COMMONWEALTH OF PENNSYLVANIA

Legislative Journal

WEDNESDAY, JUNE 22, 2022

SESSION OF 2022 206TH OF THE GENERAL ASSEMBLY No. 28

SENATE

WEDNESDAY, June 22, 2022

The Senate met at 11 a.m., Eastern Daylight Saving Time.

The PRESIDENT pro tempore (Senator Jacob D. Corman III) in the Chair.

PRAYER

The Chaplain, Reverend DR. DANIEL R. MOORE, of Guinston Presbyterian Church, Airville, offered the following prayer:

Will you join me in prayer?

Heavenly Father, in the Parable of the Tenants, Jesus tells of a wealthy nobleman who entrusts his servants with different sums of money and goes away on a long trip. In his absence, they are supposed to use what has been assigned to them wisely and profitably for their master. When he returns, the nobleman calls them to give an account of how they have invested his wealth. He then rewards or punishes them accordingly.

As we near the end of the fiscal year, our Senators are working hard to find fruitful ways to use the tax dollars entrusted to them by the people of Pennsylvania. Help them; give them wisdom; reveal to them the places where the needs are the greatest and where the financial support will have the maximum impact. Open their minds to creative budgeting ideas that surprise even themselves. Show them how to best use the people's hard-earned money to best help those who gave it and those in need. No doubt, there are sharply divided opinions about what is best. There will be discussions, debates, and even arguments. Through it all, help our elected representatives to recognize the motives of those they disagree with, and to respect them for their deeply held convictions, especially when they run contrary to their own. Let this mutual esteem pave the way for productive deliberations that will result in a budget that promotes the well-being of the people of our State. Let it be something both they and their constituents can be proud of.

Father, I want to go one step further and ask that You do something amazing in Pennsylvania. Make the work done here on the budget this year be something that becomes a model that other States will want to emulate. Enable Pennsylvania's Senators to raise the bar on civil discourse and statesmanship. Help them not only to craft a fiscally responsible spending package that meets the needs of many people, but also allow their method of crafting it to be an example for other legislative bodies to envy. And may the end result be a State that is well run, people whose needs are being met, and in harmony that amazes everyone who sees it. All this we pray for the benefit of the people of Pennsylvania, but we pray it ultimately for Your glory and in the name of Your Son, Jesus Christ the Savior and Lord over all. Amen.

The PRESIDENT pro tempore. The Chair thanks Reverend Dr. Moore, who is the guest today of Senator Phillips-Hill.

PLEDGE OF ALLEGIANCE

(The Pledge of Allegiance was recited by those assembled.)

BILL INTRODUCED AND REFERRED

The PRESIDENT pro tempore laid before the Senate the following Senate Bill numbered, entitled, and referred as follows, which was read by the Clerk:

June 22, 2022

Senators BREWSTER, COSTA, FONTANA and MENSCH presented to the Chair **SB 1294**, entitled:

An Act designating a bridge, identified as Bridge Key 36017, on that portion of Pennsylvania Route 56 over the Kiskiminetas River, Vandergrift Borough, Westmoreland County, and Parks Township, Armstrong County, as the Rudy Minarcin Memorial Bridge.

Which was committed to the Committee on TRANSPORTATION, June 22, 2022.

HOUSE MESSAGES

HOUSE BILLS FOR CONCURRENCE

The Clerk of the House of Representatives presented to the Senate the following bills for concurrence, which were referred to the committees indicated:

June 22, 2022

HB 2049 -- Committee on Law and Justice.

HB 2104 -- Committee on Environmental Resources and Energy.

HB 2115 -- Committee on State Government.

HB 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2661 and **2662 --** Committee on Appropriations.

HOUSE CONCURS IN SENATE BILL

The Clerk of the House of Representatives returned to the Senate **SB 403**, with the information the House has passed the same without amendments.

BILLS SIGNED

The PRESIDENT pro tempore (Senator Jacob D. Corman III) in the presence of the Senate signed the following bills:

SB 403 and **SB 709**.

BILLS REPORTED FROM COMMITTEES

Senator VOGEL, from the Committee on Agriculture and Rural Affairs, reported the following bill:

SB 1289 (Pr. No. 1803) (Amended)

An Act amending the act of December 7, 1982 (P.L.784, No.225), known as the Dog Law, in short title and definitions, further providing for definitions; in licenses, tags and kennels, further providing for issuance of dog licenses, compensation, proof required, deposit of funds, records, license sales, rules and regulations, failure to comply, unlawful acts and penalty, for applications for dog licenses, fees and penalties, for kennels, providing for fee increases, further providing for requirements for kennels, for revocation or refusal of kennel licenses, for dogs temporarily in the Commonwealth and for health certificates for importation; in dangerous dogs, further providing for court proceedings, certificate of registration and disposition, for requirements, for public safety and penalties and for construction of article; in injury to dogs, further providing for selling, bartering or trading dogs; and, in enforcement and penalties, further providing for enforcement and penalties.

Senator TOMLINSON, from the Committee on Consumer Protection and Professional Licensure, reported the following bills:

SB 511 (Pr. No. 1804) (Amended)

An Act amending the act of September 27, 1961 (P.L.1700, No.699), known as the Pharmacy Act, further providing for authority to administer injectable medications, biologicals and immunizations; and abrogating inconsistent regulations.

SB 548 (Pr. No. 1805) (Amended)

An Act amending Titles 40 (Insurance) and 75 (Vehicles) of the Pennsylvania Consolidated Statutes, providing for peer-to-peer car sharing; and, in financial responsibility, providing for group insurance for peer-to-peer car sharing programs.

LEGISLATIVE LEAVES

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Westmoreland, Senator Kim Ward.

Senator K. WARD. Mr. President, I request temporary Capitol leaves for Senator Browne, Senator Mastriano, and Senator Regan, and a legislative leave for Senator Yaw.

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Allegheny, Senator Fontana.

Senator FONTANA. Mr. President, I request a legislative leave for Senator Anthony Williams.

The PRESIDENT pro tempore. Senator Kim Ward requests temporary Capitol leaves for Senator Browne, Senator Mastriano, and Senator Regan, and a legislative leave for Senator Yaw.

Senator Fontana requests a legislative leave for Senator Anthony Williams.

Without objection, the leaves will be granted.

LEAVE OF ABSENCE

Senator K. WARD asked and obtained a leave of absence for Senator GORDNER, for today's Session, for personal reasons.

BILL REPORTED FROM COMMITTEE

Senator TOMLINSON, from the Committee on Consumer Protection and Professional Licensure, reported the following bill:

HB 1186 (Pr. No. 2411)

An Act amending the act of February 14, 1986 (P.L.2, No.2), known as the Acupuncture Licensure Act, further providing for definitions, for regulation of the practice of acupuncture, for penalties and for approval of acupuncture educational programs.

SENATE CONCURRENT RESOLUTION

WEEKLY RECESS

Senator K. WARD offered the following resolution, which was read as follows:

In the Senate, June 22, 2022

RESOLVED, (the House of Representatives concurring), Pursuant to Article II, Section 14 of the Pennsylvania Constitution, that when the Senate recesses this week, it reconvene the week of Monday, June 27, 2022, unless sooner recalled by the President pro tempore; and be it further

RESOLVED, Pursuant to Article II, Section 14 of the Pennsylvania Constitution, that when the House of Representatives recesses this week, it reconvene the week of Monday, June 27, 2022, unless sooner recalled by the Speaker of the House of Representatives.

On the question,

Will the Senate adopt the resolution?

The yeas and nays were required by Senator K. WARD and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A majority of the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate present the same to the House of Representatives for concurrence.

GUESTS OF SENATOR DEVLIN ROBINSON PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Allegheny, Senator Robinson.

Senator ROBINSON. Mr. President, joining us in the gallery today is one of two summer interns of mine, Will Brobson. Will is working with us this summer in my office here in Harrisburg. Will grew up in Harrisburg, Pennsylvania, and attended Bishop McDevitt High School, graduating in 2021. As a high school student, Will achieved successes in academics, athletics, and extracurriculars. He was awarded the Diploma of Distinction in social studies and achieved the rank of Eagle Scout after completing an amphitheater at his high school. Along with his teammates, Will won the men's AA swimming State championship title in 2021.

Will is now a rising sophomore in the Elliot School of International Affairs at The George Washington University in Washington, D.C., where he studies international affairs with a concentration in security policy. Will is enrolled in a rigorous course load of history, international politics, calculus, physics, and Russian, and continues to swim for The George Washington club swim team and attended the club's swimming national championship in Atlanta, Georgia, this past semester. Will is also a member of the George Washington TRAiLS, an outdoor group focused on hiking, high-adventure activities, and community service, where he was asked to assist in leading historical hikes at battlefields like Gettysburg, Antietam, and Bull Run. As a member of the Naval Reserve Officers Training Corps at George Washington, Will was selected to receive the Military Order of the World Wars Award of Merit for academic and physical excellence, as well as embodying the order's motto: "It is nobler to serve than to be served."

Upon his graduation, Will plans on commissioning as an officer in the United States Navy and following it with a career of service, whether it be in the Navy or in State or Federal government. Will is joined in the gallery today by his father, Justice Kevin Brobson. Mr. President, Will has proven to be a bright young man with a very promising future, and we are thrilled to have him in our office this summer. I ask my colleagues to extend a warm Senate welcome to Will Brobson and his family.

Thank you, Mr. President.

The PRESIDENT pro tempore. Would the guests of Senator Robinson please rise so the Senate can give you our usual warm welcome.

(Applause.)

GUESTS OF SENATOR KRISTIN PHILLIPS-HILL PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from York, Senator Phillips-Hill.

Senator PHILLIPS-HILL. Mr. President, I rise to introduce our guest Chaplain, Reverend Dr. Daniel Moore of Guinston Presbyterian Church in Airville. No stranger to the Senate, Dr. Moore has opened the Senate with prayer on multiple occasions, and it is great to have him back here with us today. I had the pleasure of hosting Dr. Moore, along with his daughters, Tamsin, Marilla, and Cora, as my guest shadows today. They wanted to take an in-depth look at how their State legislature operates and had the opportunity to attend some committee meetings this morning before Senate Session convened. Thank you, Dr. Moore, for your thoughtful, timely, and meaningful prayer. I hope that you and your family enjoy the rest of your visit here today. Would my colleagues please join me in welcoming Dr. Moore and his daughters, Tamsin, Marilla, and Cora, back to the Senate.

Thank you, Mr. President.

The PRESIDENT pro tempore. Would the guests of Senator Phillips-Hill please rise so the Senate can give you our usual warm welcome.

(Applause.)

GUESTS OF SENATOR CHRISTINE M. TARTAGLIONE PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Philadelphia, Senator Tartaglione.

Senator TARTAGLIONE. Mr. President, today in the Senate gallery we have two interns from my district offices in Philadelphia. I would like to first introduce Michelle Johnson. Michelle is a hardworking intern in my office and a proud mother to her 6-year-old son, named Truman. She has been passionately advocating and working with and for the public for as long as she can remember. Her grandfather was involved in the community for approximately the last 40 years and taught her the importance of helping others less fortunate. She joined my team on Monday and will be providing constituent service at my Allegheny Avenue office and is doing a great job.

Second, I would like to introduce Jayla Turner. Jayla is a recent graduate of Tacony Academy Charter High School in Philadelphia and will be attending Lincoln University on scholarship this fall as a political science major, with a minor in business administration. She has future ambitions of running for office including, possibly, running for the State Senate. Jayla started with us just over a week ago at the Bridge Street office providing constituent service and has been a real asset to our team. Mr. President, I would like to ask my colleagues to please give a warm Senate welcome to Jayla and Michelle.

The PRESIDENT pro tempore. Would the guests of Senator Tartaglione please rise so we can give you our usual warm welcome.

(Applause.)

GUESTS OF SENATOR SHARIF T. STREET PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Philadelphia, Senator Street.

Senator STREET. Mr. President, today I rise to introduce an impressive group of young people who, knowing that we were going to be working on the budget, reached out to me and said they wanted to come and talk with us, be with us, and let us know their position. These young people, who are the Men for Positive Change's Youth Council leadership for boys and girls, came here to join us and to talk to us about the fact that they want to encourage us to support programs like theirs, that have the added effect of making sure that young people are safe as we go into their summer months and can avoid the challenges of violence. This group is a mentoring leadership group with a strong focus on youth entrepreneurship and are working with many other programs to keep young people in the community engaged in

positive activities and away from the ills and challenges of violence that young people can get caught up with. They have come here to observe our process, be inspired, and hopefully inspire us to support programs like theirs. I ask all Members of the Senate to rise and give a rousing welcome for the Men for Positive Change's Youth Council leadership for boys and girls. Please rise, guests.

The PRESIDENT pro tempore. Would the guests of Senator Street please rise so the Senate may give you our usual warm welcome.

(Applause.)

GUEST OF SENATOR ELDER A. VOGEL PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Beaver, Senator Vogel.

Senator VOGEL. Mr. President, it is with great pleasure I rise to introduce my Rochester district office intern, Caleb Dawson. Caleb is the son of Bill and Angie Dawson from Zelienople in Butler County. He began his internship with us in May and finishes in August, but I wanted to take a moment to acknowledge him and all his hard work over the past month. He is a graduate of Seneca Valley High School and is a junior at the University of Mount Union in Alliance, Ohio, where he is majoring in marketing and management. Caleb received a music and volleyball scholarship. While on campus, he also finds time to participate with the men's volleyball team and the concert choir. He is also a member of the Alpha Tau Omega fraternity, where he is recruitment chair. In the past month, Caleb has worked closely with my Rochester staff on a number of tasks. He has witnessed firsthand the hard work and dedication it takes to assist constituents on various issues. Last week, he had the pleasure of working with my Harrisburg staff and the hard work they do each Session week. This week he is here shadowing me in meetings and during Session. Mr. President, I would like to ask my Senate colleagues to give Caleb a warm Senate welcome.

The PRESIDENT pro tempore. Would the guest of Senator Vogel please rise so the Senate can give you our usual warm welcome.

(Applause.)

GUEST OF SENATOR LISA M. BOSCOLA PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Northampton, Senator Boscola.

Senator BOSCOLA. Mr. President, the introduction of my guest today is bittersweet. Sierra Serfass has been working in my office since 2018, and sadly, her time in my office is coming to an end, and I am really going to miss her. While working in my office she is a very valued employee. She has a gift of understanding social media that is going to be very hard to replace. But I must say, it was during the pandemic that Sierra really rose to the occasion, working every single day and beyond normal office hours. Like all of you in this Chamber, we had to react quickly to a new world order with new programs, ever-changing information, and voluminous phone calls.

