COMMONWEALTH OF PENNSYLVANIA

LEGISLATIVE JOURNAL

MONDAY, MARCH 17, 2008

SESSION OF 2008 192D OF THE GENERAL ASSEMBLY No. 20

HOUSE OF REPRESENTATIVES

The House convened at 1 p.m., e.d.t.

THE SPEAKER (DENNIS M. O'BRIEN) PRESIDING

PRAYER

The SPEAKER. The prayer will be offered by Bishop Joseph P. McFadden, who is the guest of Representative Tim Hennessey and the Irish Caucus.

BISHOP JOSEPH P. McFADDEN, Guest Chaplain of the House of Representatives, offered the following prayer:

Let us bow our heads and pray for God's blessing:

Almighty God, You are the source of all goodness and love. Today we come before You, knowing that You are always with us and ever attentive to our needs. As we gather on this day, we also celebrate all those in our Commonwealth with Irish heritage. We join with them in recognizing their patron saint, St. Patrick, at his great faith in You.

We ask You, Lord, to help us always to appreciate the gift of every human life and the various ethnic peoples and cultures that make up the mosaic of the world You have made. May we always appreciate the diversity of gifts that come to us from all the different nationalities and peoples that have immigrated to this great nation seeking life, liberty, and the freedom to pursue their dreams without fear.

As our Representatives gather today, give them the wisdom and knowledge to be effective in fashioning laws that truly reflect the furtherance of the common good. Help them to be courageous in seeking all that is truly right and just, and may their work be fruitful for all the people of Pennsylvania.

On this day, when we recognize the contributions of the Irish, especially here in the Commonwealth, we call upon You to be with our legislators. In the words of St. Patrick, we ask that you pilot their efforts. We pray that Your might will uphold them, Your wisdom will guide them, Your eyes look before them, Your ear to hear them, Your word to speak in them, Your hand to guard them, Your way to lie before them, Your shield to protect them, Your host to secure them, against the snares of devils, against temptations of vice, against inclinations of nature, against everyone who shall wish them ill, afar and near, alone, and in the multitude.

Heavenly Father, on this day, we ask that for our Representatives, the road may rise before them, that the wind may always be at their back, and that You will forever hold them in the palm of Your hand. We ask this in the name of the Lord. Amen.

PLEDGE OF ALLEGIANCE

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

JOURNALS APPROVED

The SPEAKER. The Journals of Tuesday, September 25; Wednesday, September 26; Thursday, September 27; Monday, October 1; Wednesday, October 3; and Thursday, October 4 of 2007 are now in print. Will the House approve those Journals?

On the question,
Will the House agree to the motion?
Motion was agreed to.

JOURNAL APPROVAL POSTPONED

The SPEAKER. Without objection, approval of the Journal of Wednesday, March 12, 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 CRUZ from Philadelphia be placed on leave for today. The Chair sees no objection. The leave will be granted.

The Chair turns and recognizes the minority whip, who requests that Representative TRUE of Lancaster County, Representative GEIST of Blair County, and Representative PETRI of Bucks 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.

The following roll call was recorded:

PRESENT–199

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

ADDITIONS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Petri	True

LEAVES ADDED–5

Dally	Hennesssey	Kotik	True
Ellis			

LEAVES CANCELED–4

Ellis	Kotik	Petri	True

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

GUESTS INTRODUCED

The SPEAKER. May I have the attention of the members of the House. I would like to welcome to the hall of the House a group of Blue Hens from the University of Delaware. These guests are seated in the rear of the House. They are touring the Capitol today in conjunction with their masters of public administration studies at the University of Delaware. As part of their studies, they are working as legislative fellows in the Delaware Legislature. Their trip today is coordinated by Shelly Cook, a former intern in the Speaker's Office – welcome back, Shelly – and by Dr. Jerome Lewis, director of the university's Institute for Public Administration. Would you please rise and be recognized.

Also, we would like to welcome to the floor of the House, as the guests of Representative Glen Grell, students from Camp Hill High School participating in the German American Partnership Program. These students are from Altenburg, Germany, and are the guests, as I said, of Representative Glen Grell. They are in the balcony. Would you please rise and be recognized.

ST. PATRICK'S DAY PROGRAM

COYLE SCHOOL IRISH DANCERS PRESENTED

The SPEAKER. At this moment the Chair would like to invite Representative Hennessey, who is chairman of the Irish Caucus, along with Representative Killion, who is the treasurer, to come forward, and I would ask Representative Hennessey to take the rostrum for today's festivities.

Mr. HENNESSEY. Thank you, Mr. Speaker.

Ladies and gentlemen of the House, we have a treat for you today. By the way, happy St. Patrick's Day. We have a treat, so let me— Okay. We will take a round of applause. That is fine.

Mr. Speaker, Your Excellency, Bishop McFadden, the head of education for the Archdiocese of Philadelphia joins us today. Ladies and gentlemen of the House and assorted staff, without whom we probably could not get much done here in the House, happy St. Patrick's Day again.

I want to thank Speaker O'Brien for allowing us a few moments to indulge ourselves in a bit of Irish tradition here. Although I will note that with a name like O'Brien he really did not take a whole lot of coaxing in order to allow us to bring in some dancers for you from the Coyle School of Irish Dance, here in Harrisburg.

Girls, if you are ready. I think we are going to do a slip jig and a reel, or rather, maybe a reel first and then a slip jig. The dance is going to be led off by Reilly Allen, and – I have her permission; I have all the girls' permission to tell you their ages – Reilly is 12 years old, Erin Ulrich is 11 years old, and Abby Jordan and Patrice Lonardi are 10 years old, from the Coyle School of Irish Dance. Manning the music is Reilly's sister, MacKenna, who danced for us a few years ago on the House floor. So first we will have a reel from the Coyle School of Irish dancers.

(The reel was performed by Coyle School Irish Dancers.)

Mr. HENNESSEY. Thank you, girls. And now we are going to have a slip jig.

(The slip jig was performed by Coyle School Irish Dancers.)

Mr. HENNESSEY. Thank you, girls. Good kids doing good things. We read a lot of things in the newspaper and some of that information is bad or not always the most flattering, but it is nice to see good kids doing good things, and there are a lot more good kids in the Commonwealth of Pennsylvania doing good things than the ones who get the news.

On behalf of Tom Killion and myself, on behalf of the Irish Caucus of the Pennsylvania House of Representatives, thank you very much for being an appreciative audience. Thank you, girls, for dancing – Patrice, Abby, Reilly, and Erin – and MacKenna for manning the CD (compact disk) player. Thank you very much, and these girls are from the Coyle School of Irish Dance in Harrisburg. We should also thank their parents because the parents are the ones who shell out the money to pay for these colorful outfits and to pay for the dancing lessons, but you are keeping a tradition alive here in the Commonwealth, and thank you very much for that. Thank you all.

Thank you, Mr. Speaker.

ANNOUNCEMENT BY MR. BOYD

The SPEAKER. For what purpose does the gentleman, Representative Boyd, rise?

Mr. BOYD. Mr. Speaker, pursuant to rule 53, I rise today to announce to all the members of the House that I plan to call up House Discharge Resolution No. 2 for a vote tomorrow.

The SPEAKER. The Chair thanks the gentleman.

Will the gentleman approach the rostrum.

(Conference held at Speaker's podium.)

CALENDAR

BILL ON THIRD CONSIDERATION

The House proceeded to third consideration of **SB 1137, PN 1827,** 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; 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.

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

Mr. **EACHUS** offered the following amendment No. **A06326:**

Amend Sec. 2 (Sec. 712), page 30, lines 11 and 12, by inserting a bracket before "THESE" in line 11 and after "(E)." in line 12

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.

This was a drafting problem that we identified during debate, that was an LRB (Legislative Reference Bureau) issue; very technical in nature. I would appreciate the membership's support. Thank you.

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

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Petri	True

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 third consideration as amended?
Bill as amended 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?

Mr. S. SMITH. Mr. Speaker?
The SPEAKER. The Chair recognizes the minority leader, Representative Smith.
Before the gentleman begins his remarks, the Chair will ask all members to take their seats. Members will please take their seats.
The Chair recognizes the minority leader, Representative Smith.
Mr. S. SMITH. Thank you, Mr. Speaker.
Mr. Speaker, on SB 1137, I just had a few comments. I was not sure if other members were intending on debating this. I realize that it received quite a bit of debate and discussion last week. However, in spite of that, Mr. Speaker, I do not think a lot of those concerns have readily been addressed, nor do I think, Mr. Speaker, that the various – excuse me, Mr. Speaker – or have the various concerns been completely addressed. As a matter of fact, I think some of them have actually probably increased.
When I look at this legislation, Mr. Speaker, it seems to me that there are two different ways that you can go about addressing the issue of health care, and I guess it depends a little bit on what one's definition of that issue is. In my mind, it deals with two key components. One is the actual cost of health-care insurance, and the second is the availability of that to the individuals, to the citizens of Pennsylvania.
As we have talked in the past week or so, the House Republicans have put forth a plan that would achieve those very much stated goals. They would do it without creating that huge bureaucracy, without looking at spending over a billion dollars in the next few years to basically bail out of one insurance program, the Mcare (Medical Care Availability and Reduction of Error) program, while digging ourselves that same hole on an ensuing program. Mr. Speaker, the proposal that the House Republicans have put forth would do all of this through the competitive marketplace, through putting more individual responsibility into the system as opposed to what SB 1137 as amended does, and I think it is important for us to make those distinctions.
This legislation, Mr. Speaker, does not even begin to take effect until $120 million has been appropriated by the General Assembly to start it. Secondly, Mr. Speaker, this legislation is woefully underfunded, even in its first year, if a Federal waiver is not achieved, and quite frankly, it is very debatable if that Federal waiver would be awarded, given the parameters set forth in this legislation. I would add to that, Mr. Speaker, that even given those two constraints, the fact that the Federal waiver, that that money that I believe represents 40, 45 percent of the cost of operating this program, even though that is not approved and we have not approved the $120 million, which is somewhere out there – I guess it is somewhere in the belly of the Governor's budget; I certainly did not see that being identified – but on top of that, Mr. Speaker, this legislation requires us to increase spending significantly over the next few years.
It is in fact, Mr. Speaker, a tax increase waiting to happen. In the House Republicans' plan, we can get from here to there without looking at those kinds of tax increases, without relying on a Federal waiver, and without initially having to appropriate $120 million to initiate this program.
Mr. Speaker, I noticed that as we lamented last week, the amendment that is the embodiment of the bill at this point was just brought forth at a fairly late date and without a lot of time to really digest it and scrutinize it. And while we discussed that last week, Mr. Speaker, I do note that quickly after the enactment of the legislation, that some of the groups that are interested in this have certainly perked their ears up a little bit. The physicians around the State recognize that this legislation does not achieve the goals that they were looking at. They are concerned about the fact that in order for them to participate in the Mcare program, that they are tied into, they are tied into this program as well as the Medical Assistance Program.
Mr. Speaker, I think they are concerned with the fact that this legislation does nothing, does nothing to resolve the immediate concerns relative to the Mcare program. We have all come pretty far on figuring out how to phase, an agreeable way to phase out Mcare. This legislation, because of the triggering mechanism, because of the fact that it does not become effective until the $120 million is appropriated, this legislation will do nothing to address that concern over the next couple of months. Clearly, the abatement assessments are out and those bills are due, and I think we are sending a very, very bad message to the health-care providers in Pennsylvania.
Mr. Speaker, I guess that is probably driven by the fact that the administration has been absolutely insistent on the fact that the Mcare issue is absolutely tied to his Cover All Pennsylvanians proposal, even though we all know that his plan, his own people admit that his plan does not cover all Pennsylvanians. This plan does not cover all Pennsylvanians. It maybe covers more, but it does not cover all. The Republican plan arguably covers more, arguably would make more health-care insurance more accessible and more available to people across Pennsylvania.
So we have the doctors, the medical community, who are now concerned with this as they have got a better chance to digest it. Their concerns are valid.
Mr. Speaker, I see that the Pennsylvania Farm Bureau has sent out a letter. One of the key comments, they are asking that this legislation be postponed, that "time is needed to address and resolve potentially harmful impact of the legislation on an existing group health insurance program…." The Farm Bureau's letter, which is dated March 14, 2008, goes on to say that "Although the 'Pennsylvania Access To Basic Care' Program (PA ABC) which would be created by Senate Bill 1137 differs in many respects from the Cover All Pennsylvanians initiative, its potentially harmful impact on the future of Farm Bureau's group health

insurance program is the same." Mr. Speaker, as I read that, my interpretation, my understanding of their letter is that the Farm Bureau is concerned that this legislation, as well as the Governor's Cover All Pennsylvanians proposal, would indeed have a negative impact on the availability of insurance, health insurance that individual farmers might be able to have. Now, they are probably a special group in some respect in that, as an individual farmer, they probably do not qualify under the grant program that SB 1137 possesses, that is available to small businesses, because of them being individuals. So when you are looking at a health-care proposal, a plan that is supposed to make insurance more affordable and more accessible to individuals, clearly their concerns are that this is going to make it less accessible and maybe less affordable to individual farmers who need to be a part of a group plan through something like this to make it affordable but would not qualify under the business grant program that is proposed as part of SB 1137.

Mr. Speaker, speaking of the grant program, I have been asking some questions. I read through that last week before the amendment ran, and I have to say, Mr. Speaker, I have a tough time figuring out what small businesses are actually going to benefit from that grant program. It sounds good on the surface, but when you really look at it, it is going to have the reverse impact. Small businesses that are struggling and maybe not making a profit year to year to year in the same vein, or maybe their program changes, the business operation changes significantly from year to year, those individuals are not going to be eligible for assistance under this program. It may even be possible, Mr. Speaker, that the net effect of the grant program that is proposed in SB 1137 would actually be of more benefit to a business who is doing well than to a business who is struggling to make ends meet.

Now, I do not know if you have talked to businesses in your district about this, with the short notice that we have had to digest how this grant program – which, of course, its intention is to provide a benefit to help small employers continue to provide health insurance to their employees. That is an excellent stated goal, Mr. Speaker. It is one that the House Republican plan addresses and, I think, addresses in a more comprehensive and balanced manner. The grant program that is provided in this legislation, Mr. Speaker, is so convoluted that I have got to think it is one of those things where the small business guy, that guy in your district who maybe has 12 or 15 employees, who is working day and night just to keep them going – the kind of guy who almost is not even in business for himself anymore. I have these businesses in my district, Mr. Speaker. They are practically not in business for themselves anymore. They are in business to keep a dozen or two dozen or 30 or 40 employees working.

The SPEAKER. Will the gentleman suspend. The noise level is entirely too loud. Members will take their conversations off the floor. Conferences in the side aisles will break up. The gentleman is in order and may proceed.

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

Mr. Speaker, just to conclude that point, I know businesses in my district, and I am not saying the guy is working for nothing, but I can tell you whenever you go talk to them and they are facing certain issues in their business world, that most of them, several of them, they feel as committed to staying in business to keep those families who are the beneficiary of their employees, to keep them afloat, to keep them in business, to keep them working.

I know businesspeople who have a small business that they would just, the smart thing for them to do would just be to sell the business out, cash in, and go south. But they stick around, not because they are making so much money they cannot quit, but because they have a commitment to their community. Those are the types of people that we need to be enhancing. Those are the types of businesses that we need to be providing incentive for them to be able to do this in a right and proper way. This grant program that is provided in this bill, Mr. Speaker, does not accomplish that. I appreciate that the intent is well meant, but, Mr. Speaker, it simply does not get us where we need to go.

Lastly, Mr. Speaker, I guess I am a little bit concerned that the reason this legislation is in such a rush and the reason that we are going to ignore some of the concerns that have been raised in just a few days of the actual language being available, in less than a week, in less than a week of the language actually being available for the concerns to be raised and not addressed, it bothers me, Mr. Speaker, that this is just something that we have to move promptly because it is election season, because the Governor needs to be able to show some movement on his health-care plan so that he has some leverage with the Senate.

Mr. Speaker, this House has a stronger duty than that, Mr. Speaker. We have a duty beyond just giving leverage to the Governor. That is not what our job is. Our job is to look at these issues in a comprehensive manner and try to put forth the best plan possible. Mr. Speaker, this legislation is not the best job we can do. At best, Mr. Speaker, it is a message that health-care availability, affordability, is an issue in Pennsylvania. Yes, Mr. Speaker, we carry that same message. But I think, Mr. Speaker, we need to make this legislation better. We need to go farther, Mr. Speaker. It is too big an issue for us just to punt this to the Senate and say, you guys figure out how to do this best; you guys worry about it; we are just going to send something that says health care, then we can all go home and put it in our newsletters or whatever and say, I voted for a comprehensive health-care plan that will cover all Pennsylvanians, even when we know if you say that, you are lying through your teeth. It is not going to cover all Pennsylvanians. It is not going to address all the issues that face the Pennsylvanians who are in need of affordable and accessible health care. As a matter of fact, Mr. Speaker, it is going to threaten some of those that currently have insurance. It is going to put them in jeopardy as we look at the crowd-out issue.

So, Mr. Speaker, because of those concerns I would ask the members to vote against SB 1137, and let us try to do this right, as opposed to doing what is politically expedient in election season, Mr. Speaker. Thank you.

LEAVE OF ABSENCE CANCELED

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

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER. Representative Beyer.

Mrs. BEYER. Thank you, Mr. Speaker.

It is a little intimidating following my leader on this issue, but if Representative Eachus would stand for a brief interrogation.

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

Mrs. BEYER. Thank you, Mr. Speaker.

Can you tell me the total amount of uncompensated care that hospitals spend each year, or at least, perhaps, even last year or in 2006, on patients who had no health coverage at all?

Mr. EACHUS. Let me just make sure I have your question correct. You are asking for the amount of uncompensated care that hospitals in our system have statewide, Mr. Speaker?

Mrs. BEYER. Yes.

Mr. EACHUS. That would be about $1.4 billion a year.

Mrs. BEYER. Do you believe that if we move this bill to the Senate and we recognize that the Senate will, I am sure, do their due diligence and work on it, do you believe that if we pass some kind of health-care plan for individuals who have no insurance, that we may see, in fact, see a reduction in what the State budget allocates for medical assistance every year?

Mr. EACHUS. Well, it is possible, but the clear fact is that 71 percent of uninsured adults are employed in Pennsylvania. So many of them are not medical assistance qualified, and the trouble is, for small businesses, that the rising cost of small business insurance continues to outstrap responsible small businesses' ability to pay.

I would hope that it might be an unintended outcome, but the real clear issue is to try and cover more people who are working, hardworking families in Pennsylvania, but just cannot afford health-care access.

Mrs. BEYER. Thank you, Mr. Speaker. That ends my interrogation. May I speak on the bill, please?

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

Mrs. BEYER. I am going to vote for SB 1137 on final passage, and I just want to tell everyone briefly why.

Approximately 30 percent of the residents of the Lehigh Valley, which I am proud to represent, being one of the Representatives, approximately 30 percent of those folks are uninsured. Lehigh Valley Hospital and Health Care Network, St. Luke's Hospital and Health Care Network, Sacred Heart Hospital – those three hospitals alone, every year, spend approximately $50 million in uncompensated care. That is money that they cannot establish community health-care clinics. That is money they cannot use for flu shot clinics. That is money that they cannot spend on research and development. That is money they cannot spend on telehealth medicine. That is money that these hospitals cannot reinvest in their facilities, into their equipment.

Mr. Speaker, it is time to stop kicking the can down the road. We know that the lack of health care, those folks that are uninsured in the State of Pennsylvania is an incredible drain on our economy. It is time for this legislature to stop kowtowing to special interest and to stand up for the people that they represent, the people that voted them here. I can tell you that I have 30 percent of my constituents that have no health care. I think it is important for this legislature to take this step to move this bill to the Senate, to force the Senate to look hard at it, to figure out a compromise so that we can send a proper health-care bill to the Governor. It does not make any sense, and in fact, it is contradictory that this legislature, last year— Mr. Speaker, may I have order?

May I have order, please, Mr. Speaker? I would like to—

The SPEAKER. The lady is correct. Once more, the Chair will ask the members to please hold their conversations to a minimum. If they are necessary, please take them to the anteroom.

Representative Beyer.

Mrs. BEYER. Last year, this legislature passed Cover All Kids, because we believed that we should have healthy children in Pennsylvania. To me, it is a contradiction to have unhealthy parents raising healthy children. It makes absolutely no sense. We have an obligation to the citizens of this Commonwealth, and I think it is vitally important that this legislature move to do something. We know that this will not be the final bill that we see. But I have great confidence that the Senate is willing to do something, and it is the obligation of the House of Representatives to send them a bill that they can work with. The United States is 44th in the world in the health of its citizens. It is time the great Commonwealth of Pennsylvania stepped forward and did something.

And finally, Mr. Speaker, I wanted to thank Representative Eachus for his hard work last week. He stood for 8 hours debating this bill, and oftentimes he was given invective instead of dialogue, and I would like to thank him for all that he did last week.

Mr. Speaker, I urge my colleagues to vote affirmatively for this bill. Thank you, Mr. Speaker.

The SPEAKER. The Chair thanks the lady.

GUESTS INTRODUCED

The SPEAKER. The Chair would like to recognize, as the guests of the minority whip, Representative Argall, Tom Cara, who is a member of Tamaqua's Borough Council, and Seyi Kayode from Nigeria. They are seated to the left of the Speaker. Would you please join in welcoming them to the floor of the House.

ANNOUNCEMENT BY SPEAKER

The SPEAKER. The Chair would also like to announce Rabbi Isaacson, as promised last week, has presented the House with hamantashen in honor of Purim, and the pages will be distributing those to the members.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER. Representative Turzai.

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

First of all, I would like to wish all my colleagues and those listening today, happy St. Patrick's Day.

On the bill, Mr. Speaker. Mr. Speaker, with all due respect, I do recognize that we want to make sure that quality health care is available to as many persons as possible, and I do applaud that goal, and I share that goal with my colleague from the Lehigh Valley who just spoke. She spoke passionately and she cares. I do, however, think that the paradigm that we are headed down today is not really the appropriate approach. The Democratic plan ultimately wants government-run, government-mandated health care. The Democratic plan pretends that it can provide health care that is universal and inexpensive and maintain top-quality health care by having the government manage it and fund it with your tax dollars. This is fiction. There is no utopian government plan that will provide health care that is inexpensive, universal, and maintains top quality. That is why Hillary Clinton's plan failed so miserably.

In fact, under this plan, there will be, one, more uninsured individuals than we presently have today. Two, it will be more expensive and you will be paying it with your tax dollars. And

three, there will assuredly be less quality in terms of the delivery of the health care.

With respect to the uninsured, why will there be more uninsured? The Democratic plan will result in less insured, not more, by promoting what is called the crowd-out. Crowd-out is not good. 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.

Second, why will it be more expensive? Mr. Speaker, the Governor originally proposed a tax on employer's payroll, then shifted to a tax on cigarettes, on tobacco. There will be other taxes coming out of the General Fund, which is your personal income tax, your sales tax. Ultimately, somebody has to pay for government-run, government-mandated health care.

Third, and in many ways the most important issue here, there will be less quality, make no mistake about it. Government bureaucrats have never made decisions about the delivery of health care better than health-care providers and their patients. I ask each of you as Pennsylvanians, do you want the government to ultimately be making the decisions about your health care?

The Republicans want to make sure that the patients receive top-quality health care. They want the best medical specialists, the best doctors, the best nurses, and the best hospitals. We want great medical care that continues to be delivered in a prompt manner. Remember, time is of the essence for health-care treatment to be top quality.

The Democratic plan will ultimately push us to socialized medicine with long waiting lines, denied services, and less skilled care. Go look at Europe. There will be fewer health-care providers under a socialized medicine approach. These professionals, in the end, do not want to work for the government as technicians.

Now, if we are serious about promoting, going from 93 percent insured to 100 percent insured, and if you want to do something that is really bold, I think there has to be a discussion about requiring that every citizen of Pennsylvania, adult citizen, must secure health insurance, whether it be through their employer or through an individual plan.

But make sure that they are able to obtain their health insurance through the private sector, health brokers, health insurance agents, and also that they can get the delivery of that health care through private-sector hospitals, health-care providers, nurses, et cetera.

I think this is the wrong paradigm. I would urge a "no" vote. I do applaud everybody's objective in trying to make sure that top-quality health care is available for all, but this is not the correct approach.

Thank you very much, Mr. Speaker.

The SPEAKER. Representative Thomas.

Mr. THOMAS. Thank you, Mr. Speaker.

Mr. Speaker, I listened very attentively to the last speaker and to the speaker before that and to the minority leader, and as I listened to them, Mr. Speaker, the question that kept going over and over in my mind, and that is, against the fact that there are over 800,000 people in this great Commonwealth without access to affordable health insurance, the question, the primary question that I must ask, if not now, then when? If not by this august body, then who? And if not this proposal, what other proposal?

Now, we have had several proposals made, but I do not know of any alternative proposals that have the realistic capacity to reduce the 800,000 pool of uninsured Pennsylvanians by more than 200,000. I do not know of any alternative proposal that is able to do that. And, Mr. Speaker, yes, it is going to cost money, some of which is not included in SB 1137, but, Mr. Speaker, can we afford to go another day, another week, another month, without taking affirmative steps to deal with the growing uninsured population in Pennsylvania.

And, Mr. Speaker, we have to thank the Governor for his stewardship in advancing Cover All Kids. I have to thank the members of the House Intergovernmental Affairs Committee, both Republicans and Democrats, who, once Cover All Kids was advanced, immediately moved to request the Federal government provide Pennsylvania with an expeditious waiver that would allow for implementation of Cover All Kids. I have to thank both Republicans and Democrats who moved immediately on that.

And I cite that, Mr. Speaker, because I strongly believe that the issue of health care for the uninsured is not a Republican or Democratic issue. It is a people's issue. It is the welfare, the future, the stability of our great Commonwealth that is at stake, because, Mr. Speaker, people who cannot access affordable health care cannot go to work, cannot deal with their families, cannot deal with their communities, and, Mr. Speaker, it has a rippling effect on the economy, a rippling effect on the working community, a rippling effect on families across this great Commonwealth.

Mr. Speaker, yes, it is going to cost money, but, Mr. Speaker, we are not relying on, we are not putting the burden all on one source to meet the growing cost of universal health care in Pennsylvania. It is spread out. There will be additional dollars on cigarettes. There will be additional dollars on tobacco products. There will be some movement with the Mcare Fund. There will be some other options that we will have to consider. But, Mr. Speaker, what is required on Monday, March the 17th, is that we step forward and bring sunlight to this issue rather than continuing down this path of darkness.

Who are the 800,000 uninsured, Mr. Speaker, in Pennsylvania? Mr. Speaker, they are the maintenance workers, cafeteria workers, pages, our security that work in those capacities but in the private sector. They are hardworking people who happen to work for small employers that cannot provide health-care insurance. So, Mr. Speaker, as we walk through this great Capitol, on the House side and the Senate side, and we look at these everyday workers and smile with them, Mr. Speaker, recognize that there are those who are similarly situated in the private sector that are without health insurance.

The 800,000, some of the 800,000, Mr. Speaker, are single moms who are working two and three jobs, paying minimum wage, with employers who are unable to provide health insurance. Mr. Speaker, they are people who have faced catastrophes in the last 12 months or in the last 2 years, who, through no fault of their own, are unable to maintain affordable health insurance. Mr. Speaker, those are the 800,000 people. I thank God that none of the 203 in the Pennsylvania House or the 50 in the Pennsylvania Senate are a part of the 800,000, because we have looked out for ourselves. We have looked out for ourselves.

So, Mr. Speaker, I am talking about folks who have not been as blessed as we have but cannot afford to wait another day without relief coming to them. Those are the 800,000, Mr. Speaker. Those are the people in our communities, whether it is Elk County or whether it is Montgomery County, that need help, that need help, that are not begging, not looking for a handout but looking for a hand-up. Mr. Speaker, as lawmakers, as lawmakers we have been

endowed with the power to do something about this most critical issue in the Commonwealth of Pennsylvania. Let us take our responsibility and our obligation as strong for others as we have taken it for ourselves.

Mr. Speaker, if not for the least of these, then whom do we really represent? And, Mr. Speaker, money will always be an issue, it will always be an issue, but the constituents that I have talked to have said that there are some issues, there are some issues that they do not mind paying a couple dollars more, that they do not mind some sacrifice as long as the sacrifice makes life better for Pennsylvanians.

SB 1137 is an affirmative step to making life better in the Commonwealth of Pennsylvania. SB 1137 has no meaning without Cover All Kids. Cover All Kids was step one. This is step two, because we have been waiting for the Federal government and we know, Mr. Speaker, that as long as the Federal government stays on this track that it is on, then States are going to see lesser and lesser and lesser dollars and resources to help States with issues like the growing population of uninsured. We know that.

So, Mr. Speaker, it is more incumbent upon us to do that which is in the best interest of Pennsylvanians. And so I urge my colleagues on both sides of the aisle, do not treat this as an "R" or a "D" or as an "I." Treat this as standing up, standing up; there come those moments in life when we have to do not what is comfortable and convenient, but do what is controversial. Do what is not right there in front of us. We have to do what is right, rather than what is politically expedient. It would be politically expedient to wait another day. It would be politically expedient to go back to another hearing. It would be politically expedient to wait till next year. It would even be politically expedient to wait till we had $120 million. That is the politically expedient thing to do. But the right thing to do for the people of Pennsylvania is to move SB 1137, start the negotiations, and say to Pennsylvanians, from one end to the other, now is the time, now is the time that we are going to make universal health care a reality in the Commonwealth of Pennsylvania. Not now, then when? Not us, then who? If not this proposal, if not this proposal, then what proposal? I do not know of any others that would reach as many people.

Thank you, Mr. Speaker.

The SPEAKER. Representative DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support SB 1137 and I do so and I hope this—

The SPEAKER. The gentleman will suspend. The Chair will ask again for members to hold their conversations to a minimum.

Representative DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

And I do so and I hope this body does it bipartisanly, voting on this bill. You know, Mr. Speaker, the Pennsylvania Assembly has made significant progress in recent years, bipartisan. You heard a couple of my colleagues mention the fact that we passed Cover All Kids, thereby making private health insurance available to every Pennsylvania child and opening the door for them to receive wellness services and preventive care. Now, when we were doing the argument on Cover All Kids, we heard all kinds of arguments why we should not be initiating this program. Yet, it is a program we can all be proud of.

We also passed legislation, bipartisanly, to reduce the frequency of hospital-acquired infections and expand the scope of practice for nurse practitioners and other professionals, thereby trying to reduce the cost, and that is what we are talking about, Mr. Speaker, when we talk about health-care cost. We need to reduce it. And this General Assembly did that bipartisanly. We also passed Act 13, and my good friend, Representative Micozzie, was the leader of that. And what that did, Mr. Speaker, it reduced the frequency of medical malpractice claims and the cost of such litigation, besides other things to reduce costs.

And, Mr. Speaker, we have made substantial progress, yet we have not done it yet, towards passing the statewide smoking ban. Hopefully we can get that done and reduce health-care costs. Now, the next step we are talking about is this bill here, 1137. We are trying to broaden participation for working men and women to have, and I say this to you, working men and women, to have access to health care.

Now, not only does that save us money, because today every family pays $1,000 for the uninsured when they go to the emergency room, and we pick it up in our health-care costs; approximately $400 for an individual goes on his health-care plans because of uncompensated care. So what we are actually doing today is trying to reduce costs. Now, I have heard this stated by my good friend, the minority leader, saying it is election season. Well, Mr. Speaker, maybe thank God it is election season, and maybe we will get something done for the uninsured who need this coverage, because it certainly has not been done in the last 12 years.

I also heard from my good friend up here, from Philadelphia, talking about money. Hopefully this will save us money. It will save us money not only because of the fact we cut down on compensated care; it will save our employers money because of the fact their employees will not have to wait until they get too sick, end up in the emergency room, and then they lose the production of these employees. That costs small businesses a tremendous amount of money, which they cannot afford to absorb.

So, Mr. Speaker, this is a win-win situation. And I hope it is a piece of legislation that, once again, we can pass bipartisanly. And if you have an alternative that you want to do, you certainly have a Republican Senate over there that you can put in there to try to make the bill better if you think this does not go far enough. So I am asking for an affirmative vote on this. Thank you, Mr. Speaker.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I rise to oppose final passage of SB 1137, and I do so based on some facts, Mr. Speaker. And the first fact about SB 1137 is it ignores the 70 percent that were identified in the Office of Health Care Reform as their major concern with why there is an inaccessibility to health insurance is because it costs too much. The overwhelming majority, 70 percent, by the administration's own office, said the single largest concern is the cost of health care and health insurance, and SB 1137 does absolutely nothing to control the cost of health care and health insurance. In fact, in the members across the aisle's own talking points, the primary identified issue on controlling costs has to do with fewer people using emergency rooms.

Mr. Speaker, I will share with you, on the House Republican Task Force, we had a brilliant piece of legislation introduced by my good friend, Representative Evans, John Evans, from Erie, that would absolutely deal with the overutilization of emergency rooms. Mr. Speaker, that bill received not one hearing. There was no discussion about SB 1137, even though repeatedly the administration said we love the ideas behind Representative Evans's bill; not one hearing, Mr. Speaker.

Let me talk to you about another fact, Mr. Speaker. SB 1137 does not identify a sustainable funding mechanism. Mr. Speaker, please let me read to you from the legislation itself, under the funding mechanisms: "ANY MONEYS DERIVED FROM WHATEVER SOURCES AND DESIGNATED SPECIFICALLY TO FUND THE PROGRAM." Mr. Speaker, we are going to put into law that language, that any money that is derived from any methods – let me read it again – "ANY MONEYS DERIVED FROM WHATEVER SOURCES AND DESIGNATED SPECIFICALLY TO FUND THE PROGRAM." Mr. Speaker, I heard a good friend of mine from Lancaster County reference holding people upside down by their legs and shaking the last dime and penny out of their pocket to pay for this program.

Mr. Speaker, let me go on and say there is no real answer in this legislation to the issue with crowd-out. There is no answer in this legislation to what happens to an employer who finds himself in a position where it is cheaper to move his individuals off of the private pay program and into ABC or PA ABC. Last week when we heard about this bill, I asked some questions on the floor. What is to stop a business from reincorporating under a different name, filing, changing from an S corp to a limited liability partnership? There were no answers.

Mr. Speaker, another question that there were no answers to is, this legislation gives preference to individuals who are on other government programs. If they move off of MA (medical assistance), they are automatically accepted into PA ABC. What happens if there is no room, Mr. Speaker? If it is not an entitlement, if it is not an entitlement and there is a waiting list, but this immediately says people who move off of MA get in, does that mean somebody gets kicked out, Mr. Speaker? Is there any method in here to have somebody removed from PA ABC? There are not answers to these questions, Mr. Speaker. There are no facts to back this legislation up. There are no answers to the issue with reimbursement concerns.

Every hearing that the Insurance Committee heard, the testimony was the same, that inadequate reimbursements for MA and Medicare patients is cost shifted to the private payers, in effect raising costs. I would argue, Mr. Speaker, that when fully implemented, PA ABC will actually increase the cost of health care. It will increase it because it will be a further tax or a further cost shift to the private sector. Physicians, medical professionals, insurance companies, all have testified in insurance hearings that that is a fact.

Mr. Speaker, there are about five things I just identified. As I say that, Mr. Speaker, I want to say this. I really do applaud the administration for coming up with its programs about a year ago, over a year ago. When I first got elected in 2002 and was sworn in in 2003, the number one issue on my mind was the cost of health care. As a small employer, I endured the ever-increasing premiums that my business was paying to cover its families, its employees and their families. Mr. Speaker, in fact, I think one of the first pieces of legislation I had passed, in a bipartisan fashion in this General Assembly, was a House bill that provided for tax credits for health savings accounts for employers who provide them to their employees. I believe, Mr. Speaker, it passed unanimously in two successive sessions. It is a keystone to our plan that the House Republicans put forth. Mr. Speaker, in this session, the current session, 2007-08, not one hearing on HB 121, no consideration for anything that the House Republicans put together.

Mr. Speaker, I have to tell you, of all of that, my major concern, my major concern, Mr. Speaker, is this bill, as a gut-and-replace amendment, was introduced at 1:57 last week, with less than 3 minutes for any amendments and any consideration. We had a lot of discussion about whether that violated our House rules and it was ruled by the Chair that it did not. But I will guarantee you something, Mr. Speaker, if it did not violate the letter of the rule, it violated the spirit of the rule. The spirit of the rule is that we would have ample time to consider legislation and have debate on legislation. And frankly, Mr. Speaker, we did not have that chance with this. I want to read if I can, Mr. Speaker— Mr. Speaker, may I have some order?

The SPEAKER. The gentleman is correct.

Mr. BOYD. Thank you, Mr. Speaker.

I want to read to the chamber from an editorial board, an editorial that came out yesterday. It happened to be an editorial board I was fortunate enough to have an appointment scheduled with on Thursday, after the meeting. I walked in the meeting and I flopped the legislation down on the table, and I told that group of editors of the newspaper, here, you have 3 minutes to consider this. They said that is ridiculous. Here is their editorial: "On Monday, state representatives are expected to approve a measure aimed at providing health coverage to…uninsured Pennsylvanians.

"It's a laudable goal. But the way" – please hear this, Mr. Speaker – "the way the House is operating is akin to a surgeon doing open-heart surgery without previously seeing the patient or having any pretesting done to understand the particulars of the problem, what complications might come up, whether it could exacerbate the trouble or whether it could cause harmful side effects." Mr. Speaker, if surgeons operated the way this House is operating now, we would be subject to a malpractice suit, we would be subject to liability issues.

Mr. Speaker, we, many of us on both sides of the aisle, have looked at this legislation now. Myself, I have identified five or six problems that I think need addressed in this legislation. But, Mr. Speaker, we were not given time to amend the legislation. We were not given consideration to actually talk about what might be wrong, the unintended consequences, the issue of crowd-out, the issue of poor reimbursement rates. All of these things are absolutely essential, and I have to say, Mr. Speaker, as somebody who worked diligently in the Insurance Committee and worked with the chairman across the aisle on the health-associated infection bill and any number of other legislative initiatives, I am really disappointed that there were no hearings on this legislation and there were no hearings held on the Republican Task Force alternative. All we held hearings on, Mr. Speaker, was Governor Rendell's Prescription for Pennsylvania. We traversed the State. We went all over the place, and I was with the chairman when he did that, but no conversation, not one, about this legislative proposal before it was run last week; not one hearing, public hearing, on the initiatives identified by the House Republican Task Force; private meetings telling us how much they like some of our proposals, but not one of them made it into this package, not one of them made it into any hearings. Mr. Speaker, I am very disappointed with that.

Mr. Speaker, I am going to be voting "no," and it is not because I do not care about the people of Pennsylvania, it is not because I do not care about the uninsured. In fact, the reason that I am voting "no" is because I care about the cost of health insurance and health care. I am going to be voting "no" because I do not want to see more employers out of the marketplace. I do not want to see more poor reimbursement rates and a further cost shifting onto the private sector. The Hospital Association has deep concerns; the

Medical Society has deep concerns. Nobody got a good look at this, and yet, Mr. Speaker, here we are moving the ball down the field.

Mr. Speaker, frankly, our playbook is misguided. We should have had an opportunity to have hearings on this legislation and give it a serious consideration before we are being forced to put up these votes.

Thank you, Mr. Speaker.

The SPEAKER. Representative DeWeese.

Mr. DeWEESE. With all due respect to the gentleman from Lancaster who preceded me at the microphone, his lineal, political antecedents in the Republican Caucus had 12 years of a robust majority, including 8 when the Ridge-Schweiker team commanded the executive branch. They did nothing. They did nothing. They did nothing on health care.

Second and final point relative to his commentaries, the essence of our proposal, in many, many facets, mirrors the exactitude of the Governor's. The proposal was vetted aggressively across the Commonwealth in hearings. So he may be specifically correct that the definitive proposal was, or at least the bill number was not shown throughout the State. Essentially, 70, 80, 85 percent of the measure had been discussed ad infinitum, so it has got to be recollected that at least we picked up the field marshal's baton, that we have taken, with the help of Mr. Eachus and his team, a health-care proposal and moved it forward, and we will send it to the Commonwealth's Senate. We did not sit on our proverbial hands, and the way it was done, his argument about that also rings hollow because we debated every single facet of health care that could possibly be debated last week, hour upon hour upon hour upon hour, instead of a 1-minute gut-and-replace that happened for years and years and years.

And if they had had – and again I repeat myself; common sense mandates that I do – if they had had 102 votes, and God knows they may today or tomorrow or whenever, they could have contravened the momentum of this proposal. So hour and hour and hour and hour, it was debated, if 102 votes would have held sway, the Republican proposal would have been incorporated into the body of the bill. By a very narrow margin it was not, and then at the end, the Eachus amendment was embraced by a wide variety of GOP stalwarts, notwithstanding the gentleman from Lancaster County's disinclination to embrace the proposal.

This is a very good start. Is it perfect? Of course not. But it takes it to the State Senate. And for 12 years when we were in the health-care desert and did not debate this vital issue of insuring 700,000 Pennsylvanians that do not have insurance tonight, there was sloth and inaction on the part of the Republican leadership. Today there is aggressive, forward momentum for health care to take this proposal, send it to the Senate. It can be honed and refined, of course, but it is a start, and I would ask for an affirmative vote.

The SPEAKER. The Chair recognizes the minority leader, Representative Smith.

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

Twelve years we did nothing. That is what the majority leader just said, 12 years when Republicans were in control of this House, we did nothing. Oddly enough, Mr. Speaker, while he may be in the desert, the fact is, 92 percent of the people in Pennsylvania have access to some level of health care and health-care insurance; 92 percent. So through those 12 years, it was not like we were holding together a system that was not improving. It was improving, Mr. Speaker; 92 percent of the people of Pennsylvania have health care. That means the objective is, how do you reach the other 8 percent without impinging on those 92 percent that have insurance? But, Mr. Speaker, the majority leader said we did nothing. I wonder what was in their newsletters when they talked about PACENET (Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier), the expansion of CHIP, establishment of CHIP and then the expansion of CHIP, the Children's Health Insurance Program. I wonder what was in their newsletters, Mr. Speaker, when the adultBasic program, ABC, was initially created. To say we did nothing, Mr. Speaker, is flat out incorrect. The fact is, Mr. Speaker, you want to characterize this issue as a Democrat issue, that Republicans do not care about people having insurance, we do not care about those people, just let them starve in the streets or die in the streets. That is a ridiculous characterization, Mr. Speaker. It is one that you know is not true. The fact is, Mr. Speaker, we have done things when we were in the majority. We did deal with these issues. We dealt with them as best as we could – CHIP expansion, ABC, PACENET.

Mr. Speaker, the plan before you is not the Governor's plan. It is significantly different from the Governor's plan. To suggest that those hearings and all of that discussion on the Governor's plan somehow negates the need to further discuss this plan, to further understand this plan, is also misleading, Mr. Speaker, and just simply not correct.

Mr. Speaker, the Republicans do care about this issue, the Republicans have dealt with this issue, and the Republicans, Mr. Speaker, would like to see us reach out to those other 8 percent in a way that does not jeopardize the 92 percent. The plan before you, Mr. Speaker, in fact does. It affects them. It affects that 92 percent, those people who do have health insurance today, that do have access to quality health care. This legislation, Mr. Speaker, affects them. That is the crowd-out issue, and we should not ignore that. Mr. Speaker, this legislation is not ready for prime time. Mr. Speaker, I appreciate the effort, the intentions, on the part of the House Democrats, but this is not the answer. This is not the solution. This is just political expedience because it is election season. We have to pass something to say we are moving forward, Mr. Speaker. That is not the reason to do this. We need to address that 8 percent that currently does not have insurance, Mr. Speaker. We need to do it without jeopardizing the 92 percent that currently has insurance, that has availability of health care. And, Mr. Speaker, let the record reflect that the Republicans have dealt with health-care issues in the past and we can deal with them in the future.

Thank you, Mr. Speaker.

The SPEAKER. Representative Watson.

Mrs. WATSON. Thank you, Mr. Speaker.

Perhaps I will take the tone down a little bit, but I guess it would require some folks to listen a little more intently. I want to get away from something of what I have seen has been an awful lot of political rhetoric in the midst of all of this, and I would like to do, just if I might, Mr. Speaker, a brief review and a timeline here. When people talk about, well, the Republican plan and the Democratic plan, Representative Boyd and I did take concern about health care and we have for a long time, so we went to our very own leadership and over a year ago asked to form a task force. That task force, we handpicked the people. We did not say too much about that but we did. We deliberately picked folks that we knew had some background tied to health care. We also geographically picked everyone, Mr. Speaker, so that all parts of Pennsylvania would be represented and covered.

The first order of business, Mr. Speaker, that we did was to send each member that we asked to serve back to his or her district and say, please, go if you do not know. Seek out everyone you can find who is uninsured, find out why. When we met, we knew there were certain things that there were characteristics that were common, whether you were uninsured and in rural Pennsylvania or you were uninsured and in urban Pennsylvania, or suburban, wherever you might be – the north, the south, the east, the west, the center part of the State. Number one, it was related to cost, and that became important, and everybody kept saying – well, people we met who said, well, I even have insurance right now; yeah, I got some but I will not be able to keep it or I will not be able to offer it to my employees if the cost keeps going up.

Those were the things that brought us then to designing what really is about a 12-package bill or a group of bills of 12 that are discussing, really answering Cover All Pennsylvanians, but most importantly, providing access and in a short amount of time, not sacrificing or playing off what I seem to be seeing here, the 92 versus the 8 percent. And when somebody asked me, I had an editor say to me, can you not reduce it to one sentence, and I am trying to think, how do I reduce 12 bills, over a year's worth of work, to one sentence? And I said okay. He said, what do you really want, and I said, do you know what we want? We want everyone to have a job and health care. That was the whole focus that we worked on. That was what was behind it. That is not to say that the gentleman from Luzerne does not care, did not work, too, and in fact, I had hoped we would work together. I will tell you, Mr. Speaker, that we were not able to get any of the bills for a hearing, any of the bills up for discussion in a committee, any of that. Do we assume that everything that is in this Republican plan, somehow by idea, is all perfect, and therefore if we are talking today about the gut-and-replace amendment that went into SB 1137, it is all bad? Certainly not. Is there common ground to work? You bet there is. But the one thing we cannot do, Mr. Speaker, is reduce this to Rs, Ds, I do not care, urban, rural, whatever you want to do for groups, and in the midst of it are people who are watching, who are listening, who do not have health care, those who have it and are afraid they are going to lose it, employers who want to offer it but cannot afford it, employers who offer it now but may have to stop offering it, and have them all working against each other and then pinning a hope on them and saying as I heard this very day said, oh, we are going to give this to thousands when, quite frankly, the last time we met, the one time we had any debate, and those who had complained that it was long for 9 hours but it was the only time we even got to start talking about this, and for many, because I looked over and I went by, I know how many of you – I am the English teacher, remember – I know how many of you had not seen it until that day and I know how many really had not even read it. But above all, I did get out of the prime sponsor that the first year, maybe 144,000, moving those from adultBasic and those from the waiting list, there are only going to be 14,000 slots available to all those people out there who do not have health care. So the one thing I know today is, we absolutely and no one should leave here and go use words like "all" and "how many" and "thousands," when that is not true, because people depend on us and want us to tell the truth, and above all, this is far too serious an issue to play politics with such an issue.

Mr. Speaker, there is no specific funding mechanism included in the legislation, and it is based on, which makes me crazy, declining funding sources. There are those who would say that increasing a tax on smoking is a tax and they do not vote for taxes, or putting a tax on smokeless tobacco is a tax; they do not vote for taxes. Quite frankly, Mr. Speaker, where I come from, they would consider it my religious duty to continue to tax cigarettes because most of my folks do not want anybody to smoke at all. But the point is, we are doing a good job of getting people not to smoke. Why would you tie a revenue source that you know is going to decline to something that is so important like offering health care? I do not understand it, Mr. Speaker. It defies basic logic. And what is more, it promises people something that we cannot deliver.

Many have talked about the timeline, Mr. Speaker, the fact that the bill was – I am sorry; the amendment was filed to a regular bill at 1:57 on Tuesday the 11th, and by 2 o'clock you were not able to file amendments. There are those in this very House who complained bitterly that they had to sit through 9 hours of discussion, and I heard calls for, I just want to go home. Mr. Speaker, this is far too important to just want to go home, and that is something we all might like to do. Mr. Speaker, I do not understand the timeline here in terms of reform, and by the way, it is a year since the House rules in reform went in when this was offered.

I have heard indeed the majority leader complain about things that happened in the past, and indeed, I was here for a little bit of them. Some of it I did not like either, but, Mr. Speaker, that is not an excuse then to say, but we can go you one better and find a way that within the rules to do the very same thing.

Mr. Speaker, this amendment needs further discussion. It never was before a committee. It is substantially different from Cover All Pennsylvanians and very well may be a good thing. There may be pieces in it that are great, but it has never really been discussed and it has never, what I call, seen the real light of day, and indeed, the stakeholders themselves have questions. You have heard about the Pennsylvania Farm Bureau. The Hospital Association has a number of questions. The Medical Society has questions. And quite frankly, when I went home this weekend and started telling it and took it to some people, my local people have questions. My local doctors asked me questions. Some of them actually saw something on PCN (Pennsylvania Cable Network) and said to me, but I do not understand. And I heard from those who are uninsured who said, there is something wrong here and why are people not agreeing and why is there not just a plan that everybody can agree to?

MOTION TO RECOMMIT

Mrs. WATSON. Mr. Speaker, for all of that and everything that I have been saying, Mr. Speaker, I would like to make a motion.

The SPEAKER. The lady will state her motion.

Mrs. WATSON. Thank you, Mr. Speaker.

I would like to move that SB 1137 as amended with this huge amendment be referred to the Health and Human Services Committee. I serve on that committee, and I know the two gentlemen who are chairmen. They would give this hearings. And, Mr. Speaker, this is not a delay tactic that some will say, because, Mr. Speaker, part of my amendment, I want to refer it to the Health and Human Services Committee of the House to a date certain that hearings would be held, that hearings would conclude, and we would be back to discuss this back on May 12. That gives us ample time to schedule hearings, be they in all parts of the State. That gives ample time for those major stakeholders to weigh

in on the six and eight questions they have already presented us with or the members of the Farm Bureau and rural Pennsylvania to talk about, Mr. Speaker.

Mr. Speaker, I want a date certain. I would like it to go to Health and Human Services, Mr. Speaker, and we will do a good job to really understand that what we send to the Senate has the opportunity to pass and is something that really will help the people of Pennsylvania.

The SPEAKER. It has been moved by Representative Watson that SB 1137 be recommitted to the Committee on Health and Human Services for the purpose of hearings, to be reported back to the floor by May 12.

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

The SPEAKER. On the motion, Representative Eachus.

Mr. EACHUS. Mr. Speaker, thank you.

I rise to oppose this motion because the House of Representatives is a deliberative body. We need to exercise our authority as it relates to our ability to discuss and deliberate the key issues of the day, and I believe that this is a very key issue.

Also, in deliberations with the chairman of the Health and Human Services Committee, he feels strongly that we resolve this issue and, like me, that it is our opportunity to move a very important issue forward. So I oppose any motion to send this back to the Health and Human Services Committee with the chairman of the committee as well.

PARLIAMENTARY INQUIRY

The SPEAKER. On the motion, Representative Kenney.

Mr. KENNEY. Thank you, Mr. Speaker.

Mr. Speaker, a parliamentary inquiry.

Was the motion to bring the bill back on May – to send the bill to committee? Let me ask you this: What was the motion by the woman from Bucks County?

The SPEAKER. The lady moves that SB 1137 be recommitted to the Committee on Health and Human Services for the purpose of holding public hearings with the intent of reporting it back to the floor on May 12.

Mr. KENNEY. Mr. Speaker, I would, if I may, Mr. Speaker, speak—

The SPEAKER. The gentleman is in order.

The House will come to order. The gentleman is entitled to be heard.

Mr. KENNEY. Mr. Speaker, as the Republican chairman, I have no problem in supporting the gentlelady from Bucks County's motion. I believe we have the ability to look at SB 1137. It is a very complex issue. I would hope that we could move it back to the floor prior to May 12, because I think it is such an important issue, but I would support the woman's motion. Thank you.

The SPEAKER. Representative Oliver, on the motion to recommit.

Mr. OLIVER. Mr. Speaker, as the majority chairman of the Health and Human Services Committee, I would oppose that motion. We have certainly had heavy debate on it up to the present time, and I cannot see any reason why to put it back in committee. Thank you.

The SPEAKER. The Chair recognizes the minority leader, Representative Smith.

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

Mr. Speaker, I realize how things go around here, but I would like to just let the record reflect that we really should support this motion so that we can in fact thoroughly review this bill that has not been in the public domain. The guts, the main elements of this legislation, have not been in the public domain for 1 week yet, less than a week, and for this legislative body who is so deliberative, so deliberative that we cannot take a few weeks to truly review this legislation, I think, Mr. Speaker, is irresponsible.

The fact is, Mr. Speaker, we can make this bill better. I heard the members, the Democrat leaders, talk about working collaboratively, working with them on this legislation, and while we have had a lot of discussions over December and January or so this past year, the fact is, when this specific legislation was being crafted, the doors were shut and the blinds were pulled and nobody got a good look at it until a few days ago.

Mr. Speaker, support the motion to recommit. Allow this body to actually be deliberative, to evaluate, and hopefully make this legislation better and stronger, because the fact is, Mr. Speaker, whatever happens with the whole issue is going to be tied into the budget deliberations of June. It is not like this legislation is going to the Governor's desk in the next 2 days. It is going to be discussed. Why do we want to forgo our ability to put constructive input, to put a better work product out of this body, Mr. Speaker? Vote to recommit.

The SPEAKER. Representative DeWeese.

Mr. DeWEESE. Delay, delay, delay. I would ask that we reject the gentlelady, Mrs. Watson's motion to recommit. I would ask for a negative vote.

The SPEAKER. Representative Metcalfe.

Mr. METCALFE. Thank you, Mr. Speaker.

Mr. Speaker, one of the earlier speakers said this is not a Democrat-Republican issue. What a sharp contrast we have, Mr. Speaker; the chairman, the Republican chairman of the committee that this will be assigned to, rising and saying he does not have a problem with receiving this before his committee and reviewing this legislation. Then the Democratic chairman stands, the majority chairman. He is opposed to it. Then the minority leader stands – let us hold off and check this out. The majority leader stands – no; we have to push forward.

Mr. Speaker, this is obviously an issue that has a clear divide among philosophical lines, Mr. Speaker. Mr. Speaker, for those of you that want Hillary-care-light, let us hold off a little bit and review it a little bit more. I think with Hillary-care-light, the people will ultimately reject it as they did with Hillary-care. So let us reject this attempt to push forward with Hillary-care-light, and let us let the committee take another look at it.

Thank you, Mr. Speaker.

The SPEAKER. On the motion, Representative Watson.

Mrs. WATSON. Thank you, Mr. Speaker.

Mr. Speaker, please understand something, to be very clear on this motion, this motion was not meant to delay, and quite frankly, it was meant to be even more deliberative.

I know, like many of you, those who I know particularly well and talked to, that many of you do take pride in reading everything, in trying to learn, in calling people for background information because we always have so much. We did not have the time to give this due diligence.

