–If coverage is provided to eligible dependents under a LifeLine health plan, the coverage shall include dependent children of the insured from the moment of birth and for adopted dependent children with prior coverage from the date of the interlocutory decree of adoption. The participating insurer may require that the insured give notice to it of any newborn child within 90 days following the birth of the newborn child and of any adopted child within 60 days of the date the insured has filed a petition to adopt.

(c) Exclusion.–Participating insurers may exclude coverage under a LifeLine health plan for an individual who has not been covered by a health benefit plan for more than 30 days for up to one year for medical conditions for which medical advice or treatment was received by the individual during the 12 months prior to the effective date of the individual's LifeLine health plan policy.

(d) Applicability.–No law, regulation or administrative directive requiring the coverage of a health care benefit or service or requiring the reimbursement, utilization or inclusion of a specific category of licensee shall apply to LifeLine health plans delivered or issued for delivery in this Commonwealth under the authority granted under this chapter, including the provision of the benefits or requirements mandated by Article VI-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or by regulations promulgated under this chapter.

Section 4305. Facilitation by the department of access to standard health benefit plans and related information.

(a) Duty of department.–The department shall take all actions necessary to effectuate the provisions of this chapter such that participating insurers are able to make standard benefit plans available not later than 180 days following the effective date of this section.

(b) Demonstration of coverage.–

(1) Each insurer shall, not more than 90 days after the effective date of this section, demonstrate to the commissioner all of the following:

(i) If it has health benefit plans in force covering a sufficient number of individuals to qualify as a participating insurer.

(ii) If qualified as a participating insurer, that it has the capacity to issue standard health benefit plans and provide information sufficient to permit the department to discharge the responsibilities assigned to it under subsection (d).

(iii) If qualified as a participating insurer, that it has undertaken a process to make standard benefit plans available not later than 180 days following the effective date of this section.

(2) The commissioner shall notify an insurer of its qualification as a participating insurer under this subsection.

(c) Demonstration of capacity.–

(1) An insurer shall, within 30 days of first providing coverage under health benefit plans to a sufficient number of individuals to qualify as a participating insurer under this chapter, demonstrate to the commissioner all of the following:

(i) That it has the capacity to issue standard health benefit plans and provide information sufficient to permit the department to discharge the responsibilities assigned to it under subsection (d).

(ii) That it has undertaken a process to make standard benefit plans available not later than 180 days

following provision of the information to the commissioner.

(2) The commissioner shall notify an insurer of its qualification as a participating insurer under this subsection.

(d) Facilitation.–The department shall facilitate the availability of information relating to standard health benefit plans by electronic and other media, inclusive of pricing and benefit information and all other relevant information, such that prospective purchasers of the plans have the ability to compare benefits, terms, conditions and pricing among all participating insurers.

(e) Provision of information.–Participating insurers shall provide the department, at its request, with information sufficient to enable it to discharge its responsibilities under subsection (d).

Section 4306. Records and reporting.

A participating insurer shall provide an annual report to the department in a form prescribed by the department enumerating all of the following:

(1) The number of individuals covered under standard health benefit plans, coverage provided both directly to individuals and through employers.

(2) The number of persons receiving coverage both under LifeLine health benefit plans and through high deductible health plans.

Section 4307. Petition for exception.

(a) Petition.–An insurer may, after the third anniversary of its qualification as a participating insurer, petition the commissioner to be relieved of the obligation to offer LifeLine health plans under this chapter. The commissioner may grant the petition upon a finding that the petitioner has used its commercially reasonable best efforts to market and issue the coverage and that continuation of the efforts would not provide LifeLine health plan coverage to a sufficient number of individuals to justify continued efforts to market and issue the coverage.

(b) Arrangements.–The commissioner shall, as a condition for approving a petition described under subsection (a), require that arrangements be made for the orderly disposition of outstanding coverage.

On the question,

Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Killion on the amendment.

Mr. KILLION. Thank you, Mr. Speaker.

My amendment, A06114, is a basic LifeLine policy amendment. As we heard in earlier debate, the House Republican task force really took a look at the uninsured of Pennsylvania, and what we found was that they are not a homogeneous group, that there are lots of reasons why people are uninsured.

What this amendment does, it provides a basic policy, a mandate-free policy, a policy that individuals can afford and will require the Insurance Department to issue rules that would require insurers to have over 100,000 lives, to offer this policy without mandates. They will be priced fairly cheaply but still provide catastrophic coverage, the kind of coverage people need so that when they get sick, they do not lose their homes, they do not have to dip into their retirement money. They really go after those folks that have money that can afford insurance but cannot afford the high cost of policies that are loaded up in the private sector.

This policy would provide 21 days of inpatient care, both surgical and medical. It would allow four primary visits a year with a $10 copay. It provides surgery and anesthesia coverage. It provides chemotherapy and radiation coverage, maternity coverage, newborn baby coverage, but it is a basic policy. It really goes back to what insurance was originally all about: the idea that we want to protect ourselves from catastrophic losses. Those small losses that we can absorb ourselves and pay, pay for out of our own pocket on a daily basis, we could do that.

What this provides is a safety net, and it will keep people from going on adultBasic. We are all in agreement that we want to make sure that people of Pennsylvania have insurance, but I do not think we should go in the direction of forcing everyone into a government one-size-fits-all program.

I would ask for the members to support this. It is a simple concept. It goes back to the early days of what insurance was all about, to provide catastrophic coverage to protect people's assets in the event they become seriously ill.

I ask for the support of my colleagues. Thank you, Mr. Speaker.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support the Killion amendment.

Again, as we discussed the whole issue of the cost of health care throughout the past – really now it has been over 12 months – clearly one of the things that we needed to accomplish was increased competition within the insurance market. This amendment is actually the substance of one of our House bills that was in our package, which would, in fact, provide for increased and enhanced competition in the health insurance marketplace.

We focus a lot about the cost of health care. Unfortunately, I do not think we spend enough time discussing the cost of health insurance and the role that insurers provide in this process.

I think that this amendment really would not have any substantive impact on the crux, if you will, of the future Eachus amendment, but it would be really an addition and an enhancement to it in terms of increasing the competitive marketplace for small employers, for people to get access to health insurance.

Mr. Speaker, I would encourage the members to support the Killion amendment.

Thank you, Mr. Speaker.

On the question recurring,

Will the House agree to the amendment?

The following roll call was recorded:

YEAS–96

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern

Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	True
Ellis	Maher	Pickett	Turzai
Evans, J.	Major	Pyle	Vereb
Everett	Mantz	Quigley	Vulakovich
Fairchild	Marshall	Quinn	Watson

NAYS–103

Belfanti	George	Mann	Shimkus
Bennington	Gerber	Markosek	Siptroth
Biancucci	Gergely	McCall	Smith, K.
Bishop	Gibbons	McGeehan	Smith, M.
Blackwell	Goodman	McI. Smith	Solobay
Brennan	Grucela	Melio	Staback
Buxton	Haluska	Mundy	Sturla
Caltagirone	Hanna	Myers	Surra
Carroll	Harhai	O'Brien, M.	Tangretti
Casorio	Harkins	Oliver	Taylor, R.
Cohen	Hornaman	Pallone	Thomas
Conklin	James	Parker	Vitali
Costa	Josephs	Pashinski	Wagner
Cruz	Keller, W.	Payton	Walko
Curry	Kessler	Petrarca	Wansacz
Daley	King	Petrone	Waters
DeLuca	Kirkland	Preston	Wheatley
DePasquale	Kortz	Ramaley	White
Dermody	Kotik	Readshaw	Williams
DeWeese	Kula	Roebuck	Wojnaroski
Donatucci	Leach	Sabatina	Yewcic
Eachus	Lentz	Sainato	Youngblood
Evans, D.	Levdansky	Samuelson	Yudichak
Fabrizio	Longietti	Santoni	
Frankel	Mahoney	Seip	O'Brien, D.,
Freeman	Manderino	Shapiro	Speaker
Galloway			

NOT VOTING–0

EXCUSED–4

Adolph	Hershey	Marsico	Taylor, J.

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **MILNE** offered the following amendment No. **A04914:**

Amend Title, page 1, lines 18 through 22, by striking out all of said lines and inserting

data, for the definition of "account," for abatement program, for eligibility, for procedure, for certificate of retention, for the Health Care Provider Retention Account and for expiration; and providing for healthy living and wellness tax incentives.

Amend Sec. 1 (Sec. 711), page 3, line 18, by inserting a bracket before "Unless"

Amend Sec. 1 (Sec. 711), page 3, line 20, by inserting a bracket after "for" and inserting immediately thereafter

For

Amend Sec. 1 (Sec. 711), page 3, line 23, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 3, line 26, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 3, line 29, by striking out "Up to"

Amend Sec. 1 (Sec. 711), page 5, line 4, by striking out "paragraphs (3) and" and inserting

paragraph

Amend Sec. 1 (Sec. 711), page 5, line 5, by striking out "$500,000 and shall be set" and inserting

$750,000 and shall be set by the commissioner

Amend Sec. 1 (Sec. 712), page 8, line 18, by striking out "or (4)"

Amend Sec. 1 (Sec. 712), page 8, line 22, by striking out the bracket before "$250,000"

Amend Sec. 1 (Sec. 712), page 8, line 29, by inserting a bracket before "zero]"

Amend Sec. 1 (Sec. 712), page 9, line 4, by striking out "711(d)(3) and (4)" and inserting

711(d)(4)

Amend Sec. 1 (Sec. 712), page 10, line 5, by inserting a bracket before "(e)"

Amend Sec. 1 (Sec. 712), page 11, line 14, by inserting a bracket after "(m)."

Amend Bill, page 18, by inserting between lines 8 and 9

Section 3. The definition of "account" in section 1101 of the act 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:

"Account." The Health Care Stabilization and Provider Retention Account established in section 1112.

* * *

Amend Sec. 3, page 18, line 9, by striking out "3" and inserting

4

Amend Sec. 3 (Sec. 1102), page 18, line 17, by inserting a bracket before "for"

Amend Sec. 3 (Sec. 1102), page 18, line 21, by inserting a bracket after "2005" and inserting immediately thereafter

until the liability of the fund under section 712(c)(2)(iii) is zero

Amend Bill, page 19, lines 5 through 30; page 20, lines 1 through 30, page 21, lines 1 through 10, by striking out all of said lines on said pages and inserting

Section 5. Sections 1105(c) and 1112 of the act, added December 22, 2005 (P.L.458, No.88), are amended to read:

Section 1105. Certificate of retention.

* * *

(c) Tax.–An amount owed the Commonwealth under subsection (b) shall be considered a tax under section 1401 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code. The Department of Revenue shall provide assistance to the Insurance Department in any collection effort. Any amount collected under this chapter, including administrative and legal costs, shall be deposited into the [Health Care Provider Retention Account] account.

* * *

Section 1112. Health Care Stabilization and Provider Retention Account.

(a) Fund established.–There is established within the General Fund a special account to be known as the Health Care Stabilization and Provider Retention Account. Funds in the account shall be subject to an annual appropriation by the General Assembly to the Department of Public Welfare. The Department of Public Welfare shall administer funds appropriated under this section consistent with its duties under section 201(1) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

[(b) Transfers from Mcare Fund.–By December 31 of each year, the Secretary of the Budget may transfer from the Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712(a) to the account an amount equal to the difference between the amount deposited under section 712(m) and the amount granted as discounts under section 712(e)(2) for that calendar year.]

(c) Transfers from account.–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).

(d) Other deposits.–The Department of Public Welfare may deposit any other funds received by the department which it deems appropriate in the account.

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

(f) Allocation.–Money in the account shall be allocated annually by the Secretary of the Budget as follows:

(1) (Reserved)

(2) Five million dollars shall be transferred to be used for the healthy living and wellness tax incentives established under Chapter 17.

Section 6. The act is amended by adding a section to read:

Section 1114.1. (Reserved)

Section 7. The act is amended by adding a chapter to read:

CHAPTER 17

HEALTHY LIVING AND WELLNESS TAX INCENTIVES

Section 1701. Scope.

This chapter relates to tax incentives for wellness services and healthy living equipment and products.

Section 1702. 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:

"Annual limitation." $2,500.

"Annual personal income tax return." The return required to be filed under section 330 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Code." The act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Department." The Department of Revenue of the Commonwealth.

"Healthy living product." Exercise equipment used in a residential property, nutritional supplements purchased by a taxpayer, a membership to a gym, exercise facility or a similar facility, the cost of a class or a course providing for the instruction of a physical activity, including martial arts, sports, dance or similar activities.

"Qualified expense." The cost incurred for the purchase at the sale at retail or use of a healthy living product or a wellness service.

"Tax credit." The healthy living and wellness tax credit.

"Taxable income." The term shall have the same meaning as given to it in section 301 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Taxpayer." The term shall have the same meaning as given to it in section 301 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Wellness service." Pregnancy care, fitness centers, weight management, nicotine cessation, stress management and other similar services.

Section 1703. Healthy living and wellness tax credit.

(a) Application.–A taxpayer may apply on the annual personal income tax return for a tax credit for qualified expenses as provided under this chapter.

(b) Department duties.–The following apply:

(1) The department shall provide a form by which a taxpayer may apply for the tax credit.

(2) The department shall make the form available with the annual personal income tax return.

(3) The department shall not grant a tax credit for a qualified expense that was not incurred by the taxpayer.

(4) The department shall prescribe a method by which a taxpayer may apply for the tax credit, including making available a method by which a taxpayer may claim and provide proof of qualified expenses when applying for the tax credit.

(5) The department shall grant a tax credit to a taxpayer who satisfies the requirements of this section.

(c) Computation.–A taxpayer who applies under subsection (a) shall be eligible to receive a tax credit for the taxable year equal to the amount of qualified expenses incurred by the taxpayer.

(d) Limitations.–The following apply:

(1) The amount of a tax credit awarded to a taxpayer under this section shall not exceed the annual limitation.

(2) A taxpayer shall be ineligible for a tax credit if the taxpayer is not up to date with all tax payments for tax liabilities prior to the tax year for which a taxpayer is applying for a tax credit.

(3) The amount of a tax credit awarded to a taxpayer under this section shall not result in taxable income being less than zero.

Section 1704. Sales and use tax exclusion.

In addition to the exclusions from tax provided for under section 204 of the code, the sale at retail or use of healthy living products and wellness services shall not be subject to the tax imposed under Article II of the code.

Section 1705. Construction.

To the extent necessary, a term used in this chapter that is not defined in section 1702 shall carry the same meaning given to it under Article II or III of the code unless the context clearly indicates otherwise.

Section 1706. Regulations.

The department shall promulgate rules and regulations as necessary for effectuating the provisions of this chapter.

Section 1707. Applicability.

This chapter shall apply to taxable years beginning after June 30, 2008.

Section 8. This act shall take effect as follows:

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

(i) The repeal of section 712(e) of the act.

(ii) The amendment of the definition of "account" in section 1101 of the act.

(iii) The amendment of section 1102(a) of the act.

(iv) The amendment of section 1105(c) of the act.

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

(vi) The addition of section 1114.1 of the act.

(vii) The addition of Chapter 17 of the act.

(2) The remainder of this act shall take effect immediately.

On the question,

Will the House agree to the amendment?

AMENDMENT WITHDRAWN

The SPEAKER. The Chair recognizes Representative Milne on the amendment.

Mr. MILNE. Mr. Speaker, my amendment establishes a wellness tax credit to encourage people to take advantage of opportunities to improve their health. I think it is a way that people can manage their potential health issues in a way that we can generate savings for the system as a whole.

However, in the interest of hastening deliberations of the House, I will withdraw this amendment at this time.

Thank you.

On the question recurring,
Will the House agree to the bill on second consideration?

The SPEAKER. The Chair recognizes the gentleman from Lehigh County, Representative Reichley, who offers amendment A06—

The House will be at ease.

The House will come to order.

GUESTS INTRODUCED

The SPEAKER. The Chair would like to recognize, as the guests of Representative Mark Keller, the Heritage Christian School from Loysville, and they are in the gallery. Would you please stand and be recognized.

CONSIDERATION OF SB 1137 CONTINUED

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **BOYD** offered the following amendment No. **A06069:**

Amend Title, page 1, line 22, by striking out "AND"
Amend Title, page 1, line 22, by removing the period after "SECTIONS" and inserting
; and permitting certain insurance to be offered for sale to small employers.
Amend Bill, page 21, by inserting between lines 9 and 10
Section 7.1. The following shall apply:
(1) Notwithstanding the provisions of this act or any other law, an insurer may offer any health insurance plan to a small employer that is approved for sale to small employers in any other state.
(2) The Insurance Department shall promulgate regulations to effectuate this section.

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Boyd on the amendment.

Mr. BOYD. Thank you, Mr. Speaker. I appreciate this.

Mr. Speaker, amendment A06069 again gets at something that was a part of, I believe, some of our bipartisan discussions as we were talking about the issue of health care and health insurance. And again, that is a part of the discussion that has to do with competition among insurers. And what this piece of legislation does, it would allow companies who are licensed to write insurance policies outside of the State of Pennsylvania to write policies within the Commonwealth. It would give us the ability to, if you will, expand and enhance the pool of providers of health insurance and give consumers more tools to shop.

Mr. Speaker, again, the market really is what controls costs and prices most effectively, and competition always drives quality up and drives prices down, and everything that we do in this marketplace, we cannot forget about increasing access to health insurance. This is going to help more providers of health insurance write policies in Pennsylvania.

I fundamentally believe that if we are really concerned about the cost of health care and health insurance, that we are going to want more competition. I believe that that is something that is a bipartisan issue. I believe members on both sides of the aisle, having sat in the Insurance Committee under the chairmanship of Chairman DeLuca, we have had many conversations in hearings about the need to enhance competition.

I am asking the members to consider supporting this amendment. I am asking it knowing that if the Eachus amendment goes in, this will not be a part of the piece of legislation, but it is an opportunity for the members to show and demonstrate that they are as concerned about the costs for everyone in the Commonwealth and lowering the cost of health insurance and getting more competition in the health insurance industry as they are about the large omnibus Eachus amendment.

Mr. Speaker, I would encourage the members to seriously take a look at this amendment. I know it has been a long morning already, but I am asking them to take a serious look at this, and consider a "yes" vote on this amendment as a demonstration that they are going to look at this as this process moves forward.

Thank you, Mr. Speaker.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–96

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	True
Ellis	Maher	Pickett	Turzai
Evans, J.	Major	Pyle	Vereb
Everett	Mantz	Quigley	Vulakovich
Fairchild	Marshall	Quinn	Watson

NAYS–103

Belfanti	George	Mann	Shimkus
Bennington	Gerber	Markosek	Siptroth
Biancucci	Gergely	McCall	Smith, K.
Bishop	Gibbons	McGeehan	Smith, M.
Blackwell	Goodman	McI. Smith	Solobay
Brennan	Grucela	Melio	Staback
Buxton	Haluska	Mundy	Sturla
Caltagirone	Hanna	Myers	Surra
Carroll	Harhai	O'Brien, M.	Tangretti
Casorio	Harkins	Oliver	Taylor, R.
Cohen	Hornaman	Pallone	Thomas
Conklin	James	Parker	Vitali
Costa	Josephs	Pashinski	Wagner

Cruz	Keller, W.	Payton	Walko
Curry	Kessler	Petrarca	Wansacz
Daley	King	Petrone	Waters
DeLuca	Kirkland	Preston	Wheatley
DePasquale	Kortz	Ramaley	White
Dermody	Kotik	Readshaw	Williams
DeWeese	Kula	Roebuck	Wojnaroski
Donatucci	Leach	Sabatina	Yewcic
Eachus	Lentz	Sainato	Youngblood
Evans, D.	Levdansky	Samuelson	Yudichak
Fabrizio	Longietti	Santoni	
Frankel	Mahoney	Seip	O'Brien, D.,
Freeman	Manderino	Shapiro	Speaker
Galloway			

NOT VOTING–0

EXCUSED–4

Adolph	Hershey	Marsico	Taylor, J.

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **REICHLEY** offered the following amendment No. **A06120:**

Amend Title, page 1, line 20, by removing the comma after "program" and inserting
and
Amend Title, page 1, line 21, by striking out "and" and inserting
; providing for a disease management tax credit; further providing
Amend Bill, page 20, by inserting between lines 26 and 27
Section 5.1. The act is amended by adding a chapter to read:

CHAPTER 15
DISEASE MANAGEMENT TAX CREDIT

Section 1501. Scope.

This chapter relates to disease management insurance policy tax credits.

Section 1502. 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:

"Department." The Department of Revenue of the Commonwealth.

"Disease management insurance policy." A group or individual health insurance policy that includes a disease management program.

"Disease management program." A set of interventions designed to improve the health of individuals, especially those with certain ailments or diseases. A disease management program may include:

(1) Identifying patients and matching the intervention with need.

(2) Support for adherence to evidence-based medical practice guidelines, including providing medical treatment guidelines to physicians and other providers, and providing support services to assist the physician in monitoring the patient.

(3) Services designed to enhance patient management and adherence to an individualized treatment plan, including patient education, monitoring and reminders, and behavior modification programs aimed at encouraging lifestyle changes.

(4) Routine reporting and feedback loops, including communication with patient, physician, health plan and ancillary providers, and practice profiling.

(5) Collection and analysis of process and outcome measures.

"Pass-through entity." Any of the following:

(1) A partnership, limited partnership, limited liability company, business trust or other unincorporated entity that for Federal income tax purposes is taxable as a partnership.

(2) A Pennsylvania S corporation.

"Primary contractor." A person licensed to conduct business in this Commonwealth that develops, implements or monitors disease management programs.

"Qualified tax liability." The liability for taxes imposed under Article III (relating to personal income tax), IV (relating to corporate net income tax) or VI (relating to capital stock franchise tax) of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The term includes the liability for taxes imposed under Article III of the Tax Reform Code of 1971 on a sole proprietor, partner, shareholder, owner or member of a pass-through entity.

"Secretary." The Secretary of Revenue of the Commonwealth.

"Service provider." A person licensed to conduct business in this Commonwealth that is selected by the primary contractor to provide disease management programs.

"Small business." A taxpayer with fewer than 50 employees.

"Tax credit." The disease management insurance policy tax credit authorized under this chapter.

"Taxpayer." An entity subject to tax under Article III (relating to personal income tax), IV (relating to corporate net income tax) or VI (relating to capital stock franchise tax) of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The term includes:

(1) the partner, shareholder, owner or member of a pass-through entity that receives a tax credit; or

(2) a sole proprietor.

Section 1503. Credit for disease management insurance policies.

(a) Application.–

(1) A taxpayer who purchases and provides a disease management insurance policy to employees in a taxable year may apply for a tax credit as provided in this chapter. By September 15, a taxpayer must submit an application to the department for premiums paid in the taxable year that ended in the prior calendar year.

(2) A taxpayer with 50 or more employees who purchases and provides a disease management insurance policy to employees in a taxable year may apply for a tax credit as provided in this chapter. By September 15, a taxpayer must submit an application to the department for premiums paid in the taxable year that ended in the prior calendar year.

(b) Tax credit.–A taxpayer qualified under subsection (a)(1) shall receive a tax credit for the taxable year in the amount of $500 for each employee of the taxpayer covered by a disease management insurance policy. A taxpayer qualified under subsection (a)(2) shall receive a tax credit for the taxable year in an amount equal to 50% of the cost to the taxpayer for providing health care coverage for employees, contingent on proof the purchased coverage utilizes disease management protocols.

(c) Notification of credit.–By December 15 of the calendar year following the close of the taxable year, the department shall notify the taxpayer of the amount of the taxpayer's tax credit approved by the department.

Section 1504. Certification requirement.

(a) Application.–In order to qualify for the tax credit, a taxpayer, in conjunction with the Department of Labor and Industry and the Insurance Department, shall make application for the certification of the disease management program purchased as part of the disease management insurance policy. The Insurance Department shall develop the certification criteria.

(b) Reapplying.–In the subsequent tax year, a taxpayer reapplying for the tax credit must provide verification to the Department of Labor and Industry and the Insurance Department that

the disease management program meets the certification requirements and continues to be purchased by the taxpayer.

Section 1505. Carryover, carryback, refund and assignment of credit.

(a) General rule.–If the taxpayer cannot use the entire amount of the tax credit for the taxable year in which the tax credit is first approved because the amount of the tax credit exceeds the tax liability of the taxpayer for the year in which the tax credit under section 1503 (relating to credit for disease management insurance policies) is to be applied, the excess may be carried over to succeeding taxable years and used as a credit against the qualified tax liability of the taxpayer for those taxable years. Each time the tax credit is carried over to a succeeding taxable year, it shall be reduced by the amount that was used as a credit during the immediately preceding taxable year. The tax credit may be carried over and applied to succeeding taxable years for no more than 15 taxable years following the first taxable year for which the taxpayer was entitled to claim the credit.

(b) Application of tax credit.–A tax credit approved by the department for premiums incurred in a taxable year shall first be applied against the taxpayer's qualified tax liability for the current taxable year as of the date on which the credit was approved before the tax credit may be applied against any tax liability under subsection (a).

(c) Unused tax credit.–A taxpayer is not entitled to assign, carry back or obtain a refund of an unused tax credit.

Section 1506. Time limitations.

A taxpayer is not entitled to a tax credit for health insurance premiums providing for disease management programs incurred in taxable years ending after December 31, 2010.

Section 1507. Limitation on credits.

(a) Allocation for small businesses.–Forty percent of available funds shall be allocated exclusively for small businesses. However, if the total amounts allocated to either the group of applicants exclusive of small businesses or the group of small business applicants is not approved in any fiscal year, the unused portion will become available for use by other qualifying taxpayers.

(b) Proration of tax credits.–

(1) If the total amount of tax credits applied for by all taxpayers, exclusive of small businesses, exceeds the amount allocated for those credits, the tax credit to be received by each applicant shall be prorated by the department among all applicants, exclusive of small businesses, who have qualified for the credit.

(2) If the total amount of tax credits applied for by all small businesses exceeds the amount allocated for those credits, the tax credit to be received by each small business applicant shall be prorated by the department among all small business applicants who have qualified for the credit.

Section 1508. Shareholder, owner or member pass-through.

(a) Pennsylvania S corporations.–If a Pennsylvania S corporation does not have an eligible tax liability against which the tax credit may be applied, a shareholder of the Pennsylvania S corporation is entitled to a tax credit equal to the tax credit determined for the Pennsylvania S corporation for the taxable year multiplied by the percentage of the Pennsylvania S corporation's distributive income to which the shareholder is entitled.

(b) Pass-through entities.–If a pass-through entity other than a Pennsylvania S corporation does not have an eligible tax liability against which the tax credit may be applied, an owner or member of the pass-through entity is entitled to a tax credit equal to the tax credit determined for the pass-through entity for the taxable year multiplied by the percentage of the pass-through entity's distributive income to which the owner or member is entitled.

(c) Entitlement.–The credit provided under subsection (a) or (b) is in addition to any tax credit to which a shareholder, owner or member of a pass-through entity is otherwise entitled under this chapter. However, a pass-through entity and a shareholder, owner or member of a pass-through entity may not claim a credit under this chapter for the same premium or employee.

Section 1509. Accountability.

(a) Review procedures.–Any taxpayer that receives a tax credit under this chapter shall be subject to a performance review by the Department of Labor and Industry, in conjunction with the Insurance Department. As appropriate, the performance review shall be based upon information submitted to the department that includes the following:

(1) The contractor's or service provider's strategic goals and objectives for disease management programs.

(2) The contractor's or service provider's annual performance plan setting forth how these strategic goals and objectives are to be achieved and the specific methodology for evaluating results, along with any proposed methods for improvement.

(3) The contractor's or service provider's annual performance report setting forth the specific results in achieving its strategic goals and objectives for disease management, including any changes in the health of participants in the disease management program.

(4) The progress made in achieving expected program priorities and goals.

(5) Any other information deemed necessary by the department.

(b) Penalty.–If a performance review indicates that a primary contractor or a service provider failed to comply with contract requirements or meet performance goals, taxpayers may be subject to a reduction in or ineligibility for future tax credit funding under this chapter.

Section 1510. Report to General Assembly.

(a) Submission of report.–The secretary shall submit an annual report indicating the effectiveness of the credit provided by this chapter no later than March 15 following the year in which the credits were approved to the Governor, the chairmen and the minority chairmen of the Public Health and Welfare Committee and the Appropriations Committee of the Senate and the chairmen and minority chairmen of the Health and Human Services Committee and the Appropriations Committee of the House of Representatives.

(b) Contents.–The report shall include the names of all taxpayers utilizing the credit as of the date of the report and the amount of credits approved and utilized by each taxpayer.

(c) Public information.–Notwithstanding any law providing for the confidentiality of tax records, the information contained in the report shall be public information.

(d) Recommendations.–The report may also include any recommendations for changes in the calculation or administration of the credit.

Section 1511. Termination.

The department shall not approve a tax credit under this chapter for taxable years ending after December 31, 2010.

Section 1512. Regulations.

The secretary shall promulgate regulations necessary for the implementation and administration of this chapter.

On the question,

Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Reichley on the amendment.

Mr. REICHLEY. Thank you, Mr. Speaker.

Good afternoon, fellow members of the House.

This amendment would establish something which we have talked about quite a bit over the last few years called a disease management tax credit.

As some of the members may be familiar, there is a certain health treatment protocol called disease management, which seeks to attack chronic illnesses in a very aggressive fashion. This particular tax credit would be provided to all businesses,

but with a special carveout for small businesses of 50 employees or fewer to encourage them to purchase disease management health-care policies. By obtaining such a policy, the employer would then receive a $500-per-employee tax credit. We believe this would not only standardize the use of disease management, which is something along the line of a wellness initiative, which many policies already utilize, but it would then put competitive pressures on the privately purchased health-care insurance out there on the market.

When a business has a potential tax credit in hand, it can then go to its insurance broker and say, look, I want to buy a disease management tax policy which is going to help make my employees healthier. It will be addressing chronic illnesses such as asthma, diabetes, heart disease, with an aggressive treatment protocol, plus I get $500 per employee for that. And I think this kind of philosophy is really a much better way of going about addressing the issue of the uninsured, of making health insurance more affordable. By putting competitive pressures in the hands of the private sector, we can help to reduce the number of people who potentially would be without health insurance. As you make the health insurance more attractive and more affordable for the private employer, that means that there are fewer uninsured out there in the market.

So I would ask the members to please look very carefully at this. I know we have had a lot of going back and forth on partisan issues, but when you really take a look at it, what is in the best interests of Pennsylvania business, and particularly small business, which employs the overwhelming number of individuals throughout the Commonwealth, this is exactly the kind of incentive, through the tax code, that we need to utilize.

Thank you, Mr. Speaker.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–97

Argall	Gabig	Mensch	Raymond
Baker	Geist	Metcalfe	Reed
Barrar	Gillespie	Micozzie	Reichley
Bastian	Gingrich	Millard	Roae
Bear	Godshall	Miller	Rock
Benninghoff	Grell	Milne	Rohrer
Beyer	Harhart	Moul	Ross
Boback	Harper	Moyer	Rubley
Boyd	Harris	Murt	Samuelson
Brooks	Helm	Mustio	Saylor
Cappelli	Hennessey	Nailor	Scavello
Causer	Hess	Nickol	Schroder
Civera	Hickernell	O'Neill	Smith, S.
Clymer	Hutchinson	Payne	Sonney
Cox	Kauffman	Peifer	Stairs
Creighton	Keller, M.	Perry	Steil
Cutler	Kenney	Perzel	Stern
Dally	Killion	Petri	Stevenson
Denlinger	Mackereth	Phillips	Swanger
DiGirolamo	Maher	Pickett	True
Ellis	Major	Pyle	Turzai
Evans, J.	Mantz	Quigley	Vereb
Everett	Marshall	Quinn	Vulakovich
Fairchild	McIlhattan	Rapp	Watson
Fleck			

NAYS–102

Belfanti	Galloway	Manderino	Shimkus
Bennington	George	Mann	Siptroth
Biancucci	Gerber	Markosek	Smith, K.
Bishop	Gergely	McCall	Smith, M.
Blackwell	Gibbons	McGeehan	Solobay
Brennan	Goodman	McI. Smith	Staback
Buxton	Grucela	Melio	Sturla
Caltagirone	Haluska	Mundy	Surra
Carroll	Hanna	Myers	Tangretti
Casorio	Harhai	O'Brien, M.	Taylor, R.
Cohen	Harkins	Oliver	Thomas
Conklin	Hornaman	Pallone	Vitali
Costa	James	Parker	Wagner
Cruz	Josephs	Pashinski	Walko
Curry	Keller, W.	Payton	Wansacz
Daley	Kessler	Petrarca	Waters
DeLuca	King	Petrone	Wheatley
DePasquale	Kirkland	Preston	White
Dermody	Kortz	Ramaley	Williams
DeWeese	Kotik	Readshaw	Wojnaroski
Donatucci	Kula	Roebuck	Yewcic
Eachus	Leach	Sabatina	Youngblood
Evans, D.	Lentz	Sainato	Yudichak
Fabrizio	Levdansky	Santoni	
Frankel	Longietti	Seip	O'Brien, D.,
Freeman	Mahoney	Shapiro	Speaker

NOT VOTING–0

EXCUSED–4

Adolph	Hershey	Marsico	Taylor, J.

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mrs. **WATSON** offered the following amendment No. **A06012:**

Amend Title, page 1, lines 15 through 22, by striking out "further providing for medical" in line 15 and all of lines 16 through 22 and inserting
further providing for medical professional liability insurance, for the Medical Care Availability and Reduction of Error Fund, for the definition of "account," for abatement program, for procedure, for certificate of retention, for the Health Care Provider Retention Account and for expiration; and providing for the Health Care Provider Retention Reserve Account.

Amend Bill, page 1, lines 25 and 26; pages 2 through 20, lines 1 through 30; page 21, lines 1 through 10, by striking out all of said lines on said pages and inserting

Section 1. Sections 711(d) and 712(c), (e) and (m) 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], 2005, 2006 and 2007, 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] For policies issued or renewed in calendar year [2006 and each year thereafter subject to paragraph (4)] 2008, the basic insurance coverage shall be:

(i) [$750,000] $550,000 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] $550,000 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] For policies issued or renewed [three years after the increase in coverage limits required by paragraph (3)] in calendar year 2009 and for each year thereafter, the basic insurance coverage shall be:

(i) [$1,000,000] $600,000 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] $600,000 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 2010 and each year thereafter, the commissioner shall increase the required per occurrence or claim basic insurance coverage by $50,000 increments for a participating health care provider that is not a hospital and for a hospital until such time as the required per occurrence or claim basic insurance coverage is $750,000.

(6) For policies issued or renewed in the calendar year immediately following the calendar year in which the required per occurrence or claim basic insurance coverage is $750,000 and 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.

* * *

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 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), (4) or (5) 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.] $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a health care provider except a hospital or $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate for a hospital, minus the amount required for basic insurance coverage under section 711(d)(3) or (4) or the amount the commissioner determines as the required basic insurance coverage under section 711(d)(5), as appropriate.

(iii) If the basic insurance coverage requirement is increased in accordance with section [711(d)(4)] 711(d)(6) 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.

* * *

[(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).]

* * *

(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,] 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 of Error Fund. These funds shall be used to reduce surcharges and assessments [in accordance with subsection (e). Beginning January 1, 2014, and each year thereafter, the surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the General Fund] levied under this section.

* * *

Section 2. The definition of "account" 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:

"Account." The Health Care Stabilization and Provider Retention Account established in section 1112.

* * *

Section 3. 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] and each year thereafter until the liability of the fund under section 712(c)(2)(iii) is zero, 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.–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).

Section 4. Sections 1104, 1105 and 1112 of the act, added December 22, 2005 (P.L.458, No.88), are amended to read:

Section 1104. Procedure.

(a) Application.–A health care provider may apply to the Insurance Department for an abatement of the assessment imposed for the previous calendar year specified on the application. The application must be submitted by the second Monday of February of the calendar year specified on the application and shall be on the form required by the Insurance Department. The department shall require that the application contain all of the following supporting information:

(1) A statement of the applicant's field of practice, including any specialty.

(2) Except for physicians enrolled in an approved residency or fellowship program, a signed certificate of retention.

(3) A signed certification that the health care provider is an eligible applicant under section 1103 for the program.

(4) Such other information as the Insurance Department may require.

(a.1) Electronically filed application.–A hospital may submit an electronic application on behalf of all health care providers when the hospital is responsible for payment of the health care provider's assessment under this act and the hospital has received prior written approval from the Insurance Department.

(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 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.

(2) The Insurance Department shall notify the Department of Public Welfare that the applicant has self-certified as eligible for a 50% abatement of the imposed assessment 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.

(3) Notwithstanding paragraph (2), upon the required basic insurance coverage being increased under section 711(d)(3), (4) or (5), the Insurance Department shall annually increase the abatement each applicant is entitled to claim under paragraph (2) by 10%.

(c) Refund.–If a health care provider paid the assessment for the calendar year prior to applying for an abatement under subsection (a), the health care provider may, in addition to the completed application required by subsection (a), submit a request for a refund. The request shall be submitted on the form required by the Insurance Department. If the Insurance Department grants the health care provider an abatement of the assessment for the calendar year in accordance with subsection (b), the Insurance Department shall either refund to the health care provider the portion of the assessment which was abated or issue a credit to the health care provider's professional liability insurer.

Section 1105. Certificate of retention.

(a) Certificate.–The Insurance Department shall prepare a certificate of retention form. The form shall require a health care provider seeking an abatement under the program to attest that the health care provider will continue to provide health care services in this Commonwealth for at least one full calendar year following the year for which an abatement was received pursuant to this chapter.

(a.1) Hospital responsibility.–When a hospital has submitted an application on behalf of a health care provider, the hospital shall be responsible for ensuring compliance with the certificate of retention and shall indemnify the health care provider retention account for each health care provider who fails to continue to provide medical services within this Commonwealth for the year following receipt of the abatement.

(b) Repayment.–

(1) Except as provided in paragraph (2), if a health care provider receives an abatement but, prior to the end of the retention period, ceases providing health care services in this Commonwealth, the health care provider shall repay to the Commonwealth 100% of the abatement received plus administrative and legal costs, if applicable. A health care provider subject to this paragraph shall provide written notice to the Insurance Department within 60 days of the date of cessation of health care services.

(2) Paragraph (1) shall not apply to a health care provider who is any of the following:

(i) A health care provider who is enrolled in an approved residency or fellowship program.

(ii) A health care provider who dies prior to the end of the retention period.