In my district office, Sierra was given the task of working with our small business community throughout the pandemic, keeping them informed of updated regulations, new grant opportunities at all levels of government, and overall, being an advocate for changes in the programs that would help them survive and thrive. Now, as you can well imagine, Sierra's email was remarkably busy. She was a true pro, never complaining, just doing the work. She recognized that our offices were the lifeline for these people who were confused, angry, and nervous. Whether it was a Federal program, State program, county program, or local program, she dove in, becoming a source of information for the businesses and a master of the follow-up with program managers.

So, Sierra is moving on, and I am so proud of the work that she has done for me and for my constituents. I am excited to see her career blossom. She is going to be a marketing director for a prominent Philadelphia law firm. As you can tell, I am going to miss her tremendously. While I might not be able to call her an employee anymore, I will always consider her a friend. So, Senate, please give her your usual warm welcome.

The PRESIDENT pro tempore. Would the guest of Senator Boscola please rise so the Senate can give you our usual warm welcome.

(Applause.)

GUESTS OF SENATOR MARIO M. SCAVELLO PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Monroe, Senator Scavello.

Senator SCAVELLO. Mr. President, I would like to welcome Maya Palka and Natalia Juchnicki, very special guests who are visiting me here in the Capitol today. Maya and Natalia are both 13 years old and will be attending Pocono Mountain West High School in the fall in Monroe County. Maya is an avid swimmer. Her favorite subject is history; she plays the trumpet in the school band and is also in the choir. Natalia is also in the school band and choir. Natalia plays the saxophone, and her favorite subject is history. I expect great things from these two young ladies, especially being students who love history. Please join me in giving Maya Palka; Natalia Juchnicki; and Maya's parents, Igor and Margaret--who are personal friends of myself and my wife, Mary Ann--who are seated in the gallery, and please give them our usual warm Senate welcome.

The PRESIDENT pro tempore. Would the guests of Senator Scavello please rise so the Senate can give you our usual warm welcome.

(Applause.)

GUESTS OF SENATOR TIMOTHY P. KEARNEY PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Delaware, Senator Kearney.

Senator KEARNEY. Mr. President, I rise today to introduce my two interns, who are here from my district offices in Springfield and Upper Darby: Miles Richardson and Ashyana Mosakowski, both of whom are seated in the gallery. Miles joined my office as a summer intern to gain experience in policymaking and constituent services. He grew up in East Lansdowne and graduated from Penn Wood High School in 2019. Miles is a rising junior attending George Washington University on a university alumni scholarship, pursuing a bachelor's degree in political science with a minor in film studies. During his first 2 years of college, he served on the university student association as deputy

chief of staff, competed in the National Parliamentary Debate Society, and is a member of the Black Student Union. Additionally, Miles has served as a judge of elections for both precincts of East Lansdowne Borough in the previous four elections. In the future, he aspires to become a leader for his community and help build a better tomorrow.

Ashyana Mosakowski joined my office as an intern, again, to gain experience in many political fields. She grew up in Springfield and graduated from Villa Maria Academy High School last year. She is a rising sophomore at American University, as a recipient of the dean's scholarship, where she studies political science with a concentration in law. There, she is a member of the university chorus and has experience on the American Bhangra Crew dance team. She hopes to study abroad in a French-speaking country to use French, her second language, as much as possible. This summer, she served as a poll worker for the 2022 Pennsylvania primary and is continuing her job at the Ridley YMCA on the childcare staff. She is also enjoying spending time with friends and family. In the future, Ashyana seeks to pursue a government- and law-related career and hopes to see more women of color in positions of power by the time she is in the workforce. I hope the Senate will join me in welcoming my new interns, Miles and Ashyana, with their usual warm welcome.

The PRESIDENT pro tempore. Would the guests of Senator Kearney please stand so the Senate can give you our usual warm welcome.

(Applause.)

GUESTS OF SENATOR SCOTT E. HUTCHINSON PRESENTED TO THE SENATE

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Venango, Senator Hutchinson.

Senator HUTCHINSON. Mr. President, I rise today to introduce Jillian Ranko. Jillian is interning in both my district and Capitol offices this summer, serving the constituents of the 21st Senatorial District proudly, and we are glad to have her here with us today. Jillian is currently a rising junior at Penn State University, studying to obtain a bachelor of science degree in agricultural and extension education with a minor in sustainability. Jillian has also completed work study programs and internships at Penn State's extension administration office and the Beaver County extension office and has recently completed a semester at the Disney internship program in Florida. Jillian is the current secretary of the Pennsylvania Alpaca Owners and Breeders Association, where she has worked to increase group communication and efficiency to its board members and 100 delegates, and she was also the 2019 Pennsylvania Alpaca Princess. She is currently a sister at the Delta Theta Sigma social professional agricultural fraternity, and she has served as their THON primary chairperson, secretary, and rush chairperson. Jillian also previously served as president of the Pennsylvania 4-H State Council. Jillian's dedicated leadership to the agricultural community throughout our district and across our Commonwealth is truly inspiring, and we are grateful to have her in our office assisting us this summer. If you would join me in offering a warm Senate welcome to Jillian Ranko.

The PRESIDENT pro tempore. Would the guest of Senator Hutchinson please rise so the Senate can give you our usual warm welcome.

(Applause.)

For more guests, Senator Hutchinson.

Senator HUTCHINSON. Mr. President, I also rise today to introduce the national champion Butler High School Golden Tornado Boys' Track and Field Team. This team consists of Guinness Brown, Isaac Busler, Raine Gratzmiller, Drew Griffith, Carson Knight, Ryder Kriley, Landon Lacey, Tristan McGarrah, Presley Ornelas, Jacob Pomykata, Tyler Rekich, CJ Singleton, Lucas Slear, Sage Vavro, and Brayden Young. Coached by Bill Elliott, Christine McGarrah, Fred Pinto, head coach Mike Seybert, John Williams, athletic director Bill Mylan, Jerry McGarrah, and Rick Davanzati. These boys have had an incredible season, topped off by their stellar performance at nationals. Most notably, their distance medley relay quartet, consisting of Brown, Griffith, Kriley, and Singleton, took home first place in their event by a landslide. Their winning time of 9 minutes and 56.84 seconds at the nationals ranks seventh all-time in the United States among high schools. They beat the runner-up, Ridgefield, Connecticut, by 12 seconds and surpassed the previous Pennsylvania State record by 8 seconds. Please join me in welcoming this championship team and congratulating them on this historic season.

The PRESIDENT pro tempore. Would the guests of Senator Hutchinson please rise so the Senate can give you our usual warm welcome

(Applause.)

LEGISLATIVE LEAVE CANCELLED

The PRESIDENT pro tempore. Senator Mastriano has returned, and his temporary Capitol leave is cancelled.

SPECIAL ORDER OF BUSINESS ANNOUNCEMENT BY THE SECRETARY

The SECRETARY. Permission has been granted for the Committee on Consumer Protection and Professional Licensure to meet today off the floor to consider the following bills: Senate Bill No. 485, Senate Bill No. 1160, Senate Bill No. 1161 and Senate Bill No. 1287.

RECESS

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Lancaster, Senator Aument.

Senator AUMENT. Mr. President, I request a recess of the Senate for purposes of two off-the-floor committee meetings, first the Committee on Health and Human Services to be held in the Rules room, followed by the Committee on Finance, followed by a Republican caucus to be held in the Majority Caucus Room.

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Allegheny, Senator Fontana.

Senator FONTANA. Mr. President, after the two off-the-floor committee meetings, Senate Democrats will caucus in the rear of the Chamber.

The PRESIDENT pro tempore. For purposes of two off-the-floor committee meetings to be held in the Rules room, first the Committee on Health and Human Services, followed by the Committee on Finance, followed by Republican and Democratic caucuses to be held in their respective caucus rooms, without objection, the Senate stands in recess.

AFTER RECESS

The PRESIDENT pro tempore. The time of recess having expired, the Senate will come to order.

LEGISLATIVE LEAVE

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Westmoreland, Senator Kim Ward.

Senator K. WARD. Mr. President, I request a legislative leave for Senator Judy Ward.

The PRESIDENT pro tempore. Senator Kim Ward requests a legislative leave for Senator Judy Ward. Without objection, the leave will be granted.

RECESS

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Westmoreland, Senator Kim Ward.

Senator K. WARD. Mr. President, I request a recess of the Senate for purposes of a meeting of the Committee on Appropriations to be held here on the floor, followed by a meeting of the Committee on Consumer Protection and Professional Licensure to be held in the Rules room.

The PRESIDENT pro tempore. For purposes of off-the-floor committee meetings, first the Committee on Appropriations to be held here on the floor, followed by the Committee on Consumer Protection and Professional Licensure to be held in the Rules room in the rear of the Chamber, without objection, the Senate stands in recess.

AFTER RECESS

The PRESIDENT pro tempore. The time of recess having expired, the Senate will come to order.

LEGISLATIVE LEAVES CANCELLED

The PRESIDENT pro tempore. Senator Regan and Senator Browne have returned, and their temporary Capitol leaves are cancelled.

CALENDAR

THIRD CONSIDERATION CALENDAR

BILL OVER IN ORDER

SB 1 -- Without objection, the bill was passed over in its order at the request of Senator K. WARD.

BILL LAID ON THE TABLE

SB 137 (Pr. No. 110) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, in budget and finance, establishing the Drug Recognition Expert Training Fund.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill was laid on the table.

SB 137 TAKEN FROM THE TABLE

Senator K. WARD. Mr. President, I move that Senate Bill No. 137, Printer's No. 110, be taken from the table and placed on the Calendar.

The motion was agreed to by voice vote.

The PRESIDENT pro tempore. The bill will be placed on the Calendar.

BILLS OVER IN ORDER

SB 358, SB 457 and **SB 676** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON THIRD CONSIDERATION AND FINAL PASSAGE

HB 723 (Pr. No. 3155) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of December 18, 2001 (P.L.949, No.114), known as the Workforce Development Act, further providing for title of act; in preliminary provisions, further providing for declaration of policy, for definitions and for lobbying; in board, further providing for establishment, for membership, for conflicts of interest, for plan, functions and responsibilities and for State performance management system and providing for performance accountability system; in local workforce investment areas and boards, further providing for establishment, for membership, for conflicts of interest, for plan, functions and responsibilities and for local performance measures; in critical job training grants, further providing for purpose, for definitions, for program operation and for grants; in workforce leadership grants, further providing for innovative programs; in industry partnerships, further providing for definitions, for industry clusters, for grant program operation, for interdepartmental cooperation and for industry and labor market research and providing for dissemination of industry and labor market research to educational institutions; in miscellaneous provisions, further providing for construction; and making editorial changes.

Considered the third time and agreed to,

And the amendments made thereto having been printed as required by the Constitution,

On the question,

Shall the bill pass finally?

The yeas and nays were taken agreeably to the provisions of the Constitution and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A constitutional majority of all the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate return said bill to the House of Representatives with information that the Senate has passed the same with amendments in which concurrence of the House is requested.

BILLS OVER IN ORDER

SB 745, SB 775, SB 871, SB 956 and **HB 972** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL LAID ON THE TABLE

SB 993 (Pr. No. 1287) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law, in preliminary provisions, further providing for definitions.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill was laid on the table.

SB 993 TAKEN FROM THE TABLE

Senator K. WARD. Mr. President, I move that Senate Bill No. 993, Printer's No. 1287, be taken from the table and placed on the Calendar.

The motion was agreed to by voice vote.

The PRESIDENT pro tempore. The bill will be placed on the Calendar.

BILLS OVER IN ORDER

HB 996 and **SB 1032** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON THIRD CONSIDERATION AND FINAL PASSAGE

SB 1093 (Pr. No. 1685) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of December 15, 1971 (P.L.596, No.160), known as the Outdoor Advertising Control Act of 1971, further providing for definitions.

Considered the third time and agreed to,

And the amendments made thereto having been printed as required by the Constitution,

On the question,

Shall the bill pass finally?

The yeas and nays were taken agreeably to the provisions of the Constitution and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A constitutional majority of all the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate present said bill to the House of Representatives for concurrence.

BILL OVER IN ORDER

SB 1147 -- Without objection, the bill was passed over in its order at the request of Senator K. WARD.

BILL ON THIRD CONSIDERATION AND FINAL PASSAGE

SB 1173 (Pr. No. 1534) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of May 1, 1933 (P.L.216, No.76), known as The Dental Law, further providing for general powers of the State Board of Dentistry.

Considered the third time and agreed to,

On the question,

Shall the bill pass finally?

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Lancaster, Senator Martin.

Senator MARTIN. Mr. President, Senate Bill No. 1173 would amend Pennsylvania's Dental Law to allow those in the dental profession to earn some of the required continuing education hours by either directly providing or supporting direct dental care to uninsured and/or underinsured populations. It is a fact that poor oral health has been linked to several health issues, including but not limited to heart disease, cancer, and diabetes. That said, substantial portions of our respective communities lack access to the routine care necessary to stave off these long-term health consequences. Thankfully, there are several entities, including charitable organizations, that work to close this gap by providing pop-up clinics run largely by volunteers. Those who participate not only hone their skills, but expose themselves, in many cases, to progressive dental emergencies that arise from lack of routine care. I believe this type of volunteerism should be encouraged and its value should be properly recognized, which was the catalyst behind Senate Bill No. 1173. Specifically, Senate Bill No. 1173 would allow up to 3 hours of total required biennial continuing education requirements be accrued by volunteering in this

manner. My office worked with the stakeholders and the Pennsylvania Dental Association to ensure that these hours could be properly documented and to prevent these critical hours from being accrued simply by performing administrative care. Continuing education is imperative for many professions, and we went to great lengths to ensure that its importance was not diluted. Passage today would not only improve the healthcare of many of our constituents in the short term, but as mentioned before, it will go a long way in preventing long-term diseases, which, of course, means less of a financial burden on Pennsylvania taxpayers and, more importantly, improve the health of so many of our citizens and their children. I would ask my colleagues to give an affirmative vote to Senate Bill No. 1173.

Thank you, Mr. President.

And the question recurring,
Shall the bill pass finally?

The yeas and nays were taken agreeably to the provisions of the Constitution and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A constitutional majority of all the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate present said bill to the House of Representatives for concurrence.

BILLS OVER IN ORDER

HB 1614, HB 1660 and **HB 1868** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

SECOND CONSIDERATION CALENDAR

BILL OVER IN ORDER

HB 118 -- Without objection, the bill was passed over in its order at the request of Senator K. WARD.