Yes, personally, would I also like to see some of the bills that I spend a year putting together, along with Representative Boyd and the committee, come out? Sure, but that is not what this motion is, Mr. Speaker. This motion is to say that this gut-and-replace amendment changes things greatly, is not Cover All Pennsylvanians, is not something that you who are the good, deliberative legislators that most of you are and want to take the time and want to understand and do not care about, just I have to go home because it is Wednesday, or any of that nonsense that went on, you would like to do that. And more importantly, that whether it is newspaper people to take a look because this is reform and transparency, whether it is individuals who have health care, whether or not it is stakeholders such as doctors, hospitals, groups like the Farm Bureau, they would have time to weigh in, to take a look, and I would assume that we would come back with something by that one certain date that would be even better.

I do not understand, Mr. Speaker, why everybody would not support this. This is the way we are organized by the committee system. It should be in a committee. It should be discussed when it has major changes. If it is good, it will withstand all of that. If it needs to be made better, Mr. Speaker, in those – what? – less than 2 months, it will be made better.

Thank you, Mr. Speaker.

The SPEAKER. Representative Marguerite Quinn.

Ms. QUINN. Thank you, Mr. Speaker.

I rise to support the motion from the gentlelady from Bucks.

As a member of the Insurance Committee, you know, I would like to bring forward to you some testimony that we had at a 12/5, December 5, Insurance Committee meeting, and I am going to quote my colleague from across the aisle, Representative Frankel. This was on the subject that we have at hand: "We do intend to work collaboratively to address this" issue. "It's the only way…" that we could "…get it done, ultimately, is to get an agreement. This is not an issue that can be done without support from both sides of the aisle, and ultimately, it is to be inclusive to address these issues to work to move it forward. This effort is to get this moving and accelerate it because it really needs to be addressed. People are clamoring for it, I think we…have heard from constituents who have asked us to deal with the issue of the uninsured. The Governor has heard that and made it his chief priority and we want to deal with it, as well as, dealing with protecting the abatement and dealing with the unfunded liability. These are things that are going to be part of our discussions together and I can speak for Representative DeLuca, who I spoke to earlier today, that he shares that sentiment as well." At which point my colleague, Mike Vereb, asked, "And Representative Boyd will have a…" seat "…at that table, correct?" The answer was, "Yes."

I am here to support this because I do not believe that has happened. I do agree that there have been discussions on health care over the past 12 months, but it is not on this bill. Mr. Speaker, that is like saying we have talked about property tax when we have two different bills. I do not think that is fair to our constituents. I do not think that is fair especially to freshman members of this class, 25 percent of this body, who have come in here in earnest to respect the new rules and to have in-earnest discussions, and I think we are letting our constituents down.

Last week, in case any of you have noticed, we marked the 1-year anniversary of our new House rules, and I am disappointed. I do not think that they have been fulfilled in the spirit of the rules that we put forward.

I ask members of the House to just recommit this. Let us do it right the first time. That is what I ask of my kids. Do it right; do not just get it done.

Thank you.

The SPEAKER. Representative Boyd, on the motion.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I will be very brief, but I did want to respond to delay, delay, delay.

Mr. Speaker, this body, it has been referred to as a deliberative body, and I would agree that I have heard some of the best debate on this issue since I have been here, and I am really grateful that we are finally talking about the need to lower the cost of health care and health insurance, but I have to say that the motion that is made by the gentlelady from Bucks County is not a delay tactic. If in fact its intention was to derail this train, then she would have made a motion to table this bill. The motion was not to table. The motion was not even just to recommit. The motion was actually to recommit it to committee for hearings and bring it back at a date certain, a date certain less than 1 month from now.

Mr. Speaker, I would argue that what we are about to do is vote on perhaps the most sweeping change in public policy that we are going to be facing, that I have faced since I have been here in 2003, and I can say that from experience having dealt with the health insurance and health-care industry as a businessperson.

Mr. Speaker, the stakeholders that this is going to infect – affect – maybe I should use the word "infect" – the business community, small employers, large employers, the Hospital Association, the Pennsylvania Medical Society—

POINT OF ORDER

Mr. EACHUS. Mr. Speaker? Mr. Speaker?

Point of order.

The SPEAKER. For what purpose does the gentleman rise?

Mr. EACHUS. We are on a motion to recommit this to a committee, sir. Substantive debate, is that available to members on this?

The SPEAKER. The debate on the underlying premise of the bill is not in order. The gentleman will limit his remarks to the motion to recommit.

Mr. BOYD. By all means, Mr. Speaker.

The point to my remarks is simply this: We have not heard from any of the stakeholders. We have not heard other than some fast letters that were shot off as early as this morning trying to determine what the net impact is. Mr. Speaker, how can we vote on something that we really do not know the net impact on the providers, the doctors, the hospitals? Small, rural hospitals were brought up early by my colleague, Mr. Baker, and I would say his county, but I forget what it is; sorry about that.

But, Mr. Speaker, we have to give this at least 1 month to allow the stakeholders to weigh in and talk about the net impact and maybe, heaven forbid, maybe make some suggestions that we might be able to amend this piece of legislation and maybe make it a little bit better. It is hard to imagine that this thing came out and was introduced at 1:57 last week with no look by anybody else other than a small group of people, and they got it right the first time. I do not think that that happened, Mr. Speaker, and I think there are some adjustments that need made to this legislation, and all we are asking for is time to hear from groups. Let them weigh in, and let us try and do this right. Let us not do what we were

attempting to do with open records and do it fast but not do it right. Let us take the time and get it right, Mr. Speaker.

Thank you.

The SPEAKER. Representative Eachus.

Mr. EACHUS. Mr. Speaker, thank you.

There have been a lot of arguments made about the lack of stakeholder work, the lack of fair approach to the House rules, a lack of bipartisanship. I can tell you, Mr. Speaker, that I oppose this motion to recommit because we have had a whole subset of those things. We have met the muster of our House rules that our Speaker's Reform Commission set forth. You might not like the way we tactically addressed those, but we met the rules and we have a ruling by this House that says that we met the House rules. You may not like the way this approach took force, but, Mr. Speaker, I oppose this recommittal, recommittal back to the Health and Human Services Committee because we tried to find the framework of bipartisanship between Christmastime and today. We could not find that.

And as far as the stakeholders have gone, Mr. Speaker, I oppose this motion to recommit because many stakeholders have been met with. Many have been supportive of this proposal. There are some that are still concerned, but the majority of the stakeholders within the health-care arena have been met with, and I would say, once and for final, that we oppose this motion to recommit.

The SPEAKER. On the motion to recommit, Representative Gabig.

Mr. GABIG. Why is everybody picking on me?

Happy St. Patrick's Day to you, Mr. Speaker.

The SPEAKER. And to you.

Mr. GABIG. March 17, just to correct the record of one of the earlier speakers, a good friend of mine.

I just heard the gentleman from Luzerne County say that many stakeholders support his amendment and some do not, and the problem with the procedure that the majority in the House has adopted is, I as a member do not know who those are because there have not been any committee hearings on it. Some of my colleagues over here are also wondering, as I was wondering, who they are. I see he is reaching in his pocket to a list. No; no. He is pulling something else out. A card, a card, indeed, with the correct spelling of his name on it, no doubt.

But I was wondering if the gentleman could share with the rest of the House, in these smoke-filled rooms that he was in where different stakeholders were coming in, I guess over the weekend when we were not here, tell us who the stakeholders are that support this and who the stakeholders are that oppose it and what they were told and who was in those rooms and in those meetings. Was PCN there? Were the newspapers there? Who were in these meetings where people were agreeing to this and not agreeing to this? I say that rhetorically. I am not going to ask for interrogation.

The problem is, because of the way they are ramming this through the House, this major piece of legislation, whether you agree with the underlying philosophy or not, it is wrong, and that is why the gentlelady, my classmate from 2000 – what a great class – has a great idea that we should actually maybe have a hearing on this Eachus amendment, Eachus amendment. We should have a hearing on it, and we should hear from those quote, unquote, "stakeholders" who agree with it and why and those that oppose it, and that would be a deliberative process that I think we could all be proud of. So I stand in support of the gentlelady's motion.

On the question recurring,

Will the House agree to the motion?

The following roll call was recorded:

YEAS–98

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

NAYS–102

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
Curry	Keller, W.	Payton	Walko
Daley	Kessler	Petrarca	Wansacz
DeLuca	King	Petrone	Waters
DePasquale	Kirkland	Preston	Wheatley
Dermody	Kortz	Ramaley	White
DeWeese	Kotik	Readshaw	Williams
Donatucci	Kula	Roebuck	Wojnaroski
Eachus	Leach	Sabatina	Yewcic
Evans, D.	Lentz	Sainato	Youngblood
Fabrizio	Levdansky	Samuelson	Yudichak
Frankel	Longietti	Santoni	
Freeman	Mahoney	Seip	O'Brien, D.,
Galloway	Manderino	Shapiro	Speaker

NOT VOTING–0

EXCUSED–3

Cruz	Geist	True

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,
Shall the bill pass finally?

The SPEAKER. The Chair recognizes Representative Gabig.
Mr. GABIG. On final passage, Mr. Speaker.
I want to thank my leadership for their position throughout this debate. I want to thank the gentleman from Allegheny County, Mr. Turzai, for his leadership. I want to especially thank our task force members, Mrs. Watson and Mr. Boyd, for their hard work and all those who worked on the task force, and I certainly want to thank my colleagues on the other side, Mr. Eachus and the others, for their hard work and the debate that we have had. But I am not going to be able to support final passage, and I have some reasons why, and I would like to share them with my colleagues and anyone else that might be interested.

Today is St. Patrick's Day, and I am not going to say we heard a lot of blarney in here earlier because that would not be right. I am not sure what blarney means. So for me to say we have heard a lot of blarney, I might be saying something that I might be insulting or offensive to somebody, but I certainly do not mean it in that way. What I mean to say is that I hear some of these statistics and I find them hard to swallow. I think it was Mark Twain that said "there are lies, there are damn lies, and then there are statistics."

I heard something about uncompensated care, and that is the reason to vote for this, because we are going to solve uncompensated care somehow by passing this, and the problem with that, of course, is uncompensated care means that somebody is being charged for something and somebody is not getting the full bill, and where a lot of that uncompensated care comes from is – guess what? – government programs, Medicaid and Medicare. There are charges that they do not cover and then somebody is left holding the bag for it, and that is called uncompensated care.

There are also people that we have heard about, uninsured, the quote, unquote, "uninsured," that might be also called, in some cases, self-insured, and when they go get care at a hospital or some other places, they are charged an enormous rate under our system. If you have a group rate, it is much cheaper. If you go in there as an individual to have the same care, the same procedure, under our system the way it is today, an individual is charged a much higher amount of money. They do not get this discount, this group discount. There are some problems with it and that is good and bad, but that is a big system and that is the way it is, but those uninsured can pay that bill and pay a lot of that bill, but it might not be fully paid. So that is considered to be uncompensated care, but people were paid money. The studies that I have looked at, there is maybe 1 percent, 1 percent is what we are looking at on that, and there is something we need to do about that. We need to look at that. But this bill as amended does nothing to address that issue, nothing. It will make it worse, in fact, as we heard earlier.

The other problem I have from living in my district, and I know this is unique to my district, but I am not sure if there is anyone in my district that does not have access to some basic health care. And I have seen these statistics again, and I do not know where they come up with about how many people are, quote, unquote, "uninsured" in Cumberland County. I do not know how the government knows who is insured and not insured, but right across the street from my district office, right across the street is something called the Sadler Health Center. It is one of those things that we heard about from Representative Boyd and others that is a Federal health clinic, an initiative of President Bush to expand these Federal health clinics. So everybody in that geographic region that is covered by that health center, which is right across from my district office, can walk in there for very reasonable amounts of money and not only have medical care but have dental care. There is a dentist on staff there, basic dental care, and so I know that. I know everybody in my district has basic health-care options, and that is why Representative Evans' bill was so important. It has been stuck in committee, never going to get a chance to come out here. It could be sent back to committee and made part of a bipartisan effort. His bill would expand the opportunities of the constituents in my district at the Sadler Health Center. And my district, as I understand it, is not the only district in the Commonwealth of Pennsylvania that has this type of option. In fact, I have been told that there are, I think, 190-some clinics. There are 40-some full-time clinics, if you will, and 150 satellite clinics, for a total of 190 across the Commonwealth.

Now, this is a great option, and this is not going to be some massive universal socialized medicine response to what we are facing when we have 93 percent with coverage and we are only looking at the 7 percent that do not have coverage. Now, that number, 93 percent, is an enormous success story for Pennsylvania that we should all be proud of on both sides of the aisle. We are in the top half in terms of national standards when we look at that. In fact, if you think about auto insurance, we are mandated in Pennsylvania to have auto insurance. It is against the law not to have auto insurance in Pennsylvania. In fact, if you do not have auto insurance and you are caught, it is a crime. You are prosecuted for failing your financial responsibility. Now, we do not have that for health insurance, but guess what? The rate for the coverage in Pennsylvania is higher for health insurance than it is for auto insurance. That is a great success story that we should all be proud of.

We do not need this massive unfunded – it is called, I think it is called ABC, is what the Democrat leadership is calling this plan, and they are very strong in saying it is not the Governor's Cover All Pennsylvanians. That was a bad plan. We are not running that one. But at least the Governor – and I had a lot of problems and questions with his plan – but at least the Governor had enough courage, enough fortitude to say how he was going to pay for his plan. He said we are putting taxes on people to pay for this big socialized medicine plan that I have here in Pennsylvania.

The House leadership will not even tell us whom they are going to tax when this thing goes into effect. So they are hiding the ball. There is a tax coming, a massive tax for this entitlement program that they want to push through, but they will not tell us where it is coming. Oh, just wait. Just let us spend the money now, and we will figure out how we will pay later. Well, that is classic Harrisburg culture. Go out, figure it out, and somebody else will pay for it. You get all the credit for spending the money, but how are you going to put up that tax vote?

So those are the problems that I have. We had a great alternative that had to be put in piecemeal with amendments that were all voted down on a partisan basis, all the amendments that we put in.

Oh, yes, this is a great point; this is a great point that I almost forgot as I got ready to sit down here. This plan of theirs, $63,000 you could be making to get on this plan, subsidized taxpayer fund, $63,000. Now, I do not know how somebody

making $63,000 cannot, quote, unquote, "afford" to go get their own, but this could be somebody, $63,000, who smokes cartons of cigarettes a month, smokes cartons of cigarettes a month, can get on this plan; drinks cases of beer a month, cases of beer and smokes cigarettes, they can get on this plan. Somebody else who makes much less than that is going to have to pay for them. Somebody who leads a healthy life, does not smoke and does not drink, making $18,000, who has their own health care is going to have to subsidize this person, and why, you ask yourselves. That plan makes no sense, does it, you say to yourself. So you ask yourself, why would they possibly put through a plan where the poorer people who are living healthier lives are going to have to pay for these wealthier people that are living unhealthy lives and they will not go out and buy their own insurance or get a job where it is provided. Why? I do not know the answer to that. You are going to have to ask the Democratic leadership to answer that question, but it is wrong. It is plain old wrong, and I cannot support it.

Thank you, Mr. Speaker.

The SPEAKER. The House will come to order.

Representative Scavello.

Mr. SCAVELLO. Thank you, Mr. Speaker.

I would also like to join Representative Turzai and wish everyone a happy Thanksgiving as well.

The SPEAKER. Did the gentleman intend to say thanksgiving? Thanksgiving for St. Paddy's Day, perhaps.

Mr. SCAVELLO. Forgive me. I am thinking of my comments, Mr. Speaker. I am thinking of my comments.

Can I have a little quiet in the room, Mr. Speaker, please?

The SPEAKER. The House will come to order.

Mr. SCAVELLO. Last Tuesday at 1:57, an amendment, the 25-page amendment, was added to this SB 1137 – was it 1:58? Excuse me – and I looked at the bill. We are going to cover, we are going to cover the uninsured in Pennsylvania, and we used some comparisons today that it is similar to the CHIP program, but it really is not, because the CHIP program, it covered all kids, that covered all kids. Here we are covering 143,000. I supported it, Mr. Speaker, but, you know, I figured today that I would get a report exactly how many of the 10,000 or so citizens that I have in Monroe County that are not insured, how many of those citizens would be insured under this legislation, and I do not have a report in front of me. Is there anyone here that can help me with that, Mr. Speaker?

The SPEAKER. Can the gentleman be more specific on his interrogation?

Mr. SCAVELLO. Yes. Mr. Speaker, I have in front of me an estimate on how many uninsured adults that live in my county, which is 10,470, and what I would like to know – and I supported the bill the other day – I would like to know, because I know it was rushed out there, the amendment was rushed out there, how many of those citizens, if we pass this legislation, would be insured after this legislation passes?

The SPEAKER. The Chair reminds the gentleman that he has to direct that interrogation to a specific individual.

Mr. SCAVELLO. Could Mr. Eachus stand for interrogation, the maker of the amendment?

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

Mr. EACHUS. Thank you, Mr. Speaker.

Let me try and be as concise as I can. In Monroe County, your home county, Mr. Speaker, there are currently 1298, 1,298 people currently on the adultBasic waiting list. I can tell you with definitiveness that those people would immediately get access to health care, and we know that the statewide average is another 143,000 citizens who would get health-care access. But we know with definitiveness in your county that 1298 people will get access to health care under the PA ABC Program immediately.

Mr. SCAVELLO. Mr. Speaker, I am in a growing county— I have finished my interrogation. Thank you, Mr. Speaker.

Mr. EACHUS. My pleasure.

Mr. SCAVELLO. I am in a growing county—

The SPEAKER. The gentleman is in order and may proceed with his comments.

Mr. SCAVELLO. Thank you.

I am in a growing county, and as you know, Monroe has been growing. Actually, the population doubled in the last 15 to 20 years, and we keep getting – the representation from Philadelphia moves to Monroe County. However, the dollars associated with those moves still continues to go to Philadelphia.

I am looking at these sheets here, and I see that Philadelphia has 138,950 uninsured. I am looking at the legislation, and I am being told that it is going to insure 143,000 residents. So I am looking at that 138,950 number and I am looking at 143,000, and I am saying to myself, am I here voting to raise taxes, possible taxes, because there is a $120 million hole in this, to the citizens of my community and insure folks somewhere else and not in Monroe? Unfortunately, the distributions have never fallen the right way for us in a growing county.

And I am really questioning anyone here that thinks that they are doing the right thing. I heard the gentlelady from Lehigh County earlier talk about the amount of folks that were uninsured in her area, but I would tell her to look at those numbers very closely. How many of those uninsured in your area are going to be covered?

Consider this, Mr. Speaker: We talk about Cover All Kids. We covered all kids, and that is the right way to go. Here we are not. At the most in 5 years, it will be 217 folks that will be covered out of the 800,000.

My question is, if I am going to put a vote down, I want to get a fair share in Monroe, and it is obvious I do not have anything in writing that is going to do that.

I also want to bring up that the majority leader earlier on made a comment about that under the Republican rule there was nothing done in health care, and outside of the items that were mentioned by the minority leader, Representative Smith, there was also a certain bill called joint and several liability that would have helped to reduce the cost of medical insurance, medical costs, throughout – to the insurance, to the doctors – and reduce the cost of health care, that he challenged in court, and of course that did not happen. We ended up losing that piece of legislation, and today, today, we might not be worrying about Medicare because that Medicare fund would have been probably solvent.

I have a lot of questions, Mr. Speaker, and I am going to stand here and I am going to oppose this unless I have definitive numbers on exactly how many of those 10,000 uninsured folks in Monroe County are going to be funded with this legislation.

Thank you.

The SPEAKER. Representative Leach.

Mr. LEACH. Thank you, Mr. Speaker.

I will be brief. I just wanted to reply to a couple of points that had been made that I think it is important to clear up the record on.

There was a point made by a couple of different speakers that the 92 percent of Pennsylvanians have some form of health care. While that is largely accurate, it is important to point out that 31 percent of those 92 percent, 31 percent of Pennsylvanians, have access to health care because of a government program, because of Medicare, Medicaid – Federal programs, 17 percent, and State programs, 14 percent. I know that some of my friends on the other side of the aisle, not all of them but some of them, oppose those programs. So to say that we have done something because 92 percent of Pennsylvanians have access to health care when a third of them have such access because of things that you opposed seems to me to require a breathtaking level of chutzpah.

I would also say that one of the speakers mentioned that everyone has access to basic health care or almost everyone has access to basic health care in Pennsylvania. Again, that is not accurate. There are some statutes that require if you are involved in an accident, an emergency of some kind, if you are hit by a bus, that you be stabilized at a hospital. They cannot turn you away, but they can turn you away for long-term care. If you need chemotherapy, if you need physical therapy, if you need a liver transplant, if you need ongoing neurological care, that is something that you are not required to get and in fact do not get, and in fact, in the clinics that one of the speakers mentioned, you are not going to get that sort of treatment.

So one of two things happens, Mr. Speaker: Either people get the treatment, who do not have coverage at all, get the treatment through the beneficence of a hospital, but I can tell you I have two major hospital centers in my district and I speak to many more hospital administrators around my area, certainly, and the provision of indigent care and the provision of uncompensated care is undermining the financial health and stability of our hospitals. That is number one, and that is when people get the care. Many people do not get the care at all that they need as a result of not having coverage.

A study that just came out, I think either today or yesterday, according to Families USA, they estimate that nearly two working-age Pennsylvanians – that is, between 25 and 64 – two working-age Pennsylvanians die each day due to a lack of health insurance; approximately 710 people in 2006. Between 2000 and 2006, the number of adults who are of working age who are estimated to have died because of lack of health insurance is 4,800 people. Across the United States in 2006, twice as many people died from not having health insurance as died from homicide, and these are just deaths. These are not all of the conditions that are worsened, the conditions that are not treated early because people cannot afford to get early treatment, that occur because of a lack of health insurance.

Now, I do not want to revisit the debate on Hillary-care, but I would say that I remember when that was being debated, the big threat – remember the Harry and Louise ads that we saw – the big concern was that people were going to be put into HMOs (health maintenance organizations) and not be allowed to choose their own doctor and have to get permission to see certain doctors. Now, of course, Hillary-care did not pass, but that did; that came to pass. People now are often denied the opportunity to see their doctors.

What else has happened since Hillary-care did not pass is that the number of uninsured Americans has gone from 39 million to 47 or 48 million. So when you say that Hillary-care failed miserably, it was obviously never given a chance, but what we can say for sure is that doing nothing has failed miserably. And the fact is that all we are hearing from some of the members here is more boilerplate about socialized medicine and government health-care programs.

Now, first of all, SB 1137 is not socialized medicine. Everyone who gets coverage from this program will get coverage from a private, free market, for-profit insurance company. So the idea of socialized medicine is just ridiculous. But I believe that government has a role in helping Americans get access to health care. And if you disagree with me, that is fine, but I assume that means you want to repeal Medicare, you want to repeal Medicaid, you want to repeal PACE (Pharmaceutical Assistance Contract for the Elderly) and PACENET, you want to repeal SSI (supplemental security income), you want to repeal SCHIP (State Children's Health Insurance Program), you want to repeal adultBasic, because if you do not believe that the government has any role in helping people get health care, you are against, definitionally, all of those programs. Now, if you are for any of those programs, then you agree with me that government does have a role. And I have not heard anyone with the courage to stand up and call for the repeal of those programs here today. We just keep hearing the same sort of sloganeering about, oh, it is government health care. Well, the Veterans' Administration is government health care. There is government health care all across the economy, and to say that government does not have a role just does not recognize the basic realities in America today.

There are major problems with doing nothing, Mr. Speaker, and I will finish with this. There is the obvious problem of cost shifting. One estimate I saw is almost 7 cents of every dollar we spend on health care is helping to pay for uncompensated care. We are all paying more because other people cannot afford to buy health insurance.

Problem number two is, as I mentioned, the undermining of the financial health and stability of our hospitals, and we all talk about wanting to make sure that our doctors and hospitals thrive and that we have access to the health care here in Pennsylvania, and of course there is the moral issue of almost 800,000 of our fellow citizens who cannot get the medical care that they need. In my own family we have had a number of very difficult health-care issues over the past year. My brother-in-law died of lymphoma at the age of 42. It was a terrible thing to go through, but at least he had access to the best health care America has to offer. I can only imagine what it is like to go through something like that – and his final chemotherapy, incidentally, was $25,000 a month – I can only imagine what it is like to go through something like that and not be able to get the medicine you need, not being able to see the doctors you need to see. That is obscene, Mr. Speaker, in a State and a nation as wealthy as ours and considering what else we spend money on.

I urge a "yes" vote for this very important bill which will make sure many more families in Pennsylvania at least face a health-care crisis with the peace of mind knowing that they will have access to everything they need to help them beat whatever illness they are fighting.

Thank you, Mr. Speaker.

The SPEAKER. Representative Seip.

Mr. SEIP. Thank you, Mr. Speaker.

Mr. Speaker, my colleague from Lehigh County mentioned the fact that there is a tremendous problem with uncompensated care. Mr. Speaker, uncompensated care is one of the biggest cost drivers

in our health-care system. I worked in two hospitals as a licensed social worker, and I can tell you that people without health care are showing up at the emergency room because they have no alternative. Many times they are forced to go there to get treatment that they need. This is a cycle that perpetuates our higher cost. People show up without coverage; costs for the hospital and costs for the providers go up. More people fall off because they cannot afford their insurance; more people go to the hospital for uncompensated care; the cost goes up again. The cycle just keeps perpetuating. We cannot allow this to go on and let our health-care system collapse.

Mr. Speaker, I urge the passage of SB 1137, not later, but today.

Thank you, Mr. Speaker.

The SPEAKER. Representative Metcalfe.

Mr. METCALFE. Thank you, Mr. Speaker.

Mr. Speaker, as I said during the earlier part of this debate, one of the former speakers had risen and said this is not an R-versus-D issue, Mr. Speaker. Mr. Speaker, he is right. This is not about Republican versus Democrat. This is about another big government program versus individual choice, Mr. Speaker. This is about more liberal tax-and-spend government elitists who think that they know what is right for the people versus the people actually making the right choices for themselves, Mr. Speaker.

Mr. Speaker, one of the previous speakers was standing and lamenting that so many have talked about socialized medicine. Well, Mr. Speaker, that is exactly what more government programs intervening into the marketplace for health care is. More government programs delivering health care is another addition in a piecemeal approach to giving Pennsylvania citizens socialized medicine, universal health care, whatever label you want to put on it – Hillary-care. Whatever label you want to put on it, that is what this is moving us in the direction of, Mr. Speaker. This is socialized medicine versus free market solutions that empower individuals to make the best health-care choices for themselves, Mr. Speaker.

Mr. Speaker, this is not about Republican versus Democrat. It is about bureaucratic-controlled health-care decisions versus decisions being made by moms and dads and grandparents. Mr. Speaker, this is about expanding government health care, expanding big government programs, expanding the control of government into the lives of people rather than bringing forth commonsense marketplace, free marketplace solutions that will empower individuals to make the best choices for themselves, Mr. Speaker.

Mr. Speaker, this legislation is bad policy. This legislation is not going to help the people of Pennsylvania. This is about proposing to take from one to give to another.

Talking about those who are uninsured, well, Mr. Speaker, there are some folks out there who are uninsured who are not choosing to spend and prioritize their spending on their own health-care insurance. Certainly that is not all, but there is certainly a percentage of them, Mr. Speaker.

Mr. Speaker, to give yet another government program that ultimately is going to have to be funded by taxpayer dollars in some way, shape, or form, which this legislation does not necessarily address how – it just talks about appropriating, Mr. Speaker – Mr. Speaker, this is talking about spending more tax dollars on someone else's health care when it was talked about earlier that 92 percent of the people have health care. So you are going to take from those who have and try and give to those who have not and some of that because of their own choices and priorities, Mr. Speaker.

Mr. Speaker, it is time to bring forth real solutions for the real working men and women of Pennsylvania and not to put forth another program that, as one of the earlier speakers said, will most likely in a disproportionate way benefit a lot of folks in Philadelphia compared to the other folks across Pennsylvania. Mr. Speaker, I know my taxpayers in Butler County do not want to see more of their tax dollars being taken to provide for their neighbor's health care, especially when their neighbor lives in Philadelphia.

Mr. Speaker, there are continued encroachments upon the liberties of the people of Pennsylvania, and this is yet another one, another way to redistribute wealth, another way to get at the tax dollars of the hardworking men and women of this State, to take from one to give to another so you have government elitists who have the power in their hands to choose and make health-care decisions for individuals.

Mr. Speaker, it is time to protect the taxpayers of this Commonwealth. This new program, this new, ultimately, spending plan that is going to force one neighbor to pay for the health insurance of another, is not the right policy. Mr. Speaker, it is time to end the tax-and-spend and increasing-debt ways of this administration and this General Assembly as far as they have supported them in it.

Thank you, Mr. Speaker.

The SPEAKER. Representative DeWeese.

Mr. DeWEESE. In the 1960s along the broad-bosomed banks of the Potomac River, Republican Federal Congressmen and Senators made the same speech that we just heard from the honorable gentleman from Butler about Medicare and Medicaid in the 1960s. They were wrong then and he is wrong today.

The SPEAKER. Representative Rohrer.

Mr. ROHRER. Thank you, Mr. Speaker.

Mr. Speaker, I have been listening, as we all have now, for this lengthy debate today and then what we were engaged in last week, a lot of discussion back and forth about strengths and weaknesses of the approach that we have before us in this bill, with opinions felt very, very strongly on both sides of the issue, and I have been trying to listen and see how to frame my approach on this, and I will share something that I hope will perhaps put a little different view on really the debate that we are having here today, and it was shared with me by a physician in my district over the weekend.

Mr. Speaker, I do not believe that there is anyone sitting here who does not understand that the issue of health care, the cost of health care, and to some extent the availability of health care, but to a less extent, is an issue of major concern to our people. It is indeed.

Anytime that you are sick, health-care coverage and availability to quality care is absolutely something that we all need. Yet on the other hand, Mr. Speaker, as we look at what has been before us here now, I think the issue that is really before us is one that goes to the heart of philosophy. It goes to the heart of actually how we are attempting to do what we would all like to see, and that is the best quality of care available to everyone who needs it whenever they need it. That is the goal.

We have talked about universal health care. We have talked about government's involvement in health care. Mr. Speaker, I believe that this is the issue that we are really debating here today and perhaps help those who are watching and those who are sitting here to frame this, and that is this: Is anyone here really opposing

universal care? Now, think about it. Does anybody here really not want to have health care, quality care, available to all who want it? The answer is no. What are we talking about, though? We are talking about not universal health care; we are talking about socialized health care and socialized medicine standing in contrast to universal care, because, Mr. Speaker, one just has to do a short amount of investigation to understand that there are multiple ways to provide universal health care.

The approach we are talking about here today is socialized medicine. It is government involvement using taxpayer dollars to pay for health care. That is not to be confused with universal health care. As one of my colleagues said, we require, as an example, that in order to drive a car in Pennsylvania, you have to have insurance coverage. That is universal, an application to those who are going to drive, but it is not socialized because other taxpayers are not subsidizing those who are driving their cars. If you drive a car, you pay for your own insurance. Yet here we are talking about recognizing that there is a need, but the plan before us is one that steps in and says, we are going to use taxpayer dollars, and that is why the comments about the cost of the program, and the problem is coming up with money to pay for it. Well, that is what you have with socialized medicine. You have got to come up with taxpayer dollars somewhere – through a tax increase; through cutting other programs and redirecting funding; from, in this case, extorting it from the Mcare program for the docs and making them pay for it. Somehow you have got to come up with the money. That is really the debate we are talking about here.

At the end of the day, are we better off? How much better off is the individual out there now who has care, has health insurance, but finding it difficult to pay the premium? Or the person who would like health-care coverage and insurance to cover it but cannot afford it?

Does this plan, if passed, help to accomplish access? No. Frankly, it actually will not. By trying to force medical providers into a plan where you either participate or we are not going to give you some reimbursement or whatever it may be, that is going to decrease access. That is going to decrease access, not increase it.

How about affordability? I do not think that this— We have not heard where this really increases affordability, except for those who may be subsidized in order to get some amount of care.

How about quality? This does not deal with quality of care. As a matter of fact, it does not do anything with quality of care.

How about availability? Well, no, not availability either.

Mr. Speaker, we are talking two philosophical approaches of how to deliver the best of care to the most people in the most effective way. That is all of our goal, and I would agree that is neither Democrat nor Republican. But there is a huge philosophical difference when we say that government's role goes beyond identifying the causes of the problem of why the cost of care is high and why government's interest in going beyond identifying why our medical providers are leaving this State, and therefore, availability and access has shrunk, and instead of fixing the problems, we attempt to reach into other taxpayers' pockets to subsidize a program that really is not government's business to be involved in in the first place.

Should we be compassionate? Absolutely. Do we need to be aware of the need that exists? Absolutely we should be. But is it our responsibility in this General Assembly to take from some to give to others who do not have? No. It is our responsibility to remove the barriers, to identify those causes, and they have been identified, and many of them have already been discussed here, and I am not going to go through them. But our business ought to be about identifying the cost drivers in health care and the limitations for those who would like to have health insurance but cannot afford it. That is our business, and that has not been the discussion today on this issue. SB 1137 does not focus on those issues. If it would, the entire debate today and before would have been entirely different, and we would be coming at hard solutions.

This is not a solution. This is not a solution to the problem, and, Mr. Speaker, that is why I will not be able to support this. And really, those who are watching should understand that there is a huge divide. The goal is the same, but there is a huge divide. Socialized medicine, universal health care, they are not the same.

Can socialized medicine accomplish universal health care? Yes, it can. But do we want to arrive at that goal of having health care for all by government paying for it and being involved in making it happen and subsidizing and interfering with the market? The answer is, no, we do not. It has never worked anywhere in the history of this world, and we should not be furthering it and pushing it forward today.

Thank you, Mr. Speaker.

The SPEAKER. Representative Cutler.

Mr. CUTLER. Thank you, Mr. Speaker.

I was wondering if the maker of the amendment that went into this bill, Mr. Eachus, would stand for brief interrogation?

The SPEAKER. Representative Eachus indicates he will stand for interrogation. Representative Cutler is in order and may proceed.

Mr. CUTLER. Thank you, Mr. Speaker.

Mr. Speaker, are you aware of the number of companies that currently offer medical malpractice insurance in the Commonwealth?

Mr. EACHUS. I believe there are more than 50 companies in Pennsylvania that are currently providing medical malpractice insurance in Pennsylvania, Mr. Speaker. Those include risk-retention groups and others.

Mr. CUTLER. And by risk-retention groups, are you referring to the self-insured physician groups?

Mr. EACHUS. Correct.

Mr. CUTLER. What about the number of commercial insurers that are in the Commonwealth?

Mr. EACHUS. Well, as you know, Mr. Speaker, medical malpractice was an issue that the House Insurance Committee, of which I was a member for almost 8 years, dealt with in a comprehensive way. We provided reforms that really stabilized the insurance marketplace for medical malpractice.

We had major problems in medical malpractice with jury shopping. We have eliminated that. With witnesses who are expert witnesses being arbitrary, we have certified that. We have made sure that you cannot move the jury to Philadelphia just to get a better award, and a number of other issues that have helped stabilize the insurance marketplace for medical malpractice and lower the amount of claims in the system currently as well as allow for lower costs for insurance. As well you know, we put together the Mcare program to subsidize physicians for the cost of their health care as well.

Mr. CUTLER. Well, Mr. Speaker, first of all, I would like you to bring up all the great programs that the majority leader said did not happen over the last 12 years under the former administration.

Second of all, those were all great programs, and I certainly understand that, but it did not answer the question of, are you

aware of how many companies are currently offering insurance in the Commonwealth?

Mr. EACHUS. Since 2002 there were 57 new licensed companies providing medical malpractice insurance in Pennsylvania – 57, Mr. Speaker.

Mr. CUTLER. 57 new companies and not self-insured groups? I just want to be clear.

Mr. EACHUS. In total.

Mr. CUTLER. All right. In total. All right. Thank you.

Is that a sufficient number of new companies to offer sufficient competition in the Commonwealth with regard to the medical malpractice liability insurance market?

Mr. EACHUS. Absolutely, Mr. Speaker.

Mr. CUTLER. Who is responsible for certifying the number of companies as well as the— Mr. Speaker, who makes the determination that the market is viable in order to support the amount of insurance that is out there that the doctors will require, and how much of the Mcare abatement is actually paid?

Mr. EACHUS. Well, Mr. Speaker, the Insurance Department would have to certify the companies that are providing medical malpractice insurance. But let me say, another indicator of physicians being able to buy coverage in the private market is by looking at the number of doctors obtaining coverage from the Joint Underwriting Association, the JUA, the medical malpractice insurer of last resort in Pennsylvania. Enrollment for the JUA has dropped to the lowest level since 2001, since we have implemented the reforms that I referred to earlier.

Mr. CUTLER. Mr. Speaker, is it not fair, though, to say that from 2001 until present we have seen a very strong stock market that may have attributed to some of the insurance company profits and profitability?

Mr. EACHUS. I do not know, Mr. Speaker. I am looking at the Bush economy right now, and all indicators show that we are in a recession.

Mr. CUTLER. Mr. Speaker, I am not referring to now; I am referring to 2001 until, say, about 9 months ago.

Mr. EACHUS. Well, I can only use today as a reference, Mr. Speaker. As you know, mortgage rates, it is tough to get a mortgage in this country right now. It is tough to get a good job with a living wage. So, you know, I have to use my reference of today. I have no facts on yesterday.

Mr. CUTLER. Your memory does not go back for the last 6 years, Mr. Speaker?

Mr. EACHUS. When you get to be 45, Mr. Speaker, your memory is going to slip a little, too.

Mr. CUTLER. I am so sorry to hear that, Mr. Speaker, and I do not look forward to that day.

However, are you familiar, Mr. Speaker, with the combined ratio with regard to the insurance industry?

Mr. EACHUS. Can you repeat the question, Mr. Speaker?

Mr. CUTLER. Mr. Speaker, are you familiar with what is commonly referred to as the "combined ratio" in the insurance industry?

Mr. EACHUS. No, I am not.

Mr. CUTLER. All right, Mr. Speaker. Thank you.

That will be all for my interrogation. May I speak on the bill, please?

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

Mr. CUTLER. First of all, I would like to address some comments regarding government programs made by the majority leader, the honorable gentleman from Greene County, with regard to Medicare and Medicaid. As is often the case in politics, the truth is often somewhere in the middle.

You know, the two camps are saying that Medicare and Medicaid are the answer for everything. The other says that it is a costly government program. The reality is, it is in the middle.

Medicare and Medicaid underpay chronically – chronically underpay the actual cost of services that they consume. The reason that this is so important is because every other person who has health insurance ends up making up these premiums. A recent study by the Pennsylvania Health Care Cost Containment Council indicated that Medicare typically pays 16 percent less than the actual cost provided for the services that they consume.

Additionally, Mr. Speaker, Medicare and Medicaid programs not only underfund, but Medicaid even underfunds more than – please hear me – the State-run program underfunds even less money, pays less money for the services that they consume than Medicare itself does, Mr. Speaker. And why is this important? Because those patient populations account for almost 60 percent of the patients that we see in hospitals, and yet they only account for 40 percent of the revenues.

So, Mr. Speaker, the reason I asked about the combined ratio is, why is it so important? One of the problems that we have in the insurance industry and the medical malpractice industry specifically is the cost to provide that coverage to our physicians. The combined ratio is really nothing more than a term that is utilized to define expenses versus dollars collected.

And, Mr. Speaker, I would like to point out a few points regarding the last couple medical malpractice crises and why I think it is so important that the Mcare Fund maintain its current reserve levels.

Mr. Speaker, in this State we have recently had three medical malpractice crises – the mid-1970s, the mid-1980s, and the most recent one ended in about 2002. The honorable gentleman pointed out many good reasons that that helped change, whether it was the Mcare Fund, whether it was the lack of venue shopping rules instituted by the courts. Those were great provisions. They all helped. However, the other reality, Mr. Speaker, is the stock market was returning to normal gains during that same time period. Mr. Speaker, it is no coincidence that each and every medical malpractice crises is preceded by a drop in the stock market.

Mr. Speaker, the combined ratio, the average combined ratio in the insurance industry at the end of 2001 was 1.4, and I know you are probably asking, what does that mean? That means for every dollar in premiums collected, the insurance companies paid out $1.40. By 2002, that number was up to $1.65: every dollar collected, $1.65 paid out. Mr. Speaker, nobody can run a business on those kinds of margins.

And the reason that the stock market influences so greatly is because of their investment portfolios. On years where their rating might be a dollar-for-dollar or a small profit or a small loss, they can make up the difference by investing the money. Mr. Speaker, in bad market downturns, this is not the case. You are probably saying, why is this important? It is so important because, Mr. Speaker, the S&P (Standard & Poor's) 500 is down 15 percent year-to-date. We should not fool ourselves and think that the medical malpractice crisis is over. We should not fool ourselves to think that we cannot have another one.

Mr. Speaker, we have a downturn in the economy now, as the previous gentleman so eloquently pointed out, and the reality is this: We will see that in increased medical malpractice liability insurance premiums in the future. Mr. Speaker, one of the reasons

for that is the poor performing stock market. The other is the amount of legal expenses that are currently built into the system.

One of my colleagues referenced the joint and several liability earlier that was left high and dry by the Governor. Mr. Speaker, 40 percent of every dollar is spent on medical malpractice defense – 40 percent is spent on defense – and 62.3 percent of those cases are decided in favor of the defendant. Think about that. That is a lot of unneeded costs that are currently in the system that we could save money right now, and yet this bill does not address that.

Mr. Speaker, a prior colleague referenced emergency room visits and said how that is a plague on our current hospital system, and I agree. Mr. Speaker, the problem is this: If people cannot afford insurance and they have a government-subsidized or a government-run insurance, there is still no deterrent not to use the emergency room. There is none. Mr. Speaker, if they cannot afford to buy insurance, they cannot afford a copay, and most people who have insurance have large copays to keep them out of the emergency room. I have seen them as high as $500 per visit. Mr. Speaker, this plan has no guarantee of doing that.

Mr. Speaker, I think it is incredibly foolish to raid the Mcare Fund to fund another program that is completely unrelated to the liability nature of our medical industry right now. Mr. Speaker, we have a bill coming due. Let us not fool ourselves. We are going to see premiums go up over the next year or two because of the poor performing stock market and the poor performing investments made by insurance companies. It is foolish to spend that money today, Mr. Speaker, when we know the bill is coming to fund a completely unrelated program.

Mr. Speaker, in closing, I think we need more competition in the medical malpractice market, and we need to keep our reserve to prepare for bad times, bad times that we are more than likely in.

Mr. Speaker, we need real tort reform to decrease the amount of money currently being spent on medical malpractice defense that wins anyway. We need to keep costs down for health care. We need to stop cost shifting. Remember, Medicare and Medicaid chronically underfunding, chronically underfunding what they consume is essentially a 16-percent tax on everybody else who has health care. We need to remember that, Mr. Speaker, and we need to improve quality and we need to control the costs of the combined ratios for insurance companies. And most importantly, Mr. Speaker, we need to keep physicians in the Commonwealth and practicing.

Mr. Speaker, SB 1137 in its current form does none of these. It does not do this. It offers insurance to some; I will give it that. It offers insurance through a very small portion of the 800,000 who need help.

And, Mr. Speaker, we have really got two choices here today. We can help some by charging everyone, or we could support proposals that help everyone and cost nothing new to the taxpayers, Mr. Speaker, and that is the one that I am going to support. That is the package of bills that I support.

Mr. Speaker, I support helping everyone, not a select group, Mr. Speaker, and more importantly, I support lowering the overall costs of health care. I think that is why this is so, so important, and I will be a "no" vote on SB 1137. Thank you.

The SPEAKER. Representative Reichley.

Mr. REICHLEY. Thank you, Mr. Speaker.

Would the gentleman from Luzerne, the lead advocate on this measure, stand for brief interrogation?

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

Mr. REICHLEY. Thank you, Mr. Speaker.

First off, Mr. Speaker, in deference to my colleague from Monroe County who became a little confused about which holiday we are celebrating, happy Groundhog Day, Mr. Speaker, just because it does seem like we are right back in the same situation we were before.

And, Mr. Speaker, you seem to be looking well, because one of the members over here was a little concerned about your welfare from last week's question, but—

Mr. EACHUS. Mr. Speaker, I appreciate your concern for my welfare. I could use some sun.

Mr. REICHLEY. Okay. Well, I agree. That would be good for all of us, so.

Mr. Speaker, I think in the conversations that we have had on this bill both today and last week, it has been necessary to clarify some answers to the questions. In listening to your responses, I believe to the gentleman, Mr. Gabig, you indicated that there – or maybe it was Mr. Scavello; I apologize – that there would be an immediate transfer of those individuals who are on the waiting list for adultBasic into the ABC Program. Would that be correct, under your amendment?

Mr. EACHUS. Yes. Those citizens who are currently on the waiting list – there are 80,000 right now – would be immediately eligible once we pass this proposal.

Mr. REICHLEY. Now, Mr. Speaker, your language does cause me to raise another question. When you say they are immediately eligible, does that mean they are guaranteed coverage under your amendment?

Mr. EACHUS. No, Mr. Speaker.

Mr. REICHLEY. So the problem we have right now with a waiting list on adultBasic would not be entirely solved by your amendment. Is that correct?

Mr. EACHUS. Well, let me talk to you about the waiting list itself. As people get employed and they get insurance, they may not need the insurance when they get the call from the adultBasic program. So what this would do is it would recalculate that list and support as many people as possibly could be covered.

As I told you in last week's discussion, that immediately upon passage of PA adultBasic, the 55,000 people who are currently in adultBasic would be transferred to the new CARE (Continuing Access with Relief for Employers) coverage platform, and 143,000 additional Pennsylvanians would be eligible for the PA ABC Program.

Mr. REICHLEY. And I believe when you state that 143,000 are eligible, you are taking the 55,000 currently on adultBasic and adding the 80,000, 85,000 or so that are on the waiting list. Is that correct?

Mr. EACHUS. That is correct.

Mr. REICHLEY. But the money that is currently allocated for adultBasic, which is roughly about $60 million, that would be transferred over to provide the funding for your program. Is that correct?

Mr. EACHUS. Yes, sir. The tobacco settlement funding and the—

Mr. REICHLEY. Community Health Reinvestment?

Mr. EACHUS. Yeah; what is the fund? Yes, the other fund that was negotiated with the Blues, the Community—

Mr. REICHLEY. Community Health Reinvestment.

Mr. EACHUS. The Community Health Reinvestment Fund would be transferred as well.

Mr. REICHLEY. Right; the surcharge from about 3 years ago, I believe.

Mr. EACHUS. There is about $150 million a year in that.

Mr. REICHLEY. All right. But that still leaves us with a necessity for the Commonwealth to come up with roughly $120 million to provide the additional coverage for that. Is that correct?

Mr. EACHUS. As I explained last week, Mr. Speaker, we have set up a fund called the SAFE Fund that would be able to take other revenue that this legislature would define from savings within State government perhaps and potentially other options for revenue that we would determine during the budget process, closer to June.

Mr. REICHLEY. But the cost for the benefit to be provided under your amendment would be more expensive than what is available under adultBasic, because you have added a prescription coverage and a behavioral health component to it. Is that correct?

Mr. EACHUS. Well, you would be surprised the scales of economy that come into play when you put a good formulary for prescription drugs in place with a medical model. When you lack the ability to get prescription drugs, there is a higher rate of health problems that are outcomes of people not being able to get prescription drugs with the adultBasic program. They end up coming back into the doctor more often. With a prescription drug formulary in a health plan, like, frankly, the legislature has, the ability to have a better health outcome when you unify those two methodologies is much greater. So in many cases you get a lower cost of care as it relates to the health side of the equation. So the health side of the equation costs go down, and you see the investment in the prescription drug formulary yielding really better health outcomes for citizens.

Mr. REICHLEY. Mr. Speaker, are you able to describe today then what the nature of that formulary will be under this plan?

Mr. EACHUS. I explained to you last week, Mr. Speaker, that will be up to the Insurance Department. I cannot.

Mr. REICHLEY. And I recall that. That is why I was curious about your sudden enthusiasm for the savings to be derived from a formulary. You have referred to the health-care plan for the members in the chamber here. Are you stating that the formulary or the prescription plan utilized for House members will be the same as that provided under your amendment?

Mr. EACHUS. That will be up to the Department of Insurance, Mr. Speaker.

Mr. REICHLEY. I guess is the answer no then, or you do not know?

Mr. EACHUS. As I said, the bill is silent as it relates to the formulary design for the prescription drug proposal, so it would be up to the Department of Insurance to set that formulary and put those regulations in place.

Mr. REICHLEY. Mr. Speaker, is the amendment, or the bill as it is now amended, also silent as to what the reimbursement rate would be for medical providers?

Mr. EACHUS. Intentionally, Mr. Speaker, because it is important that we have the ability for the Insurance Department, the insurance companies who will deliver this product, and the provider networks – hospitals, doctors, and others – to have a say in what a fair reimbursement rate would be. So we did not want to set that amount. We want the ability for those communities to come together with the Insurance Department and make a fair deal for reimbursement.

Mr. REICHLEY. And without knowing what the reimbursement rate will be for the doctors who are out there going to be providing these services, the bill as amended currently, though, compels any physician who would participate in the Mcare plan to accept that reimbursement rate. Is that correct?

Mr. EACHUS. That is correct. And today if someone uninsured walks into a doctor's office, they either get turned down and pushed out the door because the doctor does not cover the uninsured, or the doctor will do the care and be compensated at zero.

Mr. REICHLEY. Or they will do what has also been criticized, is go to an emergency room. Is that correct?

Mr. EACHUS. Well, uncompensated care, as I said, is $1.4 billion in costs to our health-care system, and much of that comes through the emergency room door, Mr. Speaker.

Mr. REICHLEY. And, Mr. Speaker, by requiring a physician to participate in this plan under your amended language, is there anything which compels a patient to go to a participating physician?

Mr. EACHUS. I am sorry. One more time, Mr. Speaker?

Mr. REICHLEY. Sure. You just referenced the situation that takes place. Under the language of your amendment, though, in the amended bill, is there anything which compels a patient to go to a participating physician for primary care?

Mr. EACHUS. Under the PA ABC Program, all physicians in Pennsylvania would be participating in this program.

Mr. REICHLEY. Is there anything which compels a patient to go to one of the physicians for a primary office visit rather than going to an emergency room?

Mr. EACHUS. No.

Mr. REICHLEY. So you would have the exact same situation that occurs now, Mr. Speaker, where people go to emergency rooms for primary treatment rather than going to a physician. Even if they are on adultBasic, even if they are on medical assistance, they go to the emergency room.

Mr. EACHUS. No. You are leaving out one of the key components of the additional CARE platform we are putting in the plan design, which is disease management, Mr. Speaker. One of the key components in making sure that people with – high-risk patients especially – COPD (chronic obstructive pulmonary disease), folks who have diabetes, folks who have other kinds of problems that are relating to heart disease, those people would have someone, a clinical manager within the company that is being provided, their insurance company is providing this product. It is not a government program. These are insurance companies providing the products, so there would be a disease management component where the care management plan would be developed between the patient and the insurance company providing the care. So you are going to have much more management of where people are supposed to go, when they are supposed to be there, and what health outcome should be expected within the system.

Mr. REICHLEY. Well, Mr. Speaker, that is true with regard to disease management, which I agree with you is a wonderful program. I, in fact, had introduced legislation and an amendment, which most of your members rejected, to include a tax credit for private employers to include disease management in their current health insurance plans. But be that as it may, it still gets back to the basic question, even if you have a disease management plan in place to deal with heart disease, asthma, diabetes, there is not,

Mr. Speaker, anything which requires the patient to go to a primary care physician for an office visit rather than going to an emergency room for treatment. Is that not right?

Mr. EACHUS. Well, let me tell you, today a person walks into an emergency room or a doctor, especially a doctor's office, and either cannot get care or the doctor cannot get paid. Under this proposal, the doctor gets paid and the hospital gets paid, and it fills the gap of those who are uninsured, driving the cost down for everybody.

Mr. REICHLEY. But you cannot tell us how much the doctor gets paid. Is that correct?

Mr. EACHUS. As I said earlier, Mr. Speaker, I am happy to answer your questions over and over again, but this is silent to what the doctors will be paid, and we will leave that to the Insurance Department. It does not matter how many ways you ask the question, I am going to answer it the same way.

Mr. REICHLEY. Well, you keep referring back to virtues which you state are unresolved. You keep mentioning the fact that a doctor will get paid to provide this treatment, but you cannot tell us how much the doctor is getting paid. Can you tell us how much the hospitals will get paid for treating these patients?

Mr. EACHUS. Mr. Speaker, I have asked and answered this question three times, Mr. Speaker. Is the gentleman out of order?

Mr. REICHLEY. I do not think so, Mr. Speaker. I am just trying to get an answer to the question.

The SPEAKER. The purpose—

Mr. EACHUS. I have a question, Mr. Speaker. Parliamentary inquiry.

The SPEAKER. If the gentleman will cease. The purpose of interrogation, one, is to ask questions that the gentleman does not know the answers to, and the second is that standing for interrogation is totally discretionary. If the gentleman has indicated that he has asked the question, I would believe that would be sufficient. And the gentleman could ask the question in another way.

Mr. REICHLEY. Yes, Mr. Speaker. Does the bill address the issue of hospital reimbursement any differently than it addresses the issue of physician reimbursement?

Mr. EACHUS. No.

Mr. REICHLEY. So we still do not know how much hospitals or doctors get paid. Okay.

Mr. Speaker, on the CARE grants for small businesses, you mentioned that those would be grants provided to businesses that apply, and there is a $42 million fund that is first come, first served. If all the money is more or less consumed with distributing the grants, that is it for the fiscal year. Is that correct?

Mr. EACHUS. Yes, sir, Mr. Speaker. As I told you, we think, on the Democratic side, that it is a good conservative start to making sure that small businesses that currently provide health care in a responsible way to their low-wage employees get the benefit of a CARE grant. Yes, Mr. Speaker.

Mr. REICHLEY. Mr. Speaker, would not the grant be taxable as income to the business in the following year?

Mr. EACHUS. No, Mr. Speaker; it would not be taxable.

Mr. REICHLEY. Why would the grant not be taxable?

Mr. EACHUS. It would not be taxable, Mr. Speaker.

Mr. REICHLEY. And why not? Why would it not be regarded under the personal income tax code or under the appropriate tax code as being income?

Mr. EACHUS. Well, it would relate to the business's tax liability. If they have no tax liability, they have zero tax liability, they would not be eligible for a CARE grant. But if they have tax liability, the CARE grant would be calculated against their current tax liability. So it would not be as you described.

Mr. REICHLEY. Well, Mr. Speaker, is this not essentially the same as a refund back to a taxpayer?

Mr. EACHUS. Mr. Speaker, I can just tell you one more time – I have answered it three times – it is not taxable.

Mr. REICHLEY. And in the following tax year, an individual who receives a refund gets taxed upon that refund as income such as you would with this grant.

Mr. EACHUS. I do not know anything about the other scenario you have discussed.

Mr. REICHLEY. Okay. Those are all the questions I have for the gentleman, Mr. Speaker. Thank you.

The SPEAKER. Would the gentleman like to make a comment?

Mr. REICHLEY. Briefly, Mr. Speaker. On the amendment.

The SPEAKER. The gentleman is in order.