(iii) A health care provider who is disabled and unable to practice prior to the end of the retention period.

(iv) A health care provider who is called to active military duty prior to the end of the retention period.

(v) A health care provider who retires and who is at least 70 years of age prior to the end of the retention period.

(c) Tax.–An amount owed the Commonwealth under subsection (b) shall be considered a tax under section 1401 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code. The Department of Revenue shall provide assistance to the Insurance Department in any collection effort. Any amount collected under this chapter, including administrative and legal costs, shall be deposited into the [Health Care Provider Retention Account] account.

(d) Failure to pay.–The Insurance Department shall notify the appropriate licensing board of any failure to pay an amount required of a licensee under this section. Upon such notification, the licensing board shall suspend or revoke the license of the licensee.

Section 1112. Health Care Stabilization and Provider Retention Account.

(a) Fund established.–There is established within the General Fund a special account to be known as the Health Care Stabilization and Provider Retention Account. Funds in the account shall be subject to an annual appropriation by the General Assembly [to the Department of Public Welfare. The Department of Public Welfare shall administer funds appropriated under this section].

(a.1) Abatement program appropriations.–Funds appropriated to the Department of Public Welfare for the abatement program shall be administered by the Department of Public Welfare consistent with its duties under section 201(1) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(a.2) Health care stabilization appropriations.–(Reserved).

[(b) Transfers from Mcare Fund.–By December 31 of each year, the Secretary of the Budget may transfer from the Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712(a) to the account an amount equal to the difference between the amount deposited under section 712(m) and the amount granted as discounts under section 712(e)(2) for that calendar year.]

(c) [Transfers] Abatement transfers from account.–The Secretary of the Budget [may] shall annually transfer from the account to the Medical Care Availability and Reduction of Error (Mcare) Fund an amount [up] equal to the aggregate amount of abatements granted by the Insurance Department under section 1104(b)[.], minus the sum of the amount deposited in the fund under section 712(m) and any payments of the assessment levied under section 712(d).

(d) Other deposits.–The Department of Public Welfare may deposit any other funds received by the department which it deems appropriate in the account.

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

Section 5. Section 1115 of the act, amended October 27, 2006 (P.L.1198, No.128), is repealed:

[Section 1115. Expiration.

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

Section 6. The act is amended by adding a section to read:

Section 1116. Health Care Provider Retention Reserve Account.

(a) Establishment.–There is established within the General Fund a special account to be known as the Health Care Provider Retention Reserve Account. The funds in the account shall only be used for the purpose of reducing unfunded liability under Chapter 7.

(b) Transfer.–Notwithstanding any other provision of this act, the Secretary of the Budget shall, as of December 31, 2007, transfer all funds in the account into the Health Care Provider Retention Reserve Account.

Section 7. Section 1211 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, is repealed insofar as it is inconsistent with the provisions of this act.

Section 8. This act shall take effect immediately.

On the question,

Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Watson on the amendment.

Mrs. WATSON. Thank you, Mr. Speaker.

Amendment 6012 gets rid of the Mcare Fund, but does it in 6 years, does it in a way that protects our doctors, keeps them practicing in Pennsylvania, and ends this whole discussion that we have been having about abatement and how long. I think it does it in a reasonable manner that the doctors can live with, that we can all live with, and, Mr. Speaker, more importantly, I think it is something the Senate would agree to.

I have grave concerns, Mr. Speaker, as I have been sitting and looking at the calendar, of whatever we do today going back to the Senate, and if they do not like a piece of it – because it is going to be so full of things – and they do not act on it, and even if they did immediately, our doctors already got their bills. Their bills are due by the 31st of this month. I have grave concerns for these folks, that they are going to have to pay this. And I know I have heard about, well, they could get a refund and all that. I am sorry, Mr. Speaker, I have already identified myself as something of a pessimist, but I just do not believe that that is the way to go.

What I have here in this amendment and I would encourage people to consider is the fact that this takes care of Mcare abatement, protects doctors, does it in a reasonable time, and does it so we could get confirmation from the Senate, and above all, our doctors are not left caught in the middle or paying bills they can ill afford, or, well, maybe they will get some money back.

Mr. Speaker, this is critical and it is important. It is important for the doctors of Pennsylvania, and, Mr. Speaker, it is important for the patients that those doctors go to.

Thank you, Mr. Speaker.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–96

Argall	Fleck	McIlhattan	Rapp
Baker	Gabig	Mensch	Raymond
Barrar	Geist	Metcalfe	Reed
Bastian	Gillespie	Micozzie	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Godshall	Miller	Rock
Beyer	Grell	Milne	Rohrer
Boback	Harhart	Moul	Ross
Boyd	Harper	Moyer	Rubley
Brooks	Harris	Murt	Saylor
Cappelli	Helm	Mustio	Scavello
Causer	Hennessey	Nailor	Schroder
Civera	Hess	Nickol	Smith, S.
Clymer	Hickernell	O'Neill	Sonney
Cox	Hutchinson	Payne	Stairs
Creighton	Kauffman	Peifer	Steil
Cutler	Keller, M.	Perry	Stern
Dally	Kenney	Perzel	Stevenson
Denlinger	Killion	Petri	Swanger
DiGirolamo	Mackereth	Phillips	True
Ellis	Maher	Pickett	Turzai
Evans, J.	Major	Pyle	Vereb
Everett	Mantz	Quigley	Vulakovich
Fairchild	Marshall	Quinn	Watson

NAYS–103

Belfanti	George	Mann	Shimkus
Bennington	Gerber	Markosek	Siptroth
Biancucci	Gergely	McCall	Smith, K.
Bishop	Gibbons	McGeehan	Smith, M.
Blackwell	Goodman	McI. Smith	Solobay
Brennan	Grucela	Melio	Staback
Buxton	Haluska	Mundy	Sturla
Caltagirone	Hanna	Myers	Surra
Carroll	Harhai	O'Brien, M.	Tangretti
Casorio	Harkins	Oliver	Taylor, R.
Cohen	Hornaman	Pallone	Thomas
Conklin	James	Parker	Vitali
Costa	Josephs	Pashinski	Wagner
Cruz	Keller, W.	Payton	Walko
Curry	Kessler	Petrarca	Wansacz
Daley	King	Petrone	Waters
DeLuca	Kirkland	Preston	Wheatley
DePasquale	Kortz	Ramaley	White
Dermody	Kotik	Readshaw	Williams
DeWeese	Kula	Roebuck	Wojnaroski
Donatucci	Leach	Sabatina	Yewcic
Eachus	Lentz	Sainato	Youngblood
Evans, D.	Levdansky	Samuelson	Yudichak
Fabrizio	Longietti	Santoni	
Frankel	Mahoney	Seip	O'Brien, D.,
Freeman	Manderino	Shapiro	Speaker
Galloway			

NOT VOTING–0

EXCUSED–4

Adolph	Hershey	Marsico	Taylor, J.

Less than the majority having voted in the affirmative, the question was determined in the negative and the amendment was not agreed to.

On the question recurring,
Will the House agree to the bill on second consideration?

Mr. **EACHUS** offered the following amendment No. **A06103:**

Amend Title, page 1, lines 15 through 22, by striking out "further providing for medical" in line 15 and all of lines 16 through 22 and inserting
further providing for medical professional liability insurance, for the Medical Care Availability and Reduction of Error Fund and for actuarial data; establishing the Pennsylvania Access to Basic Care (PA ABC) Program Fund and 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; establishing the Pennsylvania Access to Basic Care (PA ABC) Program; providing for Continuing Access with Relief for Employers (CARE) Grants, 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.

Amend Bill, page 1, lines 25 and 26; pages 2 through 20, lines 1 through 30; page 21, lines 1 through 10, by striking out all of said lines on said pages and inserting

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
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.

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, amended 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

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 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) May currently be enrolled in the AdultBasic Program or is on the waiting list for that program on the effective date of this section.

(7) 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.

(8) 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 insurance 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 on payroll 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 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 this act or 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 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 enrollment 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 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% 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.–For an individual whose household income is greater than 300% of the Federal poverty level, 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 with the 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% 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 permit 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. 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 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 basic 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 AdultBasic 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 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.

(7) At the request of an eligible adult, 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, 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) 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 individuals 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, 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, 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, eligible employee or eligible employer.

(c) Excess payment.–If a payment has been made to an insurer by the department for an eligible adult, 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 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. 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 14. The amendment of section 712(e) of the act shall apply retroactively to December 31, 2007.

Section 15. 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.

On the question,

Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Eachus on the amendment.

Mr. EACHUS. Thank you, Mr. Speaker.

Mr. Speaker?

The SPEAKER. For what purpose does the gentleman, Representative Daley, rise?

Mr. DALEY. Mr. Speaker, a parliamentary inquiry.

The SPEAKER. The gentleman will state his point of parliamentary inquiry.

Mr. DALEY. Mr. Speaker, I have discussed with my leaders, Mr. McCall and Mr. DeWeese, about the protracted debate that we are going to be dealing with since early this morning and throughout the afternoon, and as the majority chairman of the Commerce Committee, we had a meeting scheduled this morning for 9:30. I would ask the Chair to consider a brief—

The SPEAKER. The gentleman will approach the rostrum.

Mr. DALEY. Thank you, Mr. Speaker.

The SPEAKER. Representative Eachus.

Mr. EACHUS. Mr. Speaker, I am happy to allow a short break to allow the chairman of the Commerce Committee to convene his meeting. But let me say this, Mr. Speaker: I would like it to be a very short process, and if it is only 10 or 15 minutes, I would agree to that as long as members did not leave the floor, because we are going to start right in on this.

COMMERCE COMMITTEE MEETING

The SPEAKER. The Chair recognizes Representative Daley.

Mr. DALEY. Mr. Speaker, the Commerce Committee meeting is an immediate meeting. We have one bill to vote out of committee, HB 2297. It is absolutely of extreme importance that we do this today, and I ask that we take a short break to do that.

Mr. Speaker, we want to have this meeting in the majority Appropriations caucus room that they have on the E floor, if that would be appropriate. It is the conference room, Mr. Speaker, the majority Appropriations conference room.

The SPEAKER. The Chair thanks the gentleman.

The Commerce Committee will meet immediately in the Appropriations conference room on the E floor.

JUDICIARY COMMITTEE MEETING

The SPEAKER. For what purpose does Representative Caltagirone rise?

Mr. CALTAGIRONE. Thank you, Mr. Speaker.

The House Judiciary Committee will meet in front of the Lieutenant Governor's Office for a brief meeting to vote some bills. Thank you.

The SPEAKER. The Judiciary Committee will meet immediately in front of the Lieutenant Governor's Office.

STATEMENT BY MAJORITY LEADER

The SPEAKER. Representative DeWeese.

Mr. DeWEESE. Thank you very much.

Relative to scheduling, both chairmen have indicated to me these meetings would be brief, 10 or 15 minutes, so I would recommend that at the Speaker's discretion, we allow for a short break and then return to business.

The SPEAKER. For what purpose does the gentleman, Representative Maher, rise?

Mr. MAHER. Thank you, Mr. Speaker.

I was just making sure that the rostrum was aware that when we get to debating this amendment that I am seeking recognition.

The SPEAKER. The Chair will not overlook that, Representative Maher.

Mr. MAHER. Thank you.

PROFESSIONAL LICENSURE COMMITTEE MEETING

The SPEAKER. For what purpose does Representative Sturla rise?

Mr. STURLA. Mr. Speaker, the House Professional Licensure Committee will meet immediately in room 60, East Wing, at the break.

The SPEAKER. The Chair thanks the gentleman.

The Professional Licensure Committee will meet at the break in room 60, East Wing.

ANNOUNCEMENT BY SPEAKER

The SPEAKER. The Chair expects that the House will reconvene in the neighborhood of 2:10 to 2:15, so this House will recess until the call of the Chair.

For what purpose does the gentleman, Representative Cutler, rise?

Mr. CUTLER. Mr. Speaker, I just wanted to raise again the point of parliamentary inquiry regarding a fiscal note regarding the amendment that we began to debate.

The SPEAKER. We will attend to that issue when we return.

Mr. CUTLER. Thank you.

The SPEAKER. For what purpose does the gentleman, Representative Killion, rise?

Mr. KILLION. Mr. Speaker, just a quick question.

You had said 2:15, or did you mean 1:15?

The SPEAKER. Oh, I am sorry. The Chair thanks the gentleman.

Mr. KILLION. Okay.

The SPEAKER. His eyes are failing him. It is between 1:10 and 1:15. The Chair thanks the gentleman.

RECESS

The SPEAKER. This House will stand in recess until the call of the Chair.

AFTER RECESS

The time of recess having expired, the House was called to order.

CONSIDERATION OF SB 1137 CONTINUED

PARLIAMENTARY INQUIRY

The SPEAKER. The Chair recognizes Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

May I ask a quick point of parliamentary inquiry before we get started?

The SPEAKER. The gentleman will state his point of parliamentary inquiry.

Mr. EACHUS. If amendment 6103, the Eachus amendment, passes, what other amendments would then be in order that are currently on the schedule?

The SPEAKER. Unless informed otherwise, the Chair's understanding is that all other amendments, with the exception of A06119 and A06123, have been withdrawn – all but those amendments have been withdrawn.

Mr. EACHUS. Thank you, Mr. Speaker.

Mr. Speaker, I have to tell you, I am honored to be in the well today on behalf of my district and the people of Pennsylvania. Over the past 6 years, since Governor Rendell came to town, we have been very fortunate here in the General Assembly to focus on health-care access for Pennsylvanians.

I have personally been fortunate to work in a bipartisan way to expand prescription drugs for senior citizens through the PACE (Pharmaceutical Assistance Contract for the Elderly) and PACENET (Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier) programs two times in the last 6 years.

I also have to tell you that another proud moment for all of us should have been last year's passage of the Children's Health Insurance Program, the Cover All Kids proposal, which allows for coverage of children at a very cost-affordable price, which by 2008 will allow for all children to access affordable insurance.

Also, in this very legislative session, we have had significant activity on access to health-care issues. As the prime sponsor of HB 700 earlier in this session, we have taken components of that bill, including a variety of scope-of-practice bills that allow for professionals in the medical field to expand their scope of practice in Pennsylvania and provide national-quality health care on a broader level.

And I also have to tell you that the good bipartisan work that was passed to lower hospital-acquired infections and put together a national protocol, which was passed in this House and then passed in the Senate and signed by the Governor earlier this year, showed significant advancements in access to health care, quality of health care, and today we deal with affordability and access of the last group. And that group, Mr. Speaker, is adults from 19 to 64 years old who cannot get or cannot afford health insurance in this Commonwealth.

Seventy-one percent of the uninsured adults in Pennsylvania are employed. They work. Forty-four percent of the employed uninsured work full time, and 27 percent of the uninsured have been without health insurance for the last 5 years.

We propose today in this amendment what we call the Pennsylvania Access to Basic Care coverage, the PA ABC Program. It will provide basic care to the uninsured without damaging the private market. It will also assist small employers to provide employee-based coverage, and it will take care of the Mcare and unfunded liability issues that so many physicians across the Commonwealth and hospital systems are concerned about.

What is in this coverage, and who is covered? Let us start with who is covered. The PA ABC Program will cover individuals as well as many employees of small businesses. The PA ABC moves the current adultBasic program, created under Governor Ridge, and creates the PA ABC Program, and as soon as we pass this bill, it would eliminate the 80,000-person waiting list that is currently in the adultBasic program.

What are the requirements for eligibility of the PA ABC Program? Individuals between 19 and 64 years old. You have to be uninsured for 180 days continuously. You would meet household income requirements, which I will explain a little later. You have to be a legal U.S. citizen – I will repeat that – a legal U.S. citizen; a PA resident for 3 months or 90 days; and you have to be ineligible for Medicare and also Medicaid.

To qualify as an employer, for employer-based coverage for small businesses across Pennsylvania, you have to have between 2 to 50 employees, less than 50 employees. You have to have not covered your employees for 180 days preceding the date of application. Also, the pay, an average annual wage, less than 300 percent of Federal poverty, and also have offered enrollment in the ABC Program to all employees and must enroll at least one-half of the eligible employees in your employee pool. So if you have got 10 employees, you have to enroll at least 5.

What are the premiums for this new PA ABC Program? Premiums are based off of the Federal poverty and household income. Individuals and employees earning up to 200 percent of poverty, or in real terms, a family income for a family of four of $42,400, will pay a premium of between zero and $50, depending upon where their household income is.

Currently Federal guidelines allow us to assist Pennsylvanians who earn up to 200 percent of the Federal poverty guidelines with their premiums. If the Federal government, under this legislation, allows us to assist Pennsylvanians with a greater reimbursement under the Federal waiver program, we would be allowed to expand coverage additionally.

Individuals beginning between 200 percent of poverty and 300 percent of poverty can buy PA ABC at the full premium cost, which is only $311.47 per month. The PA ABC will also serve as the insurer of last resort – let me say it again – the insurer of last resort for individuals earning 300 percent of Federal poverty, or in real terms, a family of four with an income of $63,600.

What are the benefits under this program? Our PA ABC Program raises the bar for basic care. It builds on the adultBasic platform created by Governor Ridge, and it adds four additional important benefits that do not currently exist under the adultBasic program.

First, prescription drug coverage. How can you have a health plan without prescription drug coverage? This adds it.

Inpatient and outpatient behavioral health services for those who may require mental health services, preventative and wellness care, and chronic disease management.

And how does this PA ABC Program assist small employers? Our plan rewards small employers who do the right thing. I was a small employer before I got here. This rewards small employers who are currently providing health insurance for those who meet Federal poverty guidelines, which are the poorest, hardest working people in this economy. These employers would now be eligible for $42 million in Continuing Access with Relief for Employers, or CARE grants. Eligible employers who want to provide health-care insurance to their eligible employees but cannot afford it may purchase the PA ABC Program or a portion of the premium.

So you have got basic ABC coverage with all the benefits within it. We also will be providing a platform for health savings accounts, HSAs, within the new PA ABC Program. Those we will make available for individuals earning between 200 percent and 300 percent of poverty, as long as they have benefits that are equivalent to ABC. So it has to meet the same benefit platform that I laid out earlier in the HSA that would be offered in the traditional PA ABC coverage.

How do we fund it? There will be lots of questions on this today, I am sure. The PA ABC Program is not and will never be an entitlement. Let me repeat that: This is not an entitlement program. We are the provider of last resort. The PA ABC Program will provide coverage as long as the funding remains.

Where will the funding come from, and what are the potential sources? Currently, we will take existing tobacco settlement and community health reinvestment funds that are currently funding the adultBasic program and use them for the PA ABC Program. We will take available balances from the health-care provider retention account, after funding has been provided, to guarantee that the Mcare unfunded liability is taken care of. We will also use premiums – the $40 and $50 and also the small employer contributions – take those premiums to contribute toward funding this program as well.

The Governor's Office will have to negotiate, and we will deal with an amendment a little later today on this issue, the Republican amendment that we will agree to, that will deal with Federal matching funds, that the Federal government will contribute to those people within this program who are eligible, under those negotiations. And we will also use additional resources designated by the General Assembly in what we call the supplemental assistance and funding account, the SAFE Fund. The General Assembly must designate at least $120 million to the SAFE Fund before the PA ABC Program can be triggered.

On to Mcare, our final component. Two hundred and fifty-eight million dollars of the health-care provider retention account will be immediately set aside to reduce unfunded Mcare liability after the fund ends in 2017. Abatements for providers will continue. Let me repeat that for physicians across the Commonwealth: We will not break our contract with you. We will continue to give Mcare abatements through 2017.

To qualify for an abatement, however, in addition to the present rules under the Mcare program, all providers must accept the PA ABC Program and the Cover All Kids – which is the proposal that covers children – in service areas without restriction. Mcare coverage will be phased in over a 10-year period, while coverage in the private market will gradually decrease each year by $50,000 increments. By 2017, the private market will insure all medical malpractice insurance in the Commonwealth.

In conclusion, the PA ABC Program is groundbreaking, it is comprehensive, and it will provide access to quality of care and ensure that the Mcare abatement process continues.

Let me say, this debate today is about covering adults in Pennsylvania who cannot afford or who cannot get access to health insurance. This innovative program deals with how we cover the uninsured and give them access, how we fund it, and how we guarantee our physicians and the medical malpractice issues that are inextricably linked to this proposal will be dealt with in a responsible way to make sure that physicians are fairly compensated and their Mcare coverage is underwritten through 2017. And for our young doctors, we guarantee a reserve that will help pay down the unfunded liability in the Mcare, which we are all very concerned about as it relates to recruitment of physicians for Pennsylvania in the future.

I have to say, as I said before, the accomplishments on prescription drugs for seniors that we did under PACE and PACENET, the accomplishments in the last 6 years that we forged on children's health insurance access, the last issue is to help cover the hundreds of thousands of Pennsylvanians whom we need to guarantee access to health-care coverage, because if you do not have health care in Pennsylvania, frankly, you can lose everything, and I see people— I know all of us in our district offices, those of us who serve our constituents, are all frustrated when a constituent comes in and we have to tell them, I am sorry; there is no available access in your income category. The PA ABC Program helps us accomplish the task that we will never have to say that again.

Mr. Speaker, that is a summary of the amendment, and I am happy to stand for questions.

The SPEAKER. Representative Maher.

Mr. MAHER. Thank you, Mr. Speaker.

I would appreciate if the gentleman who introduced the amendment could answer some questions.

The SPEAKER. The gentleman, Representative Eachus, indicates he will stand for interrogation. Representative Maher is in order and may proceed.

Mr. MAHER. Thank you, Mr. Speaker.

I was looking at the effective date provisions, and I must confess, I may be misunderstanding what is happening here, which is why I am asking these questions. I mean, after all, no one outside of those who were in the smoke-filled room saw any of this amendment until 5 p.m. yesterday.

And I am looking at page 6, line 9. This talks about the supplemental funding, that the surcharges levied that are deposited into the Mcare Fund says, "These funds shall be used to reduce surcharges and assessments in accordance with subsection (e)." Am I understanding that correctly?

Mr. EACHUS. Would you repeat the site for me, Mr. Speaker?

Mr. MAHER. Page 6, line 9. It talks about the surcharges that are deposited into the Mcare Fund and recites, if I understand correctly, the existing statutory language which requires that those surcharges that are deposited into the Mcare Fund be used to reduce surcharges and assessments in accordance with subsection (e).

Mr. EACHUS. If I could please take a minute, Mr. Speaker, and confer with our staff, and I will try to get you a very clear answer to your question.

Mr. Speaker, after conferring with our counsel, that will be a technical amendment that we will repair on third consideration.

Mr. MAHER. I am sorry, Mr. Speaker. I do not think I understood the answer. I was asking, is it correct that your amendment provides that the surcharges collected will be used to reduce surcharges and assessments in accordance with subsection (e)? Am I understanding what you have in your amendment before us, not some hypothetical amendment but the amendment before us?

Mr. EACHUS. I will be right with you.

Mr. Speaker, I will be happy to answer your question in the most concise way I can. That sentence will be stricken on third consideration, and it will be a technical issue. It should not have appeared, so we will work on that.

Mr. MAHER. So I think then what you are saying is that the amendment you intend to offer is not the amendment that we have before us? Is that correct?

Mr. EACHUS. It is a mistake in the Reference Bureau, and we will be fixing it on third consideration, Mr. Speaker.

Mr. MAHER. Well, I will not concede that that is a technical amendment in any way, shape, or form. It seems to me it is a terribly substantive question, that if you are intending to repeal a provision that provides for surcharges and assessments that are collected to be restricted for their use, that is a very substantive question. That is not a technical question.

Mr. EACHUS. Let me repeat my answer to you, Mr. Speaker. I cannot be more concise. It is a technical issue that we are working on with the Reference Bureau.

Mr. MAHER. Thank you, Mr. Speaker.

I am not going to concede by any agreement that this is technical, but we will have that conversation at the appropriate time.

Mr. EACHUS. I will be happy to do that.

Mr. MAHER. I will continue asking questions.

In terms of effective dates, if I am understanding the effective dates here, I am looking on page 25, and it is sort of arcane. It talks about the amendment of section 712(e) and 712(m) will take effect July 1, but it then also says that the amendment of 712(e) will apply retroactively to December 31. So if I am understanding this correctly, on July 1, would this, as presented in this amendment, on July 1 we will suddenly erase all that should have happened under law from January 1 to June 30? Is that the intent?

Mr. EACHUS. Could you rephrase that? You took a little while to get there, Mr. Speaker. I just want to make sure I understand your question concisely.

Mr. MAHER. Well, I am trying to understand. I really am.

Page 25, line 43, says, "The following provisions shall take effect July 1…or immediately, whichever is later…," and one of them is the amendment of section 712(e). So on July 1, the amendment of section 712(e) would become effective, but then just above there on line 40 it says, "The amendment of section 712(e)…shall apply retroactively to December 31…." So I am just trying to understand what happens, that right now the State has legal obligations to be providing assistance to health-care providers from the Mcare Fund and to be providing discounts to providers of health care from the Mcare Fund. And from January 1 of this year to June 30 of this year, if enacted as written here, that come July 1, the State is supposed to then undo everything that it was required to do in the first 6 months of the year? Am I understanding that correctly?

Mr. EACHUS. What that relates to, Mr. Speaker, is letters of credit outstanding on deceased physicians. We should not be assessing those physicians. They are dead. That is the answer.

Mr. MAHER. So now— Well, now I am really confused. Can we visit section 712(e), because I thought that section had something more to do than dealing with physicians who have gone on, and so maybe when you eliminate section 712(e) on page 5—

Mr. EACHUS. I think I understand your question. We took out the discounts.

Mr. MAHER. So what about the discounts that the State is obligated to provide through June 30? Are you going to ask all these doctors and health-care providers to send checks in to refund those discounts that they are legally entitled to currently?

Mr. EACHUS. We are not going to be discounting up until the end of 2007. Starting with 2008, we will not be discounting any further.

Mr. MAHER. But the law as it is today requires those discounts.

Mr. EACHUS. And this will change the current law.

Mr. MAHER. But not until July 1. So I am asking for the legally required discounts to physicians and health-care providers that they are legally entitled to right now – and in February and March and April and May and June – what happens to those? Are you suggesting that the administration will simply ignore existing law until July 1? I would hope not.

Mr. EACHUS. It goes retroactive to 2007.

Mr. MAHER. But it does not apply retroactively to 2007 until July 1 of 2008. So I am asking again, the State currently has a legal obligation. It had it in January; it had it in February; it has it in March. It will have it in April; it will have it in May; it will have it in June.

Mr. EACHUS. Sure, that is correct.

Mr. MAHER. Will the State be meeting its obligation?

Mr. EACHUS. Absolutely.

Mr. MAHER. And so on July 1, when you erase that obligation retroactive to last year, then are you going to ask all these health-care providers to refund the discount that they had received?

Mr. EACHUS. I think you are misinterpreting, Mr. Speaker. As I said, again, we will not be doing discounts.

Mr. MAHER. But you are required to. Right now under the law, those discounts are required.

Mr. EACHUS. When we pass this legislation, we will no longer be using the discount program.

Mr. MAHER. But not until July 1.

Mr. EACHUS. As I said, again, it will not be retroactive.

Mr. MAHER. Well, but it says here that it is retroactive, on line 40 of page 25.

Mr. EACHUS. I am really just trying to understand your point, Mr. Speaker.

Mr. MAHER. My point is that right now, Pennsylvania has a legal obligation to all these doctors and all these health-care providers, under existing law. And that obligation, if your amendment was enacted, would continue through June 30, and then on July 1, that obligation would be erased. But assuming that the State is going to honor the existing law through June 30 – I am making that assumption, and I certainly hope the State would honor its obligations – if the State has honored its obligation to provide these discounts in January, February, March, April, May, and June, but then on July 1 you say, well, there are no more discounts and we are going to take back the

discounts that you got the first 6 months, how do you accomplish that, taking them back?

Mr. EACHUS. I can tell you this, Mr. Speaker, that the Commonwealth of Pennsylvania will honor its obligations to physicians.

Mr. MAHER. Well, I guess I am not going to get a response that is consistent with what is written here, because what is written here says that somehow or another, come July 1, everything that was owed to the physicians for the first 6 months of this year is no longer owed to them. So I suppose that means you are going to have to ask them to give you money back.

Mr. EACHUS. Mr. Speaker, is that interrogation or is it rhetorical?

Mr. MAHER. Well, it really is a question, but I guess you are just going to repeat what is not written on the page here.

Mr. EACHUS. Well, no. What I said, Mr. Speaker, let me be clear again: The Commonwealth of Pennsylvania will honor its obligations to the physicians of Pennsylvania.

Mr. MAHER. So is the Commonwealth, right now, discounting the surcharges and assessments?

Mr. EACHUS. I think I gave you an answer to that, did I not earlier, Mr. Speaker?

Mr. MAHER. I did not hear it, if you did. I am asking, is Pennsylvania, right now, discounting surcharges and assessments in accordance with existing law?

Mr. EACHUS. Well, the administration is following the law under current Pennsylvania law. Obviously, this amendment would change current Pennsylvania law.

Mr. MAHER. So the administration for January, February, and March has permitted these discounts to physicians?

Mr. EACHUS. Are you asking a question about current law—

Mr. MAHER. Yes.

Mr. EACHUS. —or are you asking a question about the amendment?

Mr. MAHER. I am asking what the current circumstance is.

Mr. EACHUS. Well, I am happy to answer questions on this amendment, Mr. Speaker, but as far as the administration goes, you will have to check with the Secretary of Legislative Affairs or the Governor's Office on those.

Mr. MAHER. All right.

Mr. EACHUS. I can tell you, I have never known the Commonwealth of Pennsylvania to not meet its obligations.

Mr. MAHER. Okay, Mr. Speaker.

Well, let me ask you another thing about how this becomes effective. The very last sentence of the 25-page amendment says, "The remainder of this act shall take effect upon publication of the notice specified under section 12 of this act." I will pause if you need to—

Mr. EACHUS. Yeah; let me review that for a moment, Mr. Speaker, okay?

Let me just make sure I am clear. Are you referring to section 12?

Mr. MAHER. Page 25, lines 51 to 53. It says, "The remainder of this act shall take effect upon publication of the notice…under section 12 of this act."

Mr. EACHUS. Yeah. If you refer to section 12, Mr. Speaker—

Mr. MAHER. Yes.

Mr. EACHUS. —the publication of notice is within that section.

Mr. MAHER. Okay. And looking at that language in section 12, it says, "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."

Mr. EACHUS. Yeah; I can give you an example of a parallel law we did the same thing for. You may remember the gaming reserve fund that we created under Act 71. We would have to publish the notice, and the program would not be triggered until there was $120 million in this supplemental assistance, the SAFE Fund. So you would have to reach that threshold.

Mr. MAHER. So that is what you were intending to do?

Mr. EACHUS. Correct.

Mr. MAHER. Well, that is not what you did, because in the circumstance you are citing, Mr. Speaker, my memory is that the gaming law created a fund and provided that disbursements from that fund would not occur until the Secretary of the Budget issued a notice that their funds had reached a certain threshold.

Mr. EACHUS. Well, what I was referring to, the parallel, was that there is a similar dollar threshold. There is a different methodology used for the rollout of the program, but the intent is exactly within section 12, as we intended.

Mr. MAHER. And so in section 12 then it says "when a law is enacted." What if another law is not enacted?

Mr. EACHUS. Can you repeat the question, Mr. Speaker?

Mr. MAHER. Section 12 provides that the Insurance Department will not be publishing this notice unless another law is enacted – not this law, not this bill, but some other bill to be named later. What if such a law is not enacted?

Mr. EACHUS. The act would not take effect until it happened, Mr. Speaker.

Mr. MAHER. All right. So if I am understanding correctly, that on July 1, you would eliminate the discounts and surcharges to health-care providers, and you would do it retroactively to December 31, and that would be the small Roman numeral (i). Roman numeral (ii) just defines health-care providers. Roman numeral (iii) is taking money from the Mcare Fund that would take effect on July 1.

Mr. EACHUS. Which page, Mr. Speaker?

Mr. MAHER. The effective dates in section 15.

Mr. EACHUS. Okay.

Mr. MAHER. So basically, if I am understanding correctly, if we were to adopt this amendment and adopt the bill with this amendment and if it were to become law, except for shortchanging the health-care providers and taking the money away from the doctors, nothing else happens – nothing else happens.

Mr. EACHUS. Well, let me say, Mr. Speaker, that is your interpretation. I do not think there would be any shortchanging at all whatsoever. But let me also say that I strongly believe that there has to be financial and fiduciary responsibility, a conservative model that gets done. And in many, many cases, we enact legislation and then that creates some triggering mechanism in the future. In this case, it will be this SAFE Fund that will have to have $120 million before the program is triggered. That is the intent, and that is what is in the law. That is what is in the amendment.

Mr. MAHER. All right.

I am going to shift over to talking about the fiscal aspects of the amendment. If I understood the way this has been characterized, and maybe I am not following it, it has been advertised as providing ABC subsidies for those up to

200 percent of FPL (Federal poverty level). Am I understanding that?

Mr. EACHUS. That is correct, for individuals and small employers.

Mr. MAHER. Now, does not your amendment actually provide for the Commonwealth to ask for Federal approval to subsidize individuals up to 300 percent of FPL?

Mr. EACHUS. It does allow for that, but the individual would have to purchase or the business would have to purchase the program at the full price of $311.42.

Mr. MAHER. Well, then why then are there copremium provisions for enrollees in the range of 200 percent FPL to 300 percent FPL?

Mr. EACHUS. It is a pretty simple answer: We are subsidizing those individuals below 200 percent of poverty, and we are allowing for those above 200 to 300 percent of poverty to purchase the program at the monthly cost of $311.42, which we think is fair.

Mr. MAHER. Well, again, that may be sort of what you are intending, but when I read what you have before us, if you look at page 16, line 39, it says, "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." And one of those Federal waivers would be to have the subsidization that is specifically provided for, as you confirm, subsidization of the 200 to 300 percent FPL. So the legislation that is before us actually allows, without anybody ever coming back to the legislature to ask for permission, allows for the subsidization of families between 200 and 300 FPL, as I am reading the page, or is there some other section that I am not discovering here that would prevent that?

Mr. EACHUS. I can give you a pretty simple answer, Mr. Speaker. Currently, under the Bush administration, there is a very conservative model that they have been supporting State programs like this one. With a new administration in Washington, hopefully we will get a higher reimbursement rate, and we will be able to adjust our program to deal with a higher than 200 percent of poverty waiver that might come in the future. I am hopeful that we will get a new administration in Washington that would do that.

Mr. MAHER. And so that is a confirmation then that your amendment actually allows for subsidization of up to 300 percent of FPL?

Mr. EACHUS. Should an administration in Washington, a new administration in Washington, make that allowable.

Mr. MAHER. And—

Mr. EACHUS. Yes, sir?

Mr. MAHER. So that is a yes?

Mr. EACHUS. That is great for people who need access to health care. It will be able to add more citizens and perhaps more layers of subsidization in the middle there. We really think that is an excellent way to create more access for more Pennsylvanians, and we are hopeful that that change in administration in Washington will see it our way, that access to affordable health care is the most important thing for Pennsylvanians.

Mr. MAHER. And so your proposal then does not actually provide just for subsidization of families of four up to $42,000, but it actually provides for subsidization of a family of four up to a $63,000-a-year income. Is that correct?

Mr. EACHUS. And let me say, again, because I think I kind of intuitively understand where you are going, that this is no entitlement program, that what we do here is allow for those who income qualify to purchase affordable insurance under this platform. This subsidization model allows for families of four, as you say, with an income of $63,000 to buy their own insurance for the subsidized rate. But once again, there are the qualifications, the requirements that I mentioned earlier, that they have to be continuously without insurance for 190 days and meet the other kinds of qualifications – age, they cannot be an illegal alien, they must be legal, et cetera. I mentioned those earlier in my comments.

Mr. MAHER. But the one thing you did not respond to there was my actual question, which is, is it correct that your amendment would allow for subsidization of health insurance premiums for families of incomes of up to $63,000?

Mr. EACHUS. Well, let me say, the way we came up with this subsidization model within here is that we know that the current administration in Washington has not offered any State that we know of a waiver higher than 200 percent of poverty. So we are trying to be conservative, but we also allow for changes in administrations in the future and the latitude for us to be able to grow the subsidized rate based on the CMS (Centers for Medicare & Medicaid Services) waiver program that many, many States, including Pennsylvania, have utilized.

Mr. MAHER. Well, I am still confused, because you keep saying 200 percent is what you are subsidizing, but your amendment that is before us says 300 percent. Is there a technical amendment to come, or is this an error that is intended?

Mr. EACHUS. No, sir. I think it is your interpretation that is just wrong.

Mr. MAHER. All right. Thank you, Mr. Speaker.

So is it correct, $63,000 would be the threshold for a family of 4 at 300 percent of FPL?

Mr. EACHUS. Is that not fantastic that we can provide families of 4 at $63,000 an affordable access for $311 a month for health care, under this platform? I have to tell you that this is a proud moment for me as a legislator, to be able to make sure that families of 4 in Pennsylvania could get access to health care, under this platform, for that price.

Mr. MAHER. I am happy that you are happy.

Mr. EACHUS. I know.

Mr. MAHER. Now, in the fiscal note it provides a projection that third-year enrollment would be 267,000 individuals.

Mr. EACHUS. Repeat?

Mr. MAHER. In the fiscal note, if I am understanding the projection, it provides that third-year enrollment would be 267,000 individuals.

Mr. EACHUS. My staff is gathering the fiscal note at the moment. I will be right with you.

Mr. MAHER. Thank you.

If it assists your staff, it is page 2 of the fiscal note, down about three-quarters of the page.

Mr. EACHUS. Do you have another question we can go to while they are gathering the paperwork, Mr. Speaker?

Mr. MAHER. Well, I am trying to reconcile that 267,000 projection for year 3 with the Governor's projection, with his proposal of—

Mr. EACHUS. Mr. Speaker, this is not the Governor's proposal. This is the House Democratic proposal.

Mr. MAHER. Well, I understand that. And theoretically, you are covering fewer people than he would have been covering. Is that correct?

Mr. EACHUS. Yeah, but we do not always agree with the administration and we had—

Mr. MAHER. And I understand that—

Mr. EACHUS. —our own proposal here that we are advancing today.

Mr. MAHER. The Governor was projecting in year 5 – 260,000 individuals – a program that would cover more Pennsylvanians. But you are saying your program, which is going to cover fewer Pennsylvanians, is going to have more enrolled by year 3 than the Governor's broader plan would have had by year 5? That is what I am trying to understand.