BILLS ON SECOND CONSIDERATION AND REREFERRED

HB 129 (Pr. No. 2718) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law, in determination of compensation, appeals, reviews and procedure, further providing for rules of procedure and for place of hearing.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

HB 146 (Pr. No. 915) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 61 (Prisons and Parole) of the Pennsylvania Consolidated Statutes, in Pennsylvania Board of Probation and Parole, further providing for parole power.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

SB 152 and **HB 223** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION, AMENDED AND REREFERRED

SB 225 (Pr. No. 948) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, in quality healthcare accountability and protection, further providing for definitions and for responsibilities of managed care plans, providing for preauthorization review standards and for preauthorization costs, further providing for continuity of care, providing for step therapy, further providing for required disclosure and for operational standards and providing for initial review of preauthorization requests and adverse determinations, for preauthorization denial grievances and for access requirements in service areas; and making an editorial change.

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

PHILLIPS-HILL AMENDMENT A5018 ADOPTED

Senator PHILLIPS-HILL offered the following amendment No. A5018:

Amend Bill, page 1, lines 23 through 31; page 2, lines 1 through 12; by striking out all of said lines on said pages 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,"

in quality health care accountability and protection, further providing for definitions, for responsibilities of managed care plans, for financial incentives prohibition, for medical gag clause prohibition, for emergency services, for continuity of care, providing for medication assisted treatment, further providing for procedures, for confidentiality, for required disclosure, providing for medical policy and clinical review criteria adopted by insurer, MCO or contractor, further providing for internal complaint process, for appeal of complaint, for complaint resolution, for certification, for operational standards, providing for step therapy considerations, for prior authorization review and for provider portal, further providing for internal grievances process, for records, for external grievance process, for prompt payment of claims, for health care provider and managed care plan, for departmental powers and duties, for penalties and sanctions, for compliance with National Accrediting Standards; and making editorial changes.

Amend Bill, page 34, lines 5 through 30; pages 35 through 56, lines 1 through 30; page 57, lines 1 through 26; by striking out all of said lines on said pages and inserting:

Section 1. The definitions of "complaint," "drug formulary," "enrollee," "grievance," "health care service," "prospective utilization review," "provider network," "retrospective utilization review," "utilization review" and "utilization review entity" in section 2102 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, are amended and the section is amended by adding definitions to read:

Section 2102. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

* * *

"Administrative policy." A written document or collection of documents reflecting the terms of the contractual or operating relationship between an insurer, MCO, contractor and a health care provider.

"Administrative denial." A denial of prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with written administrative standards for the administration of benefits under a health insurance policy, MCO contract or CHIP contract. The term does not include a denial based on medical necessity.

"Adverse benefit determination." A determination by an insurer, MCO, contractor or a utilization review entity designated by the insurer, MCO or contractor that a health care service has been reviewed and, based upon the information provided, does not meet the insurer's, MCO's or contractor's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

* * *

"Applicable governmental guidelines." Clinical practice and associated guidelines issued under the authority of the United States Department of Health and Human Services, United States Food and Drug Administration, Centers for Disease Control and Prevention, Department of Health or other similarly situated Federal or State agency, department or subunit thereof focused on the provision or regulation of medical care, prescription drugs or public health within the United States.

"Children's Health Insurance Program" or "CHIP." The children's health care program under Article XXIII-A.

"CHIP contract." The agreement between an insurer and the Department of Human Services to provide for services to a CHIP enrollee.

* * *

"Clinical review criteria." The set of written screening procedures, decision abstracts, clinical protocols and practice guidelines used by an insurer, MCO or contractor to determine the necessity and appropriateness of health care services.

"Closely related service." One or more health care services subject to prior authorization that are closely related in purpose, diagnostic utility or designated health care billing code and provided on the same date of service such that a prudent health care provider, acting within the scope of the health care provider's license and expertise, might reasonably be expected to perform such service in conjunction with or in lieu of the originally authorized service in response to minor differences in observed patient characteristics or needs for diagnostic information that were not readily identifiable until the health care provider was actually performing the originally authorized service. The term does not include an order for or administration of a prescription drug or any part of a series or course of treatments.

"Complaint." A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of [a managed care plan] an insurer, MCO or contractor, which has not been resolved by the [managed care plan] insurer, MCO or contractor and has been filed with the [plan] insurer, MCO or contractor or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

"Complete prior authorization request." A request for prior authorization that meets an insurer's, MCO's or contractor's administrative policy requirements for such a request and that includes the specific clinical information necessary only to evaluate the request under the terms of the applicable medical policy. To the extent a health care provider network agreement requires medical records to be transmitted electronically, or a health care provider is capable of transmitting medical records electronically to support a complete prior authorization request for a health care service, the health care provider shall ensure the insurer has electronic access to, including the ability to print, the medical records that have been transmitted electronically, subject to any applicable law and the health care provider's corporate policies. The inability of a health care provider to provide such access shall not constitute a reason to deny an authorization request.

* * *

"Contractor." An insurer awarded a contract under section 2304-A to provide health care services. The term includes an entity and an entity's subsidiary which is established under this act, the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act or 40 Pa.C.S. Ch. 61 (relating to hospital plan corporation) or 63 (relating to professional health services plan corporations).

* * *

"Drug formulary." A listing of [managed care plan] insurer, MCO or contractor preferred therapeutic drugs.

* * *

"Enrollee." Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a [managed care plan] health insurance policy, MCO contract or CHIP contract.

"Grievance." As provided in subdivision (i), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have [a managed care plan] an insurer, MCO, contractor or utilization review entity reconsider a decision solely concerning the medical necessity [and], appropriateness, health care setting, level of care or effectiveness of a health care service. If the [managed care plan] insurer, MCO or contractor is unable to resolve the matter, a grievance may be filed regarding the decision that:

(1) disapproves full or partial payment for a requested health care service;

(2) approves the provision of a requested health care service for a lesser scope or duration than requested; or

(3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

The term does not include a complaint.

* * *

"Health care service." Any covered treatment, admission, procedure, medical supplies and equipment or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee [under a managed care plan contract.]

"Health insurance policy." A policy, subscriber contract, certificate or plan issued by an insurer that provides medical or health care coverage. The term does not include any of the following:

(1) An accident only policy.

(2) A credit only policy.

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

(4) A specified disease policy.

(5) A Medicare supplement policy.

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

(7) A fixed indemnity policy.

(8) A hospital indemnity policy.

(9) A dental only policy.

(10) A vision only policy.

(11) A workers' compensation policy.
(12) An automobile medical payment policy.
(13) A homeowners' insurance policy.
(14) A short-term limited duration policy.
(15) Any other similar policy providing for limited benefits.

"Inpatient admission." Admission to a facility for purposes of receiving a health care service at the inpatient level of care.

"Insurer." An entity licensed by the department to issue a health insurance policy, subscriber contract, certificate or plan that provides medical or health care coverage that is offered or governed under any of the following:

(1) Article XXIV, section 630 or any other provision of this act.
(2) A provision of 40 Pa.C.S. Ch. 61 or 63.

* * *

"MCO contract." The agreement between a medical assistance managed care organization or MCO and the Department of Human Services to provide for services to a Medicaid enrollee.

"Medical assistance managed care organization" or "MCO." A Medicaid managed care organization as defined in section 1903(m)(1)(A) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(A)) that is a party to a Medicaid managed care contract with the Department of Human Services. The term does not include a behavioral health managed care organization that is a party to a Medicaid managed care contract with the Department of Human Services.

"Medical policy." A written document formally adopted, maintained and applied by an insurer, MCO or contractor that combines the clinical coverage criteria and any additional administrative requirements, as applicable, necessary to articulate the insurer's, MCO's or contractor's standards for coverage of a given service or set of services under the terms of a health insurance policy, MCO contract or CHIP contract.

"Medical or scientific evidence." Evidence found in any of the following sources:

(1) A peer-reviewed scientific study published in or accepted for publication by a medical journal that meets nationally recognized requirements for scientific manuscripts and which journal submits most of its published articles for review by experts who are not part of the journal's editorial staff.

(2) Peer-reviewed medical literature, including literature relating to a therapy reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Limited for indexing in Excerpta Medica (EMBASE).

(3) A medical journal recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(t)(2)).

(4) One of the following standard reference compendia:
(i) The American Hospital Formulary Service-Drug Information.
(ii) Drug Facts and Comparison.
(iii) The American Dental Association Accepted Dental Therapeutics.
(iv) The United States Pharmacopoeia-Drug Information.

(5) Findings, studies or research conducted by or under the auspices of a Federal Government agency or nationally recognized Federal research institute, including:
(i) The Federal Agency for Healthcare Research and Quality.
(ii) The National Institute of Health.
(iii) The National Cancer Institute.
(iv) The National Academy of Sciences.
(v) The Centers for Medicare and Medicaid Services.
(vi) The Food and Drug Administration.
(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(6) Other medical or scientific evidence that is comparable to the sources specified in paragraphs (1), (2), (3), (4) and (5).

"Medication assisted treatment." United States Food and Drug Administration approved prescription drugs used in combination with counseling and behavioral health therapies in the treatment of opioid use disorders.

"Nationally recognized medical standards." Clinical criteria, practice guidelines and related standards established by national quality and accreditation entities generally recognized in the United States health care industry.

"Participating provider." A health care provider that has entered into a contractual or operating relationship with an insurer, MCO or contractor to participate in one or more designated networks of the insurer, MCO or contractor and to provide health care services to enrollees under the terms of the insurer's, MCO's or contractor's administrative policy.

* * *

"Prior authorization." A review by an insurer, MCO, contractor or by a utilization review entity acting on behalf of an insurer, MCO or contractor of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service. The term includes step therapy and associated exceptions for prescription drugs.

["Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.]

"Provider network." The health care providers designated by [a managed care plan] an insurer, MCO or contractor to provide health care services.

"Provider portal." A designated section or functional software module accessible via an insurer's, MCO's or contractor's publicly accessible Internet website that facilitates health care provider submission of electronic prior authorization requests.

* * *

"Retrospective utilization review." A review by [a] an insurer, MCO, contractor or utilization review entity acting on behalf of an insurer, MCO or contractor of all reasonably necessary supporting information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

* * *

"Step therapy." A course of treatment where certain designated drugs or treatment protocols must be either contraindicated or used and found to be ineffective prior to approval of coverage for other designated drugs. The term does not include requests for coverage of nonformulary drugs.

"Urgent health care service." A covered health care service subject to prior authorization in which the application of the time periods for making non-urgent care determinations:

(1) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(2) in the opinion of a physician with knowledge of the enrollee's medical condition would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

"Utilization review." A system of [prospective, concurrent] prior authorization, concurrent utilization review or retrospective utilization review performed by [a] an insurer, MCO, contractor or utilization review entity on behalf of an insurer, MCO or contractor of the medical necessity [and], appropriateness, health care setting and level of care or effectiveness of health care services prescribed, provided or proposed to be provided to an enrollee. The term does not include any of the following:

(1) Requests for clarification of coverage, eligibility or health care service verification.

(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of [a managed care plan] an insurer, MCO or contractor.

Section 2. Subarticle (b) heading of Article XXI and sections 2111, 2112 and 2113 of the act are amended to read:

(b) [Managed Care Plan] Insurer, MCO and Contractor Requirements.

Section 2111. Responsibilities of [Managed Care Plans] Insurer, MCOs and Contractors.--[A managed care plan] An insurer, MCO or contractor shall do all of the following:

(1) Assure availability and accessibility of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services.

(2) Consult with health care providers in active clinical practice regarding professional qualifications and necessary specialists to be

included in the [plan] health insurance policy, MCO contract or CHIP contract.

(3) Adopt and maintain a definition of medical necessity used by the [plan] health insurance policy, MCO contract or CHIP contract in determining health care services.

(4) Ensure that emergency services are provided twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for emergency services.

(5) Adopt and maintain procedures by which an enrollee can obtain health care services outside the [plan's] health insurance policy's, MCO contract's or CHIP contract's service area.

(6) Adopt and maintain procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the [plan's] insurer's, MCO's or contractor's established standards are met, be permitted to receive:

(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

The referral to or designation of a specialist shall be pursuant to a treatment plan approved by the [managed care plan] insurer, MCO or contractor in consultation with the primary care provider, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a health care provider participating in the [plan] health insurance policy, MCO contract or CHIP contract.

(7) Provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the [plan] health insurance policy, MCO contract or CHIP contract to obtain maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological care, without prior approval from a primary care provider. The health care services shall be within the scope of practice of the selected health care provider. The selected health care provider shall inform the enrollee's primary care provider of all health care services provided.

(8) Adopt and maintain a complaint process as set forth in subdivision (g).

(9) Adopt and maintain a grievance process as set forth in subdivision (i).

(10) Adopt and maintain credentialing standards for health care providers as set forth in subdivision (d).

(11) Ensure that there are participating health care providers that are physically accessible to people with disabilities and can communicate with individuals with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990 (Public Law 101-336, 42 U.S.C. § 12181 et seq.).

(12) Provide a list of health care providers participating in the [plan] health insurance policy, MCO contract or CHIP contract to the department every two (2) years or as may otherwise be required by the department. The list shall include the extent to which [health care] participating providers [in the plan] are accepting new enrollees.

(13) Report to the department and the Insurance Department in accordance with the requirements of this article. Such information shall include the number, type and disposition of all complaints and grievances filed with the [plan] insurer, MCO or contractor.

Section 2112. Financial Incentives Prohibition.--No [managed care plan] insurer, MCO or contractor shall use any financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee. Nothing in this section shall be deemed to prohibit [a managed care plan] an insurer, MCO or contractor from using a capitated payment arrangement or other risk-sharing arrangement.

Section 2113. Medical Gag Clause Prohibition.--(a) No [managed care plan] insurer, MCO or contractor may penalize or restrict a health care provider from discussing:

(1) the process that the [plan] insurer, MCO or contractor or any entity contracting with the [plan] insurer, MCO or contractor uses or proposes to use to deny payment for a health care service;

(2) medically necessary and appropriate care with or on behalf of an enrollee, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or

(3) the decision of any [managed care plan] insurer, MCO or contractor to deny payment for a health care service.

(b) A provision to prohibit or restrict disclosure of medically necessary and appropriate health care information contained in a contract with a health care provider is contrary to public policy and shall be void and unenforceable.

(c) No [managed care plan] insurer, MCO or contractor shall terminate the employment of or a contract with a health care provider for any of the following:

(1) Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.

(2) Filing a grievance pursuant to the procedures set forth in this article.

(3) Protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide medically necessary and appropriate health care.

(d) Nothing in this section shall:

(1) Prohibit [a managed care plan] an insurer, MCO or contractor from making a determination not to pay for a particular medical treatment, supply or service, enforcing reasonable peer review or utilization review protocols or making a determination that a health care provider has or has not complied with appropriate protocols.

(2) Be construed as requiring [a managed care plan] an insurer, MCO or contractor to provide, reimburse for or cover counseling, referral or other health care services if the [plan] insurer, MCO or contractor:

(i) objects to the provision of that service on moral or religious grounds; and

(ii) makes available information on its policies regarding such health care services to enrollees and prospective enrollees.

