THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL No. 20 Session of 1991

INTRODUCED BY KUKOVICH, RICHARDSON, PISTELLA, JOSEPHS, KOSINSKI, STUBAN, VAN HORNE, STISH, GIGLIOTTI, LAUGHLIN, PESCI, BELARDI, HARPER, McNALLY, FREEMAN, ROEBUCK, STURLA, RITTER, HALUSKA, MARKOSEK, GEORGE, WAMBACH, DELUCA, LAGROTTA, KASUNIC, ROBINSON, CAPPABIANCA, HANNA, CARN, TIGUE, HERMAN, BELFANTI, MIHALICH, DALEY, BUNT, JAMES, BISHOP, VEON, MAIALE, TANGRETTI, TRELLO, HUGHES, MELIO, PRESTON, LEVDANSKY, TRICH, WILLIAMS, R. C. WRIGHT, THOMAS, STEELMAN AND TELEK, MARCH 11, 1991

AS RE-REPORTED FROM COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, AS AMENDED, DECEMBER 11, 1991

AN ACT

1	Providing a comprehensive plan for health care for the indigent;	<
2	providing further duties of the Department of Health, the	
3	Department of Public Welfare and the Department of Revenue;	
4	providing for a hospital payment system and for certain	
5	responsibilities under the medical assistance program;	
6	providing primary health care programs for children and	
7	adults; establishing the Pennsylvania Health Care Fund;	
8	providing for certain tax credits; providing for enforcement	
9	and civil penalties; providing for certain health care	
10	studies; further providing for eligibility for medical	
11	assistance; and making repeals.	
12	TABLE OF CONTENTS	
13	Chapter 1. General Provisions	
14	Section 101. Short title.	
15	Section 102. Legislative findings and intent.	
16	Section 103. Definitions.	

- 17 Chapter 3. Pennsylvania Hospital Fair Share Program
- 18 Section 301. Establishment and purpose.

- 1 Section 302. Computation.
- 2 Section 303. Disproportionate share hospital.
- 3 Section 304. Expenditures from fund.
- 4 Section 305. Provision of charity care by hospitals.
- 5 Section 306. Use of fund moneys to reduce costs shifted to
 - other health care payors.
- 7 Chapter 5. Medical Assistance Program
- 8 Section 501. Hospital responsibilities under medical assistance
- 9 program.

6

- 10 Section 502. Medical assistance outreach.
- 11 Section 503. Pennsylvania Children's Medical Assistance
- 12 program.
- 13 Chapter 7. Primary Health Care Programs
- 14 Section 701. Children's Health Care Plan.
- 15 Section 702. Uninsured workers and adults.
- 16 Section 703. Outreach and quality assurance.
- 17 Chapter 9. Pennsylvania Health Care Fund
- 18 Section 901. Establishment.
- 19 Section 902. Purpose.
- 20 Section 903. Administration.
- 21 Section 904. Assessment.
- 22 Section 905. Civil penalty.
- 23 Section 906. Financial provisions.
- 24 Chapter 11. Small Business Health Insurance Tax Credit
- 25 Section 1101. Eligibility.
- 26 Section 1102. Calculation of credit.
- 27 Section 1103. Rules and regulations.
- 28 Section 1104. Reports to General Assembly.
- 29 Chapter 13. Access to Health Care
- 30 Section 1301. Health maintenance organizations.

- 1 Section 1302. Continuity on replacement of a group policy.
- 2 Section 1303. Extension of benefits for disabled persons.
- 3 Section 1304. Continuity for individual who changes groups.
- 4 Section 1305. Limitations on exclusions and waiting periods.
- 5 Section 1306. Waiting period for preexisting conditions.
- 6 Section 1307. Enforcement.
- 7 Chapter 15. Studies and Hearings on Health Care
- 8 Section 1501. Hospital uncompensated charity care study.
- 9 Section 1502. Medicaid reimbursement.
- 10 Section 1503. Cost of mandated health benefits.
- 11 Section 1504. Physician acceptance of medical assistance
- 12 patients.
- 13 Section 1505. Subsidies provided by health service corporation
- 14 and hospital plan corporations.
- 15 Chapter 31. Miscellaneous Provisions.
- 16 Section 3101. Persons eligible for medical assistance.
- 17 Section 3102. Mandated coverage.
- 18 Section 3103. Group accident and sickness insurance.
- 19 Section 3104. Construction and application of Chapters 3 and 9.
- 20 Section 3105. Repeals.
- 21 Section 3106. Expiration.
- 22 Section 3107. Effective date.