Mr. EACHUS. Mr. Speaker, we have taken an approach to try and expand this responsibly, in a way that we felt was best. When this program is implemented, the 80,000 people on the adultBasic waiting list are gone. We also provide subsidization for those below 200 percent of poverty, for what we think are fair prices.

We also will allow families, as I said, to access the coverage for a very affordable price of just over $311 a month with very basic coverage that makes sure that families are covered, that there is wellness, that there are prescription drugs within it. And I am not sure I understand exactly what your question is, but our intent is to try and grow this program responsibly and cover it with what we believe is a very fiscally responsible and conservative model here, which is not, once again – I will say it again – this is not an entitlement program, this is the insurer of last resort.

Mr. MAHER. And this insurer of last resort, you project, would be insuring 267,000 individuals by year 3?

Mr. EACHUS. Let me say something: I am hopeful, I think that is probably close. We are hoping to get over a quarter of a million people covered. That would advance the adultBasic program by over 100,000, 150,000 people. I am hopeful that if we get a new administration in Washington, we could increase that to 350,000 people. And it is our goal to try and cover as many Pennsylvanians and allow for affordable access to health insurance. That is what the goal of this proposal is all about.

Mr. MAHER. And with that 267,000 people, how many of them does your projection assume would have previously been insured through their work?

Mr. EACHUS. Pardon me, Mr. Speaker. I did not understand your question.

Mr. MAHER. How many of those 267,000 that you are projecting would be individuals who had previously had health insurance through work?

Mr. EACHUS. You would have to be uninsured for 180 days to get this health insurance, and that is it. I mean, there is really no way to do the calculus.

Mr. MAHER. Some people then would have been getting their health insurance through work and now will be getting it through Pennsylvania. And I am just asking how many do you project that is going to be?

Mr. EACHUS. Well, I think you are trying to say that there somehow would be some crowding. What we have done in this proposal is to guarantee that we block that crowding by making sure that the individuals, in any business, would have 180 days without coverage.

And let me say something to those responsible employers out there who are covering low-income employees: We will allow for CARE grants, which will be able to help subsidize your employees within your business to help make you maintain the coverage you have so that we do not have a disruption of the private insurance marketplace.

Mr. MAHER. And so do you not know how many of those 267,000 you project would have had insurance through their work before? If you do not know, that is okay.

Mr. EACHUS. What I can say affirmatively is that, under this proposal, 267,000 people do not have insurance today, and they will when this is implemented.

Mr. MAHER. So you are then assuming that no one will come into this program who previously had insurance at their work?

Mr. EACHUS. No, sir. You are assuming that.

Mr. MAHER. Well, you just said 267,000 who do not have insurance would be the 267,000 that would be in. So I am assuming that means that those who currently have insurance would not be in.

Mr. EACHUS. Mr. Speaker—

Mr. MAHER. I am just trying to follow your logic here.

Mr. EACHUS. Mr. Speaker, I have to tell you, I am happy to try and answer the questions, but this is not a rhetorical exercise either.

Mr. MAHER. I agree with you.

Mr. EACHUS. I am being as direct as I can with you, Mr. Speaker.

Mr. MAHER. All right.

Mr. EACHUS. But let me say our goal is to cover Pennsylvanians, and I think this proposal does a darn good job of it.

Mr. MAHER. Now, let us look at the math of what you characterize as a conservative funding formula. When I look at the projected State share – now I am going to use the 3-year-out numbers that correspond with the fiscal note – the community health reinvestment money from the Blues, the money that would be taken from the Tobacco Fund, together leaves a deficit of about $165 million in year 3, if I am understanding correctly.

Mr. EACHUS. You are not understanding correctly, Mr. Speaker. There is no deficit.

Mr. MAHER. Well, let me ask you this: The adultBasic money that you are assuming from tobacco is $79 million, roughly. Is that correct? The Governor is projecting that is what the tobacco money is that you are taking, $79 million in year 3, and maybe you disagree with him about that, too.

Mr. EACHUS. Tobacco, that is correct.

Mr. MAHER. So $79 million comes from the tobacco. Now, the macing of the Blues is to provide $88 million in fiscal year 11.

Mr. EACHUS. Correct.

Mr. MAHER. So the sum of those two together is $167 million.

Mr. EACHUS. Yes, sir. That is correct. We are trying to find a model that guarantees coverage for as many Pennsylvanians as we can possibly—

Mr. MAHER. Okay.

Mr. EACHUS. —cover under this proposal.

Mr. MAHER. So there is $167 million going into the fund. What else is going into that fund?

Mr. EACHUS. Well, as I told you before in my earlier comments – I am happy to review them again for you – in my discussion at the beginning, the funding model includes the tobacco settlement funds that are currently being used for

adultBasic, the community health reinvestment funds that are currently being used for adultBasic, available health-care provider retention funds, premiums paid by individuals and employers, which will also be included, and the Federal matching money, as well as money that would be deposited in the SAFE Fund that we discussed earlier.

Mr. MAHER. And I do not find those numbers in the fiscal note, any amounts for those things. But the numbers I do find is that there is $167 million coming from tobacco, coming from the Blues, and that the State's share net of premiums is projected at $333 million. So if you are spending $333 million, net of whatever premiums you are collecting, and you are taking $167 million from the Tobacco Fund and from the Blues, then there is still $165 million, $166 million that somebody else has got to pay. And I am just asking who is paying that?

Mr. EACHUS. Well, Mr. Speaker—

Mr. MAHER. I do not see who is paying that.

Mr. EACHUS. Mr. Speaker, I understand exactly what you are saying. As you saw in the line late on the amendment, the SAFE Fund will have to reach a threshold of $120 million and the legislature is going to have to determine where that comes from. So we are going to have to have an additional discussion about how we fund this. But let me say something, there is nothing, in my opinion, more important to House Democrats than covering health care at an affordable level – at a price that is affordable – for those who have none. If you do not have health insurance, Mr. Speaker, it is almost impossible to survive in a modern society.

Mr. MAHER. Thank you, Mr. Speaker.

That concludes my interrogation. I would like to be recognized on the amendment.

THE SPEAKER PRO TEMPORE (MATTHEW E. BAKER) PRESIDING

The SPEAKER pro tempore. The Chair has so recognized and may proceed.

Mr. MAHER. This is a curious amendment. It is advertised as subsidizing those up to household incomes of $42,000, when it actually is creating subsidies for households up to $63,000. And we are told that is not a typo, they just are characterizing the bill as one thing when the bill actually says another.

On the other hand, we have the bill providing that funds from surcharges collected under existing law shall be used to reduce surcharges on physicians and health-care providers, right now, except for the section that provides for those discounts is eliminated. So all this money that is going in from surcharges to help reduce the cost of medical malpractice insurance for health-care providers in Pennsylvania, under this amendment, all that money gets collected and put into a designated fund for a designated purpose that cannot be accomplished.

Now we are told, although the bill says that, they do not mean it. And there is very substantive change that is being passed off as some sort of a minor technical glitch. Hundreds of millions of dollars, a commitment to health-care providers across Pennsylvania being abrogated, and we are told it is a technical amendment to come.

The effective date on this is also kind of curious, because if this were to become law, make no bones about it, what you heard is that except for making health care more expensive for Pennsylvanians by eliminating the support of medical malpractice for health-care providers, taking money away from the tobacco funds from all the good purposes it is put to currently there, those moneys will not go to where they have been intended. And how many people will get more health care under this law? If this law is enacted with this amendment, the sum total of people that will have extended health care come July, come December, come a year from now, under this law, would be zero.

No Pennsylvanian would have health care under this amendment. No Pennsylvanian who does not have it today would have it because of this amendment, because it would be prohibited, because this amendment says nothing will happen unless some other law that we have not even seen passes. So this amendment really comes down to being a bit of a dog and pony show.

It is 25 pages that says we are giving health care away, but we are not. In fact, we made sure, by this complicated series of effective dates that you cannot expect folks who are reading this at home to easily follow and understand, but when you sort through the effective dates, you discover no one gets expanded health-care coverage in Pennsylvania, under this law. It would take another law yet to come. So if you mean to do something for Pennsylvanians, I would suggest you need to do something else, because all this is doing is pretending. Now, not everything in this amendment is noxious. There certainly are some worthy points in this amendment, and to ensure, Mr. Speaker— If I could just be at ease for one moment.

PARLIAMENTARY INQUIRY

REQUEST TO DIVIDE AMENDMENT

Mr. MAHER. To ensure that the variety of proposal that is included in this amendment can be considered by members who want to embrace what is good and reject what is bad, Mr. Speaker, I am going to make inquiry, and I had alerted the Parliamentarian ahead of time, the Office of the Parliamentarian ahead of time that I would be making this inquiry – making an inquiry along these lines, I suppose.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. MAHER. Thank you, Mr. Speaker.

Is this amendment divisible on page 1, between lines 17 and 18?

THE SPEAKER (DENNIS M. O'BRIEN) PRESIDING

The SPEAKER. The Chair has determined that the amendment is not divisible.

Mr. MAHER. Excuse me, Mr. Speaker? The amendment, you are saying, is not divisible?

The SPEAKER. Not at that point.

Mr. MAHER. Can the Speaker educate me as to why the amendment is not divisible at that point?

The SPEAKER. At the point that the gentleman requests the amendment to be divided, both remaining parts have to be sustainable independently—

Mr. MAHER. They are.

The SPEAKER. —and they are not.

Mr. MAHER. They are, sir. How are they not?

The SPEAKER. The Chair does not debate that.

Mr. MAHER. Mr. Speaker, I am asking a straightforward question. Please explain to me why you have concluded that lines 1 through 17 and the section that follows—

The SPEAKER. The Chair does not—

Mr. MAHER. —cannot stand on their own.

The SPEAKER. The gentleman will suspend. The Chair does not stand for interrogation. If the gentleman wants to approach the podium, he can confer with the Parliamentarian.

Mr. MAHER. The gentleman approached the podium some hours ago, Mr. Speaker, to discuss this concept. And I am not sure why we cannot have the conversation in the light of day as a parliamentary inquiry.

But let me ask you then, on page 3, is this divisible between lines 54 and 55?

The SPEAKER. The Chair advises the gentleman it is not divisible at that point.

Mr. MAHER. And may I make a parliamentary inquiry, Mr. Speaker, as to why you conclude it is not divisible at that point?

The SPEAKER. The same reason, the two parts cannot stand independently.

Mr. MAHER. Again, Mr. Speaker, I am just asking a straightforward question.

The SPEAKER. There is no page and line reference.

Mr. MAHER. It starts off, sir, by saying section 2, section 712(c) of the act. It is a freestanding section.

The SPEAKER. The Chair has answered the gentleman's inquiry. There is no page or line reference.

Mr. MAHER. All right. Now, on page 1, maybe this will help me understand— On page 1, between lines 17 and 18, both start off with a page and line reference.

The SPEAKER. Again, for the same reasons they cannot stand by themselves.

Mr. MAHER. And, Mr. Speaker, again, I am really trying to understand why, since these ones start with page and line references and seem to be stand-alone propositions to my eye, what it is you see about them that causes you to conclude that they are not, as a parliamentary inquiry.

The SPEAKER. The second part – it is a constitutional issue – the second part cannot stand by itself because—

Mr. MAHER. And the second part—

The SPEAKER. There is no—

Mr. MAHER. I am sorry. The second part cannot stand by itself because why?

The SPEAKER. There is no title to describe what is in the remainder of the amendment.

Mr. MAHER. It certainly does not require that if you look at Mason's Manual, sir.

The SPEAKER. The Constitution trumps Mason's Manual, sir.

Mr. MAHER. And can you point to me in the Constitution where it says an amendment must refer to the title as opposed to the bill? An amendment can speak to the bill; we certainly see amendments like that every day.

The SPEAKER. There is significant case law that supports the ruling of the Chair.

Mr. MAHER. So the Chair's ruling is that an amendment now, to be in order, must always start with "Amend Title"?

The SPEAKER. Very simply stated, when there is a request as to whether an amendment is divisible, both parts at the point of division have to be able to sustain themselves independently. Where the gentleman has asked if the amendment is divisible, they do not stand independently.

Mr. MAHER. Well, thank you, Mr. Speaker.

You have provided me with a new tool to keep in mind in the future. I am sure we will have occasion to address that. Now, sir, I suppose you are similarly going to decline to divide the question on page 8, between lines 33 and 34?

The SPEAKER. I would not assume. Would the gentleman state again his point of division?

Mr. MAHER. Page 8, between lines 33 and 34.

The SPEAKER. No; it is not divisible.

Mr. MAHER. And with this enlightened approach to questions of divisibility, on page 7, between lines 45 and 46?

The SPEAKER. The answer is no.

Mr. MAHER. And page 9, between lines 46 and 47?

The SPEAKER. The answer is no.

Mr. MAHER. This is really remarkable. Page 10, between lines 33 and 34?

The SPEAKER. The answer is no.

Mr. MAHER. And page 12, before the first line?

The SPEAKER. There is only directory language on page 1 in the very beginning up to line 20. Everything else in the remainder of that amendment is substantive language. It cannot be divided, for the information of the member.

Mr. MAHER. I am sorry. I did not quite understand that. Could you repeat that, please? It was too loud; it was too loud.

The SPEAKER. The directory language is on page 1. Therefore, the rest of the amendment is substantive language. It cannot be divided because it cannot stand independently.

Mr. MAHER. Well, I will not even ask you to repeat that. It sure does not make any sense to me. Now, I will just for the benefit of the members share that some time ago I did sit on the rostrum and it was at a time when our actual Parliamentarian needed to step away, in all deference to the gentleman, and I conferred with a member of the Speaker's Office on the question of whether or not this amendment was divisible on page 1, between lines 17 and 18. And I grant that, on further reflection, the gentleman may have a different opinion, but for all the reasons I have ever seen, this bill is clearly divisible – this amendment is divisible in so many different places.

Now, of course, that privilege that exists under our rule 63 is being denied to us as members. So your opportunity to actually consider this gut-and-replace amendment for its constituent parts, your right as a member representing the people of Pennsylvania to act on this proposal for all of its separate elements is being denied. And I know there is not much point in appealing the ruling of the Chair at the moment, so I will save everybody the drama and time of entering eight different appeals of the ruling of the Chair.

But I find it really a sad day when an amendment like this is introduced in the fashion that it was, a stealth amendment hidden from the view of everyone on the planet, except for a handful of people, until 5 p.m. last night; an amendment that does not have in its language what it is advertised as doing; an amendment that is going to pick the pockets of health-care providers in Pennsylvania; an amendment that is going to lead to $180 million of extra taxes in Pennsylvania, if it ever becomes law.

But of course, as you understand from the gobbledygook version of effective dates, none of this is going to become effective except for picking the pockets of health-care providers

and taking money away from the Pennsylvanians who benefit from the use of the tobacco settlement funds today.

So you are going to be taking money away from Pennsylvania health-care programs. You will be taking money away and making health care more expensive in Pennsylvania, with this amendment. And nobody – not one Pennsylvanian – will ever see expanded health care under this amendment, unless some other law at some future date is passed.

And we do not have any idea, according to my understanding of what the guy who introduced this amendment said, he has no idea what law that might be or when it might be. It is incredible. And I guess this is what happens when people try to do lawmaking in the dark. When people do things behind closed doors, they can come out to your caucus room and tell you the bill does one thing when, in fact, it does another.

They can tell you it is for 200 percent, when actually it is for families of $63,000. They can tell you they are not taking money away from docs, but that is what they are doing. They do not tell you they are going to raise the cost of health care for every Pennsylvanian who gets it. They do not tell you that they are taking money away from health-care programs for the neediest Pennsylvanians that exist today from the Tobacco Fund.

And that all is certain to happen. But what is not going to happen with this amendment, is not one Pennsylvanian will have any more options for health care than they have right now – not one. But you can be certain that we will lose doctors. You can be certain that we will have fewer options for Pennsylvania in health care.

And then I suppose down the road we will get a bill, and it is going to be a bill that has got the bill. And it says, oh, well, here is your $180 million tax increase. Across the first 3 years, $300 million of taxes are going to be necessary for this, in just the first 3 years. By their own projections, they are saying they are not assuming that anyone who currently has health insurance will come in to this program.

Well, we already know from adultBasic as it exists, there is quite a migration. You know, heck, when the government is giving stuff away, why should you ever pay for it? This program is being set up in a way that is not really going to help any Pennsylvanians. I repeat, not one Pennsylvanian is going to have more health care unless some other law that has not even been written as a bill yet becomes a law at some future date. So what is the point? Why do a gut-and-replace stealth amendment, rushing it through this House, for an amendment that will have no effect, no benefit to any Pennsylvanian unless some other law that we do not even know about becomes enacted.

Well, all I can conclude is it is a ruse. It is an election year dog and pony show. Folks want to be able to fool their constituents and say, we did something about health care when, in fact, all you are doing is raising the cost of health care, and by very cleverly structuring these effective dates so nobody will have expanded health care in Pennsylvania. You bury that in all these different cross-references on page 25. What is the point?

What is the point of doing an amendment, doing a bill that if it becomes law ensures that nothing happens to benefit Pennsylvanians, but guarantees that the cost of health care will go up, because the cost of malpractice insurance will go up. I do not understand it, but I sure as heck cannot support it. And it is a darn shame, because we could have repaired some of these problems if the divisions of the amendment that I had sought were permitted. You would have had the opportunity to vote for a health-care expansion that could have actually come into effect, instead of one which is simply a ruse intended to fool Pennsylvanians, and I will not support this sort of sham. Thank you, Mr. Speaker.

The SPEAKER. Representative Baker.

Mr. BAKER. Thank you very much, Mr. Speaker.

Will the gentleman, Mr. Eachus, kindly stand for a period of questioning and interrogation?

The SPEAKER. The gentleman indicates that he will stand for interrogation. Representative Baker is in order and may proceed.

Mr. BAKER. Thank you very much, Mr. Speaker.

Mr. Speaker, as I understand it, a part of the Governor's plan and the House Democrat plan was to place approximately $200 million in a restricted account from the Mcare surplus in order to pay for any obligations after 2017, when under this amendment, the Mcare Fund does not receive any additional funding from physicians. Is this addressed in your legislation? And if so, where? And if not, how can we be assured, under your amendment, that there will be revenues to pay for the residual obligations to the Mcare Fund after the physicians and hospitals no longer pay into it after 2018?

Mr. EACHUS. Mr. Speaker, if you would check the bill if you have a copy of it. Do you have a copy of the legislation?

Mr. BAKER. I do; I have your amendment.

Mr. EACHUS. Page 11, line 34, number (2), in addition—

Mr. BAKER. I am sorry, Mr. Speaker. I cannot hear the gentleman.

The SPEAKER. The gentleman is entitled to be heard. Members will please take their seats. I know it has been a long day. Conversations will please break up in the rear of the House and in the aisles.

The gentleman is in order and may proceed.

Mr. BAKER. Would you kindly repeat that?

Mr. EACHUS. Sure, Mr. Speaker. If you look at page 11, line 34, (2), do you see that section?

Mr. BAKER. Yes, I do.

Mr. EACHUS. Okay. We set aside $258 million in a reserve fund that after January 1, 2018, will be an obligation to guarantee the unfunded liability within the fund.

Mr. BAKER. Thank you very much.

Mr. EACHUS. You are welcome.

Mr. BAKER. My second question, can you please define what the phrase "active provider" means on lines 53 and 54, on page 9? It is also referenced on lines 56 and 57 and on the next page as well, on pages 9 and 10. What is the intent of that?

Mr. EACHUS. Let me explain: If you are a physician and you are actively practicing and you have patients that you are actively treating, that would be what we are referring to. We are trying to not refer to physicians who might still have a license but be retired, who might care, passively, for their families or some other folks.

Mr. BAKER. So it is basically for doctors already providing care?

Mr. EACHUS. Yes, Mr. Speaker.

Mr. BAKER. Thank you very much. And can you tell me what rate physicians will be paid, under your amendment and new health-care plan?

Mr. EACHUS. Mr. Speaker, what this instructs the Insurance Department to do is to work with the provider community and set those rates. We do not instructively set rates in this

legislation. That would be determined by the department and the providers, whether they are hospitals or physicians.

Mr. BAKER. Will that be reevaluated on a yearly basis, or how frequently will that be made?

Mr. EACHUS. Annually, with insurers.

Mr. BAKER. Okay. And does your amendment permit the physician the opportunity to first know what she will be paid for providing services under your health-care plan before they must submit to the additional eligibility criteria, as contained within your amendment?

Mr. EACHUS. Could you repeat that really quickly for me, Mr. Speaker? It is a little loud in here. Mr. Speaker, can I get some— Just a little bit of order? Thank you.

The SPEAKER. The Chair will once again ask the conferences in the rear of the House to break up. Conferences in the rear of the House will break up. Members will take their seats.

Mr. BAKER. If I could just go back to the previous question first, it is my understanding that the premiums are calculated annually, not the provider rates. Is that correct?

Mr. EACHUS. Yeah, but as my staff tells me, part of the rates are part of the premium. So they are kind of inextricably linked together.

Mr. BAKER. You are saying that they are both considered annually?

Mr. EACHUS. What determines the rates is the premium. I am sorry; what determines the premium is the rates that get paid. Obviously, if the rates have to be adjusted, and they may have to be adjusted in the future, maybe we have some health inflation, you might have some rise or decrease. So those rates get set each year by the premiums within.

Mr. BAKER. Let me move on to the next question. Does your amendment permit the physician – and I am repeating that other question that you did not hear – does your amendment permit the physician the opportunity to first know what he or she will be paid for, in terms of providing services under your health-care plan, before they must submit to the additional eligibility criteria, as contained within your amendment?

Mr. EACHUS. We think it is fair to ask providers to be part of the Pennsylvania ABC Program in order to get their abatements, and we do link the two in this legislation. They have to provide PA ABC insurance coverage and Cover All Kids for children.

Mr. BAKER. I think there is a fair amount of reasonable concern by our doctors regarding this because although they wish they could treat every single patient, unfortunately, they must also make some solid business decisions. And when you have a government payer and programs that pay close to or below the medical assistance rates, which is oftentimes less than what it costs, hard decisions have to be made by doctors. So for instance, the primary care physicians in my legislative district will receive approximately $1,134 in abatement in 2008, under your plan. However, if they were required to participate in yet another government program that pays below the cost of providing the care, it may not be a prudent business decision to participate in an abatement program. So how would you persuade them to do this?

Mr. EACHUS. For me, Mr. Speaker, it is an easy balance. Over the 10-year period, we are going to give doctors over $3 billion in abatements. All we are going to ask the physicians to do is make sure they cover the adults under the PA ABC Program and cover Pennsylvania's children under the Children's Health Insurance Program, the Cover All Pennsylvanians proposal. We just think that is fair – $3 billion for doctors, and you have to cover the folks in the pool. Simple enough.

Mr. BAKER. Regarding the additional eligibility requirements that are contained within your amendment, how will this affect the private contractual employment relationship between the hospital and the physician? For instance, many hospitals pick up the premiums for tertiary-care specialists – neurosurgeons, and some treating family physicians.

As an example, what if the physician has tax liabilities outstanding with the Department of Revenue and his employer pays his liability costs. Would the hospital be penalized for its employee's failure to meet his or her obligations? And would they then require hospitals to be the enforcer of the Department of Revenue to collect those taxes?

Mr. EACHUS. Mr. Speaker, even though hospitals pay abatements— I am sorry; even though hospitals sometimes pay physicians' insurance, the abatements go to individual doctors. They are intended to be for individual doctors, under the law.

Mr. BAKER. So—

Mr. EACHUS. That relationship—

Mr. BAKER. The hospital would not be penalized if there is a violation between the doctor and the eligibility criteria?

Mr. EACHUS. No. I think, at least my interpretation, Mr. Speaker, is that the hospital acts as a conduit for its physicians. The abatements go to individual physicians within that hospital. So there would not be any— It would not be described as you described it.

Mr. BAKER. Okay. Thank you.

Mr. EACHUS. Sure.

Mr. BAKER. And regarding your amendment, again on eligibility requirements for physicians to qualify for abatement, what occurs if the Commonwealth offers a drug information service – there is a continuing-education requirement, it seems to me, within your amendment – and if, for instance, hypothetically, they are required to attend a drug information seminar and they have an office full of patients, it may well be under these programs that they are supposed to be treating patients, and they miss this.

How do you deal with that issue, because doctors are very, very busy, especially in critical access areas, rural areas, there are not a lot of doctors. They may not be able to have the time to do this. And how do you deal with the issue of rescheduling and complying with the criteria for eligibility in your amendment?

Mr. EACHUS. Let me say, Mr. Speaker, that we add a benefit, a prescription drug enhancement to this adult PA ABC Program, that that new system, that new enhancement, we do not think it is unreasonable to have physicians understand how that protocol works and how physicians will be able to deliver it so that patients are getting proper health outcomes.

So as it relates to the additional pharmaceutical enhancement benefits under the PA ABC Program, which is really essential to wellness for Pennsylvanians who are part of this program, we think that a requisite responsibility would not be too onerous for physicians to have some basic understanding of the protocol itself.

Mr. BAKER. So there will be protocols set up to be as flexible as possible, I hope, to allow these doctors to take these teleconferencing seminars to retain their eligibility?

Mr. EACHUS. Yes, exactly. They can do this remotely from an office on a computer. The department is going to try and make this as flexible and easy for physicians to get the basic training on the pharmaceutical enhancement as possible.

Mr. BAKER. And something that is rather isolated, I am sure, and is an exception to the rule, but about a month ago I had a surgeon approach me in my legislative district who had his identity stolen. And he had tax liens, IRS (Internal Revenue Service) liens, judgments and all sorts of things filed over a 3-year period, registered at the courthouse. Now, under your amendment, if you have unpaid taxes, you are not going to get this abatement. You are not eligible for this. Is there going to be special consideration to help individuals who do not always fit into the hole that the peg was set up for?

Mr. EACHUS. Well, that is unfortunate what happened to your constituent, Mr. Speaker. I have had constituents who have had theft of their identity as well. It is a brave new world. But I do believe that we do not intend to make this an onerous responsibility. So I am happy to work with the gentleman to see if we cannot resolve any anomaly that might occur with someone's identity theft and some tax lien that might be incurred by that kind of situation. I am happy to work directly with you on that proposal, with the administration going forward.

Mr. BAKER. It would be good if we could put something in there with respect to if a physician is a victim of crime and these incidents occur. In this case there were over $200,000, $300,000 that this physician, this surgeon, had to resolve and it is going to take a very long time. It would be very, very difficult to see him become ineligible because of what your language is in the amendment with respect to unpaid taxes and trying to clear his name.

Mr. EACHUS. Thank you. Happy to work with you on that.

Mr. BAKER. Thank you very much. Your information has been very helpful. Thank you, Mr. Speaker. That concludes my interrogation.

LEAVE OF ABSENCE

The SPEAKER. The Chair recognizes the minority whip, who requests that Representative RUBLEY be placed on leave for the remainder of the day. The Chair sees no objection, and the leave will be granted.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER. The Chair recognizes Representative Nickol.

Mr. NICKOL. Thank you, Mr. Speaker.

As a valuable reminder to the members, the surplus in the health-care provider retention account was created over the last several years when the Secretary of the Budget did not transfer the funds in the account to pay Mcare assessments. As a result, those health-care providers who did not receive the 100-percent abatement ended up paying higher Mcare assessments to help subsidize those providers who did receive the 100-percent abatement.

In other words, despite our pretensions – or perhaps intentions – over the last several years, the Commonwealth essentially paid the Mcare abatements by charging one group of health-care providers higher Mcare assessments to help pay for the assessment of another group of health-care providers.

Mr. Speaker, would the sponsor of this amendment consent to interrogation?

The SPEAKER. The gentleman, Representative Eachus, indicates that he will stand for interrogation. The gentleman is in order and may proceed.

Mr. NICKOL. Thank you, Mr. Speaker.

I am curious if there is language in the Eachus amendment that would require the Budget Secretary to make the necessary transfers from the health-care provider retention account to pay for the full cost of Mcare abatements that we would continue under this legislation. Or could we end up in the same predicament, where the Secretary of the Budget does not transfer the money and the Mcare abatements continue to be self-funded by health-care providers themselves?

Mr. EACHUS. Mr. Speaker, we have not changed current law. So what stands today would stand after this amendment was passed.

Mr. NICKOL. Thank you. A second question: Participating health-care providers will undoubtedly be paying more for primary coverage as a result of the increase for primary coverage in steps of $50,000 each year. So as a practical matter, health-care providers will likely end up paying more for medical liability insurance with passage of this amendment. Am I correct? Because I think it is important that we do not oversell the product we are working on today to health-care providers.

Mr. EACHUS. Mr. Speaker, it would cost more in the private market, but you might refer to page 11, line 3. At year 5— Remember, we take the Mcare abatement and we phase it out over a 10-year period. We move $50,000 of insurance in each year to the private market and reduce the State's liability over that 10-year period. At year 5, we compensate physicians, general practitioners, and those who are compensated at the 50-percent level today at an increased rate in year 5, year 6, of 56.5, and it goes up over a 5-year period to 100 percent to help offset the cost of the medical malpractice insurance to those providers.

Those physicians who are currently at the 100-percent rate, they would be fully maintained, their abatement, through that 10-year period. So there is no erosion of abatement during that 10-year phase-down period. So we account for the increased cost by accelerating the percentage of abatement, which is basically money to doctors from this fund. We help supplement the cost of their care for that 10-year period.

Mr. NICKOL. So, Mr. Speaker, if I understand what you are saying, yes, health-care providers will be paying more for their primary level of coverage as their liability goes up in steps of $50,000. But, if I understand you correctly, you are saying that this section would result in a reduction in their Mcare assessment itself, over the same period of time?

Mr. EACHUS. In years 6 through 10 of the 10-year period, in that abatement period, but let me also say at the same time, we provide hundreds of thousands of additional Pennsylvanians health care. And let us not lose our focus here. We have an abatement program that subsidizes physicians and we voted for additional tobacco revenue to do that. And we have helped physicians underwrite the cost of their medical malpractice. We, as Democrats, just think it is fair to have a coverage platform that allows for average working families to have health care for Pennsylvanians.

Mr. NICKOL. So physicians would be paying more— Do I understand you correctly, to the narrow question of will physicians be paying more for their primary coverage, under this legislation, as the primary coverage steps up in increments of $50,000 a year?

Mr. EACHUS. I do not think you can lead to that conclusion because the insurance marketplace is cyclical. As we have seen by the reforms we have passed in the Insurance Committee, of which I was a member, we have passed an array, a variety of reforms that reduced both the amount of medical malpractice cases in the stream – we have seen reductions in the amount of cases across the Commonwealth and the amount of awards the juries have awarded – and we have seen a squeezing of the total amount of cases filed because of the reforms this legislature passed. So I do not think you can jump to the conclusion that the insurance marketplace is just going to react this way. We are, as I said again, going to increase Mcare abatements to physicians from year 6 through 10 of the 10-year period. They are going to be fairly offset costs while we are providing additional health insurance to those who are currently uninsured in Pennsylvania.

Mr. NICKOL. Thank you for the response, even though it really did not specifically, I feel, answer my question. But let us move on.

It is not clear to me what happens in your amendment to the auto CAT Fund surcharge funds, which is presently about $42 million annually that currently, under current law, are deposited in the Mcare Fund until the year 2012.

Mr. EACHUS. The resources you are referring to continue to go to Mcare until 2018, January 1, when the Mcare abatement ends.

Mr. NICKOL. Is that language in the amendment?

Mr. EACHUS. Yes, Mr. Speaker. It would be page 6, line 11.

Mr. NICKOL. Okay. Thank you. Another question: Your amendment, regardless, especially, requires a provider to actively, as my understanding, requires a provider to actively participate in both CHIP and adultBasic in order to qualify for the abatement. Is that correct?

Mr. EACHUS. Yes, Mr. Speaker.

Mr. NICKOL. My follow-up question is, is there any exemption for practices that are limited to senior citizens or pediatrics?

Mr. EACHUS. No; there is not.

Mr. NICKOL. The amendment also requires all physicians who take the abatement to get trained in the value of prescribing generics. Certain medical professions – radiologists, pathologists quickly come to mind – do not prescribe. Would they be exempt anywhere in here from the training?

Mr. EACHUS. Well, they have a license to prescribe whatever they like, Mr. Speaker. They are physicians. And we do have an enhanced prescription drug platform which will be determined by the Department of Insurance. So I do not think you can necessarily determine what will be in that enhanced prescription drug benefit, but if the physician has a license, he can prescribe.

Mr. NICKOL. Thank you. I am not sure what the value of training would be for them, to require it.

If you could please look at page 9 of the bill, I have a question. With regard to the definition of "health care provider," which is changed, heretofore hospitals were able to claim the abatement for physicians that are employed by the hospital and submit the paperwork and get the abatement paid since they are paying the abatement and the underlying medical liability coverage as well. In your change in the language here, by eliminating the reference to section 702 of the act, which in turn refers to section 103, we essentially remove hospitals from the definition of "health care provider." Will hospitals be able to continue to receive the Mcare abatement for the physicians that they employ and for whom they make payments in Mcare assessments?

Mr. EACHUS. Yes; hospitals will still be able to do that. Yes; they will. Yes; yes.

Mr. NICKOL. Thank you.

That completes my interrogation. If I could extend my remarks?

The SPEAKER. The gentleman is in order and may proceed.

Mr. NICKOL. I note in one of the handouts from the other side of the aisle, publicity with regard to this piece of legislation, there is one note that says we are the only State in the nation that currently funds a program like this for our doctors. I would like to note for the members that we are also the only State in the nation with a liability of this nature, an unfunded liability this large, and one of the very few States that has an entity such as the Mcare Fund. I think there are two such States. So the fact that we are the only State that currently funds such a program would not itself be that exceptional, since we are basically the only State with this problem.

I served here 18 years. This is my 18th year as a legislator. I served, before that, 18 years as a staff member in the Senate. And perhaps I remember a lot of the history better than many members here, but Mcare is actually a relic of the past, reflecting on poor State management of the previous medical catastrophe loss trust fund.

The billion dollar-plus unfunded liability for that fund was due to the creation of a program where the costs exceeded the resources and years of delay until the General Assembly resolved the situation. Ironically, this issue touches also on the auto CAT Fund and the surcharge, a similar case of State mismanagement of an insurance program where the costs exceeded the revenues for many years and resulted in a huge unfunded liability.

The auto CAT Fund debt has finally been discharged with a surcharge on moving violations under the Motor Vehicle Code. But the auto CAT Fund surcharge lives on today, much like the Johnstown flood tax, long after its intended purpose and will continue until 2018, and it is being paid currently into the Mcare Fund to help cover this liability.

The Mcare assessments today are intergenerational, new physicians are having to pay these assessments for a liability incurred by others, many of whom are now long retired. The Mcare assessment is a wet blanket on physician recruitment and retention in Pennsylvania and feeds through to higher medical costs for all of us. It is not just an assessment paid by health-care providers; we all pay for it in the end.

I was a member of a commission last year that was created in legislation by the General Assembly, and we were assigned a task of looking at the Mcare Fund and seeing what we could do to come up with eliminating the Mcare Fund and paying off the liability. Here is a copy of the report if anybody is interested in going through it in detail.

If you read this report, we have it within our power to eliminate the Mcare Fund and retire its debt if we concentrate our attentions to that task, but today we appear to be directed to

use the available funds to jump-start or expand the adultBasic program. I guess there is nothing as attractive as an unguarded pot of money in State government. So rather than use the money to retire this debt and eliminate the Mcare Fund, we are going to create another program.

I intend to vote against the Eachus amendment. It is not that I am against any expansion of adultBasic if appropriate funding could be found. It is because I believe in the sound legal precept known as the first law on holes. That is when you are in a hole and want to get out, stop digging. Let us use the available funds in the health-care provider retention account to fill the hole, pay off the Mcare liability, and eliminate the Mcare Fund once and forever before we start digging a new hole with a new program.

Thank you, Mr. Speaker.

The SPEAKER. Representative Petri.

Mr. PETRI. Mr. Speaker, I am inquiring as to whether the maker of the amendment will stand for brief interrogation?

The SPEAKER. Representative Eachus has indicated that he will stand for interrogation. Representative Petri is in order and may proceed.

Mr. PETRI. Thank you, Mr. Speaker.

On page 9 of the bill, in the section entitled "PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM FUND," there is a definition that is not defined. There are words used, "service area," and what it says in subparagraph (6) of section 7 is that "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." What, Mr. Speaker, is meant by a health-care provider's service area?

Mr. EACHUS. Just the area where you live, Mr. Speaker.

Mr. PETRI. Okay. Well, we have a number of physicians that live in, let us take a town in Bucks County, Newtown Borough. Is the service area Newtown Borough, is it Bucks County, or is it the southeast region, Mr. Speaker?

Mr. EACHUS. Just based on the patients that come in the office to see him.

Mr. PETRI. So if a patient travels 200 miles to come and see a physician, is that their service area, Mr. Speaker?

Mr. EACHUS. The coverage would follow the patient.

Mr. PETRI. I am sorry; I did not catch that answer.

Mr. EACHUS. Just like in any insurance policy, the coverage would follow the patient. So the reimbursement would go to the physician, just like today.

Mr. PETRI. Okay. So if I understand your answer, Mr. Speaker, it could be a very, very broad area.

Mr. EACHUS. Well, no. I do not think it is so broad. I think it is just where you live, as I said.

Mr. PETRI. Okay.

Mr. EACHUS. Based on where you live.

Mr. PETRI. Next question: There is a provision at subparagraph 11, (i), that requires health-care providers to attend "…at least one Commonwealth-sponsored independent drug information service session, either in person or by videoconference." What is the purpose, Mr. Speaker, of having a plan that requires a health-care provider to attend an independent drug information service session?

Mr. EACHUS. Yeah, I think I answered it before, but I am happy to repeat myself, Mr. Speaker. In the PA ABC Program, we are going to provide pharmaceutical enhancement, a benefit for pharmacy. So it is important for physicians to understand the clinical protocols inside that pharmacy benefit. So it is a short training. You should be able to do it from your computer in your office without any onerous burden.

Mr. PETRI. Well, I understand that it is possibly not very burdensome, but the question really is, and I do not think you answered it unless I did not understand your answer, Mr. Speaker, and that is, what would be the purpose of it? What is it that we hope doctors learn about prescription drugs in that plan? Is it that they should learn about the dangers of importation of pharmaceuticals from foreign countries? What is the reason for requiring this attendance?