Section 3. Section 2116(a) and (b) of the act are amended and the section is amended by adding a subsection to read:

Section 2116. Emergency Services.--(a) If an enrollee seeks emergency services and the [emergency] health care provider determines that emergency services are necessary, the [emergency] health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the [managed care plan. The managed care plan] insurer, MCO or contractor. No insurer, MCO or contractor shall require a health care provider to submit a request for prior authorization for an emergency service. The insurer, MCO or contractor shall pay all reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all copayments, coinsurances or deductibles[.], including testing and other diagnostic services that are medically necessary to evaluate or treat an emergency medical condition prior to the point at which the condition is stabilized. When processing a reimbursement claim for emergency services, [a managed care plan] an insurer, MCO or contractor shall consider both the presenting symptoms and the services provided. The [emergency] health care provider shall notify the enrollee's [managed care plan] insurer, MCO or contractor of the provision of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary. If an enrollee is admitted to inpatient care or placed in observation immediately following receipt of a covered emergency service, the inpatient facility shall have a minimum of twenty-four (24) hours to notify the enrollee's insurer, MCO or contractor of the admission or placement with such timeframe to start at the later of:

(1) the time of the inpatient admission or placement; or

(2) in the case of an enrollee that is unconscious, comatose or otherwise unable to effectively communicate pertinent information, the time at which the inpatient facility knew or reasonably should have known, through diligent efforts, the identity of the enrollee's insurer, MCO or contractor.

(b) For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103 (relating to definitions), that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical

services agency that has that ability, the [managed care plan] insurer, MCO or contractor may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.

* * *

(e) Nothing in this section shall require an insurer, MCO or contractor to waive application of otherwise applicable clinical review criteria.

Section 4. Section 2117 of the act is amended to read:

Section 2117. Continuity of Care.--(a) Except as provided under subsection (b), if [a managed care plan] an insurer, MCO or contractor initiates termination of its contract with a participating health care provider, an enrollee may continue an ongoing course of treatment with that health care provider at the enrollee's option for a transitional period of up to sixty (60) days from the date the enrollee was notified by the [plan] insurer, MCO or contractor of the termination or pending termination. The [managed care plan] insurer, MCO or contractor, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the [managed care plan] insurer, MCO or contractor under the same terms and conditions as applicable for participating health care providers.

(b) If the [plan] insurer, MCO or contractor terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the [plan] insurer, MCO or contractor, the [plan] insurer, MCO or contractor shall not be responsible for health care services provided to the enrollee following the date of termination.

(c) If the [plan] insurer, MCO or contractor terminates the contract of a participating primary care provider, the [plan] insurer, MCO or contractor shall notify every enrollee served by that provider of the [plan's] insurer's, MCO's or contractor's termination of its contract and shall request that the enrollee select another primary care provider.

(d) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment in a [managed care plan] health insurance policy, MCO contract or CHIP contract. The [managed care plan] insurer, MCO or contractor, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the [managed care plan] insurer, MCO or contractor under the same terms and conditions as applicable for participating health care providers.

(e) [A plan] An insurer, MCO or contractor may require a nonparticipating health care provider whose health care services are covered under this section to meet the same terms and conditions as a participating health care provider.

(f) Nothing in this section shall require [a managed care plan] an insurer, MCO or contractor to provide health care services that are not otherwise covered under the terms and conditions of the [plan] health insurance policy, MCO contract or CHIP contract.

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

Section 2118. Medication assisted treatment.--(a) An insurer, MCO or contractor shall make available without initial prior authorization coverage of at least one United States Food and Drug Administration approved prescription drug classified as Medication Assisted Treatment.

(b) Nothing in this section shall prohibit an insurer, MCO or contractor from designating preferred medications for the relevant component of medication assisted treatment when multiple medications are available, subject to applicable requirements for documenting and posting any relevant medical policy or prescription drug formulary information.

(c) With the exception of prior authorization for initial coverage, nothing in this section shall prohibit an insurer, MCO or contractor from requiring prior authorization on subsequent requests for medication assisted treatment to ensure adherence with clinical guidelines.

Section 6. Sections 2121, 2131 and 2136 of the act are amended to read:

Section 2121. Procedures.--(a) [A managed care plan] An insurer, MCO or contractor shall establish a credentialing process to enroll qualified health care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.

(b) The department shall establish credentialing standards for [managed care plans.] insurers, MCOs and contractors. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for [managed care plans] insurers, MCOs and contractors.

(c) [A managed care plan] An insurer, MCO or contractor shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.

(d) [A managed care plan] An insurer, MCO or contractor shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the [plan's] insurer's, MCO's or contractor's provider network. [A managed care plan] An insurer, MCO or contractor shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of [a managed care plan] an insurer, MCO or contractor shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

(e) No [managed care plan] insurer, MCO or contractor shall exclude or terminate a health care provider from participation in the [plan] health insurance policy, MCO contract or CHIP contract due to any of the following:

(1) The health care provider engaged in any of the activities set forth in section 2113(c).

(2) The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.

(3) The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.

(f) If [a managed care plan] an insurer, MCO or contractor denies enrollment or renewal of credentials to a health care provider, the [managed care plan] insurer, MCO or contractor shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.

Section 2131. Confidentiality.--(a) [A managed care plan] An insurer, MCO, contractor and a utilization review entity shall adopt and maintain procedures to ensure that all identifiable information regarding enrollee health, diagnosis and treatment is adequately protected and remains confidential in compliance with all applicable Federal and State laws and regulations and professional ethical standards.

(b) To the extent [a managed care plan] an insurer, MCO or contractor maintains medical records, the [plan] insurer, MCO or contractor shall adopt and maintain procedures to ensure that enrollees have timely access to their medical records unless prohibited by Federal or State law or regulation.

(c) (1) Information regarding an enrollee's health or treatment shall be available to the enrollee, the enrollee's designee or as necessary to prevent death or serious injury.

(2) Nothing in this section shall:

(i) Prevent disclosure necessary to determine coverage, review complaints or grievances, conduct utilization review or facilitate payment of a claim.

(ii) Deny the department, the Insurance Department or the Department of [Public Welfare] Human Services access to records for purposes of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with this article and other laws of this Commonwealth. Records shall be accessible only to department employes or agents with direct responsibilities under the provisions of this subparagraph.

(iii) Deny access to information necessary for a utilization review entity to conduct a review under this article.

(iv) Deny access to the [managed care plan] insurer, MCO or contractor for internal quality review, including reviews conducted as part of the [plan's] insurer's, MCO's and contractor's quality oversight process. During such reviews, enrollees shall remain anonymous to the greatest extent possible.

(v) Deny access to [managed care plans] insurers, MCOs, contractors, health care providers and their respective designees for the purpose

of providing patient care management, outcomes improvement and research. For this purpose, enrollees shall provide consent and shall remain anonymous to the greatest extent possible.

Section 2136. Required Disclosure.--(a) [A managed care plan] An insurer, MCO or contractor shall supply each enrollee and, upon written request, each prospective enrollee or health care provider with the following written information. Such information shall be easily understandable by the layperson and shall include, but not be limited to:

(1) A description of coverage, benefits and benefit maximums, including benefit limitations and exclusions of coverage, health care services and the definition of medical necessity used by the [plan] health insurance, MCO contract or CHIP contract in determining whether these benefits will be covered. The following statement shall be included in all marketing materials in boldface type:

> This [managed care plan] health insurance policy or contract may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

The notice shall be followed by a telephone number to contact the [plan] insurer, MCO or contractor.

(2) A description of all necessary prior authorizations or other requirements for nonemergency health care services as required in section 2154(b).

(3) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, copayments, deductibles and other charges, annual limits on an enrollee's financial responsibility and caps on payments for health care services provided under the [plan] health insurance policy, MCO contract or CHIP contract.

(4) An explanation of an enrollee's financial responsibility for payment when a health care service is provided by a nonparticipating health care provider, when a health care service is provided by any health care provider without required authorization or when the care rendered is not covered by the [plan] health insurance policy, MCO contract or CHIP contract.

(5) A description of how the [managed care plan] insurer, MCO or contractor addresses the needs of non-English-speaking enrollees.

(6) A notice of mailing addresses and telephone numbers necessary to enable an enrollee to obtain approval or authorization of a health care service or other information regarding the [plan] health insurance policy, MCO contract or CHIP contract.

(7) A summary of the [plan's] health insurance policy's, MCO contract's or CHIP contract's utilization review policies and procedures.

(8) A summary of all complaint and grievance procedures used to resolve disputes between the [managed care plan] insurer, MCO contractor and an enrollee or a health care provider, including:

(i) The procedure to file a complaint or grievance as set forth in this article, including a toll-free telephone number to obtain information regarding the filing and status of a complaint or grievance.

(ii) The right to appeal a decision relating to a complaint or grievance.

(iii) The enrollee's right to designate a representative to participate in the complaint or grievance process as set forth in this article.

(iv) A notice that all disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice and that all notices of decisions will include information regarding the basis for the determination.

(9) A description of the procedure for providing emergency services twenty-four (24) hours a day. The description shall include:

(i) A definition of emergency services as set forth in this article.

(ii) Notice that emergency services are not subject to prior approval.

(iii) The enrollee's financial and other responsibilities regarding emergency services, including the receipt of these services outside the [managed care plan's] insurer's, MCO's or contractor's service area.

(10) A description of the procedures for enrollees to select a participating health care provider, including how to determine whether a participating health care provider is accepting new enrollees.

(11) A description of the procedures for changing primary care providers and specialists.

(12) A description of the procedures by which an enrollee may obtain a referral to a health care provider outside the provider network when that provider network does not include a health care provider with appropriate training and experience to meet the health care service needs of an enrollee.

(13) A description of the procedures that an enrollee with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:

(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

(14) A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at least annually.

(15) A list of the information available to enrollees or prospective enrollees, upon written request, under subsection (b).

(b) Each [managed care plan] insurer, MCO or contractor shall, upon written request of an enrollee or prospective enrollee, provide the following written information:

(1) A list of the names, business addresses and official positions of the membership of the board of directors or officers of the [managed care plan] insurer, MCO or contractor.

(2) The procedures adopted to protect the confidentiality of medical records and other enrollee information.

(3) A description of the credentialing process for health care providers.

(4) A list of the participating health care providers affiliated with participating hospitals.

(5) Whether a specifically identified drug is included or excluded from coverage.

(6) A description of the process by which a health care provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

(7) A description of the procedures followed by the [managed care plan] insurer, MCO or contractor to make decisions about the experimental nature of individual drugs, medical devices or treatments.

(8) A summary of the methodologies used by the [managed care plan] insurer, MCO or contractor to reimburse for health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between [a managed care plan] an insurer, MCO, contractor and a health care provider.

(9) A description of the procedures used in the [managed care plan's] insurer's, MCO's or contractor's quality assurance program.

(10) Other information as may be required by the department or the Insurance Department.

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

Section 2137. Medical policy and clinical review criteria adopted by an insurer, MCO or contractor.--(a) An insurer, MCO or contractor shall make available its current medical policies on the insurer's, MCO's and contractor's publicly accessible Internet website or provider portal. The insurer's, MCO's or contractor's medical policies shall include reference to the clinical review criteria used in developing the medical policy. If an insurer's, MCO's or contractor's medical policy incorporates licensed third-party standards that also limit the insurer's, MCO's or contractor's ability to publish those standards in full, the insurer's, MCO's or contractor's posted policies shall clearly identify these sources.

(b) An insurer, MCO or contractor shall review each adopted medical policy on at least an annual basis.

(c) An insurer, MCO or contractor shall notify health care providers of discretionary changes to medical policies at least thirty (30) days prior to application of the changes. The following apply:

(1) In the case of policy changes due to changes in Federal or State law, regulation or binding agency guidance, an insurer, MCO or contractor shall notify health care providers at least thirty (30) days prior to the application of the changes, except that in cases where the timing of changes in binding guidance makes such advance notice impracticable, an insurer, MCO or contractor shall make commercially reasonable efforts to notify providers of such changes prior to their application.

(2) Notification of changes may be provided through the posting of an updated and dated medical policy reflecting the change or through other reasonable means.

(3) In the case of changes to medical policies that modify, eliminate or suspend either clinical or administrative criteria and that directly result

in less restrictive coverage of a given service, an insurer, MCO or contractor shall notify health care providers within (30) days after application of such change.

(d) Clinical review criteria adopted by an insurer, MCO or contractor at the time of medical policy development or review shall:

(1) Be based on nationally recognized medical standards.

(2) Be consistent with applicable governmental guidelines.

(3) Provide for the delivery of a health care service in a clinically appropriate type, frequency, setting and duration.

(4) Reflect the current quality of medical and scientific evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature.

(e) Nothing in this section shall require an insurer, MCO or contractor to provide coverage for a health care service that is otherwise excluded from coverage under a health insurance policy, MCO contract or CHIP contract.

Section 8. Sections 2141, 2142(a) and (b), 2143, 2151(e) and 2152(a)(3), (4)(i) and (7) and (c) of the act are amended to read:

Section 2141. Internal Complaint Process.--(a) [A managed care plan] An insurer, MCO or contractor shall establish and maintain an internal complaint process [with two levels of review] by which an enrollee shall be able to file a complaint [regarding a participating health care provider or the coverage, operations or management policies of the managed care plan].

(b) The complaint process shall consist of [an initial] a review [to] by a committee of three or more individuals, a third of which shall not be employed by the insurer, MCO or contractor and shall include all of the following:

[(1) A review by an initial review committee consisting of one or more employes of the managed care plan.]

(2) The allowance of a written or oral complaint.

(3) The allowance of written data or other information.

(4) A review or investigation of the complaint which shall be completed within thirty (30) days of receipt of the complaint.

(5) A written notification to the enrollee regarding the decision of the [initial] review committee within five (5) business days of the decision. [Notice shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee.

(c) The complaint process shall include a second level review that includes all of the following:

(1) A review of the decision of the initial review committee by a second level review committee consisting of three or more individuals who did not participate in the initial review. At least one third of the second level review committee shall not be employed by the managed care plan.

(2) A written notification to the enrollee of the right to appear before the second level review committee.

(3) A requirement that the second level review be completed within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee regarding the decision of the second level review committee within five (5) business days of the decision.] The notice shall include the basis for the decision and the procedure for appealing the decision to the department or the Insurance Department.

Section 2142. Appeal of Complaint.--(a) An enrollee shall have [fifteen (15) days] four (4) months from receipt of the notice of the decision from the [second level] review committee to appeal the decision to the department or the Insurance Department, as appropriate.

(b) All records from the [initial] review [and second level review] shall be transmitted to the appropriate department in the manner prescribed. The enrollee, the health care provider or the [managed care plan] insurer, MCO or contractor may submit additional materials related to the complaint.