PROVIDING A COMPREHENSIVE PLAN FOR HEALTH CARE FOR THE INDIGENT, <---
FOR OPERATION OF MEDICAL ASSISTANCE, FOR PRIMARY HEALTH CARE
PROGRAMS, FOR ACCESS TO HEALTH CARE, FOR HEALTH INSURANCE
REFORM AND FOR STUDIES ON HEALTH CARE; FURTHER PROVIDING FOR
STATE FUNDS AND FOR POWERS AND DUTIES OF ADMINISTRATIVE
AGENCIES; IMPOSING PENALTIES; AND MAKING REPEALS.

- 29 TABLE OF CONTENTS
- 30 CHAPTER 1. GENERAL PROVISIONS
- 31 SECTION 101. SHORT TITLE.
- 32 SECTION 102. LEGISLATIVE FINDINGS AND INTENT.

- 1 SECTION 103. DEFINITIONS.
- 2 CHAPTER 5. MEDICAL ASSISTANCE PROGRAM
- 3 SECTION 501. HOSPITAL RESPONSIBILITIES UNDER MEDICAL
- 4 ASSISTANCE PROGRAM.
- 5 SECTION 502. MEDICAL ASSISTANCE OUTREACH.
- 6 SECTION 503. PENNSYLVANIA CHILDREN'S MEDICAL ASSISTANCE
- 7 PROGRAM.
- 8 CHAPTER 7. PRIMARY HEALTH CARE PROGRAMS
- 9 SECTION 701. CHILDREN'S HEALTH CARE.
- 10 SECTION 702. UNINSURED WORKERS AND ADULTS.
- 11 SECTION 703. OUTREACH AND QUALITY ASSURANCE.
- 12 CHAPTER 11. ACCESS TO HEALTH CARE
- 13 SECTION 1101. MANAGED CARE ORGANIZATIONS.
- 14 SECTION 1102. ENFORCEMENT.
- 15 CHAPTER 13. HEALTH INSURANCE REFORMS
- 16 SECTION 1301. CONTINUITY ON REPLACEMENT OF A GROUP CONTRACT
 17 OR POLICY.
- 18 SECTION 1302. CONTINUITY OF COVERAGE FOR INDIVIDUAL WHO 19 CHANGES GROUPS.
- 20 SECTION 1303. EXTENSION OF BENEFITS FOR DISABLED PERSONS.
- 21 SECTION 1304. PREEXISTING CONDITIONS.
- 22 CHAPTER 15. STUDIES AND HEARINGS ON HEALTH CARE
- 23 SECTION 1501. HOSPITAL UNCOMPENSATED CHARITY CARE STUDY.
- 24 SECTION 1502. MEDICAL ASSISTANCE REIMBURSEMENT.
- 25 SECTION 1503. COST OF MANDATED HEALTH BENEFITS.
- 26 SECTION 1504. PHYSICIAN ACCEPTANCE OF MEDICAL ASSISTANCE
 27 PATIENTS.
- 28 SECTION 1505. SUBSIDIES PROVIDED BY HEALTH SERVICE
- 29 CORPORATION AND HOSPITAL PLAN CORPORATIONS.
- 30 CHAPTER 31. MISCELLANEOUS PROVISIONS

1	SECTION 3101. MANDATED COVERAGE.
2	SECTION 3102. GROUP ACCIDENT AND SICKNESS INSURANCE.
3	SECTION 3103. SEVERABILITY.
4	SECTION 3104. REPEALS.
5	SECTION 3105. EXPIRATION.
6	SECTION 3106. EFFECTIVE DATE.
7	The General Assembly of the Commonwealth of Pennsylvania
8	hereby enacts as follows:
9	CHAPTER 1 <—
10	GENERAL PROVISIONS
11	Section 101. Short title.
12	This act shall be known and may be cited as the Health Care
13	Partnership Act.
14	Section 102. Legislative findings and intent.
15	(a) Declaration. The General Assembly finds and declares
16	that:
17	(1) All citizens of this Commonwealth have a right to
18	affordable and reasonably priced health care and to
19	nondiscriminatory treatment by health insurers and providers.
20	(2) The uninsured health care population of this
21	Commonwealth is over one million persons, and many thousands
22	more lack adequate insurance coverage. Approximately two-
23	thirds of the uninsured are employed or dependents of
24	employed persons.
25	(3) Over one third of the uninsured health care
26	population are children. Uninsured children are of particular
27	concern because of their need for ongoing preventative and
28	primary care. Measures not taken to care for such children
29	now will result in higher human and financial costs later.
30	Access to timely and appropriate primary care is particularly
199	10H0020B2886 - 5 -

serious for women who receive late or no prenatal care which
 increases the risk of low birth weights and infant mortality.