Mr. REICHLEY. I realize this is a very divisive issue. I think that over the last 14 months we have heard numerous times the majority leader say that he wants to engage in a bipartisan dialogue on these issues, and yet in this particular situation, we have seen the Republicans shut out from any fruitful consideration. The gentleman— Actually, Mr. Speaker, I do have one more question. Would the gentleman stand, Mr. Speaker? I am sorry. Could the gentleman stand for one more brief interrogation?

The SPEAKER. The gentleman indicates he would be glad to.

Mr. REICHLEY. Thank you.

Mr. Speaker, I think in response to Mr. Gabig's questions you did mention that you had consulted with numerous stakeholders. Would you be able to tell the House who those are?

Mr. EACHUS. Well, I can define a few members of your caucus whom I met with individually and in groups. I met with Chairman Micozzie. I met with Representative Watson and Representative Boyd. And in December the minority leader was there as well. So I have met with numerous members from your side of the aisle in hopes we could forge bipartisanship on this issue. Beyond that, many stakeholders have been in my office – doctors, lawyers, and Indian chiefs, and everybody in between.

Mr. REICHLEY. Well, did the doctors, lawyers, and Indian chiefs participate in the language in your amendment, in the drafting of it, in providing ideas and language?

Mr. EACHUS. Mr. Speaker, this was a process developed by House Democratic staff and discussed with many stakeholders. There is no lobbyist writing this bill because this is a bill that covers the uninsured and we did not feel that Harrisburg lobbyists should be engaged in writing this legislation, because it addresses a very simple issue, that there is a significant problem with the cost of insurance, and we believe on this side of the aisle you need to cover it.

Mr. REICHLEY. So I take it, Mr. Speaker, that you did not consult with any association of the hospitals?

Mr. EACHUS. We had discussions with those groups, but no one, and I say it again, no one wrote this legislation. This was a Democratic member and staff written proposal.

Mr. REICHLEY. So I take it that those conversations with Chairman Micozzie, Representative Boyd, Representative Watson, and the minority leader did not yield anything that you put in your amendment?

Mr. EACHUS. Oh no. I think they dealt with wonderful opportunities. We have included the CARE grants, which mirror the tax credits that your side put forward. We put an HSA

(health savings account) model in which will allow for competition in the health savings account process, which will create the same CARE platform as the adultBasic model but allow for younger employees to get a more competitive price on a product that they would design on their own to be sold, let me say, in the private market by those who are health underwriters.

Mr. REICHLEY. And you did not have the participation of the Medical Society or the Orthopaedic Society in drafting this amendment?

Mr. EACHUS. I met with all those, and the Hospital Association.

Mr. REICHLEY. All right. I appreciate your standing for—

Mr. EACHUS. But no one, once again I will repeat, no one wrote this legislation who is a lobbyist. This was written by us on the Democratic side and our staff.

Mr. REICHLEY. Thank you, Mr. Speaker.

Now back on the amendment, Mr. Speaker.

The SPEAKER. The gentleman is in order.

Mr. REICHLEY. I appreciate the clarification from the gentleman from Luzerne, that he underscored that no lobbyist wrote that, and I think that is wonderful. Certainly we should rely upon legislators and their staff to do that. I think it also underscores the fact that this is a political party-driven piece of legislation, which does not have any interest in getting participation from the stakeholders, which does not have any interest in getting participation from other members of the Republican Party or the Republican Caucus, and this is meant as some kind of power squeeze on physicians. We are 14 days away from the point at which the extension of the abatement will kick in on physicians. There is some idea that somehow if we include this language that we will now be forcing the Senate to comply with this legislation. I would just question the members that if the Senate decides we do not want to take the House language on such a huge issue in such a haphazard way and remove that language and send it back to the House, are the members on the other side of the aisle really prepared to vote against doctors when SB 1137 returns to us?

Thank you very much, Mr. Speaker. I urge a "no" vote on SB 1137.

ANNOUNCEMENT BY MR. BOYD

The SPEAKER. For what purpose does the gentleman, Representative Boyd, rise?

Mr. BOYD. Thank you, Mr. Speaker.

I would like to clarify an announcement I made earlier, if I may, Mr. Speaker.

The SPEAKER. The gentleman is in order.

Mr. BOYD. Pursuant to rule 21, I rise to announce to all the members of the House that I plan to call up House Discharge Resolution No. 2 for a vote on March 31 or any legislative day thereafter.

The SPEAKER. The Chair thanks the gentleman.

LEAVE OF ABSENCE

The SPEAKER. The Chair recognizes the minority whip, who requests that Representative HENNESSEY be placed on leave for the remainder of the day. The Chair sees no objection. The leave will be granted.

CONSIDERATION OF SB 1137 CONTINUED

The SPEAKER. Representative Benninghoff. The gentleman waives off. The Chair thanks the gentleman.

Representative Maher.

Mr. MAHER. Mr. Speaker, you will be as happy as many of our colleagues to hear that many of the concerns I was going to raise have been addressed, and I will not repeat them. However, I do need some clarification on the bill as amended, and I would ask that the gentleman who is taking responsibility for this draft respond to some questions.

The SPEAKER. The gentleman, Representative Eachus, indicates he will stand for interrogation. The gentleman, Representative Maher, is in order and may proceed.

Mr. MAHER. Thank you.

Now, I am having a bit of a challenge pointing out the page and line numbers I would like you to refer to, because as of a couple of minutes ago, of course, this bill is not even in print in its current form. So please bear with me, and I am going to use page and reference numbers for the version that existed at the beginning of the day.

Mr. EACHUS. I am sorry. What was your question, Mr. Speaker? I missed it.

Mr. MAHER. The question would be on page 43, line 9, "ELIGIBLE ADULT" is defined as an individual who meets a number of requirements. One of those requirements, requirement No. (7), is that the individual has a household income no greater than 300 percent of the Federal poverty level. Am I understanding that correctly?

Mr. EACHUS. Correct.

Mr. MAHER. Thank you.

And as you continue through the definition section, there is a definition of "INDIVIDUAL," which says, "A PERSON WHO MEETS ALL THE REQUIREMENTS OF AN ELIGIBLE ADULT" – which is the definition we just talked about – "BUT WHOSE HOUSEHOLD INCOME IS GREATER THAN 300% OF THE FEDERAL POVERTY LEVEL." Is that correct?

Mr. EACHUS. Yes.

Mr. MAHER. All right. Then, Mr. Speaker, and this is fairly important, if SB 1137 is voted into law as it stands, there will be no individuals eligible for coverage, none, because an eligible adult is defined as an individual with income less than 300 percent of the Federal poverty level, and an individual is defined as someone who is otherwise eligible, whose income is greater than 300 percent of the Federal poverty level, and I submit to the members of this House that we cannot have a qualification that embraces anyone if it says you have got to be higher than 300 percent and you have got to be lower than 300 percent at the same time.

Mr. EACHUS. Was there a question in there, Mr. Speaker?

Mr. MAHER. I am asking, can you identify how many people are both higher and lower than 300 percent of the Federal poverty level?

Mr. EACHUS. Mr. Speaker, I just think your interpretation is wrong, that the language is clear.

Mr. MAHER. Please explain how an individual— Which of those did I misunderstand, because I thought you confirmed each of them?

Mr. EACHUS. Well, we have debated this in our caucus, and our legal counsel has said that your interpretation is incorrect.

Mr. MAHER. Well, forgive me for needing to be reluctant to representations of what was said in secret meetings off the floor of this House, but I am asking you about what is printed on the page, and what is printed on the page is that an eligible adult is an individual with income less than 300 percent of FPL (Federal poverty level) and an individual is someone with income greater than 300 percent of FPL. How can someone be both higher and lower of FPL at the same time?

Mr. EACHUS. I will repeat, Mr. Speaker, I just find your interpretation to be incorrect.

Mr. MAHER. Which part is incorrect, sir? Help me understand it because I am reading the plain words.

The SPEAKER. The gentlemen will suspend. The Chair will ask the gentlemen not to speak over each other.

Mr. EACHUS. Once again, I just find the way you are interpreting the two different sections to be incorrect, wrong. If you are happy to debate it, you would like to debate it, go right ahead.

Mr. MAHER. Sir, could you perhaps help me understand where the interpretation has come in. I am reading the plain words on the page. One says, to be eligible, you have got to be above 300 percent. The other says you have got to be below 300 percent. I am asking, which is it?

Mr. EACHUS. Once again, I will answer in exactly the way I said earlier. I just think you are not looking at this in the way that conforms to the way the act is written and your interpretation is wrong.

Mr. MAHER. All right. Well, thank you, Mr. Speaker. I will conclude my interrogation and just add a couple of thoughts.

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

Mr. MAHER. This is pretty serious business. This bill eliminates health insurance for 50,000 Pennsylvanians, eliminates it, and advertises some other program that has been discussed at some length, but to be eligible for that program, the way this is written, and I will read it again for the members because this is not tricky: " 'ELIGIBLE ADULT.' AN INDIVIDUAL WHO MEETS…THE FOLLOWING:" number (7), "… HOUSEHOLD INCOME…NO GREATER THAN 300% OF THE FEDERAL POVERTY LEVEL…." An eligible adult, an individual with no more than 300 percent of the Federal poverty level. An "INDIVIDUAL" is defined, "INDIVIDUAL": "A PERSON…WHOSE HOUSEHOLD INCOME IS GREATER THAN 300% OF THE FEDERAL POVERTY LEVEL."

Now, maybe this is another illustration of the risks taken when there is lawmaking in the dark. But I doubt any one of us, unless you are dealing in particle physics, can say something is there and not there at the same time. And even in particle physics, it is there and not there for such a brief moment that it would not make any difference anyway.

Now, the gentleman who is offering this bill today says we just should not worry about it, that it is a matter of interpretation. But I submit to you, if you look at the bill, which I realize is hard because it is not even in print in its current version yet, but if you look at the bill and the immediately preceding edition, which the gentleman has confirmed to me reads the same on these points, you will see that eligible individuals have got to be greater than 300 percent of FPL and they need to be less than 300 percent of FPL, and I submit to you that that is zero Pennsylvanians.

Now, maybe the maker of the bill meant it to say something else. I dearly expect he did intend for the bill to say something else, but that is not for us to say. And I will remind the members that under the Statutory Construction Act, the notion that someone like the gentleman, Mr. Eachus, can say it just is not so means nothing. The first place you go is the plain language on the page, and the plain language on this bill is you are eliminating adultBasic, eliminating it, kicking 50,000 families off the insurance rolls, and you are replacing it with nothing.

Now, if you mean to do something different, I would suggest you ask the maker of the bill to pull the bill back and roll it back to third consideration, do a technical correction, and make the bill say whatever he means for it to say.

You know, it is a darn shame to have this moment in time, this opportunity, where we could really do some good things for health care in Pennsylvania, and instead, we have a bill that only guarantees this much: AdultBasic enrollees will be out of business. The cost for malpractice insurance will increase because money has been taken away from that program. Other health programs that go out to every community in the State will be curtailed because the money from the tobacco program is being taken away. And who is going to be eligible? Well, I guess we will have to wait and see what the courts will ultimately decide because this bill says nobody is eligible.

Thank you, Mr. Speaker.

The SPEAKER. Representative Saylor.

Mr. SAYLOR. Mr. Speaker, I rise today to also oppose SB 1137 as presented here on the House floor. I find it interesting that we all talk about government-run programs. This State and the other 49 States across this country are facing a huge crisis with Medicaid and Medicare costs, providing health-care coverage for those individuals. And here we go again, wanting to propose another government-run program. You know, the Federal government has done a lousy job, if you ask our senior citizens, at managing their retirement accounts and Social Security, and yet we are going to ask State government to manage the health-care costs of seniors and others throughout this State who are currently not insured, young people.

The whole reason, I believe, that this bill as amended in the House did not have public hearings was simply because it could not stand the light of day. This bill, if it had testimony at a public hearing, would have been criticized by just about everybody, from consumers to health-care companies, pharmacists, doctors, nurses, just everybody. This bill does nothing to help solve the problems here in Pennsylvania in the area of health care. It does not solve the problem of cost, it does not solve the problem of coverage, and it surely does not solve the issue of quality of care in Pennsylvania. This bill does nothing but make promises to the consumers and people who need health care in Pennsylvania. And more importantly, it is going to take people now who have health-care plans that are covered by their companies and their businesses and put them on the government health-care programs. That is not the way to solve the problems of health care.

We need to encourage more employers in Pennsylvania, to encourage them to provide health-care coverage for their employees rather than disincentives to do so. This bill will move forward huge tax increases. Just in the next 3 years alone, if this bill were to become law, it will increase the cost of Pennsylvania of well over $800 million. While we still already face a crisis here in this State, as the Governor and all have been talking about, how do we fund the current requirements on Medicaid?

It is interesting, over the weekend we had an article in the Altoona Mirror that said, "But the way the House is operating is akin to a surgeon doing open-heart surgery without previously

seeing the patient or having any pretesting done to understand the particulars of the problem, what complications might come up, whether it could exacerbate the trouble or whether it could cause harmful side effects.

"Patients wouldn't be willing to accept those actions from a doctor, and we shouldn't accept it from our lawmakers."

This bill is bad legislation. Everybody here on the House floor understands that if this bill makes it to the Senate, this bill is going to die because there is no support among consumers, there is no support among doctors or hospitals to provide this bill. It is so poorly written.

Again, I ask for a negative vote on this piece of legislation. Thank you, Mr. Speaker.

The SPEAKER. Representative Clymer.

Mr. CLYMER. Thank you, Mr. Speaker.

Mr. Speaker, I just have an observation I would like to make in this debate. The Pennsylvania Gaming Control Board, monthly or routinely issues figures on the millions of dollars that it takes from the seven casinos. As I said, we get these reports, and we know from past studies that too many of our most vulnerable citizens, those who can ill afford to gamble, are attracted to the casinos. The question is, how many of these citizens are using household money that should go toward health-care premiums? Instead, they spend it at the casinos. Now, we have seven opened with seven more to go, and we know that the number of those who will be spending those hard-earned dollars is only going to accelerate. There will be more. And I think we need to find out because we need to find out exactly who it is in this income group that is gambling away their money.

Within the near future I plan to introduce a resolution to have the Legislative Budget and Finance Committee do a study by income of those who are attracted to the casinos and spending the moneys that they cannot afford to spend and should go for other things such as health-care insurance. I only bring this up because it is an important issue and one that we in the General Assembly are going to have to contend with. We cannot bury it. It is there. We have to consider it. Hopefully this study, I am going to make a request, will shed some light. In the meantime, it makes me support opposing SB 1137 because we need to certainly consider how we are going to help those who, because of the gambling operation in this Commonwealth, are going to need our assistance.

Thank you, Mr. Speaker.

The SPEAKER. Is there any other member seeking recognition before the Chair recognizes Representative Eachus?

On the question recurring,
Shall the bill pass finally?

The SPEAKER. Agreeable to the provisions of the Constitution, the yeas and nays will now be taken.

The following roll call was recorded:

YEAS–118

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

NAYS–81

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

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

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 return the same to the Senate with the information that the House has passed the same with amendment in which the concurrence of the Senate is requested.

The SPEAKER. The House will be at ease.

STATE GOVERNMENT COMMITTEE MEETING

The SPEAKER. For what purpose does Representative Josephs rise?

Ms. JOSEPHS. To make an announcement.

The SPEAKER. The lady is in order.

Ms. JOSEPHS. Thank you.

I want to advise the members of the House State Government Committee we will meet today at the call of the Chair in the lobby outside of the Lieutenant Governor's Office. They all have e-mails what the agenda is, but I could say it for the public, HB 2356, which we are going to rerefer at the request of the committee chair to which we are going to refer it.

The SPEAKER. The lady's announcement is that she is calling her meeting at the call of recess. Is that correct?

Ms. JOSEPHS. Sir, whenever you think it would work out well. I would like to do it today, if we are in recess, if we are at ease, if we are at a break. I would appreciate it.

The SPEAKER. At the first opportunity.

Ms. JOSEPHS. Thank you, sir.

The SPEAKER. The Chair thanks the lady.

Will Representative Josephs approach the rostrum, please.

(Conference held at Speaker's podium.)

The SPEAKER. The House will come to order.

GUESTS INTRODUCED

The SPEAKER. The Chair would like to recognize, as the guests of Representative Frankel, Pittsburgh City Council President Doug Shields and his wife, Brigitt, and Pittsburgh City Council member Bruce Krause. Would you please stand and be recognized. Welcome to the floor of the House.

The House will be at ease.

The House will come to order.

RESOLUTION PURSUANT TO RULE 35

Mr. McGEEHAN called up **HR 638, PN 3408,** entitled:

A Resolution declaring March 2008 as "Irish American Heritage Month" in Pennsylvania.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

ANNOUNCEMENT BY SPEAKER

The SPEAKER. The Chair would like to take this opportunity to recognize a very lucky individual who happened to be born on March 17, Representative Gary Haluska. Happy birthday.

RESOLUTIONS PURSUANT TO RULE 35

Mr. WILLIAMS called up **HR 602, PN 3247,** entitled:

A Resolution honoring the late Representative David P. Richardson, Jr., a member of the Pennsylvania House of Representatives from 1973 to 1995.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. WILLIAMS called up **HR 603, PN 3248,** entitled:

A Resolution honoring the late Senator Roxanne H. Jones, a member of the General Assembly from 1984 to 1996.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. WILLIAMS called up **HR 601, PN 3246,** entitled:

A Resolution commemorating the achievements and contributions the late Honorable K. Leroy Irvis made to the General Assembly and the Commonwealth of Pennsylvania.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Ms. MUNDY called up **HR 615, PN 3282,** entitled:

A Resolution congratulating the Luzerne County Historical Society on the 150th anniversary of its incorporation.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

Freeman

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. CLYMER called up **HR 617, PN 3293,** entitled:

A Resolution designating the week of March 16 through 22, 2008, as "MPS Week" in Pennsylvania in memory of Ryan Taylor Mask of Sellersville, Bucks County.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mrs. GINGRICH called up **HR 628, PN 3330,** entitled:

A Resolution recognizing the week of March 9 through 15, 2008, as "Girl Scout Week" in Pennsylvania.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

Adolph	Gabig	Marshall	Rohrer
Argall	Galloway	Marsico	Ross
Baker	George	McCall	Rubley
Barrar	Gerber	McGeehan	Sabatina
Bastian	Gergely	McI. Smith	Sainato
Bear	Gibbons	McIlhattan	Samuelson
Belfanti	Gillespie	Melio	Santoni
Benninghoff	Gingrich	Mensch	Saylor
Bennington	Godshall	Metcalfe	Scavello
Beyer	Goodman	Micozzie	Schroder
Biancucci	Grell	Millard	Seip
Bishop	Grucela	Miller	Shapiro
Blackwell	Haluska	Milne	Shimkus
Boback	Hanna	Moul	Siptroth
Boyd	Harhai	Moyer	Smith, K.
Brennan	Harhart	Mundy	Smith, M.
Brooks	Harkins	Murt	Smith, S.
Buxton	Harper	Mustio	Solobay
Caltagirone	Harris	Myers	Sonney
Cappelli	Helm	Nailor	Staback
Carroll	Hershey	Nickol	Stairs
Casorio	Hess	O'Brien, M.	Steil
Causer	Hickernell	O'Neill	Stern
Civera	Hornaman	Oliver	Stevenson
Clymer	Hutchinson	Pallone	Sturla
Cohen	James	Parker	Surra
Conklin	Josephs	Pashinski	Swanger
Costa	Kauffman	Payne	Tangretti
Cox	Keller, M.	Payton	Taylor, J.
Creighton	Keller, W.	Peifer	Taylor, R.
Curry	Kenney	Perry	Thomas
Cutler	Kessler	Perzel	Turzai
Daley	Killion	Petrarca	Vereb
Dally	King	Petri	Vitali
DeLuca	Kirkland	Petrone	Vulakovich

Denlinger	Kortz	Phillips	Wagner
DePasquale	Kotik	Pickett	Walko
Dermody	Kula	Preston	Wansacz
DeWeese	Leach	Pyle	Waters
DiGirolamo	Lentz	Quigley	Watson
Donatucci	Levdansky	Quinn	Wheatley
Eachus	Longietti	Ramaley	White
Ellis	Mackereth	Rapp	Williams
Evans, D.	Maher	Raymond	Wojnaroski
Evans, J.	Mahoney	Readshaw	Yewcic
Everett	Major	Reed	Youngblood
Fabrizio	Manderino	Reichley	Yudichak
Fairchild	Mann	Roae	
Fleck	Mantz	Rock	O'Brien, D.,
Frankel	Markosek	Roebuck	Speaker
Freeman			

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. PAYNE called up **HR 632, PN 3396,** entitled:

A Resolution designating March 20, 2008, as "Volunteer Forest Firefighter and Forest Fire Warden Day" in Pennsylvania.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. PAYNE called up **HR 637, PN 3407,** entitled:

A Resolution designating the month of March 2008 as "DeMolay Month" in Pennsylvania.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

Adolph	Gabig	Marshall	Rohrer
Argall	Galloway	Marsico	Ross
Baker	George	McCall	Rubley
Barrar	Gerber	McGeehan	Sabatina
Bastian	Gergely	McI. Smith	Sainato
Bear	Gibbons	McIlhattan	Samuelson
Belfanti	Gillespie	Melio	Santoni
Benninghoff	Gingrich	Mensch	Saylor
Bennington	Godshall	Metcalfe	Scavello
Beyer	Goodman	Micozzie	Schroder
Biancucci	Grell	Millard	Seip
Bishop	Grucela	Miller	Shapiro
Blackwell	Haluska	Milne	Shimkus
Boback	Hanna	Moul	Siptroth
Boyd	Harhai	Moyer	Smith, K.
Brennan	Harhart	Mundy	Smith, M.
Brooks	Harkins	Murt	Smith, S.

Buxton	Harper	Mustio	Solobay
Caltagirone	Harris	Myers	Sonney
Cappelli	Helm	Nailor	Staback
Carroll	Hershey	Nickol	Stairs
Casorio	Hess	O'Brien, M.	Steil
Causer	Hickernell	O'Neill	Stern
Civera	Hornaman	Oliver	Stevenson
Clymer	Hutchinson	Pallone	Sturla
Cohen	James	Parker	Surra
Conklin	Josephs	Pashinski	Swanger
Costa	Kauffman	Payne	Tangretti
Cox	Keller, M.	Payton	Taylor, J.
Creighton	Keller, W.	Peifer	Taylor, R.
Curry	Kenney	Perry	Thomas
Cutler	Kessler	Perzel	Turzai
Daley	Killion	Petrarca	Vereb
Dally	King	Petri	Vitali
DeLuca	Kirkland	Petrone	Vulakovich
Denlinger	Kortz	Phillips	Wagner
DePasquale	Kotik	Pickett	Walko
Dermody	Kula	Preston	Wansacz
DeWeese	Leach	Pyle	Waters
DiGirolamo	Lentz	Quigley	Watson
Donatucci	Levdansky	Quinn	Wheatley
Eachus	Longietti	Ramaley	White
Ellis	Mackereth	Rapp	Williams
Evans, D.	Maher	Raymond	Wojnaroski
Evans, J.	Mahoney	Readshaw	Yewcic
Everett	Major	Reed	Youngblood
Fabrizio	Manderino	Reichley	Yudichak
Fairchild	Mann	Roae	
Fleck	Mantz	Rock	O'Brien, D.,
Frankel	Markosek	Roebuck	Speaker
Freeman			

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

* * *

Mr. STABACK called up **HR 609, PN 3261,** entitled:

A Resolution designating March 27, 2008, as "Helen Phillips CASUAL Day for Colon Cancer Awareness" in northeastern Pennsylvania.

On the question,
Will the House adopt the resolution?

The following roll call was recorded:

YEAS–199

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

NAYS–0

NOT VOTING–0

EXCUSED–4

Cruz	Geist	Hennessey	True

The majority having voted in the affirmative, the question was determined in the affirmative and the resolution was adopted.

APPROPRIATIONS COMMITTEE MEETING

The SPEAKER. The Chair recognizes Representative Evans.
Mr. D. EVANS. Mr. Speaker, is it in proper order for me to call a House Appropriation Committee meeting?
The SPEAKER. The gentleman is in order.
Mr. D. EVANS. Mr. Speaker, I would like to call the House Appropriations Committee meeting in the majority caucus room immediately.
The SPEAKER. At the call of recess.
Mr. D. EVANS. Thank you, Mr. Speaker.
The SPEAKER. The Appropriations Committee will meet in the majority caucus room at the recess.

The Chair recognizes the majority leader, Representative DeWeese.

STATE GOVERNMENT COMMITTEE MEETING

The SPEAKER. While the gentleman is in conference, the Chair recognizes Representative Josephs.

Ms. JOSEPHS. Thank you, Mr. Speaker.

At the recess the House State Government Committee will meet in room 245, Main Capitol, which is just beyond the Post Office here and easy to find, to consider the business of rereferring a bill. Thank you, Mr. Speaker.

The SPEAKER. The Chair thanks the lady.

The State Government Committee will meet at the recess in room 245.

RULES COMMITTEE MEETING

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

Mr. DeWEESE. Mr. Speaker, the Rules Committee meeting that had been discussed for this evening will be postponed until tomorrow at 10:45 a.m. There will be a Rules Committee meeting in the majority caucus room at 10:45 a.m. tomorrow. Thank you.

The SPEAKER. The Chair thanks the gentleman.

The Rules Committee will meet tomorrow morning at 10:45 in the majority caucus room.

SUBCOMMITTEE MEETING

The SPEAKER. For what purpose does the lady, Representative Youngblood, rise?

Ms. YOUNGBLOOD. Mr. Speaker, to call an Intergovernmental Affairs Subcommittee on Information and Technology meeting at the call of recess in room 121, East Wing.

The SPEAKER. The Chair thanks the lady.

Are there any other announcements?

RECESS

The SPEAKER. This House will stand in recess until 5:15.

AFTER RECESS

The time of recess having expired, the House was called to order.

The SPEAKER. The House will come to order. Members will report to the floor.

HOUSE BILL INTRODUCED AND REFERRED

No. 2380 By Representative D. EVANS

An Act to provide from the General Fund for the expenses of the Executive, Legislative and Judicial Departments of the Commonwealth, the public debt and the public schools for the fiscal year July 1, 2008, to June 30, 2009, for certain institutions and organizations, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2008; to provide appropriations from the State Lottery Fund, the Energy Conservation and Assistance Fund, the Hazardous Material Response Fund, The State Stores Fund, the Milk Marketing Fund, the Home Investment Trust Fund, the Emergency Medical Services Operating Fund, the Tuition Payment Fund, the Banking Department Fund, the Firearm Records Check Fund, the Ben Franklin Technology Development Authority Fund and the Tobacco Settlement Fund to the Executive Department; to provide appropriations from the Judicial Computer System Augmentation Account to the Judicial Department for the fiscal year July 1, 2008, to June 30, 2009; to provide appropriations from the Motor License Fund for the fiscal year July 1, 2008, to June 30, 2009, for the proper operation of the several departments of the Commonwealth and the Pennsylvania State Police authorized to spend Motor License Fund moneys; to provide for the appropriation of Federal funds to the Executive Department of the Commonwealth and for the payment of bills remaining unpaid at the close of the fiscal year ending June 30, 2008; to provide for the additional appropriation of Federal and State funds from the General Fund for the Executive and Judicial Departments of the Commonwealth for the fiscal year July 1, 2007, to June 30, 2008, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2007.

Referred to Committee on APPROPRIATIONS, March 17, 2008.

BILL REPORTED FROM COMMITTEE

HB 2356, PN 3418 By Rep. JOSEPHS

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.

STATE GOVERNMENT.

BILL REREFERRED

The SPEAKER. The Chair moves, at the request of the majority leader, that HB 2356, PN 3418, be rereferred to the Committee on Veterans Affairs and Emergency Preparedness.

On the question,
Will the House agree to the motion?
Motion was agreed to.

BILLS REREPORTED FROM COMMITTEE

HB 1845, PN 2516 By Rep. D. EVANS

An Act amending Title 18 (Crimes and Offenses) of the Pennsylvania Consolidated Statutes, further providing for possession of firearm with altered manufacturer's number and for altering or obliterating marks of identification.

APPROPRIATIONS.

HB 2252, PN 3291 By Rep. D. EVANS

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.

APPROPRIATIONS.

HB 2297, PN 3347 By Rep. D. EVANS

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.

APPROPRIATIONS.

The SPEAKER. These bills will be placed on the supplemental calendar.

BILLS REREPORTED FROM COMMITTEE

HB 2313, PN 3348 By Rep. D. EVANS

A Supplement to the act of April 1, 1863 (P.L.213, No.227), entitled "An act to accept the grant of Public Lands, by the United States, to the several states, for the endowment of Agricultural Colleges," making appropriations for carrying the same into effect; and providing for a basis for payments of such appropriations, for a method of accounting for the funds appropriated and for certain fiscal information disclosure.

APPROPRIATIONS.

HB 2314, PN 3349 By Rep. D. EVANS

An Act making an appropriation to the Fox Chase Institute for Cancer Research, Philadelphia, for the operation and maintenance of the cancer research program.

APPROPRIATIONS.

HB 2315, PN 3350 By Rep. D. EVANS

A Supplement to the act of July 28, 1966 (3rd Sp.Sess., P.L.87, No.3), entitled "An act providing for the establishment and operation of the University of Pittsburgh as an instrumentality of the Commonwealth to serve as a State-related university in the higher education system of the Commonwealth; providing for change of name; providing for the composition of the board of trustees; terms of trustees, and the power and duties of such trustees; authorizing appropriations in amounts to be fixed annually by the General Assembly; providing for the auditing of accounts of expenditures from said appropriations; providing for public support and capital improvements; authorizing the issuance of bonds exempt from taxation within the Commonwealth; requiring the chancellor to make an annual report of the operations of the University of Pittsburgh," making appropriations for carrying the same into effect; providing for a basis for payments of such appropriations, for a method of accounting for the funds appropriated and for certain fiscal information disclosure.

APPROPRIATIONS.

HB 2316, PN 3351 By Rep. D. EVANS

An Act making appropriations to the Wistar Institute, Philadelphia, for operation and maintenance expenses and for AIDS research.

APPROPRIATIONS.

HB 2317, PN 3352 By Rep. D. EVANS

A Supplement to the act of November 30, 1965 (P.L.843, No.355), known as the Temple University–Commonwealth Act, making appropriations for carrying the same into effect; providing for a basis for payments of such appropriations; and providing a method of accounting for the funds appropriated and for certain fiscal information disclosure.

APPROPRIATIONS.

HB 2318, PN 3353 By Rep. D. EVANS

An Act making an appropriation to the Central Penn Oncology Group.

APPROPRIATIONS.

HB 2319, PN 3354 By Rep. D. EVANS

An Act making an appropriation to Lancaster Cleft Palate for outpatient-inpatient treatment.

APPROPRIATIONS.

HB 2320, PN 3355 By Rep. D. EVANS

A Supplement to the act of July 7, 1972 (P.L.743, No.176), known as the Lincoln University-Commonwealth Act, making an appropriation for carrying the same into effect; providing for a basis for payments of the appropriation; and providing a method of accounting for the funds appropriated and for certain fiscal information disclosure.

APPROPRIATIONS.

HB 2321, PN 3356 By Rep. D. EVANS

An Act making an appropriation to the Burn Foundation, Philadelphia, for outpatient and inpatient treatment.

APPROPRIATIONS.

HB 2322, PN 3357 By Rep. D. EVANS

An Act making an appropriation to The Children's Institute, Pittsburgh, for treatment and rehabilitation of certain persons with disabling diseases.

APPROPRIATIONS.

HB 2323, PN 3358 By Rep. D. EVANS

An Act making an appropriation to the Trustees of Drexel University, Philadelphia.

APPROPRIATIONS.

HB 2324, PN 3359 By Rep. D. EVANS

An Act making an appropriation to The Children's Hospital of Philadelphia for comprehensive patient care and general maintenance and operation of the hospital.

APPROPRIATIONS.

HB 2325, PN 3360 By Rep. D. EVANS

An Act making an appropriation to the Beacon Lodge Camp.

APPROPRIATIONS.

HB 2326, PN 3361 By Rep. D. EVANS

An Act making appropriations to the Trustees of the University of Pennsylvania.

APPROPRIATIONS.

HB 2327, PN 3362 By Rep. D. EVANS

An Act making appropriations to the Carnegie Museums of Pittsburgh for operations and maintenance expenses and the purchase of apparatus, supplies and equipment.

APPROPRIATIONS.

HB 2328, PN 3363 By Rep. D. EVANS

An Act making appropriations to the Philadelphia Health and Education Corporation for the Colleges of Medicine, Public Health, Nursing and Health Professions and for continuation of pediatric services.

APPROPRIATIONS.

HB 2329, PN 3364 By Rep. D. EVANS

An Act making an appropriation to the Franklin Institute Science Museum for maintenance expenses.

APPROPRIATIONS.

HB 2330, PN 3365 By Rep. D. EVANS

An Act making an appropriation to the Academy of Natural Sciences for maintenance expenses.

APPROPRIATIONS.

HB 2331, PN 3366 By Rep. D. EVANS

An Act making appropriations to the Thomas Jefferson University, Philadelphia.

APPROPRIATIONS.

HB 2332, PN 3367 By Rep. D. EVANS

An Act making an appropriation to the African-American Museum in Philadelphia for operating expenses.

APPROPRIATIONS.

HB 2333, PN 3368 By Rep. D. EVANS

An Act making an appropriation to the Everhart Museum in Scranton for operating expenses.

APPROPRIATIONS.

HB 2334, PN 3369 By Rep. D. EVANS

An Act making an appropriation to the Philadelphia College of Osteopathic Medicine, Philadelphia.

APPROPRIATIONS.

HB 2335, PN 3370 By Rep. D. EVANS

An Act making an appropriation to the Mercer Museum in Doylestown, Pennsylvania, for operating expenses.

APPROPRIATIONS.

HB 2336, PN 3371 By Rep. D. EVANS

An Act making an appropriation to the Whitaker Center for Science and the Arts in Harrisburg, Pennsylvania, for operating expenses.

APPROPRIATIONS.

HB 2337, PN 3372 By Rep. D. EVANS

An Act making an appropriation to the Pennsylvania College of Optometry, Philadelphia.

APPROPRIATIONS.

HB 2338, PN 3373 By Rep. D. EVANS

An Act making an appropriation to the University of the Arts, Philadelphia, for instruction and student aid.

APPROPRIATIONS.

HB 2339, PN 3374 By Rep. D. EVANS

An Act making appropriations to the Trustees of the Berean Training and Industrial School at Philadelphia for operation and maintenance expenses.

APPROPRIATIONS.

HB 2340, PN 3375 By Rep. D. EVANS

An Act making an appropriation to the Johnson Technical Institute of Scranton for operation and maintenance expenses.

APPROPRIATIONS.

HB 2341, PN 3376 By Rep. D. EVANS

An Act making an appropriation to the Williamson Free School of Mechanical Trades in Delaware County for operation and maintenance expenses.

APPROPRIATIONS.

HB 2342, PN 3377 By Rep. D. EVANS

An Act making an appropriation to the Lake Erie College of Osteopathic Medicine, Erie.

APPROPRIATIONS.

HB 2380, PN 3438 By Rep. D. EVANS

An Act to provide from the General Fund for the expenses of the Executive, Legislative and Judicial Departments of the Commonwealth, the public debt and the public schools for the fiscal year July 1, 2008, to June 30, 2009, for certain institutions and organizations, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2008; to provide appropriations from the State Lottery Fund, the Energy Conservation and Assistance Fund, the Hazardous Material Response Fund, The State Stores Fund, the Milk Marketing Fund, the Home Investment Trust Fund, the Emergency Medical Services Operating Fund, the Tuition Payment Fund, the Banking Department Fund, the Firearm Records Check Fund, the Ben Franklin Technology Development Authority Fund and the Tobacco Settlement Fund to the Executive Department; to provide appropriations from the Judicial Computer System Augmentation Account to the Judicial Department for the fiscal year July 1, 2008, to June 30, 2009; to

provide appropriations from the Motor License Fund for the fiscal year July 1, 2008, to June 30, 2009, for the proper operation of the several departments of the Commonwealth and the Pennsylvania State Police authorized to spend Motor License Fund moneys; to provide for the appropriation of Federal funds to the Executive Department of the Commonwealth and for the payment of bills remaining unpaid at the close of the fiscal year ending June 30, 2008; to provide for the additional appropriation of Federal and State funds from the General Fund for the Executive and Judicial Departments of the Commonwealth for the fiscal year July 1, 2007, to June 30, 2008, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2007.

APPROPRIATIONS.

COMMUNICATIONS

The SPEAKER. The Speaker is in receipt of the following reports, which the clerk will read.

The following communications were read:

A communication dated February 4, 2008, from the Secretary of the Department of Community and Economic Development, providing a copy of the department's Annual Financing Strategy Report for Business and Economic Stimulus Programs, submitted in accordance with Act 12 of 2004.

A communication dated February 26, 2008, from the Acting Insurance Commissioner, submitting a copy of the department's annual report regarding the adultBasic health insurance program for calendar year 2007.

A communication dated February 26, 2008, from the Acting Insurance Commissioner, submitting a copy of the department's annual report regarding the Children's Health Insurance Program for calendar year 2007.

A communication dated February 29, 2008, from the Acting Secretary of the Department of Labor and Industry, submitting a copy of the department's report entitled "Analysis of the Pennsylvania Minimum Wage Increases in 2007."

A communication dated February 22, 2008, from the Small Business Advocate, submitting a copy of the office's executive summary for calendar year 2007.

A communication dated February 26, 2008, from the Acting Insurance Commissioner, providing a copy of the department's report regarding the "Flood Insurance Consumer Education Plan," submitted in accordance with Act 10 of Special Session No. 2 of 1996.

(Copies of communications are on file with the Journal clerk.)

HOUSE RESOLUTIONS INTRODUCED AND REFERRED

No. 642 By Representatives LEVDANSKY, STABACK, GODSHALL, SURRA, BRENNAN, CALTAGIRONE, CARROLL, CAUSER, CONKLIN, CUTLER, DALLY, DeLUCA, EVERETT, FLECK, FRANKEL, GERGELY, GOODMAN, HANNA, HARHART, HORNAMAN, JAMES, KORTZ, LONGIETTI, MAHER, McCALL, MENSCH, MILLARD, PASHINSKI, PAYNE, PEIFER, PICKETT, PYLE, QUINN, READSHAW, ROAE, RUBLEY, SAYLOR, SONNEY, STERN, TRUE, VULAKOVICH, WALKO, BEYER, J. WHITE, MAHONEY, YOUNGBLOOD, KULA, ROHRER, BAKER, WOJNAROSKI, BELFANTI, MACKERETH and BOYD

A Resolution directing the Legislative Budget and Finance Committee to conduct an evaluation and study of the Pennsylvania Game Commission's current deer management program and practices.

Referred to Committee on GAME AND FISHERIES, March 17, 2008.

No. 644 By Representatives MANDERINO, BELFANTI, BENNINGTON, BOBACK, BOYD, BRENNAN, CALTAGIRONE, CAPPELLI, CAUSER, CLYMER, CONKLIN, CURRY, CUTLER, DeLUCA, DENLINGER, FRANKEL, GEORGE, GODSHALL, GOODMAN, HARHAI, HARKINS, HELM, HENNESSEY, HORNAMAN, JAMES, JOSEPHS, KENNEY, KORTZ, LENTZ, LONGIETTI, MANN, McCALL, McGEEHAN, McILVAINE SMITH, MICOZZIE, MUNDY, MUSTIO, MYERS, NAILOR, M. O'BRIEN, O'NEILL, PALLONE, PARKER, PAYNE, PETRONE, READSHAW, REICHLEY, RUBLEY, SANTONI, SAYLOR, SEIP, SIPTROTH, K. SMITH, STERN, SWANGER, THOMAS, WALKO, WATSON, J. WHITE, WOJNAROSKI, MOYER, SHIMKUS, FREEMAN, GINGRICH, YOUNGBLOOD and MURT

A Resolution directing the Legislative Budget and Finance Committee to conduct a study of the availability and accessibility of obstetrical services in this Commonwealth.

Referred to Committee on HEALTH AND HUMAN SERVICES, March 17, 2008.

No. 646 By Representatives CLYMER, BAKER, BEYER, BRENNAN, CREIGHTON, DENLINGER, FLECK, GINGRICH, HENNESSEY, HERSHEY, HESS, MANTZ, MILNE, MURT, MUSTIO, ROHRER, STERN, SWANGER and TRUE

A Resolution memorializing the Congress of the United States to pass the Warrant Officer Aaron Walsh Stop DOD-Sponsored Gambling Act.

Referred to Committee on VETERANS AFFAIRS AND EMERGENCY PREPAREDNESS, March 17, 2008.

HOUSE BILLS INTRODUCED AND REFERRED

No. 2350 By Representatives YEWCIC, ROHRER, BELFANTI, BEYER, BIANCUCCI, BRENNAN, CAPPELLI, CLYMER, DENLINGER, GEIST, GIBBONS, GOODMAN, HENNESSEY, HESS, HORNAMAN, KAUFFMAN, KULA, MAHONEY, MENSCH, MILLARD, MILNE, MURT, MUSTIO, PHILLIPS, PYLE, READSHAW, SCAVELLO, SIPTROTH, K. SMITH, SOLOBAY, SWANGER, J. TAYLOR, THOMAS, TRUE, CAUSER, HALUSKA, MARKOSEK, METCALFE, PETRARCA, SAINATO, TANGRETTI, GINGRICH, ROAE, YOUNGBLOOD, ADOLPH, ARGALL, BARRAR, BASTIAN, BEAR, BENNINGHOFF, BOYD, CIVERA, CREIGHTON, COX, CUTLER, ELLIS, GABIG, GRELL, HELM, HICKERNELL, HUTCHINSON, M. KELLER, MAHER, MAJOR, McILHATTAN, MOUL, PAYNE, PERRY, QUIGLEY, REICHLEY, ROCK, SAYLOR, SCHRODER, S. H. SMITH, SONNEY, STERN, VULAKOVICH, SEIP and TURZAI

An Act amending Title 23 (Domestic Relations) of the Pennsylvania Consolidated Statutes, in child protective services, providing for the detection of child rapists and predators; imposing duties on certain health care practitioners to determine whether children are 13 years of age or older; providing for reporting by treating health care practitioners, for law enforcement, for fetal tissue and DNA samples, for duties of the Office of Attorney General and for certain immunity; and imposing penalties.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2357 By Representatives HORNAMAN, MELIO, FAIRCHILD, BELFANTI, BISHOP, BRENNAN, CALTAGIRONE, CONKLIN, DePASQUALE, FABRIZIO, FLECK, FRANKEL, FREEMAN, GEORGE, GODSHALL, GRUCELA, HARHAI, HERSHEY, JAMES, KORTZ, LENTZ, MAHONEY, MANN, McGEEHAN, McILVAINE SMITH, MENSCH, MOYER, NAILOR, M. O'BRIEN, PALLONE, PETRARCA, PHILLIPS, RAMALEY, READSHAW, SAINATO, K. SMITH, SURRA, THOMAS, WATERS, WOJNAROSKI, YUDICHAK, MILLARD, GOODMAN, SONNEY, LEACH, SIPTROTH, MURT, KULA, J. WHITE, SWANGER and MILNE

An Act amending Title 51 (Military Affairs) of the Pennsylvania Consolidated Statutes, further providing for paralyzed veteran's pension.

Referred to Committee on VETERANS AFFAIRS AND EMERGENCY PREPAREDNESS, March 17, 2008.

No. 2358 By Representatives GOODMAN, MELIO, FAIRCHILD, ARGALL, BELFANTI, BEYER, BIANCUCCI, BISHOP, BRENNAN, BUXTON, CALTAGIRONE, CAPPELLI, CARROLL, COHEN, DALEY, DePASQUALE, DeWEESE, FABRIZIO, FLECK, FRANKEL, FREEMAN, GEORGE, GODSHALL, GRELL, GRUCELA, HARHAI, HARHART, HARKINS, HARPER, HICKERNELL, HORNAMAN, HUTCHINSON, JAMES, JOSEPHS, KORTZ, KOTIK, KULA, LEACH, LENTZ, MAHONEY, MANN, McCALL, McGEEHAN, McILVAINE SMITH, MENSCH, MILLARD, MILNE, MOYER, MURT, MYERS, NAILOR, PALLONE, PASHINSKI, PAYNE, PHILLIPS, PYLE, QUINN, RAMALEY, READSHAW, REICHLEY, RUBLEY, SANTONI, SCAVELLO, SEIP, SIPTROTH, SOLOBAY, SONNEY, STABACK, STERN, R. STEVENSON, SWANGER, THOMAS, WALKO, J. WHITE, WOJNAROSKI, YOUNGBLOOD, K. SMITH and VULAKOVICH

An Act amending Title 51 (Military Affairs) of the Pennsylvania Consolidated Statutes, further providing for blind veteran's pension.

Referred to Committee on VETERANS AFFAIRS AND EMERGENCY PREPAREDNESS, March 17, 2008.

No. 2359 By Representatives KENNEY, K. SMITH, WATSON, REICHLEY, TRUE, KAUFFMAN, ROSS, MYERS, BISHOP, MUNDY, FRANKEL, MANN, McGEEHAN, BEYER, GOODMAN, SAYLOR, DeLUCA, COHEN, KILLION, SIPTROTH, MOYER, PICKETT, YOUNGBLOOD, MURT, HARHAI, RUBLEY, JAMES, HARPER and STURLA

An Act requiring information relating to parenting and prenatal depression, postpartum depression, postpartum psychosis and other emotional trauma counseling to be provided to a woman who is pregnant or has just given birth; and providing for the powers and duties of the Department of Health.

Referred to Committee on HEALTH AND HUMAN SERVICES, March 17, 2008.

No. 2360 By Representatives DeLUCA, CASORIO, CUTLER, DALEY, HORNAMAN, KORTZ, MAHONEY, PETRONE, SIPTROTH and J. WHITE

An Act amending the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act, further providing for prohibited acts and penalties.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2361 By Representatives DeLUCA, HARHAI, HARKINS, KORTZ, MAHONEY, MILLARD, MURT, PAYNE, READSHAW, SIPTROTH, K. SMITH, SONNEY and J. WHITE

An Act amending the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act, defining "law enforcement officer"; and further providing for prohibited acts and penalties.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2362 By Representatives DeLUCA, BELFANTI, CALTAGIRONE, DONATUCCI, FRANKEL, GEIST, GEORGE, GRELL, HARHAI, HENNESSEY, JAMES, JOSEPHS, MAHONEY, MILNE, MOUL, MURT, MYERS, O'NEILL, PETRONE, PYLE, SAYLOR, SEIP, SIPTROTH, K. SMITH, SOLOBAY, J. WHITE and YOUNGBLOOD

An Act amending Title 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, further providing for the disbursement of the proceeds from forfeited property.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2363 By Representatives DeLUCA, BIANCUCCI, CREIGHTON, FRANKEL, GINGRICH, GODSHALL, HARHAI, HARKINS, HENNESSEY, HORNAMAN, KULA, MAHONEY, MANN, MICOZZIE, MILLARD, PETRONE, SIPTROTH, THOMAS and J. WHITE

An Act providing for the termination of law enforcement officers upon testing positive for a controlled substance.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2364 By Representatives GERGELY, CALTAGIRONE, CARROLL, CLYMER, CUTLER, DALEY, FRANKEL, GIBBONS, GILLESPIE, GOODMAN, HORNAMAN, JOSEPHS, KAUFFMAN, KORTZ, KOTIK, KULA, LEVDANSKY, MAHONEY, McGEEHAN, McILHATTAN, MOUL, MOYER, MURT, PEIFER, PETRONE, READSHAW, SIPTROTH, K. SMITH, SONNEY, WALKO, J. WHITE, WOJNAROSKI and YOUNGBLOOD

An Act authorizing the Commonwealth of Pennsylvania to join the Interstate Wildlife Violator Compact; providing for the form of the compact; imposing additional powers and duties on the Governor and the Compact Administrator; and limiting the applicability of suspension powers.

Referred to Committee on GAME AND FISHERIES, March 17, 2008.

No. 2365 By Representatives GERGELY, KORTZ, BELFANTI, BRENNAN, CARROLL, CREIGHTON, GEORGE, GOODMAN, GRUCELA, HARKINS, HESS, LENTZ, McILVAINE SMITH, MILNE, PETRONE, PYLE, READSHAW, SEIP, SIPTROTH, SURRA, SWANGER, THOMAS, WANSACZ, J. WHITE and YOUNGBLOOD

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, further providing for closing of school or department and for powers and duties of board of control.

Referred to Committee on EDUCATION, March 17, 2008.

No. 2366 By Representatives WATSON, BOYD, NICKOL, YOUNGBLOOD, LEVDANSKY, BEYER, CLYMER, GEIST, GEORGE, GINGRICH, M. KELLER, KING, McILVAINE SMITH, R. MILLER, PYLE, RUBLEY, SAYLOR, THOMAS, O'NEILL, SIPTROTH and MURT

An Act amending the act of June 27, 2006 (1st Sp.Sess., P.L.1873, No.1), known as the Taxpayer Relief Act, further providing for collection of installment payments of school real property taxes.

Referred to Committee on FINANCE, March 17, 2008.

No. 2367 By Representatives CALTAGIRONE, DALEY, HENNESSEY, MUNDY, THOMAS and YOUNGBLOOD

An Act amending Title 71 (State Government) of the Pennsylvania Consolidated Statutes, transferring county employees to State employment; and establishing the Transferred County Employee Leave Fund.

Referred to Committee on STATE GOVERNMENT, March 17, 2008.

No. 2368 By Representatives MACKERETH, GILLESPIE, R. MILLER, BENNINGTON, CALTAGIRONE, CAPPELLI, HALUSKA, JAMES, JOSEPHS, LEACH, McGEEHAN, MOUL, MOYER, MUNDY, PASHINSKI, PAYNE, PICKETT, PYLE, ROSS, RUBLEY, SCAVELLO, SIPTROTH, K. SMITH, SOLOBAY, SONNEY, THOMAS, VITALI, J. WHITE and YOUNGBLOOD

An Act amending Title 23 (Domestic Relations) of the Pennsylvania Consolidated Statutes, further providing for grounds for divorce.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2369 By Representatives STEIL, BELFANTI, BOYD, CLYMER, EVERETT, FRANKEL, GINGRICH, GRELL, HARHAI, HARKINS, MAHONEY, McILHATTAN, MILNE, MURT, O'NEILL, RUBLEY, SHIMKUS, SIPTROTH, SWANGER, THOMAS, WALKO and YOUNGBLOOD

An Act regulating child labor; conferring powers and duties on the Department of Labor and Industry and the Department of Education; imposing penalties; and making a repeal.

Referred to Committee on LABOR RELATIONS, March 17, 2008.

No. 2373 By Representatives CASORIO, WOJNAROSKI, COHEN, EACHUS, BEYER, BUXTON, CALTAGIRONE, CAPPELLI, CARROLL, FRANKEL, GODSHALL, GOODMAN, GRUCELA, HARHAI, KESSLER, KORTZ, KOTIK, KULA, MAHONEY, MANN, MOYER, MURT, MYERS, M. O'BRIEN, PALLONE, READSHAW, REICHLEY, SCAVELLO, K. SMITH, J. WHITE, YOUNGBLOOD, BIANCUCCI, SIPTROTH, BOBACK, CONKLIN, WALKO and BRENNAN

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, requiring school districts to develop a bullying and student intimidation prevention plan.

Referred to Committee on EDUCATION, March 17, 2008.

No. 2378 By Representatives SURRA, PHILLIPS, ARGALL, CIVERA, COHEN, DERMODY, DeWEESE, EACHUS, MAJOR, McCALL, S. H. SMITH, STERN and TURZAI

An Act providing for the use of the Forum Building in the City of Harrisburg.

Referred to Committee on STATE GOVERNMENT, March 17, 2008.

No. 2381 By Representatives HANNA, BELFANTI, BOYD, CAUSER, GEORGE, GODSHALL, HARKINS, MARSHALL, PHILLIPS, READSHAW, ROHRER, RUBLEY, M. SMITH, SURRA, WOJNAROSKI and YOUNGBLOOD

An Act amending Title 34 (Game) of the Pennsylvania Consolidated Statutes, further providing for organization of commission and for its powers and duties.

Referred to Committee on GAME AND FISHERIES, March 17, 2008.

No. 2382 By Representatives BIANCUCCI, CALTAGIRONE, KOTIK, PETRONE, CARROLL, COHEN, FRANKEL, HENNESSEY, JOSEPHS, KULA, O'NEILL, RAMALEY, SIPTROTH, K. SMITH and YOUNGBLOOD

An Act amending Title 22 (Detectives and Private Police) of the Pennsylvania Consolidated Statutes, in private police, repealing provisions relating to appointment by nonprofit corporations.

Referred to Committee on JUDICIARY, March 17, 2008.

No. 2383 By Representatives CLYMER, ADOLPH, ARGALL, BEAR, BELFANTI, BEYER, BOBACK, BOYD, CALTAGIRONE, CAPPELLI, COHEN, CREIGHTON, DALLY, EVERETT, FRANKEL, FREEMAN, GEIST, GEORGE, GIBBONS, GILLESPIE, GINGRICH, GODSHALL, GOODMAN, GRELL, GRUCELA, HARHAI, HARHART, HARKINS, HELM, HENNESSEY, HESS, HORNAMAN, JAMES, JOSEPHS, KAUFFMAN, M. KELLER, KENNEY, KILLION, KOTIK, KULA, LENTZ, LONGIETTI, MARSHALL, McGEEHAN, McILHATTAN, MELIO, MICOZZIE, R. MILLER, MOUL, MOYER, MURT, MYERS, D. O'BRIEN, O'NEILL, PETRONE, PHILLIPS, PYLE, RAMALEY, RAPP, READSHAW, REICHLEY, SAYLOR, SCAVELLO, SIPTROTH, K. SMITH, STERN, SWANGER, J. TAYLOR, TRUE, WATSON, J. WHITE, WOJNAROSKI and YOUNGBLOOD

An Act amending the act of June 27, 2006 (1st Sp.Sess., P.L.1873, No.1), known as the Taxpayer Relief Act, further providing for proof of

claim.

Referred to Committee on FINANCE, March 17, 2008.

CALENDAR CONTINUED

BILLS ON SECOND CONSIDERATION

The House proceeded to second consideration of **HB 2005, PN 2837,** entitled:

An Act amending the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, further providing for conditions subject to which policies are to be issued; and providing for health insurance coverage for certain children of insured parents and for affordable small group health care coverage.

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

Mr. **NICKOL** offered the following amendment No. **A04553:**

Amend Title, page 1, line 11, by inserting after "providing"
for additional investment authority for subsidiaries, for real estate which may be acquired, held and conveyed,

Amend Bill, page 1, lines 17 through 20, by striking out all of said lines and inserting

Section 1. Section 405.2(c) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, amended December 21, 1995 (P.L.714, No.79), is amended to read:

Section 405.2. Additional Investment Authority for Subsidiaries.–
* * *

(c) (1) At no time shall a domestic life insurance company make an investment in any subsidiary which will bring the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) of its total admitted assets as of the immediately preceding thirty-first day of December. In determining the amount of investments of any domestic life insurance company in subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose. <u>A domestic life insurance company may increase the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries in excess of ten per centum (10%) but at no time in excess of fifteen per centum (15%) of its total admitted assets as of the immediately preceding thirty-first day of December if the increase has been approved in writing by the Insurance Department prior to making the investment. If the Insurance Department does not approve or disapprove the increased investment limit within thirty (30) days of receipt of a request for approval, the increased investment shall be deemed approved.</u>

(2) The limitations set forth in clause (1) of this subsection shall not apply to investments in any subsidiary which is:

(i) An insurance company or a health maintenance organization holding a certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(ii) A holding company to the extent its business consists of the holding of the stock of, or otherwise controlling, its own subsidiaries.