Mr. EACHUS. Well, it really is just to assist the physician, to help them in their prescribing and make sure that proper clinical protocols are being met.

Mr. PETRI. And by protocols, what do you mean, Mr. Speaker?

Mr. EACHUS. Well, I am not an expert in pharmacy, Mr. Speaker, but the benefit and the training will be determined by the Insurance Department. It should not be that much of a burden on physicians.

Mr. PETRI. Mr. Speaker, what is going to be in this health-care plan that will be offered? What types of coverages?

Mr. EACHUS. I will repeat what the coverage model is for you, Mr. Speaker. Within the PA ABC Program, we are going to provide preventative and wellness care, chronic disease management, prescription drug coverage, inpatient and outpatient behavioral health services, and the existing delivery system already in the adultBasic program, hospitalization and the like.

Mr. PETRI. Mr. Speaker, at section 1313, subparagraph (a), under "Benefits," is it not true that this is a "may" provision and that would allow the insurance commission to decide what kind of coverages exist under this program?

Mr. EACHUS. No. They will not be able to change the basic benefit package, but it will give discretion—And I mentioned there could be an HSA model here where the individual insurance company could go to the Insurance Department and consumers can adjust internal benefits within that platform based on price to try and create a lower cost benefit and a more competitive insurance marketplace. So you would have to keep the basic ABC platform, you would not be able to change those, but consumers might want, for example, less hospital days to stay if they are a young person or some other benefit to be able to save some money. It really is a consumer-friendly decision.

Mr. PETRI. Mr. Speaker, does this plan intend to use a pharmacy carveout? Is this plan dependent upon substantial savings, and if so, what amount in order to fund the program?

Mr. EACHUS. Let me say the enhanced pharmaceutical benefit will be determined by the Insurance Department. But right now, in adultBasic today, there is no prescription drug coverage, and it is impossible for a person who has surgery to be able to get— They need prescription drugs for wellness. So this additional enhancement is going to be a significant step forward for wellness for patients in the PA ABC Program.

Mr. PETRI. I understand that, but in your projections of this plan, is it contemplated that you will be using savings from a pharmacy carveout in order to fund this program?

Mr. EACHUS. I think we will try to find savings in the entire program; it would not just be pharmacy. Wherever we can find savings, that will be the efficient and effective way, the responsible way to run this program. So it would not surprise me if it is a savings model for many cases – whether it is days of stay, clinical protocols for physicians, or additional pharmacy

proposals that would save money – I think that would be responsible in this proposal.

Mr. PETRI. Mr. Speaker, on another topic: This bill depends upon a Federal waiver, and it has specific provisions, Mr. Speaker, that talk about what happens when the Department of Welfare receives approval of a waiver. But, Mr. Speaker, what happens to this program if there is no receipt of a Federal waiver?

Mr. EACHUS. I think we are working on an agreed-to process on that waiver right now, but other States have received this waiver, and from my understanding, the administration has been in discussions with CMS. I think it is pretty obvious that because other States have received this waiver, we will get it, too. It is a very key part of the proposal.

Mr. PETRI. Mr. Speaker, let me try and ask the question a different way: Will this program be withdrawn or does it fail on its own terms if a Federal waiver is not received?

Mr. EACHUS. The Federal waiver is a key component of the program.

Mr. PETRI. So, Mr. Speaker, if a Federal waiver is not received, there would have to be additional State revenue used to fund the hole, would there not?

Mr. EACHUS. I would agree that this program should not start until we get a Federal waiver.

Mr. PETRI. Okay. But, Mr. Speaker, is there anything in this bill that indicates clearly that this program does not start without that Federal waiver?

Mr. EACHUS. We are working on an amendment with Republican members and leadership on that matter right now.

Mr. PETRI. Mr. Speaker, under section 1317, subparagraph (3), there is a provision that talks about eligibility in order to meet Federal funding requirements. Are there any provisions in here that deal with State funding requirements and ensuring that the program does not proceed without adequate State funding?

Mr. EACHUS. We think that the model we have created from the State funding model, as I have told you, the current tobacco settlement money that we are using for adultBasic, the retention fund resources, the additional payments from those who are involved in the program, as well as the money that we deposited into the SAFE Fund would be an adequate State funding model. We have run a very thorough analysis, and we really believe this is a very conservative model that is sustainable well into the future.

Mr. PETRI. Mr. Speaker, on the bill.

The SPEAKER. The gentleman is in order and may proceed.

Mr. PETRI. Mr. Speaker, I believe that this bill is rushed, it is hurried, and it has been done without hearings, and the number of questions that are arising today indicate that it is not ready for prime time. It is not even ready for the floor of this House, in my opinion.

There are a number of problems which we have identified. One thing that we did as a Bucks County delegation last year, Mr. Speaker, was to hold a local hearing, and to my knowledge, it was the only hearing that has occurred on this concept outside of an Appropriations hearing. In other words, it is the only hearing where the stakeholders had a chance to give us feedback. And what we heard loud and clear from our physicians and our health-care professionals in Bucks County, Mr. Speaker, is that the projected model for funding and for payment to doctors was far too low. Doctors often complain even about the level of reimbursement they get from the Blues. Under this plan, the actuarial model, as originally put forth by the administration, assumed a payment schedule of medical assistance plus 5 percent, and at that rate, doctors clearly indicated that they would not even be able to pay their nursing staff with that level of reimbursement, Mr. Speaker.

So when we roll out a plan that is going to have inadequate funding for doctors to meet their ongoing expenses, forget making a profit, but even be able to pay their bills, Mr. Speaker, you know that doctors are not going to sign up. And during a recent Appropriations hearing, I asked if there was pushback from the doctors and was told by the administration that there was no pushback. Well, talk to any doctor you know about reimbursement rates and you know that they have to at least be able to make a living.

This bill, Mr. Speaker, requires a doctor to sign up and to accept anyone in their service area, and we just heard during interrogation that service area follows the patient, not the doctor. So anywhere your patient decides to go is where his service or his or her service area is. So in other words, you could end up being a physician that not only loses a little bit each time but loses a little bit a lot of times with every patient. So the fact that there is not a clear definition of "service area" is already a fatal flaw.

In addition, and it has been discussed by a number of other previous speakers, the concept of tying and mandating, that in order to continue to receive your Mcare abatement, you have to sign up for the program is improper. If it was a new program, something that we had just decided that we were going to pick up a doctor's Mcare assessment to some degree, you might be able to say, okay, well, you are getting a public benefit and you should provide a public service. But we have been on this road for a number of years and we have made certain promises and pledges to doctors who have continued their practice in reliance on what we have told them and what we have done.

I just heard from a doctor the other day in my district who tells me that if he does not get his Mcare assessment by March 31, he may have to close his practice. That is one of the last few orthopedic surgeons we have in Bucks County. Well, doctor, if you are watching tonight, I told you this would happen. They are trying to tie your ability to get an Mcare abatement to signing up for a service area that could include the entire State of Pennsylvania as your patient recipients – pretty heavy burden.

Going on further, there is an odd little provision in here that requires doctors to attend health-care sponsored independent drug information services. The real intent of this provision, in my mind, in my belief, is to require doctors to use generic drugs. And generic drugs are appropriate in many circumstances and there ought to be ways to encourage people to use generic drugs, but we ought to be very careful at a time when even importing of dog food can be dangerous, to be encouraging importation of drugs that are not really designed to do what the doctor believes needs to be done for their patient. It is another way, Mr. Speaker, of removing the patient from their own health care, because the advice of their doctor will end up being secondary to their own needs.

Going on further, there are some other fatal flaws in this bill. In particular is— Mr. Speaker, may I have some order?

THE SPEAKER PRO TEMPORE (JOSEPH A. PETRARCA) PRESIDING

The SPEAKER pro tempore. The gentleman is correct.

Will the House please come to order. The gentleman is entitled to be heard.

Mr. PETRI. Mr. Speaker, this benefit plan depends upon a waiver, and even the sponsor agreed that we should not proceed until we have a Federal waiver in hand. Well, that is not what this bill does. This bill requires the plan to move forward with or without a Federal waiver. That is not appropriate. It is also not prudent.

Probably the worst error in this bill that I see is a complete abdication of any legislative authority over this program. The clear language in subsection (a) of section 1313 says, "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."

Make no mistake, you are not offering your constituents anything, or maybe you are offering them everything. It depends upon the Insurance Commissioner, someone who is not even elected to serve. So when you go and send your newsletters saying you have got all these benefits, you better check with the Insurance Commissioner first, because they may have nothing or they may have everything. It all depends upon the Insurance Commissioner, because, you see, we really do not know what this plan is going to cost.

Two weeks ago in Appropriations, we were told that soon we will have the new model and the new pricing. So what? We are supposed to vote before we know what we are doing around here? Is that reform? Is that what this legislature is about? Well, that is about what you are about to do. You are about to vote for a plan that allows the Insurance Commission to decide what is offered, what the price is, what the level of reimbursement is, and you have completely abdicated your responsibilities. Shame on you if you vote for this; shame on you.

Let us get to the practical aspects of this bill. Let us really talk about what is going to happen. It appears that this amendment will pass, but, doctors, that does not mean you will get your Mcare abatement, because I do not believe the Senate will take this measure up. March 31 will come and go, and unless the Governor, by Executive order, extends the time period for you to pay your errors and omissions coverage, you are out of luck. So those members who want to vote for this, you have abdicated your authority. You are giving nothing, and you are giving everything. There is a tax increase in here; I can guarantee you. Look at the little fine print that says such other sources as the State will grant, and remember, shame on you.

I urge you to vote "no."

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Turzai.

Mr. TURZAI. Mr. Speaker, if I could just ask a few questions, and then I will have a few remarks.

I know you may have covered this ground, but in the discussion—

The SPEAKER pro tempore. Will the gentleman suspend.

Representative Eachus consents to interrogation?

Mr. EACHUS. Yes, I will stand for interrogation, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Mr. TURZAI. I just was having a difficult time following some of the numbers. In the first year of the implementation of your proposed amendment, how many additional people are you saying that would be covered under adultBasic?

Mr. EACHUS. Mr. Speaker, if you refer to the fiscal note—

Mr. TURZAI. I do not have it, and I apologize.

Mr. EACHUS. —the first year is 143,000 adults, which immediately eliminates the adultBasic waiting list and exceeds that by about another 60,000 adults.

Mr. TURZAI. And what would the total cost, the total cost of those 143,000 individuals, providing coverage for those proposed 143,000 be?

Mr. EACHUS. State cost is $213 million. Total cost, $501 million to cover all these additional adults in Pennsylvania.

Mr. TURZAI. And that would be just the first year?

Mr. EACHUS. Correct, Mr. Speaker.

Mr. TURZAI. And what is the number of individuals that would be covered, if you have this information, for the second year and the cost for the second year?

Mr. EACHUS. 215,000 adults will be covered in year 2, at a total cost of $808 million.

Mr. TURZAI. $880 million?

Mr. EACHUS. Yes, sir, Mr. Speaker. We are currently spending millions of dollars on adultBasic to cover a very small population. We think that the coverage platform we are creating will not only be more beneficial, but we will be able to cover hundreds of thousands more Pennsylvanians with affordable health coverage.

Mr. TURZAI. The 215,000 in the second year, are the 143,000 that you are projecting a subset of that 215,000?

Mr. EACHUS. Yes.

Mr. TURZAI. Okay. And, sir, with respect to that $880 million—

Mr. EACHUS. $808; excuse me.

Mr. TURZAI. I apologize; $808 million. Have you specifically identified in this amendment where the taxpayer funding is going to come for that $808 million?

Mr. EACHUS. Yes, Mr. Speaker. As I mentioned early in my comments, there are no taxes currently in the Eachus amendment.

Mr. TURZAI. I understand, but we are going to have to come up with $808 million. You are probably going to need companion legislation. Can you identify where you are going to come up with that funding?

Mr. EACHUS. Sure. The State's share is $280 million, and we will be using our existing tobacco settlement and community health reinvestment funds that are in adultBasic. We will be using the health-care provider retention account funds that we talked about, just under half of that amount. We will be using individual's payments within the Pennsylvania ABC Program. We will be using Federal matching resources that will come in as well as additional revenue that will be determined during the budget process that will go into the SAFE account, that I mentioned earlier today.

Mr. TURZAI. Thank you very much.

Mr. EACHUS. Of course.

Mr. TURZAI. Mr. Speaker, I appreciate it.

The SPEAKER pro tempore. Mr. Turzai, are you finished with your interrogation?

Mr. TURZAI. Yes, I am finished with interrogation. Thank you.

May I remark on the—

The SPEAKER pro tempore. On the amendment?

Mr. TURZAI. On the amendment.

The SPEAKER pro tempore. The gentleman is in order.

Mr. TURZAI. Thank you.

Mr. Speaker, the Governor in his proposal, in putting out his proposal, said that there were some 800,000 uninsured Pennsylvanians. Pennsylvania's population is 93 percent covered, one of the highest in the nation in terms of coverage for health care.

This program, ultimately at a cost nearing $1 billion, is arguably going to pick up or help to provide coverage for 215,000 people, only a quarter of the people that the Governor says need to be covered.

I actually fear that this proposal is going to result in more people not covered with health insurance by their employers through the private sector and that more and more people are going to get on waiting lists to be covered by a government-run, government-funded plan that was designed to be, really, the last resort for those who do not have coverage.

What is at stake here – and I do want to make it clear that the Democratic Party has backed significantly away from what their Governor wants, but they are following a significant paradigm shift here. They are saying, ultimately, that they do not want adultBasic to be the last resort. They are ultimately saying that they want government-run, government-funded health care to be the first place that we begin to look, and that is the problem with crowd-out and it is the problem with their plan.

There is no utopian answer to providing health care that makes it inexpensive, top-quality, and universal. That is why Hillary Clinton's plan failed so miserably in 1994.

Government bureaucrats have never and cannot make decisions about the delivery of health care better than private-sector health-care providers and their patient. In fashioning a health-care alternative, Representative Scott Boyd and Representative Kathy Watson and our task force in our caucus worked hand in hand with hospitals, health-care providers, health-care underwriters and brokers, pharmaceuticals, and health-care insurers. Each of these private-sector groups provides significant benefits and roles in providing top-quality health care today, and that is what we have, top-quality health care.

We are, under this proposal, looking to sacrifice that quality because we have not been working with the people on the front line. Each of these people is a significant private-sector employer of Pennsylvania citizens that helps our economy to thrive. Under this plan, we are going to push those people out of jobs and move it to government bureaucrats.

Mr. Speaker, also, crowd-out is bad. A thriving economy has many good private-sector employers. These employers provide significant health-care benefits that do not require public tax dollars. A plan that forces or encourages employers to stop providing health-care coverage for their employees exacerbates the problem of uninsured persons; it does not alleviate the problem.

We must focus on finding ways to reduce the cost of health care. I concede that. We have to provide more affordable health care. I concede that. I want to work hand in hand with the private sector to make that happen. What our task force did is they said, we must in some way focus on the cost-drivers in a pragmatic manner, not one that has government bureaucrats mandating aspects of health-care delivery to hospitals and other health-care providers, but one that allows the market to be able to offer products to individuals to provide coverage in the existing framework and paradigm because that ensures top-quality health care and health-care delivery.

Furthermore, significant medical malpractice reform must be a component part of any plan to lower the cost of health care. There is no doubt that overutilization of health-care services is spurred on, in part, by the need to practice defensive medicine.

This plan, as proposed under the gentleman's amendment, provides nothing for health savings accounts or health reimbursement accounts, which is where the private sector is heading. They are vehicles which provide lower cost alternative insurance coverage without sacrificing quality. They actually make sure that individuals, consumers, have a choice in their health-care coverage. These types of policies essentially provide patients the opportunity to make informed decisions about their health care.

The Republican alternative creates tax rewards, not tax penalties for employers and employees to get or keep insurance coverage. While it is going to take another bill or an amendment to fund the particular program that the good Representative has put on the floor, make no mistake about it, there will need to be a tax increase component to this. The Governor, in fact, proposed a tax on cigarettes or other tobacco products. Earlier he had proposed a tax on employers. You will need a tax at some point to fund this proposal that is being put out for us to vote on. We think tax rewards – tax incentives, not tax penalties – is the better approach.

Finally, this plan is arguably using adultBasic, but as I said, it is not using it as a last resort. To be honest with you, I believe adultBasic needs to be relooked at. Representative Mark Mustio from Allegheny County had actually introduced a bill that retools or relooks at adultBasic. I think adultBasic needs to be using a voucher approach that incorporates things like health savings accounts. I would like to have something forward-thinking as to how we approach adultBasic so that there is an element of consumer choice, an element of personal responsibility, and one that does not wipe out the private sector, either on health-care delivery or in terms of health-care insurance.

I recently got an e-mail from one of my constituents, a Ms. Schmid, and she is opposed to this proposal, and I just want to quote, in part, her language in the e-mail I received. You know, this "…proposal is a government program. The government would design it and tell contractors how to administer it. It is absolutely not a private-sector program.

"Regardless of the technical legal definition of entitlement program, advocates talk about a…mandate to cover everyone. That's creating an entitlement mentality and expectation that the government rather than employers or individuals will take care of people.

"Everyone wants the uninsured to be covered but government's role should be limited to helping the private sector insure more people rather than replacing the private sector with a government quasi-entitlement. It should focus on reducing costs which push up premiums and…. Government should also target those uninsured who truly need help…" but not look to crowd out those people that are already getting appropriate health-care coverage.

I think that that letter supports the position that I am taking in opposition to this amendment, and while I do extol two points – one, the idea that we need to make health care more affordable, I just think that the government-funded paradigm does not work, and second, the fact that there has been, essentially, a repudiation of significant parts of the Governor's proposal, I like that – the fact of the matter is, it is still not the appropriate vehicle. And I wish that we could get a vote, a full up-or-down vote on many of the ideas put forth by my colleagues, Representative Boyd and Representative Watson. I think they have done yeoman's work, and I would ask that, please, there be a "no" vote on this particular amendment.

Thank you very, very much.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Barrar.

Mr. BARRAR. Thank you, Mr. Speaker.

I would like to ask the gentleman if he would stand for brief interrogation, please.

Mr. EACHUS. Mr. Speaker, I will stand for interrogation.

Mr. BARRAR. Mr. Speaker, are you aware in this amendment and with this health-care premium, are there any mandates that are currently assessed that our current private health-care insurers are required to have? Are there any mandates that are being waived at this time?

Mr. EACHUS. Not to my knowledge, Mr. Speaker.

Mr. BARRAR. So we are going to require the same mandates on this plan that we do on current health, like the mental health requirements, the diabetes requirements in the same sense that they are required—

Mr. EACHUS. Are you referring to the plan design, the components within—

Mr. BARRAR. Yes.

Mr. EACHUS. —the ABC Program?

Mr. BARRAR. Yes. The ABC Program; sorry.

Mr. EACHUS. The ABC Program will have certain benefits within, and I have explained those a couple of times. The Insurance Department will be able to have insurance companies bid for these products and set the price, and they will have to commit at that price. So the plan design gets set by the Department of Insurance.

Mr. BARRAR. What are the revenue streams? Well, so right now we really do not know if there are mandates that are going to be waived. I think one of the things we looked at in our health insurance reforms were to look at some of the mandates and see which ones are more costly and eliminate them, and I think that would do a lot to bring down the cost of health insurance. We are just wondering if that is how you achieve such a low premium, and if that is true, then we should extend the same type of mandate relief to all private health-care companies.

Mr. EACHUS. You see, what you call mandates are really what the components of the plan design are. I think the use of mandate— You know, I was on the Insurance Committee with Chairmen Micozzie and DeLuca for some years. These are not mandates; these are required benefits within the ABC platform. So I think that we just have a difference of opinion of what a mandate is. But this will afford a very reliable coverage for those who are uninsured. We really believe that the basic insurance components are essential – wellness, hospitalization, disease management, the ability to have a prescription benefit within this component, which does not exist today.

Mr. BARRAR. Do you know how drug and alcohol is treated there, the rehabilitation for drug and alcohol? Do we treat it the exact same way that we require our private health-care companies to?

Mr. EACHUS. Well, we do have a benefit for behavioral health, but within that behavioral health component, there would be a D and A component.

Mr. BARRAR. Would it be exactly as we mandate other companies to do?

Mr. EACHUS. Well, it would get set by the Department of Insurance.

Mr. BARRAR. Will it be exactly as we were— I mean, we require them to provide 30 days. If I am correct, we require them to provide 30 days. Will our plan have the exact same coverage? I mean, if it is not, then we are basically— We are requiring the private health insurance company to require them to— We are mandating that they have that coverage, and if we are not going to do the same, I want to know.

Mr. EACHUS. Each of the components within the plan design will be up to the Department of Insurance to put the final touches on.

Mr. BARRAR. Have you done a— I guess you have done an actuarial study on this to see what the projected costs will be?

Mr. EACHUS. What we have is a fiscal note.

Mr. BARRAR. Okay. On the fiscal note, how many years does this look— On the fiscal note, does it just cover 1 year or does it go 4, 5, 6, years into the future?

Mr. EACHUS. No, Mr. Speaker. This fiscal note goes out to 2011.

Mr. BARRAR. Okay. In 2011, what are the expected premiums to be? Are you expecting them to stay exactly what they are today?

Mr. EACHUS. Well, we know that in this first year, the plan will cost $311 a month, just a little over that for the person who buys the coverage between 200 and 300 percent of poverty, and as I said, for a family of four, that is $63,000-plus in income. So they would be able to buy this program for $311 a month. I do not know about you, Mr. Speaker, but there is no family coverage in Pennsylvania that you can get for just about under 600 bucks a month. A lot of this coverage is $750, $800, and it is surely not as good as the coverage that we would have as members of the House.

Mr. BARRAR. I will agree with you. This is an easy way to get the consumer on the hook. What I want to make sure is that in 5 years from now the consumer can afford it. What is that rate today expected to be in 5 years, in 2011? What do you expect that rate to be in 2011?

Mr. EACHUS. I think it depends on a whole lot of variables, but as I said, we are going to continue to try and find efficiencies inside this program so that we can continue to lower costs for the consumers who are involved in it. Right now—

Mr. BARRAR. So what you are saying—

Mr. EACHUS. Excuse me?

Mr. BARRAR. Go ahead; sorry.

Mr. EACHUS. Right now we are increasing immediately in year 1 the coverage to 143,000 additional uninsured Pennsylvanians. We think that that is a responsible move, and we really think that this kind of investment that we are making in this amendment is really about trying to take care of access for the uninsured.

Mr. BARRAR. I know you keep touting the benefits of the plan today, but are the benefits of the plan affordable 5 years from now, is pretty much what my question is. If we lose revenue, is there a contingency plan to make that revenue up somewhere else?

Mr. EACHUS. Mr. Speaker, let me say again, this is not an entitlement program. If the costs exceed— If prices grow, there will be, there could be, potentially, a waiting list for more people on the outside of this program. We have done the very best we can to cover as many Pennsylvanians as we can. We believe that we can get up to 272,000 additional lives in just a few years. That means that those people who now have no insurance, no insurance, can access this health-care coverage which is affordable, and for those who are in the lowest income levels, we would help subsidize their coverage.

Mr. BARRAR. I think we both agree it is affordable today. We just do not— None of us have a clue what it will cost 5 years from now. From what you have said, you have absolutely no plan how to make up that revenue if the premium increases or if we lose revenue from somewhere.

Are you aware of the fact that in 2010, the Community Health Reinvestment Fund, the agreement with the Blues expires in 2010?

Mr. EACHUS. I am, Mr. Speaker, and there may be other opportunities for additional resources through the negotiations with Blue Cross companies. I am hopeful that they will be willing to contribute to this really important access to health-care issue for Pennsylvanians, but I say, again, to you, I do not think that we should stop and wait and show inaction. I think we need to move forward. There are people right now losing everything in this Commonwealth because they cannot get access to affordable insurance, and this amendment does exactly that.

Mr. BARRAR. I disagree with you. I think it is foolish to move forward with a plan that we know a large percentage of the revenues that we expect to subsidize this plan with are going to expire at some point in time. We know the tobacco settlement funds are going to decrease every year. We know this Community Health Reinvestment Fund is going to expire in 2010. We have no clue to what the future of this plan is, unless you have inside information that is not available to us.

There is another grant program you mentioned earlier about – there is a grant that will be offered to small businesses in order to afford this coverage of, I think, $42 million a year?

Mr. EACHUS. That is called the CARE Fund. It is a grant to small employers. We want them to keep their private insurance coverage. We do not want them to dump their coverage and come in. So it is one way of stopping the crowd-out that Mr. Turzai mentioned earlier, the gentleman from Allegheny, by incenting, with a grant, those employers who meet the qualifications, and I mentioned what those qualifications were earlier. We think by helping them with a grant, we can keep them insuring, responsibly, the low-income employees they have got.

There are many employers – I was a small businessman myself before I got here – many employers care deeply about providing health care for their employees, and that health care continues to grow and grow in cost. I know when I was in business, I was getting 15- to 20-percent increases from the Blue Cross companies that I did business with in northeastern Pennsylvania. That growth, we believe that the CARE grant can help offset the cost of that for responsible employees who meet the qualifications and help make sure that we keep the private insurance coverage where it should be.

Mr. BARRAR. So how many years is the CARE grant guaranteed for?

Mr. EACHUS. 10.

Mr. BARRAR. So by passage of this legislation, we are committing for 10 years that that $42 million will be available.

Mr. EACHUS. Yes, Mr. Speaker; a year, per year.

Mr. BARRAR. I know this question was asked earlier, and I apologize because I was interrupted and did not hear your full answer. The reimbursements back to our doctors – and this is a question that may have been asked several times – how was that to be determined?

Mr. EACHUS. They will get set between the Insurance Department and the insurers.

Mr. BARRAR. So the doctors will have an opportunity to negotiate that?

Mr. EACHUS. Yeah, of course, there will be a negotiation in that paradigm.

Mr. BARRAR. I know when we were talking about Cover All Kids in this plan or Cover All Pennsylvanians, this plan is different. I know that doctors were very, very angry about the reimbursement that was being discussed. Most of them said that they would not participate in a plan with the reimbursement that low. Is that why, because of the feedback we got from the doctors on the Cover All Pennsylvanians, is that why now we made it mandatory for them to participate in order to receive the health-care provider retention funds?

Mr. EACHUS. I have got to tell you, I do not think it is that calculating. We really felt strongly on this side that in the Eachus amendment that we should allow the Insurance Department and insurers, hospitals, and doctors to have a discussion about those rates rather than setting a hard line in the sand in this bill that would be either high or low. So I am hopeful that there is a fair reimbursement to physicians, but that should not be a barrier to finding a way to cover those who do not have health insurance in Pennsylvania.

Mr. BARRAR. Okay. That is all I have, Mr. Speaker. Thank you.

The SPEAKER pro tempore. The Chair thanks the gentleman.

LEAVE OF ABSENCE

The SPEAKER pro tempore. The Chair recognizes the minority whip, who requests leave for the remainder of the day for Representative CAPPELLI. Without objection, that leave will be granted.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER pro tempore. The Chair recognizes the gentleman, Mr. Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

I was wondering if the gentleman would stand for a few questions?

The SPEAKER pro tempore. The gentleman indicates that he will stand for interrogation. You may proceed.

Mr. BOYD. Thank you, Mr. Speaker, very much.

Mr. Speaker, I apologize. You know the furor of the activity of the day. You may have answered some of these questions before, and I will try and be as brief as I can.

Mr. EACHUS. Mr. Speaker, no apology required.

Mr. BOYD. All right. Thank you, sir.

One of the questions I wanted to ask is, in the amendment as it is drafted, you tie the Mcare abatement to requiring providers to offer ABC coverage. That is a correct statement? Participate – be provider participants?

Mr. EACHUS. The physicians in Pennsylvania, if they get an Mcare abatement, would be required to accept the PA ABC Program and the Cover All Kids proposal for children. That way there is capacity of physicians ready to accept these new patients.

Mr. BOYD. Okay. Is there any reason that you did not extend that to MA (medical assistance) patients, at this point?

Mr. EACHUS. Pardon me?

Mr. BOYD. Is there any reason that you did not extend that to medical assistance? I know Representative Kenney has had an amendment in this language that he had talked about doing at periodic times. It seems that what we are doing is we might be setting up kind of almost a little bit of a class warfare system, where we are not requiring physicians to take MA patients but we will be requiring them to take the ABC patients.

Mr. EACHUS. Let me say something to you: I get a lot of this back home, Mr. Speaker. Average hardworking families, who are working hard every day, really do not feel like their government is making a difference. In this case, it takes people, not people on medical assistance or welfare, it takes the ability to give access to hardworking families, to give available health-care access to affordable insurance coverage for the adults in their families. We already did this for the children last year. When we provide it to the adults, we close the gap. And I really think it is the fair thing to do for those hardworking families from $15,000 an individual – that is the Federal poverty guidelines at 150 percent – up to those families of four of $63,000 a year. I think it is a fair thing to do to provide access to health care for them.

Mr. BOYD. I understand. Do you have any concern of the fact that the providers will not have to see MA patients, but they will have to see ABC patients? Are we not creating sort of a class, you know, potentially setting up a little bit of a class warfare of who gets seen by physicians, under this legislation?

Mr. EACHUS. As you know, the Eachus amendment is dealing with the Pennsylvania ABC Program and access for the Cover All Kids proposal, the children in Pennsylvania. We are not focused today on medical assistance and that policy.

Mr. BOYD. Thank you, Mr. Speaker.

I know you have some good coaching beside you, and I think you have answered this one already, but what tax increases do you need to fund this plan? You mentioned in the list of funding provisions, which I have a little later on in my notes, I think it is tobacco revenue. What taxes are you proposing in this legislation?

Mr. EACHUS. None.

Mr. BOYD. What taxes will you need to make this legislation solvent?

Mr. EACHUS. None.

Mr. BOYD. So if we pass this, there will be no reason in the future to raise any additional revenue than is already available through the State to fully fund ABC as it is presented today?

Mr. EACHUS. That is a decision that the General Assembly can make in the future. Today we deal with no taxes.

Mr. BOYD. Mr. Speaker, what are the reimbursement rates that you anticipate under this program? One of the big concerns that we heard repeatedly in insurance hearings with the Governor's original proposal was less than adequate reimbursement rates. In fact, as recently as within the last 2 weeks, some of the preliminary data that was available on some things out of the administration was that the reimbursement rates would be about 5 percent over Medicaid. Is that what you anticipate with this?

Mr. EACHUS. Well, let me put it to you this way, the rates that we discussed in the House Democratic proposal, the Eachus amendment, were 20 percent higher than what the Governor had offered in the HB 700 version I offered earlier this year. But we felt strongly that we should leave those out for now and allow for strong negotiations between the provider community and the Insurance Department on those rates.

Mr. BOYD. So if I understand what you said clearly, then those rates are going to be negotiated down the road. Is that a correct statement?

Mr. EACHUS. Between the insurance companies, the provider community, and the Insurance Department.

Mr. BOYD. Very good. Do you have any concern that similar situations that developed in Massachusetts may develop in Pennsylvania, whereby as revenues came up a little bit short because there were more people that applied for the program than they anticipated, the government, i.e., the State of Massachusetts, came back on the provider network and said, sorry, but we are going to have to start cutting your reimbursement rates to make our numbers work?

Mr. EACHUS. Let me be clear again: The Massachusetts model was a mandated plan for all people who lived in Massachusetts. Ours is not an entitlement program. Let me say it again: This is not an entitlement program; it is not a mandated program. Individuals can opt in to this or small businesses can opt in to this if they can meet the certain qualifications that I discussed, but this is no mandate.

Mr. BOYD. So I understand it is not a mandate, and I have heard you say, repeatedly, it is not an entitlement. The question is, will there then – do you anticipate, at some point in time, a waiting list for this program? Will you see people waiting to get enrolled in ABC as we do right now in the current adultBasic?

Mr. EACHUS. I do not know that, but I can tell you that, as I said, in year 1, there are 143,000 people added to our insurance program. We believe we can get to over a quarter million additional insured lives in the ABC Program, and we really think that is the priority. As far as the waiting list goes, it is just hard to tell.

Mr. BOYD. Mr. Speaker, onto another subject, and I know you answered this; I apologize. The premium rate that you expect on these policies, if my memory serves me right, is about $320ish? Is that fair?

Mr. EACHUS. For the person who buys the program on their own, $311 a month, per month.

Mr. BOYD. In essence, that becomes kind of like the base figure that what you are talking about is the premium.

Mr. EACHUS. No. I think I understood your question.

Mr. BOYD. When I say the base, I mean that is the number of what the premium is, and if you are at lower income, you get subsidized, but generally speaking, the cost is about $311?

Mr. EACHUS. Yeah. As I said, the people between above medical assistance to 200 percent of poverty would have a subsidized rate between zero and $50. Those above 200 percent of poverty and 300 percent of poverty – as an example, once again, a family of four, $63,000 in income – could buy this insurance for $311 per month.

Mr. BOYD. Okay.

Mr. EACHUS. With the benefits within it, which are hospitalization and prescription drugs and everything in between.

Mr. BOYD. And that is $311 per person.

Mr. EACHUS. Per person, per month.

Mr. BOYD. Okay.

Now, just out of curiosity's sake, with that premium, is that flat across the board? It has nothing do with age, any medical underwriting? If a 55-year-old retired individual applied and a 22-year-old, the rate would be $311?

Mr. EACHUS. $311 for everybody who qualifies.

Mr. BOYD. Okay. Thank you, Mr. Speaker.

Then I guess, intermixed with my questions, is it okay if I make a couple of comments, because it will keep my mind clear as I go through here?

Mr. EACHUS. Sure, if you want to come back, we will entertain another discussion.

Mr. BOYD. Okay, I will try and—

The SPEAKER pro tempore. Has the gentleman finished his interrogation?

Mr. BOYD. Not yet. No; I have more.

Mr. Speaker, then another comment that I have heard you make a number of times is that ABC becomes the insurer of last resort, and I do not want to put words in your mouth; that is what is there. How does that reconcile with the social mission of the Blues, that they currently are the insurer of last resort? Are you proposing in this that we end up eliminating the Blues' social mission and make them a for-profit entity and then a taxpaying entity?

Mr. EACHUS. It does not change the Blues' social mission.

Mr. BOYD. As the insurer of last resort, it seems to me then we are going to create two insurers of last resort. If that is the case, why would the Commonwealth need two insurers of last resort then?

Mr. EACHUS. No, Mr. Speaker. Currently under the adultBasic program, as you know, the Blues companies provide insurance under the adultBasic program. They see that as part of their social mission, so this is just an extension of that. It offers more people the benefits across the Commonwealth. It offers a better benefit package and subsidizes in a much fairer way the expansion of this program. It does not change the relationship between the Blues, their social mission. It is consistent with the adultBasic model that we have currently, and we really just think it is going to expand the ability to provide more insurance to more people in Pennsylvania for an affordable price.

Mr. BOYD. Thank you, Mr. Speaker.

If there is simply not enough money to cover everybody who applies for the new PA ABC, what happens to those applying we do not have the money for?

Mr. EACHUS. Well, we are assuming, with our financial analysis, that there will be enough money in the modeling to take care of the individuals we discussed today. But as I said, this is no entitlement. There could be someday in the future a waiting list, but it is hard to tell.

Mr. BOYD. Okay. Thank you, Mr. Speaker.

So to be clear, the alternative is not necessarily that we would have to raise taxes; the alternative is people might have to wait for the service.

Mr. EACHUS. Yeah, theoretically, but once again – I said it earlier – I do not think it is responsible to wait, because people are losing everything without health insurance access in this Commonwealth. If you do not have it and you need an operation, and we have seen people in our offices who need it, people who are in dire straits from a health position who need to go to the hospital, have no insurance, and they lose everything, I think we need to act now, and the model we have come up with is extremely responsible.

Mr. BOYD. Thank you, Mr. Speaker.

If I can move to a couple of questions about the employer side of this. You know, you bring employers into this through your CARE program and some other innovative ideas that you have come up with.

I want to ask about an employer who employs people who work in Pennsylvania but are not Pennsylvania corporations. Say a major national corporation that has a sales rep who is located, is kind of an independent rep, maybe even works on straight commission in Pennsylvania, but the company, the parent company, is in New Jersey or California, and they are covered under a health insurance plan provided by their parent company in another State, but they work in Pennsylvania. Would they be precluded from participating in the program because they are not really working for a Pennsylvania employer? It seems the way the language is drafted, they would be excluded from the program benefits of Pennsylvania ABC.

Mr. EACHUS. Once again, Mr. Speaker, if you are a resident of Pennsylvania, you are a legal resident, you are a U.S. citizen, you have to be uninsured for 180 days. You have to also be ineligible for medical assistance and Medicare, you have to be between the ages of 19 and 64, and you have to be a Pennsylvania resident for 90 days. Those are the eligibility requirements for an individual. That person, if they met those requirements in Pennsylvania, they could come into the program and purchase their own insurance.

Mr. BOYD. So the employee would qualify for ABC, but the benefits that would be provided to the employer, potentially, through the tax credit programs, they would not qualify for.

Mr. EACHUS. It has to be a Pennsylvania-based company.

Mr. BOYD. Okay. Thank you, Mr. Speaker. I did want to clarify that.

On your 180-day waiting period, do you have any provisions in your legislation— How do you address corporations that change their status? As an example, in recent years Pennsylvania passed some tax increases in, I believe it was 1991, that really drove a lot of corporations to refile from being a C corp to an S corp. And then most recently there has been a wave of business entities that have been created, being LLCs (limited liability companies) or even LLPs, limited liability partnerships. So is there any mechanism in your bill to stop an employer who ends up, for whatever reason, dropping health coverage or wanting to get into the health coverage, having the 180-day waiting period, simply reincorporating as a different entity and then they would qualify immediately for health coverage?

Mr. EACHUS. Well, if I understand the scenario that you are saying, you are saying the company decides to change its corporation, reincorporate under a new corporate name, and

then come in under and try and get insurance through the back door. I am hopeful that we would not allow that, Mr. Speaker. I am hopeful that we can find a regulatory way of dealing with that. It is a good question, though, and I will have to consult with the administration on that, because we do not want to incent behavior for cheating business owners to be able to opt in through some corporate maneuvering to be able to cheat their way through these program regulations.

Mr. BOYD. Yeah, and I hear what you are saying in that regard, and I brought it up for a couple of reasons. One is, I assume a truly legitimate, newly created corporation, which hopefully you and I agree on this one, we want as many of those guys coming in and incorporating in the State as we can. Would they immediately qualify to have their employees into ABC?