* * *

Section 2143. Complaint Resolution.--Nothing in this subdivision shall prevent the department or the Insurance Department from communicating with the enrollee, the health care provider or the [managed care plan] insurer, MCO or contractor as appropriate to assist in the resolution of a complaint. Such communication may occur at any time during the complaint process.

Section 2151. Certification.--* * *

(e) [A licensed] An insurer [or a managed care plan], MCO or contractor with a certificate of authority shall comply with the standards and procedures of this subdivision but shall not be required to obtain separate certification as a utilization review entity.

Section 2152. Operational Standards.--(a) A utilization review entity shall do all of the following:

* * *

(3) Ensure that a health care provider is able to verify that an individual requesting information on behalf of the [managed care plan] insurer, MCO or contractor is a legitimate representative of the [plan] insurer, MCO or contractor.

(4) Conduct utilization reviews based on the medical necessity [and], appropriateness, health care setting, level of care or effectiveness of the health care service being reviewed and provide notification within the following time frames:

(i) A [prospective utilization review] prior authorization decision shall be communicated [within two (2) business days of the receipt of all supporting information reasonably necessary to complete the review.] pursuant to the review timelines contained in section 2154(g).

* * *

(7) Notify the health care provider of additional facts or documents required to complete the utilization review within forty-eight (48) hours of receipt of the request for review[.] or pursuant to section 2154(h) for missing clinical information for all requests for prior authorization.

* * *

(c) Utilization review that results in a denial of payment for a health care service, not including an administrative denial, shall be made by a licensed physician, except as provided in subsection (d) or section 2154(c) for all requests for prior authorization.

* * *

Section 9. The act is amended by adding sections to read:

Section 2153. Step Therapy Considerations.--The following:

(1) If an insurer's, MCO's or contractor's medical policy adopted under section 2137 incorporates step therapy criteria for prescription drugs, an insurer, MCO or contractor shall consider as part of the insurer's, MCO's or contractor's initial prior authorization process or a request for an exception to the insurer's, MCO's or contractors step therapy criteria, and based on the enrollee's individualized clinical condition, the following:

(i) Contraindications, including adverse reactions.

(ii) Clinical effectiveness or ineffectiveness of the required prerequisite prescription drugs or therapies.

(iii) Past clinical outcome of the required prerequisite prescription drug or therapy.

(iv) The expected clinical outcomes of the requested prescription drug prescribed by the enrollee's health care provider.

(v) For new enrollees, whether the enrollee has already satisfied a step therapy protocol with their previous health insurer that required trials of drugs from each of the classes that are required by the current insurer's, MCO's or contractor's step therapy protocol.

(2) The provisions of section 2154 shall apply to step therapy reviews conducted under this section.

Section 2154. Prior Authorization Review.--(a) (1) Insurer, MCO or contractor review of a request for prior authorization shall be based upon the insurer's, MCO's or contractor's medical policy, administrative policy and all medical information and evidence submitted by the requesting provider.

(2) At the time of review, an insurer, MCO or contractor shall also verify the enrollee's eligibility for coverage under the terms of the applicable health insurance policy, MCO contract or CHIP contract.

(3) Appeals of administrative denials shall be subject to the complaint process under subarticle (g).

(b) An insurer, MCO or contractor shall make available a list, posted in a publicly accessible format and location on the insurer's, MCO's or contractor's publicly accessible Internet website, and provider portal, that indicates the health services for which the insurer, MCO or contractor requires prior authorization.

(c) Other than an administrative denial, a request for prior authorization may only be denied upon review by a properly licensed medical professional with appropriate training, knowledge or experience in the same or similar specialty that typically manages or consults on the health care service in question. Alternatively, an insurer, MCO or contractor may satisfy this requirement through the completion of the review by a

licensed medical professional in consultation with an appropriately qualified third-party medical professional, licensed in the same or similar medical specialty as the requesting health care provider or type of health care provider that typically manages the enrollee's associated condition, provided that any compensation paid to the consulting professional may not be contingent upon the outcome of the review. Nothing in this section shall compel an insurer, MCO or contractor to obtain third-party medical professionals in the same specialty or subspecialty.

(d) In the case of a denied prior authorization, the insurer, MCO or contractor shall make available to the requesting health care provider a licensed medical professional for a peer-to-peer review discussion. The peer-to-peer reviewer provided by the insurer, MCO or contractor shall meet the standards under subsection (c) and have authority to modify or overturn the prior authorization decision. The procedure for requesting a peer-to-peer review shall be available on the insurer's, MCO's or contractor's publicly accessible Internet website and provider portal. An insurer's, MCO's or contractor's peer-to-peer procedure shall include, but not be limited to, ability to request a peer-to-peer discussion:

(1) during normal business hours; or

(2) outside normal business hours subject to reasonable limitations on the availability of qualified insurer, MCO or contractor staff. In the event an insurer, MCO or contractor uses a third-party vendor or utilization review entity to conduct peer-to-peer reviews for denials administered by the vendor or entity, the procedure under subsection (i) shall include contact information and information on the hours of availability of the vendor or entity necessary for a requesting health care provider to schedule a peer-to-peer discussion.

(e) A health care provider may designate, and an insurer, MCO or contractor shall accept, another licensed member of the health care provider's affiliated or employed clinical staff with knowledge of the enrollee's condition and requested procedure as a qualified proxy for purposes of completing a peer-to-peer discussion. Individuals eligible to receive a proxy designation shall be limited to licensed health care providers whose actual authority and scope of practice is inclusive of performing or prescribing the requested health care service. Such authority may be established through a supervising physician consistent with applicable State law for non-physician practitioners. The insurer, MCO or contractor must accept and review the information submitted by other members of a health care provider's affiliated or employed staff in support of a prior authorization request. The insurer, MCO or contractor may not limit interactions with an insurer's, MCO's or contractor's clinical staff solely to the requesting health care provider.

(f) A peer-to-peer discussion shall be available to a requesting health care provider from the time of a denial of prior authorization until the internal grievance process commences. If a peer-to-peer discussion is available prior to adjudicating a prior authorization request, the peer-to-peer shall be offered within the timeline in subsection (g).

(g) An insurer's, MCO's or contractor's decision to approve or deny prior authorization shall be rendered within the following timeframes and following the submission of a prior authorization request:

(1) An insurer, MCO or contractor shall issue a prior authorization determination for a medical health care service in accordance with the following timeframes:

(i) Review of request for urgent health care services as expeditiously as the enrollee's health condition requires but no more than seventy-two (72) hours.

(ii) Review of request for non-urgent medical services not more than fifteen (15) calendar days.

(2) Insurers, MCOs and contractors shall issue a prior authorization determination for a prescription drug medication or render a decision on step therapy under section 2153 in accordance with the following timeframes:

(i) Review or urgent request not more than twenty-four (24) hours.

(ii) Review of standard request not more than two (2) business days and not to exceed seventy-two (72) hours.

(3) If at any time after requesting prior authorization the health care provider determines the enrollee's medical condition requires emergency services, such services may be provided under section 2116.

(h) (1) In the event that a prior authorization request is missing clinical information that is reasonably necessary to complete a review, the insurer, MCO or contractor shall notify the health care provider of any missing clinical information necessary to complete the review within twenty-four (24) hours of receipt of the prior authorization request for urgent health care services or within two (2) business days of receipt of all other types of prior authorization requests and allow the requesting health care provider or any member of the requesting health care provider's clinical or administrative staff to submit such information within the established review time lines. A request for information under this subsection shall be made with sufficient specificity to enable the health care provider to identify the necessary clinical or other supporting information necessary to complete review.

(2) The period of time in which the health care provider is gathering the requested documentation shall be added to the time frame provided under subsection (g).

(i) An insurer, MCO or contractor may supplement submitted information based on current clinical records or other current medical information for an enrollee as available, provided that the supplemental information is also made available to the enrollee or health care provider as part of the enrollee's authorization case file upon request. In response to any request for missing information, an insurer, MCO or contractor shall also accept supplemental information from any member of the health care provider's clinical staff.

(j) If a health care provider performs a closely related service, the insurer, MCO or contractor may not deny a claim for the closely related service for failure of the health care provider to seek or obtain prior authorization, provided that:

(1) The health care provider notifies the insurer, MCO or contractor of the performance of the closely related service no later than seventy two (72) hours following completion of the service but prior to the submission of the claim for payment. The submission of the notification shall include the submission of all relevant clinical information necessary for the insurer, MCO or contractor to evaluate the medical necessity and appropriateness of the service.

(2) Nothing in this subsection shall be construed to limit an insurer's, MCO's or contractor's consideration of medical necessity and appropriateness of the closely service, nor limit the need for verification of the enrollee's eligibility for coverage.

Section 2155. Provider portal.--(a) Within eighteen (18) months following the effective date of this section, an insurer, MCO or contractor shall establish a provider portal that includes, at minimum, the following features:

(1) Electronic submission of prior authorization requests.

(2) Access to an insurer's, MCO's or contractor's applicable medical policies.

(3) Information necessary to request a peer-to-peer review.

(4) Contact information for an insurer's, MCO's or contractor's relevant clinical or administrative staff.

(5) For any prior authorization service not subject to electronic submission via the provider portal, copies of any applicable submission forms.

(6) Instructions for the submission of prior authorization requests in the event that an insurer's, MCO's or contractor's provider portal is unavailable for any reason.

(b) Within six (6) months following the establishment of provider portals under subsection (a), an insurer, MCO or contractor shall make available to health care providers and their affiliated or employed staff access to training on the use of the insurer's, MCO's or contractor's provider portal.

(c) Within eighteen (18) months following the establishment of provider portals under subsection (a), a health care provider seeking prior authorization shall submit such request via an insurer's, MCO's or contractor's provider portal, provided that:

(1) Submission via provider portal shall only be required to the extent an insurer's, MCO's or contractor's provider portal is available and operational at the time of attempted submission.

(2) Submission via an insurer's, MCO's or contractor's provider portal shall only be required to the extent the health care provider has access to the insurer's, MCO's or contractor's operational provider portal.

(3) Insurers, MCOs and contractors may elect to maintain allowances for submission of prior authorization requests outside of the provider portal.

Section 10. Sections 2161, 2162, 2163, 2166, subarticle (k) heading of Article XXI and sections 2171, 2181, 2182 and 2191 of the act are amended to read:

Section 2161. Internal Grievance Process.--(a) [A managed care plan] An insurer, MCO or contractor shall establish and maintain an

internal grievance process [with two levels of review] and an expedited internal grievance process by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service within four (4) months of receiving an adverse benefit determination. An enrollee who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.

(b) The internal grievance process shall consist of [an initial] a review that includes all of the following:

(1) A review by [one] three or more persons selected by the [managed care plan] insurer, MCO or contractor who did not previously participate in the decision to deny payment for the health care service.

(2) The completion of the review within thirty (30) days of receipt of the grievance.

(3) A written notification to the enrollee and health care provider[.] of the right to appear before the review committee within five (5) business days of receiving the internal grievance.

(4) A written notification to the enrollee and health care provider regarding the decision within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure to file a request [for a second level review of] appealing the decision as an external grievance.

[(c) The grievance process shall include a second level review that includes all of the following:

(1) A review of the decision issued pursuant to subsection (b) by a second level review committee consisting of three or more persons who did not previously participate in any decision to deny payment for the health care service.

(2) A written notification to the enrollee or the health care provider of the right to appear before the second level review committee.

(3) The completion of the second level review within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee and health care provider regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure for appealing the decision.]

(d) Any [initial review or second level] review conducted under this section shall include a licensed physician, or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service.

(e) Should the enrollee's life, health or ability to regain maximum function be in jeopardy, an expedited internal grievance process shall be available which shall include a requirement that a decision with appropriate notification to the enrollee and health care provider be made within forty-eight (48) hours of the filing of the expedited grievance.

Section 2162. External Grievance Process.--(a) [A managed care plan] An insurer, MCO or contractor shall establish and maintain an external grievance process by which an enrollee or a health care provider with the written consent of the enrollee may appeal the denial of a grievance following completion of the internal grievance process. The external grievance process shall be conducted by an independent utilization review entity not directly affiliated with the [managed care plan] insurer, MCO or contractor.

(b) To conduct external grievances filed under this section:

(1) The department shall randomly assign a utilization review entity on a rotational basis from the list maintained under subsection (d) and notify the assigned utilization review entity and the [managed care plan] insurer, MCO or contractor within two (2) business days of receiving the request. If the department fails to select a utilization review entity under this subsection, the [managed care plan] insurer, MCO or contractor shall designate and notify a certified utilization review entity to conduct the external grievance.

(2) The [managed care plan] insurer, MCO or contractor shall notify the enrollee or health care provider of the name, address and telephone number of the utilization review entity assigned under this subsection within two (2) business days.

(c) The external grievance process shall meet all of the following requirements:

(1) Any external grievance shall be filed with the [managed care plan] insurer, MCO or contractor within [fifteen (15) days] four (4) months of receipt of a notice of denial resulting from the internal grievance process. The filing of the external grievance shall include any material justification and all reasonably necessary supporting information. Within five (5) business days of the filing of an external grievance, the [managed care plan] insurer, MCO or contractor shall notify the enrollee or the health care provider, the utilization review entity that conducted the internal grievance and the department that an external grievance has been filed.

(2) The utilization review entity that conducted the internal grievance shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within fifteen (15) days of receipt of notice that the external grievance was filed. Any additional written information may be submitted by the enrollee or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.

(3) The utilization review entity conducting the external grievance shall review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the enrollee or the health care provider.

(4) An external grievance decision shall be made by:

(i) one or more licensed physicians or approved licensed psychologists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; or

(ii) one or more physicians currently certified by a board approved by the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.

(5) Within sixty (60) days of the filing of the external grievance, the utilization review entity conducting the external grievance shall issue a written decision to the [managed care plan] insurer, MCO or contractor, the enrollee and the health care provider, including the basis and clinical rationale for the decision. The standard of review shall be whether the health care service denied by the internal grievance process was medically necessary and appropriate under the terms of the [plan] health insurance policy, MCO contract or CHIP contract. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the external grievance decision. There shall be a rebuttable presumption in favor of the decision of the utilization review entity conducting the external grievance.

(6) The [managed care plan] insurer, MCO or contractor shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under paragraph (5) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.

(7) All fees and costs related to an external grievance shall be paid by the nonprevailing party if the external grievance was filed by the health care provider. The health care provider and the utilization review entity or [managed care plan] insurer, MCO or contractor shall each place in escrow an amount equal to one-half of the estimated costs of the external grievance process. If the external grievance was filed by the enrollee, all fees and costs related thereto shall be paid by the [managed care plan] insurer, MCO or contractor. For purposes of this paragraph, fees and costs shall not include attorney fees.