(iii) A corporation whose business primarily consists of direct or indirect ownership, operation or management of assets authorized as investments pursuant to sections 404.1 and 406.

(iv) A company engaged in any combination of the activities described in subclauses (i), (ii) and (iii) of this clause. Investments made pursuant to subclause (i) shall not be restricted in amount provided that after such investment, as calculated for NAIC annual statement purposes, the insurer's surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. Investments made pursuant to subclause (ii), or to the extent applicable in this subclause, shall in addition not be subject to any limitations on the amount of a domestic life insurance company's assets provided for under any other provision of this act and which might otherwise be applicable: Provided, however, That such life insurance company's investments, to the extent that such life insurance company provided the funds therefor, in each of the subsidiaries of such holding company shall be subject to the limitations, if any, applicable to such investment as if the holding company's interest in each such subsidiary were instead owned directly by the life insurance company. Investments made pursuant to subclause (iii), or, to the extent applicable, this clause, shall be counted in determining the limitations contained in applicable subsections of sections 404.2 and 406: Provided, however, That the value as calculated for annual statement purposes, but not in excess of the cost thereof, of such investment shall include only funds provided by the insurance company therefor. Investments made in other subsidiaries of such life insurance company by any subsidiary described in subclauses (i), (ii), (iii) and this subclause or by a person whose business primarily consists of direct or indirect ownership, operation or management of real property and interest therein under section 406 shall be deemed investments made by the insurance company only to the extent the funds for such investment were provided by such insurance company.
* * *

Section 2. Section 519(e) of the act, amended December 18, 1992 (P.L.1519, No.178), is amended to read:

Section 519. Real Estate Which May Be Acquired, Held, and Conveyed.–A domestic stock fire, stock marine, or stock fire and marine insurance company may, directly or indirectly, alone or in combination with one or more other persons or entities (except that no domestic stock fire, stock marine, or stock fire and marine insurance company may participate in a general partnership), acquire by purchase, lease or otherwise or receive, hold, or convey real estate, or any interest therein:
* * *

(e) As an investment for the production of income or capital appreciation, or so acquired for development, improvement, maintenance or construction and maintenance for such investment purposes, provided that the aggregate cost of investments in unimproved real estate under this subsection shall not exceed the lesser of ten per centum (10%) of the company's admitted assets or forty-five per centum (45%) of its capital and surplus. <u>Investments under this subsection, including investments in limited partnership interests or other entities where the entities are engaged primarily in holding real estate or interests in real estate under this subsection and corporations that are engaged primarily in holding real estate or interests in real estate as defined in this subsection and the majority of whose voting securities are owned directly or indirectly through one or more intermediaries, shall not exceed twenty-five per centum (25%) of the company's admitted assets.</u>

Section 3. Section 519.1(c)(1) of the act, amended February 17, 1994 (P.L.92, No.9), is amended to read:

Section 519.1. Additional Investment Authority for Subsidiaries.–
* * *

(c) (1) At no time shall a domestic stock fire, stock marine or stock fire and marine insurance company make an investment in any subsidiary which will bring the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) of its total admitted assets as of the immediately preceding thirty-first day of December. In determining the amount of investments of any domestic stock fire, stock marine or stock fire and marine insurance company in

subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose. A domestic stock fire, stock marine or stock fire and marine insurance company may increase the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries in excess of ten per centum (10%) but at no time in excess of fifteen per centum(15%) of its total admitted assets as of the immediately preceding thirty-first day of December if the increase has been approved in writing by the Insurance Department prior to making the investment. If the Insurance Department does not approve or disapprove the increased investment limit within thirty (30) days of receipt of a request for approval, the increased investment shall be deemed approved.

* * *

Section 4. Section 617(A)(3) and (9) of the act, repealed and added May 25, 1951 (P.L.417, No.99) and January 18, 1968 (1967 P.L.969, No.433), are amended to read:

Amend Sec. 2, page 3, line 6, by striking out "2" and inserting
5

Amend Sec. 3, page 4, line 12, by striking out "3" and inserting
6

Amend Sec. 4, page 23, line 2, by striking out "4" and inserting
7

Amend Sec. 5, page 23, line 13, by striking out "5" and inserting
8

Amend Sec. 5, page 23, line 14, by inserting after "sections"
405.2(c), 519(e), 519.1(c)(1),

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

AMENDMENT WITHDRAWN

The SPEAKER. The Chair recognizes Representative Nickol on the amendment. The gentleman withdraws his amendment. The Chair thanks the gentleman.

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

Mr. **KILLION** offered the following amendment No. **A04620:**

Amend Title, page 1, line 14, by striking out "and" and inserting a comma

Amend Title, page 1, line 14, by removing the period after "coverage" and inserting
and for LifeLine health insurance.

Amend Sec. 3, page 4, line 12, by striking out "an article" and inserting
articles

Amend Sec. 3, page 23, by inserting between lines 1 and 2

ARTICLE XLIII
LIFELINE HEALTH INSURANCE

Section 4301. Scope of article.

This article 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 article 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) This act.
(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 article 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 article, including the provision of the benefits or requirements mandated by Article VI-A or by regulations promulgated under this article.

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 article 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 article, 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 article. 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.

Amend Sec. 5, page 23, line 15, by inserting after "617.1"
and Article XLIII

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

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

The House will be at ease.

The House will come to order.

AMENDMENT PASSED OVER TEMPORARILY

The SPEAKER. The Killion amendment will be over temporarily.

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

Mr. **McGEEHAN** offered the following amendment No. **A06122:**

Amend Title, page 1, line 11, by inserting after "for"

prohibition of unfair discrimination and for

Amend Bill, page 1, lines 17 through 20, by striking out all of said lines and inserting

Section 1. Section 353 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, amended June 10, 1947 (P.L.495, No.225) and repealed in part April 28, 1978 (P.L.202, No.53), is amended to read:

Section 353. Unfair Discrimination Prohibited.–(a) The following acts are prohibited:

(1) Unfair discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of life, health and accident insurance, covered by this act, and any other lines and kinds of insurance not within the scope of The Fire Marine and Inland Marine Regulatory Act and The Casualty and Surety Rate Regulatory Act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever[, is prohibited].

(2) Refusing to renew an insurance policy on owner-occupied private residential properties on the basis of surrounding properties being unoccupied.

(b) Any person, corporation, insurance company, association, or exchange that shall, either as principal or agent, issue, or cause to be issued, any policy or contract of insurance within this Commonwealth, contrary to this section, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding five hundred dollars ($500.00).

(c) Upon satisfactory evidence of the violation of this section by any such person, corporation, insurance company, association, or exchange, the Insurance Commissioner may, in his discretion, pursue any one or more of the following courses of action: (1) Suspend or revoke the license of such offending person, corporation, insurance company, association, or exchange; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such person, corporation, insurance company, association, or exchange; (3) impose a penalty of not more than five hundred ($500) dollars for each and every act in violation of this act.

Section 1.1. Section 617(A)(3) and (9) of the act, repealed and added May 25, 1951 (P.L.417, No.99) and January 18, 1968 (1967 P.L.969, No.433), are amended to read:

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

AMENDMENT WITHDRAWN

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

Mr. McGEEHAN. Thank you, Mr. Speaker.

I did not have an opportunity to inform the Chair that I am going to withdraw this amendment. I want to thank Chairman DeLuca for agreeing to run this as a freestanding bill out of the Insurance Committee. Thank you very much.

The SPEAKER. The Chair thanks the gentleman.

LEAVE OF ABSENCE

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

The House will be at ease.

The House will come to order.

ANNOUNCEMENT BY SPEAKER

The SPEAKER. The Chair would like to recognize that it is also the birthday of Kathy McCormac, who happens to be standing in the back of the House.

The House will be at ease.

The House will come to order.

CONSIDERATION OF HB 2005 CONTINUED

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

Ms. **HARPER** offered the following amendment No. **A06040:**

Amend Title, page 1, line 11, by inserting after "for"

effect of act on existing laws and, in insurance holding companies, for definitions and for

Amend Title, page 1, line 12, by striking out "and"

Amend Title, page 1, line 14, by inserting after "parents"

; further providing for acquisition of control of or merger with domestic insurer and for acquisitions involving insurers not otherwise covered; establishing the Insurance Restructuring Board; providing for its powers and duties; establishing an account; providing for health care reporting

Amend Title, page 1, line 14, by removing the period after "coverage" and inserting

; and making inconsistent repeals.

Amend Bill, page 1, lines 17 through 20, by striking out all of said lines and inserting

Section 1. Section 108 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

Section 108. Effect of Act on Existing Laws.–The provisions of this act, so far as they are the same as those of existing laws, shall be construed as a continuation of such laws and not as new enactments. The repeal by this act of any provision of law shall not revive any law heretofore repealed or superseded, nor shall such repeal affect any act done, liability incurred, or any right accrued or vested, or any suit or prosecution pending or to be instituted to enforce any right or penalty or punish any offense under the authority of the repealed laws. The provisions of this act shall not limit the jurisdiction and authority of the Office of Attorney General, including, but not limited to, the jurisdiction and authority granted pursuant to the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

Section 2. Section 617(a)(3) and (9) of the act, repealed and added May 25, 1951 (P.L.417, No.99) and January 18, 1968 (1967 P.L.969, No.433), are amended to read:

Amend Sec. 2, page 3, line 6, by striking out "2" and inserting

3

Amend Bill, page 4, line 12, by striking out all of said line and inserting

Section 4. The definitions of "insurer" and "person" in section 1401 of the act, amended December 20, 2000 (P.L.967, No.132), are amended and the section is amended by adding a definition to read:

Section 1401. Definitions.–As used in this article, and for the purposes of this article only, the following words and phrases shall have the meanings given to them in this section:

* * *

"Insurer." Any health maintenance organization, preferred provider organization, company, association [or], exchange, hospital plan

corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), authorized by the Insurance Commissioner to transact the business of insurance in this Commonwealth except that the term shall not include:

(1) the Commonwealth or any agency or instrumentality thereof;

(2) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision; or

(3) fraternal benefit societies[; or

(4) nonprofit medical and hospital service associations].

* * *

"Person." An individual, an insurer, a corporation, a partnership, a limited liability company, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert. The term shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

* * *

"Shareholder." A record holder or record owner of shares of an insurer.

(1) The term shall include all of the following:

(i) A member of an insurer that is a domestic nonstock corporation under 15 Pa.C.S. Ch. 21 (relating to nonstock corporations) or a prior statute.

(ii) A member, as defined in 15 Pa.C.S. § 5103 (relating to definitions), of an insurer that is a domestic nonprofit corporation under 15 Pa.C.S. Ch. 51 (relating to general provisions) or a prior statute.

(iii) A subscriber of an insurer that is a domestic reciprocal exchange under Article X or a prior statute.

(2) The term shall not include any subscriber, insured or customer of:

(i) a hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or

(ii) a professional health service plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

* * *

Section 5. Section 1402 of the act, amended or added December 18, 1992 (P.L.1519, No.178) and December 21, 1998 (P.L.1108, No.150), is amended to read:

Section 1402. Acquisition of Control of or Merger or Consolidation with Domestic Insurer.–(a) (1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would directly or indirectly or by conversion or by exercise of any right to acquire, be in control of such insurer, and no person shall enter into an agreement to merge or consolidate with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request or invitation is made or any such agreement is entered into or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the department and has sent to such insurer a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the department in the manner hereinafter prescribed.

(2) For purposes of this section, a "domestic insurer" shall include any person controlling a domestic insurer unless such person as determined by the department is either directly or through its affiliates primarily engaged in business other than the business of insurance. Such person shall, however, file a preacquisition notification with the department containing the information set forth in section 1403(c)(2) thirty (30) days prior to the proposed effective date of the acquisition. Failure to file is subject to section 1403(e)(3). For purposes of this section, "person" shall not include any securities broker holding, in the usual and customary manner, less than twenty per centum (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

(b) The statement to be filed with the department under this section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger, consolidation or other acquisition of control referred to in subsection (a) is to be effected, hereinafter called "acquiring party," and

(i) if such person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years; or

(ii) if such person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to those positions. This list shall include for each individual the information required by subparagraph (i).

(2) The source, nature and amount of the consideration used or to be used in effecting the merger, consolidation or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection (a) which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (a), and a statement as to the method by which the fairness of the proposal was arrived.

(6) The amount of each class of any security referred to in subsection (a) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (a) in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection (a) during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid therefor.

(9) A description of any recommendations to purchase any security referred to in subsection (a) made during the twelve calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in subsection (a) and, if distributed, of additional soliciting material relating thereto.

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(12) Such additional information as the department may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(c) If the person required to file the statement referred to in subsection (a) is a partnership, limited partnership, syndicate or other group, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection (a) is a corporation, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to such corporation, each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten per centum (10%) of the outstanding voting securities of such corporation.

(d) If any material change occurs in the facts set forth in the statement filed with the department and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the department and sent to such insurer within two (2) business days after the person learns of such change.

(e) If any offer, request, invitation, agreement or acquisition referred to in subsection (a) is proposed to be made by means of a registration statement under the Securities Act of 1933 (48 Stat. 74, 15 U.S.C. § 77a et seq.), or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 (48 Stat. 881, 15 U.S.C. § 78a et seq.), or under a State law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) may utilize such documents in furnishing the information called for by that statement.

(f) (1) The department shall approve any merger, consolidation or other acquisition of control referred to in subsection (a) unless it finds any of the following:

(i) After the change of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.

(ii) The effect of the merger, consolidation or other acquisition of control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:

(A) the informational requirements of section 1403(c)(2) and the standards of section 1403(d)(2) shall apply;

(B) the merger, consolidation or other acquisition shall not be disapproved if the department finds that any of the situations meeting the criteria provided by section 1403(d)(3) exist; and

(C) the department may condition the approval of the merger, consolidation or other acquisition on the removal of the basis of disapproval within a specified period of time.

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger, consolidation or other acquisition of control.

(vi) The [acquisition] merger, consolidation or other acquisition of control is likely to be hazardous or prejudicial to the insurance buying public.

(vii) The merger, consolidation or other acquisition of control is not in compliance with the laws of this Commonwealth, including Article VIII-A.

(2) If the merger, consolidation or other acquisition of control is approved, the department shall so notify the person filing the statement and the insurer [whose stock] that is proposed to be acquired, and such a determination is hereafter referred to as an approving determination. Notice shall also be given by the department of any determination which is not an approving determination. If an approving determination is made by the department and not otherwise, the proposed offer and acquisition may thereafter be made and consummated on the terms and conditions and in the manner described in the statement and subject to such conditions as may be prescribed by the department as hereinafter provided. An approving determination by the department shall be deemed to extend to offers or acquisitions made pursuant thereto within one year following the date of determination. The department may, as a condition of its approving determination, require the inclusion in any offer of provisions requiring the offer to remain open a specified minimum length of time, permitting withdrawal of shares deposited prior to the time the offeror becomes bound to consummate the acquisition and requiring pro rata acceptance of any shares deposited pursuant to the offer. The department shall hold a hearing before making the determination required by this subsection if, within ten (10) days following the filing with the department of the statement, written request for the holding of such hearing is made either by the person proposing to make the acquisition, by the insurer [whose stock] that is proposed to be acquired or, if [such] the issuer of stock proposed to be acquired is not an insurer, by the [insurance company] insurer controlled by such issuer. Otherwise, the department shall determine in its discretion whether such a hearing shall be held. Thirty (30) days' notice of any such hearing shall be given to the person proposing to make the acquisition, to the issuer whose stock is proposed to be acquired and, if such issuer is not an insurer, to the insurance company controlled by such issuer. Notice of any such hearing shall also be given to such other persons, if any, as the department may determine.

(3) The department may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the proposed acquisition of control.

(g) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the department by order shall exempt therefrom as:

(1) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

(2) as otherwise not comprehended within the purposes of this section.

(h) The following shall constitute a violation of this section:

(1) the failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b);

(2) the effectuation or any attempt to effectuate an acquisition of control of or merger or consolidation with a domestic insurer unless the department has given its approval thereto; or

(3) a violation of section 819-A.

(i) The department shall, within seventy-two hours of receiving a statement filed under this section, provide notification to the Office of Attorney General that the filing was received.

Section 6. Section 1403(a), (b) and (d), added December 18, 1992 (P.L.1519, No.178), are amended to read:

Section 1403. Acquisitions Involving Insurers not Otherwise Covered.–(a) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Acquisition." Any agreement, arrangement or activity the consummation of which results in a person acquiring, directly or indirectly, the control of another person and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance [and],mergers and consolidations.

"Involved insurer." Includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger or consolidation.

(b) (1) Except as exempted in paragraph (2), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this Commonwealth.

(2) This section shall not apply to any of the following:

(i) An acquisition subject to approval or disapproval by the department pursuant to section 1402.

(ii) A purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this Commonwealth. If a purchase of securities results in a presumption of control as described in the definition of "control" in section [1301] 1401, it is not solely for investment purposes unless the insurance department of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary insurance department to the Insurance Department of the Commonwealth.

(iii) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the department in accordance with subsection (c)(2) thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by this paragraph.

(iv) The acquisition of already affiliated persons.

(v) An acquisition if, as an immediate result of the acquisition:

(A) in no market would the combined market share of the involved insurers exceed five per centum (5%) of the total market;

(B) there would be no increase in any market share; or

(C) in no market would:

(I) the combined market share of the involved insurers exceeds twelve per centum (12%) of the total market; and

(II) the market share increases by more than two per centum (2%) of the total market.

For the purpose of this subparagraph, a market means direct written insurance premium in this Commonwealth for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this Commonwealth.

(vi) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business.

(vii) An acquisition of an insurer whose domiciliary insurance department affirmatively finds that such insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary insurance department to the Insurance Department of the Commonwealth.

(3) Sections 1409(b) and (c) and 1411 shall not apply to acquisitions provided for in this subsection.

* * *

(d) (1) The department may enter an order under subsection (e)(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this Commonwealth or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c).

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1), the department shall consider the following:

(i) Any acquisition covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards as follows:

(A) if the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more; or

(B) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more.

A highly concentrated market is one in which the share of the four largest insurers is seventy-five per centum (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in paragraph (1). For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven per centum (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition [or merger], merger or consolidation covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (1) if:

(A) there is a significant trend toward increased concentration in the market;

(B) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(C) another involved insurer's market is two per centum (2%) or more.

(iii) For the purposes of this paragraph:

(A) The term "insurer" includes any company or group of companies under common management, ownership or control.

(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the department shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this Commonwealth and the relevant geographical market is assumed to be this Commonwealth.

(C) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(iv) Even though an acquisition is not prima facie violative of the

competitive standard under subparagraphs (i) and (ii), the department may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subparagraphs (i) and (ii), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

(3) [An] Except for a merger, consolidation or acquisition of control involving a hospital plan corporation or professional health services plan corporation, an order may not be entered under subsection (e)(1) if:

(i) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(ii) the acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

* * *

Section 7. The act is amended by adding sections to read:

Section 1404.1. Insurance Restructuring Public Interest Review Board.–(a) The Insurance Restructuring Public Interest Review Board is established to review the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation as defined in this act and in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

(b) The board shall consist of the following members:

(1) The Auditor General or a designee.

(2) The Secretary of Public Welfare or a designee.

(3) The Secretary of Health or a designee.

(4) The Majority Leader of the Senate or a designee.

(5) The Minority Leader of the Senate or a designee.

(6) The Majority Leader of the House of Representatives or a designee.

(7) The Minority Leader of the House of Representatives or a designee.

(8) A member of the general public who is an individual insured under a hospital plan corporation or professional health services plan corporation appointed by the Governor.

(9) A person who is currently or who has been a health care provider pursuant to a contract with a hospital plan corporation or professional health services plan corporation appointed by the Governor.

(c) A majority of the members of the board shall select a chairperson and other officers as they shall determine.

(d) The board shall convene within 45 days after the effective date of this section. The board shall meet at least four times annually. Additional meetings shall be held at the call of the chairperson or on the submission of a request signed by a majority of the members of the board.

(e) A majority of the members of the board shall constitute a quorum. Except as provided in subsection (g) or (h), all business of the board shall be conducted by a quorum.

(f) No member of the board shall be entitled to compensation for services performed as a member of the board, but shall be entitled to reimbursement for all necessary and reasonable expenses incurred in connection with the performance of the duties as a member of the board.

(g) The board shall have the following powers and duties:

(1) To receive and review all filings submitted to the department relating to the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation and all accompanying data or other information. The department may redact information determined to be a trade secret. Confidential material shall be available for review in executive session of the board. A board member, financial expert or auditor who releases confidential information shall be subject to a civil penalty not to exceed $1,000 per violation.

(2) To hold at least one public hearing on a merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation at which the department shall present findings relating to the merger, consolidation or other acquisition of control.

(3) To make written recommendations to the department. Recommendations under this paragraph must be approved by at least seven members of the board.

(4) To appoint such financial experts or auditors as necessary to:

(i) Review the merger, consolidation or other acquisition of control.

(ii) Determine the amount of net economic benefit, savings, proceeds or other moneys that will be derived from the merger, consolidation or other acquisition of control.

(iii) Determine the amount of reserves of the health plan corporation and the professional health services plan corporation and the amount of the reserves of the newly merged, consolidated or acquired entity.

(iv) Determine the amount currently dedicated for the hospital plan corporation's and the professional health services plan corporation's social mission, as defined in section 2501, for the prior year and the current year.

(v) Review other amounts that will be available for the corporate social mission, as defined in section 2501, following any approval of the merger, consolidation or other acquisition of control.

(5) To consider the development of timelines, and any changes thereto, for conducting and completing activities under this subsection. The cost of the financial experts or auditors shall be paid for by the hospital plan corporation or professional health services plan corporation.

(h) The department shall present the following to the board:

(1) Findings and recommendations on the merger, consolidation or other acquisition of control to the insurance restructuring board, including an analysis of whether the hospital plan corporation or professional health services plan corporation has met all the requirements of sections 1402 and 1403.

(2) A written response to each recommendation submitted by the board under subsection (g)(3), including a detailed written explanation of the reason the recommendation will or will not be adopted.

(3) A written determination that the merger, consolidation or other acquisition of control will result in a sustained reduction in health care premiums for Pennsylvania policyholders and a written finding that describes the reason or reasons the department believes the merger, consolidation or other acquisition of control is consistent with public interest.

(i) The board shall have 30 days to review and respond to the written responses to recommendations provided under subsection (h). The department shall not approve the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation for 60 days after it has fully complied with subsection (h).

Section 1404.2. Account.–(a) There is hereby established in the State Treasury a restricted receipt account for the deposit of funds under this section.

(b) Any net economic benefits, including proceeds, savings, funds or moneys derived from the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation which are to be used to fund any portion of a health care or health care related program of, or to be administered by, the Commonwealth shall be deposited into the restricted receipt account under subsection (a) in the State Treasury.

(c) No contracts or written agreements between the Commonwealth and the hospital plan corporation or professional health services plan corporation may be entered into relating to the disbursement or spending of the economic benefits, proceeds, savings, funds or moneys resulting

from the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation until the funds are appropriated pursuant to subsection (d).

(d) No moneys may be transferred or paid from the account unless appropriated by the General Assembly for health-related purposes.

Section 8. The act is amended by adding articles to read:

ARTICLE XXV
HEALTH CARE REPORTING

Section 2501. Definitions.

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

"Social mission." Services, projects and community activities, including activities to improve health care or make health care more affordable and accessible in the service area, and all other charitable and benevolent activities of a hospital plan corporation or health services plan corporation.

Section 2502. Hospital plan corporation.

Each hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) shall annually provide to the department, the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives a list, including a description and cost, of all advertising contracts and all contracts entered into and expenditures made during that calendar year relating to the social mission of the health plan corporation. The information shall be provided by December 1 of each year. The hospital plan corporation shall also provide a list and description of all contracts and expenditures relating to the health plan corporation's social mission planned for the upcoming calendar year.

Section 2503. Professional health services plan corporation.

Each professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health service plan corporations) shall annually provide to the department, the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives a list, including a description and cost, of all advertising contracts and all contracts entered into and expenditures made during the calendar year relating to the social mission of the professional health services plan corporation. The information shall be provided by December 1 of each year. The professional health services plan corporation shall also provide a list and description of all contracts and expenditures relating to the health services plan corporation's social mission planned for the upcoming calendar year.

Section 2504. Retroactivity.

The provisions of sections 2502 and 2503 shall be retroactive to January 1, 2005. Reports for the years 2005 and 2006 shall be submitted within 90 days of the effective date of this section.

Amend Sec. 4, page 23, line 2, by striking out "4" and inserting
9

Amend Sec. 4, page 23, by inserting between lines 9 and 10

(3) The act of December 19, 1990 (P.L.834, No.198), known as the GAA Amendments Act of 1990, is repealed insofar as it is inconsistent with this act.

Amend Sec. 4, page 23, line 10, by striking out "(3)" and inserting
(4)

Amend Bill, page 23, by inserting between lines 12 and 13

Section 10. This act shall not apply to any merger, consolidation or other acquisition of control completed or consummated prior to the effective date of this section and, if required, following the issuance of an approving determination.

Section 11. This act shall apply to any application, statement or other plan or proposal relating to a merger, consolidation or other acquisition of control filed with the Insurance Department on or after January 1, 2007.

Amend Sec. 5, page 23, line 13, by striking out "5" and inserting
12

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

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

Ms. HARPER. Mr. Speaker, I filed a number of similar amendments. If you will give me a minute, I will let you know which one we should go with.

The SPEAKER. The House will be temporarily at ease.

Ms. HARPER. Thank you.

The SPEAKER. The Chair recognizes Representative Harper.

Ms. HARPER. Thank you, Mr. Speaker.

It appears that some of my other amendments are not timely filed, so I am going to have to go with the one that you called, which is A06040.

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

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

Ms. HARPER. Thank you, Mr. Speaker.

Ninety-six percent of the people in my county are insured for health insurance, and the vast majority of them are insured with Independence Blue Cross. Independence Blue Cross has announced its plan to merge with Highmark, and as I understand the current law, the only one who gets a say in that is the Insurance Commissioner. I believe that the decision should be reviewed by someone who has a great stake in this issue, and that would include at least one policyholder. So my amendment just simply proposes that any merger of the Blue Cross insurance companies would require an independent review board which would include, among members of the legislature, also at least one person who has health insurance to see whether the merger would, in fact, adversely affect their interest. Thank you, Mr. Speaker.

The SPEAKER. On the amendment, the Chair recognizes Chairman DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, I oppose this amendment. We had passed this amendment twice and sent it over to the Senate. There is no need for us to pass it again, and it does not pertain to HB 2005. So I would ask the membership to vote "no" on this today.

The SPEAKER. Will the House agree to the amendment?

Representative Harper, for the second time.

Ms. HARPER. Thank you, Mr. Speaker.

I do not disagree with the gentleman who just spoke. I would only say that if we have twice voted for this amendment, because we recognize the importance of its subject, which is allowing a greater scrutiny of the Blues merger, then we should vote for it again, and in that vein, I would ask my colleagues to vote "yes" so that we can have a greater scrutiny of the Blues merger to make sure that the interests and rights of the policyholders who depend on Independence Blue Cross in my district, that their interests are reviewed and well served.

Thank you, Mr. Speaker.

The SPEAKER. Representative Boyd.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, I just rise briefly to support the Harper amendment. I believe it was a hearing that we had with the Acting Insurance Commissioner, the current Insurance

Commissioner, I think, and the Finance Committee, where in discussions over this issue we talked about the factors that go into a decision of approving or disapproving a merger such as this, and in that hearing we had discussions about the fact that the health-care industry in Pennsylvania would be, in the next 20 years, approaching a trillion-dollar industry. And that is something, I think the comment was made that that is a lot of responsibility. Fifty-two percent of the policies in Pennsylvania would be under the direction of one company, a merged Highmark and Independence Blue Cross. While there is a lot of discussion about cost savings that would be generated from this and a lot of information, clearly there needs to be some oversight, and the concerns of ratepayers, the concerns of constituents, have to be represented in this discussion. And in fact, we need to do everything we can to continue to encourage more competition within the insurance industry, providing individuals more access to affordable health insurance. We just spent many, many hours discussing that issue, and it seems that not voting for the Harper amendment would fly in the face of trying to drive the cost down for everybody.

So I rise to support the Harper amendment and encourage members to think through a potential merger of Highmark and IBC (Independence Blue Cross). Thank you, Mr. Speaker.

The SPEAKER. Representative Eachus.

Mr. EACHUS. Thank you, Mr. Speaker.

I just wanted to be clear about this amendment. We oppose this amendment, Mr. Speaker. There is a time to deal with this content. Now is not the time. We rise to oppose the Harper amendment.

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

The following roll call was recorded:

YEAS–94

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

NAYS–104

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

NOT VOTING–0

EXCUSED–5

Cruz	Geist	Hennessey	True
Ellis			

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?

The clerk read the following amendment No. **A04620:**

Amend Title, page 1, line 14, by striking out "and" and inserting a comma

Amend Title, page 1, line 14, by removing the period after "coverage" and inserting

and for LifeLine health insurance.

Amend Sec. 3, page 4, line 12, by striking out "an article" and inserting

articles

Amend Sec. 3, page 23, by inserting between lines 1 and 2

ARTICLE XLIII
LIFELINE HEALTH INSURANCE

Section 4301. Scope of article.

This article 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 article 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) This act.

(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 article 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 article, including the provision of the benefits or requirements mandated by Article VI-A or by regulations promulgated under this article.

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 article 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 article, 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 article. 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.

Amend Sec. 5, page 23, line 15, by inserting after "617.1"

and Article XLIII

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

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

Mr. KILLION. Thank you, Mr. Speaker.

Amendment 4620 is the LifeLine amendment. It provides basic insurance coverage for individuals. It is a catastrophic coverage plan. What this does is it allows someone to buy a product in the market. It will be developed by the Insurance Department and be required by all insurers to offer, all larger insurers, those with more than 100,000 lives within their coverage that they cover. It is a basic policy that does not have all the bells and whistles and the mandates of the very, very expensive policies, but it does provide what a lot of folks need for what we believe will be a much cheaper price. It provides catastrophic coverage, the coverage that folks when they are uninsured could lead to losing their homes, losing their retirement. This provides coverage so a family knows for a cheap price that if someone in their family gets ill, they will have the coverage needed for those large expenses.

It provides 21 days of in-hospital treatment, maternity coverage, newborn coverage, chemotherapy coverage, all those catastrophic things that can put a family under, but at the same time, it is cheaper because it does not have all the bells and whistles. It is a basic LifeLine policy, and if we want to keep the private sector involved, and I think both sides of the aisle want to do this, this is a way to do that and address the need for lower premium products in the marketplace. It does nothing to the underlying bill.

Often, many of the amendments that have been offered affect the underlying bill. This does not do that. It simply complements it. It keeps the private sector involved, provides a product that is available to consumers at a lower price, does not have all the bells and whistles, but they can put their head on the pillow at night and know that for this lower price, they are not going to lose their house, they are not going to lose their savings, they are not going to lose their retirement money; that if someone in their family gets ill, the coverage is there.

I ask my colleagues to vote in favor of this amendment. I would like to say again that it does not affect the underlying bill, just the opposite, it complements it, and it keeps the private sector in the Commonwealth in this business.

Thank you, Mr. Speaker.

The SPEAKER. Chairman DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, I am not going to prolong the argument on this amendment. We voted this amendment down twice on 2037; two times this bill was argued about, this amendment was argued about twice and we voted it down. I am asking the membership to vote this down again today.

The SPEAKER. Will the House agree to the amendment? Before the Chair recognizes the prime sponsor, is there any other member seeking recognition?

Representative Killion, for the second time.

Mr. KILLION. If I could just follow up on my good friend, chairman of the Insurance Committee. Yes, we have voted two times, but let us make the third time a charm. Thank you.

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

The following roll call was recorded:

YEAS–96

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

NAYS–102

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
Curry	Keller, W.	Payton	Walko
Daley	Kessler	Petrarca	Wansacz
DeLuca	King	Petrone	Waters
DePasquale	Kirkland	Preston	Wheatley
Dermody	Kortz	Ramaley	White
DeWeese	Kotik	Readshaw	Williams
Donatucci	Kula	Roebuck	Wojnaroski
Eachus	Leach	Sabatina	Yewcic
Evans, D.	Lentz	Sainato	Youngblood
Fabrizio	Levdansky	Samuelson	Yudichak
Frankel	Longietti	Santoni	
Freeman	Mahoney	Seip	O'Brien, D.,
Galloway	Manderino	Shapiro	Speaker

NOT VOTING–0

EXCUSED–5

Cruz	Geist	Hennessey	True
Ellis			

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?

The SPEAKER. The gentleman, Representative Boyd, withdraws his amendment. The Chair thanks the gentleman.

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

Mr. **SCHRODER** offered the following amendment No. **A04770:**

Amend Title, page 1, lines 1 through 14, by striking out all of said lines and inserting

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing for small group health benefits.

Amend Bill, page 1, lines 17 through 23; pages 2 through 22, lines 1 through 30; page 23, lines 1 through 17, by striking out all of said lines on said pages and inserting

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding an article to read:

ARTICLE XXII
SMALL GROUP HEALTH BENEFITS

Section 2201. Scope of article.

This article relates to health benefit plans offered by an insurer to employees of small employers.

Section 2202. Definitions.

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

"Community rate." An insurer's rating methodology that is based on the experience of all risks covered by that plan without regard to health status, occupation or any other factor. An insurer may adjust its community rate for age, geographic region as approved by the Insurance Department and family composition.

"Department." The Insurance Department of the Commonwealth.

"Health benefit plan." Any 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 shall not include any of the following:

(1) Accident only policy.
(2) Limited benefit policy.
(3) Credit only policy.
(4) Long-term or disability income policy.
(5) Specified disease policy.
(6) Medicare supplement policy.
(7) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.
(8) Fixed indemnity.
(9) Dental only.
(10) Vision only.
(11) Workers' compensation policy.
(12) Automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

"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 this act or any of the following:

(1) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.
(2) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.
(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

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

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

"Small employer." In connection with a group health plan with respect to a calendar year and a plan year, an employer who employs an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two such employees on the first day of the plan year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination whether an employer is a small employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year.

"Small group health benefit plan." A health benefit plan offered to a small employer.

"Standard plan." The health benefit package established by the Insurance Department in accordance with section 2203(d).

Section 2203. Health insurance rate increases and standard plan.

(a) Applicability.–This section shall apply to all small group health benefit plans and individual health benefit plans issued, made effective, delivered or renewed in this Commonwealth after the effective date of this section.

(b) Premium rates.–

(1) All insurers shall establish community rates for plans subject to this section and shall file the rates with the department as required by law.

(2) An insurer shall apply all risk adjustment factors under subsection (c)(1)(i), (ii) and (iii) consistently with respect to all plans subject to this section.

(3) An insurer shall not charge a rate that is more than 33% above or below the community rate, as adjusted as permitted under paragraph (1).

(4) An insurer shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles. Rates shall not be excessive, inadequate or unfairly discriminatory.

(c) Additional rate review.–

(1) In conjunction with and in addition to the standards set forth under the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act, and all other applicable statutory and regulatory requirements, the department may disapprove a rate filing based upon the following:

(i) The rate is not actuarially sound.

(ii) The increase is requested because the insurer has not operated efficiently or has factored in experience that conflicts with recognized best practices in the health care industry.

(iii) The increase is requested because the insurer has incurred costs of additional care due to avoidable hospital-acquired infections and avoidable hospitalizations due to ineffective chronic care management, after data for the incidents has become available to and can be analyzed by the insurer and the department.

(iv) For small group health plans, the medical loss ratio is less than 85%.

(2) In the event a small group health benefit plan has a medical loss ratio of less than 85%, the department may, in addition to any other remedies available under law, require the insurer to refund the difference to policyholders on a pro rata basis as soon as practicable following receipt of notice from the department of such requirement but in no event later than 120 days following receipt of the notice. The department shall establish procedures for the circumstances under which the refunds will be required.

(3) The filing and review procedures set forth under the Accident and Health Filing Reform Act shall apply to any filing conducted under this section.

(d) Standard plan required.–

(1) An insurer shall not offer a plan that does not meet the minimum benefits specified in the standard plan developed by the department in accordance with the following criteria:

(i) Plans offered by an insurer on an expense-incurred basis shall be actuarially equivalent to at least the minimum benefits required to be offered under the standard plan.

(ii) The standard plan shall at least include all of the benefits of the basic benefit package.

(iii) The standard plan shall not contain preexisting condition exclusion.

(2) The standard plan may include options for deductible and cost-sharing provisions if the department determines that the provisions meet all of the following:

(i) Dissuade consumers from seeking unnecessary services.

(ii) Balance the effect of cost-sharing in reducing premiums and in effecting utilization of appropriate services.

(iii) Limit the total cost-sharing that may be incurred by an individual in a year.

(3) Each individual in this Commonwealth who applies to an insurer for enrollment in a plan offered by the insurer shall be accepted as an enrollee.

(4) The department shall forward a notice of the elements of the standard plan to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. Insurers subject to the provisions of this section shall be required to begin offering the standard plan as soon as practicable following the publication but in no event later than 120 days following the publication.

(e) Optional additional coverage.–

(1) An insurer may offer benefits in addition to those in the standard plan if the additional benefits meet all of the following:

(i) Are offered and priced separately from benefits specified in the standard plan.

(ii) Do not have the effect of duplicating any of the benefits in the standard plan.

(iii) Are clearly specified as enhancements to the standard plan.

(2) Each benefit offered in addition to the standard plan that increases health care choices or lowers the cost-sharing arrangement is subject to all of the provisions of this section applicable to the standard plan.

(3) The department may prohibit an insurer from offering an additional benefit under this section if the department finds that the additional benefit will be sold in conjunction with the standard plan of the insurer in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this section or other statute.

(f) Regulations.–The department may promulgate regulations necessary for the implementation and administration of this article.

Section 2. This act shall take effect in 120 days.

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, imagine for a moment that you are the owner of a small business in Pennsylvania and maybe you have 10, 20 employees or so, and all of sudden one of your employees – you heretofore had a healthy, young workforce, and then all of a sudden one of your employees has a major illness. Maybe they have heart trouble; maybe they have cancer; maybe they have a chronic condition that needs to be treated but just will not go away. Mr. Speaker, under the current rating methodology for small business health insurance policies in Pennsylvania, you as a business owner would see your premiums skyrocket.

Mr. Speaker, a number of years back when we went from community rating for small businesses to demographic rating, you had outcries from the small businesses in your areas who were affected and impacted by that. Many of them had double and triple premium increases from the previous year, from factors that they could not control. Mr. Speaker, those employers were forced to either give up coverage for their employees or pay an exorbitant price for coverage and perhaps cut back in other areas – for instance, not expanding, not growing their business, not hiring more workers.

Mr. Speaker, this amendment will take us back to when small businesses were rated under what is called community rating in Pennsylvania. And why do I think this is the better way to go? Under community rating, the insurer rates and underwrites the risk over a large pool of insureds, under its entire pool of small businesses that it insures. Under the current demographic rating, it is only your individual business that is rated, so one illness can drive your premiums up to an unaffordable level.

Mr. Speaker, there are other problems with the current demographic rating as we have it in Pennsylvania as well. It is highly discriminatory. If an employer has a young woman of childbearing years, that employer is going to be subject to a higher premium because of demographic rating. Mr. Speaker, by spreading the risk out over the largest possible pool, we will eliminate and greatly reduce the wild premium spikes and increases that we have seen over the past few years in the small group market.

Mr. Speaker, just last week when we were debating other health insurance issues, the gentleman, Mr. Eachus, made a statement, and he said something to the effect that there are no solutions to insurance price increases for small employers, and he was talking about nongovernmental or private-sector solutions. Mr. Speaker, I would take issue with that. Adopting this amendment to this bill to go to community rating will go a long way towards achieving stability in the small group marketplace. And I must also give credit to where credit is due. I mentioned Mr. Eachus. This bill is identical to his HB 1601, which he introduced earlier this session.

And, Mr. Speaker, because of the work that we have done in the Insurance Committee and the study that many of us have given to this issue, I long ago came to the conclusion that either some sort of modified demographic rating that excluded health underwriting, excluded rating a policy based on health conditions, was the best way to insure the small business market. So, Mr. Speaker, that is why I introduced this amendment, and I urge and ask for your support.

LEAVES OF ABSENCE

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

The Chair recognizes the majority whip, who requests that Representative KOTIK be placed on leave. The Chair sees no objection. That leave will also be granted.

CONSIDERATION OF HB 2005 CONTINUED

The SPEAKER. The Chair recognizes Chairman DeLuca on the amendment.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, I rise to support the Schroder amendment, and I want to commend him. He has been working a long time on this type of amendment, and I think he hit the two keywords for small businesses, stability and predictability. That is very important for our small business community out there. Now, if you are worried about small businesses, you should vote for the Schroder amendment, and I am asking my side of the aisle here to vote "yes" on the Schroder amendment. His amendment makes this bill a better bill, so I am asking for a "yes" vote on the Schroder amendment.

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

The following roll call was recorded:

YEAS–179

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

NAYS–17

Bear	Denlinger	Metcalfe	Rohrer
Boyd	Godshall	Micozzie	Sonney
Causer	Hickernell	Perry	Stern
Cox	Hutchinson	Rapp	Tangretti
Cutler			

NOT VOTING–0

EXCUSED–7

Cruz	Ellis	Hennessey	True
Dally	Geist	Kotik	

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?

The SPEAKER. The House will be at ease.
The Chair informs Chairman DeLuca that amendment A05921 is now out of order.
The Chair recognizes Chairman DeLuca.
Mr. DeLUCA. Thank you, Mr. Speaker.
Mr. Speaker, this amendment, because of the Schroder amendment, was out of order, and I requested a replacement amendment, which you have, A06314, so I would like to run it.
The SPEAKER. The House will be at ease.
The replacement amendment, A06314, is in order.

On the question recurring,
Will the House agree to the bill on second consideration as amended?
Mr. **DeLUCA** offered the following amendment No. **A06314:**

Amend Sec. 1 (Sec. 2203), page 3, line 46 (A04770), by removing the period after "section" and inserting
except that all of paragraph (1)(iii) shall apply to all group health benefit plans subject to filing under the Accident and Health Filing Reform Act without regard to the size of the groups covered by the plan.

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

The SPEAKER. The Chair recognizes Chairman DeLuca on the amendment.
Mr. DeLUCA. Thank you, Mr. Speaker.
Mr. Speaker, what this amendment does, the change means that any rate request, either an increase or the original base rate, must account for the following: the best practices for cost controls, including costs related to health care, associated infections, chronic care management. And it also provides that these important cost control provisions will be applicable to all rate filings regardless of the size of the group to be insured. It is the same amendment that we had before.
The SPEAKER. Will the House agree to the amendment?
Representative Boyd.
Mr. BOYD. If the maker would stand for a real brief interrogation, please?
The SPEAKER. Chairman DeLuca indicates he will stand for interrogation. Representative Boyd is in order and may proceed.
Mr. BOYD. Thank you, Mr. Speaker.
I just want to clarify. So this is the same amendment that went in before? Was this amendment voted earlier today or in committee or what?
Mr. DeLUCA. This is the same amendment we had on the schedule that was out of order because of the Schroder amendment.
Mr. BOYD. All right. So when the Schroder amendment went in—
Mr. DeLUCA. It put it out of order.
Mr. BOYD. Okay.
Mr. DeLUCA. And we had a replacement amendment for it—
Mr. BOYD. All right.
Mr. DeLUCA. —ready to go.
Mr. BOYD. Thank you, Mr. Speaker. I just wanted to clarify which it was.

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

The following roll call was recorded:

YEAS–196

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

NAYS–0

NOT VOTING–0

EXCUSED–7

Cruz	Ellis	Hennessey	True

Dally Geist Kotik

The majority having voted in the affirmative, the question was determined in the affirmative and the amendment was agreed to.

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

The SPEAKER. Will the House agree to the bill?
The Chair recognizes Representative Maher.
Mr. MAHER. Thank you, Mr. Speaker.
Would the maker of the bill respond to interrogation, please?
The SPEAKER. The gentleman, Chairman DeLuca, indicates he will stand for interrogation. Representative Maher is in order and may proceed.
Mr. MAHER. Thank you, Mr. Speaker.
On page 21, line 19, section 4209, subsection (b)— You need a minute?

Mr. DeLUCA. Hold on a minute, Representative Maher.
Mr. Speaker, will the gentleman repeat the question, please?
Mr. MAHER. Thank you, Mr. Speaker.
The SPEAKER. If the gentleman will suspend. The noise level is reaching a high level. The individuals will please end their conversations. Conversations will cease.
The gentleman will repeat his question for the gentleman.
Mr. MAHER. Thank you, Mr. Speaker.
Page 21, line 19, section 4209, subsection (b), am I understanding this subsection correctly, that the Insurance Department will be exempt from following the law dealing with the Independent Regulatory Review Commission, exempt from following the law on the Commonwealth documents, exempt from following the law under the Commonwealth Attorneys Act for 3 years?
The SPEAKER. The gentleman will approach the rostrum.

(Conference held at Speaker's podium.)

LEAVE OF ABSENCE CANCELED

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

CONSIDERATION OF HB 2005 CONTINUED

The SPEAKER. The House will come to order.
The Chair recognizes Representative Maher.
Mr. MAHER. Thank you, Mr. Speaker.
I appreciate the conference we just had, because given the amendments that had been adopted, a lot of the page and line references are no longer applicable, and in conversation, in a nice bipartisan spirit, we sorted out the couple of substantive points that we were going to get out. So I ask the other members' indulgences if we are not citing line and chapter at the moment because we will have to wait for it to be reprinted.
As I understand it, the bill as amended to this point provides that the Insurance Department can establish minimum standard benefits for health insurance. And I truly appreciate that you are working on the fly here because of the changes, so if you need a minute to read that language—
Mr. DeLUCA. You are correct.
Mr. MAHER. —please do.
Mr. DeLUCA. The Insurance Department will establish that, Mr. Speaker.
Mr. MAHER. The Insurance Department will establish these standard benefits?
Mr. DeLUCA. That is correct.
Mr. MAHER. Now, currently a lot of employers in Pennsylvania have plans that are known as cafeteria plans, where they can offer a variety of types of coverage to their employees, and the employees can decide how much they want to gamble, how much they want to spend, and it really leaves that decision with the employee. Would benefits, health insurance benefits, offered through cafeteria plans be subject to this minimum standard benefit?
Mr. DeLUCA. No, Mr. Speaker. As a matter of fact, they can still do what they are doing right now.

Mr. MAHER. That is good.
And also, in terms of establishing a minimum standard benefit, what would prevent the Department of Insurance from simply outlawing health savings accounts by saying that those plans did not provide a minimum standard benefit because that puts so much of the decisionmaking power in the hands of the individual who is insured to make decisions?
Mr. DeLUCA. Mr. Speaker, if you go to page 3, line 51, it establishes what they can do and what they cannot do, right on lines 51 to 59, and over to the next page, on page 4.
Mr. MAHER. And so is it your belief that as that is presented, the Insurance Department would be prohibited—
Mr. DeLUCA. Absolutely.
Mr. MAHER. —from establishing standards that would undermine HSAs?
Mr. DeLUCA. Absolutely, Mr. Speaker. Certainly, we would not be for giving them that power.
Mr. MAHER. Thank you, Mr. Speaker.
Further in the bill as amended, it provides that the Insurance Department can review rates and, I imagine, limit rates if the Insurance Department concludes that the insurer is somehow or another in conflict with recognized best practice in the health-care industry?
Mr. DeLUCA. Mr. Speaker, if you go to page 3 and you go to lines 21 to 32, if you want me to read it, I will read it, but I think it is about time we require, if you look at that paragraph, the insurance companies to do that, what we have underlined there; if you look at lines 21 through 32.
Mr. MAHER. In the bill or an amendment? Part of the challenge we have right now is that we are speaking on second consideration of the bill as amended but we do not actually have such a document. So maybe—
Mr. DeLUCA. It is in the bill, Mr. Speaker, as amended; in the bill as amended. Do you have that in front of you?
Mr. MAHER. As amended with today's amendments, I do not think— That has not been provided to us.
Mr. DeLUCA. Well, let me read it to you then; I will read it to you, Mr. Speaker: "The rate is not actuarially sound," number (i). Number (ii), "The increase is requested because the insurer has not operated efficiently or has factored in experience that conflicts with recognized best practices in the health care industry." Number

(iii), "The increase is requested because the insurer has incurred costs of additional care due to avoidable hospital-acquired infections and avoidable hospitalizations due to ineffective chronic care management, after data for the incidents has become available to and can be analyzed by the insurer and the department."

Mr. MAHER. Thank you, Mr. Speaker.

And that was very helpful, actually.

So if I understand correctly, if a patient suffers some avoidable infection or other unfortunate outcome with the health-care provider, then the insurer will be financially punished by the Insurance Department because a health-care provider made a mistake with respect to a patient?

Mr. DeLUCA. Really, Mr. Speaker, when we pass the next bill, that is not going to happen, but will the insurer be penalized, as I understand it, if one of these situations happens?

Mr. MAHER. Is it my understanding that what you just read said that if the rate included costs associated with avoidable infections and so forth that are suffered by patients and the cost to treat them, it would seem to me that the patient has already suffered in that scenario, and I am trying to understand why the insurance company gets punished for a mistake that is attributed to someone else.

Mr. DeLUCA. I think what—

Mr. MAHER. I know we all want to reduce—

Mr. DeLUCA. If you are ready, Mr. Speaker, go ahead.

Mr. MAHER. I know we all want to reduce the incidence of errors with health-care providers to provide incentives, but I am not quite sure how it is fair to punish the person paying the bill for mistakes that were made by someone they are paying to do some work. It seems to me it would be sort of like saying that if you bought gasoline at the pump that had water in it and it fouled up your engine and the insurance company paid to fix the problem with your car, then you would punish the insurance company for taking care of the person who had the problem, even though it was not their problem. They did not create the problem. It seems to me we are punishing the wrong party under that scenario.

Mr. DeLUCA. Mr. Speaker, I personally believe that the insurance companies have a responsibility to their insurers to control cost, and that is exactly what this section does, and if we are going to err, we will err on the side of the consumers and the fact that we want to reduce the costs to our insurers out there. This whole thing is about reducing cost, and there is no way you should— If you are creating the problem, I understand where you are coming from, but on the same token, they should be held responsible to make them more responsible when they have these situations happen.

Mr. MAHER. So then you would imagine that the insurer would decline to pay a bill for a patient who has already suffered this avoidable infection or other unfortunate result with a health-care provider. The insurers would decline to pay?

Mr. DeLUCA. Mr. Speaker, that is correct, and I do have a bill that is going to address that, HB 2098, that will be coming up next. As you know, we already did that type of legislation on Medicare, the Governor did it on the Medicaid, and we will be doing it for private insurers.

Mr. MAHER. So your bill as drafted then presupposes punishing insurance companies for something which is not only entirely legal currently but is their obligation currently. They are obliged to pay the bills of the individuals whom they insure, and I understand you have some other legislation that may alter that, but that is not part of this legislation, is it?

Mr. DeLUCA. Mr. Speaker, you might characterize it as punishment. I do not characterize it as punishment. I characterize it as accountability, holding the insurance carriers accountable. Now, you might classify it as punishment. To me, that is not punishment. We hold them accountable for what they are doing.

Mr. MAHER. Okay. So then if I understand correctly, under your bill if an insurer pays a claim that they are legally obligated to pay, they will be denied being allowed to charge rates to recover the claims that they pay?

Mr. DeLUCA. Are you saying—

Mr. MAHER. I think I do understand, so maybe we will move on.

Mr. DeLUCA. I hope you are not saying that we should be able to require them to recover. Is that what I hear you saying, for incidents, for mistakes that are happening?

Mr. MAHER. Well, it says the Insurance Department—

Mr. DeLUCA. Right; the Insurance Department—

Mr. MAHER. —will reduce rates for a number of reasons, and one of them is if it includes costs associated with payments for avoidable infections and so forth, and I may be misreciting those words again because we are dealing with a document that has been amended but we do not have a conformed copy in front of us.

On the one hand, if I am a patient, I expect my insurance companies to pay the bill if I have got coverage.

Mr. DeLUCA. Mr. Speaker, I think you and I have a basic disagreement on how we interpret this language and how we figure whom we are going to hold accountable. You say it is punishment. I do not say it is punishment. I say it is accountability, and I do not think we are going to settle that by arguing back and forth here. So that is all I can tell you, Mr. Speaker.

Mr. MAHER. So this other bill that is to come – and I know this is probably broader than interrogation on this bill, but since you referred to it – this other bill that is to come, will that grant immunity to insurers so that they do not pay claims to patients if in their judgment those claims arose from health care needed to address some sort of avoidable error?

Mr. DeLUCA. I think what we will do, Mr. Speaker, we will address that with the next bill. That is not in this bill, which you are talking about immunity and that.

Mr. MAHER. Right. All right.

Mr. DeLUCA. So if you want to address that with the next bill, I will be happy to address it with you.

Mr. MAHER. Thank you, Mr. Speaker.

Mr. Speaker, that concludes my inquiries related to HB 2005 on second consideration. I would like to speak briefly on the bill.

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

Mr. MAHER. Mr. Speaker, I think there are a lot of useful topics that are visited on by HB 2005. I know I will look forward to reading a conformed version, given all these amendments that have been considered.

But I would encourage, I would encourage the maker of the bill to consider whether in the case— If we are concerned about patients, why would we require by law that insurers do not pay claims or have their rates reduced. It seems to me that that is encouraging individual patients to have endless conversations with insurance companies in the years ahead about whether or not their claim should be covered, and if I hear anything from my constituents, it is not that there is an absence of issues about whether or not certain things are covered. It is that it is too confusing already about what is covered. And I think this is really going to create unfortunate tension where insurance companies,

whether you want to call it punished or have their rates reduced, however you want to call it, if they pay the claims that their current contracts would require them to pay, it seems to me that that is something you really do need to take a look at, and to the extent that there are other questions that may arise in the conformed version, I just wish that this chamber would have had a chance to consider this in a fashion that people could actually read before we need to move on this evening.

Thank you, Mr. Speaker.

The SPEAKER. Representative Ross.

Mr. ROSS. Thank you, Mr. Speaker.

Mr. Speaker, would the author of the legislation submit to interrogation?

The SPEAKER. Chairman DeLuca indicates he will stand for interrogation. Representative Ross is in order and may proceed.

Mr. ROSS. Thank you, Mr. Speaker.

Mr. Speaker, I want to refer to the section that relates to college student insurance requirements. I will give you a moment to get to that section. It is on page 16, at least before the bill was—

Mr. DeLUCA. Mr. Speaker, before we get back and forth, that is no longer in the bill. The whole page has been taken out because of the Schroder amendment.

Mr. ROSS. Okay. So all of the provisions relating to college students in this previous bill are now removed?

Mr. DeLUCA. That is correct.

Mr. ROSS. Thank you, Mr. Speaker. That concludes my interrogation and my comments.

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 2098, PN 3231,** entitled:

An Act establishing a system for payment or reduction in payment for preventable serious adverse events within Commonwealth programs; informing health insurers of payment policies used by Medicaid and Medicare; and providing for the powers and duties of the Department of Public Welfare, the Insurance Department, the Department of Health and the Department of State.