Mr. EACHUS. As long as they have not offered insurance for 180 days consecutively.

Mr. BOYD. Yeah, but, if I am an entrepreneurial guy and started a new business, I could come in and— I did not have anything before, I am just starting a new startup company, a venture company, I would qualify for participating in ABC.

Mr. EACHUS. As soon as you got your tax identification number, you could apply as a new business.

Mr. BOYD. Okay. All right.

So then other businesses that are recreated, subsidiaries and so on and so forth that might be created out of a parent corporation, it sounds like we do maybe have some language we are going to have to take a look at, because we want to encourage new employers to the State, but we do not want to allow other employers— You are creating almost a penalty for existing employers to try and get into this program.

Another question I have for you, I want to focus on the 2 to 50 employers. What happens when I hire the 51st person?

Mr. EACHUS. You are ineligible for the PA ABC Program.

Mr. BOYD. Do you think that that might be a disincentive from companies in that size range from growing their employee base?

Mr. EACHUS. If there is profit involved in growth, as a former businessman myself, you are going to grow.

Mr. BOYD. Which would lead me to another kind of question/comment. There are different levels of employees that qualify. Part-time employees would not necessarily qualify for ABC, less than 20 hours per week, correct? So what I might end up doing is hiring a lot of part-time people.

Mr. EACHUS. But the individuals can purchase the insurance, the PA ABC insurance, on their own, if they meet the income qualifications.

Mr. BOYD. Okay. Thank you, Mr. Speaker.

Mr. EACHUS. Sure.

Mr. BOYD. That is a good answer.

Oh, just out of curiosity's sake, is there any intent in the legislation as it is drafted that the program would provide any State subsidy for governments in their health-care programs?

Mr. EACHUS. No.

Mr. BOYD. If, in fact, townships, their programs are less, I mean, can they opt in to this?

Mr. EACHUS. No; no government involvement.

Mr. BOYD. Okay. I do not want to waste people's time now. I would like to see where that is in the language, because I can conceive of individuals working for townships that are not paid, you know, local governments sometimes do not pay that well and they may not have that rich a benefit program. They may opt out of their existing benefit program and want to get into PA ABC. So there is a mechanism in there to stop that?

Mr. EACHUS. The requirement in the law – and my staff, my legal staff, said they would show you – you have to have a tax identification number, a tax ID number. Governments do not have those.

Mr. BOYD. Understood. However, an individual who could work for a city government, a township government, could buy into the program, and if their wage was less than 200 percent of poverty level, it would be subsidized.

Mr. EACHUS. Absolutely. The individual can purchase this program under those conditions, yes.

Mr. BOYD. And I am sure that you have answered this one before, but I want to make sure I am clear on it: Has the Federal government ever granted a waiver similar to the one that we are requesting today?

Mr. EACHUS. Thank you, Mr. Speaker. Here is your answer: Arizona, California, Indiana, Iowa, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, and Wisconsin – and that is not a Democratic primary map, either, Mr. Speaker.

Mr. BOYD. Those have all been granted and are fully operational for programs like this?

Mr. EACHUS. Yep. I will be happy to provide you the list with a copy of the benefits provided.

Mr. BOYD. Another question, Mr. Speaker: How does this program— There is a large group of workers in the Commonwealth of Pennsylvania – and I am going to say this with a straight face – that are really foundational to our economy, and those are members of the labor unions, and they have benefits through their labor union. How does that relate to where that falls in? Does a labor union fall in as an employer under ABC, or is it, you know— I said that for Chairman Belfanti, by the way.

Mr. EACHUS. The answer is no.

Mr. BOYD. So labor unions could not benefit from the employer side of benefits that are currently provided to employers under ABC?

Mr. EACHUS. Correct. But once again, if the individual who works in a union income qualifies, they could purchase as an individual.

Mr. BOYD. I need help understanding the issue of— Somehow it seems that, in your language, you have help for employers but only employers that pay less than 300 percent of wages to their employees, and I am trying to understand why that would be. I mean, would we not want to encourage employers to pay as high a wage as possible? So it seems that to qualify for, I think it is the CARE grants, you have to pay your workers lower wages, and that does not make sense to me. I would think that what we would want to be doing is encouraging employers to pay their workers as high a wage as possible. Is there a mistake, or was this your intent?

Mr. EACHUS. Mr. Speaker, in my opening comments I told you that 76 percent of adults, uninsured, have incomes of 300 percent of poverty or less. So there is a large population of those who are currently employed who fall in this category. So we are really trying to target those employees and employers who are focusing on hardworking, struggling families. If you are making— The median on this would be, for a business, would only be $31,200. That is not very much for a family of four. So I am trying to help those families that are struggling with access to affordable insurance, and if people are above

those guidelines – 200 to 300 percent – they can buy in at the unsubsidized rate of $311 a month.

Mr. BOYD. I can understand where you are going with the employee. I am kind of wondering why the employer would not qualify. Let us say I am paying my employees 350 or 400 percent of poverty level, and I believe I am a good employer – which I hope I was when I was running my company full time and wanted to take good care of my employees – it seems to me that this would penalize me from receiving the benefits of the CARE grants, and I do not know why we would do that.

Mr. EACHUS. Well, 58 percent of the uninsured are under the 200 percent of poverty or less. That is really where we are targeting, that is where we are targeting – the hardworking, struggling workers of Pennsylvania whose incomes are below 200 percent of poverty.

Mr. BOYD. Well, Mr. Speaker, I believe that that wraps up most of my questions.

If I could, Mr. Speaker, just briefly on the bill.

The SPEAKER pro tempore. The gentleman is in order.

Mr. BOYD. Mr. Speaker, first of all, I appreciate the gentleman being willing to answer all those questions, and the one issue I want to try and focus on about this plan is, I think, the fact that we have so many questions. And while I commend the maker of the amendment's efforts to answer the questions, I think there are a lot of unanswered issues with the legislation, particularly the way it is drafted.

I truly wish, and I believe the maker would attest to this, I have spent a lot of time working on this issue, and we did not always agree on everything but we did have some good dialogue, and I believe that you could tell by the exchange on the floor there was a lot more dialogue that could happen.

One of the concerns that I kind of wanted to raise with the maker, but it is really more of a comment, is the issue of everybody would pay the same for the premium – $311. Now, that sounds, on its purest sense, totally fair, and I understand why that would be that way, but I want to say that what that is going to, in effect, do— Mr. Speaker, could I—

The SPEAKER pro tempore. The gentleman is entitled to be heard. Will members please take their seats.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I am trying to make, I think, a relatively important point, and that is, the fact that the premium is the same for everybody across the board is really going to, I think, develop an adverse selection situation, because I can tell you right now that a young person at the age of 23 can go out today and get an insurance policy, a good health insurance policy, for well under the $311 a month. In fact, Mr. Speaker, they can get it for half of that.

So what I am telling you is that young people are not going to opt in to ABC; they are going to opt in to something that is less expensive. And as they do that, you are going to have an adverse selection situation where you are going to drive people who have greater needs – older individuals – into ABC, and that, in effect, is going to raise that cost. The 318 bucks is not going to come remotely close to covering those premiums.

So while I commend the maker for the construct of what he is trying to accomplish, there are some problems with it the way it has been orchestrated and the way it has been put together, and I would encourage the members to vote "no" on this amendment, but not with the intent of killing it; with the intent of looking at this in the future and trying to fix any number of these problems that we see in this.

Why, Mr. Speaker, why would we disincentivize employers to pay their employees less so they can qualify for a grant from the government for the health care? I mean, that does not make any sense. Do we not want to be providing employers the tools to increase wages for their employees? But what we are doing is, we are saying if you pay your employees crappy, you will qualify for a grant, but if you pay them well, you will not. What sense does that make? It just does not make any sense. So, Mr. Speaker, I understand why some of this stuff is here and I understand the answers, but it does not negate the fact that the language in the bill is drafted in this way.

Mr. Speaker, I could go on, and we are all tired, and I am especially tired, so suffice it to say that there are enough holes in this legislation as it is drafted. While you can love the intent, while you can really want to support this, there are problems with it and it needs fixed. It is the same situation we ran into with the open records law. We can make a decision and vote for something that we know needs some repair and do, really, the politically expedient thing, or we can take the time and we can work together and try and get this right.

I have and my colleague, Representative Watson, have consistently extended a hand across the aisle. We provided all our legislation. Every piece of our plan was out there, offered. Some of the items have been incorporated, but we have never really had a full sharing and dialogue. And there are reasons for that on probably both sides of the aisle, but I, again, extend that offer and say, look, let us do the right thing, let us vote this down at this point in time, and let us get a chance to rework this and try and come up with something that works for everybody in Pennsylvania, not just a select few.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Steil.

Mr. STEIL. Thank you, Mr. Speaker.

I would like to interrogate the prime sponsor of the amendment, please.

The SPEAKER pro tempore. The gentleman indicates that he will stand for interrogation.

Mr. STEIL. Thank you, Mr. Speaker.

Mr. Speaker, my questions go to, really, dealing with eligible employers, and I am particularly interested in looking at the effect on small business here. So I am beginning with the definition of "eligible employer." That is on page 13, line 27. Number (2) under that says, one of the conditions is that the employer has not offered, and the operative words are "'health care coverage," through any plan or program during the prior 180 days. Now, the operative words of "health care coverage," I am assuming, then refer to the definition of "health care coverage," which falls on page 14, line 21, which says "A health benefit plan or other form of health care coverage...." And again, I assume the operative words are "health benefit plan," because there is a definition for "health benefit plan," which then refers one to section 1313, which defines what a "health benefit plan" is.

Now, my question is, this scope, this plan— Everything that is defined under section 1313 may well go beyond what small employers, small business employers, are currently offering, and they may also be paying wages that are well above so that

they do not qualify under that. Was that the intent of the legislation?

Mr. EACHUS. We really made the definition as broad as we possibly could because we do want employers in Pennsylvania to keep their employee-based insurance coverage.

Mr. STEIL. I understand that, but it would appear from this then that what you are trying to accomplish is to drive every employer to the definition of a "health benefit plan" under section 1313 as the minimum provided insurance. Is that the intent?

Mr. EACHUS. No. There are no mandates on small businesses in this bill.

Mr. STEIL. All right. If an employer is currently offering health benefit coverage that does not meet the standard as defined in section 1313, and they pay their employees above the 300 percent of poverty level, what options are available to them?

Mr. EACHUS. Well, can you help me, Mr. Speaker? I was a small businessman, and I know you are, too. Can you tell me how you envision a plan that might not qualify?

Mr. STEIL. Well, for example—

Mr. EACHUS. We made this definition very broad so that it would take in pretty much the modern insurance models that are available to small employers.

Mr. STEIL. For example, some small employers are self-insuring. In other words, they may self-insure a certain level of coverage and then provide a high-deductible plan beyond that. So they might self-insure for the first $5,000 and then bring in a $5,000 high-deductible plan after that. So it covers all major injuries, but they are self-insured for the first $5,000. And as part of that self-insurance plan, they may not include dental. They may not include behavioral health programs. So what I am saying is, not every one of these items may necessarily be included in the plan or the coverage that a small business buys.

Mr. EACHUS. We really tried to make the definition broad. If you are self-insured, you are insured. If you are offering some other insurance platform, an HSA or something, you are insured. So if you are offering a benefit to your employees, you would not be eligible for this program. But remember, I say again, individual employees, if the income qualifies and the employer did not qualify, could opt in to purchase this ABC Program on their own.

Mr. STEIL. Yes, but my point is that this entire list of elements in the health benefit plan, if some of those elements are missing, then the employer is not an eligible employer.

Mr. EACHUS. No, I think you are mixing the benefit plan design with the insurance definition. The insurance definition is very broad. If you are offering health insurance to your employees, you do not qualify. If you are offering no insurance for 180 days, you do qualify.

Mr. STEIL. Okay. Then the next question is, if an employer is not an eligible employer under the definitions as provided here, for whatever the reason—

Mr. EACHUS. 100 employees, let us say.

Mr. STEIL. Or for whatever other reason. Even if they are less but they do not qualify because they have provided health-care coverage within 180 days – whatever it is, they do not qualify. What options are available to their employees at that point? May the employee make a judgment as to the coverage included in this plan and adopt this coverage as opposed to what their employer is already offering?

Mr. EACHUS. Just a moment. I want to make sure I give you a clear answer.

We are working on that answer for you, Mr. Speaker. I know it is in here.

The legislation is silent on that issue.

Mr. STEIL. Okay. So that is an issue we would still have to address.

All right. My next question then goes to page 17; it is under section 1306, "Participation by eligible employers and eligible employees," and it is specifically line 33 – it begins on line 32 – "Allow health insurance premiums to be paid by eligible employees on a pretax basis...." But I did not see a definition for "pretax basis"; I assume that is State taxes only.

Mr. EACHUS. Only Pennsylvania taxes.

Mr. STEIL. All right. So they would still be subject to Federal taxes unless— If they were incorporated in some sort of an HSA plan, would that count as complying with this section?

Mr. EACHUS. Are you asking whether they could insure their employees?

Mr. STEIL. Yes.

Mr. EACHUS. If they had an HSA, that would probably be the definition of "insurance" being provided to their employees.

Mr. STEIL. Okay. And the last question that I have is, I believe I understood that you said even with this plan, if this was adopted and put into effect just this way, there will still be Pennsylvanians who are working who will not be included in the plan. There still will be a group of uninsured working people in Pennsylvania.

Mr. EACHUS. As I said earlier, this is not like the Massachusetts plan. It is not a mandated coverage for all employees, and it is not an entitlement program. So if an employee decides not to accept insurance, they do have their own exposure in this. We do not force anyone in; we do not force any small business, but we do create a platform which we think is very affordable, and we estimate that we can cover in the first year 143,000 and in the out-years over a quarter of a million new lives insured in Pennsylvania. We think that is a high goal.

Mr. STEIL. So I guess I interpret from that then that anyone who wants into the plan will be able to get in.

Mr. EACHUS. If they income qualify and meet all the requirements and they opt in to the program, they want to be in the program, they would be eligible.

Mr. STEIL. All right. Thank you, Mr. Speaker. That ends my interrogation. I would like to make a few comments.

The SPEAKER pro tempore. The gentleman is in order and may proceed.

Mr. STEIL. Thank you, Mr. Speaker.

We are getting there. I think that in terms of what small business people need in Pennsylvania, this plan does move the ball forward. It does include things that small employers have tried to accomplish. Unfortunately, I do not think it gets us far enough. I think there are still too many questions with regard to small businesses, and particularly those small businesses who have creatively implemented health-care plans that met their needs.

And in many of those companies, those needs are defined by their marketplace. They have implemented health-care plans that provide coverage that is consistent with their ability to pay for it and their ability to attract employees. This plan, unfortunately, takes some of those eligible companies and

makes them ineligible for this kind of coverage. And I am afraid, afraid very much, that this program begins to drive health-care coverage to a level of coverage, an inclusionary coverage, that goes beyond where many small businesses are right now. It begins to set the floor for what coverage and standards should be.

So for those reasons I would oppose amendment A6103. Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Reichley.

Mr. REICHLEY. Thank you, Mr. Speaker.

Would the prime sponsor of the amendment stand for brief, well, hopefully brief interrogation?

The SPEAKER pro tempore. The gentleman indicates that he will. You may proceed.

Mr. REICHLEY. Thank you, Mr. Speaker.

Mr. Speaker, let me first say I appreciate your patience and stamina in answering hours of questions here. Hopefully you will be able to get through these as expeditiously as possible.

My first question would be for you, Mr. Speaker, really relating back to some areas that were initially brought up by Representative Baker and then Representative Petri. On page 10 of the bill, from lines 24 through 33, there is reference in terms of the requirements upon health-care providers that they attend at least one Commonwealth-sponsored independent drug information service. Is that correct?

Mr. EACHUS. That is correct, Mr. Speaker, and it is 2 hours of training – just 2 hours.

Mr. REICHLEY. I understand the 2 hours of training, Mr. Speaker.

Is there a definition anywhere within the amendment of "independent drug information service session"?

Mr. EACHUS. No.

Mr. REICHLEY. Okay. Are you able to describe for us whether these independent drug information service sessions will involve what is referred to as "counterdetailing"?

Mr. EACHUS. Since they are not described, I could not.

Mr. REICHLEY. Mr. Speaker, I am assuming that you are aware of a program which is currently being pursued by PACE and PACENET in which they are spending $1 million in the current fiscal year to send Commonwealth employees out to physicians to attempt to have them use generic drugs instead of prescription drugs?

Mr. EACHUS. I cannot tell you that I am familiar with that. I may have read about it, but I am working on this proposal today.

Mr. REICHLEY. I understand, Mr. Speaker, but since you are the sponsor of the amendment, I am hoping to gain some clarity from you as to whether you envision that this would be part of the information drug sessions that are going to be required of physicians.

Mr. EACHUS. I guess it could be, but as I said, it is not mentioned in the bill.

Mr. REICHLEY. Mr. Speaker, why would it be necessary for physicians who do not regularly utilize prescription drugs to participate in these Commonwealth-sponsored independent drug information service sessions?

Mr. EACHUS. You mean like a pathologist, Mr. Speaker?

Mr. REICHLEY. A pathologist—

Mr. EACHUS. A coroner?

Mr. REICHLEY. —a podiatrist, any one of a number of the different medical—

Mr. EACHUS. Well, I think—

Mr. REICHLEY. —any one of a number of different medical practices that do not frequently utilize prescription drugs.

Mr. EACHUS. You mean prescribe prescription drugs, Mr. Speaker? Are you talking about prescription—

Mr. REICHLEY. I am not sure there is any other kind of prescription drug other than a prescribed one.

Mr. EACHUS. I am not trying to be smart. I just want to be clear about how I am answering your question. Are you talking about physicians who do not actively prescribe drugs?

Mr. REICHLEY. Yes.

Mr. EACHUS. Like a pathologist who works in a laboratory, for example?

Mr. REICHLEY. If that person is a doctor, is that person receiving an Mcare abatement, Mr. Speaker?

Mr. EACHUS. Licensed doctors get Mcare abatements.

Mr. REICHLEY. So you are stating that a pathologist would have to undergo this session?

Mr. EACHUS. I think that would be defined by the Department of Insurance once the regulations were promulgated.

Mr. REICHLEY. Well, this is very similar to a proposal that had actually been offered earlier in the session, Mr. Speaker, in which it was going to require physicians to attend training in which health-care providers were going to be instructed by the Commonwealth about using generic drugs instead of prescription drugs. Is that what you are envisioning with this?

Mr. EACHUS. Well, Mr. Speaker, we are trying to make sure we get proper clinical quality, and this is going to be a new system provided under the PA ABC Program. We do not think that 2 hours of basic training on a computer in your office is really too much to ask of Pennsylvania's physicians.

Mr. REICHLEY. I understand that you are trying your best to answer these questions, Mr. Speaker, but does the amendment clarify if the department is going to be promulgating regulations regarding this information service?

Mr. EACHUS. Mr. Speaker, I am having a hard time hearing the speaker.

Mr. REICHLEY. Mr. Speaker, if you want to gavel the House?

The SPEAKER pro tempore. The gentleman is entitled to be heard. Will conversations on the floor please break up. Members, please take your seats.

Mr. REICHLEY. I think my questions are directed somewhat to your reference to the level of benefits that are being offered under your amendment, Mr. Speaker. Are you able to clarify whether there is going to be an open formulary or a closed formulary as part of the prescription benefit?

Mr. EACHUS. No. The pharmaceutical enhancement that is offered in the new PA ABC benefits platform will be determined by the Department of Insurance.

Mr. REICHLEY. Well, what is frustrating about that—

Mr. EACHUS. We are not instructive – I am sorry, Mr. Speaker – we are not instructive at that level in this legislation.

Mr. REICHLEY. Are you familiar, Mr. Speaker, with the attempts by the administration to include what is called a pharmaceutical carveout within the Medicaid program over the last 2 to 3 years?

Mr. EACHUS. I am familiar, yes.

Mr. REICHLEY. And the repeated efforts by the legislature to rebuff those efforts so that specific language has been put in to reject the attempt by the administration to include a pharmacy carveout?

Mr. EACHUS. I am familiar with that.

Mr. REICHLEY. Is it your intention that that be one of the options which is available to the Department of, I gather it is Insurance, in setting forward this package of benefits?

Mr. EACHUS. Well, I do not know what model the Insurance Department will come together in its final analysis, but I hope that it is a model that is efficient and guarantees the lowest cost health-care prescription drug benefit to consumers in this program. I think we need to be cost sensitive. We need to be very focused on how much we pay for the product, just as we are in other programs in State government. What that development of that model will be will be up to the Department of Insurance.

Mr. REICHLEY. Well, Mr. Speaker, you are leaving a lot of the members in the dark here, because I am sure you are familiar with the fact that the pharmaceutical industry is one of the major employers in the Commonwealth. Is that correct?

Mr. EACHUS. I am.

Mr. REICHLEY. And I think it is important that companies such as Sanofi Pasteur, GlaxoSmithKline, Merck, and numerous others which have production, sales, and marketing staff who are numbering in the thousands throughout many districts – whether it is up in the northeast, whether it is in the suburban counties around Philadelphia – that they deserve to know, under your amendment, whether their prescription drugs, those brand-name drugs, would be carved out or excluded from the pharmacy benefit that you are providing under your amendment. Are you able to do that?

Mr. EACHUS. I just think that your and my priorities differ. My priorities are about the 5766 people in Lehigh County who are currently on the adultBasic waiting list that we will immediately get care to.

Now, I understand that you are interested in pharmaceutical jobs and pharmaceutical profits and the ability for them to have a negotiated settlement, but my priority and I believe that most of the members of my caucus, on the Democratic side, are focused on access to affordable health care. What the insurance model is and what the costs of the prescription drugs are to consumers is important to us. What model gets developed inside of the department, I hope it is cost effective. That is all I can tell you.

Mr. REICHLEY. So you are unwilling to answer a yes-or-no question, Mr. Speaker, as to whether you intend to preclude the Insurance Department from engaging in a pharmacy carveout, which would limit the drugs which are available to those 5700 people in Lehigh County and the people in Luzerne County and the people in Montgomery County and the people in Erie County? Is that what you are looking to do to achieve the savings? Just answer that—

Mr. EACHUS. Let me say—

Mr. REICHLEY. Just answer that question, Mr. Speaker.

Mr. EACHUS. Let me say to you very clearly – in the clearest words I can give you, Mr. Speaker – we are not instructive about the model that gets developed for the pharmaceutical enhancement within this program, and I hope that the Department of Insurance comes up with a model that creates low cost for consumers in Pennsylvania and makes sure that consumers in Pennsylvania get a fair price so that we can insure more lives and guarantee the 5700 people in Lehigh County, that they get off the waiting list tomorrow.

Mr. REICHLEY. So the administration would be available to engage in the kinds of procedures they are currently undertaking, where the Department of Public Welfare is letting out a request for proposal, an RFP, which would carve out pharmacy under Medicaid in the Lehigh area and the southeast area, directly contradicting what the legislation has said in the past?

Mr. EACHUS. You are going to have to talk to the Governor's Policy Office on how they develop their policies, Mr. Speaker.

Mr. REICHLEY. You have mentioned that you have a hole of $120 million within your proposed funding for this program. Does that include reference to the CARE grant program?

Mr. EACHUS. No, Mr. Speaker. The CARE grants will be transferred.

Mr. REICHLEY. Is there a direct source of funding for the CARE grants?

Mr. EACHUS. No, Mr. Speaker.

Mr. REICHLEY. Where would the money be coming from then, Mr. Speaker?

Mr. EACHUS. From the same pot of resources. We take from the tobacco settlement funds, contributions from individuals and employers, and the model that I explained earlier in my discussion.

Mr. REICHLEY. Well, in referencing to the sources of income for money found from page 15, line 44, over to page 16, line 9, we are referring specifically to subsection (5), and it says, "Any moneys derived from whatever sources and designated specifically to fund the program." Are you able to define that section (5) with greater clarity? Page 16, lines 8 to 9.

Mr. EACHUS. Mr. Speaker, on line 8, it is real plain language, and I know you are a capable attorney, so "Any moneys derived from whatever sources and designated specifically to fund the program." That is very clear, legal language.

Mr. REICHLEY. Well, with all due respect, Mr. Speaker, I think that is extremely ambiguous language, and it does not tell us anything. Are you able to describe from what sources that contemplates drawing money from?

Mr. EACHUS. The sources will be at the discretion of the General Assembly.

Mr. REICHLEY. I am sorry, Mr. Speaker. Could you repeat that?

Mr. EACHUS. The sources will be at the discretion of the General Assembly.

Mr. REICHLEY. Well, Mr. Speaker, with language such as that, would it not allow the Governor to transfer funds within the course of a fiscal year without obtaining legislative approval?

Mr. EACHUS. They would have to be appropriated by the General Assembly, I believe.

Mr. REICHLEY. Could not the Governor, in reviewing various line items as he has done in the past, transfer funds out of various line items or various departments to be put into this program as described under clause (5) without legislative approval? In fact, he vetoed legislation in November of 2006 because that amended language was in the bill.

Mr. EACHUS. As you know, Mr. Speaker, as a member of the Appropriations Committee yourself, that would be a

decision made by the Appropriations Committee and the budget process.

Mr. REICHLEY. With all due respect, Mr. Speaker, you are incorrect about that, that the Governor has exercised authority to transfer funds from within line items and within departments, two purposes, in the course of a fiscal year which he deems appropriate without obtaining legislative approval. Would your language here on page 16, lines 8 through 9, prevent that at all?

Mr. EACHUS. These are specific funds, not general funds.

Mr. REICHLEY. How could it be specific if you have not told me where they are coming from? It says "any moneys."

Mr. EACHUS. It is. It is any moneys that the General Assembly determines to put in in this source language.

Mr. REICHLEY. Does not the Governor have the ability to borrow from selected funds, including the workers' compensation fund, the Motor License Fund, the Lottery Fund, within the course of a fiscal year?

Mr. EACHUS. I do not think that your comments are even germane to this, Mr. Speaker.

Mr. REICHLEY. Well, Mr. Speaker, since you are the self-described expert on this amendment—

Mr. EACHUS. Mr. Speaker?

Mr. REICHLEY. —I think it is incumbent upon you to answer the questions.

The SPEAKER pro tempore. Will the gentleman suspend.

Mr. EACHUS. Mr. Speaker, I just would appreciate—

The SPEAKER pro tempore. Would both gentleman suspend? Both gentlemen suspend, please.

Mr. EACHUS. Of course.

The SPEAKER pro tempore. We are under interrogation, and both gentlemen should confine their answers to interrogation.

The gentleman may proceed.

Mr. REICHLEY. Thank you, Mr. Speaker.

I will move off the issue of page 16, clause (5). Let me ask you about the CARE grant program at this time.

At the bottom of page 18, roughly around line 49, going over onto page 19 of the amendment, it describes the conditions of eligibility for an employer to be able to apply to obtain a CARE grant. Is that correct, Mr. Speaker?

Mr. EACHUS. Yes.

Mr. REICHLEY. And specifically, at the top of page 19, it has reference to a qualification that an employer "has a tax liability for the year in which application is made for the CARE grant." Is that correct?

Mr. EACHUS. That is correct.

Mr. REICHLEY. But, Mr. Speaker, if you read further down the page, it says that if the employer does not have a tax liability, the employer is not eligible for the CARE grant. Is that not correct?

Mr. EACHUS. Can you ask the question again, Mr. Speaker? Thank you.

Mr. REICHLEY. Sure.

Further down on page 19 it states that if the employer— Can you hear me?

Mr. EACHUS. I can now, Mr. Speaker. Thank you.

Mr. REICHLEY. I see your assistant there, struggling.

Mr. EACHUS. Well, we are all working on it down here.

Mr. REICHLEY. Okay. I will talk a little louder.

That on page 19, further down on the page, it states, I believe, that an employer that does not have a tax liability is not eligible for the CARE grant.

Mr. EACHUS. That is correct, Mr. Speaker. You have to have a Pennsylvania tax liability.

Mr. REICHLEY. But since you are describing that it has to be for the tax liability for the year in which the application is made, if an employer is applying for a CARE grant for 2008, they will not know until April of 2009 what their tax liability is. So under your amendment, the employer is really crossing his fingers to apply for a CARE grant when, at the end of the year when he is paying his taxes, he may not have a tax liability.

Mr. EACHUS. Yeah; I do not think this is any different than many State grant programs that we have. The individual would put their information down and then they would wait for the State grant. I do not think there is any change of the model that we are using. This would be a DCED component, so it would be right out of the Department of Community and Economic Development.

Mr. REICHLEY. But, Mr. Speaker, in those situations, those companies are subject to a tax, not that one has to subsequently establish a tax liability. Is that not correct?

Mr. EACHUS. Can you— One more time? I want to make sure— I am not a tax guy; I do health-care policy.

Mr. REICHLEY. Okay. You have stated that this is no different than other programs in which companies would apply, but in those situations, the company is actually subject to the tax. It is not a matter of establishing, after the fact, that they have a tax liability. In your situation, under your amendment, you are requiring them to apply for the grant prior to when they know what their true tax liability is. So if they end the fiscal year or their calendar year, tax year, without a tax liability, they have already put in for the grant.

Mr. EACHUS. They would apply for the grant, the department would review the application, and then they would get the award afterwards. So it is not a— What you are describing is the ability to have some application period that would precede their ability to do their State taxes. That is not the intent of this legislation. I think you are misinterpreting. They would have to have their tax liability established, and then they would be able to apply.

Mr. REICHLEY. But the grant, the language of page 19, lines 1 and 2, says that the grant is to be applied for the tax liability for the year in which the application is made, not for the following year when you are paying your taxes.

Mr. EACHUS. I do not understand what the problem with that is, Mr. Speaker. I mean, I do not see your nuance.

Mr. REICHLEY. The problem would be, Mr. Speaker, that an employer, in hopes of getting this grant, of being able to afford health insurance for their employees, is submitting a grant in which they may not be eligible by the time they are actually submitting the tax returns. And because the language of the amendment says that you are doing it in the year in which you are applying for the grant, it is not a matter of looking backward at what your tax liability was the year before, but because of the way this language is, it is in the year in which you are applying for the grant.

Mr. EACHUS. I think the application process is forward in this language, and I just do not see it the way you do.

Mr. REICHLEY. Would you agree, Mr. Speaker, that 70 percent of Pennsylvania corporations do not have any tax liability because they do not make a profit?

Mr. EACHUS. I do not know, Mr. Speaker.

Mr. REICHLEY. So the large number of corporations would not be eligible for this tax credit – or those tax grants, excuse me.

Mr. EACHUS. But once again, the individuals within the corporations, if they meet the income qualifications, can still go out and apply for the Pennsylvania adultBasic coverage. So if the company that you work for does not meet the qualifications and you meet the income qualifications, you could still go out and buy this platform for yourself and be subsidized, if you are within those income bands.

Mr. REICHLEY. So you are truly driving employers to eliminate their health-care coverage in the hopes that the salary level which they will continue to pay puts them within 200 percent of Federal poverty lines?

Mr. EACHUS. No; I do not think there is going to be any artificial deflation of wages in this case. I think those that are struggling at the bottom are already feeling the pinch of higher gas prices and all the things that are affecting working families, and we are trying to target those families who need the help the most so we can create more access to affordable health care. I do not think there is going to be any wage deflation. I just do not see that.

Mr. REICHLEY. I understand the emphasis, under your last comments, would be toward families, but then this CARE grant program is a misnomer, because it will be fairly unattainable to many Pennsylvania companies.

Mr. EACHUS. We set aside $42 million in CARE grants that will be available to companies that qualify. We think that is a fair way to offset those responsible employers that are providing health care for those low-income working families, the low-income working adults in these companies. We think this is a very fair solution.

Mr. REICHLEY. Well, would not a company, Mr. Speaker, be in a position of stating, all right, I will not be providing employer-provided health care, that means I will be saving an expense; I can increase your salaries, but then that moves those people up above your income cutoffs to apply for the benefit.

Mr. EACHUS. As a small businessman myself who took over my family business after my dad passed away, I think that the employers who are responsible and care about their employees are struggling out there to be able to afford access to health care. And I can tell you that family businesses like mine, every day, every year, see those increases from the insurance companies that stretch the costs beyond their ability to provide the coverage, and those responsible employees want to provide an employee-based coverage that meets the needs of their employees. And it is price – not any government regulation – but it is insurance costs, maybe even gouging of insurance companies, that is forcing the price of this product up for small businesses and beyond the reach of working families. This platform gives small businesses CARE grants to subsidize their ability to keep coverage in place and help incentivize coverage. I just do not see it your way.

Mr. REICHLEY. Well, Mr. Speaker, those same struggling companies you have identified, there is no obligation or requirement within your amendment that if a company is eligible and receives the CARE grant in year 1, they are going to get it the following year. Is that correct?

Mr. EACHUS. Each year they get evaluated based on the qualifications for the CARE grants.

Mr. REICHLEY. So the company that has been able to eek out a profit and they are maintaining their employees and they apply for a CARE grant, and the next year, because of these companies you said are struggling, they do not have a tax liability; they do not have taxable income. They are not then eligible for the CARE grant. So therefore, it becomes even more onerous on them to maintain the coverage for the employees.

Mr. EACHUS. And let me tell you something, Mr. Speaker. Today small employers are caught in a vice. There is no solution to the rising costs of insurance for those small employers. This CARE grant proposal, for the first time, advances a small business benefit to the responsible employer who maintains and keeps health insurance for their employees. This is a huge step forward, and the status quo for me, for small employers today, the status quo is unacceptable.

Mr. REICHLEY. What is the amount of the CARE grants, Mr. Speaker?

Mr. EACHUS. $42 million a year.

Mr. REICHLEY. No; to the individual company. What is the amount that would be granted to an individual company?

Mr. EACHUS. I am sorry; can you repeat the question?

Mr. REICHLEY. What is the amount that would be granted to the individual company?

Mr. EACHUS. Twenty-five percent of the employees that they buy for and 50 percent for the spouse, added to that coverage.

Mr. REICHLEY. And is there any requirement upon the company that receives the CARE grant in year 1 to maintain that employee force into year 2?

Mr. EACHUS. There is no mandate on the companies in this. It is fully— It is optional for companies to do this.

Mr. REICHLEY. So the company that applies for the CARE grant in year 1, receives the money, can lay off employees and then not apply for the CARE grant in year 2?

Mr. EACHUS. Let me say something, in tough economic times, employers lay off employees. I do not think this CARE grant proposal has anything to do with layoffs.

Mr. REICHLEY. Well, what I am trying to get at, Mr. Speaker, is whether the amount is consistent that an employer can count on year to year. And if they are getting an amount in year 1 because of the employee force, you said 25 percent of salaries to the employees. Is that correct? Or the cost for the employee's health insurance?

Mr. EACHUS. No. Twenty-five percent of the cost of the insurance for that employee.

Mr. REICHLEY. And 50 percent—

Mr. EACHUS. For the spouse.

Mr. REICHLEY. And is the 50 percent for the spouse a mandated part of the application of the CARE grant? Let me try to simplify the question: Must the employer provide coverage to the dependents to apply for the CARE grant?

Mr. EACHUS. No; no requirement.

Mr. REICHLEY. So what is the level of predictability for an employer to be able to say, okay, I am going to get X amount back for the CARE grant, based upon this maintenance of workforce?

Mr. EACHUS. One more time, sir.

Mr. REICHLEY. How does a company have any level of predictability about the money to be received back through a CARE grant?

Mr. EACHUS. Well, right now there are no CARE grants at all and they are stranded on an island without any help, so I think this advances the cause for small businesses in a serious way. I understand what you are trying to say, but I just think

what we are putting forward is a serious step forward for small business.

Mr. REICHLEY. But my question, Mr. Speaker, is if I am the Doug Reichley Hardware Store, employing 10 people, and I apply to you for the CARE grant program, how do I then, in looking forward to my next year's expenditures say, okay, I am going to be able to get this amount back from the State through a CARE grant, based upon my application, just for employees. Or do I necessarily have to apply with the dependents? What happens to me as the employer if there are other employers who apply for the 25 percent including the employees plus 50 percent for the dependents, or if they do not, what is the predictability?

Mr. EACHUS. As I said to you, I was a small businessman myself, with seven employees. The individual business and planning decisions that I make are my own. This CARE grant offering is not some internal manipulation by government inside small business. It is an offering to be able to support small businesses who require, no, who do the responsible thing and provide health insurance to low-income adults and working families. We think this is a step forward. I understand you do not like it, but I think it is a step forward.

Mr. REICHLEY. Well, Mr. Speaker, I prefer if you do not try to predict what I like and do not like. What I am trying to do is get some truthful answers from you.

Mr. EACHUS. Fair enough; fair enough.

Mr. REICHLEY. The last thing I would like to ask you about, Mr. Speaker, is on page 21, when it goes into the duties of the department. And again, would this refer to the Insurance Department or the Department of Public Welfare? Which department would it refer to? Page 21, lines 23 through 42. Which department is referred to?

Mr. EACHUS. The Insurance Department, Mr. Speaker.

Mr. REICHLEY. Mr. Speaker, then, I guess my question goes down in listing the duties of the department and administering this program, specifically in paragraph 2(ii)(A) it states that, "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 AdultBasic Program or the Public Welfare Code.…" You are familiar with that portion of the amendment. Is that correct?

Mr. EACHUS. Yes, I am, Mr. Speaker.

Mr. REICHLEY. Mr. Speaker, under what legal basis does the department have the ability to unilaterally amend the contracts?

Mr. EACHUS. Mr. Speaker, let me give you an example: The Federal government is very prescriptive with their language. They do not really care about what we do here in the State. So when these waivers come in, for example, if they said there would be a $25 copayment and we could not exceed that, the department may have to adjust current standards to conform with the Federal U.S. government CMS waiver requirements.

Mr. REICHLEY. I understand that, Mr. Speaker, but if you are the provider who is contracted to provide services in adultBasic, and you have negotiated a rate from the department to provide services at that rate, how do you provide the Insurance Department – constitutionally, legally, or otherwise – the ability to unilaterally, on their own say, that contract is no good. The rate at which we are compensating is no good. This is the new rate.

Mr. EACHUS. Let me say something: The way I see it is, the waiver comes in from the Federal government and then the regulations get promulgated and then insurance companies come in and make offerings based on the platform we have created. They will be very standard— The waiver will already be in place, at least in my opinion, so that the insurance company will have certainty about what their cost-accountability and their actuarial modeling should look like.

Mr. REICHLEY. Does that mean, Mr. Speaker, that you are willing to wait to have this legislation effective, only after the Commonwealth has received Federal waivers?