(d) The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this article. The department may remove a utilization review entity from the list if such an entity is incapable of performing its responsibilities in a reasonable manner, charges excessive fees or violates this article.

(e) A fee may be imposed by [a managed care plan] an insurer, MCO or contractor for filing an external grievance pursuant to this article which shall not exceed twenty-five ($25) dollars.

(f) Written contracts between [managed care plans] insurers, MCO or contractor and health care providers may provide an alternative dispute resolution system to the external grievance process set forth in this article if the department approves the contract. The alternative dispute resolution system shall be impartial, include specific time limitations to initiate appeals, receive written information, conduct hearings and render decisions and otherwise satisfy the requirements of this section. A written decision pursuant to an alternative dispute resolution system shall be final and binding on all parties. An alternative dispute resolution system shall not be utilized for any external grievance filed by an enrollee.

Section 2163. Records.--Records regarding grievances filed under this subdivision that result in decisions adverse to enrollees shall be maintained by the [plan] insurer, MCO or contractor for not less than three (3) years. These records shall be provided to the department, if requested, in accordance with section 2131(c)(2)(ii).

Section 2166. Prompt Payment of Claims.--(a) [A licensed] An insurer [or a managed care plan], MCO or contractor shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

(b) If [a licensed] an insurer [or a managed care plan], MCO or contractor fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or [managed care plan] insurer, MCO or contractor shall not be required to pay any interest calculated to be less than two ($2) dollars.

(k) Health Care Provider [and Managed Care Plan], Insurer, MCO and Contractor Protection.

Section 2171. Health Care Provider [and Managed Care Plan], Insurer, MCO and Contractor Protection.--(a) [A managed care plan] An insurer, MCO or contractor shall not exclude, discriminate against or penalize any health care provider for its refusal to allow, perform, participate in or refer for health care services when the refusal of the health care provider is based on moral or religious grounds and that provider makes adequate information available to enrollees or, if applicable, prospective enrollees.

(b) No public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a [plan] health insurance policy, MCO contract, CHIP contract or operating, expanding or improving an existing [plan] health insurance policy, MCO contract or CHIP contract because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other [plans] health insurance policies, MCO contracts or CHIP contracts when the refusal is based on moral or religious grounds.

Section 2181. Departmental Powers and Duties.--(a) The department shall require that records and documents submitted to [a managed care plan] an insurer, MCO, contractor or utilization review entity as part of any complaint or grievance be made available to the department, upon request, for purposes of enforcement or compliance with this article.

(b) The department shall compile data received from [a managed care plan] an insurer, MCO or contractor on an annual basis regarding the number, type and disposition of complaints and grievances filed with [a managed care plan] an insurer, MCO or contractor under this article.

(c) The department shall issue guidelines identifying those provisions of this article that exceed or are not included in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance. These guidelines shall be published in the Pennsylvania Bulletin and updated as necessary. Copies of the guidelines shall be made available to [managed care plans] insurers, MCOs, contractors, health care providers and enrollees upon request.

(d) The department and the Insurance Department shall ensure compliance with this article. The appropriate department shall investigate potential violations of the article based upon information received from enrollees, health care providers and other sources in order to ensure compliance with this article.

(e) The department and the Insurance Department shall promulgate such regulations as may be necessary to carry out the provisions of this article.

(f) The department in cooperation with the Insurance Department shall submit an annual report to the General Assembly regarding the implementation, operation and enforcement of this article.

Section 2182. Penalties and Sanctions.--(a) The department or the Insurance Department, as appropriate, may impose a civil penalty of up to five thousand ($5,000) dollars for a violation of this article.

(b) [A managed care plan] An insurer, MCO or contractor shall be subject to the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

(c) The department or the Insurance Department may maintain an action in the name of the Commonwealth for an injunction to prohibit any activity which violates the provisions of this article.

(d) The department may issue an order temporarily prohibiting [a managed care plan] an insurer, MCO or contractor which violates this article from enrolling new members.

(e) The department may require [a managed care plan] an insurer, MCO or contractor to develop and adhere to a plan of correction approved by the department. The department shall monitor compliance with the plan of correction. The plan of correction shall be available to enrollees of the [managed care plan] insurer, MCO or contractor upon request.

(f) In no event shall the department and the Insurance Department impose a penalty for the same violation.

Section 2191. Compliance with National Accrediting Standards.--Notwithstanding any other provision of this article to the contrary, the department shall give consideration to [a managed care plan's] an insurer's, MCO's or contractor's demonstrated compliance with the standards and requirements set forth in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance or other department-approved quality review organizations in determining compliance with the same or similar provisions of this article. The [managed care plan] insurer, MCO or contractor, however, shall remain subject to and shall comply with any other provisions of this article that exceed or are not included in the standards of the National Committee for Quality Assurance or other department-approved quality review organizations.

Section 11. This act shall apply to health insurance policies offered, issued or renewed on or after January 1, 2024.

Section 12. This act shall take effect in 30 days.

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

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from York, Senator Phillips-Hill.

Senator PHILLIPS-HILL. Mr. President, this amendment is the product of more than a year of working collaboratively with both the patient and provider coalition and the insurance industry, both of which have spent countless hours to provide input to this amendment. This amendment would do several things. It creates a new, more effective process for prior authorization review that keeps everything consistent and transparent from start to finish. It updates timelines for stages of review and ensures that all denials are made by properly licensed medical professionals in the same or similar specialty.

Additionally, the underlying bill only applies to managed care plans, which are Medicaid-managed care organizations and gatekeeper commercial insurance plans. This amendment would expand applicability to Medicaid; the Children's Health Insurance Program, known as CHIP; and fully insured commercial plans. The amendment also requires insurers to establish a provider portal for electronic submission, which will streamline the process and make submissions more efficient. The amendment requires the insurer to make all medical policies and clinical review criteria available on their publicly accessible website or portal, creating transparency on how insurers base their decisions. Additionally, the amendment streamlines the existing two levels of internal compliant and internal grievance review into a single review.

Finally, it makes significant changes to step therapy procedures, including aligning step therapy and prior authorization reviews so that the processes are similar. Mr. President, I respectfully ask my colleagues to cast an affirmative vote for this amendment to Senate Bill No. 225.

Thank you, Mr. President.

And the question recurring,
Will the Senate agree to the amendment?

The yeas and nays were required by Senator PHILLIPS-HILL and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A majority of the Senators having voted "aye," the question was determined in the affirmative.

On the question,

Will the Senate agree to the bill on second consideration, as amended?

It was agreed to.

Ordered, To be printed on the Calendar for third consideration.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill, as amended, was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

SB 297, HB 397, SB 527, SB 692, SB 718 and **SB 749** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION AND REREFERRED

SB 766 (Pr. No. 1799) -- The Senate proceeded to consideration of the bill, entitled:

An Act establishing the Adult Education and Workforce Recovery Grant Program and the Adult Education and Workforce Recovery Grant Program Fund; and imposing powers and duties on the Department of Education.

Considered the second time and agreed to,

Ordered, To be printed on the Calendar for third consideration.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

HB 803, SB 895, HB 940, SB 965 and **SB 1018** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION AND REREFERRED

SB 1035 (Pr. No. 1358) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 20 (Decedents, Estates and Fiduciaries) of the Pennsylvania Consolidated Statutes, in trusts, further providing for definitions, for trust instrument controls and mandatory rules - UTC 105, for governing law - UTC 107, for situs of trust, for nonjudicial settlement agreements - UTC 111, for charitable purposes; enforcement - UTC 405, for trust for care of animal - UTC 408, for noncharitable trust without ascertainable beneficiary - UTC 409, for reformation to correct mistakes - UTC 415, for modification to achieve settlor's tax objectives - UTC 416, for spendthrift provision - UTC 502, for creditor's claim against settlor - UTC 505(a), for overdue distribution - UTC 506, for revocation or amendment of revocable trust - UTC 602, for trustee's duties and powers of withdrawal - UTC 603, for accepting or declining trusteeship - UTC 701, for trustee's bond - UTC 702, for cotrustees - UTC 703, for vacancy in trusteeship and appointment of successor - UTC 704, for resignation of trustee and filing resignation, for compensation of trustee - UTC 708, for duty to administer trust - UTC 801, for duty of loyalty - UTC 802, for powers to direct - UTC 808, for duty to inform and report, for discretionary powers and for powers of trustees - UTC 815, providing for directed trusts, further providing for remedies for breach of trust--UTC 1001, providing for nonjudicial account settlement and further providing for reliance on trust instrument - UTC 1006, for exculpation of trustee - UTC 1008, for certification of trust - UTC 1013 and for title of purchaser.

Considered the second time and agreed to,

Ordered, To be printed on the Calendar for third consideration.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILL OVER IN ORDER AND LAID ON THE TABLE

HB 1041 (Pr. No. 3137) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in pupils and attendance, further providing for home education program.

Without objection, the bill was passed over in its order at the request of Senator K. WARD.

Pursuant to Senate Rule 9, the bill was laid on the table.

BILLS OVER IN ORDER

HB 1103, SB 1127 and **SB 1135** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION AND REREFERRED

SB 1152 (Pr. No. 1795) -- The Senate proceeded to consideration of the bill, entitled:

An Act establishing the Overdose Mapping System; providing for implementation and for use; and conferring powers and imposing duties on the Pennsylvania State Police.

Considered the second time and agreed to,

Ordered, To be printed on the Calendar for third consideration.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

SB 1180 and **SB 1182** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION, AMENDED AND REREFERRED

SB 1203 (Pr. No. 1759) -- The Senate proceeded to the consideration of the bill, entitled:

An Act preventing the Commonwealth from dealing with persons associated with the Government of Russia or the Government of Belarus; and imposing duties on the Treasury Department and the Attorney General.

On the question,

Will the Senate agree to the bill on second consideration?

ARGALL AMENDMENT A5069 AGREED TO

Senator ARGALL offered the following amendment No. A5069:

Amend Bill, page 2, line 9, by striking out the period after "entity" and inserting:

who is owned or controlled by, or acting for or on behalf of, Russia or Belarus as defined by the Office of Foreign Assets Control of the United States Department of Treasury as of the effective date of this definition.

Amend Bill, page 2, lines 12 through 26, by striking out ", using" in line 12 and all of lines 13 through 26 and inserting:

publish a list of persons.

Amend Bill, page 2, line 28, by striking out "every 90 days" and inserting:

annually

Amend Bill, page 3, line 2, by inserting after "into":

, be a party to

Amend Bill, page 3, line 5, by inserting after "for":

, be associated with

Amend Bill, page 3, line 7, by inserting after "for":

, receive

Amend Bill, page 3, lines 10 through 30; page 4, lines 1 through 9; by striking out all of said lines on said pages and inserting:

(a) Notice.--The Treasury Department shall publish a list of persons on its publicly accessible Internet website under section 3.

(b) Challenge.--A person may challenge the person's inclusion on the list under section 3 to the Attorney General. If the person demonstrates to the satisfaction of the Attorney General that the person should not be included on the list the person shall be stricken from the list.

Amend Bill, page 4, lines 12 through 16, by striking out "THAT ARE EXEMPTED FROM THIS ACT" in line 12 and all of lines 13 through 16 and inserting:

as identified as critical by the United States Department of the Interior under Executive Order 13817. Any person who provides, obtains or supplies a mineral identified as critical minerals or materials to the Federal Government or United States domiciled business shall, upon notification to the Treasury Department, be removed from the list and exempted from any restrictions imposed by this act. This list shall be reviewed annually and updated by the Treasury Department.

Section 7. Construction.

Nothing in this act shall be construed to prohibit transactions authorized by the Federal Government or under Federal law.

Amend Bill, page 4, line 17, by striking out "7" and inserting:

8

Amend Bill, page 4, line 18, by striking out "30" and inserting:

60

On the question,

Will the Senate agree to the amendment?

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Schuylkill, Senator Argall.

Senator ARGALL. Mr. President, this is a technical amendment suggested by the State Treasurer to make this bill similar to existing prohibitions which we have already placed on Iran and Sudan. The goal is to ensure that Pennsylvania tax dollars cannot be used to support the Russian government's invasion of Ukraine.

And the question recurring,

Will the Senate agree to the amendment?

It was agreed to.

On the question,

Will the Senate agree to the bill on second consideration, as amended?

It was agreed to.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill, as amended, was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

SB 1209, SB 1226, SB 1227, SB 1228 and **SB 1229** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION AND REREFERRED

SB 1243 (Pr. No. 1800) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in terms and courses of study, providing for economics and personal finance course graduation requirement and further providing for economic education and personal financial literacy programs; and abrogating regulations.

Considered the second time and agreed to,

Ordered, To be printed on the Calendar for third consideration.

Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

SB 1251 and **SB 1265** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILLS ON SECOND CONSIDERATION AND REREFERRED

SB 1277 (Pr. No. 1738) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in terms and courses of study, providing for parental notification relating to instructional materials and books containing sexually explicit content.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

SB 1278 (Pr. No. 1739) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, providing for student well-being.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

SB 1281, SB 1282, SB 1286, HB 1500, HB 1594 and **HB 1866** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION

HB 1867 (Pr. No. 3278) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, providing for Purple Star School Program.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.

BILL OVER IN ORDER

HB 1947 -- Without objection, the bill was passed over in its order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION
AND REREFERRED

HB 2039 (Pr. No. 2385) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of November 24, 1998 (P.L.882, No.111), known as the Crime Victims Act, in crime victims, further providing for rights.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

HB 2075, HB 2116, HB 2148 and **HB 2157** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILLS ON SECOND CONSIDERATION
AND REREFERRED

HB 2169 (Pr. No. 3288) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, establishing the Lifeline Scholarship Program.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

HB 2209 (Pr. No. 2976) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 68 (Real and Personal Property) of the Pennsylvania Consolidated Statutes, in land banks, further providing for legislative findings and purpose, for board, for powers and for disposition of property and providing for exemption from realty transfer tax.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILLS OVER IN ORDER

HB 2214, HB 2265 and **HB 2271** -- Without objection, the bills were passed over in their order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION
AND REREFERRED

HB 2412 (Pr. No. 2973) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 51 (Military Affairs) of the Pennsylvania Consolidated Statutes, in the Governor as Commander-in-Chief, providing for use of Pennsylvania National Guard for special State duty; and making a related repeal.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

BILL OVER IN ORDER

HB 2447 -- Without objection, the bill was passed over in its order at the request of Senator K. WARD.

BILL ON SECOND CONSIDERATION

HB 2464 (Pr. No. 2978) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending the act of November 24, 1998 (P.L.882, No.111), known as the Crime Victims Act, in crime victims, providing for legal standing.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.