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

Mr. **DeLUCA** offered the following amendment No. **A05981:**

Amend Sec. 5, page 4, line 21, by inserting before "The"
(a) Notice of preventable serious adverse events.–
Amend Sec. 5, page 4, lines 23 and 24, by striking out "that health payors shall be permitted to" and inserting
for which health payors may
Amend Sec. 5, page 4, by inserting between lines 24 and 25
(b) Notice of CMS rule.–The department shall transmit notice of the effective date of the CMS Hospital-Acquired Conditions, Including Infections, Final Rule, to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.
Amend Sec. 7, page 5, line 4, by striking out "patient"
Amend Sec. 7, page 5, line 5, by inserting after "seeking"
or causing to be sought
Amend Sec. 7, page 5, line 6, by inserting after "patient"
or responsible party of the patient
Amend Bill, page 5, by inserting between lines 7 and 8
Section 19. Applicability.
This act shall apply to preventable serious adverse events that occur after the later of the following:
(1) Publication of the notice under section 5(b) of the act.
(2) October 1, 2008.
Amend Sec. 20, page 5, line 9, by striking out "in 180 days" and inserting
immediately

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

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

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, this amendment clarifies two things. This bill will not take effect until the Federal Medicare program starts. It is expected to begin in October of this year. Since the bill will allow insurance companies to not pay for the same mistakes that Medicare will not pay for, this change will follow that effective date.

It also clarifies the requirements of the Department of State to investigate and, it provides, to try to collect payments from the patient or the responsible party of the patient for claims not paid by the insurance company under the law, and I ask for an affirmative vote on this amendment.

LEAVE OF ABSENCE CANCELED

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

CONSIDERATION OF HB 2098 CONTINUED

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

The following roll call was recorded:

YEAS–198

Adolph	Gabig	Marshall	Rohrer
Argall	Galloway	Marsico	Ross
Baker	George	McCall	Rubley
Barrar	Gerber	McGeehan	Sabatina
Bastian	Gergely	McI. Smith	Sainato
Bear	Gibbons	McIlhattan	Samuelson
Belfanti	Gillespie	Melio	Santoni
Benninghoff	Gingrich	Mensch	Saylor
Bennington	Godshall	Metcalfe	Scavello
Beyer	Goodman	Micozzie	Schroder
Biancucci	Grell	Millard	Seip
Bishop	Grucela	Miller	Shapiro
Blackwell	Haluska	Milne	Shimkus
Boback	Hanna	Moul	Siptroth
Boyd	Harhai	Moyer	Smith, K.
Brennan	Harhart	Mundy	Smith, M.
Brooks	Harkins	Murt	Smith, S.
Buxton	Harper	Mustio	Solobay

Caltagirone	Harris	Myers	Sonney
Cappelli	Helm	Nailor	Staback
Carroll	Hershey	Nickol	Stairs
Casorio	Hess	O'Brien, M.	Steil
Causer	Hickernell	O'Neill	Stern
Civera	Hornaman	Oliver	Stevenson
Clymer	Hutchinson	Pallone	Sturla
Cohen	James	Parker	Surra
Conklin	Josephs	Pashinski	Swanger
Costa	Kauffman	Payne	Tangretti
Cox	Keller, M.	Payton	Taylor, J.
Creighton	Keller, W.	Peifer	Taylor, R.
Curry	Kenney	Perry	Thomas
Cutler	Kessler	Perzel	Turzai
Daley	Killion	Petrarca	Vereb
DeLuca	King	Petri	Vitali
Denlinger	Kirkland	Petrone	Vulakovich
DePasquale	Kortz	Phillips	Wagner
Dermody	Kotik	Pickett	Walko
DeWeese	Kula	Preston	Wansacz
DiGirolamo	Leach	Pyle	Waters
Donatucci	Lentz	Quigley	Watson
Eachus	Levdansky	Quinn	Wheatley
Ellis	Longietti	Ramaley	White
Evans, D.	Mackereth	Rapp	Williams
Evans, J.	Maher	Raymond	Wojnaroski
Everett	Mahoney	Readshaw	Yewcic
Fabrizio	Major	Reed	Youngblood
Fairchild	Manderino	Reichley	Yudichak
Fleck	Mann	Roae	
Frankel	Mantz	Rock	O'Brien, D.,
Freeman	Markosek	Roebuck	Speaker

NAYS–0

NOT VOTING–0

EXCUSED–5

Cruz	Geist	Hennessey	True
Dally			

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?

Mr. **BOYD** offered the following amendment No. **A05966:**

Amend Title, page 1, lines 1 through 7, by striking out all of said lines and inserting
Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," further providing for effect of act on existing laws and, in insurance holding companies, for definitions, for acquisition of control of or merger with domestic insurer and for acquisitions involving insurers not otherwise covered; establishing the Insurance Restructuring Board; providing for its powers and duties; establishing an account; establishing a system for payment or reduction in payment for preventable serious adverse events within Commonwealth programs; informing health insurers of payment policies used by Medicaid and Medicare; providing for the powers and duties of the Department of Public Welfare, the Insurance Department, the Department of Health and the Department of State; providing for health care reporting; and making an inconsistent repeal.

Amend Bill, page 1, lines 10 through 19; pages 2 through 4, lines 1 through 30; page 5, lines 1 through 9, by striking out all of said lines on said pages and inserting

Section 1. Section 108 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

Section 108. Effect of Act on Existing Laws.–The provisions of this act, so far as they are the same as those of existing laws, shall be construed as a continuation of such laws and not as new enactments. The repeal by this act of any provision of law shall not revive any law heretofore repealed or superseded, nor shall such repeal affect any act done, liability incurred, or any right accrued or vested, or any suit or prosecution pending or to be instituted to enforce any right or penalty or punish any offense under the authority of the repealed laws. The provisions of this act shall not limit the jurisdiction and authority of the Office of Attorney General, including, but not limited to, the jurisdiction and authority granted pursuant to the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

Section 2. The definitions of "insurer" and "person" in section 1401 of the act, amended December 20, 2000 (P.L.967, No.132), are amended and the section is amended by adding a definition to read:

Section 1401. Definitions.–As used in this article, and for the purposes of this article only, the following words and phrases shall have the meanings given to them in this section:

* * *

"Insurer." Any health maintenance organization, preferred provider organization, company, association [or], exchange, hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), authorized by the Insurance Commissioner to transact the business of insurance in this Commonwealth except that the term shall not include:

(1) the Commonwealth or any agency or instrumentality thereof;

(2) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision; or

(3) fraternal benefit societies[; or

(4) nonprofit medical and hospital service associations].

* * *

"Person." An individual, an insurer, a corporation, a partnership, a limited liability company, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert. The term shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

* * *

"Shareholder." A record holder or record owner of shares of an insurer.

(1) The term shall include all of the following:

(i) A member of an insurer that is a domestic nonstock corporation under 15 Pa.C.S. Ch. 21 (relating to nonstock corporations) or a prior statute.

(ii) A member, as defined in 15 Pa.C.S. § 5103 (relating to definitions), of an insurer that is a domestic nonprofit corporation under 15 Pa.C.S. Ch. 51 (relating to general provisions) or a prior statute.

(iii) A subscriber of an insurer that is a domestic reciprocal exchange under Article X or a prior statute.

(2) The term shall not include any subscriber, insured or customer of:

(i) a hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or

(ii) a professional health service plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

* * *

Section 3. Section 1402 of the act, amended or added December 18, 1992 (P.L.1519, No.178) and December 21, 1998 (P.L.1108, No.150), is amended to read:

Section 1402. Acquisition of Control of or Merger or Consolidation with Domestic Insurer.–(a) (1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would directly or indirectly or by conversion or by exercise of any right to acquire, be in control of such insurer, and no person shall enter into an agreement to merge or consolidate with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request or invitation is made or any such agreement is entered into or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the department and has sent to such insurer a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the department in the manner hereinafter prescribed.

(2) For purposes of this section, a "domestic insurer" shall include any person controlling a domestic insurer unless such person as determined by the department is either directly or through its affiliates primarily engaged in business other than the business of insurance. Such person shall, however, file a preacquisition notification with the department containing the information set forth in section 1403(c)(2) thirty (30) days prior to the proposed effective date of the acquisition. Failure to file is subject to section 1403(e)(3). For purposes of this section, "person" shall not include any securities broker holding, in the usual and customary manner, less than twenty per centum (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

(b) The statement to be filed with the department under this section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger, consolidation or other acquisition of control referred to in subsection (a) is to be effected, hereinafter called "acquiring party," and

(i) if such person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years; or

(ii) if such person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to those positions. This list shall include for each individual the information required by subparagraph (i).

(2) The source, nature and amount of the consideration used or to be used in effecting the merger, consolidation or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection (a) which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (a), and a statement as to the method by which the fairness of the proposal was arrived.

(6) The amount of each class of any security referred to in subsection (a) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (a) in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection (a) during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid therefor.

(9) A description of any recommendations to purchase any security referred to in subsection (a) made during the twelve calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in subsection (a) and, if distributed, of additional soliciting material relating thereto.

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(12) Such additional information as the department may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(c) If the person required to file the statement referred to in subsection (a) is a partnership, limited partnership, syndicate or other group, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection (a) is a corporation, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to such corporation, each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten per centum (10%) of the outstanding voting securities of such corporation.

(d) If any material change occurs in the facts set forth in the statement filed with the department and sent to such insurer pursuant to this section, an amendment setting forth such change, together with

copies of all documents and other material relevant to such change, shall be filed with the department and sent to such insurer within two (2) business days after the person learns of such change.

(e) If any offer, request, invitation, agreement or acquisition referred to in subsection (a) is proposed to be made by means of a registration statement under the Securities Act of 1933 (48 Stat. 74, 15 U.S.C. § 77a et seq.), or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 (48 Stat. 881, 15 U.S.C. § 78a et seq.), or under a State law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) may utilize such documents in furnishing the information called for by that statement.

(f) (1) The department shall approve any merger, consolidation or other acquisition of control referred to in subsection (a) unless it finds any of the following:

(i) After the change of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.

(ii) The effect of the merger, consolidation or other acquisition of control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:

(A) the informational requirements of section 1403(c)(2) and the standards of section 1403(d)(2) shall apply;

(B) the merger, consolidation or other acquisition shall not be disapproved if the department finds that any of the situations meeting the criteria provided by section 1403(d)(3) exist; and

(C) the department may condition the approval of the merger, consolidation or other acquisition on the removal of the basis of disapproval within a specified period of time.

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger, consolidation or other acquisition of control.

(vi) The [acquisition] merger, consolidation or other acquisition of control is likely to be hazardous or prejudicial to the insurance buying public.

(vii) The merger, consolidation or other acquisition of control is not in compliance with the laws of this Commonwealth, including Article VIII-A.

(2) If the merger, consolidation or other acquisition of control is approved, the department shall so notify the person filing the statement and the insurer [whose stock] that is proposed to be acquired, and such a determination is hereafter referred to as an approving determination. Notice shall also be given by the department of any determination which is not an approving determination. If an approving determination is made by the department and not otherwise, the proposed offer and acquisition may thereafter be made and consummated on the terms and conditions and in the manner described in the statement and subject to such conditions as may be prescribed by the department as hereinafter provided. An approving determination by the department shall be deemed to extend to offers or acquisitions made pursuant thereto within one year following the date of determination. The department may, as a condition of its approving determination, require the inclusion in any offer of provisions requiring the offer to remain open a specified minimum length of time, permitting withdrawal of shares deposited prior to the time the offeror becomes bound to consummate the acquisition and requiring pro rata acceptance of any shares deposited pursuant to the offer. The department shall hold a hearing before making the determination required by this subsection if, within ten (10) days following the filing with the department of the statement, written request for the holding of such hearing is made either by the person proposing to make the acquisition, by the insurer [whose stock] that is proposed to be acquired or, if [such] the issuer of stock proposed to be acquired is not an insurer, by the [insurance company] insurer controlled by such issuer. Otherwise, the department shall determine in its discretion whether such a hearing shall be held. Thirty (30) days' notice of any such hearing shall be given to the person proposing to make the acquisition, to the issuer whose stock is proposed to be acquired and, if such issuer is not an insurer, to the insurance company controlled by such issuer. Notice of any such hearing shall also be given to such other persons, if any, as the department may determine.

(3) The department may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the proposed acquisition of control.

(g) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the department by order shall exempt therefrom as:

(1) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

(2) as otherwise not comprehended within the purposes of this section.

(h) The following shall constitute a violation of this section:

(1) the failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b);

(2) the effectuation or any attempt to effectuate an acquisition of control of or merger or consolidation with a domestic insurer unless the department has given its approval thereto; or

(3) a violation of section 819-A.

(i) The department shall, within seventy-two hours of receiving a statement filed under this section, provide notification to the Office of Attorney General that the filing was received.

Section 4. Section 1403(a), (b) and (d), added December 18, 1992 (P.L.1519, No.178), are amended to read:

Section 1403. Acquisitions Involving Insurers not Otherwise Covered.–(a) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Acquisition." Any agreement, arrangement or activity the consummation of which results in a person acquiring, directly or indirectly, the control of another person and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance [and],mergers and consolidations.

"Involved insurer." Includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger or consolidation.

(b) (1) Except as exempted in paragraph (2), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this Commonwealth.

(2) This section shall not apply to any of the following:

(i) An acquisition subject to approval or disapproval by the department pursuant to section 1402.

(ii) A purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this Commonwealth. If a purchase of securities results in a presumption of control as described in the definition of "control" in section [1301] 1401, it is not solely for investment purposes unless the insurance department of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the

domiciliary insurance department to the Insurance Department of the Commonwealth.

(iii) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the department in accordance with subsection (c)(2) thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by this paragraph.

(iv) The acquisition of already affiliated persons.

(v) An acquisition if, as an immediate result of the acquisition:

(A) in no market would the combined market share of the involved insurers exceed five per centum (5%) of the total market;

(B) there would be no increase in any market share; or

(C) in no market would:

(I) the combined market share of the involved insurers exceeds twelve per centum (12%) of the total market; and

(II) the market share increases by more than two per centum (2%) of the total market.

For the purpose of this subparagraph, a market means direct written insurance premium in this Commonwealth for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this Commonwealth.

(vi) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business.

(vii) An acquisition of an insurer whose domiciliary insurance department affirmatively finds that such insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary insurance department to the Insurance Department of the Commonwealth.

(3) Sections 1409(b) and (c) and 1411 shall not apply to acquisitions provided for in this subsection.

* * *

(d) (1) The department may enter an order under subsection (e)(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this Commonwealth or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c).

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1), the department shall consider the following:

(i) Any acquisition covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards as follows:

(A) if the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more; or

(B) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more.

A highly concentrated market is one in which the share of the four largest insurers is seventy-five per centum (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in paragraph (1). For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven per centum (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition [or merger], merger or consolidation covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (1) if:

(A) there is a significant trend toward increased concentration in the market;

(B) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(C) another involved insurer's market is two per centum (2%) or more.

(iii) For the purposes of this paragraph:

(A) The term "insurer" includes any company or group of companies under common management, ownership or control.

(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the department shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this Commonwealth and the relevant geographical market is assumed to be this Commonwealth.

(C) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(iv) Even though an acquisition is not prima facie violative of the competitive standard under subparagraphs (i) and (ii), the department may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subparagraphs (i) and (ii), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

(3) [An] Except for a merger, consolidation or acquisition of control involving a hospital plan corporation or professional health services plan corporation, an order may not be entered under subsection (e)(1) if:

(i) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(ii) the acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

* * *

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

Section 1404.1. Insurance Restructuring Public Interest Review Board.–(a) The Insurance Restructuring Public Interest Review Board is established to review the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan

corporation as defined in this act and in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

(b) The board shall consist of the following members:

(1) The Auditor General or a designee.

(2) The Secretary of Public Welfare or a designee.

(3) The Secretary of Health or a designee.

(4) The Majority Leader of the Senate or a designee.

(5) The Minority Leader of the Senate or a designee.

(6) The Majority Leader of the House of Representatives or a designee.

(7) The Minority Leader of the House of Representatives or a designee.

(8) A member of the general public who is an individual insured under a hospital plan corporation or professional health services plan corporation appointed by the Governor.

(9) A person who is currently or who has been a health care provider pursuant to a contract with a hospital plan corporation or professional health services plan corporation appointed by the Governor.

(c) A majority of the members of the board shall select a chairperson and other officers as they shall determine.

(d) The board shall convene within 45 days after the effective date of this section. The board shall meet at least four times annually. Additional meetings shall be held at the call of the chairperson or on the submission of a request signed by a majority of the members of the board.

(e) A majority of the members of the board shall constitute a quorum. Except as provided in subsection (g) or (h), all business of the board shall be conducted by a quorum.

(f) No member of the board shall be entitled to compensation for services performed as a member of the board, but shall be entitled to reimbursement for all necessary and reasonable expenses incurred in connection with the performance of the duties as a member of the board.

(g) The board shall have the following powers and duties:

(1) To receive and review all filings submitted to the department relating to the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation and all accompanying data or other information. The department may redact information determined to be a trade secret. Confidential material shall be available for review in executive session of the board. A board member, financial expert or auditor who releases confidential information shall be subject to a civil penalty not to exceed $1,000 per violation.

(2) To hold at least one public hearing on a merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation at which the department shall present findings relating to the merger, consolidation or other acquisition of control.

(3) To make written recommendations to the department. Recommendations under this paragraph must be approved by at least seven members of the board.

(4) To appoint such financial experts or auditors as necessary to:

(i) Review the merger, consolidation or other acquisition of control.

(ii) Determine the amount of net economic benefit, savings, proceeds or other moneys that will be derived from the merger, consolidation or other acquisition of control.

(iii) Determine the amount of reserves of the health plan corporation and the professional health services plan corporation and the amount of the reserves of the newly merged, consolidated or acquired entity.

(iv) Determine the amount currently dedicated for the hospital plan corporation's and the professional health services plan corporation's social mission, as defined in section 2501, for the prior year and the current year.

(v) Review other amounts that will be available for the corporate social mission, as defined in section 2501, following any approval of the merger, consolidation or other acquisition of control.

(5) To consider the development of timelines, and any changes thereto, for conducting and completing activities under this subsection. The cost of the financial experts or auditors shall be paid for by the hospital plan corporation or professional health services plan corporation.

(h) The department shall present the following to the board:

(1) Findings and recommendations on the merger, consolidation or other acquisition of control to the insurance restructuring board, including an analysis of whether the hospital plan corporation or professional health services plan corporation has met all the requirements of sections 1402 and 1403.

(2) A written response to each recommendation submitted by the board under subsection (g)(3), including a detailed written explanation of the reason the recommendation will or will not be adopted.

(3) A written determination that the merger, consolidation or other acquisition of control will result in a sustained reduction in health care premiums for Pennsylvania policyholders and a written finding that describes the reason or reasons the department believes the merger, consolidation or other acquisition of control is consistent with public interest.

(i) The board shall have 30 days to review and respond to the written responses to recommendations provided under subsection (h). The department shall not approve the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation for 60 days after it has fully complied with subsection (h).

Section 1404.2. Account.–(a) There is hereby established in the State Treasury a restricted receipt account for the deposit of funds under this section.

(b) Any net economic benefits, including proceeds, savings, funds or moneys derived from the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation which are to be used to fund any portion of a health care or health care related program of, or to be administered by, the Commonwealth shall be deposited into the restricted receipt account under subsection (a) in the State Treasury.

(c) No contracts or written agreements between the Commonwealth and the hospital plan corporation or professional health services plan corporation may be entered into relating to the disbursement or spending of the economic benefits, proceeds, savings, funds or moneys resulting from the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation until the funds are appropriated pursuant to subsection (d).

(d) No moneys may be transferred or paid from the account unless appropriated by the General Assembly for health-related purposes.

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

ARTICLE XXV

PREVENTABLE SERIOUS ADVERSE EVENTS

Section 2501. Scope of article.

This article relates to preventable serious adverse events.

Section 2502. Definitions.

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

"Centers for Medicare and Medicaid Services" or "CMS." The Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

"Department." The Insurance Department of the Commonwealth.

"Facility." A health care facility as defined in section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or an entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Health care provider." A health care facility or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, a certified registered nurse practitioner, a physician assistant, a

chiropractor, a hospital, an ambulatory surgery center, a nursing home or a birth center.

"Health payor." An individual or entity providing a group health, sickness or accident policy, subscriber contract or program issued or provided by an entity under this act or any of the following:

(1) The act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

(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).

(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

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

"Preventable serious adverse event." A clearly defined condition or negative consequence of care that results in unintended injury or illness that could have been anticipated and prepared for, but that occurs because of an error or other system failure and results in a patient's death, loss of a body part, disability or loss of bodily function lasting more than seven days.

Section 2503. Payment policy for preventable serious adverse events.

(a) General rule.–The following criteria shall be used by health payors in determining when payment or partial payment to a health care provider will be withheld:

(1) A preventable serious adverse event must occur.

(2) The preventable serious adverse event must be within the control of the health care provider.

(3) The preventable serious adverse event must occur in a health care facility.

(b) Language addressing payment policy.–Payments can only be withheld by health payors for services related to a preventable serious adverse event or care made necessary by the preventable serious adverse event if the agreement or contract between the health payor and health care provider contains language addressing payment policy for preventable serious adverse events.

(c) Restriction.–Health care providers shall not seek payment directly from patients or the responsible party of the patient for preventable serious adverse events.

Section 2504. Duties of Department of Public Welfare.

(a) Department responsibilities.–The Department of Public Welfare is responsible for the following:

(1) Determining payment policy under medical assistance with respect to reduced reimbursements to health care providers for preventable serious adverse events. This payment policy includes the criteria and clearly stated payment policies affecting health care providers.

(2) Publishing the payment policy in the Pennsylvania Bulletin following a 30-day public comment period.

(b) Ongoing reviews.–Nothing in this section shall affect ongoing reviews of medical assistance services conducted by the Department of Public Welfare.

(c) Hospital payment policy.–Nothing in this section shall require the department to alter, amend or reissue any payment policy for inpatient hospitals relating to preventable serious adverse events that was promulgated prior to the effective date of this article.

Section 2505. Duties of department.

The department shall annually notify health payors of the list of preventable serious adverse events that CMS is using under the Medicare program and for which health payors shall be permitted to withhold reimbursement under section 2503.

Section 2506. Duties of Department of Health.

In accordance with the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, the Department of Health shall be responsible for investigating patient complaints regarding a health care facility that is seeking payment directly from the patient for a preventable serious adverse event.

Section 2507. Duties of Department of State.

The Department of State shall be responsible for investigating patient complaints regarding a health care provider that is not a health care facility that is seeking payment directly from the patient for a preventable serious adverse event.

ARTICLE XXVI
HEALTH CARE REPORTING

Section 2601. Definitions.

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

"Social mission." Services, projects and community activities, including activities to improve health care or make health care more affordable and accessible in the service area, and all other charitable and benevolent activities of a hospital plan corporation or health services plan corporation.

Section 2602. Hospital plan corporation.

Each hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) shall annually provide to the department, the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives a list, including a description and cost, of all advertising contracts and all contracts entered into and expenditures made during that calendar year relating to the social mission of the health plan corporation. The information shall be provided by December 1 of each year. The hospital plan corporation shall also provide a list and description of all contracts and expenditures relating to the health plan corporation's social mission planned for the upcoming calendar year.

Section 2603. Professional health services plan corporation.

Each professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health service plan corporations) shall annually provide to the department, the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives a list, including a description and cost, of all advertising contracts and all contracts entered into and expenditures made during the calendar year relating to the social mission of the professional health services plan corporation. The information shall be provided by December 1 of each year. The professional health services plan corporation shall also provide a list and description of all contracts and expenditures relating to the health services plan corporation's social mission planned for the upcoming calendar year.

Section 2604. Retroactivity.

The provisions of sections 2602 and 2603 shall be retroactive to January 1, 2005. Reports for the years 2005 and 2006 shall be submitted within 90 days of the effective date of this section.

Section 6. The act of December 19, 1990 (P.L.834, No.198), known as the GAA Amendments Act of 1990, is repealed insofar as it is inconsistent with this act.

Section 7. This act shall not apply to any merger, consolidation or other acquisition of control completed or consummated prior to the effective date of this section and, if required, following the issuance of an approving determination.

Section 8. This act shall apply to any application, statement or other plan or proposal relating to a merger, consolidation or other acquisition of control filed with the Insurance Department on or after January 1, 2007.

Section 9. This act shall take effect as follows:

(1) The addition of Article XXV of the act shall take effect in 180 days.

(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 Boyd on the amendment.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, this amendment has to do with the subject that we talked a little bit earlier about, and it has to do with the impending potential merger of the Blues – Highmark and IBC – and what this amendment would do, Mr. Speaker, is it puts into statute some controls, if you will, on the process of that merger going forward.

Mr. Speaker, the first thing it does is it brings in notification of the Attorney General for the Attorney General's review of the proposed merger, and I understand that is related to the fact that the Blues, their parent companies, are nonprofits, and the Attorney General's Office reviews mergers of nonprofits, to my understanding.

Beyond that, Mr. Speaker, it puts together a Blues restructuring board, and the purpose of that board would be to develop both legislative and community input into the impact of the Blues merger.

Just for the record for everybody, hopefully most folks here know, an approval of a merger of Highmark and IBC would create one company that would control over 50 percent. It is approximately 52 percent of all of the insurance policies in the Commonwealth of Pennsylvania. I believe it would create one of the third or fourth largest health insurance providers in the entire nation.

The board, Mr. Speaker, that is in this amendment, as I said, would include community members, but it would also require that board to have a public hearing and actually make written recommendations to the Department of Insurance. Without this amendment, Mr. Speaker, under current statute, the sole decision in terms of approving a merger, I believe, would fall under the Department of Insurance, and that really limits the oversight, if you will, and really the input of the community in that process and also this legislative body. There would be legislative appointees, appointees from the Governor's Office. Beyond the written recommendations, the board would also review the financial benefits of the merger. It would also look at the reserves of the proposed merger that would be created, look at the amount of revenue that is dedicated to the social mission that the Blues would have, Mr. Speaker. And ultimately, it would look at the net economic impact of the merger and discuss the issue of the Blues' reserves.

Mr. Speaker, earlier tonight we voted on final passage of SB 1173, and in SB 1173 the Eachus amendment that was put into that language, one of the funding mechanisms to that proposal is community reinvestment dollars. That money is direct money that comes from the Blues that they would recognize from their – currently there is money coming in from a prior discussion with the administration on the Blues' social mission, but also there is a lot of discussion that goes on about the merger of the current two Blues that are proposing to merge and how that net economic benefit would be recognized by the State.

Many of us have a lot of concerns about the net impact of that, and the real question is, what are those economic benefits? Let us quantify them with dollars, and let us really discuss how that revenue would be utilized. All of that discussion would be a part of this amendment if it would go into HB 2098.

So, Mr. Speaker, I would just advocate and ask for an affirmative vote on amendment 5966.

The SPEAKER. The Chair recognizes Chairman DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, my good friend from Lancaster, I respectfully disagree with him right now, because the fact is, we have passed this amendment twice. We are all concerned about the merger of the Blues, but this amendment has been passed twice. It does not need to be put in every bill, health-care bill, that we are going to be sending over there.

Senator White and I are very concerned about the merger, and that is why I am asking this body to vote "no" on the Boyd amendment, because of the fact it has already been voted on twice and sent over to the Senate. There are concerns about the merger. We will be addressing the merger, the Senate will be addressing the merger, and I do not believe this is where we should be addressing it, in another bill, when we already sent it over twice.

Therefore, I ask this body to vote "no" on this amendment.

The SPEAKER. Representative Harper.

Ms. HARPER. I would like to speak in favor of the Boyd amendment, Mr. Speaker.

The SPEAKER. The lady is in order.

Ms. HARPER. With all due deference to the chairman of the Insurance Committee, who I recognize has the best interest of Pennsylvanians at heart, because the issue of the Blues merger is such a big issue for Blues-insured people across Pennsylvania who have no say in what is going on and no assurance that the Insurance Commissioner will review their concerns with respect to the merger, I would respectfully ask my colleagues, once again, to support the concept of heightened scrutiny of the merger by voting "yes" on the Boyd amendment.

Apparently the Senate has not gotten the message, and it seems to me that the House sometimes needs to speak a little louder. Passing the Boyd amendment would do that.

Thank you, Mr. Speaker.

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

The following roll call was recorded:

YEAS–84

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

NAYS–113

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

NOT VOTING–1

Taylor, J.

EXCUSED–5

Cruz	Geist	Hennessey	True
Dally			

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 as amended?

Mr. **BOYD** offered the following amendment No. **A05967:**

Amend Title, page 1, lines 1 through 7, by striking out all of said lines and inserting

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," transferring the Medical Care Availability and Reduction of Error (Mcare) Act; establishing a system for payment or reduction in payment for preventable serious adverse events within Commonwealth programs; informing health insurers of payment policies used by Medicaid and Medicare; and providing for the powers and duties of the Department of Public Welfare, the Insurance Department, the Department of Health and the Department of State.

Amend Bill, page 1, lines 10 through 19; pages 2 through 4, lines 1 through 30; page 5, lines 1 through 9, by striking out all of said lines on said pages and inserting

Section 1. The title of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

AN ACT

Relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; providing for medical care availability and reduction of errors; and repealing existing laws.

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

ARTICLE XXII
HEALTH CARE COST
SUBARTICLE A
MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR
CHAPTER 1
PRELIMINARY PROVISIONS

Section 2201. Scope of subarticle.

This subarticle relates to medical care availability and reduction of error.

Section 2202. Declaration of policy.

The General Assembly finds and declares as follows:

(1) It is the purpose of this subarticle to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.

(2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.

(3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.

(4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.

(5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.

(6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania.

Section 2203. Definitions.

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

"Birth center." An entity licensed as a birth center under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Claimant." A patient, including a patient's immediate family, guardian, personal representative or estate.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Guardian." A fiduciary who has the care and management of the estate or person of a minor or an incapacitated person.

"Health care provider." A primary health care center or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center and, except as to section 2252(a), an officer, employee or agent of any of them acting in

the course and scope of employment.

"Hospital." An entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Immediate family." A parent, a spouse, a child or an adult sibling residing in the same household.

"Medical professional liability action." Any proceeding in which a medical professional liability claim is asserted, including an action in a court of law or an arbitration proceeding.

"Medical professional liability claim." Any claim seeking the recovery of damages or loss from a health care provider arising out of any tort or breach of contract causing injury or death resulting from the furnishing of health care services which were or should have been provided.

"Nursing home." An entity licensed as a nursing home under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Patient." A natural person who receives or should have received health care from a health care provider.

"Personal representative." An executor or administrator of a patient's estate.

"Primary health center." A community-based nonprofit corporation meeting standards prescribed by the Department of Health which provides preventive, diagnostic, therapeutic and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

Section 2204. Liability of nonqualifying health care providers.

Any person rendering services normally rendered by a health care provider who fails to qualify as a health care provider under this subarticle is subject to liability under the law without regard to the provisions of this subarticle.

Section 2205. Provider not a warrantor or guarantor.

In the absence of a special contract in writing, a health care provider is neither a warrantor nor a guarantor of a cure.

CHAPTER 3
PATIENT SAFETY

Section 2211. Scope of chapter.

This chapter relates to the reduction of medical errors for the purpose of ensuring patient safety.

Section 2212. 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:

"Abortion facility." A facility or medical facility as defined in 18 Pa.C.S. § 3203 (relating to definitions) which is subject to this chapter pursuant to section 2219.6(b) or (c) and which is not subject to licensure under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Ambulatory surgical facility." An entity defined as an ambulatory surgical facility under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Authority." The Patient Safety Authority established in section 2213.

"Board." The board of directors of the Patient Safety Authority.

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

"Fund." The Patient Safety Trust Fund established in section 2215.

"Health care worker." An employee, independent contractor, licensee or other individual authorized to provide services in a medical facility.

"Incident." An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event.

"Infrastructure." Structures related to the physical plant and service delivery systems necessary for the provision of health care services in a medical facility.

"Infrastructure failure." An undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.

"Licensee." An individual who is all of the following:

(1) Licensed or certified by the department or the Department of State to provide professional services in this Commonwealth.

(2) Employed by or authorized to provide professional services in a medical facility.

"Medical facility." An ambulatory surgical facility, birth center, hospital or abortion facility.

"Patient safety officer." An individual designated by a medical facility under section 2219.

"Serious event." An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.

Section 2213. Establishment of Patient Safety Authority.

(a) Establishment.–There is established a body corporate and politic to be known as the Patient Safety Authority, which shall be an independent agency. The powers and duties of the authority shall be vested in and exercised by a board of directors, which shall have the sole power under section 2214(a) to employ staff, including an executive director, legal counsel, consultants or any other staff deemed necessary by the authority. Individuals employed by the authority as staff shall be deemed employees of the Commonwealth for the purpose of participation in the Pennsylvania Employee Benefit Trust Fund.

(b) Composition.–The board of the authority shall consist of 11 members composed and appointed in accordance with the following:

(1) The Physician General or a physician appointed by the Governor if there is no appointed Physician General.

(2) Four residents of this Commonwealth, one of whom shall be appointed by the President pro tempore of the Senate, one of whom shall be appointed by the Minority Leader of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives and one of whom shall be appointed by the Minority Leader of the House of Representatives, who shall serve terms coterminous with their respective appointing authorities.

(3) A health care worker residing in this Commonwealth who is a physician and is appointed by the Governor, who shall serve an initial term of three years.

(4) A health care worker residing in this Commonwealth who is licensed by the Department of State as a nurse and is appointed by the Governor, who shall serve an initial term of three years.

(5) A health care worker residing in this Commonwealth who is licensed by the Department of State as a pharmacist and is appointed by the Governor, who shall serve an initial term of two years.

(6) A health care worker residing in this Commonwealth who is employed by a hospital and is appointed by the Governor, who shall serve an initial term of two years.

(7) Two residents of this Commonwealth, one of whom is a health care worker and one of whom is not a health care worker, appointed by the Governor, who shall each serve a term of four years.

(c) Terms.–With the exception of paragraphs (1) and (2), members of the board shall serve for terms of four years after completion of the initial terms designated in subsection (b) and shall not be eligible to serve more than two full consecutive terms.

(d) Quorum.–A majority of the members of the board shall constitute a quorum. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its

members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board.

(e) Meetings.–The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly, which shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings). Meetings of the board may be held anywhere within this Commonwealth.

(f) Chairperson.–The chairperson shall be the person appointed under subsection (b)(1).

(g) Formation.–The authority shall be formed by July 22, 2002.

(h) Sole public entity.–For purposes of section 924 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 299b-24), the authority is the sole public entity eligible to be certified as a patient safety organization as defined in section 921(4) of the Public Health Service Act (42 U.S.C. § 299b-21(4)) when conducting patient safety activities, as defined in section 921(5) of the Public Health Service Act (42 U.S.C. § 299b-21(5)), which fall within the scope of the authority's responsibilities.

Section 2214. Powers and duties.

(a) General rule.–The authority shall do all of the following:

(1) Adopt bylaws necessary to carry out the provisions of this chapter.

(2) Employ staff as necessary to implement this chapter.

(3) Make, execute and deliver contracts and other instruments.

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend funds in the fund and other funds that are made available to the authority from any source consistent with the purposes of this chapter.

(5) Contract with a for-profit or registered nonprofit entity or entities, other than a health care provider, to do the following:

(i) Collect, analyze and evaluate data regarding reports of serious events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of this Commonwealth.

(ii) Transmit to the authority recommendations for changes in health care practices and procedures which may be instituted for the purpose of reducing the number and severity of serious events and incidents.

(iii) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce serious events and incidents.

(iv) Conduct reviews in accordance with subsection (b).

(6) Receive and evaluate recommendations made by the entity or entities contracted with in accordance with paragraph (5) and report those recommendations to the department, which shall have no more than 30 days to approve or disapprove the recommendations.

(7) After consultation and approval by the department, issue recommendations to medical facilities on a facility-specific or on a Statewide basis regarding changes, trends and improvements in health care practices and procedures for the purpose of reducing the number and severity of serious events and incidents. Prior to issuing recommendations, consideration shall be given to the following factors that include expectation of improved quality care, implementation feasibility, other relevant implementation practices and the cost impact to patients, payors and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on the department's and the authority's publicly accessible World Wide Web site.

(8) Meet with the department for purposes of implementing this chapter.

(b) Anonymous reports to the authority.–A health care worker who has complied with section 2218(a) may file an anonymous report regarding a serious event with the authority. Upon receipt of the report, the authority shall give notice to the affected medical facility that a report has been filed. The authority shall conduct its own review of the report unless the medical facility has already commenced an investigation of the serious event. The medical facility shall provide the authority with the results of its investigation no later than 30 days after receiving notice pursuant to this subsection. If the authority is dissatisfied with the adequacy of the investigation conducted by the medical facility, the authority shall perform its own review of the serious event and may refer a medical facility and any involved licensee to the department for failure to report pursuant to section 2219.4(e) and (f).

(c) Annual report to General Assembly.–

(1) The authority shall report no later than May 1, 2003, and annually thereafter to the department and the General Assembly on the authority's activities in the preceding year. The report shall include:

(i) A schedule of the year's meetings.

(ii) A list of contracts entered into pursuant to this section, including the amounts awarded to each contractor.

(iii) A summary of the fund receipts and expenditures, including a financial statement and balance sheet.

(iv) The number of serious events and incidents reported by medical facilities on a geographical basis.

(v) The information derived from the data collected, including any recognized trends concerning patient safety.

(vi) The number of anonymous reports filed and reviews conducted by the authority.

(vii) The number of referrals to licensure boards for failure to report under this chapter.

(viii) Recommendations for statutory or regulatory changes which may help improve patient safety in the Commonwealth.

(2) The report shall be distributed to the Secretary of Health, the chair and minority chair of the Public Health and Welfare Committee of the Senate and the chair and minority chair of the Health and Human Services Committee of the House of Representatives.

(3) The annual report shall be made available for public inspection and shall be posted on the authority's publicly accessible World Wide Web site.

Section 2215. Patient Safety Trust Fund.

(a) Establishment.–There is hereby established a separate account in the State Treasury to be known as the Patient Safety Trust Fund. The fund shall be administered by the authority. All interest earned from the investment or deposit of moneys accumulated in the fund shall be deposited in the fund for the same use.

(b) Funds.–All moneys deposited into the fund shall be held in trust and shall not be considered general revenue of the Commonwealth but shall be used only to effectuate the purposes of this chapter as determined by the authority.

(c) Payment.–Commencing July 1, 2002, each licensed medical facility shall pay the department a surcharge on its licensing fee, and each abortion facility not subject to State licensure shall pay an assessment as necessary to provide sufficient revenues to operate the authority. When determining the assessment for an abortion facility, the department shall apply the same methodology utilized for an ambulatory surgical facility. The total payment for all medical facilities shall not exceed $5,000,000. The department shall transfer the total payments to the fund within 30 days of receipt.

(d) Base amount.–For each succeeding calendar year, the department shall determine each medical facility's proportionate share of the authority's budget. The total amount shall not exceed $5,000,000 in fiscal year 2002-2003 and shall be increased according to the Consumer Price Index in each succeeding fiscal year.

(e) Expenditures.–Moneys in the fund shall be expended by the

authority to implement this chapter.

(f) Dissolution.–In the event that the fund is discontinued or the authority is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the medical facilities in proportion to their financial contributions to the fund.

(g) Failure to make payment.–If, after 30 days' notice, a medical facility fails to pay a surcharge or assessment levied by the department under this chapter, the department may impose an administrative penalty of $1,000 per day until the surcharge is paid.

Section 2216. Department responsibilities.

(a) General rule.–The department shall do all of the following:

(1) Review and approve patient safety plans in accordance with section 2217.

(2) Receive reports of serious events and infrastructure failures under section 2219.4.

(3) Investigate serious events and infrastructure failures.

(4) In conjunction with the authority, analyze and evaluate existing health care procedures and approve recommendations issued by the authority pursuant to section 2214(a)(6) and (7).

(5) Meet with the authority for purposes of implementing this chapter.

(b) Department consideration.–The recommendations made to medical facilities pursuant to subsection (a)(4) may be considered by the department for licensure purposes under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, and, in the case of abortion facilities, for approval or revocation purposes pursuant to 28 Pa. Code § 29.43 (relating to facility approval), but shall not be considered mandatory unless adopted by the department as regulations pursuant to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

Section 2217. Patient safety plans.

(a) Development and compliance.–A medical facility shall develop, implement and comply with an internal patient safety plan that shall be established for the purpose of improving the health and safety of patients. The plan shall be developed in consultation with the licensees providing health care services in the medical facility.

(b) Requirements.–A patient safety plan shall:

(1) Designate a patient safety officer as set forth in section 2219.

(2) Establish a patient safety committee as set forth in section 2219.1.

(3) Establish a system for the health care workers of a medical facility to report serious events and incidents which shall be accessible 24 hours a day, seven days a week.

(4) Prohibit any retaliatory action against a health care worker for reporting a serious event or incident in accordance with the act of December 12, 1986 (P.L.1559, No.169), known as the Whistleblower Law.

(5) Provide for written notification to patients in accordance with section 2218(b).

(c) Approval.–By July 22, 2002, a medical facility shall submit its patient safety plan to the department for approval consistent with the requirements of this section. Unless the department approves or rejects the plan within 60 days of receipt, the plan shall be deemed approved.

(d) Employee notification.–Upon approval of the patient safety plan, a medical facility shall notify all health care workers of the medical facility of the patient safety plan. Compliance with the patient safety plan shall be required as a condition of employment or credentialing at the medical facility.

Section 2218. Reporting and notification.

(a) Reporting.–A health care worker who reasonably believes that a serious event or incident has occurred shall report the serious event or incident according to the patient safety plan of the medical facility unless the health care worker knows that a report has already been made. The report shall be made immediately or as soon thereafter as reasonably practicable, but in no event later than 24 hours after the occurrence or discovery of a serious event or incident.

(b) Duty to notify patient.–A medical facility through an appropriate designee shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee within seven days of the occurrence or discovery of a serious event. If the patient is unable to give consent, the notification shall be given to an adult member of the immediate family. If an adult member of the immediate family cannot be identified or located, notification shall be given to the closest adult family member. For unemancipated patients who are under 18 years of age, the parent or guardian shall be notified in accordance with this subsection. The notification requirements of this subsection shall not be subject to the provisions of section 2219.2(a). Notification under this subsection shall not constitute an acknowledgment or admission of liability.

(c) Liability.–A health care worker who reports the occurrence of a serious event or incident in accordance with subsection (a) or (b) shall not be subject to any retaliatory action for reporting the serious event or incident and shall have the protections and remedies set forth in the act of December 12, 1986 (P.L.1559, No.169), known as the Whistleblower Law.

(d) Limitation.–Nothing in this section shall limit a medical facility's ability to take appropriate disciplinary action against a health care worker for failure to meet defined performance expectations or to take corrective action against a licensee for unprofessional conduct, including making false reports or failure to report serious events under this chapter.

Section 2219. Patient safety officer.

A patient safety officer of a medical facility shall do all of the following:

(1) Serve on the patient safety committee.

(2) Ensure the investigation of all reports of serious events and incidents.

(3) Take such action as is immediately necessary to ensure patient safety as a result of any investigation.

(4) Report to the patient safety committee regarding any action taken to promote patient safety as a result of investigations commenced pursuant to this section.

Section 2219.1. Patient safety committee.

(a) Composition.–

(1) A hospital's patient safety committee shall be composed of the medical facility's patient safety officer and at least three health care workers of the medical facility and two residents of the community served by the medical facility who are not agents, employees or contractors of the medical facility. No more than one member of the patient safety committee shall be a member of the medical facility's board of trustees. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least monthly.

(2) An ambulatory surgical facility's, abortion facility's or birth center's patient safety committee shall be composed of the medical facility's patient safety officer and at least one health care worker of the medical facility and one resident of the community served by the ambulatory surgical facility, abortion facility or birth center who is not an agent, employee or contractor of the ambulatory surgical facility, abortion facility or birth center. No more than one member of the patient safety committee shall be a member of the medical facility's board of governance. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least quarterly.

(b) Responsibilities.–A patient safety committee of a medical facility shall do all of the following:

(1) Receive reports from the patient safety officer pursuant to section 2219.

(2) Evaluate investigations and actions of the patient safety officer on all reports.

(3) Review and evaluate the quality of patient safety measures utilized by the medical facility. A review shall include the

consideration of reports made under sections 2214(a)(5) and (b), 2217(b)(3) and 2218(a).

(4) Make recommendations to eliminate future serious events and incidents.

(5) Report to the administrative officer and governing body of the medical facility on a quarterly basis regarding the number of serious events and incidents and its recommendations to eliminate future serious events and incidents.

Section 2219.2. Confidentiality and compliance.

(a) Prepared materials.–Any documents, materials or information solely prepared or created for the purpose of compliance with section 2219.1(b) or of reporting under section 2214(a)(5) or (b), 2216(a)(2) or (3), 2217(b)(3), 2218(a), 2219(4), 2219.1(b)(5) or 2219.4 which arise out of matters reviewed by the patient safety committee pursuant to section 2219.1(b) or the governing board of a medical facility pursuant to section 2219.1(b) are confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the patient safety committee or governing board of a medical facility.

(b) Meetings.–No person who performs responsibilities for or participates in meetings of the patient safety committee or governing board of a medical facility pursuant to section 2219.1(b) shall be allowed to testify as to any matters within the knowledge gained by the person's responsibilities or participation on the patient safety committee or governing board of a medical facility, provided, however, the person shall be allowed to testify as to any matters within the person's knowledge which was gained outside of the persons's responsibilities or participation on the patient safety committee or governing board of a medical facility pursuant to section 2219.1(b).

(c) Applicability.–The confidentiality protections set forth in subsections (a) and (b) shall only apply to the documents, materials or information prepared or created pursuant to the responsibilities of the patient safety committee or governing board of a medical facility set forth in section 2219.1(b).

(d) Received materials.–Except as set forth in subsection (f), any documents, materials or information received by the authority or department from the medical facility, health care worker, patient safety committee or governing board of a medical facility solely prepared or created for the purpose of compliance with section 2219.1(b) or of reporting under section 2214(a)(5) or (b), 2216(a)(2) or (3), 2217(b)(3), 2218(a), 2219(4), 2219.1(b)(5) or 2219.4 shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any records received by the authority or department from the medical facility, health care worker, patient safety committee or governing board of a medical facility pursuant to the requirements of this subarticle shall not be discoverable from the department or the authority in any civil or administrative action or proceeding. Documents, materials, records or information may be used by the authority or department to comply with the reporting requirements under subsection (f) and section 2214(a)(7) or (c) or 2216(b).

(e) Document review.–

(1) Except as set forth in paragraph (2), no current or former employee of the authority, the department or the Department of State shall be allowed to testify as to any matters gained by reason of his or her review of documents, materials, records or information submitted to the authority by the medical facility or health care worker pursuant to the requirements of this subarticle.

(2) Paragraph (1) does not apply to findings or actions by the department or the Department of State which are public records.

(f) Access.–

(1) The department shall have access to the information under section 2219.4(a) or (c) and may use such information for the sole purpose of any licensure, approval or corrective action against a medical facility. This exemption to use the information received pursuant to section 2219.4(a) or (c) shall only apply to licensure or corrective actions and shall not be utilized to permit the disclosure of any information obtained under section 2219.4(a) or (c) for any other purpose.

(2) The Department of State shall have access to the information under section 2219.4(a) and may use such information for the sole purpose of any licensure or disciplinary action against a health care worker. This exemption to use the information received pursuant to section 2219.4(a) shall only apply to licensure or disciplinary actions and shall not be utilized to permit the disclosure of any information obtained under section 2219.4(a) for any other purpose.

(g) Original source document.–In the event an original source document as set forth in subsection (a) is determined by a court of competent jurisdiction to be unavailable from the health care worker or medical facility in a civil action or proceeding, then in that circumstance alone the department may be required pursuant to a court order to release that original source document to the party identified in the court order.

(h) Right-to-know requests.–Any documents, materials or information made confidential by subsection (a) shall not be subject to requests under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law.

(i) Liability.–Notwithstanding any other provision of law, no person providing information or services to the patient safety committee, governing board of a medical facility, authority or department shall be held by reason of having provided such information or services to have violated any criminal law, or to be civilly liable under any law, unless such information is false and the person providing such information knew or had reason to believe that such information was false and was motivated by malice toward any person directly affected by such action.

Section 2219.3. Patient safety discount.

A medical facility may make application to the department for certification of any program that is recommended by the authority that results in the reduction of serious events at that facility. The department, in consultation with the Insurance Department, shall develop the criteria for such certification. Insurers shall file with the Insurance Department a discount in the rate or rates applicable for mandated basic insurance coverage to reflect the initiation of a certified program. The Insurance Department shall review all filings in accordance with the act of June 11, 1947 (P.L.538, No.246), known as The Casualty and Surety Rate Regulatory Act. A medical facility shall receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law, consistent with the level of such discount approved by the Insurance Department. In reviewing filings under this section, the commissioner shall consider whether and the extent to which the program certified under this section is otherwise covered under a program of risk management offered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 2219.4. Medical facility reports and notifications.

(a) Serious event reports.–A medical facility shall report the occurrence of a serious event to the department and the authority within 24 hours of the medical facility's confirmation of the occurrence of the serious event. The report to the department and the authority shall be in the form and manner prescribed by the authority in consultation with the department and shall not include the name of any patient or any other identifiable individual information.

(b) Incident reports.–A medical facility shall report the occurrence of an incident to the authority in a form and manner prescribed by the authority and shall not include the name of any patient or any other identifiable individual information.

(c) Infrastructure failure reports.–A medical facility shall report the occurrence of an infrastructure failure to the department within 24 hours of the medical facility's confirmation of the occurrence or discovery of the infrastructure failure. The report to the department shall be in the form and manner prescribed by the department.

(d) Effect of report.–Compliance with this section by a medical

facility shall satisfy the reporting requirements of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(e) Notification to licensure boards.–If a medical facility discovers that a licensee providing health care services in the medical facility during a serious event failed to report the event in accordance with section 2218(a), the medical facility shall notify the licensee's licensing board of the failure to report.

(f) Failure to report or notify.–Failure to report a serious event or an infrastructure failure as required by this section or to develop and comply with the patient safety plan in accordance with section 2217 or to notify the patient in accordance with section 2218(b) shall be a violation of the Health Care Facilities Act and, in the case of an abortion facility, may be a basis for revocation of approval pursuant to 28 Pa. Code § 29.43 (relating to facility approval). In addition to any penalty which may be imposed under the Health Care Facilities Act or under 18 Pa.C.S. Ch. 32 (relating to abortion), a medical facility which fails to report a serious event or an infrastructure failure or to notify a licensure board in accordance with this chapter may be subject to an administrative penalty of $1,000 per day imposed by the department.

(g) Report submission.–Within 30 days following notice published pursuant to section 2293, a medical facility shall begin reporting serious events, incidents and infrastructure failures consistent with the requirements of this section.

Section 2219.5. Existing regulations.

The provisions of 28 Pa. Code § 51.3(f) and (g) (relating to notification) shall be abrogated with respect to a medical facility upon the reporting of a serious event, incident or infrastructure failure pursuant to section 2219.4.

Section 2219.6. Abortion facilities.

(a) General.–This section shall apply to abortion facilities.

(b) Application during current year.–An abortion facility that performs 100 or more abortions after the effective date of this subarticle during the calendar year in which this section takes effect shall be subject to the provisions of this chapter at the beginning of the immediately following calendar year and during each subsequent calendar year unless the facility gives the department written notice that it will not be performing 100 or more abortions during such following calendar year and does not perform 100 or more abortions during that calendar year.

(c) Application in subsequent calendar years.–In the calendar years following the effective date of the act of March 20, 2002 (P.L.154, No.13), known as the Medical care Availability and Reduction of Error (Mcare) Act, this chapter shall apply to an abortion facility not subject to subsection (b) on the day following the performance of its 100th abortion and for the remainder of that calendar year and during each subsequent calendar year unless the facility gives the department written notice that it will not be performing 100 or more abortions during such following calendar year and does not perform 100 or more abortions during that calendar year.

(d) Patient safety plan.–An abortion facility shall submit its patient safety plan under section 2217(c) within 60 days following the application of this chapter to the facility.

(e) Reporting.–An abortion facility shall begin reporting serious events, incidents and infrastructure failures consistent with the requirements of section 2219.4 upon the submission of its patient safety plan to the department.

(f) Construction.–Nothing in this chapter shall be construed to limit the provisions of 18 Pa.C.S. Ch. 32 (relating to abortion) or any regulation adopted under 18 Pa.C.S. Ch. 32.

CHAPTER 4

HEALTH CARE-ASSOCIATED INFECTIONS

Section 2221. Scope of chapter.

This chapter relates to the reduction and prevention of health care-associated infections.

Section 2222. 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:

"Ambulatory surgical facility." An entity defined as an ambulatory surgical facility under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Antimicrobial agent." A general term for drugs, chemicals or other substances that kill or slow the growth of microbes, including, but not limited to, antibacterial drugs, antiviral agents, antifungal agents and antiparasitic drugs.

"Authority." The Patient Safety Authority established under this subarticle.

"Centers for Disease Control and Prevention" or "CDC." The United States Department of Health and Human Services Centers for Disease Control and Prevention.

"Colonization." The first stage of microbial infection or the presence of nonreplicating microorganisms usually present in host tissues that are in contact with the external environment.

"Council." The Pennsylvania Health Care Cost Containment Council established under the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

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

"Fund." The Patient Safety Trust Fund as defined in section 2215.

"Health care-associated infection." A localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:

(1) occurs in a patient in a health care setting;

(2) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and

(3) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.

"Health Care Facilities Act." The act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Health care facility." A hospital or nursing home licensed or otherwise regulated to provide health care services under the laws of this Commonwealth.

"Health payor." An individual or entity providing a group health, sickness or accident policy, subscriber contract or program issued or provided by an entity, including any one of the following:

(1) The act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

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

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

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

(5) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(6) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

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

"Methicillin-resistant Staphylococcus aureus" or "MRSA." A strain of bacteria that is resistant to certain antibiotics and is difficult to treat medically.

"Multidrug-resistant organism" or "MDRO." Microorganisms, predominantly bacteria, that are resistant to more than one class of antimicrobial agents.

"National Healthcare Safety Network" or "NHSN." A secure Internet-based data collection system managed by the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention.

"Nationally recognized standards." Standards developed by the Department of Health and Human Services Centers for Disease Control

and Prevention (CDC) and its National Healthcare Safety Network.

"Surveillance system." An ongoing and comprehensive method of measuring health status, outcomes and related processes of care, analyzing data and providing information from data sources within a health care facility to assist in reducing health care-associated infections.

Section 2223. Infection control plan.

(a) Development and compliance.–By September 18, 2002, a health care facility and an ambulatory surgical facility shall develop and implement an internal infection control plan that shall be established for the purpose of improving the health and safety of patients and health care workers and shall include:

(1) A multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility:

(i) Medical staff that could include the chief medical officer or the nursing home medical director.

(ii) Administration representatives that could include the chief executive officer, the chief financial officer or the nursing home administrator.

(iii) Laboratory personnel.

(iv) Nursing staff that could include a director of nursing or a nursing supervisor.

(v) Pharmacy staff that could include the chief of pharmacy.