Mr. EACHUS. I am working with the gentleman from Lancaster on an amendment to that effect right now.

Mr. REICHLEY. I understand what you— But you, as the prime sponsor of the amendment, do you then take it that the only way in which the Department of Insurance would be able to amend the contracts would be after Federal waivers have been granted so that there can be that calculation made by the contractor to appropriately bid for the services, based upon what the Federal government is going to say?

Mr. EACHUS. I think the gentleman, Mr. Petri, asked the same question. The gentleman from Lancaster and I are working on language to try and resolve that issue today. So I am hopeful we can. We have agreed to that.

Mr. REICHLEY. You have agreed to delay the implementation of this program?

Mr. EACHUS. No; we have agreed to work with the gentleman from Lancaster on an amendment that would, I believe, in a certain way answer your question. Your Republican staff is working on that with the Governor's Office and our staff right now.

Mr. REICHLEY. Well, I understand that, Mr. Speaker, but let us just throw caution to the wind and say you do not have an agreement with Mr. Boyd or the Republican staff. You, as the prime sponsor of the amendment, are you stating on the floor today that you do not believe this program should be implemented until Federal waivers are received and approved by the Commonwealth to avoid the situation which I have described, where the department has engaged in a contractual service to be provided by the providers at a set rate? Based upon future waivers, which you are anticipating to receive, you then believe that rate may have to be adjusted. But to give those contractors the chance to accurately bid, you are stating you would wait until the waivers from the Federal government have been received. Is that correct?

Mr. EACHUS. Let me answer your question this way: I am inherently cautious, so I never really throw caution to the wind. But I really believe that it is very difficult for us to put this platform forward without significant Federal involvement within it, so I am working on a proposal today, with the gentleman from Lancaster, to try and resolve this issue for all of us.

Mr. REICHLEY. And I commend you for being cautious, Mr. Speaker.

Mr. EACHUS. Thank you, I appreciate that.

Mr. REICHLEY. But I think that is why all of us have to look really very carefully at this, because you are essentially asking us to buy something on the hope and prayers that somehow Federal waivers will be granted to draw down a certain level of funding when you, yourself, have admitted you have $120—

The SPEAKER pro tempore. Will the gentleman suspend. Have you concluded your interrogation?

Mr. REICHLEY. No; I have not, Mr. Speaker.

The SPEAKER pro tempore. Well, then the Chair asks that the gentleman please ask a question.

Mr. REICHLEY. I will put a question to it, Mr. Speaker. Thank you.

The SPEAKER pro tempore. Thank you.

Mr. REICHLEY. Mr. Speaker, are you not then operating on a wing and a prayer that based upon a Federal waiver being approved, you will be able to have a sufficient funding source for this?

Mr. EACHUS. I just disagree with your interpretation.

Mr. REICHLEY. But you, Mr. Speaker, I think have admitted to previous examiners that you have $120 million gap in the funding, from which source you have no idea where the money would come from. Is that correct?

Mr. EACHUS. I answered your question earlier, Mr. Speaker, on that issue.

Mr. REICHLEY. Well, do you or do you not have a $120 million gap in the projected cost of this program, from which you do not know where you will draw the money?

Mr. EACHUS. No; that will be a decision that is made through the appropriations process and through the budget.

Mr. REICHLEY. Do you have a $120 million gap in the program?

Mr. EACHUS. I do not know how many times you are going to ask that question, Mr. Speaker.

Mr. REICHLEY. Until I get a straight answer, Mr. Speaker.

Mr. EACHUS. Well, I am giving the answer that— In this legislation there are no taxes.

Mr. REICHLEY. I am not saying there are—

Mr. EACHUS. Let me be clear about that.

Mr. REICHLEY. I am not trying to imply there is a tax, Mr. Speaker.

Mr. EACHUS. There is no additional revenue. It creates a platform that triggers at $120 million in the SAFE Fund, the last page of the bill. And I have answered that question three or four times, so.

Mr. REICHLEY. Well, with all due respect, Mr. Speaker, I know you identified the money you want to take from the adultBasic component of the tobacco settlement. You have identified money you want to take from the community health reinvestment. You have identified money you want to take from the Mcare, health-care provider retention account, but I think I heard you in earlier statements state, you have $120 million gap in the overall funding for the program that you do not know where you get the money from. Is that correct or not?

Mr. EACHUS. There is no gap. We will have to decide, as a General Assembly, what the priorities are within this program during the budget process.

Mr. REICHLEY. And your fiscal note indicates— What will be the cost, based on the fiscal note, for your amendment?

Mr. EACHUS. Mr. Speaker, I have to tell you, I have answered this under – maybe you were on the floor earlier – I answered this question under previous interrogation and, Mr. Speaker, I have to tell you that if the questioning continues along the same lines of questions I have answered earlier, I just find this is— You cannot make me answer the question, I understand, five different times, over and over again. So if we cannot proceed in a way that finds new questioning, then I am going to limit my discussion.

Mr. REICHLEY. So you do not want to want answer any more questions?

Mr. EACHUS. I have answered this question.

The SPEAKER pro tempore. Will the gentleman suspend. The Chair agrees that the same question has been asked numerous times, and the Chair would ask that—

Mr. REICHLEY. Let me move on to the last part of the subsection I am referring to.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Mr. REICHLEY. Thank you, Mr. Speaker.

It states, in order to effectuate the program, not only do you provide the department the ability to unilaterally amend contracts, but then on lines 40 through 42, it says, "…or may otherwise procure services outside of the competitive procurement process of 62 Pa.C.S." Can you explain what that means?

Mr. EACHUS. Just give me a moment to review that language, okay?

Mr. Speaker, I think I have got an answer for you. It allows the department to respond to any changes from the Federal government relating to the waiver program, this language.

Mr. REICHLEY. Well, thank you, Mr. Speaker.

I understand you want to provide flexibility to the department, but I am concerned that the language of the amendment, in that particular section, seems to indicate that the department will be able to award contracts for services, or procure services outside of the competitive procurement process. Is that your intention of the language there?

Mr. EACHUS. Yes; it gives the department more agility.

Mr. REICHLEY. Would that then be similar, Mr. Speaker, to the $400 million contract just released under a no-bid situation by the Department of General Services?

Mr. EACHUS. I do not know anything about that.

Mr. REICHLEY. Well, would it be similar to the $1 million no-bid contract that was let outside of the procurement process to public finance management?

The SPEAKER pro tempore. Will the gentleman suspend. These are not questions that the gentleman appears to be seeking information about the amendment before the House.

Mr. REICHLEY. Well, Mr. Speaker, I think it is relevant because we have had a number of reports in the media in the last 2 weeks of extremely large contracts, just today, in papers in the Pittsburgh area regarding—

The SPEAKER pro tempore. Will the gentleman suspend.

Mr. REICHLEY. —hundreds of millions of dollars for legal services—

The SPEAKER pro tempore. Will the gentleman suspend. The Chair would ask the gentleman not to argue with the Chair, but please ask questions, under interrogation of Mr. Eachus, that deal with the amendment before the House.

Mr. REICHLEY. All right, Mr. Speaker. Mr. Speaker, let me just ask the final question then. Would the procurement language which you have there enable the department to award contracts worth hundreds of millions of dollars without issuing RFPs or going through a competitive bid process?

Mr. EACHUS. Absolutely, unequivocally not.

Mr. REICHLEY. Then how do you count for the language that says, "…may otherwise procure services outside of the competitive procurement process…"?

Mr. EACHUS. You asked the question; I answered it, Mr. Speaker.

Mr. REICHLEY. All right, Mr. Speaker. On the amendment, thank you.

The SPEAKER pro tempore. The gentleman is in order.

Mr. REICHLEY. Mr. Speaker, I think this amendment is fraught with gaps – dark areas that have not been sufficiently illuminated from the answers to the questions. And unfortunately, we are being asked to buy a pig in a poke. We are told this is a great program. We are going to provide health insurance to thousands of people, and yet, when you look at it, well it is not quite thousands of people and there is no guarantee of the insurance and this is yet another form of adultBasic, where there will be a waiting line.

There is no guarantee of money. Grants that could be provided to businesses are subject to them actually having a tax liability and if they do not have a tax liability, if they lose money, a company which is most vulnerable to the cost of health care in that kind of a situation would be ineligible to apply for the CARE grants, which have been touted so enthusiastically by the sponsor of the amendment, as a way to assist small businesses. I think what has been very disturbing as well is, based upon recent media reports where this administration has let no-bid contracts for hundreds of millions of dollars, including a $400 million contract, Unisys for a power data house just this past 2 weeks. And just today we read in the Pittsburgh newspapers about a law firm being able to obtain a $1.8 million contract under a no-bid situation. These are very disturbing, and the last set of the language that I referred to in the amendment does not prevent that from happening.

So I think the members have to be very careful in supporting an amendment which requests them to essentially pony up the prospects of hundreds of millions of dollars without any cost controls within this program, without any assurances that the program will not be changed in a unilateral fashion by the department. There is not an assurance for those homegrown companies in Pennsylvania that provide pharmaceuticals to hundreds of thousands of individuals to assist with their lives, that there would not be some kind of restricted formulary imposed by a department. In fact, there has just been a shrugging of the shoulders by the prime sponsor to say, well, that will have to get settled later on, or that is going to be left to the department. So I think that the members should absolutely vote against the Eachus amendment.

CONSTITUTIONAL POINT OF ORDER

Mr. REICHLEY. But before we even get to that point, Mr. Speaker, I would like to now raise the motion to challenge the constitutionality of amendment A06103, based upon Article 1, section 17.

The SPEAKER pro tempore. The gentleman, Mr. Reichley, raises a point of order that amendment No. 06130 is unconstitutional. The Speaker, under rule 4, is required to submit questions affecting the constitutionality of an amendment to the House for decision, which the Chair now does.

On the question,

Will the House sustain the constitutionality of the amendment?

The SPEAKER pro tempore. The Chair recognizes the gentleman, Mr. Reichley.

Mr. REICHLEY. Thank you, Mr. Speaker.

I raise this motion of constitutionality, or actually the lack of constitutionality, of the Eachus amendment based upon the prospect of impairment of contracts. As I mentioned, on page 21 of the amendment, from lines 35 through 40, it provides the power to the Department of Insurance, "In order to effectuate the program promptly upon receipt of all applicable waivers and approvals from the Federal Government…" to "…amend such contracts as currently exist to provide benefits under either the AdultBasic Program or the Public Welfare Code…." That would be an impairment of contracts, Mr. Speaker, and it would provide the unconstitutional authority to the Department of Insurance to impair the obligation of contracts.

If the department has entered into a contract with a provider to offer a certain level of services at a set rate, this amendment would then provide the department with the authority to say, well, we are just going to tear that up and now, without the ability to renegotiate, we are going to amend the contract. So I believe that this does violate the Constitution. I understand that there may be a need and a necessity to have the department renegotiate contracts upon the receipt of Federal waivers, but I think that problem could have been solved if the prime sponsor had said, I will not have this program go into effect until Federal waivers have been received. I understand there is a hope that a subsequent amendment will address that concern, but how else do you expect providers to be willing to contract with the Commonwealth to provide services under this program if on any given day, at any given hour, they receive a call from the Department of Insurance saying, you know what? That contract we negotiated and signed, that is no good anymore. We are telling you there is a new reimbursement rate in effect, and you cannot negotiate that away.

So I would move for the members to find that the Eachus amendment, A06103, is unconstitutional. Thank you, Mr. Speaker.

The SPEAKER pro tempore. Mr. DeWeese.

Mr. DeWEESE. I would politely disagree with the gentleman and ask that we vote against him.

The SPEAKER pro tempore. Those voting "aye" will declare the amendment to be constitutional. Those voting "no"—

For what purpose does the gentleman, Mr. Reichley, rise?

PARLIAMENTARY INQUIRY

Mr. REICHLEY. Thank you, Mr. Speaker.

I just wanted, as a parliamentary inquiry, will the Chair advise the members what the effect of the "yes" or the "no" vote is? Is the "yes" to sustain constitutionality or to sustain my motion?

The SPEAKER pro tempore. I was just doing that, Mr. Reichley. Those voting "yes" will be voting to declare the amendment constitutional.

Those voting "yes" will vote to declare the amendment to be constitutional. Those voting "no" will vote to declare the amendment to be unconstitutional.

On the question recurring,

Will the House sustain the constitutionality of the amendment?

The following roll call was recorded:

YEAS–110

Belfanti	George	Markosek	Seip
Bennington	Gerber	Marshall	Shapiro
Beyer	Gergely	McCall	Shimkus
Biancucci	Gibbons	McGeehan	Siptroth
Bishop	Goodman	McI. Smith	Smith, K.
Blackwell	Grucela	Melio	Smith, M.
Brennan	Haluska	Micozzie	Solobay
Buxton	Hanna	Moyer	Staback
Caltagirone	Harhai	Mundy	Sturla
Carroll	Harkins	Myers	Surra
Casorio	Hornaman	O'Brien, M.	Tangretti
Cohen	James	Oliver	Taylor, R.
Conklin	Josephs	Pallone	Thomas
Costa	Keller, W.	Parker	Vitali
Cruz	Kenney	Pashinski	Wagner
Curry	Kessler	Payne	Walko
Daley	King	Payton	Wansacz
DeLuca	Kirkland	Petrarca	Waters
DePasquale	Kortz	Petrone	Wheatley
Dermody	Kotik	Preston	White
DeWeese	Kula	Ramaley	Williams
Donatucci	Leach	Raymond	Wojnaroski
Eachus	Lentz	Readshaw	Yewcic
Evans, D.	Levdansky	Roebuck	Youngblood
Fabrizio	Longietti	Sabatina	Yudichak
Frankel	Mahoney	Sainato	
Freeman	Manderino	Samuelson	O'Brien, D.,
Galloway	Mann	Santoni	Speaker

NAYS–87

Argall	Fleck	McIlhattan	Reed
Baker	Gabig	Mensch	Reichley
Barrar	Geist	Metcalfe	Roae
Bastian	Gillespie	Millard	Rock
Bear	Gingrich	Miller	Rohrer
Benninghoff	Godshall	Milne	Ross
Boback	Grell	Moul	Saylor
Boyd	Harhart	Murt	Scavello
Brooks	Harper	Mustio	Schroder
Causer	Harris	Nailor	Smith, S.
Civera	Helm	Nickol	Sonney
Clymer	Hennessey	O'Neill	Stairs
Cox	Hess	Peifer	Steil
Creighton	Hickernell	Perry	Stern
Cutler	Hutchinson	Perzel	Stevenson
Dally	Kauffman	Petri	Swanger
Denlinger	Keller, M.	Phillips	True
DiGirolamo	Killion	Pickett	Turzai
Ellis	Mackereth	Pyle	Vereb
Evans, J.	Maher	Quigley	Vulakovich
Everett	Major	Quinn	Watson
Fairchild	Mantz	Rapp	

NOT VOTING–0

EXCUSED–6

Adolph	Hershey	Rubley	Taylor, J.
Cappelli	Marsico		

The majority having voted in the affirmative, the question was determined in the affirmative and the constitutionality of the amendment was sustained.

On the question recurring,
Will the House agree to the amendment?

The SPEAKER pro tempore. On the amendment, the Chair recognizes Representative Harper.

Ms. HARPER. Thank you, Mr. Speaker.

Will the gentleman from Luzerne stand for a few more questions?

The SPEAKER pro tempore. The gentleman indicates that he will.

Ms. HARPER. Thank you very much.

First, I would like to commend my colleague for doing so much work on an important issue. I do believe that this is an issue that is of interest to many Pennsylvanians and that you have come up with some many and varied solutions to the problem of Pennsylvanians who lack health care. However, the amendment is 25 pages long and also will cost hundreds of millions of dollars and we have not had a single hearing on it. My question to the gentleman is whether he would agree that we might table the amendment for today, with the stated goal of holding hearings with all of the stakeholders around the State so that we could air out the suggestions and see whether this is a good idea for Pennsylvania or not. That is my question, Mr. Speaker.

Mr. EACHUS. Mr. Speaker, there have been a multitude of committee meetings on this and I just do not think the uninsured in Pennsylvania can wait another day without the passage of this bill. This is really important in people's lives, and we have had many hearings on the issue of the uninsured.

Ms. HARPER. Mr. Speaker, I do not want to press the issue or be disagreeable, but it does seem to me that we have not had any hearings on the particular components of the plan, which was not filed in legislation at all until yesterday at 1:58 – 2 minutes before the 2 p.m. deadline for consideration today. So I would ask the gentleman if he would please agree that we should hold hearings and get the doctors, the hospitals; the insured, the uninsured; the employers, the employees; all of the stakeholders in this important process to weigh in.

Mr. EACHUS. I already answered your question; the answer is no, and I also think we need to do this today for the uninsured in Pennsylvania.

Ms. HARPER. Thank you.

Mr. Speaker, would a motion be in order to postpone now? I would like to make that motion, that we postpone or table this amendment for the purpose of holding hearings, which we can complete by, let us say, June 1.

The SPEAKER pro tempore. That motion would be in order.

MOTION TO TABLE

Ms. HARPER. Then I would like to make a motion that we table this amendment with the stated purpose of holding hearings and bring it up again on the closest convenient date to the Speaker after June 1 of this year, on this matter. May I speak on that?

The SPEAKER pro tempore. Does the lady wish to— The lady cannot table an amendment. Is she asking to table the entire bill?

Ms. HARPER. Well, Mr. Speaker, I guess I am asking to table the entire bill, because I do feel that this subject is so important that we really do need to understand all of its elements before we are forced to take a vote that might change the course of health care in Pennsylvania.

So yes, then my motion would be to table this bill until June 1, with the stated purpose of holding hearings on the Eachus amendment so that we can invite the stakeholders in Pennsylvania to address these issues and let us know how they feel about the particular components of this plan.

Mr. Speaker, I am a little unsure about the procedure at this point. Do the floor leaders debate this, or how does it work?

The SPEAKER pro tempore. Would the lady please come to the rostrum.

(Conference held at Speaker's podium.)

The SPEAKER pro tempore. The House will be at ease temporarily.

MOTION WITHDRAWN

The SPEAKER pro tempore. The Chair recognizes the lady, Representative Harper, who would like to withdraw her first motion and propose another one.

Ms. HARPER. Thank you, Mr. Speaker.

I would like to withdraw that first motion, understanding now that, in order to hold hearings, we have to give some committee the responsibility for doing that.

MOTION TO RECOMMIT

Ms. HARPER. So I am going to instead make a motion that we commit this bill to the Insurance Committee to hold hearings, with the hope that they will hold hearings expeditiously with all the stakeholders and bring it back to the floor.

I do understand that we cannot instruct the Insurance Committee to do that but that we can make a motion to recommit for that purpose, in the hopes that the Insurance Committee would do that. So my motion then is to commit to the Insurance Committee this bill, including the Eachus amendment.

The SPEAKER pro tempore. The lady, Ms. Harper, has moved to recommit SB 1137 to the Insurance Committee.

On the question,

Will the House agree to the motion?

Ms. HARPER. Mr. Speaker, does anyone have the right to speak on this?

The SPEAKER pro tempore. Yes; everyone has the right to speak on this.

Ms. HARPER. I would like to speak on this motion briefly, or should I wait until the last person to go?

The SPEAKER pro tempore. That is up to the lady. She is certainly able to speak on it now.

Ms. HARPER. I will defer to the end of the list. Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair recognizes Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support the lady's motion to commit this to the Insurance Committee. As a member of that committee, I would embrace the opportunity to look at this piece of legislation and really work in a bipartisan way to resolve any potential conflicts that I think that we have brought up with the legislation. There are a lot of unique ideas, and I certainly commend the maker for the effort. I think everybody knows that this amendment showed up at 2 o'clock yesterday and in that about 27, 28-hour period of time, we finally had a chance to do some study on it and take a good hard look at it. There are some issues with the legislation. There are some great ideas, but at the same time, I think there are some fundamental flaws in it. As a member of the Insurance Committee, I certainly would pledge my support to work in a bipartisan way to try and resolve any of these issues.

So with that said, I would just encourage the members for a "yes" vote on the Harper motion, please.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Ms. Quinn.

Ms. QUINN. Thank you, Mr. Speaker.

Soon after I was elected, I petitioned the minority leader for the right to serve on the Insurance Committee of the House. I felt it was most important to have some input and to represent my community with Doylestown Hospital, an independent hospital. And I just stand here to support Representative Harper's motion. I think that legislation that is so important to the long-term interest of the Commonwealth deserves adequate time for the stakeholder's input and for independent analysis. And I respectfully suggest that now that we have accomplished open records in the Commonwealth, that we should accomplish some open dialogue on proposed legislation on the dialogue, and this would be a fine spot to start.

When Cover All Pennsylvanians was introduced last year on March 22, soon thereafter, in the first week of April, we had 2 days of hearings in Delaware County. In May we had a hearing in Bucks County, which I hosted. And I would love to have the Insurance Committee take this on the road and have hearings on this legislation that we now know, it has been heard that this is not the Governor's bill, it is the Democratic Caucus bill, and we would like to hear and get answers to these questions and input from stakeholders. So I urge the members of this body to support the motion to have public hearings prior to a final vote. Thank you.

The SPEAKER pro tempore. The Chair thanks the lady and recognizes Representative Ellis.

Mr. ELLIS. Thank you, Mr. Speaker.

One of the themes of the last couple days is the customs of the House. Certainly we saw a set of customs yesterday explained by the majority leader, and one of the things that I think we may have already set as a custom this year was that when we do have a major issue like this, that it is, by the House's definition, a custom to put it back into a committee, the way we did with another pressing issue here in Pennsylvania – property taxes.

We were in a position to actually do something substantive in this body on property tax relief and reform, and we sent that back so we could have a few more hearings on it. I think it was, at the time, maybe we should not have, but now that I see the wisdom of the majority leader in action and know that certainly having more hearings on relieving the property tax burden of Pennsylvanians, that was a prudent decision. I agree with the majority leader, and I hope that the majority leader agrees with us now that we should recommit this back to the Insurance Committee.

So I rise today, basically, to support Representative Harper's motion. I think that this House has lost focus. I think we need to get it together and do what we are supposed to do. So everybody please support this amendment and let us get on with the process. Thank you very much, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman and recognizes Representative DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, I oppose the Harper amendment. The Insurance Committee held 11 meetings throughout the Commonwealth on health care. It was on the Governor's proposal, but it was on health care. And we learned after 11 meetings – we heard from the public, we heard from the doctors, we heard from the providers – and that is the basis for this legislation right now. To send it out there again is only delaying it and the uninsured cannot wait any longer for insurance and we need to vote this tonight.

The SPEAKER pro tempore. Representative Turzai.

Mr. TURZAI. Thank you very much, Mr. Speaker.

I rise in support of the gentlelady's motion to recommit and would like to make it clear that, as we well know, that we just saw this particular amendment, really almost just 24 hours ago. And with all due respect to the gentleman from Allegheny County, we have not gotten input from stakeholders with respect to this specific legislation. We would like to hear specifically from hospitals, health-care providers, health-care underwriters and brokers, pharmaceuticals, health-care insurers, patient groups. We would like to hear from each of these stakeholders exactly their thoughts with respect to this particular proposal. There are a lot of nuances here. We do not even have a clear understanding, conceded by the maker of this amendment, on how it is ultimately going to be funded. I think that it is a wise motion, and I would urge its support. Thank you very much.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Mrs. Watson.

Mrs. WATSON. Thank you, Mr. Speaker.

I rise in support of the Harper motion, and I do so as having spent the last 9 months – and you talked about other hearings – working on health-care reform and what we could do. I am not a member of the Insurance Committee. I promise if this goes, I will attend every one of those hearings and happily work with you. I think what we all want is the same thing, and I heard Chairman DeLuca say it: We want to provide coverage that really works for those who are uninsured, coverage that is lasting for those who are uninsured. You have heard back and forth, and certainly the honorable gentleman from Luzerne has spent lots of time, probably equal to mine and beyond, on coming up with a plan, and yet we know that there are problems within the plan, problems, perhaps, of something as simple as drafting.

This is the kind of thing that should be ironed out. I would suggest we could do it – and I am not on the committee but I would volunteer for hearings around the State – but really get to the heart of it, fix what needs to be fixed so that as we pass this and send it, we can say that it is more than a hope and a promise, that indeed it will become a reality. I know that right away we have in my e-mail, I have opposing views from two groups of doctors within that. I want the doctors to be assured and to at least have a general idea and a general agreement on what is in the bill, what their requirements are, what is going to happen. It would seem to me that in our concern for everybody, we have to have concern that is tempered with reason and purpose, and what we need to do is make sure that whatever we do is the right thing and the lasting thing. For that reason, Mr. Speaker – and I will pledge my time – I would happily support the Harper motion. Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the lady.

Representative Grell.

Mr. GRELL. Thank you, Mr. Speaker.

I, too, am a member of the Insurance Committee, and I rise in support of the motion to recommit. As a member of the Insurance Committee, I attended many of the hearings that were held last year and earlier this year. But those hearings were held on the Governor's proposal, and as the prime sponsor of this amendment has repeatedly said today, this is not the Governor's proposal.

Much of the focus of those hearings was on the 3-percent payroll tax. In addition, we focused on the scope-of-practice issues and hospital-acquired infections issues. As a result of those hearings, I think it led to solutions and separate legislation on the scope-of-practice issues and hospital-acquired infections. I would encourage the members to support the motion to recommit, because if we take this new approach – not the Governor's approach – and have some hearings, hear from the interest groups that are involved, it may lead to the kind of bipartisan solution that we are all looking for.

So I encourage the members to support the motion to recommit.

The SPEAKER pro tempore. The Chair thanks the gentleman and recognizes Representative Thomas on the motion.

Mr. THOMAS. Thank you, Mr. Speaker.

Mr. Speaker, I rise to oppose the motion to recommit this bill and subsequent amendment to the Insurance Committee. I am not on the Insurance Committee; I do not want to be on the Insurance Committee. And I am not interested in holding any hearings on an issue that has been debated, that has been polled, that has been questioned, that has been surveyed.

This issue of health care for the hundreds of thousands of people in Pennsylvania who are uninsured has been answered in the affirmative, and the affirmative answer has been to this august body – get something done. Now, some have argued that this proposal is not the Governor's proposal. This proposal is actually a combination of the Governor, Republicans, Democrats, and people from all over Pennsylvania, because they are those who support small businesses. Small businesses have made it very clear that they are not in a position to provide health-care coverage to employees who need it, that they need some support. This proposal deals with that. There are those who say that we should not close out the Mcare abatement program. This proposal provides a timetable, reasonable circumstances, and reasonable investments in dealing with medical liability insurance.

There are those who have said that we need to provide coverage to people who are uninsured. I know that the family of Dorothy Thomas, no relation to this Thomas, but a young lady in my district who lost her job with Philadelphia Housing Authority and within 180 days became very ill. She is dead today because she did not have access to quality health-care coverage. And it is sad that in 2008, we are debating whether or not people should have access to health-care coverage.

So, Mr. Speaker, in closing, we do not need any more hearings. I have a lot of respect for the author of this motion. She is usually right on point when she stands and advances certain arguments, and I believe that her heart is in the right place with this motion to recommit. The problem is, it is out of time and it is out of circumstances. The people of Pennsylvania have demanded that we do something and that we do it now, and then we get it done and move forward in making access to affordable health care a reality – a fact, no longer a fiction – in the Commonwealth of Pennsylvania.

Vote "no" on the motion to recommit.

The SPEAKER pro tempore. The Chair thanks the gentleman.

LEAVE OF ABSENCE

The SPEAKER pro tempore. The Chair recognizes the majority whip, who requests leave for the remainder of the day for Representative LENTZ. Without objection, that leave will be granted.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER pro tempore. On the motion, the Chair recognizes Representative Killion.

Mr. KILLION. Thank you, Mr. Speaker, and I will be brief.

I rise in support of the motion to recommit to the Insurance Committee by Representative Harper. As a member of the Insurance Committee, we did hold hearings around the State regarding medical care and providing coverage for insurance but nothing to do with this bill. They were informational meetings. And in all respect to my good friend from Allegheny County, the chairman of our committee, I think that what we are trying to do here is give false hope. If you look at the Federal campaign right now for President, they are talking about hope. Right now, by passing this bill, we are giving false hope to our doctors who actually believe they are going to get Mcare abatement from it, and we are giving false hope to the uninsured in Pennsylvania who actually think they might get insurance as a result of this legislative action today.

This bill is dead on arrival in the Senate; everyone knows it. If we are going to be responsible, we should separate these two issues, go back to the original language in the Senate bill, pass Mcare abatement, then come back, hold the hearings once we move this back to the Insurance Committee, and then work to provide coverage for the uninsured in Pennsylvania.

Support the motion to recommit this legislation to the Insurance Committee. Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Benninghoff.

Mr. BENNINGHOFF. Thank you, Mr. Speaker.

Very quickly, I also rise to support Representative Harper's request to recommit this for two simple reasons. I think that we need to be very clear: There were no hearings on this proposal. For some of us, it has been in our hands less than 24 hours, and it is a very important initiative for the Commonwealth. I think none of us here are opposed to providing quality health care to our individuals and making sure they have insurance. But two things I want to remind you: It was only about 8 months ago that we sat here and were told the urgency of passing Act 44 of 2007, the transportation bill, and how important that was and that we needed to do it right away and get it done, and we did not know then whether we were going to get Federal approval. Well, here we are 8 months later and guess what? We still do not know if we are going to get Federal approval and we have actually got one denial on the original request.

Why do we want to give people false hope? There is about $140 million liability of money that we need to do to even initiate this proposal, so even if we passed it tomorrow, it was signed into law by the Governor the following day, this is not going to do a single thing.

And lastly, I will remind you, there are private-sector insurances available to people. I just got off the phone with a constituent of mine who shared a proposal that he has through one of our insurance companies in the Commonwealth, which I will not mention because I do not want to give out free advertisement, but this gentleman has nine children and he and his wife pay $304, he just got a bump into it, so it is about $360 a month, and they have a 10th child on the way. We need to remind people that there are services available. My office helps people day in, day out. We are not trying to be mean-spirited, but we are not going to lie to our constituents and try to give them false hope on something that is not going to go anywhere. We want real solutions for real problems.

Be smart about this; let it go back to the committee. We can have a couple of hearings in a short duration of time and not be in the same predicament we were when we were asked to vote for the Democrat proposal on highway funding that has gone nowhere in this Commonwealth.

The SPEAKER pro tempore. The Chair thanks the gentleman.

LEAVE OF ABSENCE

The SPEAKER pro tempore. The Chair recognizes the minority whip, who requests leave for the remainder of the day for Representative PERZEL. Without objection, that leave will be granted.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER pro tempore. On the motion, the Chair recognizes Representative Cutler.

Mr. CUTLER. Thank you, Mr. Speaker.

I rise in support of the motion to recommit and to have hearings for the following reason: As my colleague pointed out just before me, this bill, even if signed tomorrow, will do nothing. We are waiting on $120 million appropriation which, according to prior testimony on the floor, would come hopefully sometime during the appropriations process, as well as another law that would have to come along to help enable this bill to even happen. So for that reason, there is no need to rush in and make hasty decisions in less than 24 hours on a 25-page bill. This bill needs to be properly vetted. This proposal itself has not been, and I would certainly encourage our members to support it and do so. Thank you.

The SPEAKER pro tempore. Mr. Maher.

Mr. MAHER. Thank you, Mr. Speaker.

As we discovered earlier this evening, this amendment – hot off the press – has got differences between what is on paper and what is described. The maker of this amendment has

already said he intends to offer yet a different version of an amendment at some future time. What I would suggest is rather than us being asked to vote on an imaginary amendment to say, well, vote for this but we will get you another amendment someday that we really meant, that we just do it the right way. Let us wait until there is a real amendment before us that actually is consistent with what is being described. And if these are mistakes, repair them. If there are changes in philosophy, admit it. But whatever it is, let us have a bona fide vote on an amendment that the public has had an opportunity to consider, that we have an opportunity to consider, and that we do not find that the prime sponsor is saying, well, that is not what he meant. So I think the opportunity to postpone is a smart one, if for no other reason, to at least make sure that the prime sponsor has the opportunity to have an amendment that reads the same way he describes it.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. Seeing no other members seeking recognition, the Chair recognizes Representative Harper.

Ms. HARPER. Thank you very much, Mr. Speaker.

I have made a motion to recommit this bill to the Insurance Committee for hearings in the hopes that they would bring it back quickly after consulting with all the stakeholders. This bill, according to its own fiscal note, will cost $501 million in 2008, $808 million in 2009, $994 million in 2010, and what it will cost thereafter is not stated.

The bill has the potential to change the landscape of how we do health insurance in Pennsylvania and how we do medical care in Pennsylvania. Surely those people who provide medical care – doctors, surgeons, therapists, insurance companies – and those who need medical care – the 12 million Pennsylvanians we represent – have an interest in this bill and whether this bill is the right solution to the issue of those who cannot afford health insurance. We have had this for 24 hours. I have made a motion to recommit to the Insurance Committee; I am not on the Insurance Committee. But this program of insurance has not been vetted by our Insurance Committee and it should have been. It should be recommitted to the Insurance Committee who can hold hearings. We can hear from all of those who are likely to be impacted by this – Pennsylvania's employers who offer health insurance, Pennsylvania's employers who do not offer health insurance, hospitals, care workers, nurses, doctors, insurance companies – everyone who has a stake should be heard on this most important subject.

I believe that the Insurance Committee can hold hearings expeditiously and bring these folks in so that we can hear from experts in this area. And it is a lot of money, and we want to make sure that the money that we are signing Pennsylvanians up to pay is money well spent to address the issues that have been discussed this afternoon. I know that many of my colleagues are anxious to provide relief to those who cannot afford insurance; this may or may not be the best way to address those concerns. But I cannot see that letting the stakeholders in the public, the members of the medical profession, and the patients they serve, have a say at hearings to discuss the plan would have any detrimental effect to the 12 million Pennsylvanians we represent.

I would ask my colleagues to recommit this bill to the Insurance Committee. I can trust the Insurance Committee to hold hearings, to get the stakeholders involved, and to make sure that whatever bill we pass, that will surely cost Pennsylvanians hundreds of millions of dollars every single year, is a well-thought-out, well-delivered product.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the lady.

On the question recurring,

Will the House agree to the motion?

The following roll call was recorded:

YEAS–87

Argall	Fleck	McIlhattan	Reed
Baker	Gabig	Mensch	Reichley
Barrar	Geist	Metcalfe	Roae
Bastian	Gillespie	Millard	Rock
Bear	Gingrich	Miller	Rohrer
Benninghoff	Godshall	Milne	Ross
Boback	Grell	Moul	Saylor
Boyd	Harhart	Moyer	Scavello
Brooks	Harper	Murt	Schroder
Causer	Harris	Mustio	Smith, S.
Civera	Helm	Nailor	Sonney
Clymer	Hennessey	Nickol	Stairs
Cox	Hess	O'Neill	Steil
Creighton	Hickernell	Peifer	Stern
Cutler	Hutchinson	Perry	Stevenson
Dally	Kauffman	Petri	Swanger
Denlinger	Keller, M.	Phillips	True
DiGirolamo	Killion	Pickett	Turzai
Ellis	Mackereth	Pyle	Vereb
Evans, J.	Maher	Quigley	Vulakovich
Everett	Major	Quinn	Watson
Fairchild	Mantz	Rapp	

NAYS–108

Belfanti	George	Marshall	Shapiro
Bennington	Gerber	McCall	Shimkus
Beyer	Gergely	McGeehan	Siptroth
Biancucci	Gibbons	McI. Smith	Smith, K.
Bishop	Goodman	Melio	Smith, M.
Blackwell	Grucela	Micozzie	Solobay
Brennan	Haluska	Mundy	Staback
Buxton	Hanna	Myers	Sturla
Caltagirone	Harhai	O'Brien, M.	Surra
Carroll	Harkins	Oliver	Tangretti
Casorio	Hornaman	Pallone	Taylor, R.
Cohen	James	Parker	Thomas
Conklin	Josephs	Pashinski	Vitali
Costa	Keller, W.	Payne	Wagner
Cruz	Kenney	Payton	Walko
Curry	Kessler	Petrarca	Wansacz
Daley	King	Petrone	Waters
DeLuca	Kirkland	Preston	Wheatley
DePasquale	Kortz	Ramaley	White
Dermody	Kotik	Raymond	Williams
DeWeese	Kula	Readshaw	Wojnaroski
Donatucci	Leach	Roebuck	Yewcic
Eachus	Levdansky	Sabatina	Youngblood
Evans, D.	Longietti	Sainato	Yudichak
Fabrizio	Mahoney	Samuelson	
Frankel	Manderino	Santoni	O'Brien, D.,
Freeman	Mann	Seip	Speaker
Galloway	Markosek		

NOT VOTING–0

EXCUSED–8

Adolph	Hershey	Marsico	Rubley
Cappelli	Lentz	Perzel	Taylor, J.

Less than the majority having voted in the affirmative, the question was determined in the negative and the motion was not agreed to.

On the question recurring,
Will the House agree to the amendment?

The SPEAKER pro tempore. Returning to amendment 06103, the Chair recognizes Representative Clymer.

Mr. CLYMER. Thank you, Mr. Speaker.

Mr. Speaker, I just want to draw on one issue this evening, and this is kind of dovetailing to my remarks that I made this morning about the importance of our specialty physicians and how they will be impacted by this legislation. Let me kind of draw a picture of how this is occurring here in the Commonwealth of Pennsylvania.

Today, earlier in the day, you heard that the number of licensed physicians in Pennsylvania jumped from 40,832 to 49,798, and that could be true. But what the members need to realize is that the number of physicians for direct patient care, those are the ones that are actively involved in patient care, in 2006, was 24,696. Yes, that is 24,696. You can be a licensed physician, as many are in Pennsylvania, but not actively involved. You can still carry your license if you are retired or teaching, or a host of other responsibilities, but these are the ones that we need to take a careful look at.

Also, in 1990, the physicians under 35 years of age were 15 percent. In 2006, the number had dropped to 6 percent. Those completing their residencies, those finishing their medical school and now putting out their shingle – 35 percent in Pennsylvania in 2001, 22 percent in 2006.

According to the "State of Medicine in Pennsylvania," 2007 edition, the total number of active patient care physicians in Pennsylvania is the number that I just gave you, 24,696. Declining physician recruitment and retention: Pennsylvania continues to experience difficulty recruiting and retaining physicians in training from its residency programs.