(4) The uninsured and underinsured lack access to timely 3 4 and appropriate primary and preventative care. As a result, 5 they often delay or forego health care, with the resulting 6 increased risk of developing more severe conditions, which are more expensive to treat. This tendency of the medically 7 8 indigent to delay care and to seek ambulatory care in 9 hospital based settings also causes inefficiencies in the 10 health care system.

11 (5) Health markets have been distorted through cost 12 shifts for the uncompensated health care costs of uninsured 13 citizens of this Commonwealth which has caused decreased 14 competitive capacity on the part of those health care 15 providers who serve the poor, and increased costs of other 16 health care payors.

17 (6) Cost containment efforts and increased competition 18 have and will inhibit the traditional method of funding care 19 for uninsured citizens of this Commonwealth through cost 20 shifting. This will have an even greater negative impact on 21 the ability of uninsured citizens of this Commonwealth to 22 obtain needed health care.

23 (7) Not for profit hospitals which have been granted a
24 tax free status by the State vary greatly in the amount of
25 charitable uncompensated health care they provide and on
26 average provide less than the national average. There has
27 been no uniform definition to determine the amount of charity
28 care provided by these health care institutions.
29 (8) Although the proper implementation of spend down

30 provisions under Medicaid should result in the provision of 19910H0020B2886 - 6 - 1 the vast majority of all hospital care for the uninsured
2 through the Medicaid program and hospitals vary widely in
3 their willingness to allow patients to incur expenses so they
4 can qualify for Medicaid.

5 (9) The professional health service plan corporation and 6 the hospital plan corporations which are granted an exemption 7 from the premium tax have varied greatly in the amount of 8 health services they provide to low income citizens of this 9 Commonwealth and the manner in which they have targeted their 10 subsidies.

11 (10) Many health maintenance organizations have been 12 unwilling to reach an agreement with the Department of Public 13 Welfare, to enroll as subscribers, individuals participating 14 in or eligible for Medicaid.

15 (11) No one sector can absorb the cost of providing 16 health care to all citizens of this Commonwealth who cannot 17 afford health care on their own. The cost is too large for 18 the public sector alone to bear and instead requires the 19 establishment of a public/private partnership to share the 20 costs in a manner economically feasible for all interests. 21 The magnitude of this need also requires that it be done on a 22 time-phased, cost-managed and planned basis.

23 (b) Intent. It is the intent of the General Assembly and 24 the purpose of this act to:

25 (1) Ensure access to timely and appropriate health care 26 for all citizens of this Commonwealth by providing for a 27 cost effective, comprehensive health coverage for low income 28 citizens of this Commonwealth who are unable to afford 29 coverage or obtain it through their employment. 30 (2) Provide incentives for employers to provide health

19910H0020B2886

- 7 -

insurance coverage for their employees and their uninsured
 dependents by providing for a more affordable group coverage.

3 (3) Promote the efficient use of health services by
4 assuring that care is provided in appropriate settings;
5 promoting care provided by efficient providers, consistent
6 with high quality care; and assuring that care is being
7 provided at an appropriate stage, soon enough to avert the
8 need for overly expensive treatment.

9 (4) Provide for a pooling of funds to finance the health 10 care by hospitals providing a disproportionate share of low-11 income persons, which will insure continued access to needed 12 inpatient care by low income, uninsured citizens of this 13 Commonwealth and permit disproportionate share hospitals to 14 compete fairly in the marketplace.

15 (5) Assure equity among health providers and payors by 16 providing a mechanism for providers, employers, the public 17 sector and patients to share in financing indigent health 18 care.