(vi) Physical plant personnel.

(vii) A patient safety officer.

(viii) Members from the infection control team, which could include an epidemiologist.

(ix) The community, except that these representatives may not be an agent, employee or contractor of the health care facility or ambulatory surgical facility.

(2) Effective measures for the detection, control and prevention of health care-associated infections.

(3) Culture surveillance processes and policies.

(4) A system to identify and designate patients known to be colonized or infected with MRSA or other MDRO that includes:

(i) The procedures necessary for requiring cultures and screenings for nursing home residents admitted to a hospital.

(ii) The procedures for identifying other high-risk patients admitted to the hospital who necessitate routine cultures and screening.

(5) The procedures and protocols for staff who may have had potential exposure to a patient or resident known to be colonized or infected with MRSA or MDRO, including cultures and screenings, prophylaxis and follow-up care.

(6) An outreach process for notifying a receiving health care facility or an ambulatory surgical facility of any patient known to be colonized prior to transfer within or between facilities.

(7) A required infection-control intervention protocol which includes:

(i) Infection control precautions, based on nationally recognized standards, for general surveillance of infected or colonized patients.

(ii) Intervention protocols based on evidence-based standards.

(iii) Isolation procedures.

(iv) Physical plant operations related to infection control.

(v) Appropriate use of antimicrobial agents.

(vi) Mandatory educational programs for personnel.

(vii) Fiscal and human resource requirements.

(8) The procedure for distribution of advisories issued under section 2225(b)(4) so as to ensure easy access in each health care facility for all administrative staff, medical personnel and health care workers.

(b) Department review.–No later than 14 days after implementation of its infection control plan, a health care facility and an ambulatory surgical facility shall submit the plan to the department. The department shall review each health care facility's and ambulatory surgical facility's infection control plan to ensure compliance under the Health Care Facilities Act and section 2228(3). If, at any time, the department finds that an infection control plan does not meet the requirements of this chapter or any applicable laws, the health care facility or ambulatory surgical facility shall modify its plan to come into compliance.

(c) Notification.–Upon submission to the department of its infection control plan, a health care facility and an ambulatory surgical facility shall notify all health care workers, physical plant personnel and medical staff of the facility of the infection control plan. Compliance with the infection control plan shall be enforced by the facility.

Section 2224. Health care facility reporting.

(a) Nursing home reporting.–In addition to reporting pursuant to the Health Care Facilities Act, a nursing home shall also electronically report health care-associated infection data to the department and the authority using nationally recognized standards based on CDC definitions, provided that the data is reported on a patient-specific basis in the form, with the time for reporting and format as determined by the department and the authority.

(b) Hospital reporting.–A hospital shall report health care-associated infection data to the CDC and its National Healthcare Safety Network by November 18, 2002. A hospital shall:

(1) Report all components as defined in the NHSN Manual, Patient Safety Component Protocol and any successor edition, for all patients throughout the facility on a continuous basis.

(2) Report patient-specific data to include, at a minimum, patient identification number, gender and date of birth. The patient identification number must be compatible with the patient identifier on the uniform billing forms submitted to the council.

(3) Report data on a monthly basis in accordance with protocols defined in the NHSN Manual as updated by the CDC.

(4) Authorize the department, the authority and the council to have access to the NHSN for facility-specific reports of health care-associated infection data contained in the NHSN database for purposes of viewing and analyzing that data.

(c) Strategic assessments.–Each hospital, other than those currently using a qualified electronic surveillance system, shall by December 31, 2007, conduct a strategic assessment of the utility and efficacy of implementing a qualified electronic surveillance system pursuant to subsections (d) and (e) for the purpose of improving infection control and prevention. The assessment shall also include an examination of financial and technological barriers to implementation of a qualified electronic surveillance system pursuant to subsections (d) and (e). The assessment shall be submitted to the department within 14 days of completion.

(d) Qualified electronic surveillance system.–A qualified electronic surveillance system shall include the following minimum elements:

(1) Extractions of existing electronic clinical data from health care facility systems on an ongoing, constant and consistent basis.

(2) Translation of nonstandardized laboratory, pharmacy and/or radiology data into uniform information that can be analyzed on a population-wide basis.

(3) Clinical support, educational tools and training to ensure that information provided under this subsection will assist the hospital in reducing the incidence of health care-associated infections in a manner that meets or exceeds benchmarks.

(4) Clinical improvement measurements designed to provide positive and negative feedback to health care facility infection control staff.

(5) Collection of data that is patient-specific for the entire facility.

(e) Electronic surveillance system implementation.–Except as

otherwise provided in this subsection, a hospital shall have a qualified electronic surveillance system in place by December 31, 2008. The following apply:

(1) If a determination has been made under subsection (c) that a qualified electronic surveillance system can be implemented, the hospital shall comply with subsection (f) until implementation.

(2) If a determination has been made under subsection (c) that a qualified electronic surveillance system cannot be implemented, by December 31, 2008, the hospital shall comply with subsection (f) until such time as a qualified electronic surveillance system is implemented.

(f) Surveillance system.–Until a hospital implements a qualified electronic surveillance system, the facility shall use a surveillance system that includes:

(1) A written plan of the elements of the surveillance process to include, but not be limited to, definitions, collection of surveillance data and reporting of information.

(2) Identification of personnel resources that will be used in the surveillance process.

(3) Identification of information or technological support needed to implement the surveillance system.

(4) A process for periodic evaluation and validation to ensure accuracy of surveillance.

(g) Continued reporting.–Until hospitals begin reporting to NHSN and have authorized access to the department, the authority and the council, hospitals shall continue to meet reporting requirements pursuant to Chapter 3 of this subarticle and section 6 of the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

Section 2225. Patient Safety Authority jurisdiction.

(a) Health care facility reports to authority.–The occurrence of a health care-associated infection in a health care facility shall be deemed a serious event as defined in section 2212. The report to the authority shall also be subject to all of the confidentiality protections set forth in section 2219.2. The occurrence of a health care-associated infection shall only constitute a serious event for hospitals if it meets the criteria for reporting as defined by the current CDC and NHSN Manual, Patient Safety Component Protocol and any successor edition.

(b) Duties.–In addition to its existing responsibilities, the authority is responsible for all of the following:

(1) Establishing, based on CDC definitions, uniform definitions using nationally recognized standards for the identification and reporting of health care-associated infections by nursing homes.

(2) Publishing a notice in the Pennsylvania Bulletin stating the uniform reporting requirements established pursuant to this subsection and the effective date for the commencement of required reporting by hospitals consistent with this chapter, which, at a minimum, shall begin 120 days after publication of the notice.

(3) Publishing a notice in the Pennsylvania Bulletin stating the uniform reporting requirements established pursuant to this subsection and section 2224(a) and the effective date for the commencement of required reporting by nursing homes consistent with this chapter, which, at a minimum, shall begin 120 days after publication of the notice.

(4) Issuing advisories to health care facilities in a manner similar to section 2214(a)(7).

(5) Including a separate category for providing information about health care-associated infections in the annual report under section 2214(c).

(6) Creating and conducting training programs for infection control teams, health care workers and physical plant personnel about the prevention and control of health care-associated infections. Nothing in this subarticle shall preclude the authority from working with the department or any organization in conducting these programs.

(7) Appointing an advisory panel of health care-associated infection control experts, including at least one representative of a not-for-profit nursing home, at least one representative of a for-profit nursing home, at least one representative of a county nursing home and at least two representatives of a hospital, one of which must be from a rural hospital, to assist in carrying out the requirements of this chapter.

(c) Public comment.–Prior to publishing a notice under subsection (b)(2) and (3), the authority shall solicit public comments for at least 30 days. The authority shall respond to the comments it receives during the 30-day public comment period.

Section 2226. Payment for performing routine cultures and screenings.

The cost of routine cultures and screenings performed on patients in compliance with a health care facility's and ambulatory surgical facility's infection control plan shall be considered a reimbursable cost to be paid by health payors and medical assistance upon Federal approval. These costs shall be subject to any copayment, coinsurance or deductible in amounts imposed in any applicable policy issued by a health payor and to any agreements between a health care facility, ambulatory surgical facility and payor.

Section 2227. Quality improvement payment.

(a) General rule.–Commencing on January 1, 2009, the Department of Public Welfare in consultation with the department shall make a quality improvement payment to a health care facility that achieves at least

a 10% reduction for that facility in the total number of reported health care-associated infections over the preceding year pursuant to section 2228(7)(i). For calendar year 2010 and thereafter, the Department of Public Welfare shall consult with the department to establish appropriate percentage benchmarks for the reduction of health care-associated infections in each health care facility in order to be eligible for a payment pursuant to this section.

(b) Additional quality improvement payments.–Nothing in this section shall prevent the Department of Public Welfare in consultation with the department from providing additional quality improvement payments to a health care facility that has implemented a qualified electronic surveillance system and has achieved or exceeded reductions in the total number of reported health care-associated infections for that facility over the preceding year as provided in subsection (a).

(c) Eligibility.–In addition to meeting the requirements contained in this section, to be eligible for a quality improvement payment, a health care facility must be in compliance with health care-associated reporting requirements contained in this subarticle and the Health Care Facilities Act.

(d) Distribution of funds.–Funds for the purpose of implementing this section shall be appropriated to the Department of Public Welfare and distributed to eligible health care facilities as set forth in this section. Quality improvement payments to health care facilities shall be limited to funds available for this purpose.

Section 2228. Duties of Department of Health.

The department is responsible for the following:

(1) The development of a public health awareness campaign on health care-associated infections to be known as the Community Awareness Program. The program shall provide information to the public on causes and symptoms of health care-associated infections, diagnosis and treatment prevention methods and the proper use of antimicrobial agents.

(2) The consideration and determination of the feasibility of establishing an active surveillance program involving other entities, such as athletic teams or correctional facilities for the purpose of identifying those persons in the community that are colonized and at risk of susceptibility to and transmission of MRSA bacteria.

(3) The review of each health care facility's and ambulatory surgical facility's infection control plan. This review shall be performed pursuant to the department's authority under the Health Care Facilities Act and the regulations promulgated thereunder.

(4) The development of recommendations and best practices that implement and effectuate improved screenings and cultures and other means for the reduction and elimination of health care-associated infections.

(5) The development of recommendations regarding evidence-based screening protocols for an individual with MRSA and MDRO prior to admission to a hospital.

(6) The review of strategic assessments under section 2224(c) and the provision of assistance to hospitals in implementing a qualified electronic surveillance system pursuant to the requirements of section 2224(d) and (e).

(7) The development of a methodology, in consultation with the authority and the council, for determining and assessing the rate of health care-associated infections that occur in health care facilities in this Commonwealth. This methodology shall be used:

(i) to determine the rate of reduction in health care-associated infection rates within a health care facility during a reporting period;

(ii) to compare health care-associated infection rates among similar health care facilities within this Commonwealth; and

(iii) to compare health care-associated infection rates among similar health care facilities nationwide.

(8) The development, in consultation with the authority and the council, of reasonable benchmarks to measure the progress health care facilities make toward reducing health care-associated infections. Beginning in 2010, all health care facilities shall be measured against these benchmarks. A health care facility with a rate of health care-associated infections that does not meet the benchmark appropriate to that type of facility shall be required to submit a plan of correction to the department within 60 days of receiving notification that the rate does not meet the benchmark. After 180 days, a facility that has not shown progress in reducing its rate of infection shall consult with and obtain department approval for a new plan of correction that includes resources available to assist the health care facility. After an additional 180 days, a facility that fails to show progress in reducing its rate of infection may be subject to action under the Health Care Facilities Act.

(9) Publishing a notice in the Pennsylvania Bulletin of the specific benchmarks the department shall use to measure the progress of health care facilities in reducing health care-associated infections. Prior to publishing the notice, the department shall seek public comments for at least 30 days. The department shall respond to the comments it receives during the 30-day public comment period.

Section 2229. Nursing home assessment to Patient Safety Authority.

(a) Assessment.–Commencing July 1, 2008, each nursing home shall pay the department a surcharge on its licensing fee as necessary to provide sufficient revenues for the authority to perform its responsibilities under this chapter. The total annual assessment for all nursing homes shall not be more than an aggregate amount of $1,000,000. The department shall transfer the total assessment amount to the fund within 30 days of receipt.

(b) Base amount.–For each succeeding calendar year, the authority shall determine the appropriate assessment amount and the department shall assess each nursing home its proportionate share of the authority's budget for its responsibilities under this chapter. The total assessment amount shall not be more than $1,000,000 in fiscal year 2008-2009 and shall be increased according to the Consumer Price Index in each succeeding fiscal year.

(c) Expenditures.–Money appropriated to the fund under this chapter shall be expended by the authority to implement this chapter.

(d) Dissolution.–In the event that the fund is discontinued or the authority is dissolved by operation of law, any balance paid by nursing homes remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the nursing homes in proportion to their financial contributions to the fund in the preceding licensing period.

(e) Failure to pay surcharge.–If, after 30-days' notice, a nursing home fails to pay a surcharge levied by the department under this chapter, the department may assess an administrative penalty of $1,000 per day until the surcharge is paid.

(f) Reimbursable cost.–Subject to Federal approval, the annual assessment amount paid by a nursing home shall be a reimbursable cost under the medical assistance program. The Department of Public Welfare shall pay each nursing home, as a separate, pass-through payment, an amount equal to the assessment paid by a nursing home multiplied by the facility's medical assistance occupancy rate as reported in its annual cost report.

Section 2229.1. Scope of reporting.

For purposes of reporting health care-associated infections to the Commonwealth, its agencies and independent agencies, this chapter sets forth the applicable criteria to be utilized by health care facilities in making such reports. Nothing in this subarticle shall supersede the requirements set forth in the act of April 23, 1956 (1955 P.L.1510, No.500), known as the Disease Prevention and Control Law of 1955, and the regulations promulgated thereunder.

Section 2229.2. Penalties.

(a) Violation of Health Care Facilities Act.–The failure of a health care facility to report health care-associated infections as required by sections 2224 and 2225 or the failure of a health care facility or ambulatory surgical facility to develop, implement and comply with its infection control plan in accordance with the requirements of section 2223 shall be a violation of the Health Care Facilities Act.

(b) Administrative penalty.–In addition to any penalty that may be imposed under the Health Care Facilities Act, a health care facility which negligently fails to report a health care-associated infection as required under this chapter may be subject to an administrative penalty of $1,000 per day imposed by the department.

CHAPTER 5

MEDICAL PROFESSIONAL LIABILITY

Section 2231. Scope of chapter.

This chapter relates to medical professional liability.

Section 2232. Declaration of policy.

The General Assembly finds and declares that it is the purpose of this chapter to ensure a fair legal process and reasonable compensation for persons injured due to medical negligence in this Commonwealth. Ensuring the future availability of and access to quality health care is a fundamental responsibility that the General Assembly must fulfill as a promise to our children, our parents and our grandparents.

Section 2233. 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:

"Commission." The Interbranch Commission on Venue established in section 2239.5.

"Department." The Insurance Department of the Commonwealth.

"Health care provider." A primary health care center, a personal care home licensed by the Department of Public Welfare pursuant to the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and an officer, employee or agent of any of them acting in the course and scope of employment.

"Informed consent." The consent of a patient to the performance of a procedure in accordance with section 2234.

Section 2234. Informed consent.

(a) Duty of physicians.–Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:

(1) Performing surgery, including the related administration of anesthesia.

(2) Administering radiation or chemotherapy.

(3) Administering a blood transfusion.

(4) Inserting a surgical device or appliance.

(5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner.

(b) Description of procedure.–Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure. The physician shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide.

(c) Expert testimony.–Expert testimony is required to determine whether the procedure constituted the type of procedure set forth in subsection (a) and to identify the risks of that procedure, the alternatives to that procedure and the risks of these alternatives.

(d) Liability.–

(1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient's decision whether to undergo a procedure set forth in subsection (a).

(2) A physician may be held liable for failure to seek a patient's informed consent if the physician knowingly misrepresents to the patient his or her professional credentials, training or experience.

Section 2235. Punitive damages.

(a) Award.–Punitive damages may be awarded for conduct that is the result of the health care provider's willful or wanton conduct or reckless indifference to the rights of others. In assessing punitive damages, the trier of fact can properly consider the character of the health care provider's act, the nature and extent of the harm to the patient that the health care provider caused or intended to cause and the wealth of the health care provider.

(b) Gross negligence.–A showing of gross negligence is insufficient to support an award of punitive damages.

(c) Vicarious liability.–Punitive damages shall not be awarded against a health care provider who is only vicariously liable for the actions of its agent that caused the injury unless it can be shown by a preponderance of the evidence that the party knew of and allowed the conduct by its agent that resulted in the award of punitive damages.

(d) Total amount of damages.–Except in cases alleging intentional misconduct, punitive damages against an individual physician shall not exceed 200% of the compensatory damages awarded. Punitive damages, when awarded, shall not be less than $100,000 unless a lower verdict amount is returned by the trier of fact.

(e) Allocation.–Upon the entry of a verdict including an award of punitive damages, the punitive damages portion of the award shall be allocated as follows:

(1) 75% shall be paid to the prevailing party; and

(2) 25% shall be paid to the Medical Care Availability and Reduction of Error (Mcare) Fund.

Section 2236. Affidavit of noninvolvement.

(a) General provisions.–Any health care provider named as a defendant in a medical professional liability action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth with particularity the facts which demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant.

(b) Statute of limitations.–The filing of an affidavit of noninvolvement by a health care provider shall have the effect of tolling the statute of limitations as to that provider with respect to the claim at issue as of the date of the filing of the original pleading.

(c) Challenge.–A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit which contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

(d) False or inaccurate filing or statement.–If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court upon motion or upon its own initiative shall immediately reinstate the claim against that provider. In any action where the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the false affidavit, including a reasonable attorney fee.

Section 2237. Advance payments.

No advance payment made by the health care provider or the provider's basic coverage insurance carrier to or for the claimant shall be construed as an admission of liability for injuries or damages suffered by the claimant. Notwithstanding section 2238, evidence of an advance payment shall not be admissible by a claimant in a medical professional liability action.

Section 2238. Collateral sources.

(a) General rule.–Except as set forth in subsection (d), a claimant in a medical professional liability action is precluded from recovering damages for past medical expenses or past lost earnings incurred to the time of trial to the extent that the loss is covered by a private or public benefit or gratuity that the claimant has received prior to trial.

(b) Option.–The claimant has the option to introduce into evidence at trial the amount of medical expenses actually incurred, but the claimant shall not be permitted to recover for such expenses as part of any verdict except to the extent that the claimant remains legally responsible for such payment.

(c) No subrogation.–Except as set forth in subsection (d), there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to a public or private benefit covered in subsection (a).

(d) Exceptions.–The collateral source provisions set forth in subsection (a) shall not apply to the following:

(1) Life insurance, pension or profit-sharing plans or other deferred compensation plans, including agreements pertaining to the purchase or sale of a business.

(2) Social Security benefits.

(3) Cash or medical assistance benefits which are subject to repayment to the Department of Public Welfare.

(4) Public benefits paid or payable under a program which under Federal statute provides for right of reimbursement which supersedes State law for the amount of benefits paid from a verdict or settlement.

Section 2239. Payment of damages.

(a) General rule.–In a medical professional liability action, the trier of fact shall make a determination with separate findings for each claimant specifying the amount of all of the following:

(1) Except as provided for under section 2238, past damages for:

(i) medical and other related expenses in a lump sum;

(ii) loss of earnings in a lump sum; and

(iii) noneconomic loss in a lump sum.

(2) Future damages for:

(i) medical and other related expenses by year;

(ii) loss of earnings or earning capacity in a lump sum; and

(iii) noneconomic loss in a lump sum.

(b) Future damages.–

(1) Except as set forth in paragraph (8), future damages for medical and other related expenses shall be paid as periodic payments after payment of the proportionate share of counsel fees and costs based upon the present value of the future damages awarded pursuant to this subsection. The trier of fact may vary the amount of periodic payments for future damages as set forth in subsection (a)(2)(i) from year to year for the expected life of the claimant to account for different annual expenditure requirements, including the immediate needs of the claimant. The trier of fact shall also provide for purchase and replacement of medically necessary equipment in the years that expenditures will be required as may be necessary.

(2) The trier of fact may incorporate into any future medical expense award adjustments to account for reasonably anticipated inflation and medical care improvements as presented by competent evidence.

(3) Future damages as set forth in subsection (a)(2)(i) shall be paid in the years that the trier of fact finds they will accrue. Unless the court orders or approves a different schedule for payment, the annual amounts due must be paid in equal quarterly installments rounded to the nearest dollar. Each installment is due and payable on the first day of the month in which it accrues.

(4) Interest does not accrue on a periodic payment before payment is due. If the payment is not made on or before the due date, the legal rate of interest accrues as of that date.

(5) Liability to a claimant for periodic payments not yet due for medical expenses terminates upon the claimant's death.

(6) Each party liable for all or a portion of the judgment shall provide funding for the awarded periodic payments, separately or jointly with one or more others, by means of an annuity contract, trust or other qualified funding plan which is approved by the court. The commissioner shall annually publish a list of insurers designated by the commissioner as qualified to participate in the funding of periodic payment judgments. No annuity contractor may be placed on the commissioner's list of insurers unless the insurer has received the highest rating for claims paying ability by two independent financial services within the last 12 months.

(7) If an insurer defaults on a required periodic payment due to insolvency, the claimant shall be entitled to receive the payment from the Medical Care Availability and Reduction of Error (Mcare) Fund or, if the fund has ceased operations, from the Pennsylvania Life and Health Insurance Guaranty Association or the Property and Casualty Insurance Guaranty Association, whichever is applicable.

(8) Future damages for medical and other related expenses shall not be awarded in periodic payments if the claimant objects and stipulates that the total amount of the future damages for medical and other related expenses, without reduction to present value, does not exceed $100,000.

(c) Effect of full funding.–If full funding of an award pursuant to this section has been provided, the judgment is discharged, and any outstanding liens as a result of the judgment are released.

(d) Retained jurisdiction.–The court which enters judgment shall retain jurisdiction to enforce the judgment and to resolve related disputes.

Section 2239.1. Reduction to present value.

Future damages for loss of earnings or earning capacity in a medical professional liability action shall be reduced to present value based upon the return that the claimant can earn on a reasonably secure fixed income investment. These damages shall be presented with competent evidence of the effect of productivity and inflation over time. The trier of fact shall determine the applicable discount rate based upon competent evidence.

Section 2239.2. Preservation and accuracy of medical records.

(a) Timing.–Entries in patient charts concerning care rendered shall be made contemporaneously or as soon as practicable. Except as otherwise provided for in this section, it shall be considered unprofessional conduct and a violation of the applicable licensing statute to make alterations to a patient's chart.

(b) Corrections and disposal of records.–It shall not be considered unprofessional conduct or a violation of the applicable licensing statute for a health care provider to:

(1) Correct information on a patient's chart where information has been entered erroneously or where it is necessary to clarify entries made on the chart, provided that such corrections or additions shall be clearly identified as subsequent entries by a date and time.

(2) Add information to a patient's chart where it was not available at the time the record was first created, provided that:

(i) Such additions shall be clearly dated as subsequent entries.

(ii) A health care provider may add supplemental information within a reasonable time.

(3) Routinely dispose of medical records as permitted by law.

(c) Alteration of records.–In any medical professional liability action in which the claimant proves by a preponderance of the evidence that there has been an intentional alteration or destruction of medical records, the court in its discretion may instruct the jury to consider whether such intentional alteration or destruction constitutes an adverse inference.

(d) Licensure sanction.–Alteration or destruction of medical records for the purpose of eliminating information that would give rise to a medical professional liability action on the part of a health care provider shall constitute a ground for suspension. A health care provider who is aware of alteration or destruction in violation of this section shall report any party suspected of such conduct to the appropriate licensure board.

Section 2239.3. Expert qualifications.

(a) General rule.–No person shall be competent to offer an expert medical opinion in a medical professional liability action against a physician unless that person possesses sufficient education, training, knowledge and experience to provide credible, competent testimony and fulfills the additional qualifications set forth in this section as applicable.

(b) Medical testimony.–An expert testifying on a medical matter, including the standard of care, risks and alternatives, causation and the nature and extent of the injury, must meet the following qualifications:

(1) Possess an unrestricted physician's license to practice medicine in any state or the District of Columbia.

(2) Be engaged in or retired within the previous five years from active clinical practice or teaching. Provided, however, the court may waive the requirements of this subsection for an expert on a matter other than the standard of care if the court determines that the expert is otherwise competent to testify about medical or scientific issues by virtue of education, training or experience.

(c) Standard of care.–In addition to the requirements set forth in subsections (a) and (b), an expert testifying as to a physician's standard of care also must meet the following qualifications:

(1) Be substantially familiar with the applicable standard of care for the specific care at issue as of the time of the alleged breach of the standard of care.

(2) Practice in the same subspecialty as the defendant physician or in a subspecialty which has a substantially similar standard of care for the specific care at issue, except as provided in subsection (d) or (e).

(3) In the event the defendant physician is certified by an approved board, be board certified by the same or a similar approved board, except as provided in subsection (e).

(d) Care outside specialty.–A court may waive the same subspecialty requirement for an expert testifying on the standard of care for the diagnosis or treatment of a condition if the court determines that:

(1) the expert is trained in the diagnosis or treatment of the condition, as applicable; and

(2) the defendant physician provided care for that condition and such care was not within the physician's specialty or

competence.

(e) Otherwise adequate training, experience and knowledge.–A court may waive the same specialty and board certification requirements for an expert testifying as to a standard of care if the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in or full-time teaching of medicine in the applicable subspecialty or a related field of medicine within the previous five-year time period.

Section 2239.4. Statute of repose.

(a) General rule.–Except as provided in subsection (b) or (c), no cause of action asserting a medical professional liability claim may be commenced after seven years from the date of the alleged tort or breach of contract.

(b) Injuries caused by foreign object.–If the injury is or was caused by a foreign object unintentionally left in the individual's body, the limitation in subsection (a) shall not apply.

(c) Injuries of minors.–No cause of action asserting a medical professional liability claim may be commenced by or on behalf of a minor after seven years from the date of the alleged tort or breach of contract or after the minor attains the age of 20 years, whichever is later.

(d) Death or survival actions.–If the claim is brought under 42 Pa.C.S. § 8301 (relating to death action) or 8302 (relating to survival action), the action must be commenced within two years after the death in the absence of affirmative misrepresentation or fraudulent concealment of the cause of death.

(e) Applicability.–No cause of action barred prior to March 20, 2002, shall be revived by reason of the enactment of this section.

(f) Definition.–For purposes of this section, a "minor" is an individual who has not yet attained the age of 18 years.

Section 2239.5. Interbranch Commission on Venue.

(a) Declaration of policy.–The General Assembly further recognizes that recent changes in the health care delivery system have necessitated a revamping of the corporate structure for various medical facilities and hospitals across this Commonwealth. This has unduly expanded the reach and scope of existing venue rules. Training of new physicians in many geographic regions has also been severely restricted by the resultant expansion of venue applicability rules. These physicians and health care institutions are essential to maintaining the high quality of health care that our citizens have come to expect.

(b) Establishment of Interbranch Commission on Venue.–The Interbranch Commission on Venue for actions relating to medical professional liability is established as follows:

(1) The commission shall consist of the following members:

(i) The Chief Justice of the Supreme Court or a designee of the Chief Justice.

(ii) The chairperson of the Civil Procedural Rules Committee, who shall serve as the chairperson of the commission.

(iii) A judge of a court of common pleas appointed by the Chief Justice.

(iv) The Attorney General or a designee of the Attorney General.

(v) The General Counsel.

(vi) Two attorneys at law appointed by the Governor.

(vii) Four individuals, one each appointed by the:

(A) President pro tempore of the Senate;

(B) Minority Leader of the Senate;

(C) Speaker of the House of Representatives; and

(D) Minority Leader of the House of Representatives.

(2) The commission has the following functions:

(i) To review and analyze the issue of venue as it relates to medical professional liability actions filed in this Commonwealth.

(ii) To report, by September 1, 2002, to the General Assembly and the Supreme Court on the results of the review and analysis. The report shall include recommendations for such legislative action or the promulgation of rules of court on the issue of venue as the commission shall determine to be appropriate.

(3) The commission shall expire September 1, 2002.

Section 2239.6. Remittitur.

(a) General rule.–In any case in which a defendant health care provider challenges a verdict on grounds of excessiveness, the trial court shall, in deciding a motion for remittitur, consider evidence of the impact, if any, upon availability or access to health care in the community if the defendant health care provider is required to satisfy the verdict rendered by the jury.

(b) Factors and evidence.–A trial court denying a motion for remittitur shall specifically set forth the factors and evidence it considered with respect to the impact of the verdict upon availability or access to health care in the community.

(c) Abuse of discretion.–An appellate court reviewing a lower court's denial of remittitur may find an abuse of discretion if evidence of the impact of paying the verdict upon availability and access to health care in the community has not been adequately considered by the lower court.

(d) Limit of security.–A trial court or appellate court may limit or reduce the amount of security that a defendant health care provider must post to prevent execution if the court finds that requiring a bond in excess of the limits of available insurance coverage would effectively deny the right to appeal.

Section 2239.7. Ostensible agency.

(a) Vicarious liability.–A hospital may be held vicariously liable for the acts of another health care provider through principles of ostensible agency only if the evidence shows that:

(1) a reasonably prudent person in the patient's position would be justified in the belief that the care in question was being rendered by the hospital or its agents; or

(2) the care in question was advertised or otherwise represented to the patient as care being rendered by the hospital or its agents.

(b) Staff privileges.–Evidence that a physician holds staff privileges at a hospital shall be insufficient to establish vicarious liability through principles of ostensible agency unless the claimant meets the requirements of subsection (a)(1) or (2).

CHAPTER 7
INSURANCE
SUBCHAPTER A
PRELIMINARY PROVISIONS

Section 2251. Scope of chapter.

This chapter relates to medical professional liability insurance.

Section 2251.1. 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:

"Basic insurance coverage." The limits of medical professional liability insurance required under section 2252(d).

"Claims made." Medical professional liability insurance that insures those claims made or reported during a period which is insured and excludes coverage for a claim reported subsequent to the period even if the claim resulted from an occurrence during the period which was insured.

"Claims period." The period from September 1 to the following August 31.

"Deficit." A joint underwriting association loss which exceeds the sum of earned premiums collected by the joint underwriting association and investment income.

"Department." The Insurance Department of the Commonwealth.

"Fund." The Medical Care Availability and Reduction of Error (Mcare) Fund established in section 2252.1.

"Fund coverage limits." The coverage provided by the Medical Care Availability and Reduction of Error (Mcare) Fund under section 2252.1.

"Government." The Government of the United States, any state, any political subdivision of a state, any instrumentality of one or more states or any agency, subdivision or department of any such government, including any corporation or other association organized by a government for the execution of a government program and subject to control by a government or any corporation or agency established under an interstate compact or international treaty.

"Health care business or practice." The number of patients to whom health care services are rendered by a health care provider within an annual period.

"Health care provider." A participating health care provider or nonparticipating health care provider.

"Joint underwriting association." The Pennsylvania Professional Liability Joint Underwriting Association established in section 2253.

"Joint underwriting association loss." The sum of the administrative expenses, taxes, losses, loss adjustment expenses, unearned premiums and reserves, including reserves for losses incurred and losses incurred but not reported, of the joint underwriting association.

"Licensure authority." The State Board of Medicine, the State Board of Osteopathic Medicine, the State Board of Podiatry, the Department of Public Welfare and the Department of Health.

"Medical professional liability insurance." Insurance against liability on the part of a health care provider arising out of any tort or breach of contract causing injury or death resulting from the furnishing of medical services which were or should have been provided.

"Nonparticipating health care provider." A health care provider as defined in section 2203 that conducts 20% or less of its health care business or practice within this Commonwealth.

"Participating health care provider." A health care provider as defined in section 2203 that conducts more than 20% of its health care business or practice within this Commonwealth or a nonparticipating health care provider who chooses to participate in the fund.

"Prevailing primary premium." The schedule of occurrence rates approved by the commissioner for the joint underwriting association.

SUBCHAPTER B
FUND

Section 2252. Medical professional liability insurance.

(a) Requirement.–A health care provider providing health care services in this Commonwealth shall:

(1) purchase medical professional liability insurance from an insurer which is licensed or approved by the department; or

(2) provide self-insurance.

(b) Proof of insurance.–A health care provider required by subsection (a) to purchase medical professional liability insurance or provide self-insurance shall submit proof of insurance or self-insurance to the department within 60 days of the policy being issued.

(c) Failure to provide proof of insurance.–If a health care provider fails to submit the proof of insurance or self-insurance required by subsection (b), the department shall, after providing the health care provider with notice, notify the health care provider's licensing authority. A health care provider's license shall be suspended or revoked by its licensure board or agency if the health care provider fails to comply with any of the provisions of this chapter.

(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, 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 2254.4(b) that additional basic insurance coverage capacity is not available, for policies issued or renewed in calendar year 2009 and each year thereafter subject to paragraph (4), the basic insurance coverage as determined by the commissioner shall be:

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

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

If the commissioner finds pursuant to section 2254.4(b) 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 year 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 2254.4(b) that additional basic insurance coverage capacity is not available, for policies issued or renewed two years after the increase in coverage limits required by paragraph (3) and for each year thereafter, the basic insurance coverage as determined by the commissioner shall be:

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

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

If the commissioner finds pursuant to section 2254.4(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 year 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) The amount of basic insurance coverage per occurrence or claim under paragraph (3) or (4) shall be no less than $500,000 and shall be set in $50,000 increments.

(6) In no event shall the total coverage for basic primary insurance and the fund, per occurrence or claim, be less than $1,000,000 or less than $3,000,000 per annual aggregate for a participating or nonparticipating health care provider, except hospitals which have total coverage limits of not less than

$1,000,000 per occurrence or less than $4,500,000 per annual aggregate.

(e) Fund participation.–A participating health care provider shall be required to participate in the fund.

(f) Self-insurance.–

(1) If a health care provider self-insures its medical professional liability, the health care provider shall submit its self-insurance plan, such additional information as the department may require and the examination fee to the department for approval.

(2) The department shall approve the plan if it determines that the plan constitutes protection equivalent to the insurance required of a health care provider under subsection (d).

(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.

(h) Excess insurance.–

(1) No insurer providing medical professional liability insurance with liability limits in excess of the fund's liability limits to a participating health care provider shall be liable for payment of a claim against the participating health care provider for a loss or damages in a medical professional liability action except the losses and damages in excess of the fund coverage limits.

(2) No insurer providing medical professional liability insurance with liability limits in excess of the fund's liability limits to a participating health care provider shall be liable for any loss resulting from the insolvency or dissolution of the fund.

(i) Governmental entities.–A governmental entity may satisfy its obligations under this chapter, as well as the obligations of its employees to the extent of their employment, by either purchasing medical professional liability insurance or assuming an obligation as a self-insurer, and paying the assessments under this chapter.

(j) Exemptions.–The following participating health care providers shall be exempt from this chapter:

(1) A physician who exclusively practices the specialty of forensic pathology.

(2) A participating health care provider who is a member of the Pennsylvania military forces while in the performance of the member's assigned duty in the Pennsylvania military forces under orders.

(3) A retired licensed participating health care provider who provides care only to the provider or the provider's immediate family members.

Section 2252.1. Medical Care Availability and Reduction of Error (Mcare) Fund.

(a) Establishment.–There is hereby established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error (Mcare) Fund. Money in the fund shall be used to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions against them in excess of the basic insurance coverage required by section 2252(d), liabilities transferred in accordance with subsection (b) and for the administration of the fund.

(b) Transfer of assets and liabilities.–

(1) (i) The money in the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is transferred to the fund.

(ii) The rights of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(2) The liabilities and obligations of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the 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 2252(d)(3) or (4) 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:

(A) except as set forth in clause (B), $1,000,000 per occurrence and $3,000 per annual aggregate, minus the amount the commissioner determines for basic insurance coverage under section 2252(d)(3) or (4); or

(B) for hospitals, $1,000,000 per occurrence and $4,500,000 per annual aggregate, minus the amount the commissioner determines for basic insurance coverage under section 2252(d)(3) or (4).

(d) Assessments.–

(1) For calendar year 2003 and for each year thereafter, 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 2252.2(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 former 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 March 20, 2002, has paid the surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to March 20, 2002.

(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 2252(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).

(f) Updated rates.–The joint underwriting association shall file updated rates for all health care providers with the commissioner by May 1 of each year. The department shall review and may adjust the prevailing primary premium in line with any applicable changes which have been approved by the commissioner.

(g) Additional adjustments of the prevailing primary premium.–The department shall adjust the applicable prevailing primary premium of each participating health care provider in accordance with the following:

(1) The applicable prevailing primary premium of a participating health care provider which is not a hospital may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency of claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods and shall be in accordance with the following:

(i) If three claims have been paid during the past five most recent claims periods by the fund, a 10% increase shall be charged.

(ii) If four or more claims have been paid during the past five most recent claims periods by the fund, a 20% increase shall be charged.

(2) The applicable prevailing primary premium of a participating health care provider which is not a hospital and which has not had an adjustment under paragraph (1) may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the severity of at least two claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods.

(3) The applicable prevailing primary premium of a participating health care provider not engaged in direct clinical practice on a full-time basis may be adjusted through a decrease in the individual participating health care provider's prevailing primary premium not to exceed 10%. Any adjustment shall be based upon the lower risk associated with the less-than-full-time direct clinical practice.

(4) The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent claims periods.

(h) Self-insured health care providers.–A participating health care provider that has an approved self-insurance plan shall be assessed an amount equal to the assessment imposed on a participating health care provider of like class, size, risk and kind as determined by the department.

(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.

(j) Payment of claims.–Claims which became final during the preceding claims period shall be paid on or before December 31 following the August 31 on which they became final.

(k) Termination.–Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination shall be returned by the department to the participating health care providers who participated in the fund in proportion to their assessments in the preceding calendar year.

(l) Sole and exclusive source of funding.–Except as provided in subsection (m), the surcharges imposed under section 701(e)(1) of the former Health Care Services Malpractice Act and assessments on participating health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. Nothing in this subsection shall prohibit the fund from accepting contributions from nongovernmental sources. A claim against or a liability of the fund shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

(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 Reduction of Error (Mcare) 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.

(n) Waiver of right to consent to settlement.–A participating health care provider may maintain the right to consent to a settlement in a basic insurance coverage policy for medical professional liability insurance upon the payment of an additional premium amount.

Section 2252.2. Administration of fund.

(a) General rule.–The fund shall be administered by the department. The department shall contract with an entity or entities for the administration of claims against the fund in accordance with 62 Pa.C.S. (relating to procurement), and, to the fullest extent practicable, the department shall contract with entities that:

(1) Are not writing, underwriting or brokering medical professional liability insurance for participating health care providers; however, the department may contract with a subsidiary or affiliate of any writer, underwriter or broker of medical professional liability insurance.

(2) Are not trade organizations or associations representing the interests of participating health care providers in this Commonwealth.

(3) Have demonstrable knowledge of and experience in the handling and adjusting of professional liability or other catastrophic claims.

(4) Have developed, instituted and utilized best practice standards and systems for the handling and adjusting of professional liability or other catastrophic claims.

(5) Have demonstrable knowledge of and experience with the professional liability marketplace and the judicial systems of this Commonwealth.

(b) Reinsurance.–The department may purchase, on behalf of and in the name of the fund, as much insurance or reinsurance as is necessary to preserve the fund or retire the liabilities of the fund.

(c) Transfers.–The Governor may transfer to the fund from the Catastrophic Loss Benefits Continuation Fund, or such other funds as may be appropriate, such money as is necessary in order to pay the liabilities of the fund until sufficient revenues are realized by the fund. Any transfer made under this subsection shall be repaid with interest pursuant to section 2 of the act of August 22, 1961 (P.L.1049, No.479), entitled "An act authorizing the State Treasurer under certain conditions to transfer sums of money between the General Fund and certain funds and subsequent transfers of equal sums between such funds, and making appropriations necessary to effect such transfers."

(d) Confidentiality.–Information provided to the department or maintained by the department regarding a claim or adjustments to an individual participating health care provider's assessment shall be confidential, notwithstanding the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

Section 2252.3. Medical professional liability claims.

(a) Notification.–A basic coverage insurer or self-insured participating health care provider shall promptly notify the department in writing of any medical professional liability claim.

(b) Failure to notify.–If a basic coverage insurer or self-insured participating health care provider fails to notify the department as required under subsection (a) and the department has been prejudiced by the failure of notice, the insurer or provider shall be solely responsible for the payment of the entire award or verdict that results from the medical professional liability claim.

(c) Defense.–A basic coverage insurer or self-insured participating health care provider shall provide a defense to a medical professional liability claim, including a defense of any potential liability of the fund, except as provided for in section 2252.4. The department may join in the defense and be represented by counsel.

(d) Responsibilities.–In accordance with section 2252.2, the department may defend, litigate, settle or compromise any medical professional liability claim payable by the fund.

(e) Releases.–In the event that a basic coverage insurer or self-insured participating health care provider enters into a settlement with a claimant to the full extent of its liability as provided in this chapter, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any claim against the fund or its duty to continue the defense of the claim.

(f) Adjustment.–The department may adjust claims.

(g) Mediation.–Upon the request of a party to a medical professional liability claim within the fund coverage limits, the department may provide for a mediator in instances where multiple carriers disagree on the disposition or settlement of a case. Upon the consent of all parties, the mediation shall be binding. Proceedings conducted and information provided in accordance with this section shall be confidential and shall not be considered public information subject to disclosure under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

(h) Delay damages and postjudgment interest.–Delay damages and postjudgment interest applicable to the fund's liability on a medical professional liability claim shall be paid by the fund and shall not be charged against the participating health care provider's annual aggregate limits. The basic coverage insurer or self-insured participating health care provider shall be responsible for its proportionate share of delay damages and postjudgment interest.

Section 2252.4. Extended claims.

(a) General rule.–If a medical professional liability claim against a health care provider who was required to participate in the Medical Professional Liability Catastrophe Loss Fund under section 701(d) of the act of October 15, 1975 (P.L.390, No.111), known as the former Health Care Services Malpractice Act, is made more than four years after the breach of contract or tort occurred and if the claim is filed within the applicable statute of limitations, the claim shall be defended by the department if the department received a written request for indemnity and defense within 180 days of the date on which notice of the claim is first given to the participating health care provider or its insurer. Where multiple treatments or consultations took place less than four years before the date on which the health care provider or its insurer received notice of the claim, the claim shall be deemed for purposes of this section to have occurred less than four years prior to the date of notice and shall be defended by the insurer in accordance with this chapter.

(b) Payment.–If a health care provider is found liable for a claim defended by the department in accordance with subsection (a), the claim shall be paid by the fund. The limit of liability of the fund for a claim defended by the department under subsection (a) shall be $1,000,000 per occurrence.

(c) Concealment.–If a claim is defended by the department under subsection (a) or paid under subsection (b) and the claim is made after four years because of the willful concealment by the health care provider or its insurer, the fund shall have the right to full indemnity, including the department's defense costs, from the health care provider or its insurer.

(d) Extended coverage required.–Notwithstanding subsections (a), (b) and (c), all medical professional liability insurance policies issued on or after January 1, 2006, shall provide indemnity and defense for claims asserted against a health care provider for a breach of contract or tort which occurs four or more years after the breach of contract or tort occurred and after December 31, 2005.

Section 2252.5. Podiatrist liability.

Within two years of the effective date of Chapter 7 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, the department shall calculate the amount necessary to arrange for the separate retirement of the fund's liabilities associated with podiatrists. Any arrangement shall be on terms and conditions proportionate to the individual liability of the class of health care provider. The arrangement may result in assessments for podiatrists different from the assessments for other health care providers. Upon satisfaction of the arrangement, podiatrists shall not be required to contribute to or be entitled to participate in the fund. In cases where the class rejects an arrangement, the department shall present to the provider class new term arrangements at least once in every two-year period. All costs and expenses associated with the completion and implementation of the arrangement shall be paid by podiatrists and may be charged in the form of an addition to the assessment.

SUBCHAPTER C

JOINT UNDERWRITING ASSOCIATION

Section 2253. Joint underwriting association.

(a) Establishment.–There is established a nonprofit joint underwriting association to be known as the Pennsylvania Professional Liability Joint Underwriting Association. The joint underwriting association shall consist of all insurers authorized to write insurance in accordance with section 202(c)(4) and (11) and shall be supervised by the department. The powers and duties of the joint underwriting association shall be vested in and exercised by a board of directors.

(b) Duties.–The joint underwriting association shall do all of the

following:

(1) Submit a plan of operation to the commissioner for approval.

(2) Submit rates and any rate modification to the department for approval in accordance with the act of June 11, 1947 (P.L.538, No.246), known as The Casualty and Surety Rate Regulatory Act.

(3) Offer medical professional liability insurance to health care providers in accordance with section 2253.1.

(4) File with the department the information required in section 2252.1.

(c) Liabilities.–A claim against or a liability of the joint underwriting association shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

Section 2253.1. Medical professional liability insurance.

(a) Insurance.–The joint underwriting association shall offer medical professional liability insurance to health care providers and professional corporations, professional associations and partnerships which are entirely owned by health care providers who cannot conveniently obtain medical professional liability insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers, professional corporations, professional associations or partnerships.

(b) Requirements.–The joint underwriting association shall ensure that the medical professional liability insurance it offers does all of the following:

(1) Is conveniently and expeditiously available to all health care providers required to be insured under section 2252.

(2) Is subject only to the payment or provisions for payment of the premium.

(3) Provides reasonable means for the health care providers it insures to transfer to the ordinary insurance market.

(4) Provides sufficient coverage for a health care provider to satisfy its insurance requirements under section 2252 on reasonable and not unfairly discriminatory terms.

(5) Permits a health care provider to finance its premium or allows installment payment of premiums subject to customary terms and conditions.

Section 2253.2. Deficit.

(a) Filing.–In the event the joint underwriting association experiences a deficit in any calendar year, the board of directors shall file with the commissioner the deficit.

(b) Approval.–Within 30 days of receipt of the filing, the commissioner shall approve or deny the filing. If approved, the joint underwriting association is authorized to borrow funds sufficient to satisfy the deficit.

(c) Rate filing.–Within 30 days of receiving approval of its filing in accordance with subsection (b), the joint underwriting association shall file a rate filing with the department. The commissioner shall approve the filing if the premiums generate sufficient income for the joint underwriting association to avoid a deficit during the following 12 months and to repay principal and interest on the money borrowed in accordance with subsection (b).

SUBCHAPTER D
REGULATION OF MEDICAL PROFESSIONAL
LIABILITY INSURANCE

Section 2254. Approval.

In order for an insurer to issue a policy of medical professional liability insurance to a health care provider or to a professional corporation, professional association or partnership which is entirely owned by health care providers, the insurer must be authorized to write medical professional liability insurance in accordance with this act.

Section 2254.1. Approval of policies on "claims made" basis.

The commissioner shall not approve a medical professional liability insurance policy written on a "claims made" basis by any insurer doing business in this Commonwealth unless the insurer shall guarantee to the commissioner the continued availability of suitable liability protection for a health care provider subsequent to the discontinuance of professional practice by the health care provider or the termination of the insurance policy by the insurer or the health care provider for so long as there is a reasonable probability of a claim for injury for which the health care provider may be held liable.

Section 2254.2. Reports to commissioner and claims information.

(a) Duty to report.–By October 15 of each year, basic insurance coverage insurers and self-insured participating health care providers shall report to the department the claims information specified in subsection (b).

(b) Department report.–Sixty days after the end of each calendar year, the department shall prepare a report. The report shall contain the total amount of claims paid and expenses incurred during the preceding calendar year, the total amount of reserve set aside for future claims, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim, judgment of court, settlement or otherwise. For final claims at the end of any calendar year, the report shall include details by basic insurance coverage insurers and self-insured participating health care providers of the amount of assessment collected, the number of reimbursements paid and the amount of reimbursements paid.

(c) Submission of report.–A copy of the report prepared pursuant to this section shall be submitted to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives.

Section 2254.3. Professional corporations, professional associations and partnerships.

A professional corporation, professional association or partnership which is entirely owned by health care providers and which elects to purchase basic insurance coverage in accordance with section 2252 from the joint underwriting association or from an insurer licensed or approved by the department shall be required to participate in the fund and, upon payment of the assessment required by section 2252.1, be entitled to coverage from the fund.

Section 2254.4. 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 subarticle 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) Pursuant to section 2252(d)(3) or (4), the commissioner shall conduct a study regarding the availability of additional basic insurance overage capacity as set forth in this subsection. In order for the commissioner to make a final determination regarding the increase of the basic insurance coverage requirement in accordance with section 2252(d)(3) or (4), 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 subarticle 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, including economic considerations, within or outside this Commonwealth in accordance with sound actuarial principles.

(3) Upon review of the study by the commissioner, a final determination shall be issued by the commissioner by July 1, 2008, and by July 1 of each year thereafter if a study is required pursuant to section 2252(d)(3) or (4).

Section 2254.5. Mandatory reporting.

(a) General provisions.–Each medical professional liability insurer and each self-insured health care provider, including the fund established by this chapter, which makes payment in settlement or in partial settlement of or in satisfaction of a judgment in a medical professional liability action or claim shall provide to the appropriate licensure board a true and correct copy of the report required to be filed with the Federal Government by section 421 of the Health Care Quality Improvement Act of 1986 (Public Law 99-660, 42 U.S.C. § 11131). The copy of the report required by this section shall be filed simultaneously with the report required by section 421 of the Health Care Quality Improvement Act of 1986. The department shall monitor and enforce compliance with this section. The Bureau of Professional and Occupational Affairs and the licensure boards shall have access to information pertaining to compliance.

(b) Immunity.–A medical professional liability insurer or person who reports under subsection (a) in good faith and without malice shall be immune from civil or criminal liability arising from the report.

(c) Public information.–Information received under this section shall not be considered public information for the purposes of the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings) until used in a formal disciplinary proceeding.

Section 2254.6. Cancellation of insurance policy.

A termination of a medical professional liability insurance policy by cancellation, except for suspension or revocation of the insured's license or for reason of nonpayment of premium, is not effective against the insured unless notice of cancellation was given within 60 days after the issuance of the policy to the insured, and no cancellation shall take effect unless a written notice stating the reasons for the cancellation and the date and time upon which the termination becomes effective has been received by the commissioner. Mailing of the notice to the commissioner at the commissioner's principal office address shall constitute notice to the commissioner.

Section 2254.7. Regulations.

The commissioner may promulgate regulations to implement and administer this chapter.

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

Section 2254.10. 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 2254.11. Allocation.

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

(1) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund, up to a maximum amount of $25,000,000, shall be transferred to the Patient Safety Trust Fund for use by the Department of Public Welfare for implementing section 407.

(2) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund, up to a maximum amount of $25,000,000, shall be transferred to the Medical Safety Automation Fund.

(3) All other funds 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.

SUBCHAPTER F
MEDICAL SAFETY AUTOMATION FUND

Section 2254.20. 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.

CHAPTER 9
ADMINISTRATIVE PROVISIONS

Section 2261. Scope of chapter.

(a) General rule.–

(1) Except as set forth in subsection (b), this chapter is in pari materia with:

(i) the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act; and

(ii) the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

(2) No duplication of procedure is required between this chapter and either:

(i) the Osteopathic Medical Practice Act; or

(ii) the Medical Practice Act of 1985.

(b) Conflict.–This chapter shall prevail if there is a conflict between this chapter and either:

(1) the Osteopathic Medical Practice Act; or

(2) the Medical Practice Act of 1985.

Section 2262. 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:

"Licensure board." Either or both of the following, depending on the licensure of the affected individual:

(1) The State Board of Medicine.

(2) The State Board of Osteopathic Medicine.

"Physician." An individual licensed under the laws of this Commonwealth to engage in the practice of:

(1) medicine and surgery in all its branches within the scope of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985; or

(2) osteopathic medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

Section 2263. Reporting.

A physician shall report to the State Board of Medicine or the State Board of Osteopathic Medicine, as appropriate, within 60 days of the occurrence of any of the following:

(1) Notice of a complaint in a medical professional liability action that is filed against the physician. The physician shall provide the docket number of the case, where the case is filed and a description of the allegations in the complaint.

(2) Information regarding disciplinary action taken against

the physician by a health care licensing authority of another state.

(3) Information regarding sentencing of the physician for an offense as provided in section 15 of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or section 41 of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

(4) Information regarding an arrest of the physician for any of the following offenses in this Commonwealth or another state:

(i) 18 Pa.C.S. Ch. 25 (relating to criminal homicide);

(ii) 18 Pa.C.S. § 2702 (relating to aggravated assault); or

(iii) 18 Pa.C.S. Ch. 31 (relating to sexual offenses).

(iv) A violation of the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act.

Section 2264. Commencement of investigation and action.

(a) Investigations by licensure board.–With regard to notices of complaints received pursuant to section 2263(1) or a complaint filed with the licensure board, the licensure board shall develop criteria and standards for review based on the frequency and severity of complaints filed against a physician. Any investigation of a physician based upon a complaint must be commenced no more than four years from the date notice of the complaint is received under section 2263(1).

(b) Action by licensure board.–Unless an investigation has already been initiated pursuant to subsection (a), an action against a physician must be commenced by the licensure board no more than four years from the time the licensure board receives the earliest of any of the following:

(1) Notice that a payment against the physician has been reported to the National Practitioner Data Bank.

(2) Notice that a payment in a medical professional liability action against the physician has been reported to the licensure board by an insurer.

(3) Notice of a report made pursuant to section 2263(2), (3) or (4).

(c) Laches.–The defense of laches is unavailable if the licensure board complies with this section.

(d) Applicability.–This section shall apply to actions against a physician initiated on or after May 20, 2002.

Section 2265. Action on negligence.

If the licensure board determines, based on actions taken pursuant to section 2264, that a physician has practiced negligently, the licensure board may impose disciplinary sanctions or corrective measures.

Section 2266. Confidentiality agreements.

(a) Confidentiality agreements.–Upon settlement of a medical professional liability action containing a confidentiality agreement or upon a court order sealing the settlement and related records for purposes of confidentiality, the agreement or order shall not be operable against the licensure board to obtain copies of medical records of the patient on whose behalf the action is commenced. Prior to obtaining medical records under this subsection, the licensure board must obtain the consent of the patient or the patient's legal representative.

(b) Applicability.–The addition of subsection (a) shall apply to settlements entered into and court orders issued on or after May 20, 2002.

Section 2267. Confidentiality of records of licensure boards.

(a) General rule.–All documents, materials or information utilized solely for an investigation undertaken by the State Board of Medicine or State Board of Osteopathic Medicine or concerning a complaint filed with the State Board of Medicine or State Board of Osteopathic Medicine shall be confidential and privileged. No person who has investigated or has access to or custody of documents, materials or information which are confidential and privileged under this subsection shall be required to testify in any judicial or administrative proceeding without the written consent of the State Board of Medicine or State Board of Osteopathic Medicine. This subsection shall not preclude or limit introduction of the contents of an investigative file or related witness testimony in a hearing or proceeding held before the State Board of Medicine or State Board of Osteopathic Medicine. This subsection shall not apply to letters to a licensee that disclose the final outcome of an investigation or to final adjudications or orders issued by the licensure board.

(b) Certain disclosure permitted.–Except as provided in subsection (a), this section shall not prevent disclosure of any documents, materials or information pertaining to the status of a license, permit or certificate issued or prepared by the State Board of Medicine or State Board of Osteopathic Medicine or relating to a public disciplinary proceeding or hearing.