Declining physician insurance reimbursement: You heard some members talk about this very important issue. Pennsylvania still has among the poorest payment in the nation from commercial insurance and from Medicaid. Increasing physician workloads: Comparative analysis of inpatient days per physician, outpatient visits per physician, surgeries per physician suggests that the workloads of Pennsylvania physicians and surgeons are substantially higher than the workloads of their counterparts nationally.

Mr. Speaker, demand for medical care: Since 1997, Pennsylvania has seen declining in the number of physicians in many specialties including family medicine, internal medicine, obstetrics, gynecology, cardiology, pathology, orthopedic surgery, general surgery, and neurosurgery. The conclusion is the Pennsylvania physician supply is under increasing strain and reflected in the stagnant numbers of young physicians practicing in Pennsylvania.

Now, here is the problem that we are looking at: Based on what I have just outlined for you a few minutes ago, is this program going to work? Is Governor Rendell's Cover All Pennsylvanians program going to be successful? If our physicians determine – and this is difficult to analyze right now because we do not have the bill in law – but if Pennsylvania physicians feel that Rendell's Cover All Pennsylvanians program is too bureaucratic and they cannot implement it or accept the payment program, we will have major health-care problems right here in Pennsylvania, and the problems will be that if the physician base, which is already dwindling – and that is what I tried to convey to you a few minutes ago – if that physician base continues to dwindle, the state of medicine in Pennsylvania would be in a crisis situation. All we need is a real loss of 3 to 5 percent of doctors, that is those who are retiring early or moving to other States, and that could bring about limited medical service in our great Commonwealth.

Again, the loss of some of our most highly medical professionals would place Pennsylvania in a medical disaster, medically and financially, because we know that the health-care industry provides enormous benefit financially to the Commonwealth.

I certainly want our citizens to receive quality and affordable health care – we all do – and that is why we need to oppose amendment 06103 and continue to try and persuade our friends on the other side of the aisle to partner with us, with Representatives Boyd and Watson's initiatives in health care, to try to bring their initiatives into this debate.

And so, Mr. Speaker, I will be opposing this, as I said, this amendment. I will be a "no" vote, but I certainly want to see the dialogue continue. I think that we are in a very precarious situation. If for some reason this bill should become law, we could face a very serious health crisis here in Pennsylvania. Is it worth it? I think we can do better, and therefore, let us continue the debate and vote "no" on the amendment.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Fairchild.

Mr. FAIRCHILD. Thank you, Mr. Speaker.

Would the maker of the amendment stand for brief interrogation?

The SPEAKER pro tempore. The gentleman indicates that he will.

Mr. FAIRCHILD. Thank you, Mr. Speaker.

On page 18, line 35, "Termination of employment," the language states that "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." I understand that is a benefit to the employee, obviously.

What does an employer have to do? Are they completely out of the loop? Is it kind of like COBRA where the—

Mr. EACHUS. Mr. Speaker, let me answer your question. When that employee is terminated, the employer has no further responsibility to the program, and the employee can pay the employer's share and keep himself covered, much like a cheaper COBRA plan, so to speak.

Mr. FAIRCHILD. Okay. But there is no additional responsibility—

Mr. EACHUS. No obligation after the termination from the employer.

Mr. FAIRCHILD. Okay. Thank you.

On page 19, line 49, "Limitation on grants," the sentence where it says, "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."

Mr. EACHUS. Mr. Speaker, we have allocated $42 million for CARE grants. In each year, once that money is gone, there

will be no additional CARE grants offered until the next budget year; first come, first served.

Mr. FAIRCHILD. So the first one in the door, so if the department gets – the first day, that is the mailing date – the department gets $90 million worth of applications, the first $42 million envelopes that are opened will get the— Is that the way it works?

Mr. EACHUS. I would like to tell you that when I was a businessman, I made decisive decisions every day. You have got to be decisive in order to qualify.

Mr. FAIRCHILD. But how do we justify this to small businesses if we say this is – and I appreciate what you are trying to do – but how do we universally go back and tell our small businesses that this is a great opportunity for you if there is only $42 million available? Do you have any estimates on how much will be required?

Mr. EACHUS. Each year under this proposal, the department will take a look at the effectiveness of the entire program, including the CARE grants. They may recommend, after the first year, that we need to allocate more resources, and we can, as a matter of priority in the General Assembly, decide to put higher allocation into the CARE grants in the future.

Mr. FAIRCHILD. What guaran—

Mr. EACHUS. I am sorry; my apology. We think $42 million is a good first step to begin the CARE grant program.

Mr. FAIRCHILD. That was my follow-up question. You think $42 million will cover the first year's applications?

Mr. EACHUS. We think it is a good conservative first step.

Mr. FAIRCHILD. Thank you.

Page 20, line 35, this speaks to the language that says, "Pays an average annual wage that is not greater than 300% of the Federal poverty limit for an individual." My concern is that, especially in small businesses, you have a great fluctuation sometimes in workforces, depending on if you are in the construction business, depending on how the economy is. If you are in a lot of businesses, there are fluctuations, and in so being, you hire employees, additional employees, if needed. You may seek a different branch of your company, try to grow the company, but what happens when you are one employee away from that 300-percent figure? What do I do as a company? And do I say, if I hire that person we need or if I do not lay off such and such, then I am going to be over the limit?

Mr. EACHUS. Well, once again and from my own experience, businessmen have to make those kinds of tough decisions every day, and the decision those businessmen would have to make is whether they engage in this program or whether they would allow their income-qualified employees to come into the program as individuals.

Mr. FAIRCHILD. I am just curious, have you done a matrix? You said you were a small businessperson and so was I, but using that scenario of getting to that limit, would you or I be better off by getting rid of an employee or not expanding, or is this program that good that it does not matter? We just go ahead and do business as usual and whatever?

Mr. EACHUS. I am not sure I can answer that. It is going to be an individual decision made by that individual businessman about what is best for his company. Mr. Speaker, I wish I could be more—

Mr. FAIRCHILD. Well, I am not sure either.

Mr. EACHUS. I think it is really an individual decision, though.

Mr. FAIRCHILD. I am not sure either, and that is part of the problem I have with this whole timing thing. We have been here since— Well, we were in caucus, started at 8:30 this morning, and I would love to go back and ask a couple of my small businesses, let us just figure this thing out on paper, how this comes out. But if you have not done it, I have not done it, and I doubt if anybody else in here has done it, but it certainly would— I just have reservations voting for this without having really gone through the scenario and some reality checks on how it fits in.

On page 21, line 4, where it says, "…an eligible employer shall be subject to a 1% increase in the base premium for each month after the latter of the following…," and then it goes on to list a number of criteria. Do I understand this correctly that it says that "…base premium for each month after the latter of the following…," and then "…twelve months from the date of the effective date of this section; or…twelve months…." So after that 12-month period, each month I will get, as a small business, I will get assessed a 1-percent increase?

Mr. EACHUS. Yes, I do. There is no assessment. Let me be clear about what we are trying to do: When the program begins on day 1, companies in Pennsylvania will have 12 months to buy in to that program. If they do not want to buy in, for each month they do not decide – let us say they do not decide for 12 months – they will pay an extra $12 in premium. This is mirrored after a Federal law that impacted Medicare Part D. As senior citizens know, CMS put this in place if they did not make a decision about their drug plan. So we thought this was a good model that related to incentivizing people to get in quickly.

The other thing is, if you are a new business, the 12 months would begin ticking when you get your tax ID number.

Mr. FAIRCHILD. So this only applies— We are only talking about a year timeframe then?

Mr. EACHUS. No; if you do not sign up for 36 months, it is $36 extra.

Mr. FAIRCHILD. So if I do not sign up for 5 years—

Mr. EACHUS. It is 60 months.

Mr. FAIRCHILD. It is 60 percent?

Mr. EACHUS. $60.

Mr. FAIRCHILD. It is a 60-percent increase?

Mr. EACHUS. Yes; it will be $1 a month each month you delay signing up.

Mr. FAIRCHILD. But the language says a 1-percent increase in the base premium. Are you saying the base premium is at $1?

Mr. EACHUS. $3.10 a month, roughly.

Mr. FAIRCHILD. Okay.

Mr. EACHUS. If you do not sign up, it is $3.10 a month for every month you do not sign up. Do I have the math right? Okay.

Mr. FAIRCHILD. All right. That is all the questions I have. I would like to make a brief statement.

The SPEAKER pro tempore. The gentleman is in order and may proceed.

Mr. FAIRCHILD. Thank you, Mr. Speaker.

I appreciate the gentleman from Luzerne answering the questions.

I am going to vote "no" on this proposal, simply because I would like more time to review it. I would like to take it back to my district. I would like to throw it around my district to the medical community, the hospital, to the universities, to my businesspeople, and to the individuals there – both actively

employed and those who are not employed – and just get a feeling of what is in here.

I think just by the testimony tonight, there are scenarios in here that have not been tested, nobody has cranked them out, no one has put them on a spreadsheet. There is a lot of work to do here. And if I thought that this would be passed by the Senate next week and the Governor would sign it, I might have a different opinion, but I think there have just been enough questions, and I am concerned that, really, we are going to have to see some major changes in this legislation.

So if you really believe that there are going to be major changes, then I would hope that you would join me and say we have got a problem here. Let us go back to the well one more time. No one will disagree that this is not a cutting amendment. And maybe it is exactly the right way to go, but I just have a feeling, whether you are in the majority or the minority, you have got a little sense in the back of your mind where, I am really not sure about this, there is an awful lot in here. But we are moving forward, and again, I thank all those who have participated in this process.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Representative Micozzie.

Mr. MICOZZIE. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support A06103. This amendment has three major components: Number one, taking care of our medical providers through abatement, privatizing Mcare, and dealing with the Mcare unfunded liability; number two, providing financial assistance to our small employers who are doing the right thing by insuring their employees; expanding health insurance coverage for our low-income working adults.

Mr. Speaker, you may remember that my bill became law, in Act 13, that reformed the catastrophic medical liability loss fund and became Act 13 in early 2000.

As many of you may know, also, it has been a long-sought goal of mine to get the State out of the medical malpractice insurance business. I have been working on this issue as chairman of the Insurance Committee for the last decade, together with Chairman DeLuca and Chairman Colafella before him. We held numerous discussions, hearings, and informational meetings regarding this issue.

I am glad to see this amendment finally accomplishes the goals. It provides our doctors abatements for 10 years and, at the same time, same period, phases out the Mcare Fund and pays off the unfunded liability of the fund when it officially ends. It is done over 10 years so that the disruption of the private market is minimized.

In addition, the Insurance Committee held 11 hearings on the Governor's health-care plan last year. We learned a lot from these hearings. We listened to struggling small business owners, medical providers, consumers, unions, the insurance industry, and so on and so on. Two things were apparent throughout these discussions: We needed to provide some financial assistance to our small businesses which are providing coverage for their employees, and we needed to expand coverage for struggling working adults. This amendment does both of these things. It provides $42 million a year in grants for our small businesses providing coverage to their employees and expands coverage for low-income working adults. In fact, once this legislation is effective, all of the Pennsylvanians on the adultBasic waiting list who desperately need insurance coverage will get it.

I urge all my colleagues to support this comprehensive amendment to provide hope to all Pennsylvanians who need health insurance coverage. This program is reasonable and financially sustainable. I urge you to vote "yes" on A06103.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the gentleman and recognizes Representative Watson on the amendment.

Mrs. WATSON. Thank you, Mr. Speaker.

Would the gentleman, when he is able, would the gentleman stand for brief interrogation – the maker of amendment, please.

Mr. EACHUS. Happy to, Mr. Speaker.

The SPEAKER pro tempore. The gentlelady is in order.

Mrs. WATSON. Thank you, Mr. Speaker.

A few questions. Certainly I applaud the work that has been done. Personally speaking, I would like to have spent more time helping you with some of this, but at the same time I have some very serious questions, if we could go through that. And it is my concern when we are talking about the uninsured, and even the previous speaker, we talked about adultBasic folks who are on the waiting list.

If you could go to page 12, around line 57, if I am right here, while adultBasic enrollees and those on the waiting list are eligible, do they have the priority for enrollment, because you keep referring to first come, first served. So I guess I am trying to organize, because indeed these are the people for whom this promise is the most critical. I recognize – I believe, at least – it refers to transferring people over, but my question would be particularly that waiting list. Do they move first or are they in the pool with everyone else who is about to apply, including the business owner who has to get half of his employees on? How is this going to work in terms of order?

Mr. EACHUS. It is our intent to take care of the waiting list first, and those 80,000 adults out there waiting, who are waiting on the adultBasic program right now, should know that is a certainty, that we are trying to reach that conclusion with this legislation.

Mrs. WATSON. Thank you, Mr. Speaker.

Now, if they would, in effect, come first, may I ask – and I apologize; it has been a long day and my memory may be going – but I believe, did you mention you felt that the total that you could cover would be 250,000? Is that in the first year or further down the line?

Mr. EACHUS. 143,000 in the first year and just about 250,000 by year 4.

Mrs. WATSON. All right. If in the first year then it is that 143,000, 144,000, and 80,000 will be taken up by moving first those who are on the waiting list and eligible, I guess my question is then, how does that work for – and one of the other Representatives, I believe, had mentioned this – for the small business owner who is trying to get his employees on, because if we have a total number of slots, are we not setting up that even though they try and they do it, we are going to have employers who, literally, they may be there and ready, but they will not get their people in because there is no room?

Mr. EACHUS. Mr. Speaker, once again we do not set up this program as an entitlement program; it is the insurer of last resort. We think that it is a responsible way to make sure that we move this program with responsible steps forward, incrementally, in a conservative way, to make sure that our fiscal modeling makes sure that there is access, but it is the insurer of last resort.

Mrs. WATSON. Okay. Thank you, Mr. Speaker.

Following that, and certainly I would applaud being consistently conservative, because I guess – and you have heard me say it over and over again – I am loath to make a promise that I know I cannot keep. And if I make a promise as important as this would be to someone who is uninsured, I do not want to keep it just for a year or two, perhaps through no fault of the State, but come back and say to them, oops; sorry, we do not have any money or, oops, we have to scale back and so we have got to take 10,000 who did have coverage off the coverage.

Following then the people who would go on this program, those who transfer from another government program, do they get any kind of priority in this system, I will call it? I would have said pecking order, but I do not mean that in a derogatory way. Do they have any priority over those on the waiting list for this program or are they also automatically enrolled, much like the waiting list, because I could not find that in your amendment? I am trying to figure out how it works and who goes in what order.

Mr. EACHUS. If coverage is available when that individual applies and they meet the eligibility requirements, they can get it.

Mrs. WATSON. Okay. But they do not get any special where they are automatically put over to it?

Mr. EACHUS. No.

Mrs. WATSON. Is that somewhere that I missed when I read it?

Mr. EACHUS. It is not.

Mrs. WATSON. Okay. But it will not be – and I guess that was my question – people transferring even from some of the others, they are not going to bump current enrollees? It is automatic that if you have adultBasic right now, you automatically start, that you are the first group that goes in under this program?

Mr. EACHUS. No.

Mrs. WATSON. I am sorry; I am not sure what the no means.

Mr. EACHUS. Are you saying that they were in the ABC?

Mrs. WATSON. If they are on adultBasic right now, are they just automatically – they are the first group of people, the 40-some thousand who are currently on adultBasic as we have it. Are they just the first group that is automatically moved, and then the second group that is automatically moved to the 144,000, would that be then those who are on the waiting list?

Mr. EACHUS. The 55—

Mrs. WATSON. So if I have got 40,000 and 80,000, I am already up to 120,000.

Mr. EACHUS. Roughly there are 55,000 people in the adultBasic program.

Mrs. WATSON. Okay.

Mr. EACHUS. Those people get auto-enrolled into this program and then the people, the 80,000 waiting on the list, they go first and then the slots that are available when individuals apply—

Mrs. WATSON. Right.

Mr. EACHUS. —they would be considered by the availability of the slots.

Mrs. WATSON. Okay. Thank you, Mr. Speaker.

But perhaps I am a bit obtuse, but that would suggest to me – if I am quick doing math in my head – that of 144,000 slots total available for the program, we are going to move 50,000 – your number, I thought it was less – but 55,000 plus 80,000. So we are already up at about 130,000 of 144,000, and I guess that is my question. So we really only have 13,000, 14,000 available?

Mr. EACHUS. Once again, I want to tell you the House Democrats never intended to make this an entitlement program, notwithstanding all the offerings that were made by other organizations. This program is a very serious step forward to cover the uninsured and will grow by year 4 up to almost a quarter of a million, perhaps over a quarter of a million adults in Pennsylvania who do not have insurance today that will. So we think that that gradual stepping up is a responsible and conservative fiscal way of approaching this.

Mrs. WATSON. I understand. Thank you, Mr. Speaker.

The stepping up – your phrase – and moving from year 1 to year 3 to year 5, that also is predicated then on additional funding coming in? Does that get to – the 250,000 you talk about – does that get to the 300 percent going back and getting kind of a variation on the waiver, that you still need to get a waiver to begin with and then get a variation?

Mr. EACHUS. No; I do not think the number is connected to the waiver.

Mrs. WATSON. Okay. But the waiver is connected to the money which pays for the individuals?

Mr. EACHUS. The waiver is a very important element of the fiscal planning for this.

Mrs. WATSON. Yes, sir.

Mr. EACHUS. And as I told you before, the other States across the country that have seen waivers— We think that there really is not going to be a barrier to this waiver. So once we get that, it is really going to create the cornerstone of our funding, as it relates to Federal and State share.

Mrs. WATSON. Mr. Speaker, since you brought it up – and I have the list of the other States that have it – but one thing that was not on there was how long they have had it.

And allow me to, if I might add some information. I have a couple contacts in Washington, DC, and when all this came up, I have tried to do every bit of homework I could do. I contacted them, and what I am hearing and regardless – and I know we are going to get down to that party thing, and I am not going there – but they are telling me, in general, money is not there no matter who is in charge, and they are looking to offload to the States. In the short time I have been here, Mr. Speaker, I understand that happens. And when I did my history and looked back, that has happened regardless of who was in charge. No matter what political party, they tend to offload things to us, and certainly you have had a longer career here than I, and you know, honestly, that is true. It does not matter who is down there, that tends to be what happens.

So I guess that is my concern, and that is the reason for asking you. Do we have validation how long, because I am worried that we get the waiver and 2 years down, they go, whoops; sorry, no money, and they take it back. They change it, they cut it back, and suddenly we are short of funds.

Mr. EACHUS. I hate to go to the party thing, but you know I may have to. I mean, this administration has left us short on education through No Child Left Behind, they have left us short on funding for transportation and transit, and they have left us short in many ways. But as it relates to health care, this administration – and I cannot speak for them; you will have to talk to them directly about their negotiations – but they have had success in negotiating for children's health insurance and the Cover All Kids proposal. They negotiated on this waiver program for children in Pennsylvania just a year and a half ago.

So there is some relationship there. It is a necessity to have that. We really need that funding to make this go.

Mrs. WATSON. All right. If I might then switch gears a little bit. Page 17, line 25, it places a requirement on employers that they are to enroll a certain number of participants – I believe it is 50 percent of all their eligible employees – before anyone can participate. And the way I read it, it says, "…shall…Offer to all eligible employees the opportunity to participate in the program and enroll at least one-half of the eligible employees." But again, I go back to the total that could be in the slots, and also, if you have some young employees who go, I do not want to be enrolled because I am 30, I am fabulous and fit and wonderful, and I do not want to do that. In effect, it would negate the employer and the other employees from getting it. Am I correct in that, that that is a possible scenario?

Mr. EACHUS. Well, I want to make sure I get the nuance in your question correct, because I read the section, but I am not sure what element of that language is unclear.

Mrs. WATSON. I guess I am following from the language. If I am understanding that the process would be the employer offers to all eligible employees the opportunity to participate in the program, but to get into the program, the employer is going to have to enroll at least one-half of his eligible or her eligible employees. My question then gets to, if that is the threshold and they are one short because you have got some young employees who go, I do not care. I do not want to pay for anything. I just do not want to be a part of it. And quite frankly, there are. I mean, I can name people. And certainly in my district, when we spent all that time talking to uninsured for months and I went all over my district, I had young people who said to me, no; even if you offer it— In fact, it was offered and they said, I turned it down, and it was paid for, which amazed me, but they still did that. So that is my question, because then the employer is hurt, the rest of the employees are, because we have that— And I understand the concept of thresholds—

Mr. EACHUS. Right.

Mrs. WATSON. —but, Mr. Speaker, I am looking at that scenario and saying—

Mr. EACHUS. I am clear. If the employer cannot reach the 50-percent threshold, and, let us say, they have some uncooperative employees – that is, 10 employees; 7 do not want to cooperate, 3 want the coverage – and they only have 3 employees, they can direct those individuals, if they meet the income eligibility requirements, to the individual coverage.

Mrs. WATSON. Right. But the employer cannot get the benefit. Now, does he or she get penalized because they can only get the three?

Mr. EACHUS. There are no penalties.

Mrs. WATSON. Okay. And we have already talked about the problem of space and time, that even if I get the 50 percent, I may not be able to get my people in.

I have a lot more questions, Mr. Speaker, and I know the answers are not always going to be something that I think is there or I like. So in the interest of time, Mr. Speaker, I will stop my questions and ask if indeed I could just speak on the amendment?

The SPEAKER pro tempore. The Chair thanks the lady, and she is in order.

Mrs. WATSON. Thank you very much, Mr. Speaker.

Mr. Speaker, and I have mentioned this before, but there is no doubt I have great concern, sympathy, and actually understanding of those who are uninsured. In the long history of the time I have been married, there was a time when we did not have any health insurance due to a loss of a job. So I know what it is like to worry. I know what it is like to be concerned, and quite frankly, those were the days before there was CHIP. So there was not anything to put our child on. I understand all that. That is what drove me, along with Representative Boyd, to spend the time and spend the last, over 9 months now, working on a plan that we thought could be funded, could work, would get support in both sides of this building, and then basically help uninsured people.

At the same time, Mr. Speaker, I am a person who needs to study, needs to know, and is very sincere about putting my vote with a promise that I absolutely can keep. With 24 hours, less really, of notice, though I stayed up late to study last night, and recognizing that even some of our members perhaps have not had the opportunity I did to get the first look and start to read, and though indeed the maker of the amendment answered very responsibly all the questions that he could but recognizes that there are questions he does not have answers to and everything is not spelled out here, regretfully, and because there is a philosophical problem with this amendment that I have shared – but I will share it publicly – I absolutely do not agree with ever tying Mcare abatement to other things that I want, and in fact, we insisted in the plan we put forward last December that we did not tie that. We kept that purely separate so it would be an issue that could stand and fall and be discussed on its own merits.

All of that, Mr. Speaker, is going to let me or allow me or require me, truthfully, to regretfully vote against this. I do not want to vote against insuring uninsured. I think we have plans that could work right now and that could get support in both parts of this building. There are other issues and things that are not in here – federally qualified health centers and so forth – that I think are critically important and, I might add, not to where I am from; there is not one in Bucks County. All of that leads me to say no. I would be happy – would have voted and did vote – to hold some hearings, to redraft, to redo, to fix what needs to be fixed, and come back and do something that I feel my "yes" vote would be a promise that I know I could keep.

Again, Mr. Speaker, I am sorry and I think others will feel the same, but regretfully, I am going to have to vote "no" on this amendment.

Thank you, Mr. Speaker.

The SPEAKER pro tempore. The Chair thanks the lady.

REMARKS SUBMITTED FOR THE RECORD

The SPEAKER pro tempore. The Chair recognizes Representative Seip.

Mr. SEIP. Thank you, Mr. Speaker.

If I may, I would like to just submit my remarks for the record.

The SPEAKER pro tempore. The Chair thanks the gentleman.

Mr. SEIP submitted the following remarks for the Legislative Journal:

Thank you, Mr. Speaker.

The health-care landscape in PA has many elements, which make this such a complex issue. But I would like to focus on two particular

groups as I stand here now – the uninsured and those who are struggling to remain insured.

Mr. Speaker, in regard to those struggling to keep coverage, they are struggling because the cost keeps rising and rising and rising. When it rises enough, those folks will, sadly but surely, join those in the first group – those with no health-care coverage. During the course of today's debate, I have heard a lot about this group.

A reference about inappropriate use of ERs (emergency rooms) across this Commonwealth was made. Mr. Speaker, I concur. Our ERs are increasingly used inappropriately. I witnessed this while working in the hospital setting. I believe that people are mostly going to the ER because they do not have coverage. This perpetuates a cycle of higher cost – unreimbursed cost – which, I believe, ultimately results in higher premiums, making health-care coverage less affordable, resulting in more people becoming uninsured.

Mr. Speaker, this amendment gets at the root of the problem – getting people covered.

I urge an affirmative vote on the amendment.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER pro tempore. The Chair recognizes Representative Baker on the amendment.

Mr. BAKER. Thank you, Mr. Speaker.

Mr. Speaker, I will be very brief. I rarely get up to interrogate anyone all these years, but this is a very important issue in my district. Rosemarie Greco, the Governor's Office of Health Care Reform, provided most of the members with a listing of all the uninsured adults and the percentages relating to each of their members and their counties. And if the gentleman, Mr. Eachus, would be kind enough just for a couple more questions from me and then I will conclude, I would appreciate that very much.

The SPEAKER pro tempore. The gentleman indicates that he will stand for interrogation.

Mr. BAKER. Rosemarie from the Governor's Office had indicated that I have the highest level of uninsured adults in the entire State of Pennsylvania, and I have all the counties listed here. I actually have almost 36 percent of the uninsured adults in my entire county, in Tioga County. No other county comes close to that.

I am very concerned about helping the uninsured, but I am also very concerned that there is equal access to those rural individuals that are going to be helped, and the only counties that come close to that percentage of uninsured adults in Pennsylvania are two other rural counties.

And I need to know, you answered some very good questions to the previous speaker and you had indicated that the waiting list was going to be taken care of first, and I appreciate hearing that, but what about the thousands of other people in rural Pennsylvania or in urban Pennsylvania? How is it going to be determined? Is there going to be truly equal access and availability of help for these people, or are they going to find themselves still uninsured even though we have created a new program, or attempted to create a new program, to address their concerns? I know this is a multifaceted approach to dealing with the Mcare issues, with uninsured issues. I have many concerns about loose ends in this legislation. It is definitely far from perfect. It needs a lot of changes, as far as I am concerned, but I find your proposal meritorious in that you are trying to help a segment of society that does not have insurance and cannot afford it. So I applaud that.

I just want to know that 36 percent of the adult population in Tioga County, since they are uninsured – nearly 8,000 of them per capita – they are going to have equal access to help in this program. Could you explain to me how they definitely, maybe, or will not be helped by your amendment?

Mr. EACHUS. Mr. Speaker, I sincerely understand the problems of rural Pennsylvania, as it relates to Tioga County. And I want you to know, the rural poor are as serious an issue to Pennsylvania, to me, because I have a suburban and rural district, as urban areas, because I have a city and rural areas. I see there are 1108 people in your county as a percentage of population. That is pretty high, and I understand your concern. All 67 counties qualify for this program and all individuals who would qualify have an equal opportunity to sign up for this program. There is no weighted equation that allows some way to get in first. You have got to get eligible, get signed up.

Mr. BAKER. I remain very concerned about equal access to insurance. I do not see any assurances here. I sense some equivocation with regard to how they are going to be helped, and I want to see them helped, but I want to see it in a fair and equitable way, if at all possible proportionately. Maybe it should be based on the poorest of the poor being helped first. I do not know.

I think this does need some additional work. I supported the previous motions for recommittal just so we could have some additional dialogue and engagement with regard to how we could work on that.

I am not sure how I am going to vote. Like I said, 36 percent of the adults being uninsured in my county, no other county comes close to those figures. So I want to do what I can to help those individuals. I think we have some other proposals, and I would hope that as this moves along, whether it be in the Senate or it comes back here, that we take a serious look at that equal access issue.

Thank you very much, Mr. Speaker.

THE SPEAKER (DENNIS M. O'BRIEN) PRESIDING

The SPEAKER. The Chair recognizes the minority leader, Representative Smith.

Mr. S. SMITH. Thank you, Mr. Speaker.

I know there have been a lot of questions, a lot of debate, a lot of discussion about this amendment and this issue today, and I will not belabor the issue much longer. I just wanted to make a couple of points, kind of recapping a few things as I see it, and there have been many, many questions asked, which I believe is critical to the concerns that are posed about this amendment that is before us and the fact that we really have not had the amount of time necessary to try to work within the confines of that amendment.

The key things, Mr. Speaker, that I think are problematic with this amendment, number one, I do not feel it deals with the Mcare tail. Yes, it has a phaseout program of taking the State out of the medical malpractice insurance business. The phaseout portion of this is not all that bad. I think there was probably a little better way to do it, but I think the critical part is it does not deal with the tail. It ignores the tail, virtually, and will put Pennsylvania in a position somewhere down the road where we will have a huge liability facing us as we pay off or come to grips with paying that off.

Mr. Speaker, I think this amendment does not deal with the issue of crowd-out. I think it shifts, if this amendment were to become law, I think, Mr. Speaker, that it will shift who the uninsured are. It may be designed to pick up those who are currently on the waiting list for ABC, but the realistic effects, how the community of people that are in the insurance business that are providing insurance today, how they will react to this, will cause a shift of people who currently have insurance. They will be crowded out and put into the uninsured ranks, only swelling the problem and just kind of moving it to a different group of people.

Finally, Mr. Speaker, I think that there is a false sense of hope being put forth by this amendment in that, in reality, the fiscal note suggests that this will be running this State close to $1 billion within 3 years. When you compare that to what other States have experienced or what Massachusetts has experienced, I would suspect that that number is on the low end. And in fact, Mr. Speaker, we only really have around a quarter of that, around $250 million, that is truly available to pay for this program that is of recurring revenues. There are a few short-term and one-term pots of money that might help us absorb this over the first year or two, but clearly, Mr. Speaker, this program, fully implemented as it is proposed, is going to require a huge increase in revenues to properly run it and to execute it in a fashion that would meet the expectations that are being set forth by the proponents.

Mr. Speaker, I think it would be wrong if we were to stand here today and say we were simply opposed to this amendment and that we did not have anything – that we did not have a viable alternative.

As many speakers have said, we recognize the problem both with the uninsured, with those who simply cannot afford to purchase insurance in this marketplace. We recognize the issues as they relate to our medical providers, and clearly we stand ready to address that problem. And while we have problems with how this amendment is crafted and the cost and the implications of it, the effects of it, the long-term effects of it, we think that the many good things that we should be looking at – the utilization of health-care savings accounts; tax credits for small businesses who provide insurance, to give them the incentive to continue to provide insurance to their employees; the lifeline insurance policies which would go a long, long way in making insurance more affordable, to make a product that would clearly cover the basic needs of insurance, Mr. Speaker, to make it more affordable, the lifeline insurance policies – would go a tremendously long way on that.

Additional funding towards the Federal clinics, Mr. Speaker, this is something that would address a huge cost that our Medical Assistance Program has and that what this proposed program would have, and that is people who go to the emergency room when they really are not in an emergency need, but because they can go there and get the care for free at a very expensive location. The emergency room is probably one of the most expensive places from which to get medical care. The Federal clinics are an avenue that we have available to us that we could take advantage of additional Federal dollars and use them as a mechanism for some of that intermediate level of medical care, where someone does not quite need the attention of an emergency room but may be in need of some help beyond just what you could get at the drugstore. That would go a long way, Mr. Speaker, in providing additional care, making it available to people but doing it in a manner that will not put us in the billion-dollar range 3 years from now.

We had looked at and proposed as part of our plan, Mr. Speaker, to deal with chronic disease control and infectious control in hospitals. These are real problems that drive up the cost of medical care, Mr. Speaker, that drive up the cost of the very insurance that you want to give to these uninsured in Pennsylvania. Just giving them more insurance, Mr. Speaker, without dealing with the costs that are driving it up not only does not do that individual any good, it does not do us as a Commonwealth any good, and it does not do those who are currently paying for insurance any good. Mr. Speaker, we need to be addressing those, and our plan, what we support, would do that.

Retooling adultBasic, Mr. Speaker, would be a must in terms of maintaining this and keeping insurance available for the largest number of people in Pennsylvania as possible. Tax credits for wellness programs, Mr. Speaker, would also address this issue from a different angle that I do not believe this amendment addresses. It would allow for— The tax credits for wellness programs, Mr. Speaker, would put in place incentives for people to take better care of themselves.

When we look, Mr. Speaker, finally, real quickly, Mr. Speaker, just to go back to the Mcare issue, it is interesting that while we are all talking about getting the State out of this insurance business, out of the medical malpractice insurance business, because, obviously, the State has not run it all that well, and the marketplace has improved where the competition exists and the doctors and the medical providers can go back – that is the phaseout – to put them back into the private marketplace. We are doing that on one hand, which is a good thing, but on the other hand we are going the opposite direction with individuals and putting them into a government program to which we are going to encounter the same problems that have kind of vexed this situation with Mcare. So while we are phasing out of the medical malpractice insurance business, we are jumping into another level of insurance business when we should be putting the incentives in place to bring competition to the marketplace of insurance, to drive down the costs of that insurance, and therein you would provide a lot of opportunity for people to get insurance in this Commonwealth, Mr. Speaker, and that is really the stated goal here.

As we look at the Mcare phaseout, Mr. Speaker, I just want to emphasize again: This plan, while it does phase it out in an adequate way, it does not deal with the tail in a proper manner, Mr. Speaker. It is going to leave those very doctors and those very medical providers that are beneficiaries directly of the Mcare program and the people of Pennsylvania who are indirectly beneficiaries of the Mcare program because it has kept doctors in Pennsylvania, because it has kept that quality of care in Pennsylvania, it is going to put them in the same target 10 years from now, Mr. Speaker, because we are not addressing the whole problem. We are simply phasing it out and not facing the reality that there is this long-term liability and huge debt at the end of the line.

So, Mr. Speaker, I oppose the amendment as it has been put forth. I would continue to advocate for these things that I just enumerated, because I think they are the right direction. They are the way to go about solving this problem in a way that is going to provide the people of Pennsylvania with the greatest availability, access to care, Mr. Speaker, as well as access to insurance to cover their extended needs, and I would urge the

members to oppose this amendment and to revisit the proposals that we have put forth that clearly address the problem in a much more comprehensive way and in a way that will not leave us looking at a nearly billion dollars in day-to-day operational costs 3 years from now, and that is a huge number for this Commonwealth to absorb, even under the world of this administration.

Thank you, Mr. Speaker.

The SPEAKER. Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

Mr. Speaker, this has been a long day, and I am proud to put forward an amendment that we believe is a groundbreaking, comprehensive effort to not only provide quality of care to the uninsured but also to lower the cost of uncompensated care to our hospitals, which costs $1.4 billion a year. We also lower the cost of care for all Pennsylvanians by controlling the cost of the uninsured. We assist small businesses to continue to cover employees or to start providing coverage to low-income working families. We assist doctors by continuing the Mcare abatement and paying down the unfunded liability within Mcare; also providing $3 billion in Mcare abatements between now and 2017. We face many challenges in Pennsylvania; health-care coverage for the uninsured is a priority that can no longer wait and can no longer be ignored.

We need, together, to do the right thing by passing this amendment today so that we can put an end and begin on the journey to stopping the struggles of families in Pennsylvania who desire but cannot afford access to health insurance in this Commonwealth.

I stand proudly to put this amendment forward, and I ask for your affirmative vote.

On the question recurring,

Will the House agree to the amendment?

The following roll call was recorded:

YEAS–114

Baker	Galloway	Markosek	Seip
Belfanti	George	Marshall	Shapiro
Bennington	Gerber	McCall	Shimkus
Beyer	Gergely	McGeehan	Siptroth
Biancucci	Gibbons	McI. Smith	Smith, K.
Bishop	Godshall	Melio	Smith, M.
Blackwell	Goodman	Micozzie	Solobay
Brennan	Grucela	Moyer	Staback
Buxton	Haluska	Mundy	Sturla
Caltagirone	Hanna	Myers	Surra
Carroll	Harhai	O'Brien, M.	Tangretti
Casorio	Harkins	Oliver	Taylor, R.
Cohen	Hornaman	Pallone	Thomas
Conklin	James	Parker	Vereb
Costa	Josephs	Pashinski	Vitali
Cruz	Keller, W.	Payne	Wagner
Curry	Kenney	Payton	Walko
Daley	Kessler	Petrarca	Wansacz
DeLuca	King	Petrone	Waters
DePasquale	Kirkland	Preston	Wheatley
Dermody	Kortz	Ramaley	White
DeWeese	Kotik	Raymond	Williams
DiGirolamo	Kula	Readshaw	Wojnaroski
Donatucci	Leach	Roebuck	Yewcic
Eachus	Levdansky	Sabatina	Youngblood
Evans, D.	Longietti	Sainato	Yudichak
Fabrizio	Mahoney	Samuelson	
Frankel	Manderino	Santoni	O'Brien, D.,
Freeman	Mann	Scavello	Speaker

NAYS–81

Argall	Gabig	McIlhattan	Rapp
Barrar	Geist	Mensch	Reed
Bastian	Gillespie	Metcalfe	Reichley
Bear	Gingrich	Millard	Roae
Benninghoff	Grell	Miller	Rock
Boback	Harhart	Milne	Rohrer
Boyd	Harper	Moul	Ross
Brooks	Harris	Murt	Saylor
Causer	Helm	Mustio	Schroder
Civera	Hennessey	Nailor	Smith, S.
Clymer	Hess	Nickol	Sonney
Cox	Hickernell	O'Neill	Stairs
Creighton	Hutchinson	Peifer	Steil
Cutler	Kauffman	Perry	Stern
Dally	Keller, M.	Petri	Stevenson
Denlinger	Killion	Phillips	Swanger
Ellis	Mackereth	Pickett	True
Evans, J.	Maher	Pyle	Turzai
Everett	Major	Quigley	Vulakovich
Fairchild	Mantz	Quinn	Watson
Fleck			

NOT VOTING–0

EXCUSED–8

Adolph	Hershey	Marsico	Rubley
Cappelli	Lentz	Perzel	Taylor, J.

The majority having voted in the affirmative, the question was determined in the affirmative and the amendment was agreed to.

LEAVE OF ABSENCE

The SPEAKER. Representative DeWeese.

Mr. DeWEESE. Thank you, Mr. Speaker.

I would like to put the gentleman from Westmoreland, Mr. TANGRETTI, on leave for the rest of the evening. Thank you.