19 Section 103. Definitions.

20 The following words and phrases when used in this act shall 21 have the meanings given to them in this section unless the 22 context clearly indicates otherwise:

23 "Average annual occupancy rate." The occupancy rate of a hospital derived by dividing the total number of inpatient beds 24 25 for which the hospital is licensed times the number of days 26 between July 1 and June 30 of each year for which the beds were 27 licensed into the total days of inpatient care provided by the 28 hospital during the same period as follows: Total days of care divided by the product of total licensed beds times total days 29 beds are licensed. 30

19910H0020B2886

- 8 -

1	"Bad debt." The difference between the patient pay amount
2	due and the patient pay revenue received.
3	"Child." A person under 18 years of age.
4	"Council." The Health Care Cost Containment Council.
5	"Department." The Department of Public Welfare of the
6	Commonwealth.
7	"Disproportionate share hospital." Each hospital, including
8	distinct parts, providing a number or percentage of inpatient
9	services paid through the medical assistance program during the
10	previous fiscal year in excess of one of the means of the
11	numbers or percentages of all hospitals, as described in Chapter
12	3.
13	"EPSDT." Early periodic screening, diagnostic and testing.
14	"Fund" or "health care fund." The Pennsylvania Health Care
15	Fund established in Chapter 9.
16	"Group." Any group for which a health insurance policy is
17	written in the Commonwealth of Pennsylvania.
18	"Health maintenance organization" or "HMO." An entity
19	organized and regulated under the act of December 29, 1972
20	(P.L.1701, No.364), known as the Health Maintenance Organization
21	Act.
22	"Health service corporation." A professional health service
23	corporation as defined in 40 Pa.C.S. (relating to insurance).
24	"Hill Burton program." The hospital survey and construction
25	program provided in the Hill Burton Act (60 Stat. 1040, 42
26	U.S.C. § 291 et seq.).
27	"Hospital." An institution having an organized medical staff
28	which is engaged primarily in providing to inpatients, by or
29	under the supervision of physicians, diagnostic and therapeutic
30	services for the care of injured, disabled, pregnant, diseased
199	10H0020B2886 - 9 -

or sick or mentally ill persons. The term includes facilities 1 for the diagnosis and treatment of disorders within the scope of 2 specific medical specialties, including facilities which provide 3 4 care and treatment exclusively for the mentally ill and drug or alcohol inpatient detoxification or rehabilitative care. The 5 term does not include inpatient nonhospital activity as 6 described in 28 Pa. Code § 701.1 (relating to general 7 definitions), publicly owned inpatient facilities or skilled or 8 intermediate care nursing facilities. The term also does not 9 10 include a facility which is operated by a religious organization 11 for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are 12 13 members of a religious denomination or a facility providing 14 treatment solely on the basis of prayer or spiritual means. 15 "Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. (relating to insurance). 16 17 "MAAC." The Medical Assistance Advisory Committee. 18 "Medical assistance." The State program of medical 19 assistance established under the act of June 13, 1967 (P.L.31, 20 No.21), known as the Public Welfare Code. 21 "Medicaid." The Federal medical assistance program 22 established under Title XIX of the Social Security Act (Public 23 Law 74 271, 42 U.S.C. § 301 et seq.). "Medically indigent." Families and individuals who lack 24 25 sufficient income or financial resources through insurance or 26 other means to pay for necessary health care services. 27 "MIC." The Federal Maternal, Infant and Child Care program. 28 "Net inpatient revenue." The difference between a hospital's 29 total inpatient revenue and a hospital's total medical 30 assistance inpatient revenue. 19910H0020B2886 - 10 -

1 "Nondisproportionate share hospital." A hospital, including distinct parts, located within this Commonwealth which provided 2 3 a percentage of inpatient services paid through the medical assistance program during the previous fiscal year below the 4 mean of the percentages of all hospitals, as described in 5 6 Chapter 3. 7 "Preexisting condition exclusion." An exclusion of benefits 8 for a specified or indefinite period of time on the basis of one or more physical or mental conditions for which, before the 9 effective date of enrollment: 10 11 (1) a person experienced symptoms that would cause an 12 ordinarily prudent person to seek diagnosis, care or 13 treatment; or (2) a provider of health care services recommended or 14 15 provided medical advice or treatment to the person. 16 "Specialty and supplemental health services." Services not 17 included as primary health services, such as hospital care, home 18 health services, rehabilitative services, mental health 19 services, drug and alcohol services and ambulatory surgical 20 services. 21 "Spend down." The qualifying procedure for the Pennsylvania 22 Medical Assistance Program set forth in 55 Pa. Code, Chapter 181 23 (relating to income provisions for categorically needy nonmoney payment (NMP MA) and medically needy only (MNO MA) medical 24 25 assistance (MA)). 26 "Subgroup." An employer covered under a contract issued to a 27 multiple employer trust or to an association. 28 "Title XIX." Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.). 29 "Title XIX medical assistance." Only those aspects of the 30 19910H0020B2886 - 11 -