Section 2268. Licensure board-imposed civil penalty.

In addition to any other civil remedy or criminal penalty provided for in this subarticle, the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, the State Board of Medicine and the State Board of Osteopathic Medicine, by a vote of the majority of the maximum number of the authorized membership of each board as provided by law or by a vote of the majority of the duly qualified and confirmed membership or a minimum of five members, whichever is greater, may levy a civil penalty of up to $10,000 on any current licensee who violates any provision of this subarticle, the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act or on any person who practices medicine or osteopathic medicine without being properly licensed to do so under the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act. The boards shall levy this penalty only after affording the accused party the opportunity for a hearing as provided in 2 Pa.C.S. (relating to administrative law and procedure).

Section 2269. Licensure board report.

(a) Annual report.–Each licensure board shall submit a report not later than March 1 of each year to the chair and the minority chair of the Consumer Protection and Professional Licensure Committee of the Senate and to the chair and minority chair of the Professional Licensure Committee of the House of Representatives. The report shall include:

(1) The number of complaint files against board licensees that were opened in the preceding five calendar years.

(2) The number of complaint files against board licensees that were closed in the preceding five calendar years.

(3) The number of disciplinary sanctions imposed upon board licensees in the preceding five calendar years.

(4) The number of revocations, automatic suspensions, immediate temporary suspensions and stayed and active suspensions imposed, voluntary surrenders accepted, license applications denied and license reinstatements denied in the preceding five calendar years.

(5) The range of lengths of suspensions, other than automatic suspensions and immediate temporary suspensions, imposed during the preceding five calendar years.

(b) Posting.–The report shall be posted on each licensure board's publicly accessible World Wide Web site.

Section 2269.1. Continuing medical education.

(a) Rules and regulations.–Each licensure board shall promulgate and enforce regulations consistent with 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, as appropriate, in establishing requirements of continuing medical education for individuals licensed to practice medicine and surgery without restriction as a condition for renewal of their licenses. Such regulations shall include any fees necessary for the licensure board to carry out its responsibilities under this section.

(b) Required completion.–Beginning with the licensure period commencing January 1, 2003, and following written notice to licensees by the licensure board, individuals licensed to practice medicine and surgery without restriction shall be required to enroll and complete 100 hours of mandatory continuing education during each two-year licensure period. As part of the 100-hour requirement, the licensure board shall

establish a minimum number of hours that must be completed in improving patient safety and risk management subject areas.

(c) Review.–The licensure board shall review and approve continuing medical education providers or accrediting bodies who shall be certified to offer continuing medical education credit hours.

(d) Exemption.–Licensees shall be exempt from the provisions of this section as follows:

(1) An individual applying for licensure in this Commonwealth for the first time shall be exempt from the continuing medical education requirement for the biennial renewal period following initial licensure.

(2) An individual holding a current temporary training license shall be exempt from the continuing medical education requirement.

(3) A retired physician who provides care only to immediate family members shall be exempt from the continuing medical education requirement.

(e) Waiver.–The licensure board may waive all or a portion of the continuing education requirement for biennial renewal to a licensee who shows to the satisfaction of the licensure board that he or she was unable to complete the requirements due to serious illness, military service or other demonstrated hardship. A waiver request shall be made in writing, with appropriate documentation, and shall include a description of circumstances sufficient to show why compliance is impossible. A waiver request shall be evaluated by the licensure board on a case-by-case basis. The licensure board shall send written notification of its approval or denial of a waiver request.

(f) Reinstatement.–A licensee seeking to reinstate an inactive or lapsed license shall show proof of compliance with the continuing education requirement for the preceding biennium.

(g) Board approval.–An individual shall retain official documentation of attendance for two years after renewal and shall certify completed courses on a form provided by the licensure board for that purpose to be filed with the biennial renewal form. Official documentation proving attendance shall be produced upon licensure board demand pursuant to random audits of reported credit hours. Electronic submission of documentation is permissible to prove compliance with this subsection. Noncompliance with the requirements of this section may result in disciplinary proceedings.

(h) Regulations.–The licensure board shall promulgate regulations necessary to carry out the provisions of this section by November 30, 2002.

CHAPTER 10
VOLUNTEER HEALTH SERVICES

Section 2270.1. Scope.

This article relates to volunteer health services.

Section 2270.2. Purpose.

It is the purpose of this chapter to increase the availability of primary health care services by establishing a procedure through which physicians and other health care practitioners who are retired from active practice may provide professional services as a volunteer in approved clinics serving financially qualified persons and in approved clinics located in medically underserved areas or health professionals shortage areas.

Section 2270.3. 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:

"Approved clinic." An organized community-based clinic offering primary health care services to individuals and families who cannot pay for their care, to medical assistance clients or to residents of medically underserved areas or health professionals shortage areas. The term may include, but shall not be limited to, a State health center, nonprofit community-based clinic and federally qualified health center, as designated by Federal rulemaking or as approved by the Department of Health or the Department of Public Welfare.

"Board." The State Board of Medicine, the State Board of Osteopathic Medicine, the State Board of Dentistry, the State Board of Podiatry, the State Board of Nursing, the State Board of Optometry and the State Board of Chiropractic.

"Health care practitioner." An individual licensed to practice a component of the healing arts by a licensing board within the Department of State.

"Licensee." An individual who holds a current, active, unrestricted license as a health care practitioner issued by the appropriate board.

"Primary health care services." The term includes, but is not limited to, regular checkups, immunizations, school physicals, health education, prenatal and obstetrical care, early periodic screening and diagnostic testing and health education.

"Volunteer license." A license issued by the appropriate board to a health care practitioner who documents, to the board's satisfaction, that the individual will practice only in approved clinics without remuneration, who is:

(1) a retired health care practitioner; or

(2) a nonretired health care practitioner who is not required to maintain professional liability insurance under Chapter 7, because the health care practitioner is not otherwise practicing medicine or providing health care services in this Commonwealth.

Section 2270.4. Volunteer status.

A licensee in good standing who retires from active practice or a nonretired licensee who does not otherwise currently practice or provide health care services in this Commonwealth and is not required to maintain professional liability insurance under Chapter 7 may apply, on forms provided by the appropriate board, for a volunteer license.

Section 2270.5. Regulations.

Each board shall promulgate regulations governing the volunteer license category. The regulations shall include qualifications for obtaining a volunteer license.

Section 2270.6. License renewal; disciplinary and corrective measures.

(a) Renewal term.–A volunteer license shall be subject to biennial renewal.

(b) Fee exemption.–Holders of volunteer licenses shall be exempt from renewal fees imposed by the appropriate licensing board.

(c) Continuing education.–Except as set forth in subsection (d), holders of volunteer licenses shall comply with any continuing education requirements imposed by board rulemaking as a general condition of biennial renewal.

(d) Physicians.–

(1) Holders of volunteer licenses who are physicians shall complete a minimum of 20 credit hours of American Medical Association Physician's Recognition Award Category 2 activities during the preceding biennial period as a condition of biennial renewal and are otherwise exempt from any continuing education requirement imposed by section 2269.1, or by board rulemaking.

(2) Physicians who are covered by section 2270.12 and hold an unrestricted license to practice medicine shall complete the continuing medical education requirements established by the boards under section 2269.1 to be eligible for renewal of the unrestricted license.

(d.1) Nurses.–Holders of volunteer licenses who are nurses shall complete a minimum of 20 credit hours of continuing education during the preceding biennial period as a condition of biennial renewal and are otherwise exempt from any continuing education requirements imposed by section 12.1 of the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law, as a condition of biennial renewal.

(e) Disciplinary matters.–In the enforcement of disciplinary matters, holders of volunteer licenses shall be subject to those standards of conduct applicable to all licensees licensed by the appropriate board.

Section 2270.7. Liability.

(a) General rule.–A holder of a volunteer license who, in good faith, renders professional health care services under this chapter shall not be liable for civil damages arising as a result of any act or omission in the rendering of care unless the conduct of the volunteer licensee falls substantially below professional standards which are generally practiced

and accepted in the community and unless it is shown that the volunteer licensee did an act or omitted the doing of an act which the person was under a recognized duty to a patient to do, knowing or having reason to know that the act or omission created a substantial risk of actual harm to the patient.

(b) Application.–This section shall not apply unless the approved clinic posts in a conspicuous place on its premises an explanation of the exemptions from civil liability provided under subsection (a). The protections provided by this section shall not apply to institutional health care providers, such as hospitals or approved clinics, subject to vicarious liability for the conduct of a volunteer license holder. The liability of such institutional defendants shall be governed by the standard of care established by common law.

Section 2270.8. Report.

Beginning March 5, 1997, and every 30 days thereafter until such regulations are in effect, the chairmen of the appropriate boards shall report in writing to the Commissioner of Professional and Occupational Affairs on the status of the volunteer license regulations, who shall convey the required reports to the Consumer Protection and Professional Licensure Committee and the Public Health and Welfare Committee of the Senate and the Professional Licensure Committee and the Health and Human Services Committee of the House of Representatives.

Section 2270.9. Exemptions.

For the purposes of this chapter, volunteer licensees who are otherwise subject to the provisions of Chapter 7 shall be exempt from the requirements of that chapter with regard to the maintenance of liability insurance coverage. Volunteer licensees holding a license issued by the State Board of Chiropractic shall be exempt from the provisions of section 508 of the act of December 16, 1986 (P.L.1646, No.188), known as the Chiropractic Practice Act.

Section 2270.10. State health centers.

Services of volunteers shall not be substituted for those of Commonwealth employees.

Section 2270.11. Prescription of medication for family members.

(a) General rule.–A holder of a volunteer license who was able to prescribe medication pursuant to the laws of this Commonwealth while a licensee may prescribe medication to any member of his family notwithstanding the family member's ability to pay for that member's own care or whether that member is being treated at an approved clinic.

(b) Liability.–The liability provisions of section 2270.7(a) shall apply to a holder of a volunteer license who prescribes medication to a family member pursuant to this section, whether or not the provisions of section 2270.7(b) have been followed.

(c) Construction.–Nothing in this section shall be construed to allow a volunteer license holder to prescribe medication of a type or in a manner prohibited by the laws of this Commonwealth.

(d) Definition.–As used in this section, the term "family member" means a volunteer license holder's spouse, child, daughter-in-law, son-in-law, mother, father, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, grandparent, grandchild, niece, nephew or cousin.

Section 2270.12. Indemnity and defense for active practitioners.

A health care practitioner who provides health care services at an approved clinic without remuneration under an active nonvolunteer license shall be entitled to indemnity and defense under the terms of whatever liability insurance coverage is maintained by or provided to the practitioner to comply with Chapter 7 in the scope of their regular practice. No health care practitioner may be surcharged or denied coverage for rendering services at an approved clinic. Nothing in this section shall limit a carrier's right to refuse coverage or to adjust premiums on the basis of meritorious claims against the practitioner.

Section 2270.13. Optional liability coverage.

A holder of a volunteer license or an approved clinic acting on behalf of a volunteer licensee who elects to purchase primary insurance to cover services rendered at an approved clinic shall not be obligated to purchase excess coverage through the Medical Care Availability and Reduction of Error (Mcare) Fund.

CHAPTER 11

HEALTH CARE PROVIDER RETENTION PROGRAM

Section 2271. 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 Provider Retention Account established in section 2279.3.

"Applicant." A health care provider that is located in, resides in or practices in this Commonwealth and who applies for an abatement under section 2274.

"Assessment." The assessment imposed under section 2252.1(d).

"Emergency physician." A physician who is certified by the American Board of Emergency Medicine or by the American Osteopathic Board of Emergency Medicine and who is either employed full time by a trauma center or a hospital for the performance of services in the hospital emergency department or is working under an exclusive contract with a trauma center or a hospital for the performance of services in the hospital emergency department.

"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 2251.1.

"Licensing board." Any of the following, as appropriate to the licensee:

(1) State Board of Medicine.

(2) State Board of Osteopathic Medicine.

(3) State Board of Podiatry.

"Program." The Health Care Provider Retention Program established in section 2272.

"Trauma center." A hospital accredited by the Pennsylvania Trauma Systems Foundation as a Level I, Level II or Level III Trauma Center.

Section 2272. 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, 2007 and 2008, 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 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 2274(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 2274(b)(1).

(2) Birth centers shall retain eligibility for abatement pursuant to section 2274(b)(2) for calendar years 2003, 2004, 2005, 2006 and 2007. Commencing in calendar year 2008, birth centers shall be eligible for an abatement pursuant to section 2274(b)(1).

Section 2273. Eligibility.

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

(1) The health care provider's license has been revoked in any state within the ten most recent years or a health care provider has a license revoked during a year in which an abatement was received.

(2) The health care provider's ability, if any, to dispense or prescribe drugs or medication has been revoked in this Commonwealth or any other state within the ten most recent years.

(3) The health care provider has had three or more medical liability claims in the past five most recent years in which a judgment was entered against the health care provider or a settlement was paid on behalf of the health care provider, in an amount equal to or exceeding $500,000 per claim.

(4) The health care provider has been convicted of or has entered a plea of guilty or no contest to an offense which is required to be reported under section 2263(3) or (4) within the ten most recent years.

(5) The health care provider has an unpaid surcharge or assessment under this subarticle.

Section 2274. 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 2273 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 subarticle 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 2252.1(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 2252.1(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.

(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 2275. 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.

(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 2276. Reporting.

(a) Report.–By May 15 of 2004 and 2006, the Insurance Department shall submit a report to the Governor, the chairperson and the minority chairperson of the Banking and Insurance Committee of the Senate and the chairperson and the minority chairperson of the Insurance Committee of the House of Representatives regarding the program. The report shall include all of the following:

(1) The number of health care providers who applied for abatement under the program.

(2) The number of health care providers granted 100% abatement under the program.

(3) The number of health care providers granted 50% abatement under the program.

(4) Based upon available information, the number of health care providers who have left this Commonwealth after receiving abatement under the program.

(5) The number of and reason for any unapproved applications.

(6) Any other information relevant to assessing the success

of the program.

(b) Exception.–The report shall not release information which could reasonably be expected to reveal the individual identity of a health care provider.

Section 2277. Cooperation.

Notwithstanding any law to the contrary, all departments under the jurisdiction of the Governor shall cooperate with the Insurance Department in its administration of the program.

Section 2278. Confidentiality.

Any information submitted by an applicant to the Insurance Department under this chapter shall be confidential by law and privileged and shall not be deemed a public record under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, except that the Insurance Department may release information necessary and proper for administration and processing of specific applications or certificates of retention.

Section 2279. Violations.

The following shall apply:

(1) Any person who willfully submits false or fraudulent information under section 2274 commits a violation of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and shall, upon conviction, be subject to punishment as provided by law. Any penalty imposed for violating 18 Pa.C.S. § 4904 shall be in addition to any penalty imposed in accordance with this chapter.

(2) Any person who willfully divulges or makes known individual specific information submitted under this chapter, permits individual specific information to be seen or examined by any person or prints, publishes or makes known in any manner individual specific information commits a misdemeanor of the third degree and shall, upon conviction, be sentenced to pay a fine not exceeding $2,500 and the costs of prosecution or to undergo imprisonment for not more than one year, or both.

Section 2279.1. Refunds or credits.

The Insurance Department shall either issue refunds or credits for moneys due health care providers under this chapter.

Section 2279.2. Practice clarification.

Notwithstanding any other act to the contrary, health care providers that conduct less than 50% of their health care business or practice within this Commonwealth shall insure their professional liability consistent with the limits established under section 2252.

Section 2279.3. Health Care Provider Retention Account.

(a) Fund established.–There is established within the General Fund a special account to be known as the Health Care 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 2252.1(a) to the account an amount equal to the difference between the amount deposited under section 2252.1(m) and the amount granted as discounts under section 2252.1(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 2274(b).

(c.1) Transfers to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.–Any funds remaining in the account after the Secretary of the Budget makes the transfer under subsection (c) shall be transferred to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.

(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 2279.4. Penalties.

The penalties imposed under this chapter or any other applicable act shall be cumulative.

Section 2279.5. Rules and regulations.

The Insurance Department shall promulgate rules and regulations as necessary to carry out the provisions of this chapter.

Section 2279.6. Expiration.

The Health Care Provider Retention Program established under this chapter shall expire December 31, 2009.

CHAPTER 51

MISCELLANEOUS PROVISIONS

Section 2291. Oversight.

(a) General rule.–The Insurance Department has the authority and shall assume oversight of the Medical Professional Liability Catastrophe Loss Fund established in section 701(d) of the act of October 15, 1975 (P.L.390, No.111), known as the former Health Care Services Malpractice Act. As part of its responsibilities, the department shall do all of the following:

(1) Make all administrative decisions, including staffing requirements, on behalf of that fund.

(2) Approve the adjustment, defense, litigation, settlement or compromise of any claim payable by that fund.

(3) Collect the surcharges imposed in accordance with section 701(e)(1) of the Health Care Services Malpractice Act.

(b) Expiration.–This section shall expire October 1, 2002.

Section 2292. Prior fund.

(a) Administration.–Employees of the Medical Professional Liability Catastrophe Loss Fund on March 20, 2002 shall continue to administer that fund subject to the authority and oversight of the Insurance Department. This subsection shall expire October 1, 2002.

(b) Employees.–If an employee of that fund on March 20, 2002 is subsequently furloughed and the employee held a position not covered by a collective bargaining agreement, the employee shall be given priority consideration for employment to fill vacancies with executive agencies under the Governor's jurisdiction.

Section 2293. Notice.

When the authority has established a Statewide reporting system, the notice shall be transmitted to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

Section 2293.1. Commission on the Mcare Fund.

(a) Declaration of policy.–The General Assembly recognizes that changes in the medical professional liability insurance market have necessitated the need for a plan to address the unfunded liabilities of the Medical Care Availability and Reduction of Error (Mcare) Fund.

(b) Establishment of Commission on the Mcare Fund.–There is established a Commission on the Mcare Fund for the purpose of reviewing and making recommendations regarding appropriate and effective methods to address any future unfunded liabilities of the Mcare Fund.

(1) The commission shall consist of the following members:

(i) The Insurance Commissioner or designee of the Insurance Commissioner, who shall serve as the chairperson of the commission.

(ii) The Secretary of the Budget or designee of the Office of the Budget.

(iii) The Secretary of Revenue or a designee of the Secretary of Revenue.

(iv) Two members appointed by the President pro tempore of the Senate and two members appointed by the Minority Leader of the Senate.

(v) Two members appointed by the Speaker of the House of Representatives and two members appointed by

the Minority Leader of the House of Representatives.

(2) The commission shall establish an advisory committee composed of no more than 15 individuals with expertise in areas including: health care, medical professional liability insurance, the law, finance and actuarial analysis. The members of the advisory committee shall serve without compensation but shall be reimbursed for their actual and necessary expenses for attendance at meetings.

(3) The commission shall undertake a study of the future scope and obligations of the fund and shall submit its report to the Governor and General Assembly by November 15, 2006. The commission shall make recommendations concerning continuation of the Mcare abatement, the elimination or phaseout of the fund and other provisions for providing adequate medical professional liability insurance, including, at a minimum, an evaluation and actuarial analysis of the projected scope of the fund's future unfunded liability and any reasonable and available financing options for retiring those unfunded liabilities.

(4) The commission is authorized to incur expenses deemed necessary to implement this section. Expenses incurred for this purpose shall be paid by the fund.

(5) The commission shall expire November 30, 2006.

Section 2294. (Reserved).

Section 2295. Applicability.

(a) Patient safety discount.–Section 2219.3 shall apply to policies issued or renewed after December 31, 2002.

(b) Actions.–Sections 2234(d)(2), 2235(e), 2238, 2239, 2239.1, 2239.4 and 2239.7 shall apply to causes of action which arise on or after March 20, 2002.

Section 2296. Expiration.

Section 2219.3 shall expire December 31, 2008.

ARTICLE XXV

PREVENTABLE SERIOUS ADVERSE EVENTS

Section 2501. Scope of article.

This article relates to preventable serious adverse events.

Section 2502. Definitions.

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

"Centers for Medicare and Medicaid Services" or "CMS." The Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

"Department." The Insurance Department of the Commonwealth.

"Facility." A health care facility as defined in section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or an entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Health care provider." A health care facility or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, a certified registered nurse practitioner, a physician assistant, a chiropractor, a hospital, an ambulatory surgery center, a nursing home or a birth center.

"Health payor." An individual or entity providing a group health, sickness or accident policy, subscriber contract or program issued or provided by an entity under this act or any of the following:

(1) The act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

(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).

(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

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

"Preventable serious adverse event." A clearly defined condition or negative consequence of care that results in unintended injury or illness that could have been anticipated and prepared for, but that occurs because of an error or other system failure and results in a patient's death, loss of a body part, disability or loss of bodily function lasting more than seven days.

Section 2503. Payment policy for preventable serious adverse events.

(a) General rule.–The following criteria shall be used by health payors in determining when payment or partial payment to a health care provider will be withheld:

(1) A preventable serious adverse event must occur.

(2) The preventable serious adverse event must be within the control of the health care provider.

(3) The preventable serious adverse event must occur in a health care facility.

(b) Language addressing payment policy.–Payments can only be withheld by health payors for services related to a preventable serious adverse event or care made necessary by the preventable serious adverse event if the agreement or contract between the health payor and health care provider contains language addressing payment policy for preventable serious adverse events.

(c) Restriction.–Health care providers shall not seek payment directly from patients or the responsible party of the patient for preventable serious adverse events.

Section 2504. Duties of Department of Public Welfare.

(a) Department responsibilities.–The Department of Public Welfare is responsible for the following:

(1) Determining payment policy under medical assistance with respect to reduced reimbursements to health care providers for preventable serious adverse events. This payment policy includes the criteria and clearly stated payment policies affecting health care providers.

(2) Publishing the payment policy in the Pennsylvania Bulletin following a 30-day public comment period.

(b) Ongoing reviews.–Nothing in this section shall affect ongoing reviews of medical assistance services conducted by the Department of Public Welfare.

(c) Hospital payment policy.–Nothing in this section shall require the department to alter, amend or reissue any payment policy for inpatient hospitals relating to preventable serious adverse events that was promulgated prior to the effective date of this article.

Section 2505. Duties of department.

The department shall annually notify health payors of the list of preventable serious adverse events that CMS is using under the Medicare program and for which health payors shall be permitted to withhold reimbursement under section 2503.

Section 2506. Duties of Department of Health.

In accordance with the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, the Department of Health shall be responsible for investigating patient complaints regarding a health care facility that is seeking payment directly from the patient for a preventable serious adverse event.

Section 2507. Duties of Department of State.

The Department of State shall be responsible for investigating patient complaints regarding a health care provider that is not a health care facility that is seeking payment directly from the patient for a preventable serious adverse event.

Section 2. Repeals are as follows:

(1) The General Assembly declares that the repeal under paragraph (2) is necessary to effectuate the addition of Subarticle A of Article XXII of the act.

(2) The act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, is repealed.

Section 3. Orders and regulations which were issued or promulgated under the former act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, and which are in effect on the effective date of section 2 of this act shall remain applicable and in full force and effect until modified under Subarticle A of Article XXII of the act.

Section 4. This act shall take effect as follows:

(1) The addition of Article XXV of the act shall take effect in 180 days.

(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 Boyd on the amendment.

Mr. BOYD. Thank you, Mr. Speaker.

Mr. Speaker, real briefly, amendment A05967 actually, ultimately, what it would accomplish is extending the Mcare abatement, the current program that is in place to protect and retain physicians in the Commonwealth of Pennsylvania, for an additional year.

Again, Mr. Speaker, the primary concern that many of us had with SB 1137 that passed earlier was that it tied the extension of abatement and Mcare to a program that many of us do not believe the Senate intends to embrace. This gives the members an opportunity to vote for language that would extend the Mcare abatement for another year and give us time, if the Senate sees fit, to work on the issue of health care for all Pennsylvanians.

Thank you, Mr. Speaker.

The SPEAKER. Chairman DeLuca.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, I oppose the Boyd amendment.

Now, let me just say that one of the parts he left out is the fact that he puts all the insurance laws in one piece of legislation in this amendment. There is no way that we could possibly know what is in there, what is not in there, and it is not in the good interest of the people of the Commonwealth to put all those statutes in one place, and that is what this amendment also does. It does not just do the 1-year abatement. It does other things, too.

I ask for a "no" vote on this amendment.

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

The following roll call was recorded:

YEAS–95

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

NAYS–103

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

NOT VOTING–0

EXCUSED–5

Cruz	Geist	Hennessey	True
Dally			

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 as amended?

Mr. **KILLION** offered the following amendment No. **A06112:**

Amend Title, page 1, line 7, by removing the period after "State" and inserting

and for LifeLine health insurance.

Amend Bill, page 1, by inserting between lines 9 and 10

CHAPTER 1
PRELIMINARY PROVISIONS

Amend Sec. 1, page 1, line 10, by striking out "1" and inserting

101

Amend Sec. 1, page 1, line 12, by inserting after "Events"
and Lifeline Health Insurance
Amend Bill, page 1, by inserting between lines 12 and 13
CHAPTER 3
PREVENTABLE SERIOUS ADVERSE EVENTS
Amend Sec. 2, page 1, line 13, by striking out "2" and inserting
301
Amend Sec. 2, page 1, line 14, by striking out "act" and inserting
chapter
Amend Sec. 3, page 3, line 12, by striking out "3" and inserting
302
Amend Sec. 4, page 4, line 2, by striking out "4" and inserting
303
Amend Sec. 4, page 4, line 19, by striking out "ACT" and inserting
chapter
Amend Sec. 5, page 4, line 20, by striking out "5" and inserting
304
Amend Sec. 6, page 4, line 25, by striking out "6" and inserting
305
Amend Sec. 7, page 5, line 2, by striking out "7" and inserting
306
Amend Bill, page 5, by inserting between lines 7 and 8

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.

CHAPTER 52
MISCELLANEOUS PROVISIONS

Amend Sec. 20, page 5, line 8, by striking out "20" and inserting 5201

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

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

The House will be temporarily at ease.

The House will come to order.

AMENDMENT WITHDRAWN

The SPEAKER. The gentleman informs the Chair he is withdrawing that amendment. The Chair thanks the gentleman.

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

The SPEAKER. Is it the intention of Representative Watson to withdraw amendment A06060?

Mrs. WATSON. Yes, Mr. Speaker. Thank you very much.

The SPEAKER. The Chair thanks the lady, and it is the understanding of the Chair that Representative Boyd is withdrawing amendment A06080. The Chair thanks the gentleman.

MOTION TO SUSPEND RULES

The SPEAKER. The gentleman, Representative John Evans, moves that the rules be suspended for the immediate consideration of amendment A06242.

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

The SPEAKER. Will Representative Evans offer a brief description of the amendment?

Mr. J. EVANS. Thank you very much, Mr. Speaker.

Amendment 6242 extends assistance to nonprofit community health-based, health-care providers which primarily serve the underinsured, uninsured, and users of public health-care programs. The measure is designed to get services to where they are most needed, increase access, reduce costs, and give people an opportunity to have a medical home. People who have well-established relationships with their health-care professionals are more likely to get preventive care, avoid complications, and not use the emergency room.

In 2006 community health-care centers based at more than 174 sites across Pennsylvania recorded more than 1.7 million encounters, serving almost half a million people. Almost 129,000 of those people were uninsured. This bill would provide $22 million in annual funding from the Mcare surplus cash flow to support health centers located in underserved areas or who assist underserved populations.

The measure could help bring medical services to more than 55,000 people and to do so as quickly as the funds can be used by the system. We do not have to wait for the creation of a new bureaucracy or for the Federal government to get around to issuing waivers. The bill is intended to encourage creative approaches which address local needs. It is not a one-size-fits-all approach. After year 3 the Department of Health is required to reconfigure the allocation of funds going forward to reflect the assessment of the results of the initial grants and health needs.

The program is intended to aid nurse-managed health centers as well as the federally qualified health clinic look-alikes, clinics which meet all Federal requirements but do not receive direct Federal support as federally qualified health centers.

Mr. Speaker, as a member of the House Republican Health Care Task Force, we took a look at the tremendous success that these centers have had in communities across the Commonwealth, and we believe that with a little more funding, thousands of additional people can benefit immediately. We have more than 42 centers in Pennsylvania with 190 sites in both urban and rural areas. People of all economic levels can obtain primary health services for themselves and their families. These centers provide a full array of day-to-day medical needs and provide services such as adult and family education, pediatrics, gynecological and obstetrical care, health education and prevention services, dental services, pharmacy and behavioral health services. All centers accept public insurance like Medicare or Medicaid as well as private insurance.

By reducing potentially preventable hospitalization and avoidable emergency room visits, these centers have saved millions of dollars both to the Commonwealth and insurance companies, helping keep those costs out of the health-care cycle. We believe that with the addition of more State funding, these centers can expand their services and their hours, thereby treating more patients that would otherwise go to hospital emergency rooms.

This legislation is part of a number of recommendations our task force made in helping to ensure better access and affordability to health care in Pennsylvania. We believe that the most effective, responsible plan is one that takes a look at the root causes of why health care is so expensive and what we can do legislatively to bring those costs down.

I am asking for a suspension of the rules so that we can consider this very important amendment tonight, Mr. Speaker, and would ask for a "yea" vote from my colleagues on both sides of the aisle to get this one onto the floor tonight for an immediate vote. Thank you.

The SPEAKER. The Chair recognizes Chairman DeLuca on the motion to suspend the rules.

Mr. DeLUCA. Thank you, Mr. Speaker.

Mr. Speaker, although this is a good amendment, I certainly have to oppose the suspension of the rules.

I think the concept of the bill is very good. I am going to make a promise here today to work with the sponsor of this amendment to bring his bill out of committee and work along with the Governor's Office to pass his legislation, but today I have to ask our membership not to vote for a suspension of the rules.

The SPEAKER. The Chair will remind the members that this motion is only debatable by the majority leader and minority leader, maker of the motion, and the maker of the amendment under consideration, and the prime sponsor of the bill under consideration.

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

The following roll call was recorded:

YEAS–100

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

NAYS–98

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

NOT VOTING–0

EXCUSED–5

Cruz	Geist	Hennessey	True
Dally			

Less than a majority of the members required by the rules 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 bill on second consideration as amended?

The SPEAKER. The Chair is not aware of any other amendments pending to this legislation.
The Chair recognizes Representative Maher. The gentleman waives off.

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.)

DEMOCRATIC CAUCUS

The SPEAKER. The Chair recognizes Representative McCall.
Mr. McCALL. Thank you, Mr. Speaker.
On scheduling, the Democrats will go immediately to caucus and caucus for approximately 1 hour, until 8 o'clock, and return to the floor at that time.

REPUBLICAN CAUCUS

The SPEAKER. Representative Major.
Miss MAJOR. Thank you, Mr. Speaker.
I, too, would like to announce a Republican caucus immediately at the call of the recess. Thank you.
The SPEAKER. The Chair thanks the lady.

Are there any other announcements?

STATEMENT BY MAJORITY WHIP

Mr. McCALL. Mr. Speaker? Mr. Speaker?
The SPEAKER. Representative McCall.
Mr. McCALL. Under unanimous consent.
The SPEAKER. The gentleman is recognized under the provision of unanimous consent.
Mr. McCALL. Thank you, Mr. Speaker.
Mr. Speaker, unfortunately this evening I cannot be in my district as a good Irishman to celebrate the 61st anniversary of the Panther Valley Irish-American Association. However, the recipient tonight is a very good friend of mine. His name is Shawn Hoben. He is the chief of the fire department. He will be receiving the Shamrock Award, and I wanted to extend, certainly, my congratulations to Shawn Hoben for being the recipient of the very prestigious Shamrock Award tonight by the Panther Valley Irish-American Association.

But more importantly with that congratulation, I also want to offer my thanks to him. As a volunteer fireman, as the chief of the Summit Hill Diligence Fire Department that I am a member of to this day, I want to say thank you to the chief for his volunteerism and certainly his work to really effectively and efficiently run the Summit Hill Fire Department. I wish I could say I could tip a beer with Shawn tonight and the Panther Valley Irish-American Association, but the duties of my job prevent me from doing that. But I certainly wish my best wishes to the association and to Shawn for a successful evening tonight.
Thank you, Mr. Speaker.
The SPEAKER. The Chair thanks the gentleman.

RECESS

The SPEAKER. This House will now stand in recess until 8 p.m.

RECESS EXTENDED

The time of recess was extended until 8:15 p.m.

AFTER RECESS

The time of recess having expired, the House was called to order.

RECESS

The SPEAKER. The Chair announces its intention to recess regular session and go into special session at 8:44.
Regular session is now in recess.

AFTER RECESS

The time of recess having expired, the House was called to order.

The SPEAKER. The House will be at ease.

The House will come to order.

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.
The House will be at ease.

The House will come to order.

SUPPLEMENTAL CALENDAR A

BILL ON SECOND CONSIDERATION

The House proceeded to second consideration of **HB 1845, PN 2516,** entitled:

An Act amending Title 18 (Crimes and Offenses) of the Pennsylvania

Consolidated Statutes, further providing for possession of firearm with altered manufacturer's number and for altering or obliterating marks of identification.

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

Mr. **LEVDANSKY** offered the following amendment No. **A06178:**

Amend Title, page 1, line 3, by striking out "and" and inserting
, for additional duties for the Pennsylvania State Police,
Amend Title, page 1, line 4, by removing the period after "identification" and inserting
, for failure to report a lost or stolen firearm and for penalties.
Amend Sec. 1, page 1, line 7, by striking out "6117" and inserting
6111.1(d)
Amend Sec. 1, page 2, by inserting between lines 4 and 5
§ 6111.1. Pennsylvania State Police.
* * *
(d) Distribution.–The Pennsylvania State Police shall provide, without charge[,]:

(1) summaries of uniform firearm laws and firearm safety brochures pursuant to section 6125 (relating to distribution of uniform firearm laws and firearm safety brochures)[.]; and
(2) notices of limits pursuant to section 6111.6 (relating to notice of limits on lending or transferring a firearm).
* * *
Section 2. Title 18 is amended by adding a section to read:
§ 6111.6. Notice of limits on lending or transferring a firearm.
(a) Duty of Pennsylvania State Police.–It shall be the duty of the Pennsylvania State Police to distribute a notice about lending or transferring a firearm to every licensed firearm dealer in this Commonwealth. The notice shall be written by the Pennsylvania State Police, shall be provided at no cost and shall contain the following:

NOTICE OF LIMITS ON LENDING
OR TRANSFERRING A FIREARM

As the owner of a firearm, you are required to comply with the following legal obligations and restrictions:
(1) You may not lend or give a firearm to any person, except as provided in 18 Pa.C.S. § 6115(b).
(2) You may not sell or transfer a firearm to another person unless the sale or transfer occurs at a licensed dealer or the office of the county sheriff. Limited transfers between certain family members are permissible. See 18 Pa.C.S. § 6111(c).
(3) You must notify law enforcement within three days of discovering that your firearm is lost or stolen. See 18 Pa.C.S. § 6128(a).
(4) You could be held criminally and civilly liable for any crime committed with a firearm you purchase. See 18 Pa.C.S. § 6111(g).
(b) Distribution without charge.–The notice or a copy thereof shall be provided without charge to each purchaser of a firearm.
(c) Duty of firearms dealer.–It shall be the duty of the firearms dealer:
(1) to provide a copy of the notice and to review the text of the notice with the buyer of the firearm; and
(2) to prominently display a copy of the notice where the purchaser of a firearm can read it.
Section 3. Section 6117 of Title 18 is amended to read:
Amend Bill, page 2, by inserting between lines 23 and 24
Section 4. Title 18 is amended by adding a section to read:
§ 6128. Reporting lost or stolen firearms.
(a) Duty defined.–The owner of a firearm, upon discovering that the firearm is lost or stolen, shall report the loss or theft within three days to an appropriate law enforcement official of the municipality in which the loss or theft occurred, or if the municipality does not have a police force, to the Pennsylvania State Police. If the owner of the firearm does not know where the loss or theft occurred, the owner shall report the loss or theft within three days to the municipality where the owner resides or to the Pennsylvania State Police.
(b) Penalties.–If, after an investigation by law enforcement officials, it is determined that a firearm was recovered during a criminal investigation, that the owner of that firearm knew his firearm was lost or stolen and that the owner failed to report the loss or theft of the firearm, that person commits:
(1) A summary offense for a first violation of this section.
(2) A misdemeanor of the first degree for a second offense.
(3) A felony of the third degree for a third or subsequent offense.
Amend Sec. 2, page 2, line 24, by striking out "2" and inserting
5

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

The SPEAKER. The House will be temporarily at ease.

The House will come to order.
The Chair recognizes Representative Levdansky on the amendment.
Mr. LEVDANSKY. Thank you, Mr. Speaker.
Mr. Speaker, every week that the House is in session, we are called upon to make important decisions and difficult choices on very important issues that confront the people in Pennsylvania. Health care, energy, environmental protection, economic development are all extraordinarily important to our Commonwealth, but the vote that we are going to make tonight on this issue, it is different; it is far different. This is an amendment about life and death, life and death. It is about making an effort in the legislature to help stop the human carnage and taking a stand against the violence that is perpetrated by those who traffic in lost and stolen handguns.
Mr. Speaker, what this issue is not about, it is not about restrictions on guns. This amendment does not apply at all, at all, to the owners of rifles and shotguns. So if you are a hunter that just has rifles and shotguns, this issue does not pertain to you at all. What it does do, what it does do, is require two things of those who purchase handguns and those who sell them.
Mr. Speaker, under this amendment, the Pennsylvania State Police, who already, already provide brochures related to the uniform firearm and safety laws, they already provide that information to gun dealers, what amendment A6178 does, it also requires the State Police to distribute a notice about the lending or transferring of a firearm to every licensed firearm dealer in the Commonwealth, and it spells out that the notice shall be written by the State Police and shall be provided to the gun dealers in the Commonwealth at no cost. This notification that the State Police will produce and distribute freely to firearms dealers in the State will remind, remind those who want to purchase handguns that there are already laws on the books regarding such things as giving a firearm to a person or lending a gun to a person. It will remind them that you are not allowed to sell or transfer a firearm to another person unless that transfer occurs at licensed dealers, with certain exceptions. It reminds people that you can be criminally or

civilly liable if someone that you loan or give your gun to commits a crime; you could be held liable. It reminds the purchasers of handguns that there are already these laws on the books that they should follow.

One additional thing is added to the law. Under this amendment, under this amendment, in addition to the required notice that the State Police have to give to firearms dealers, the other thing that happens under this amendment is this: An individual, an individual that owns a handgun and if that gun is ever lost or stolen, it requires the individual that owns the gun to report that the gun is lost or stolen within 72 hours that they find out that the gun has been lost or stolen. So it creates an affirmative duty on the handgun owner that if their gun is lost or stolen, they must report it to the respective law enforcement authorities in their communities.

Mr. Speaker, if they do not, I do not understand at all why somebody would not want— I do not understand how any law-abiding handgun owner would not call the police to report that it is lost or stolen. I do not know why anyone legally owning guns would not report that their gun is lost or stolen. But if the person does not report that their gun is lost or stolen within 72 hours and if the gun is discovered in the course of a criminal investigation, if the gun is lost or stolen, not reported, and if that gun is used in a crime that is being investigated by the law enforcement authorities, that person that failed to report the gun as lost or stolen on the first offense is guilty of a summary offense, a summary offense. If the owner of handguns does this a second time, a second time a gun that they owned and is registered in their name ends up being, you know, discovered in a crime, the second time it is classified as a misdemeanor. On the third violation, and only after the third violation, will it be classified as a felony.

And the reality is, if this is going on multiple times, it is likely pretty obvious what is going on here is the person is engaged in straw purchases, straw purchases whereby people with clean background records – and understand that when you buy a gun in Pennsylvania – handgun, rifle, or shotgun – you have got to go through a criminal background check to make sure that you do not have any offenses that prohibit you from owning such a weapon. What happens is, people that have criminal backgrounds that want handguns, they find some other party to go purchase the gun and give it to them. That is the kind of phenomena and that is the way that people get around the criminal background check.

The criminal background check, when we enacted it into law over 10 years ago, we thought it would help in terms of diminishing the incidence of people who have criminal backgrounds from accessing handguns. Obviously, the criminals have tried to figure out some way to get around that, through straw purchases. This amendment is designed specifically to deal with the issue of straw purchases.

Mr. Speaker, as a gun owner, as a gun owner, yesterday I took my kids to a regulated shooting preserve and we shot some pheasants and chukars, and all day long I was telling my kids and reminding them of the gun safety that I and the NRA (National Rifle Association) hunter safety instructor taught them a couple years ago at the sportsmen's club – safe things like keep your safety on at all times on your gun; secondly, never point the gun in the direction of a human being; thirdly, be aware of your target and that which lies beyond; fourth, clean your gun regularly and store it under lock and key.

Now, we just need the fifth common sense. The fifth commonsense guideline is this: If your handgun is lost or stolen, report it to the police. This is a simple, straightforward measure designed to target the straw purchases that go on in our State and in our Commonwealth. We could do this, Mr. Speaker, by listening to the law enforcement community, to the District Attorneys Association, and the prosecutors, and others. We are convinced that this kind of legislation will make a marked improvement in the amount of violence and in the number of murders that are committed in this Commonwealth with lost and stolen handguns that are illegally purchased through the straw purchase loophole.

Mr. Speaker, I would urge an affirmative vote on the amendment.

The SPEAKER. The Chair recognizes Representative Cherelle Parker.

Miss PARKER. Thank you, Mr. Speaker.

Will the gentleman stand for brief interrogation?

The SPEAKER. The gentleman, Representative Levdansky, indicates he will stand for interrogation. Representative Parker is in order and may proceed.

Miss PARKER. Thank you, Mr. Speaker.

Mr. Speaker, let me just state for the record that although I think you did an outstanding job, I think you were extremely clear and very concise in summarizing the intent and the contents of your amendment, but I want you to be patient with me as I seek to ask you just a few questions for the benefit of the public, those who may be watching along with our members, so I can make sure that I have a very clear understanding of not only the intent of your amendment but actually what it says.

Mr. Speaker, throughout your amendment, the one that is posed in amendment 6178 to HB 1845, I constantly see the term "firearm" referenced, but when I see "firearm" referenced several times throughout the amendment, I want to make sure that you are referencing firearms as it is defined by section 1602, entitled "Definitions," of Title 18, which defines a "firearm" as a pistol or a revolver, a handgun. In other words, not rifles or firearms commonly known to be used by sportsmen or hunters, but those defined as being pistols or revolvers. Is that correct, Mr. Speaker?

Mr. LEVDANSKY. Mr. Speaker, it is section 6102, not 1602. Section 6102 of Title 18 defines "firearms" to be, in this case, a pistol or a revolver. This amendment does not pertain to rifles and shotguns.

Miss PARKER. Okay. Thank you, Mr. Speaker.

That was 6102, and again, this is the definition of "firearms" related to the definition of a pistol and/or revolver. Thank you for that clarity.

Next, Mr. Speaker, you know I often hate to do this, but today I was reading Philly.com, and there was an article in the Inquirer newspaper, Mr. Speaker, and some people were questioned about the actual contents of your amendment, and I want to be clear in stating what this article references, and I quote, "But the majority of our members oppose restrictions on the ability to purchase firearms"; again, "But the majority of our members oppose restrictions on the ability to purchase firearms." Mr. Speaker, this statement is made in response to basically summarizing or trying to measure whether or not members of this body would be supportive of your amendment, but it notes that members oppose restrictions on the ability to purchase firearms, and from my reading of your amendment, Mr. Speaker, your amendment does

nothing to impose or impinge upon an individual's right to purchase firearms. Is that correct, Mr. Speaker?

Mr. LEVDANSKY. Yes. Mr. Speaker, let me make this very clear, nothing in this amendment infringes or impinges on any law-abiding person's ability to buy a rifle, shotgun, revolver, pistol of their choosing. All that this amendment does is to establish that a person that owns a handgun, the person owns a handgun, they have the legal responsibility, the responsibility, under this amendment, to report if that handgun were to become lost or stolen.

Miss PARKER. Thank you, Mr. Speaker.

So next let me just get on to the actual contents of the amendment.

The first thing that your amendment does, Mr. Speaker, is that it directs the Pennsylvania State Police to provide brochures outlining the uniform firearms safety law to all licensed firearms dealers for distribution to anyone who purchases a firearm, which we already do, but your amendment simply adds information to that brochure. Is that correct, Mr. Speaker?

Mr. LEVDANSKY. Yes, Mr. Speaker. Under the amendment, the notification that the brochure, the flyer, that will be created by the State Police, it will remind the prospective handgun purchaser that there are already sections of Title 18, that three different sections of Title 18 already have certain restrictions relative to the transfer of guns from one individual to another, you know, potential liability – you know, if you are guilty and if you do not follow the established chain of command for transferring weapons. The notification simply outlines existing law relative to handguns. It just reminds through the notification that is provided to the gun dealer, it just simply reminds the handgun purchaser that there are certain laws on the books already relative to handguns.

Miss PARKER. Thank you, Mr. Speaker.

Mr. Speaker, the next thing in your amendment that I see that is different from any existing law is that it would require that the State Police give a notice similar to a one-pager to all licensed firearms dealers, an outline in the laws and limits on lending or transferring. Now, much of this is already law, but I just want to make sure that aside from the brochure that the State Police already have in existence, that this new one-pager has a notice given to all licensed firearm dealers that is going to, in turn, be given to anyone who purchases a handgun in Pennsylvania, that that is an addition, Mr. Speaker, something new that is listed in your amendment.

Mr. LEVDANSKY. Yes; yes. It is a—

The SPEAKER. The gentleman will suspend.

PARLIAMENTARY INQUIRY

The SPEAKER. For what purpose does the gentleman, Representative Metcalfe, rise?

Mr. METCALFE. Mr. Speaker, for the last 10 years that I have been here, it has been the tradition of the House that we do not ask questions that we know the answers to. I mean, they are both reading off sheets. I mean, it is very orchestrated. I mean, if they have legitimate questions, can we get on with the debate? I mean, I would ask that the Speaker would rein in this drama that is going on here, Mr. Speaker.

The SPEAKER. The interrogation— The House will come to order. The House will come to order.

Interrogation is the honor system. The Chair will remind all members that if you know the answer to a question, that is not the purpose of interrogation, but the simple reason that someone has notes in front of them is not an indication of that.

Representative Parker.

Miss PARKER. Mr. Speaker, I am sorry if I did something that some members on the other side are not prepared for members on my side of the aisle to do, and that was I studied and I prepared. So forgive me if I did that.

Mr. Speaker, finally, let me ask you whether or not your amendment— And, Mr. Speaker, I think for the right, for the right, my own right as a member of this very honorable and distinguished body, that I have a right, and for the benefit of the individuals who are watching, the gentleman who proffered this amendment had a right to summarize it and tell us exactly what it did when he introduced this amendment, and I as a member who wants to make sure that I, along with my constituents and all residents throughout the Commonwealth of Pennsylvania, understand what that amendment does.

And, Mr. Speaker, if I am in order, may I finish with my questioning on this amendment that I prepared for?

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

Miss PARKER. Thank you, Mr. Speaker.

In addition, Mr. Speaker, let me also state, Mr. Speaker, that one of the things that I noticed that I see in your amendment is that you include reference to a new reporting requirement for lost and stolen guns in the Commonwealth of Pennsylvania, and that requirement establishes – and I want you to correct me if I am wrong – not 24 hours, not 48 hours, but in this amendment in the notice, it makes reference to the 3-day time period established in your amendment, that once an individual discovers – and I just want to make sure I am clear – someone has to discover that their firearm is lost or stolen and then they have 3 days to report it, and you simply include that in your notice. Is that correct, Mr. Speaker?

Mr. LEVDANSKY. Yes. Mr. Speaker, under section 6128, specifically line 29 through line 31, the duty is defined for the firearm: "The owner of a firearm, upon discovering that the firearm is lost or stolen, shall report the loss or theft within three days to an appropriate law enforcement official…." So the individual has 72 hours from the moment that they discover that the gun is lost or stolen to report it to the respective law enforcement authority.

Miss PARKER. Thank you.

The SPEAKER. If the lady will suspend.

The noise level on the floor is entirely too loud. Members will please cease their conversations or take them off the floor. Conversations in the rear of House will break up. The aisles will be cleared.

Miss PARKER. Thank you, Mr. Speaker.

Mr. Speaker, in addition to that, just for the benefit of those, and I have heard this issue from members of both sides of the aisle, that in some cases, Mr. Speaker, there are municipalities that do not have their own local law enforcement in their particular area. If in fact, according to this amendment, there is someone who lives in an area where they do not have a local police force, where in fact are they to report their lost or stolen weapon?

Mr. LEVDANSKY. In many rural communities of the State, there is not a local police department. So in those instances where you do not have a local police department, you would simply report it to the Pennsylvania State Police.

Miss PARKER. Thank you.

Now, Mr. Speaker, this is on the issue that probably is one of the most contentious in the amendment, and I want to make sure that I am really clear about this.

Your amendment establishes that only after an investigation has been conducted by law enforcement and law enforcement determines that a weapon has been recovered during a criminal investigation, and not only that law enforcement has to have conducted an investigation, they have had to decide that this firearm has been recovered during a criminal investigation, but, Mr. Speaker, in order for someone to face penalties associated with this, law enforcement also has to prove that an individual knew his or her firearm was lost or stolen. Is that correct, Mr. Speaker?

Mr. LEVDANSKY. Mr. Speaker, let me answer that. I think I could best answer that question with an example.

If, for example, I was a trapper and I was running my trapline, and I carry a .22 pistol in my back pallet as a sidearm to dispatch sometimes the critter that is in the trap perhaps, if I am running my trapline and if it is a snowy environment and if I were to lose my gun and I did not recognize that I lost my gun – maybe it is the last day that I am out running my trapline this year – if I lose my gun and I do not know it is lost, I certainly then do not report it. If that gun is just lying out in the woods in the snow, and in the spring it thaws and in the fall the leaves cover it up and the gun is never found – it is never found – then it is never used in a crime, and thus, it is never subject to investigation. In those kinds of instances, if an individual absolutely loses their gun, does not realize that they have lost it, and the gun never shows up in the course of a criminal investigation, then none of the penalty provisions of this amendment would apply.

Miss PARKER. Thank you, Mr. Speaker. That concludes my interrogation.

Mr. Speaker, on the amendment.

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

Miss PARKER. Mr. Speaker, first, I need to start by thanking the gentleman from Allegheny County for proffering this very thoughtful and deliberative measure.

I want to note and I just mentioned during my caucus, Mr. Speaker, that, you know, we are familiar with the term that we often hear here in this body, and that is that our people, our constituents, the normal residents of the Commonwealth of Pennsylvania, they do not want to know how the sausage is made here; they only want to know that the sausage tastes good while they are eating their eggs. But in this case, Mr. Speaker, I really do not think that is the case.

I want to make sure that members on both sides of the aisle have a very clear understanding of the language that was used in amendment 6178 to HB 1845 and how it came about. I am not sure if members recognize that the issue of lost and stolen guns has been proffered by law enforcement across the Commonwealth of Pennsylvania consistently for over 4 years, and law enforcement, pro-police, they have asked us to give them the tools, to give them the tools that they need to help to control the flow of illegal handguns that are finding themselves on the streets of regions throughout the Commonwealth of Pennsylvania.

I mean, I heard it mentioned by members during my caucus and earlier today during the press conference, you know, Mr. Speaker, this is not simply a southeastern Pennsylvania issue. Today we had the opportunity to meet with individuals from Allegheny County and the Pittsburgh State Police who talked to us about the very simple excuses that individuals give when they have handguns that happen to turn up during the midst of criminal investigations.

In addition to that, Mr. Speaker, I want to be very specific to those of us who are in this body who consider ourselves supporters of law enforcement across the State, because our vote tonight on the Levdansky amendment, it is going to show. It is going to be a true test as to whether or not we think we know more than those individuals who put their lives on the line, and they are in the line of duty every day and they put their lives on the line to protect and to serve us, and they are law enforcement officials.

And we need to note that the Levdansky amendment, it is a pro-police amendment, Mr. Speaker. Our chiefs of police, I thought we heard that. We did not talk about the police commissioner simply from Philadelphia, but our chiefs of police throughout the Commonwealth of Pennsylvania have supported amendment 6178. They said it is a pro-police amendment, a pro-law-enforcement amendment, and it is what they need to help to curb straw purchases that are used to allow a venue for illegal guns to make their way on the street.

But aside from law enforcement officers, Mr. Speaker – and I hope the members of the body literally do pay attention to what I am about to say – this past Friday, Mr. Speaker, from about 9:30 a.m. until 1 p.m., I had the opportunity to visit our Graterford State prison – Graterford State prison, Mr. Speaker. I was there this past Friday from 9:30 until about 1 or 1:15 visiting with the Prison Society on another issue, and I took this opportunity, Mr. Speaker, to ask the inmates, many of whom are lifers – now, I do not know about you— Yes, Mr. Speaker?

The SPEAKER. The House will come to order.

For what purpose does the gentleman, Representative Thomas, rise?

Mr. THOMAS. Thank you, Mr. Speaker.

Mr. Speaker, she deserves more respect than what we are giving, and all I ask my colleagues on both sides is, let us listen to Representative Parker.

The SPEAKER. The gentleman is correct. The Chair will announce one more time that the noise level is entirely too loud. The lady is entitled to be heard. This is a very serious subject matter. Conferences in the side aisles will break up.

The lady is in order and may proceed.

Miss PARKER. Thank you, Mr. Speaker.

If I may, I want to go back and reference what I had started saying a few moments ago, and that was I referenced a visit that I took this past week on Friday from about 9:30 until 1:30 in the afternoon. I spent those hours at Graterford State prison, and I was meeting with inmates about legislation that I am proffering on another matter.

But while I was there, Mr. Speaker, I thought that the best individuals whom I could ask about whether or not this law would be effective are those individuals who know what it is like to live on the street and be involved in criminal activity on the street, because they are now convicted because of criminal activity that they were involved in. And when I asked the inmates, you know, what would happen, what would happen to crime and criminal culture on the streets of Pennsylvania if we passed a law and we passed a law requiring that lost and stolen guns be reported to the police – this is the question that I asked the inmates, and, Mr. Speaker, I hope that everyone is paying attention to the response that they gave me, because I will be honest with you, when they gave me this response, I had to ask them to repeat it, not two but three times. They said, if you pass a law in Pennsylvania

making it a requirement that any handgun that is lost or stolen, you are going to make it rough and tough to get hot heat on the street.

Now, Mr. Speaker, when I first heard this term, I said, well, you know, I am not a rapper. I said, maybe you need to repeat this for me. They said, if you pass a law, if you pass a law saying that it is mandatory to report lost and stolen handguns in the Commonwealth of Pennsylvania, we will be making it tougher to get hot heat on the street.

Now, for the benefit of the members and the people who are watching, I want to define "hot heat" for you. "Hot," Mr. Speaker, that the inmates were referring to, means stolen; "hot" means stolen. When they were referring to "heat," Mr. Speaker, they were referring to handguns. Inmates in Graterford prison said that if we pass this law, we are going to make it difficult to get hot heat on the streets of Pennsylvania.

I hope we are keeping it in mind, the list of individuals who are in support, Mr. Speaker, of this amendment. First we have said law enforcement. We have already just mentioned criminals. We have mentioned inmates in the State prison.