BILL ON SECOND CONSIDERATION AND REREFERRED

HB 2525 (Pr. No. 3286) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 18 (Crimes and Offenses) of the Pennsylvania Consolidated Statutes, in criminal history record information, providing for crime victim right of access.

Considered the second time and agreed to,
Ordered, To be printed on the Calendar for third consideration.
Upon motion of Senator K. WARD, and agreed to by voice vote, the bill just considered was rereferred to the Committee on Appropriations.

SENATE RESOLUTION No. 285, ADOPTED

Senator K. WARD, without objection, called up from page 15 of the Calendar, **Senate Resolution No. 285**, entitled:

A Resolution directing the Joint State Government Commission to conduct an assessment and analysis of public and private recycling infrastructure and operations across the Commonwealth.

And the amendments made thereto having been printed as required by the Constitution,

On the question,
Will the Senate adopt the resolution?

The yeas and nays were required by Senator K. WARD and were as follows, viz:

YEA-48

Argall	Costa	Laughlin	Schwank
Aument	Dillon	Martin	Stefano
Baker	DiSanto	Mastriano	Street
Bartolotta	Dush	Mensch	Tartaglione
Boscola	Flynn	Muth	Tomlinson
Brewster	Fontana	Phillips-Hill	Vogel
Brooks	Gebhard	Pittman	Ward, Judy
Browne	Haywood	Regan	Ward, Kim
Cappelletti	Hughes	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak

NAY-1

Hutchinson

A majority of the Senators having voted "aye," the question was determined in the affirmative.
The PRESIDENT pro tempore. The resolution is adopted.

BILLS REPORTED FROM COMMITTEE

Senator BROWNE, from the Committee on Appropriations, reported the following bills:

SB 145 (Pr. No. 1554) (Rereported)

An Act amending Title 75 (Vehicles) of the Pennsylvania Consolidated Statutes, in size, weight and load, further providing for restrictions on use of highways and bridges.

SB 892 (Pr. No. 1765) (Rereported)

An Act amending Title 75 (Vehicles) of the Pennsylvania Consolidated Statutes, in special vehicles and pedestrians, providing for electric low-speed scooter pilot program.

SB 1188 (Pr. No. 1585) (Rereported)

An Act providing for patient access to diagnostics and treatments for Lyme disease and related tick-borne illnesses; and requiring health care policies to provide certain coverage.

SB 1194 (Pr. No. 1758) (Rereported)

An Act amending Title 51 (Military Affairs) of the Pennsylvania Consolidated Statutes, in military educational programs, establishing the Military College Educational Assistance Program; and making editorial changes.

HB 331 (Pr. No. 306) (Rereported)

An Act authorizing certain financial institutions to conduct savings promotion programs.

HB 2419 (Pr. No. 2841) (Rereported)

An Act amending the act of May 31, 2018 (P.L.123, No.25), known as the Outpatient Psychiatric Oversight Act, further providing for definitions and for requirements.

HB 2420 (Pr. No. 2831) (Rereported)

An Act amending the act of May 11, 1889 (P.L.188, No.210), entitled "A further supplement to an act, entitled 'An act to establish a board of wardens for the Port of Philadelphia, and for the regulation of pilots and pilotage, and for other purposes,' approved March twenty-ninth, one thousand eight hundred and three, and for regulating the rates of pilotage and number of pilots," further providing for rates of pilotage and computation, for pilotage fees and unit charge and for charges for services.

HB 2653 (Pr. No. 3287)

An Act making appropriations from the Professional Licensure Augmentation Account and from restricted revenue accounts within the General Fund to the Department of State for use by the Bureau of Professional and Occupational Affairs in support of the professional licensure boards assigned thereto.

HB 2654 (Pr. No. 3211)

An Act making appropriations from the Workmen's Compensation Administration Fund to the Department of Labor and Industry and the Department of Community and Economic Development to provide for the expenses of administering the Workers' Compensation Act, The Pennsylvania Occupational Disease Act and the Office of Small Business Advocate for the fiscal year July 1, 2022, to June 30, 2023, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2022.

HB 2655 (Pr. No. 3212)

An Act making an appropriation from a restricted revenue account within the General Fund to the Office of Small Business Advocate in the Department of Community and Economic Development.

HB 2656 (Pr. No. 3213)

An Act making an appropriation from a restricted revenue account within the General Fund to the Office of Consumer Advocate in the Office of Attorney General.

HB 2657 (Pr. No. 3214)

An Act making appropriations from the Public School Employees' Retirement Fund and from the PSERS Defined Contribution Fund to provide for expenses of the Public School Employees' Retirement Board for the fiscal year July 1, 2022, to June 30, 2023, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2022.

HB 2658 (Pr. No. 3215)

An Act making appropriations from the State Employees' Retirement Fund and from the SERS Defined Contribution Fund to provide for expenses of the State Employees' Retirement Board for the fiscal year July 1, 2022, to June 30, 2023, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2022.

HB 2659 (Pr. No. 3216)

An Act making appropriations from the Philadelphia Taxicab and Limousine Regulatory Fund and the Philadelphia Taxicab Medallion Fund to the Philadelphia Parking Authority for the fiscal year July 1, 2022, to June 30, 2023.

HB 2661 (Pr. No. 3217)

An Act making appropriations from a restricted revenue account within the General Fund and from Federal augmentation funds to the Pennsylvania Public Utility Commission for the fiscal year July 1, 2022, to June 30, 2023.

HB 2662 (Pr. No. 3218)

An Act making appropriations from the restricted revenue accounts within the State Gaming Fund and from the restricted revenue accounts within the Fantasy Contest Fund and Video Gaming Fund to the Attorney General, the Department of Revenue, the Pennsylvania State Police and the Pennsylvania Gaming Control Board for the fiscal year beginning July 1, 2022, to June 30, 2023, and for the payment of bills incurred and remaining unpaid at the close of the fiscal year ending June 30, 2022.

SPECIAL ORDER OF BUSINESS
SUPPLEMENTAL CALENDAR No. 1

BILLS ON THIRD CONSIDERATION
AND FINAL PASSAGE

SB 892 (Pr. No. 1765) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 75 (Vehicles) of the Pennsylvania Consolidated Statutes, in special vehicles and pedestrians, providing for electric low-speed scooter pilot program.

Considered the third time and agreed to,

And the amendments made thereto having been printed as required by the Constitution,

On the question,

Shall the bill pass finally?

The yeas and nays were taken agreeably to the provisions of the Constitution and were as follows, viz:

YEA-47

Argall	Costa	Martin	Stefano
Aument	Dillon	Mastriano	Street
Baker	DiSanto	Mensch	Tartaglione
Bartolotta	Dush	Muth	Tomlinson
Boscola	Flynn	Phillips-Hill	Vogel
Brewster	Fontana	Pittman	Ward, Judy
Brooks	Haywood	Regan	Ward, Kim
Browne	Hughes	Robinson	Williams, Anthony H.
Cappelletti	Kane	Santarsiero	Williams, Lindsey
Collett	Kearney	Saval	Yaw
Comitta	Langerholc	Scavello	Yudichak
Corman	Laughlin	Schwank	

NAY-2

Gebhard	Hutchinson

A constitutional majority of all the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate present said bill to the House of Representatives for concurrence.

SB 1188 (Pr. No. 1585) -- The Senate proceeded to consideration of the bill, entitled:

An Act providing for patient access to diagnostics and treatments for Lyme disease and related tick-borne illnesses; and requiring health care policies to provide certain coverage.

Considered the third time and agreed to,

And the amendments made thereto having been printed as required by the Constitution,

On the question,

Shall the bill pass finally?

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Mercer, Senator Brooks.

Senator BROOKS. Mr. President, Senate Bill No. 1188 establishes the Lyme Disease and Related Tick-Borne Illness, Diagnosis, and Treatment Act. We have all known someone who has had, or we ourselves may have discovered, a tick on us. We often hear about Lyme disease, but the other tick-related diseases are just as crippling. Pennsylvania has ranked the highest in the country in the number of confirmed Lyme disease cases for the past decade. From 2000 to 2021, there have been more than 110,000 confirmed Lyme disease cases in this Commonwealth, but since the CDC's number only represents confirmed cases, the actual number of Lyme disease cases may be far greater. These numbers continue to increase, and Pennsylvania is categorized as a high-incidence area. Early diagnosis and appropriate treatment of these tick-borne diseases and illnesses is paramount, as reactions can affect every system and organ of the human body and often every aspect of an individual's life. Between 10 and 40 percent of Lyme disease patients may go on to suffer from complex, chronic, persistent conditions which may be more difficult to treat, debilitating, and even cause death. This is an epidemic of its own proportion, impacting Pennsylvanians in all corners of the State, not just rural Pennsylvania, but also urban and suburban counties as well. By example, in 2019, the top 5 counties in Pennsylvania with the largest number of cases, as reported by the Department of Health, begin with (1) Chester County, (2) Westmoreland County, (3) Butler County, (4) Bucks County, and (5) Montgomery County. My legislation seeks to combat long-term effects of Lyme and other tick-borne illnesses by ensuring that healthcare professionals have the most up-to-date data and information regarding tick-related diseases. The legislation provides for more thorough insurance coverage for diagnostic testing and treatment.

Mr. President, I have heard from person after person who have shared their stories of the pain and anguish that they have suffered, which could have been avoided if their insurance would have covered their treatments. This legislation would help ensure future insurance coverage for better testing, and if needed, more extensive treatment for tick-related diseases. Additionally, this legislation requires the Department of Health to work with the Tick Research Lab of Pennsylvania at East Stroudsburg University to develop an electronic database for use by the lab, the department, and healthcare professionals. The database shall include non-identifiable patient information including the tick testing information, results, and zip code and county location of where the tick was extracted via the tick lab; diagnostic testing information and results; and the surveillance criteria applied to determine the confirmed or suspected patient diagnosis from the attending healthcare professional. This legislation also requires the Department of Health to work with the Tick Research Lab of Pennsylvania at East Stroudsburg University to develop an electronic database for use by the lab, the department, and healthcare professionals. This data will help advance research to combat this crisis that is impacting the health and quality of life of so many Pennsylvanians.

I would like to thank the Lyme disease community, patients and stakeholders, the Pennsylvania Lyme Resource Network, and the Lyme Disease Society for their advocacy and ongoing support to improve the lives of people affected by tick-borne illnesses, especially the Tick Research Lab of Pennsylvania at East Stroudsburg University and its director, Nicole Chinnici, for their extensive research and commitment to reducing the tick population here in Pennsylvania and improving the quality of life of those impacted by these tick-borne illnesses. I would like to remind everyone that if you find a tick, collect it and send it in for free testing at the tick lab at ticklab.org. You will receive your results in 2 or 3 days from the lab, as well as the diseases the tick was tested for. Through the partnership of the General Assembly and the Department of Health, this testing is made possible free of charge to all Pennsylvania residents.

Thank you, Mr. President.

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Montgomery, Senator Haywood.

Senator HAYWOOD. Mr. President, I rise just to raise a concern about the legislation, although I will be voting in favor of it, with the hopes that it can be amended in the House. This legislation is important, as has already been described by my colleague, Senator Brooks. However, an amendment has been recommended by DHS so that the coverage for what would be reimbursed would only be what is called medically necessary and appropriate. Medically necessary and appropriate. If we can get that amendment in the House, then we will have legislation that is clearly aligned with the State plan, clearly aligned with what the Federal government will reimburse, and we will then not create any jeopardy for funding the program and getting Federal matching dollars.

Thank you, Mr. President.

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Cambria, Senator Langerholc.

Senator LANGERHOLC. Mr. President, I rise in full support of this legislation and, very briefly, just want to thank my colleague for her diligent work addressing this issue. This is an issue that, quite frankly, constituents and residents of Pennsylvania, of our great Commonwealth, deserve special attention. I think this is something that we can all come together on and deserves our paramount attention. Because this is a debilitating illness, and so often it goes either misdiagnosed or undiagnosed and leads to catastrophic consequences. I fully support this and look forward as this first step in continuing our efforts to address this debilitating illness, and I would ask for full support and, again, thank my colleague for her work on this legislation.

Thank you, Mr. President.

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Monroe, Senator Scavello.

Senator SCAVELLO. Mr. President, I grew up in the Monroe County area with my children, and I have seen it grow, and I have seen the effect that it has on people and how it has grown across our Commonwealth. I spoke about it in the House on many occasions--Department of Health during the Committee on Appropriations hearings. This is not going to go away, and unless we help these folks who are in a tremendous amount of pain that--a good friend of mine, he is a Representative in the House, I knew his wife very well, still know very well, she is with a cane right now because she cannot walk because of the effects from Lyme disease, and it is so hard to see that and that we cannot help them. They are on their own. They are spending the dollars to get whatever she can get. But we need to do a better job and take care of those folks out there who have had Lyme, living with Lyme right now, and we need to help them. I thank the maker of this bill to

continue forward, and, hopefully, at some point, we can help those folks who have been living with Lyme for years.

Thank you, Mr. President.

And the question recurring,
Shall the bill pass finally?

The yeas and nays were taken agreeably to the provisions of the Constitution and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A constitutional majority of all the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate present said bill to the House of Representatives for concurrence.

SB 1194 (Pr. No. 1758) -- The Senate proceeded to consideration of the bill, entitled:

An Act amending Title 51 (Military Affairs) of the Pennsylvania Consolidated Statutes, in military educational programs, establishing the Military College Educational Assistance Program; and making editorial changes.

Considered the third time and agreed to,
And the amendments made thereto having been printed as required by the Constitution,

On the question,
Shall the bill pass finally?

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Montgomery, Senator Mensch.

Senator MENSCH. Mr. President, Senate Bill No. 1194 seeks to provide a pathway for Military College of Pennsylvania cadets to commission early into the Pennsylvania Army National Guard--or the Air National Guard, if they choose--as an officer, while providing support for them to complete their bachelor's degree while they remain in a National Guard. The program is modeled after similar military education programs established in Title 51 to recruit, train, educate, and retain cadets into commission officers through the early officer reserve commissioning process. In agreeing to an 8-year service obligation, cadets will receive educational grants for attendance in the Military College of Pennsylvania, as well as to continue their education at a participating PASSHE university or, if they choose, at another college or university within the Commonwealth. Mr. President, thank you. I ask for an affirmative vote from my colleagues.

And the question recurring,
Shall the bill pass finally?