The SPEAKER. The Chair thanks the gentleman. Without objection, the leave will be granted. The Chair sees no objection.

CONSIDERATION OF SB 1137 CONTINUED

On the question,

Will the House agree to the bill on second consideration as amended?

Mr. **SCHRODER** offered the following amendment No. **A06119:**

Amend Title, page 1, lines 12 through 16 (A06103), by striking out "establishing the Pennsylvania" in line 12, all of lines 13 through 15 and "employers and for expiration of certain sections;" in line 16 and inserting

and for health insurance continuation;

Amend Sec. 4 (Sec. 752), page 8, lines 45 and 46 (A06103), by striking out "upon approval of the" in line 45 and all of line 46 and inserting

for continuation of health insurance under section 5103.2. The annual allocation under this section shall not exceed $42,000,000.

Amend Bill, pages 12 through 24, lines 1 through 59; page 25, lines 1 through 39 (A06103), by striking out all of said lines on said pages and inserting

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

Section 5103.2. Health insurance continuation.

(a) Eligibility.–A person collecting unemployment benefits shall be eligible for a rebate of 50% of the cost of any health care insurance premium the person paid during the period during which the person collects unemployment benefits.

(b) Allocation.–Funds allocated under section 752 shall be used by the Insurance Department to provide rebates under subsection (a).

(c) Regulations.–The Insurance Department shall promulgate regulations to effectuate this section.

Amend Sec. 14, page 25, line 40 (A06103), by striking out "14" and inserting

12

Amend Sec. 15, page 25, line 42 (A06103), by striking out "15" and inserting

13

Amend Sec. 15, page 25, lines 50 through 53 (A06103), by striking out all of said lines and inserting

(2) The remainder of this act shall take effect immediately.

On the question,

Will the House agree to the amendment?

AMENDMENT WITHDRAWN

The SPEAKER. The gentleman withdraws the amendment? The Chair thanks the gentleman.

On the question recurring,

Will the House agree to the bill on second consideration as amended?

The SPEAKER. For what purpose does the gentleman, Representative Pallone, rise?

Mr. PALLONE. To stretch my legs.

The SPEAKER. The Chair thanks the gentleman.

Mr. PALLONE. Thank you, Mr. Speaker.

Actually, I rise to correct the record.

The SPEAKER. Would the gentleman wait until the end of the bill and then I will recognize him.

Mr. PALLONE. Sure. Thank you, Mr. Speaker.

The SPEAKER. The Chair thanks the gentleman.

On the question recurring,

Will the House agree to the bill on second consideration as amended?

Mr. **BOYD** offered the following amendment No. **A06123:**

Amend Bill, page 25, by inserting between lines 32 and 33 (A06103)

Section 12.1. If the Department of Public Welfare receives Federal waiver or approval to amend the State Plan for Medical Assistance, the department shall transmit notice of the waiver or approval to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

Amend Bill, page 25, lines 42 through 53 (A06103), by striking out all of said lines and inserting

Section 15. This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) Section 12 of this act.

(ii) Section 12.1 of this act.

(iii) This section.

(2) The remainder of this act shall take effect upon the later of:

(i) publication of the notice under section 12 of this act; or

(ii) publication of the notice under section 12.1 of this act.

On the question,

Will the House agree to the amendment?

AMENDMENT WITHDRAWN

The SPEAKER. The gentleman indicates that he is withdrawing the amendment. The Chair thanks the gentleman.

LEAVE OF ABSENCE

The SPEAKER. The Chair recognizes the minority whip, who requests that Representative MILNE be placed on leave for the remainder of the day. The Chair sees no objection. Leave will be granted.

CONSIDERATION OF SB 1137 CONTINUED

On the question recurring,

Will the House agree to the bill on second consideration as amended?

Bill as amended was agreed to.

(Bill as amended will be reprinted.)

* * *

The House proceeded to second consideration of **HB 2233, PN 3226,** entitled:

An Act amending the act of February 9, 2004 (P.L.61, No.7), known as the Elm Street Program Act, further providing for program requirements and for rules and regulations; and repealing the expiration date of the act.

On the question,

Will the House agree to the bill on second consideration?

Mr. **FREEMAN** offered the following amendment No. **A06031:**

Amend Title, page 1, line 6, by striking out "rules and regulations" and inserting

guidelines

Amend Sec. 1 (Sec. 3), page 3, line 14, by striking out "Regulations" and inserting

Guidelines

Amend Sec. 1 (Sec. 3), page 3, line 14, by striking out "regulations" and inserting

guidelines

Amend Sec. 1 (Sec. 3), page 1, line 16, by inserting after "of]"

a period of up to

On the question,
Will the House agree to the amendment?

The SPEAKER. The Chair recognizes Representative Freeman on the amendment.

Mr. FREEMAN. Thank you, Mr. Speaker.

Mr. Speaker, I will be brief.

This is simply a technical amendment. It deals with two aspects to the bill. First, to reinstate the fact that the Elm Street manager's position is for a period of up to 5 years. That was inadvertently removed in the committee process. And two, at the request of the Department of Community and Economic Development, to make it clear that the department can use guidelines as opposed to regulations when it comes to that provision of the legislation which deals with allowing communities that had previously been in the Elm Street Program to be considered for reestablishing those designated neighborhoods.

Again, it is a technical amendment. I would urge a "yes" vote.

On the question recurring,
Will the House agree to the amendment?

The following roll call was recorded:

YEAS–193

Argall	Freeman	Mantz	Rohrer
Baker	Gabig	Markosek	Ross
Barrar	Galloway	Marshall	Sabatina
Bastian	Geist	McCall	Sainato
Bear	George	McGeehan	Samuelson
Belfanti	Gerber	McI. Smith	Santoni
Benninghoff	Gergely	McIlhattan	Saylor
Bennington	Gibbons	Melio	Scavello
Beyer	Gillespie	Mensch	Schroder
Biancucci	Gingrich	Metcalfe	Seip
Bishop	Godshall	Micozzie	Shapiro
Blackwell	Goodman	Millard	Shimkus
Boback	Grell	Miller	Siptroth
Boyd	Grucela	Moul	Smith, K.
Brennan	Haluska	Moyer	Smith, M.
Brooks	Hanna	Mundy	Smith, S.
Buxton	Harhai	Murt	Solobay
Caltagirone	Harhart	Mustio	Sonney
Carroll	Harkins	Myers	Staback
Casorio	Harper	Nailor	Stairs
Causer	Harris	Nickol	Steil
Civera	Helm	O'Brien, M.	Stern
Clymer	Hennessey	O'Neill	Stevenson
Cohen	Hess	Oliver	Sturla
Conklin	Hickernell	Pallone	Surra
Costa	Hornaman	Parker	Swanger
Cox	Hutchinson	Pashinski	Taylor, R.
Creighton	James	Payne	Thomas
Cruz	Josephs	Payton	True
Curry	Kauffman	Peifer	Turzai
Cutler	Keller, M.	Perry	Vereb
Daley	Keller, W.	Petrarca	Vitali
Dally	Kenney	Petri	Vulakovich
DeLuca	Kessler	Petrone	Wagner
Denlinger	Killion	Phillips	Walko
DePasquale	King	Pickett	Wansacz
Dermody	Kirkland	Preston	Waters
DeWeese	Kortz	Pyle	Watson
DiGirolamo	Kotik	Quigley	Wheatley
Donatucci	Kula	Quinn	White
Eachus	Leach	Ramaley	Williams
Ellis	Levdansky	Rapp	Wojnaroski
Evans, D.	Longietti	Raymond	Yewcic
Evans, J.	Mackereth	Readshaw	Youngblood
Everett	Maher	Reed	Yudichak
Fabrizio	Mahoney	Reichley	
Fairchild	Major	Roae	O'Brien, D.,
Fleck	Manderino	Rock	Speaker
Frankel	Mann	Roebuck	

NAYS–0

NOT VOTING–0

EXCUSED–10

Adolph	Lentz	Perzel	Tangretti
Cappelli	Marsico	Rubley	Taylor, J.
Hershey	Milne		

The majority having voted in the affirmative, the question was determined in the affirmative and the amendment was agreed to.

On the question,
Will the House agree to the bill on second consideration as amended?
Bill as amended was agreed to.

(Bill as amended will be reprinted.)

LEAVE OF ABSENCE

The SPEAKER. The Chair recognizes the minority whip, who requests that Representative TRUE be placed on leave for the remainder of the day. The Chair sees no objection. Leave will be granted.

BILL ON THIRD CONSIDERATION

The House proceeded to third consideration of **HB 1265, PN 3059,** entitled:

An Act amending Title 64 (Public Authorities and Quasi-Public Corporations) of the Pennsylvania Consolidated Statutes, further providing for the definitions of "commercial lending activities" and "commercial lending institutions" and for the First Industries Program.

On the question,
Will the House agree to the bill on third consideration?
Bill was agreed to.

The SPEAKER. This bill has been considered on three different days and agreed to and is now on final passage.

(Bill analysis was read.)

The SPEAKER. The question is, shall the bill pass finally?

Agreeable to the provisions of the Constitution, the yeas and nays will now be taken.

The following roll call was recorded:

YEAS–183

Argall	Galloway	Markosek	Rohrer
Baker	Geist	Marshall	Ross
Barrar	George	McCall	Sabatina
Bastian	Gerber	McGeehan	Sainato
Bear	Gergely	McI. Smith	Samuelson
Belfanti	Gibbons	McIlhattan	Santoni
Benninghoff	Gillespie	Melio	Saylor
Bennington	Gingrich	Mensch	Scavello
Beyer	Godshall	Micozzie	Schroder
Biancucci	Goodman	Millard	Seip
Bishop	Grell	Miller	Shapiro
Blackwell	Grucela	Moul	Shimkus
Boback	Haluska	Moyer	Siptroth
Boyd	Hanna	Mundy	Smith, K.
Brennan	Harhai	Murt	Smith, M.
Brooks	Harhart	Mustio	Smith, S.
Buxton	Harkins	Myers	Solobay
Caltagirone	Harper	Nailor	Sonney
Carroll	Harris	Nickol	Staback
Casorio	Helm	O'Brien, M.	Stairs
Causer	Hennessey	O'Neill	Steil
Civera	Hess	Oliver	Stern
Clymer	Hickernell	Pallone	Stevenson
Cohen	Hornaman	Parker	Sturla
Conklin	Hutchinson	Pashinski	Surra
Costa	James	Payne	Swanger
Cruz	Josephs	Payton	Taylor, R.
Curry	Keller, M.	Peifer	Thomas
Cutler	Keller, W.	Perry	Vereb
Daley	Kenney	Petrarca	Vitali
Dally	Kessler	Petri	Vulakovich
DeLuca	Killion	Petrone	Wagner
DePasquale	King	Phillips	Walko
Dermody	Kirkland	Pickett	Wansacz
DeWeese	Kortz	Preston	Waters
DiGirolamo	Kotik	Pyle	Watson
Donatucci	Kula	Quigley	Wheatley
Eachus	Leach	Quinn	White
Ellis	Levdansky	Ramaley	Williams
Evans, D.	Longietti	Rapp	Wojnaroski
Evans, J.	Mackereth	Raymond	Yewcic
Everett	Mahoney	Readshaw	Youngblood
Fabrizio	Major	Reed	Yudichak
Fairchild	Manderino	Reichley	
Fleck	Mann	Roae	O'Brien, D.,
Frankel	Mantz	Roebuck	Speaker
Freeman			

NAYS–9

Cox	Gabig	Maher	Rock
Creighton	Kauffman	Metcalfe	Turzai
Denlinger			

NOT VOTING–0

EXCUSED–11

Adolph	Lentz	Perzel	Taylor, J.
Cappelli	Marsico	Rubley	True
Hershey	Milne	Tangretti	

The majority required by the Constitution having voted in the affirmative, the question was determined in the affirmative and the bill passed finally.

Ordered, That the clerk present the same to the Senate for concurrence.

STATEMENT BY MR. CONKLIN

The SPEAKER. For what purpose does the gentleman, Representative Conklin, rise?

Mr. CONKLIN. I would like to ask the Speaker if I may just make a couple of personal comments?

The SPEAKER. Without objection, the gentleman is in order and may proceed.

Mr. CONKLIN. I just want to make a few quick comments.

I would like to thank those folks in the Ag Committee that worked diligently to make this happen, the staff. But most of all, I just want to make sure that folks know that this is just a first step, and as we move over to the Senate, I would like to work even harder on the bill with the Senate.

Thank you very much, Mr. Speaker.

The SPEAKER. The Chair thanks the gentleman.

RESOLUTION

Ms. JOSEPHS called up **HR 355, PN 2138,** entitled:

A Concurrent Resolution urging review of import-export control systems for food and drug products sourced from China.

On the question,

Will the House adopt the resolution?

The following roll call was recorded:

YEAS–192

Argall	Freeman	Mantz	Roebuck
Baker	Gabig	Markosek	Rohrer
Barrar	Galloway	Marshall	Ross
Bastian	Geist	McCall	Sabatina
Bear	George	McGeehan	Sainato
Belfanti	Gerber	McI. Smith	Samuelson
Benninghoff	Gergely	McIlhattan	Santoni
Bennington	Gibbons	Melio	Saylor
Beyer	Gillespie	Mensch	Scavello
Biancucci	Gingrich	Metcalfe	Schroder
Bishop	Godshall	Micozzie	Seip
Blackwell	Goodman	Millard	Shapiro
Boback	Grell	Miller	Shimkus
Boyd	Grucela	Moul	Siptroth
Brennan	Haluska	Moyer	Smith, K.
Brooks	Hanna	Mundy	Smith, M.
Buxton	Harhai	Murt	Smith, S.
Caltagirone	Harhart	Mustio	Solobay
Carroll	Harkins	Myers	Sonney
Casorio	Harper	Nailor	Staback
Causer	Harris	Nickol	Stairs
Civera	Helm	O'Brien, M.	Steil
Clymer	Hennessey	O'Neill	Stern
Cohen	Hess	Oliver	Stevenson
Conklin	Hickernell	Pallone	Sturla
Costa	Hornaman	Parker	Surra
Cox	Hutchinson	Pashinski	Swanger
Creighton	James	Payne	Taylor, R.
Cruz	Josephs	Payton	Thomas
Curry	Kauffman	Peifer	Turzai
Cutler	Keller, M.	Perry	Vereb
Daley	Keller, W.	Petrarca	Vitali
Dally	Kenney	Petri	Vulakovich
DeLuca	Kessler	Petrone	Wagner
Denlinger	Killion	Phillips	Walko
DePasquale	King	Pickett	Wansacz
Dermody	Kirkland	Preston	Waters
DeWeese	Kortz	Pyle	Watson

DiGirolamo	Kotik	Quigley	Wheatley
Donatucci	Kula	Quinn	White
Eachus	Leach	Ramaley	Williams
Ellis	Levdansky	Rapp	Wojnaroski
Evans, D.	Longietti	Raymond	Yewcic
Evans, J.	Mackereth	Readshaw	Youngblood
Everett	Maher	Reed	Yudichak
Fabrizio	Mahoney	Reichley	
Fairchild	Major	Roae	O'Brien, D.,
Fleck	Manderino	Rock	Speaker
Frankel	Mann		

NAYS–0

NOT VOTING–0

EXCUSED–11

Adolph	Lentz	Perzel	Taylor, J.
Cappelli	Marsico	Rubley	True
Hershey	Milne	Tangretti	

The majority of the members elected to the House having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

Ordered, That the clerk present the same to the Senate for concurrence.

STATEMENT BY MR. PYLE

The SPEAKER. For what purpose does Representative Pyle rise?

Mr. PYLE. A point of personal privilege, Mr. Speaker.

The SPEAKER. The gentleman is being asked—

Mr. PYLE. I ask for unanimous consent, sir.

The SPEAKER. Unanimous consent. The gentleman is recognized, without objection.

Mr. PYLE. Mr. Speaker, right about this time, every night that we are out here late in Harrisburg, my kids like to put PCN (Pennsylvania Cable Network) on, and I would ask for the House's indulgence to wish my daughter, Katherine Brooke, a happy ninth birthday.

Thank you, Mr. Speaker.

The SPEAKER. The Chair also extends birthday wishes.

RESOLUTIONS PURSUANT TO RULE 35

Mr. O'NEILL called up **HR 621, PN 3315,** entitled:

A Resolution recognizing the month of March 2008 as "National Mental Retardation Awareness Month" in Pennsylvania.

On the question,

Will the House adopt the resolution?

The following roll call was recorded:

YEAS–192

Argall	Freeman	Mantz	Roebuck
Baker	Gabig	Markosek	Rohrer
Barrar	Galloway	Marshall	Ross
Bastian	Geist	McCall	Sabatina
Bear	George	McGeehan	Sainato
Belfanti	Gerber	McI. Smith	Samuelson
Benninghoff	Gergely	McIlhattan	Santoni
Bennington	Gibbons	Melio	Saylor
Beyer	Gillespie	Mensch	Scavello
Biancucci	Gingrich	Metcalfe	Schroder
Bishop	Godshall	Micozzie	Seip
Blackwell	Goodman	Millard	Shapiro
Boback	Grell	Miller	Shimkus
Boyd	Grucela	Moul	Siptroth
Brennan	Haluska	Moyer	Smith, K.
Brooks	Hanna	Mundy	Smith, M.
Buxton	Harhai	Murt	Smith, S.
Caltagirone	Harhart	Mustio	Solobay
Carroll	Harkins	Myers	Sonney
Casorio	Harper	Nailor	Staback
Causer	Harris	Nickol	Stairs
Civera	Helm	O'Brien, M.	Steil
Clymer	Hennessey	O'Neill	Stern
Cohen	Hess	Oliver	Stevenson
Conklin	Hickernell	Pallone	Sturla
Costa	Hornaman	Parker	Surra
Cox	Hutchinson	Pashinski	Swanger
Creighton	James	Payne	Taylor, R.
Cruz	Josephs	Payton	Thomas
Curry	Kauffman	Peifer	Turzai
Cutler	Keller, M.	Perry	Vereb
Daley	Keller, W.	Petrarca	Vitali
Dally	Kenney	Petri	Vulakovich
DeLuca	Kessler	Petrone	Wagner
Denlinger	Killion	Phillips	Walko
DePasquale	King	Pickett	Wansacz
Dermody	Kirkland	Preston	Waters
DeWeese	Kortz	Pyle	Watson
DiGirolamo	Kotik	Quigley	Wheatley
Donatucci	Kula	Quinn	White
Eachus	Leach	Ramaley	Williams
Ellis	Levdansky	Rapp	Wojnaroski
Evans, D.	Longietti	Raymond	Yewcic
Evans, J.	Mackereth	Readshaw	Youngblood
Everett	Maher	Reed	Yudichak
Fabrizio	Mahoney	Reichley	
Fairchild	Major	Roae	O'Brien, D.,
Fleck	Manderino	Rock	Speaker
Frankel	Mann		

NAYS–0

NOT VOTING–0

EXCUSED–11

Adolph	Lentz	Perzel	Taylor, J.
Cappelli	Marsico	Rubley	True
Hershey	Milne	Tangretti	

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. DeWEESE called up **HR 565, PN 3137,** entitled:

A Resolution honoring the players and coaching staff of the Ridley High School football team for continuing the tradition of excellence of Green Raider football by capturing the Central League Championship and the 2007 PIAA District I Class AAAA Football Championship.

On the question,

Will the House adopt the resolution?

The following roll call was recorded:

YEAS–192

Argall	Freeman	Mantz	Roebuck
Baker	Gabig	Markosek	Rohrer
Barrar	Galloway	Marshall	Ross
Bastian	Geist	McCall	Sabatina
Bear	George	McGeehan	Sainato
Belfanti	Gerber	McI. Smith	Samuelson
Benninghoff	Gergely	McIlhattan	Santoni
Bennington	Gibbons	Melio	Saylor
Beyer	Gillespie	Mensch	Scavello
Biancucci	Gingrich	Metcalfe	Schroder
Bishop	Godshall	Micozzie	Seip
Blackwell	Goodman	Millard	Shapiro
Boback	Grell	Miller	Shimkus
Boyd	Grucela	Moul	Siptroth
Brennan	Haluska	Moyer	Smith, K.
Brooks	Hanna	Mundy	Smith, M.
Buxton	Harhai	Murt	Smith, S.
Caltagirone	Harhart	Mustio	Solobay
Carroll	Harkins	Myers	Sonney
Casorio	Harper	Nailor	Staback
Causer	Harris	Nickol	Stairs
Civera	Helm	O'Brien, M.	Steil
Clymer	Hennessey	O'Neill	Stern
Cohen	Hess	Oliver	Stevenson
Conklin	Hickernell	Pallone	Sturla
Costa	Hornaman	Parker	Surra
Cox	Hutchinson	Pashinski	Swanger
Creighton	James	Payne	Taylor, R.
Cruz	Josephs	Payton	Thomas
Curry	Kauffman	Peifer	Turzai
Cutler	Keller, M.	Perry	Vereb
Daley	Keller, W.	Petrarca	Vitali
Dally	Kenney	Petri	Vulakovich
DeLuca	Kessler	Petrone	Wagner
Denlinger	Killion	Phillips	Walko
DePasquale	King	Pickett	Wansacz
Dermody	Kirkland	Preston	Waters
DeWeese	Kortz	Pyle	Watson
DiGirolamo	Kotik	Quigley	Wheatley
Donatucci	Kula	Quinn	White
Eachus	Leach	Ramaley	Williams
Ellis	Levdansky	Rapp	Wojnaroski
Evans, D.	Longietti	Raymond	Yewcic
Evans, J.	Mackereth	Readshaw	Youngblood
Everett	Maher	Reed	Yudichak
Fabrizio	Mahoney	Reichley	
Fairchild	Major	Roae	O'Brien, D.,
Fleck	Manderino	Rock	Speaker
Frankel	Mann		

NAYS–0

NOT VOTING–0

EXCUSED–11

Adolph	Lentz	Perzel	Taylor, J.
Cappelli	Marsico	Rubley	True
Hershey	Milne	Tangretti	

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

SUPPLEMENTAL CALENDAR A

RESOLUTION PURSUANT TO RULE 35

Mr. WANSACZ called up **HR 578, PN 3394,** entitled:

A Resolution honoring the life and achievements of Pacifico "Joe" Stella, of Pittston Township, Luzerne County, and expressing condolences on his passing.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–192

Argall	Freeman	Mantz	Roebuck
Baker	Gabig	Markosek	Rohrer
Barrar	Galloway	Marshall	Ross
Bastian	Geist	McCall	Sabatina
Bear	George	McGeehan	Sainato
Belfanti	Gerber	McI. Smith	Samuelson
Benninghoff	Gergely	McIlhattan	Santoni
Bennington	Gibbons	Melio	Saylor
Beyer	Gillespie	Mensch	Scavello
Biancucci	Gingrich	Metcalfe	Schroder
Bishop	Godshall	Micozzie	Seip
Blackwell	Goodman	Millard	Shapiro
Boback	Grell	Miller	Shimkus
Boyd	Grucela	Moul	Siptroth
Brennan	Haluska	Moyer	Smith, K.
Brooks	Hanna	Mundy	Smith, M.
Buxton	Harhai	Murt	Smith, S.
Caltagirone	Harhart	Mustio	Solobay
Carroll	Harkins	Myers	Sonney
Casorio	Harper	Nailor	Staback
Causer	Harris	Nickol	Stairs
Civera	Helm	O'Brien, M.	Steil
Clymer	Hennessey	O'Neill	Stern
Cohen	Hess	Oliver	Stevenson
Conklin	Hickernell	Pallone	Sturla
Costa	Hornaman	Parker	Surra
Cox	Hutchinson	Pashinski	Swanger
Creighton	James	Payne	Taylor, R.
Cruz	Josephs	Payton	Thomas
Curry	Kauffman	Peifer	Turzai
Cutler	Keller, M.	Perry	Vereb
Daley	Keller, W.	Petrarca	Vitali
Dally	Kenney	Petri	Vulakovich
DeLuca	Kessler	Petrone	Wagner
Denlinger	Killion	Phillips	Walko
DePasquale	King	Pickett	Wansacz
Dermody	Kirkland	Preston	Waters
DeWeese	Kortz	Pyle	Watson
DiGirolamo	Kotik	Quigley	Wheatley
Donatucci	Kula	Quinn	White
Eachus	Leach	Ramaley	Williams
Ellis	Levdansky	Rapp	Wojnaroski
Evans, D.	Longietti	Raymond	Yewcic
Evans, J.	Mackereth	Readshaw	Youngblood
Everett	Maher	Reed	Yudichak
Fabrizio	Mahoney	Reichley	
Fairchild	Major	Roae	O'Brien, D.,
Fleck	Manderino	Rock	Speaker
Frankel	Mann		

NAYS–0

NOT VOTING–0

EXCUSED–11

Adolph	Lentz	Perzel	Taylor, J.
Cappelli	Marsico	Rubley	True
Hershey	Milne	Tangretti	

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

BILL REPORTED FROM COMMITTEE, CONSIDERED FIRST TIME, AND TABLED

HB 2252, PN 3291 By Rep. CALTAGIRONE

An Act amending Title 23 (Domestic Relations) of the Pennsylvania Consolidated Statutes, further providing for child medical support, annual fees, review of orders of support, effect of incarceration, pass-through of support and assignment of support.

JUDICIARY.

RESOLUTION REPORTED FROM COMMITTEE

HR 559, PN 3109 By Rep. CALTAGIRONE

A Resolution urging the Pennsylvania Supreme Court to enact a rule of criminal procedure allowing written jury instructions pertaining to the elements of each crime charged and any relevant defenses to be provided to jurors for use as part of the deliberative process by the jury.

JUDICIARY.

The SPEAKER. The resolution will be placed on the active calendar.

BILLS REPORTED FROM COMMITTEES, CONSIDERED FIRST TIME, AND TABLED

HB 2297, PN 3347 By Rep. DALEY

An Act amending the act of October 6, 1998 (P.L.705, No.92), known as the Keystone Opportunity Zone, Keystone Opportunity Expansion Zone and Keystone Opportunity Improvement Zone Act, providing for extension for unoccupied parcels, for additional subzones authorized and for substitution of parcels; and further providing for sales and use tax and for corporate net income tax.

COMMERCE.

SB 612, PN 663 By Rep. STURLA

An Act amending the act of January 24, 1966 (1965 P.L.1527, No.535), known as the Landscape Architects' Registration Law, further providing for application for license and qualifications and experience requirements of applicants and for continuing education.

PROFESSIONAL LICENSURE.

BILL REPORTED FROM COMMITTEE

HB 2257, PN 3267 By Rep. STURLA

An Act amending the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, providing for regulation of small residential hospices and hospice for children.

PROFESSIONAL LICENSURE.

BILL REREFERRED

The SPEAKER. The Chair moves, at the request of the majority leader, that HB 2257, PN 3267, be rereferred to the Committee on Health and Human Services.

On the question,
Will the House agree to the motion?
Motion was agreed to.

HOUSE RESOLUTION INTRODUCED AND REFERRED

No. 639 By Representatives PAYNE, BAKER, BARRAR, BASTIAN, BEYER, BOBACK, CALTAGIRONE, CAPPELLI, CIVERA, COHEN, DePASQUALE, GALLOWAY, GEIST, GEORGE, GINGRICH, GODSHALL, GOODMAN, GRUCELA, HARHAI, HARKINS, HENNESSEY, HERSHEY, HESS, JAMES, KULA, LENTZ, LONGIETTI, MAHONEY, MAJOR, MANN, MARSHALL, MICOZZIE, MILLARD, MOYER, MURT, MUSTIO, MYERS, PYLE, RAMALEY, RAYMOND, READSHAW, REICHLEY, ROHRER, SAYLOR, SCAVELLO, SIPTROTH, SOLOBAY, SONNEY, SURRA, SWANGER, THOMAS, VULAKOVICH, J. WHITE, WOJNAROSKI, ADOLPH, GIBBONS and BROOKS

A Resolution urging the United States Department of Defense to support American companies when awarding contracts regarding the replacement of its fleet of Boeing KC-135 tankers.

Referred to Committee on INTERGOVERNMENTAL AFFAIRS, March 12, 2008.

HOUSE BILLS INTRODUCED AND REFERRED

No. 2150 By Representatives DALEY, BELFANTI, BEYER, BIANCUCCI, BRENNAN, CAPPELLI, CARROLL, CASORIO, CAUSER, CONKLIN, CREIGHTON, DePASQUALE, J. EVANS, FREEMAN, GEORGE, GIBBONS, GRUCELA, HALUSKA, HANNA, HARHAI, HARHART, HARKINS, HESS, HORNAMAN, JAMES, KING, KOTIK, KULA, LEACH, LENTZ, LONGIETTI, MAHONEY, MAJOR, MANDERINO, MANN, MARSHALL, McGEEHAN, McILVAINE SMITH, MELIO, MILNE, MOUL, MUNDY, MURT, MYERS, M. O'BRIEN, PALLONE, PASHINSKI, PETRONE, PRESTON, PYLE, READSHAW, ROCK, SAINATO, SCAVELLO, SCHRODER, SHIMKUS, SIPTROTH, K. SMITH, SOLOBAY, STABACK, SURRA, SWANGER, R. TAYLOR, THOMAS, WAGNER, WANSACZ, J. WHITE, WOJNAROSKI and YUDICHAK

An Act amending Titles 24 (Education) and 71 (State Government) of the Pennsylvania Consolidated Statutes, in retirement, providing for supplemental annuities in Fiscal Year 2008-2009 and for permanent cost-of-living increases in return for additional contributions.

Referred to Committee on EDUCATION, March 12, 2008.

No. 2351 By Representatives J. WHITE, MELIO, FAIRCHILD, GRUCELA, PALLONE, SOLOBAY, BRENNAN, REICHLEY, GEORGE, BELFANTI, GOODMAN, FRANKEL, BENNINGTON, READSHAW, CALTAGIRONE, McGEEHAN, CREIGHTON, HORNAMAN, YOUNGBLOOD, PETRARCA, BIANCUCCI, MAHONEY, KOTIK, SCAVELLO, MURT, M. SMITH, MYERS, HARHAI, KULA, HUTCHINSON, STURLA, SIPTROTH, JAMES, K. SMITH, BEYER and SEIP

An Act amending Title 51 (Military Affairs) of the Pennsylvania Consolidated Statutes, further providing for eligibility and qualification requirements.

Referred to Committee on VETERANS AFFAIRS AND EMERGENCY PREPAREDNESS, March 12, 2008.

No. 2352 By Representatives MUNDY, SEIP, DeLUCA, EACHUS, FRANKEL, GERGELY, HARKINS, JOSEPHS, McILVAINE SMITH, MILNE, MURT, MYERS, PASHINSKI, PETRONE, SHIMKUS, SIPTROTH, K. SMITH, SOLOBAY, SURRA, SWANGER and YOUNGBLOOD

An Act amending the act of July 9, 1987 (P.L.220, No.39), known as the Social Workers, Marriage and Family Therapists and Professional Counselors Act, further providing for the short title, for legislative intent, for definitions, for licensure, for the licensing agency and its functions, for licensure qualifications and procedure, for exemptions, for reciprocity and for license reinstatement; providing for restrictions on use of title "Licensed Social Service Worker"; and further proscribing unlawful practice.

Referred to Committee on PROFESSIONAL LICENSURE, March 12, 2008.

No. 2353 By Representatives BIANCUCCI, DeLUCA, SURRA, KOTIK, BELFANTI, BRENNAN, CALTAGIRONE, CARROLL, GEORGE, KORTZ, LONGIETTI, MAHONEY, McCALL, McGEEHAN, MOYER, MYERS, PALLONE, PARKER, RAMALEY, READSHAW, SANTONI, SIPTROTH, SOLOBAY, WALKO, YOUNGBLOOD, YUDICHAK, J. WHITE, WAGNER, PETRONE, HENNESSEY, EACHUS, K. SMITH and HARHAI

An Act amending Title 64 (Public Authorities and Quasi-Public Corporations) of the Pennsylvania Consolidated Statutes, further providing for indebtedness.

Referred to Committee on COMMERCE, March 12, 2008.

No. 2354 By Representatives PAYNE, BAKER, BELFANTI, BEYER, CAPPELLI, CREIGHTON, FLECK, GINGRICH, GRUCELA, M. KELLER, KOTIK, MAJOR, R. MILLER, MURT, PHILLIPS, PYLE, READSHAW, SAYLOR, SIPTROTH, K. SMITH, SOLOBAY, SWANGER, PETRONE, BOBACK, O'NEILL and VULAKOVICH

An Act amending Title 18 (Crimes and Offenses) of the Pennsylvania Consolidated Statutes, further providing for arson endangering property.

Referred to Committee on JUDICIARY, March 12, 2008.

No. 2355 By Representatives FAIRCHILD, PHILLIPS, BENNINGHOFF, BROOKS, CAPPELLI, CARROLL, CAUSER, EVERETT, GEIST, GEORGE, HUTCHINSON, LONGIETTI, McILHATTAN, MILLARD, RAPP, ROAE, SCAVELLO, S. H. SMITH, R. STEVENSON, BOBACK and HERSHEY

An Act amending Title 75 (Vehicles) of the Pennsylvania Consolidated Statutes, further providing for impact of Interstate 80 conversion on associated highways and roads.

Referred to Committee on TRANSPORTATION, March 12, 2008.

No. 2356 By Representatives MARSICO, BELFANTI, BROOKS, CAPPELLI, DALLY, EVERETT, FAIRCHILD, FLECK, GEIST, GEORGE, GOODMAN, HORNAMAN, KOTIK, MAHONEY, MICOZZIE, R. MILLER, MOYER, MYERS, NAILOR, PHILLIPS, READSHAW, ROAE, R. STEVENSON, SURRA, THOMAS, WOJNAROSKI, YOUNGBLOOD, RAPP, HENNESSEY, O'NEILL, VULAKOVICH and KORTZ

An Act amending the act of August 5, 1941 (P.L.752, No.286), known as the Civil Service Act, defining "veteran"; and further providing for composition of the State Civil Service Commission.

Referred to Committee on STATE GOVERNMENT, March 12, 2008.

SENATE BILL FOR CONCURRENCE

The clerk of the Senate, being introduced, presented the following bill for concurrence:

SB 1199, PN 1810

Referred to Committee on VETERANS AFFAIRS AND EMERGENCY PREPAREDNESS, March 12, 2008.

CALENDAR CONTINUED

RESOLUTIONS

Mr. DeWEESE called up **HR 465, PN 2690,** entitled:

A Resolution urging the Federal Emergency Management Agency to review and update state, county and municipal flood maps every ten years.

On the question,
Will the House adopt the resolution?

RESOLUTION TABLED

The SPEAKER. The Chair recognizes the majority leader, who moves that HR 465 be removed from the active calendar and placed on the tabled bill calendar.

On the question,
Will the House agree to the motion?
Motion was agreed to.

RESOLUTION REMOVED FROM TABLE

The SPEAKER. The Chair recognizes the majority leader, who moves that HR 465 be removed from the tabled bill calendar and placed on the active calendar.

On the question,
Will the House agree to the motion?
Motion was agreed to.

* * *

Mr. DeWEESE called up **HR 546, PN 3041,** entitled:

A Resolution urging the Congress of the United States to exercise due diligence on behalf of the citizens of this Commonwealth and of this nation by implementing oversight, inquiry and investigation into gas and energy prices to ensure that these exceedingly high prices are both necessary and ethically ascertained.

On the question,
Will the House adopt the resolution?

RESOLUTION TABLED

The SPEAKER. The Chair recognizes the majority leader, who moves that HR 546 be removed from the active calendar and placed on the tabled bill calendar.

On the question,
Will the House agree to the motion?
Motion was agreed to.

RESOLUTION REMOVED FROM TABLE

The SPEAKER. The Chair recognizes the majority leader, who moves that HR 546 be removed from the tabled bill calendar and placed on the active calendar.

On the question,
Will the House agree to the motion?
Motion was agreed to.

BILLS REMOVED FROM TABLE

The SPEAKER. The Chair recognizes the majority leader, who moves that the following bills be removed from the tabled bill calendar:

HB 2052;
HB 2053;
HB 2297;
HB 2252; and
SB 612.

On the question,
Will the House agree to the motion?
Motion was agreed to.

BILLS RECOMMITTED

The SPEAKER. The Chair recognizes the majority leader, who moves that the following bills be recommitted to the Committee on Appropriations:

HB 2052;
HB 2053;
HB 2297;
HB 2252; and
SB 612.

On the question,
Will the House agree to the motion?
Motion was agreed to.

VOTE CORRECTIONS

The SPEAKER. The Chair recognizes Representative Pallone.

Mr. PALLONE. Thank you, Mr. Speaker. I just want to correct the record.

On amendment 04861, my button malfunctioned. I was recorded as not voting. I wanted to be recorded in the negative.

The SPEAKER. The Chair thanks the gentleman. His remarks will be spread upon the record.

Mr. PALLONE. Thank you.

The SPEAKER. The Chair recognizes Representative Sturla.

Mr. STURLA. Thank you, Mr. Speaker.

Mr. Speaker, on amendment A4861 to SB 1137, my switch malfunctioned. I wish to be recorded in the negative.

The SPEAKER. The Chair thanks the gentleman. His remarks will be spread upon the record.

Are there any other announcements?

HOUSE SCHEDULE

The SPEAKER. The Chair recognizes the majority leader, Representative DeWeese.

Mr. DeWEESE. On scheduling.

The SPEAKER. Can we have the attention of the members, please?

Mr. DeWEESE. Next week, Mr. Speaker, on Monday, we are going to attack some insurance reform legislation. We are going to work on our economic stimulus package, especially the facet that deals with our KOZs, the keystone opportunity zones.

I would like to thank the House – Democrats, Republicans. We have had a productive week, sometimes strenuous, but nevertheless, we were able to send some energy legislation to the State Senate. We will conclude with our health-care debate, we hope, next week, and we hopefully will start doing some of the nonpreferred bills that are always a part of our budget package.

So drive safely, have a nice weekend, and we will reconvene on Monday.

The SPEAKER. Are there any further announcements?

BILLS AND RESOLUTIONS PASSED OVER

The SPEAKER. Without objection, any remaining bills and resolutions on today's calendar will be passed over. The Chair hears no objection.

RECESS

The SPEAKER. The Chair recognizes Representative Bennington from Allegheny County, who moves that this House do now recess until Monday, March 17, 2008, at 1 p.m., e.d.t., unless sooner recalled by the Speaker.

On the question,

Will the House agree to the motion?

Motion was agreed to, and at 7:30 p.m., e.d.t., the House recessed.