In addition to that, Mr. Speaker, I want to respond to something that we often hear, and we often hear that, you know, we have laws already on the books that simply need to be enforced. We have laws already on the books that simply need to be enforced. The fact of the matter is, Mr. Speaker, there is no one who can tell us that there is a law in effect that requires the mandatory reporting of lost and stolen firearms in the Commonwealth of Pennsylvania.

Mr. Speaker, I want to also talk to you about how this legislation impacts our pocketbooks. You know, it is really interesting that when we are working on trying to find a way to cover more Pennsylvanians who do not have insurance, who are uninsured or underinsured, we talk about the need to keep the spin level for our State budget at a certain level. But when it comes to trying to implement a commonsense approach like the Levdansky amendment that could possibly keep handguns out of the hands of the criminal element, Mr. Speaker, we do not want to view this as a smart fiscal matter.

The fact of the matter is, the Commonwealth of Pennsylvania spends about $1.6 billion on our corrections budget – $1.6 billion, Mr. Speaker, on our corrections budget. In addition to that, for those of us who paid attention during the Appropriations Committee hearings, we heard that because our prison population is literally bursting by the seams, that there is a possibility that we could build three more, three more prisons, Mr. Speaker, build three more prisons at $200 million apiece, and where do we think we are going to get that money from?

So my message to you, Mr. Speaker, is while the moral issue associated with this is very important—

The SPEAKER. The House will come to order.

The Chair will ask once again for the members to show the speakers the appropriate level of respect. The conferences in the rear of the House and in the side aisles will break up immediately. Members will take their seats. Members will please take their seats. Members will take their seats.

Representative Parker.

Miss PARKER. Thank you, Mr. Speaker.

Mr. Speaker, I think I stopped while I was interrupted during the time when I talked about how violence, Mr. Speaker, how violence that is committed with handguns, handguns that are making themselves into the hands of criminals throughout the Commonwealth of Pennsylvania, and I mentioned not only the moral issues associated with these criminals who end up with handguns and they are committing violence and they are murdering people on the streets of the Commonwealth of Pennsylvania, but the reason why I referenced that element, Mr. Speaker, is I wanted to talk about how this is hurting our pocketbooks with the increasing numbers of our corrections budget – $1.6 billion, Mr. Speaker.

And, Mr. Speaker, I will note that it has been about two or three times that you have asked to have order in this room, but, Mr. Speaker, I have been in this room and I have listened to debate, and when individuals are talking, there are a lot of sidebars, but there is one thing I notice about when a message is being delivered on this floor, and that is sometimes, Mr. Speaker, the truth is painful. It is very painful, Mr. Speaker, and the fact of the matter is, Mr. Speaker, when we left earlier today, Mr. Speaker, in a press conference that we had on this, I had the opportunity to speak to a friend. I spoke to a friend, Mr. Speaker, who actually left the city of Philadelphia, left the city of Philadelphia and moved south, and he is a gaming and a fisheries kind of guy. He is a hunter and he is fishing with his family all the time, and he said to me during that call – I am trying to tell him why this is such a historic day in Philadelphia and why we need to pass this legislation – and he said to me, "Cherelle, you're not thinking about the fact that guns don't kill people, Cherelle." He said, "Our people kill people." And, you know, we have heard that argument time and time and time again, and I told him, "You know what, Robert?" His name is Robert. I said, "Robert, you are a very good friend of mine and I understand your perspective, but the fact of the matter is that I beg to disagree with you." The fact of the matter is that guns do kill people when they get into the hands of the wrong person. Guns do kill people when they get into the hands of the wrong person.

Mr. Speaker, as I close, close out my comments on this amendment and I ask my colleagues for an affirmative vote on amendment 6178, I want to remind members of this body about an article that I received. Mr. Speaker, from the title in the article it says, "…man arrested after police seize 410 weapons at his home" – "…man arrested after police seize 410 weapons at his home."

Now, Mr. Speaker, with a title like this, you quite naturally think that you are going to be talking about Philadelphia or maybe even in Chester, Pennsylvania, but, Mr. Speaker, as I read further into this article, Mr. Speaker, it told the story of a man from Butler County – Butler County, Mr. Speaker. And we do not mean to single out Butler, but I just received this, I just received this in the mail – 410; 410 guns, Mr. Speaker. This is being reported, Mr. Speaker, by the Pittsburgh Post-Gazette that the ATF (Bureau of Alcohol, Tobacco, Firearms and Explosives), the ATF, Mr. Speaker, recovered 410 guns, 410 guns out of the home of a citizen who had the right to purchase firearms, and he purposely sold firearms and handguns to someone who he knew was a convicted felon.

I want to say, Mr. Speaker, that the Levdansky amendment is a commonsense amendment. It was not developed keeping one side's interests in mind. To those members on both sides of the aisle who are members of the Judiciary Committee, I want you to note that we listened to you when we developed this amendment, and to be quite frank, there were those of you on this side of the aisle who, when the lost-and-stolen bill was in the Judiciary Committee, you specifically noted that if this was addressed or that was addressed, this is the commonsense amendment that I could vote for.

Mr. Speaker, the language in this amendment is tight. Even the district attorneys, Mr. Speaker, who are on board with us

100 percent, they have told us – and they are our strongest allies – they have told us, Mr. Speaker, that we, by saying that a person has to have known that their firearm was lost or stolen, they think we have weakened the amendment, Mr. Speaker. But what we have told them we did was not that we have weakened it but that we have listened to the Republicans and we have listened to the Democrats and we listened to organizations outside of our legislative body who said that this amendment is an amendment that they could support, but we needed to make sure that it was not willy-nilly language and that it did not hurt or have any unintended consequences on those individuals who believe and support wholeheartedly in their right to have handguns.

Mr. Speaker, this amendment does not seek to hurt hunters, it does not seek to hurt sportsmen, but it does seek, it does seek to let individuals throughout Pennsylvania know that if you find a way to buy legally a handgun in the Commonwealth of Pennsylvania and if you seek, if you seek to illegally sell that handgun to someone who you know illegally does not have a right, or if your handgun is lost or stolen because you purchased this handgun for your boyfriend who you know legally should not have a firearm, Mr. Speaker, it is a crime, and in the Commonwealth of Pennsylvania, we will not tolerate it.

In conclusion, Mr. Speaker, let me just state this: I want to quickly go through this so we will understand where we are nationally with this debate. We have one, two, three, four, five, six, seven, eight, we have eight States in the United States of America, Mr. Speaker, where there is some form of lost or stolen guns legislation that has either been passed, and in our case in Pennsylvania, it is just being proffered.

I ask my colleagues, particularly those of us who are in southeastern Pennsylvania, because, you know, politically the things that we do and the votes that we have cast here, we know that people pay attention, we know that people pay attention to our votes, and in addition to paying attention to our votes, Mr. Speaker, at some time, you know, there are individuals who want to run against us for public office. They make sure that they monitor our records to see how we vote on particular issues. And I make a plea to members on both sides of the aisle about this issue. I know that our potential opponents who are interested in running for election on April the 22d, they are going to be paying attention to how we vote on this issue. And, Mr. Speaker, I ask people on both sides of the aisle to remember the political ramifications of our vote. Remember that it is the police and law enforcement and our D.A.s that are telling us that this is the bill that they need, and this will help them get lost and stolen guns off the street. Mr. Speaker, I thank you.

The SPEAKER. Representative Vereb.

Mr. VEREB. Thank you, Mr. Speaker.

Would the maker of the amendment please rise for a brief interrogation?

The SPEAKER. The gentleman, Representative Levdansky, indicates he will stand for interrogation. Representative Vereb is in order and may proceed.

Mr. VEREB. Thank you.

Mr. Speaker, the new language in 6128(b) would only impose penalties for failure to report a lost or stolen firearm if the firearm, quote, "was recovered during a criminal investigation," end quote. Can you elaborate as to what that means, please?

Mr. LEVDANSKY. Mr. Speaker, what it means is pretty much what it says, if it is determined that the firearm was recovered during a criminal investigation. So there has to be a criminal investigation where the law enforcement authorities are investigating a crime that has occurred. So if they find, if that gun turns up as part of that investigation and if the person to whom that gun was purchased, if the person that purchased the gun is not the person subject to the investigation, then obviously they had a duty to report. If they did not, if they did not report the gun as lost or stolen and only if the gun is discovered and recovered during the course of a criminal investigation, then and only then does the penalty section of this amendment take effect.

Mr. VEREB. Okay. While the question seems obvious to you and to me, there is a lot of lack of definition in this building with criminal investigation, with law enforcement agency, and I guess my point to you is, on a motor vehicle stop, which is not a criminal investigation, and a concealed firearm on a driver, perhaps they show that they have a permit to carry a weapon. That is not a criminal investigation. If in fact it turns out that that gun is stolen, we can get that individual with receiving stolen property. But how does that affect at the time, being that it was not a criminal investigation, how does that affect the gun owner, if they knew it was missing?

Mr. LEVDANSKY. Mr. Speaker, if it is not a criminal investigation – and you are a law enforcement person by background, so I will defer to your judgment on what constitutes a criminal investigation – but if it is not a criminal investigation and the gun turns up, then under this amendment, then it is not subject to the penalty provision of the amendment.

Mr. VEREB. Okay. So if we had a matter which law enforcement – I will use a more specific word just so you and I can get through the logistics of this, because I think while it is important legislation and I empathize with the previous speaker's passion and certainly want to try to support it in any way I can – but let us just say police officer, one bearing a badge and uniform, conducting a routine call to the report of a violation of a protection-from-abuse order. In that matter, a protection-from-abuse order is recognized, to the best of my knowledge, as a civil matter. If a firearm turns up in that type of incident, is the maker of the amendment suggesting that at that point, that type of an incident would be a criminal investigation, if it is looking into a civil matter of a PFA, which obviously the police department has a lot of oversight on?

Mr. LEVDANSKY. Mr. Speaker, I do not know what the definitions in law or in practice are for what constitutes a criminal investigation, but I am sure that the prosecutors, the district attorneys, and the law enforcement community understands what is a criminal investigation. If it is a criminal investigation and the gun turns up and it was not reported lost or stolen, then it is subject to the penalty provision. If it is recovered and it is not a criminal investigation, it is a scenario that I described earlier where somebody running a trapline or somebody is out hunting and they drop their gun somewhere in the woods and it is never found and it is never used in a crime, thus it is never subject to an investigation, then these penalty provisions would not apply.

Mr. VEREB. Can you think of a scenario where it would not be a criminal investigation? I guess my question to you, while it seems leading, anytime a police officer is involved in a situation, we will go with the ratio of about 98 percent of the time it is a criminal investigation. Even if the police officer is on a beat walking down the street and sees the firearm you are speaking about out in the woods, sees it in the front yard of a large property, that immediately becomes a criminal investigation. So can you

think of a scenario where a police officer being involved with a firearm issue, that it would not be a criminal investigation?

Mr. LEVDANSKY. Mr. Speaker, I do not want to try to hypothesize a potential scenario to try to differentiate what is a criminal investigation and what is not a criminal investigation. I mean, I would just rather leave that up to the law enforcement community and the prosecutors to make that judgment, based on past practice and based on what is already in State statutes.

Mr. VEREB. In order to convict a person of a violation of either 6128(a) or (b), the prosecution must prove that the owner of that firearm knew his or her firearm was lost or stolen. Any idea of what evidence would need to be present to prove that type of a case?

Mr. LEVDANSKY. I am sorry, Mr. Speaker. I could not hear your question. Could you repeat it, please?

Mr. VEREB. To be honest with you, I could not hear you either. Mr. Speaker, if we could have a little bit of order in the House, it would be great.

The SPEAKER. The House will come to order.

Mr. VEREB. Thank you, Mr. Speaker.

I will summarize with this question. What needs to take you beyond a reasonable doubt? In a criminal arrest, you need to have probable cause. And what takes us to that level to prove that an owner knew his or her firearm was lost or stolen? What evidence is necessary to prove that?

Mr. LEVDANSKY. Mr. Speaker, it would have to be an investigation being conducted by the police. If it is an investigation, the gun turns up in a course of discovery on an investigation, then it is subject to these penalties. Let me also point out – I do not know if this will help you – (b) subsection (1), line 44. For the first violation, it is a summary offense. So if a gun is discovered in the course of an investigation and if the person did not report it as lost or stolen on the first violation, it is a summary offense.

What that does, Mr. Speaker, essentially, the law enforcement officer has the discretion whether or not to cite an individual for a summary offense. For example, if you are driving down the turnpike at 75 or 80 miles an hour and you are pulled over by the State Police, the officer has the ability to decide whether or not to give you a ticket for speeding or to write you up a warning. He has that discretion on summary offenses. Likewise, under this provision, if the police officer finds a gun in somebody's garbage can or on their front porch, under a chair or something, he or she, and it is a first offense, he or she has that discretion to either cite the individual or to give them a warning. That is on the first offense. So I think it makes sense on where people could make a mistake. You give the law enforcement community the discretion to decide whether it was an honest mistake or whether it was, in fact, a violation. So we give the law enforcement community that latitude to make that discretion on summary offenses. But clearly, if this happens a second time and a third time, then there seems to be a pattern, a pattern of neglect and a pattern of not reporting your lost or stolen guns, and then it would be either a misdemeanor for the second offense or a felony on the third.

Mr. VEREB. Thank you, Mr. Speaker.

As a follow-up to the scenario which you put out there, which I think we are trying to get away from but here we are with a scenario, how do we know if it is the first or second offense? On a summary, let us just say the scenario of a summary arises. How do we know that that is the first summary and not the second and/or the third?

Mr. LEVDANSKY. I do not know. How do we know that existing laws that are summaries, what do we do for existing laws that are summaries or first offenses? How would we know if it is the second one? Forget guns; forget gun laws. Okay? How do we know that it is not the second or third violation on other summaries?

Mr. Speaker, I have been advised that there are some crimes – for example, shoplifting is a misdemeanor. If you are convicted of a misdemeanor of shoplifting, it is a part of your record. It is on record at the county clerk of courts. So those kinds of violations obviously can be tracked.

Mr. VEREB. You are absolutely correct, and the gentleman from Montgomery County is correct that misdemeanors are a part of your criminal record, summaries are not. So my question again, if you could try to answer it without putting the question back on me because I really want to find out, it is going to be very important to know, especially for an officer on the street. If you are guilty, if you are charged with a motor vehicle violation by that same State trooper going down the same turnpike and you receive a citation and you receive points, ultimately when you are found guilty by the court, that becomes part of your driving record. That becomes information in which the State Police can track by your driving record. However, to the best of my knowledge, and maybe with all the attorneys in the room we can clarify, a summary offense is not part of a criminal record, and I am just trying to find out how we track, is there a mechanism in place to how we track the person when they are caught the second time?

Mr. LEVDANSKY. Mr. Speaker, I have been advised that in any circumstance where a summary offense, that additional violations beyond the initial summary, where it can be graded, that those summary offenses are, in fact, recorded in the court system as well. So if it is a summary that could lead to higher grading of crimes, my understanding is the court system records that information for future use.

Mr. VEREB. You are correct. Every action, obviously, that goes on a summary, misdemeanor, or felony level through the court system is recorded in a clerk of courts, but it is not recorded on the individual's criminal record, which is what the police run. The police, when they detain someone, do not go county by county searching records. In our retail theft, which I have not used in quite some time to charge against someone, but if I recall correctly, there is elevated grading on retail theft, and one way that that was tracked was via the fingerprint process. And I am wondering if something— That is the kind of mechanism I am looking for in your amendment. Is there something like that that tracks it? Every time a police officer signs a citation, of course it is on record. Of course it is on record. Unless that trooper happens to let you have a great day and proceed on this St. Paddy's Day home and continue down the turnpike, if he or she writes you a citation, it is part of your driving record but it is also part of the municipal court process.

So is there a mechanism in this bill— I really hope that that mechanism is in place so that the police officers that everyone here so gratefully has thrown their names around with today, in a good way, what will they have on the street or shortly thereafter when they deal with this offense to find out, is it the first or is it the second offense, because obviously, I believe what you are saying to me is a second offense then goes to a misdemeanor?

Mr. LEVDANSKY. Mr. Speaker, I do not create any new grading statutes. I do not put any new reporting requirements in this amendment. Whatever the existing statutory construction is in place today relative to summary offenses, be they summary offenses outside of guns, it is the same statutory construction that we are applying here. We are not creating a new reporting system for summary offenses for lost and stolen guns.

Mr. VEREB. I actually, unless we have a mechanism which defines a second summary offense, I actually think we are. You can be arrested a dozen times for disorderly conduct, and it never increases necessarily in crime and penalty. There is no tracking of it. You can go to every district justice in the Commonwealth and be cited for disorderly conduct and the other district courts will only know if they searched their own system, and that grading does not necessarily affect how many disorderly conducts you have.

So the question becomes, in this offense, obviously your intent, and please correct me if I am wrong, but your intent is to say, hey, if we have an uh-oh, it is a summary. When we get beyond the uh-oh and we go to a second offense, it is going to be a misdemeanor. And I happen to, I understand— I think I understand what you are trying to do. It just goes back to the underlying question, and I have the section for fingerprinting, which I do not want to sit here and read and take up the time, our valuable time this evening. It is the first Monday night we have worked this late in quite some time. I do not want to take up that time to go over the fingerprint section for retail theft, but can somebody help us out and say what will that mechanism be that will let that person know, because let us face it, if it is a second offense, that officer with a misdemeanor can detain the individual on this. So we want to make sure that those tools are in place for all the law enforcement agencies that are backing us. Is that mechanism in place?

Mr. LEVDANSKY. Mr. Speaker, you are correct. Where there is a summary offense, where multiple violations of that same summary offense occur and there is not the grading, then those records may not be retained at the court level. But where you have a summary offense where a second violation creates a misdemeanor and a third violation creates a felony offense, those records are retained.

And most likely, when you are going to report a lost or stolen gun, it is probably because someone has broken into your car or they have broken into your home. So you are reporting it, and there is a police report that is obviously written up at the same time.

So there is a record of that summary offense if you do not report it for the first violation of lost and stolen.

Mr. VEREB. Mr. Speaker, I know what you are trying to say, but I want to try to just say this. You are not answering my question. I know you are not trying to not answer on purpose. Let me just— It has been a while; 1996, I recall, is the time I hung up my hat. But I do not think in this area, these sliding grades have changed dramatically over the years. A police report from a neighboring department, you are right, that could serve as probable cause to, in fact, show that a previous run-in with this individual has occurred.

But in most cases, in most cases, when we look at the people we are really targeting, let us make something clear here, I believe in your legislation we are not really trying to target ma and pa. We are trying to target criminals. We are trying to target people who want to stretch our current gun laws to task. They are all over the Commonwealth. They are moving. They are never in the same neighborhood, necessarily. I want to know what mechanism the beat cop down at Broad and Lehigh is going to have when he runs into a person on that second offense. I want to know what mechanism is going to be in place so that that officer can take the action necessary, because, in fact, we know from history, an officer fails to detain someone they should have detained and the media gets a hold of it, and that person commits a further heinous act upon completion of interaction with that officer, then that officer is going to become the target of scrutiny. So if we do not have a mechanism, let us get— I mean, suspend the House rules, do what we have to do to put a mechanism in that is actually going to officially, not through word of mouth from neighboring departments, it is going to officially put that officer on notice that, in fact, this is not the first offense for that person.

Mr. LEVDANSKY. Mr. Speaker, this amendment does not create any new recordkeeping requirement for summary offenses. Okay? Obviously if a summary can be upgraded with second and third violations, as I said before, those records have to be retained. If you do not think that the existing reporting system, data gathering, information collecting system, if you do not think that it is effective, and I have not heard that from the law enforcement community, but if you think that that is the case, then you are always free at some point to try to include that. If you think that this is deficient, if you think the existing system is deficient without this amendment, then you are free to try to change that. But I am not prescribing that we do anything different in terms of reporting and keeping the information. The District Attorneys Association has not found that to be a problem in the context of this amendment either.

Mr. VEREB. I actually have been told by a few people that we need some clarification on whether or not the D.A.s Association is in fact on board with this bill. But I want to get back to what you are saying. I actually think for retail theft, I actually think this system works. I think we should have, if we could have maybe worked together a little bit more, we could have simply taken a mechanism that works for other sliding grading and put it in place with this amendment. That is all my point is. I am not suggesting the current system does not work. I think the current system does work, and I do think there are a lot of technologies involved that are going to help police. I do think they are there. But I just simply think in the situation, you know, later tonight when we are done, maybe look at the retail theft section, and then you can come to me tomorrow and say, now I know what you were saying. Maybe I will just move on to the next question, because we are misunderstanding each other, I believe, and then maybe we can look at this thing going forward, but I just think if this mechanism would have been in place to therefore generate a criminal record on that offense by virtue of fingerprints, having fingerprints on file, which then is an official record for police to search statewide, or nationally for that matter, on the summary offense.

The question is, the 3-day issue, number one, when does the clock start? But why did you say 3 days and maybe not 1 day? Was that just to give a window to make sure that it was stolen?

Mr. LEVDANSKY. Mr. Speaker, I think the 72-hour window is pretty generous. I mean, you know, if your gun is lost or stolen, we wanted to make it so that within 72 hours, we did not want to be overly restrictive. I think 72 hours is more than enough time. You know, I do not know exactly what the insurance code requires, but I have been informed that automobile insurance policies typically require within a certain timeframe if someone has stolen your car.

You are not going to lose your car, but if your car is stolen, insurance policies typically require within a 48- or 72-hour period that you have to report it if you want to claim that on your insurance. So I think the 72-hour period is more than enough time for an individual to report that their handgun is either lost or stolen.

Mr. VEREB. On the line of insurance, you bring up a good point. Do you know by chance if there is an obligation with insurance on homeowners? I know there is an obligation with weather damage and other types of physical damage at home, but do you know – and I do not know the answer to this question – do you know if there is an obligation under most insurance companies in Pennsylvania to report anything that was knowingly lost or stolen from your home?

Mr. LEVDANSKY. I do not know what the insurance law is. Perhaps Representative DeLuca or Representative Micozzie, who are the chairmen of the Insurance Committees, are far well versed on what insurance law and, typically, insurance policies require relative to notification.

Mr. VEREB. Just a couple more, Mr. Speaker. Thank you for your cooperation.

Your gun-in-the-woods scenario, I think it was a little bit louder than it is in here now, but run through that scenario again. I understand you are hunting, you are in the woods. You are on maybe a friend's property or your property, you drop the gun, you leave, it snows, it gets hot, it gets cold. You come back, the gun is there a year later, it was not used for a crime. Was that the scenario you had put— I do not want to put words in your mouth. I could not hear you. The scenario with the gun in the woods, can you repeat that for me, just so I can understand?

Mr. LEVDANSKY. Mr. Speaker, the point that I was making is, if you are out running a trapline, and trappers typically carry a .22 along with them, if in the course of running your trapline you lose your pistol, you lose it and you do not realize it until later, first off, all you have to do is comply with the law and call the State Police and say, I lost my .22 somewhere out on my trapline; I do not know where. But if you do not realize that you lost it, say just for a hypothetical case it is the last day of trapping season, it is your last day on your trapline and you lose your .22 pistol and you do not realize it until a year later, as long as that pistol was never used in a crime that was investigated, you would still not be subject to the penalty provisions of the law. You know, we are trying to craft language that takes in every reasonable mistake that a person could make, but at the same time, we want to pass something that is effective in terms of cutting down on straw purchases.

Mr. VEREB. Okay. So your point is then, certainly the gun owner would know, obviously, it was lost, so they would probably have an obligation to report that, and if not, potentially be guilty of a summary offense in that scenario.

Mr. LEVDANSKY. I think under any circumstance, if you lose a gun, I do not care if it is a rifle, a shotgun, a handgun, a pistol, it would be common sense, it would be common sense that you ought to report it. Why would you not, if you are a law-abiding citizen, why would you not call the law enforcement community to inform them that your gun is lost or stolen? I would be concerned that somebody found it and it is going to be used to cause somebody harm. I would want to report it. Why would somebody not, why would any law-abiding citizen not— Who could find it to be difficult to simply make a phone call? It would take you 60 seconds to make a phone call to report that your gun is lost or stolen. I do not know why any hunter, trapper, gun enthusiast, would find this at all to be problematic. I do not think that they would.

Mr. VEREB. Now, Mr. Speaker, and I am not suggesting that they should not, and I agree with you that common sense should prevail, and when common sense loses goals, I guess we do legislation. I happen to agree that the average person, you would think when they lose something as serious as a weapon of any kind, that they would report that. I happen to agree with you on that.

In this legislation, obviously I have been very active in the whole gaming issue here in Pennsylvania, and I have learned that there are many different definitions of law enforcement agency and many different interpretations. Could you just clarify for me what a law enforcement agency is, just in Pennsylvania, in terms of who has the enforcement powers of this amendment?

Mr. LEVDANSKY. Mr. Speaker, for the purposes of this amendment, your responsibility to report that your handgun is lost or stolen, for those purposes, the law enforcement community is either your local police department or the Pennsylvania State Police.

Mr. VEREB. Okay. So it would not be BIE (Bureau of Investigations and Enforcement) under the control of the Gaming Board then?

Mr. LEVDANSKY. Correct. No.

Mr. VEREB. Are they a law enforcement agency?

Mr. LEVDANSKY. Mr. Speaker, let me read from chapter 61 of Title 18 the definition of "law enforcement officer" to answer your question. A "law enforcement officer" is "Any person employed by any police department or organization of the Commonwealth or political subdivision thereof who is empowered to effect an arrest with or without warrant and who is authorized to carry a firearm in the performance of that person's duties."

Mr. VEREB. I happen to agree with that definition. Maybe our Gaming Control Board will agree since you just read that verbatim. So basically, anyone with arrest powers can enforce this amendment, this bill. Thank you for reading that.

One more, one and a half more questions. I missed your explanation as how— I agree that someone who knowingly had a gun stolen should be a little bit more responsible and attempt to report it, and there is also the other side that people do not know necessarily when it is stolen. But how does this amendment, how does it really impact straw purchasers? Whom does it impact? Does it impact the gun user? Whom does it impact in the straw purchase processes we have talked about here?

Mr. LEVDANSKY. What it does, Mr. Speaker, is this: When a person who wants to buy a handgun goes into the firearms store, first off there is a notice. You know, like when you go to buy cigarettes in a retail store, there is a posting saying you must be 18 in order to purchase cigarettes. Well, there will be a notice there reminding people that there are existing laws relative to the transfer of weapons, the ownership of weapons, and things like that. So there will be the official notice up front. And then, since the State Police already provide a brochure to the gun dealers regarding the uniform firearm safety law, and they worked with the Game Commission to devise that brochure, this just requires the State Police to put out a little flier or a little brochure, if you will, to notify the prospective handgun purchaser of all the existing laws regarding handguns, including this new requirement to report lost and stolen.

We believe, the law enforcement community believes, that when a person then knows, they have been informed on what the laws are regarding lost and stolen, transferring weapons, possession, the other statutes in place, the belief is, is that when the person who wants to buy the handgun is made aware, they will be less likely to engage in unlawful conduct. If they do, then clearly they must report the handgun as lost and stolen. It is designed to cut down the ability of people to make alibis and excuses when in incidents where straw purchases are clearly going on, clearly going on, and the person engaged in the straw purchases just comes up with the alibi, well, you know, I did not know, I guess someone stole it from me, or I lost it and I did not know.

Mr. VEREB. Okay. So this amendment, clearly with the notification, if everything goes right, the top person in the straw purchase scheme, which to my knowledge, the State Police have not been statistically tracking over the years so it is kind of hard to get a gauge on it, but we know it is obviously going on and we know that it is a problem. You are telling me that we are going to market the legislation that exists as well as this legislation. We are going to market that at the retail level so that the person who is at the top of the row is notified right up front of all legislation that could affect his lawful and/or unlawful use, sale of that weapon?

Mr. LEVDANSKY. Mr. Speaker, I would not refer to it as marketing. I would simply say that under this amendment, the firearm dealers will have a duty to inform their customers by handing them a brochure, that the customer then has been informed that there are existing statutes in place regarding ownership of handguns, regarding transfer of weapons, and regarding this new requirement to report lost and stolen. I would call this more public education and public information, rather than marketing. You know, so that an individual then will be made aware, when they buy a handgun, they will then know, they will then know that they have a duty to report it as lost and stolen if it is in fact lost and stolen.

Mr. VEREB. I am sorry to use the word, soft word as "market" in such a serious matter, but my point was the first point of notification is going to be in the retail level to that person; say, the person at the top of the tier.

Now, when a person, a straw purchaser, has weapons and is going to sell them, when they sell them illegally, they violate current law, correct?

Mr. LEVDANSKY. I think you answered your own question. You said they sell them illegally. I guess if you sell something illegally, that is a violation of law.

Mr. VEREB. No, no. My point in question, does it violate current law, was the end of that. If you listened to the whole question, it was if a person offloads a gun illegally, is it violating current, on-the-books gun law?

Mr. LEVDANSKY. Mr. Speaker, the notification, the notification booklet that will be provided to the dealer, that the dealer will give to the handgun purchaser, will remind the purchaser of a handgun that they cannot lend or give a firearm to any person except as provided under Title 18, section 6115. It will also include information to remind the handgun purchaser that they may not sell or transfer a firearm to another person unless that sale or transfer occurs at a licensed dealer. And that is existing law. And they will also in this notification inform the handgun purchaser that under existing law, not new law, under existing law, a handgun purchaser could be held criminally or civilly liable for any crime committed with a firearm under Title 18, section 6111, subsection (g). We simply cite those existing provisions and existing laws to remind prospective handgun owners that there already are these statutes on the books that regulate the purchase of handguns.

Mr. VEREB. Unfortunately, some of these interrogations at times become trickery. That is certainly not what I am trying to do. My point was, and you answered my question, it is existing law, no matter – it is existing law that is going to take care of that transfer being legal or illegal. That was my question to you. It is existing law that takes care of that person once they get the load of firearms and go to sell them. I hate to use terms of, say, like the underground market, the black market, the alley market, whatever the market could be called, but it is existing law that would address that transaction, correct?

Mr. LEVDANSKY. Mr. Speaker, to be honest with you, I know I am having trouble hearing anyhow, but I am really having difficulty hearing your questions on the floor. Again, if you just, you know, let me just say it this way. Just look on page 2 of the amendment, from line 3 through line 15, and that outlines the three sections of existing statutes in Title 18 relative to guns. Three of those, points No. (1), (2), and (4) cite already existing law, and the only new thing that is created with this amendment is point No. (3) on line 10, that you must notify law enforcement within 3 days of discovering that your gun, that your firearm, your handgun, is lost or stolen. That is the only new section of law created in this subsection.

Mr. VEREB. It is a little quieter now, so maybe we will be successful. The person – I know you are reading, and I have read along most of it with you – but a person buys weapons legally, goes into a gun store and buys a number of handguns – let us just say six of them, four of them – let us just say four weapons and leaves, and over a period of a week or two, goes into the dark market of illegally transferring a gun, knowing in his or her mind, it is like the old days of the cloned cell phones. You know you are getting a cloned phone, or you know that you are getting a phone that was acquired inappropriately. That transaction between the person that left the retail store, the transaction between that person and the person buying the firearm, are they or are they not violating current, current gun law?

Mr. LEVDANSKY. Mr. Speaker, under current gun law, you can only transfer a weapon to another person in the presence of, at a licensed firearm dealer. There are some exceptions for that; you are transferring it to a spouse, I believe, and between parents and kids and grandparents and grandkids. Other than that, you have got to, if you want to sell your gun to somebody, you have got to go to a licensed firearm dealer to effectuate that transfer. So that is existing law, so you cannot break that. If you do not do that, then you are already breaking existing law.

Mr. VEREB. We got there. That is exactly where I wanted to go. We are violating existing law, you agree, and we also will agree that the chance of a person with a Federal firearm license or a firearms dealer is not going to be out in the street transferring guns out of a trunk of a car, my point being, once that gun is physically just handed over and money is exchanged, in your opinion, with this legislation what is the status of that handgun?

Mr. LEVDANSKY. Mr. Speaker, let me try to understand your question. You are asking, what is the status of a gun where a person lawfully purchased it but then illegally transferred it to somebody else? Is that the question?

Mr. VEREB. Lawfully purchased, and I do not want to use the word "transfer" because transfer is really the legal way, legal

transfer. Let us use the words handed over and sold in violation of current gun law. What is the status of that firearm in a Crimes Code? What is the status of that gun?

Mr. LEVDANSKY. Well, that is an illegal transfer. You are not allowed to knowingly sell or transfer a gun to somebody else with the exceptions being a spouse or your kids. You have got to do it through a firearms dealer. If you do not do it through a firearms dealer, you are violating existing statute. Now, understand this: If you do it the first time, if you do not report it the first time, it is a summary. If you do it the second time, it is a misdemeanor. If you do it the third time, then it is a felony, and now you are not allowed to buy handguns anymore. So you could get away with this once or maybe twice, but by the third time, it is a felony. You get that third time that you are found to have not reported your handgun lost or stolen, that third violation triggers a felony, and unless staff corrects me, my understanding is that is a prohibited offense and then you are not allowed to purchase a handgun from that day forward.

Mr. VEREB. Mr. Speaker, thank you again for the explanation. I tend to agree with a lot of what you have said. The question is, what is the status of that gun that was bought on the street without a transfer? What is that gun classified as at that very point? It is an illegally transferred gun, we agree on that. We agree the store had all the notifications. We agree your legislation is law. We agree that the placard is up at the store, the brochure is given out. The person buys a gun or guns, goes out; we agree that handing that gun over for money of any kind without the appropriate licensed person there to do so, we agree that that is illegal. Am I correct so far? Do we agree on all that so far?

I just want to make sure we agree up to that point.

Mr. LEVDANSKY. I am doing my best to follow you. I am not saying I agree with you, but go ahead. I will wait till you finish.

Mr. VEREB. Okay. Well, it is the ending part where, I think we are all the way up to the ending part, where I think we are running into an issue. A person goes into the store, the proper markings are up, the proper handouts are given to the person purchasing a firearm covered and defined under your amendment. I will not even pick a brand or model. That weapon that the person is buying at a store is properly marketed, proper handout coming out; it is a weapon that is in your bill. And I get that gun or the person buys that gun, has all the little, you know, the packets of information that we talked about, and they go out of the store, and they transfer that gun, as, again, I hate to use the word "transfer" because we believe transfer is the lawful way to deal with moving a gun around, but the gun is not legally transferred, and we agree that that violates current law. At least I think we agree.

My point is, we have a gun. It is not being used in a crime yet, which we could probably agree also that it is going to be. But we have a gun. What is the status of that gun?

Mr. LEVDANSKY. Mr. Speaker, it is an illegally transferred gun, and until it is used in a crime, until it is used in a crime, it is an illegally transferred gun until it is used in a crime. Then it becomes a piece of evidence for which somebody could be charged and prosecuted.

Mr. VEREB. And I agree. The point I was trying to get at is, at that point, you know, my opinion could be different, but do you feel that at that point that gun is a lost or stolen gun?

Mr. LEVDANSKY. No.

Mr. VEREB. Thank you, Mr. Speaker. Thank you for your answers.

The SPEAKER. Representative Williams.

Mr. WILLIAMS. Mr. Speaker, may I interrogate the maker of the amendment?

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

Mr. WILLIAMS. Mr. Speaker, in your opinion, how does reporting lost and stolen guns help our local law enforcement around the State?

Mr. LEVDANSKY. Mr. Speaker, what it does is puts an affirmative duty on a handgun owner to report that their gun is lost and stolen. If they do not, if they do not, then there is the grading of the offenses. And eventually, if after the third offense it is a felony, obviously then those people are – it is just not an accident that you lose three handguns or you claim to have three handguns stolen and not report them. What it is designed to do is to cut down on the incidence of straw purchases. So we discourage people who engage in the practice of straw purchasing. We make that essentially, because we require them to report lost and stolen, it is targeted to the offense of straw purchasing whereby people with clean records buy guns and then transfer them to people that have criminal records.

Mr. WILLIAMS. Okay. Thank you, Mr. Speaker.

May I speak on the bill?

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

Mr. WILLIAMS. On the amendment; I am sorry. On the amendment.

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

Mr. WILLIAMS. Thank you.

Mr. Speaker, all over the Commonwealth of Pennsylvania we see, we hear, over 84 percent of the crimes that are being committed in Pennsylvania are being committed by people with lost guns who failed to report lost or stolen guns, and we find these guns to be a part of criminal activity. Mr. Speaker, all we are trying to do is to save counties, neighborhoods, and communities across Pennsylvania. You will hear a lot of debate, you will hear a lot of speeches, and you will hear a lot of people against this bill. In Philadelphia and York and Reading, Mr. Speaker, people are dying, and all we hear is that this is a Philadelphia issue.

So I urge all of you from both sides of the aisle, because this day is going to be a long day for the House of Representatives, and for a long time you are going to be hearing about the issue of trying to report lost or stolen guns and getting bills and amendments passed, so I urge everybody from both sides of the aisle to support the Levdansky amendment.

Mr. Speaker, thank you very much.

The SPEAKER. Representative Denlinger. The gentleman waives off.

Representative Manderino.

Ms. MANDERINO. Thank you, Mr. Speaker.

I rise in support of the Levdansky amendment, and I want to make a couple of points of issues that we have heard already and are likely to hear through the remainder of the discussion on this amendment. Whenever you talk about legislation designed to stem some of the root causes and some of the outcomes or the natural consequences of the gun violence, folks say this should not be about law-abiding citizens. This is about criminals and we have enough laws on the books to deal with criminals. But the reality of it is, is that is just not true when it comes to the issues of straw purchasers, because let us be honest, the definition of a straw purchaser is a person who legally has no impediment to

buying handguns legally. It is what they do with after they have legally bought those guns that has become a real problem. And when you are acting as a straw purchaser, you may be technically a law-abiding citizen because you have not been caught yet, but in my eyes and in the eyes of most of the public, you are surely a criminal who is breaking the law. And what we are about tonight is giving law enforcement the tools that they have told us they need in order to catch the lawbreakers.

As a member of the Judiciary Committee, I sat through numerous hearings. We took the issues of gun violence and all the possible approaches that we could take to dealing with these issues across the State. I think the chairman held 11 hearings in the past year or year and a half. And one of the things that law enforcement said, which was very common sense, is that they do not have the tools right now to distinguish between the truly innocent law-abiding citizen and the lawbreaker who just has not been caught yet, and they wanted us to give them the tools to catch the bad guys. That is what this is about, catching the bad guys.

I think the proposal is very well crafted as a commonsense measure. The reality of it is, is that even though on the books you are not supposed to sell or transfer illegally a gun, you are not supposed to sell or transfer a gun to someone who is not allowed to have one, law enforcement has no way to catch the folks except in a few small instances that they testified about.

When a handgun ends up at a crime scene, and God forbid in my city and in yours, we are talking about innocent people and often innocent children who have been the victims, and they trace that handgun back to the original purchaser and they go to that original purchaser as part of their investigation to find out how that handgun ended up at the scene of the crime, if the handgun was legally or illegally transferred, lost, or straw-purchased, straw-sold, they cannot distinguish because there is nothing right now that puts an affirmative obligation on people to report that item lost or stolen so they have a starting place.

As a matter of fact, the most common testimony that we heard from law enforcement from various cities was the following scenario: They go to the home of the gun purchaser, the original purchaser. The purchaser says, "oh, that gun, I lost it," or "oh, that gun, it was stolen." And sometimes during the course of the investigation, the investigating officer can get that person to say, well, when, sir, or when, ma'am, did you notice that that gun was no longer in your possession? And if the person and only if the person offers a date, and if the date that they offer and only if the date that they offer contradicts when they found the gun at the scene of the crime, do they have any way of catching that person in the potential lie that may have taken an innocent life?

Now, I realize that we are measuring innocent lives here, sometimes against innocent lives. But you know what, I will take the measured risk of an innocent law-abiding citizen who happened to have his or her gun lost or stolen and forgot to report it as such for a potential summary first offense. You know what, I will take that risk over the risk of saving the life of a child in my district or in yours.

I do not know about you, but if I get a parking ticket or if I get a speeding fine or if I get a littering fine, I have never gotten a littering fine, but I am trying to put my head in the place of a summary.

The SPEAKER. Will the lady suspend. The noise level is entirely too loud. Members will take their seats. Members will take their seats. The lady is in order and may proceed.

Ms. MANDERINO. Thank you, Mr. Speaker.

Again, it only takes one speeding ticket or one parking ticket for me to be careful next time how heavy my foot is on the accelerator, or whether I choose to park in the 20-minute loading zone and stay longer than 20 minutes. I only have to get burned once and pay that ticket once before I know, do not park in that zone anymore and do not speed around that bend on the Pennsylvania Turnpike where you know the troopers are always sitting. Well, you know what, that is a fair enough warning, and I commend the drafters of this amendment for being sensitive to the fact that you do not want to hit somebody over the head on a first offense with a felony or misdemeanor. But you know what, the person who is a truly innocent, law-abiding citizen, once is enough for them to know, that God forbid they have a second handgun stolen or a second handgun lost, they are going to pick up that phone and they are going to call law enforcement right away, and that is absolutely what we want them to do.

But who is not going to pick up the phone? You know who is not going to pick up the phone, the person who is making more money as a straw seller, an illegal, not yet caught, quote, unquote, "law abiding citizen," who is selling illegal guns on the street at such a high profit that a potential maximum fine of $300 is chump change. That is the person who is going to take the risk, and once they get caught the first time and they get caught the second time and they get caught the third time and we catch not the 1st straw purchaser, but the 10th straw purchaser and then the 100th straw purchaser, you know what, maybe, just maybe, somebody will not die tonight. That is a measured chance I am willing to take. That is why I am voting "yes" on this amendment.

The SPEAKER. Representative Rohrer. The gentleman waives off. The Chair thanks the gentleman.

Representative Turzai.

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

As a former prosecutor, I often had to deal with new statutes, and I must point out for the record that there are considerable drafting difficulties with this particular amendment, and I would like to point those out to my colleagues and for the record.

Under section 6128 of the amendment on page 2, in the first paragraph it defines the duty. It says "Duty defined," and then it puts a burden on an owner of a firearm upon discovering that the firearm is lost or stolen. However, in subsection (b) – subsection (a) is where the duty was defined – in subsection (b) it sets forth certain penalties. But in reality, the way that it is drafted, the elements of a separate crime are placed in subsection (b) of section 6128 that are in conflict with, arguably, elements in subsection (a). So it says "Penalties," and my colleague from Montgomery County was addressing this part in a different circumstance. It says, "If, after an investigation…it is determined that a firearm was recovered during a criminal investigation" – that would be element one – "that the owner of that firearm knew his firearm was lost or stolen" – that would be two – "and that the owner failed to report the loss or theft of the firearm…" – that would be three. So it appears, although it is not clear, it is ambiguous, that (a) defines a crime, (b) defines a second crime, and because (a) does not set forth any penalties, the default would make it a misdemeanor 1, because in that particular chapter, the default penalties are in section 6119 and that is a misdemeanor of the first degree. However, under (b), which has differing elements and yet that is the one that is used in a crime, it sets forth that the penalty is a summary offense for a first violation of this section. That is problematic, and I can tell you as a prosecutor getting ready to argue this in front of a judge and a jury, or as an appellate

court prosecutor trying to make some sense of this on behalf of the Commonwealth, you would be hard pressed to be able to do that.

In addition, in section 6111.6, subsection (c), it says, "Duty of firearms dealer." This is actually putting a burden on firearms dealers: "It shall be the duty of the firearms dealer: to provide a copy of the notice and to review the text of the notice with the buyer of the firearm; and to prominently display a copy of the notice...."

Now, again, because this statute does not put forth what the specific penalties are for that particular subsection, it appears, although it is not clear, that you would go to the default chapter penalty provision and that is section 6111.9. That would be a misdemeanor of the first degree for a firearms dealer that did not provide a copy of the notice and review the text of the notice, nor to prominently display a copy of the notice where the purchaser of a firearm can read it. I would contend in that particular area that that penalty is far too egregious for what the potential crime might be here.

And in addition, there is an ambiguity in there as to whether it should be intentionally, knowingly, or recklessly. I must say that with many of these types of statutes that are arguably not rationally thought out, you have these types of drafting errors, and you are making the job of a prosecutor much more difficult. I tried hundreds of cases as a prosecutor, and I can assure you that this is not a statute that either a prosecutor's office or the police would be able to readily use.

CONSTITUTIONAL POINT OF ORDER

Mr. TURZAI. I think given that ambiguity or that vagueness, it actually raises a constitutional issue, and I would like to motion at this time to, and, Mr. Speaker, you are going to have to give me the correct – to move that this particular amendment be found unconstitutional, and I would like to get a vote on that particular motion.

The SPEAKER. The gentleman, Representative Turzai, raises the point of order that amendment A06178 to HB 1845 is unconstitutional. The Speaker, under rule 4, is required to submit questions of constitutionality of an amendment to the House for decision—

MOTION WITHDRAWN

Mr. TURZAI. You know what, Mr. Speaker, I will withdraw that motion.

The SPEAKER. The Chair thanks the gentleman.

Mr. TURZAI. I will withdraw the motion.

Mr. Speaker, if I might, I would argue that given the ambiguities in the amendment, that it should be voted down. Thank you very much.

The SPEAKER. The Chair thanks the gentleman.

Representative Frankel.

Mr. FRANKEL. Thanks, Mr. Speaker.

I know it is late, and I do not know that we are going to get to vote this amendment, let alone the bill this evening, but I think the members need to know that this is not a piece of legislation that has been drawn up willy-nilly. This is a piece of legislation that has been designed after legislation that has been introduced and adopted in seven States, including States that surround us. So, so much for the issue of constitutionality that the previous speaker was about to allude to, because in those seven States, not one State Supreme Court has ruled that that legislation was unconstitutional, let alone the Federal Supreme Court. So that is a red herring.

But in the last 2 years, under the leadership of our Appropriations chair, Dwight Evans, at his insistence, and with Chairman Caltagirone of the Judiciary Committee, the Judiciary Committee went around this State and held hearings about this legislation and a couple other pieces of legislation, and we heard from law enforcement officials in every corner of Pennsylvania, and without exception, without exception, they said to us that they needed additional tools to deal with the issue of illegal weapons trafficking, handguns in particular. And of all the pieces of legislation that they said that they would like to have in their toolbox was a piece of legislation making it mandatory for the reporting of lost and stolen weapons. When I talk to my police chief in the city of Pittsburgh, he says that is what he wants. Now, none of them, none of them, say to us that this solves the problem of violence in our communities. It is a very complex issue. There are many, many aspects to it, both social and legal. It is not going to solve the problem in its entirety, but it will make progress. And I, quite frankly, trust my law enforcement officials who are charged with protecting us in our community and who are charged with protecting their own members, our own law enforcement officials. They want this legislation.

So the chiefs of police across Pennsylvania, their association individually has come to us and said, give us mandatory reporting of lost and stolen weapons. The D.A.s, while they have some qualms with some parts of this, basically in concept believe that we ought to have a piece of legislation making it mandatory for the reporting of lost and stolen weapons. As it has been noted, this is very, very tame. The first offense is a summary offense. It is a parking ticket, for crying out loud. And then the second offense is a misdemeanor, and you get three times to be made a felony. This is a very reasonable approach to dealing with lost and stolen handguns.

So ultimately, I believe that like with any other right that we have, whether it is the right to free speech, we have responsibilities. We have responsibilities with the right to free speech. We cannot incite violence with our free speech. We cannot libel somebody. We cannot yell fire in a crowded theater. We have responsibilities that are attached to that right, as well as we do with the right to own and bear firearms. We have responsibilities. And the least we can ask of people in terms of those responsibilities, the least we can ask for them, is that they report in a timely way a lost or stolen weapon because we know that that is the way, the route, that these weapons get in the hands of felons and juveniles, people who are not able to obtain them legally, and they go out and commit crimes. Law enforcement wants this. We ought to do this for our citizens in our communities.

Thank you, Mr. Speaker. Please vote to support the Levdansky amendment.

The SPEAKER. Representative Cutler.

Mr. CUTLER. Thank you, Mr. Speaker.

I was wondering if the maker of the amendment would stand for a very brief interrogation.

The SPEAKER. Representative Levdansky indicates he will stand for interrogation. Representative Cutler is in order and may proceed.

Mr. CUTLER. Mr. Speaker, we have heard a lot of discussion this evening regarding straw purchases, and I just wanted to clarify a point in your amendment, if I could. I would like to draw your

attention to page 2, line 29, where it refers to the owner of a firearm.

Mr. Speaker, with regards to being an owner, this just does not mean those who purchase firearms, correct?

Mr. LEVDANSKY. Mr. Speaker, what line are you referring to?

Mr. CUTLER. Page 2, line 29. It is right under your section 6128, subsection (a).

Mr. LEVDANSKY. Yes, under "Duty defined," "the owner of a firearm," meaning handgun.

Mr. CUTLER. Correct. But that owner did not necessarily have to purchase it. They could inherit it, correct?

Mr. LEVDANSKY. If it has been transferred to them. You know, if you give it to your spouse, those are legal transfers. So then you are the owner.

Mr. CUTLER. Okay. Thank you, Mr. Speaker.

And if I were a criminal that owned a firearm, would I be required to report it, under your proposed statute?

Mr. LEVDANSKY. Repeat the question, please.

Mr. CUTLER. Mr. Speaker, if a criminal owned a firearm or possessed a firearm under your proposed amendment, would they be required to report it if it was stolen?

Mr. LEVDANSKY. Mr. Speaker, everyone is required. Every owner of a handgun, every owner of a handgun, if the gun is lost or stolen, is required to report it as lost or stolen. No exceptions.

Mr. CUTLER. No exceptions. All right. Thank you, Mr. Speaker.

That is all for the interrogation. If I may speak on the amendment, sir.

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

Mr. CUTLER. Mr. Speaker, last April 9, 2007, as a member of the Health and Human Services Committee in Philadelphia, I was privileged to attend a hearing on gun violence. While we were there, the police testified to the fact that 85 percent of all of the felons and criminals that were involved in shootings, 85 percent of them were prior convicted felons and criminals. They were not supposed to have a handgun in the first place. Mr. Speaker, even under this proposed amendment, those individuals would be required to report that gun as lost or stolen. Mr. Speaker, additionally, they also testified to the fact that less than 1 percent, less than 1 percent of all handguns that are purchased legally are ultimately used in a crime.

Mr. Speaker, I have concerns about this, and I would draw the attention of all of the members to the *Haynes* v. *United States* Supreme Court case. I respectfully disagree with the gentleman from Allegheny who says that the Supreme Court has never ruled on this issue. Mr. Speaker, quoting from the case, it says, we hold that "a proper claim of the" constitutional "privilege against self-incrimination provides a full defense,…" a full defense, to register a firearm under section 5841, referring to a Federal firearms act.

Mr. Speaker, I would argue that this same defense would apply to the amendment that we have before us today.

CONSTITUTIONAL POINT OF ORDER

Mr. CUTLER. Mr. Speaker, additionally I would like to make a motion.

The SPEAKER. The gentleman will make his motion.

Mr. CUTLER. Mr. Speaker, I would like to make a motion that this amendment as drafted is unconstitutional according to the Fifth Amendment—

The SPEAKER. The gentleman will state what section of the Constitution.

Mr. CUTLER. Fifth Amendment of the United States Federal Constitution.

The SPEAKER. The Chair thanks the gentleman.

The gentleman, Representative Cutler, raises the point of order that amendment No. A06178 to HB 1845 is unconstitutional. The Speaker, under rule 4, is required to submit questions of constitutionality of an amendment to the House for decision.

On the question,

Will the House sustain the constitutionality of the amendment?

The SPEAKER. On that point of order, the Chair recognizes Representative Cutler.

Mr. CUTLER. Mr. Speaker, the United States Supreme Court has already ruled that an amendment or a proposed law such as this is unconstitutional under the Fifth Amendment, and again I quote, we hold that "a proper claim of the" constitutional "privilege against self-incrimination provides a full defense to prosecutions…for failure to register…" firearms. Thank you.

The SPEAKER. The Chair will remind all members that the issue of constitutionality is debatable by all members, but only once.

The Chair recognizes Representative Thomas. The gentleman waives off.

Representative Levdansky.

Mr. LEVDANSKY. Thank you.

Mr. Speaker, regarding the question of constitutionality, this legislation and similar legislation are already in law in seven other States. Nothing in this amendment prohibits anybody from their right to bear arms. There is no infringement on rights in this amendment. What this amendment does do is impose a responsibility and a duty to report that a handgun is lost and stolen. That is what it does. It promotes individual responsibility. It does not take away your rights.

Let me give you some comparisons to think about. You know, if you are a social worker, if you are a social worker and you realize that there is some child abuse going on, you have an affirmative duty to report that abuse to the proper authorities. You are affirmatively bound to report that. I cited earlier insurance policies. If your vehicle is stolen, insurance policies typically require you within a certain timeframe to report that that vehicle is lost or that that vehicle is stolen. So the reality is that, you know, this encourages responsibility. It is not an infringement on anybody's rights. You could be against the measure if you want to. If you have philosophical objections to supporting this kind of amendment, you can do that, but this is not, not, an infringement on anybody's constitutional right to bear arms, and I would ask for a negative vote.

The SPEAKER. Representative Thomas.

Mr. THOMAS. Thank you. Thank you, Mr. Speaker.

I started to let it go, but, you know, I might as well just pack up and go home if I let this go.

Mr. Speaker, it is not unconstitutional when you are required, and it is not indicative of self-incrimination when you are required to report your car when it is stolen. You are involved in an accident; you have X amount of hours in which you have to report

that stolen car. In your home, you have when you take out an insurance policy on property and/or goods inside your house, you must make a list of those things, and when those things are stolen, you must report them. If you go to school and you have books and those books are given to you and those books are stolen, you must report that.

Mr. Speaker, there is nothing unconstitutional about those mandatory requirements, and they are not tantamount to self-incrimination. This amendment does no more than ask that you report another lost or stolen good. It is not tantamount to self-incrimination. Mr. Speaker, reject this frivolous notion that there is something unconstitutional about this amendment.

POINT OF ORDER

Mr. DeWEESE. Point of order, Mr. Speaker.

The SPEAKER. Representative DeWeese.

Mr. DeWEESE. It is not exactly the midnight hour, but metaphorically, in our parliamentary setting it is. We have 60 seconds before the witching hour.

HOUSE SCHEDULE

RULES COMMITTEE MEETING

Mr. DeWEESE. I would like to announce that tomorrow at 10:45 the Rules Committee will meet. We will convene at 11 o'clock in the a.m. We will immediately repair to the caucus setting, and there are additional amendments, not only to the KOZ (keystone opportunity zone) proposal but to a variety of other proposals.

So I thought it appropriate, with only a few seconds remaining on the clock, to make those announcements. Thank you, Mr. Speaker.

The SPEAKER. The gentleman is correct. Pursuant to rule 15, the House must end debate.

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.

ANNOUNCEMENT BY MISS MAJOR

The SPEAKER. Representative Major.

Miss MAJOR. Mr. Speaker, I would just request a moment. I possibly might need to make a caucus announcement for Republicans for tomorrow.

The SPEAKER. The lady is in order.

Miss MAJOR. Mr. Speaker, I will be making a caucus announcement tomorrow after we do come to the floor at 11 o'clock, so there will be no Republican caucus prior to our coming into session tomorrow morning.

Thank you, Mr. Speaker.

The SPEAKER. The Chair thanks the lady.

ADJOURNMENT

The SPEAKER. The Chair recognizes Representative Brennan from Lehigh County, who moves that this House do now adjourn until Tuesday, March 18, 2008, at 11 a.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 11 p.m., e.d.t., the House adjourned.