The yeas and nays were taken agreeably to the provisions of the Constitution and were as follows, viz:

YEA-49

Argall	Dillon	Laughlin	Schwank
Aument	DiSanto	Martin	Stefano
Baker	Dush	Mastriano	Street
Bartolotta	Flynn	Mensch	Tartaglione
Boscola	Fontana	Muth	Tomlinson
Brewster	Gebhard	Phillips-Hill	Vogel
Brooks	Haywood	Pittman	Ward, Judy
Browne	Hughes	Regan	Ward, Kim
Cappelletti	Hutchinson	Robinson	Williams, Anthony H.
Collett	Kane	Santarsiero	Williams, Lindsey
Comitta	Kearney	Saval	Yaw
Corman	Langerholc	Scavello	Yudichak
Costa			

NAY-0

A constitutional majority of all the Senators having voted "aye," the question was determined in the affirmative.

Ordered, That the Secretary of the Senate present said bill to the House of Representatives for concurrence.

UNFINISHED BUSINESS
BILLS REPORTED FROM COMMITTEES

Senator TOMLINSON, from the Committee on Consumer Protection and Professional Licensure, reported the following bills:

SB 485 (Pr. No. 1811) (Amended)

An Act amending the act of October 10, 1975 (P.L.383, No.110), known as the Physical Therapy Practice Act, further providing for definitions, for training and license required and exceptions, for qualifications for license, examinations, failure of examinations, licensure without examination, issuing of license, foreign applicants for licensure, temporary license and perjury and for physical therapist assistant, education and examination, scope of duties and certification.

SB 1160 (Pr. No. 1812) (Amended)

An Act amending the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, further providing for definitions; and abrogating an inconsistent regulation.

SB 1161 (Pr. No. 1813) (Amended)

An Act amending the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, further providing for definitions; and abrogating an inconsistent regulation.

SB 1287 (Pr. No. 1814) (Amended)

An Act amending the act of May 3, 1933 (P.L.242, No.86), referred to as the Cosmetology Law, providing for floor space.

Senator HUTCHINSON, from the Committee on Finance, reported the following bills:

SB 1205 (Pr. No. 1610)

An Act amending the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, in waterfront development tax credit, further providing for limitations.

HB 385 (Pr. No. 3034)

An Act amending the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, in personal income tax, further providing for classes of income; and making a related repeal.

HB 1342 (Pr. No. 1440)

An Act amending the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, in inheritance tax, further providing for transfers not subject to tax.

Senator BROOKS, from the Committee on Health and Human Services, reported the following bills:

HB 1561 (Pr. No. 2317)

An Act amending the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, in general provisions, further providing for definitions and for confidentiality of records.

HB 1563 (Pr. No. 2318)

An Act amending the act of April 14, 1972 (P.L.221, No.63), known as the Pennsylvania Drug and Alcohol Abuse Control Act, further providing for definitions and for confidentiality of records.

HB 2604 (Pr. No. 3255)

An Act amending the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, in licensing of health care facilities, further providing for photo identification tag regulations.

BILLS ON FIRST CONSIDERATION

Senator BARTOLOTTA. Mr. President, I move that the Senate do now proceed to consideration of all bills reported from committees for the first time at today's Session.

The motion was agreed to by voice vote.

The bills were as follows:

SB 485, SB 511, SB 548, SB 1160, SB 1161, SB 1205, SB 1287, SB 1289, HB 385, HB 1186, HB 1342, HB 1561, HB 1563, HB 2604, HB 2653, HB 2654, HB 2655, HB 2656, HB 2657, HB 2658, HB 2659, HB 2661 and **HB 2662**.

And said bills having been considered for the first time,

Ordered, To be printed on the Calendar for second consideration.

ANNOUNCEMENTS BY THE SECRETARY

The following announcements were read by the Secretary of the Senate:

SENATE OF PENNSYLVANIA

COMMITTEE MEETINGS

THURSDAY, JUNE 23, 2022

9:00 A.M.	STATE GOVERNMENT (public hearing on Senate Bills No. 488 and 492; and House Bill No. 2524)	Room 8E-A East Wing (LIVE STREAMED)
10:30 A.M.	STATE GOVERNMENT (to consider Senate Bills No. 488, 492 and 1130; and House Bills No. 2485 and 2524) **C A N C E L L E D**	Room 8E-A East Wing (LIVE STREAMED)

MONDAY, JUNE 27, 2022

12:30 P.M.	TRANSPORTATION (to consider Senate Bills No. 167, 1123, 1249 and 1299; and House Bills No. 140, 1486 and 2526)	Room 461 Main Capitol
Off the Floor	APPROPRIATIONS (to consider Senate Bills No. 225, 1152, 1201, 1277 and 1278; and House Bills No. 129, 146, 1598, 1615, 1780, 2039, 2097, 2412 and 2426)	Senate Chamber (LIVE STREAMED)
Off the Floor	RULES AND EXECUTIVE NOMINATIONS (to consider Senate Bills No. 477 and 563 and certain Executive Nominations)	Senate Chamber (LIVE STREAMED)
Off the Floor	STATE GOVERNMENT (to consider House Bills No. 2115 and 2219)	Rules Cmte. Conf. Room.
Off the Floor	URBAN AFFAIRS AND HOUSING (to consider House Bill No. 1935)	Rules Cmte. Conf. Room.

TUESDAY, JUNE 28, 2022

10:00 A.M.	STATE GOVERNMENT (to consider Senate Bills No. 488, 492 and 1130; and House Bills No. 2115, 2219, 2485 and 2524)	Room 8E-A East Wing (LIVE STREAMED)
11:00 A.M.	TRANSPORTATION (to consider Senate Bills No. 167, 1123, 1249 and 1299; and House Bills No. 140, 1486 and 2526)	Room 461 Main Capitol
Off the Floor	APPROPRIATIONS (to consider Senate Bills No. 225, 1152, 1201, 1277 and 1278; and House Bills No. 129, 146, 1598, 1665, 1780, 2039, 2097 and 2412)	Senate Chamber (LIVE STREAMED)
Off the Floor	JUDICIARY (to consider House Bills No. 975 and 2032)	Rules Cmte. Conf. Room.
Off the Floor	RULES AND EXECUTIVE NOMINATIONS (to consider Senate Bills No. 477, 563 and 1236; and certain Executive Nominations)	Senate Chamber (LIVE STREAMED)
Off the Floor	URBAN AFFAIRS AND HOUSING (to consider House Bill No. 1935)	Rules Cmte. Conf. Room.

THURSDAY, JULY 7, 2022

10:00 A.M.	ENVIRONMENTAL RESOURCES AND ENERGY and LABOR AND INDUSTRY (joint public hearing on Importance of Pennsylvania Waterways to Energy and Economic Development)	Point Park University 201 Wood St. Pittsburgh

PETITIONS AND REMONSTRANCES

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Lebanon, Senator Gebhard.

Senator GEBHARD. Mr. President, I recently introduced a Senate resolution celebrating the 275th birthday of the Pennsylvania National Guard on December 7, 2022. The rich history of the Pennsylvania National Guard began in 1747, when Benjamin Franklin created the Associators in Philadelphia to provide for a common defense. Since then, this organization's members have stood alongside General Washington in the American Revolution, fought gallantly in the Civil War, helped liberate Paris from the Nazis in World War II, and in more recent years, provided much-needed support during peacekeeping operations across the globe. At home, the Guard has been utilized numerous times to provide humanitarian assistance during natural disasters, most notably during the flooding associated with Hurricanes Agnes and Ida.

Today, the Pennsylvania National Guard has grown to over 18,000 personnel and is the second largest of all the State National Guards. Headquartered at Fort Indiantown Gap in Lebanon County, the PA Guard hosted training for over 110,000 troops from all over the world last year. Fort Indiantown Gap is consistently ranked as one of the busiest military training centers in the United States. From providing humanitarian assistance at home to supporting military operations throughout the world, the Pennsylvania National Guard has been an invaluable resource for the citizens of our Commonwealth. Please join me in honoring their history and celebrating their 275th birthday. Thank you.

The PRESIDENT pro tempore. The Chair recognizes the gentlewoman from Montgomery, Senator Cappelletti.

Senator CAPPELLETTI. Mr. President, I believe, like so many other Pennsylvanians, that we must be trusted and free to make our own healthcare decisions within the safety of our physician-patient relationships. Today I rise to advocate for protecting access to one of the safest medical procedures that exists. The United States Supreme Court is poised to overturn *Roe* v. *Wade* any day now. That means that a person's ability to access reproductive healthcare will hinge on State legislatures all across this country. In far too many States, people who can become pregnant will be denied the necessary healthcare that they deserve. People who can become pregnant will be denied their freedom to choose their own destiny. Here in Pennsylvania, this Chamber has proven that it is willing to deny people the freedom to decide for themselves what the best reproductive healthcare choices are for them and their families. Where we are right now is truly stunning, and it feels very overwhelming.

Roe has been the law of the land for over 50 years. Generations have lived with the assumption that they have access to abortion care. Our modern way of life has been influenced and has benefited from safe abortion access, and abortion is one of the safest medical procedures that exists. Throughout the more than 20 years that it has been used in the United States, medication abortion has been proven to be overwhelmingly safe and effective. Procedural abortions are also a safe and effective medical procedure with rare complications, and they are also used to help treat miscarriages. Having an abortion is common and normal. In fact, out of 2014 abortion rates, about 1 in 4 women, or childbearing individuals, will have an abortion by the age of 45. That means that everyone in this Chamber loves someone who has had an abortion. That means it is likely that everyone in this Chamber knows someone who has had an abortion. That means that everyone in Pennsylvania knows or loves someone who has had or will have an abortion, whether or not you know it.

It is not only women and childbearing individuals who will be hurt by stripping away access to reproductive healthcare. Men are a large part of this conversation and will also face lasting consequences once access to abortion is stripped away by the conservative Supreme Court Majority and left in the hands of State governments, bodies that are largely dominated by older white men with means and resources should a loved one need access to abortion care. A 2022 report has estimated that approximately 1 in 5 men have been involved in an abortion, which is likely an underestimate as some men might misreport either because of stigma or because they are simply unaware of the abortion. I know that the people in this Chamber have their minds made up on where they stand on abortion, and I know that the Majority party will not move legislation that protects a vital and crucial healthcare procedure.

Honestly, it is sad and absolutely infuriating that this is where we are, and I know that I am not the only one who feels this way. That is why I am here today, to speak to the Pennsylvanians who are also feeling powerless and hopeless about the current state of abortion care in our country. We are not alone. We are in this together, and we are strengthened by our collective action. We still have the power to make our voices heard. I encourage Pennsylvanians to speak up and talk to your elected officials, your friends, your family, your loved ones, about why access to abortion care is important to you. Maybe you have a story that you are willing to share. Maybe you have concerns about birth control failing, or maybe you have no desire to ever become a parent. Maybe it is a decision that you cannot afford more children, or maybe you are prioritizing your own personal health because the doctor has told you that if you ever carry a pregnancy again, you will die. Whatever it is, whatever you are comfortable sharing, your voice is an important piece of this conversation, and it deserves to be heard. It might not be an easy conversation, but that does not make it any less important. Sharing your story has power. Please do not miss an opportunity to use that power.

Thank you, Mr. President.

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Allegheny, Senator Costa.

Senator COSTA. Mr. President, I offer two sets of petitions on behalf of Senator Tartaglione, one dealing with minimum wage and one dealing with Disability Pride Month. Thank you.

The PRESIDENT pro tempore. Without objection, the remarks will be spread upon the record.

(The following prepared remarks were made part of the record at the request of the gentleman from Allegheny, Senator COSTA, on behalf of the gentlewoman from Philadelphia, Senator TARTAGLIONE:)

Mr. President, I rise because today marks 5,827 days since this Commonwealth's legislature last passed an increase in our State's minimum wage. Mr. President, I do not want to speak for all Members' interactions with their constituents, but whenever I am home, I know one of the most common things I am stopped on the street to discuss is our minimum wage and the lack of action taken in the last nearly 16 years. Sixteen years, Mr. President, of doing nothing to help our lowest earners, the people who, right now, inarguably need help the most. Now, I do not know about you, Mr. President, but I think 16 years is far too long.

In 2006, I fought for a raise in the wage, and we won. We raised the minimum wage from $5.15 to $7.15--just 10 cents less than our current minimum wage of $7.25, which is mandated by the Federal government--more than 12 years ago. Mr. President, every Session since we won the last minimum wage fight, I have introduced legislation to raise the minimum wage, and this year is no different. In fact, just yesterday I ran into our former colleague with whom I negotiated the increase. He has since retired from the Senate, but he took the time to comment on my continued advocacy to increase the minimum wage since we did not tie future increases in the minimum wage to the Consumer Price Index, or CPI, way back then.

Senate Bill No. 12, my current legislation, which would raise our minimum wage and tie future increases to the CPI, is currently just sitting in the Committee on Labor and Industry. Mr. President, legislation that would boost the wages of more than 1 million workers across the Commonwealth is just stalled in committee, being buried by special interests that have no desire to see our middle class grow. Let us act for our constituents and the workers of Pennsylvania and pass Senate Bill No. 12.

Thank you, Mr. President.

Mr. President, I rise to highlight an issue near and dear to my heart. I am asking my colleagues to join me in recognizing June 6 through June 11, 2022, as Disability Pride Week in Pennsylvania. This week is designed to change the way people think about and define "disability."

Disability pride is all about accepting and honoring each person's uniqueness and seeing it as a natural and beautiful part of human diversity. It rejects the notion that certain physical, mental, or cognitive differences are negative or wrong and promotes acceptance, dignity, and pride. As all of you know, 19 years ago a boating accident put me in this wheelchair. In the accident, I fractured my vertebrae and partially severed my spinal cord. This has come with countless challenges, but also has been a blessing in disguise. I went through the stages of grief. I was angry. I asked why. But through it all, I realized l had a higher calling.

I was put in this position to be an advocate for those who have a disability. For those 19 years, I have fought to ensure Pennsylvania is a place that is accepting of all. That is why I am honored and delighted to recognize the week of June 6 through 11 as Disability Pride Week here in Pennsylvania, which coincides with the 10th anniversary of Disability Pride Philadelphia. Recognizing Disability Pride Week is crucial in recognizing that disabilities are a natural part of human diversity, and we must celebrate our differences and recognize and end ableism and stigmas.

Thank you, Mr. President.

RESOLUTION SIGNED

The PRESIDENT pro tempore (Senator Jacob D. Corman III) in the presence of the Senate signed the following resolution:

HR 203.

RECESS

The PRESIDENT pro tempore. The Chair recognizes the gentleman from Venango, Senator Hutchinson.

Senator HUTCHINSON. Mr. President, I move that the Senate do now recess until Monday, June 27, 2022, at 1 p.m., Eastern Daylight Saving Time, unless sooner recalled by the President pro tempore.

The motion was agreed to by voice vote.

The Senate recessed at 3:14 p.m., Eastern Daylight Saving Time.

(Session for June 27, 2022, was cancelled, but concsistent with the Weekly Recess Resolution, the Senate was recessed until Tuesday, June 28, 2022, at 12 m., Eastern Daylight Saving Time.)