1	medical assistance program established under Title XIX of the
2	Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et
3	seq.), for which Federal financial participation is available.
4	"Waiting period." A period of time after the effective date
5	of enrollment during which a health insurance plan excludes
6	coverage for the diagnosis or treatment of one or more medical
7	conditions.
8	"WIC." The Federal Women, Infants and Children program.
9	CHAPTER 3
10	PENNSYLVANIA HOSPITAL FAIR SHARE PROGRAM
11	Section 301. Establishment and purpose.
12	(a) Establishment. The General Assembly hereby establishes
13	the Pennsylvania Hospital Fair Share Program, to be administered
14	by the department.
15	(b) Purpose. The purpose of the program shall be to
16	identify those hospitals in this Commonwealth which provide a
17	disproportionate share of care to the medically indigent and to
18	compensate those hospitals for their services.
19	Section 302. Computation.
20	On or before the last day of January 1992, and each year
21	thereafter, the department shall:
22	(1) Determine the total number of inpatient hospital
23	days of care provided during the previous fiscal year by each
24	hospital which has entered into a medical assistance provider
25	agreement.
26	(2) Determine the number of inpatient hospital days of
27	care provided by the hospital to all persons eligible for
28	medical assistance and paid through the medical assistance
29	program during the previous fiscal year.
30	(3) Determine the number of inpatient hospital days of
199	10H0020B2886 - 12 -

1	care provided by the hospital to persons eligible for Title
2	XIX medical assistance and paid through the medical
3	assistance program during the previous fiscal year.
4	(4) Using the information from paragraphs (1) through
5	(3), calculate the following for each hospital:
б	(i) the ratio of Title XIX medical assistance days
7	to total days;
8	(ii) the ratio of total medical assistance days to
9	total days;
10	(iii) the total number of Title XIX medical
11	assistance days; and
12	(iv) the total number of all medical assistance
13	days.
14	(5) Using the information from paragraph (4), for all
15	hospitals, determine:
16	(i) the mean ratio of Title XIX medical assistance
17	days to total days;
18	(ii) the mean ratio of total medical assistance days
19	to total days;
20	(iii) the mean of the total number of Title XIX
21	medical assistance days; and
22	(iv) the mean of the total number of all medical
23	assistance days.
24	Section 303. Disproportionate share hospital.
25	A hospital is a disproportionate share hospital if any of its
26	hospital specific results determined under section 302(4) equals
27	or exceeds the corresponding mean Statewide result for all
28	hospitals determined under section 302(5). Disproportionate
29	share hospitals shall be ranked for payment purposes by the
30	ratio of Title XIX medical assistance days to total patient days
199	10H0020B2886 - 13 -

provided during the reporting period. The hospital with the 1 highest ratio of Title XIX medical assistance days to total 2 3 patient days provided during the reporting period shall be 4 assigned a numerical rank equal to the total number of 5 disproportionate share hospitals. The hospital with the lowest ratio of Title XIX medical assistance days to total patient days 6 provided during the reporting period shall be assigned a rank 7 8 number of one. Each hospital shall be assigned a disproportionate share rank weight equal to one plus the 9 10 quotient of its numerical rank divided by the total number of 11 disproportionate share hospitals. 12 Section 304. Expenditures from fund. 13 (a) Purpose. Moneys deposited in the Pennsylvania Health 14 Care Fund shall be expended on programs established under this 15 act to provide care for the medically indigent, to provide all 16 hospitals with a medical assistance payment rate subsidy, to 17 provide a disproportionate share payment to all hospitals which 18 qualify for such payment, to provide a hold harmless payment to 19 all hospitals eligible to receive such payment, and to provide 20 for Medicaid expansion as set forth in section 3101. 21 (b) Medical assistance payment rate. Amounts paid into the 22 fund shall be used to adjust medical assistance payment rates to 23 hospitals to the most recent rebased figures established by the 24 department. The department shall rebase the medical assistance 25 payment rates at least every 24 months, to reflect current cost 26 data, but such rates shall not exceed the upper limits for 27 Medicaid payment rates established at 42 CFR 447.272 (relating 28 to application of upper payment limits). 29 (c) Disproportionate share payments. Amounts paid into the 30 fund shall also be used to provide disproportionate share

19910H0020B2886

- 14 -

payments to hospitals. Disproportionate share payments to 1 hospitals shall be in the form of a rate add on. Hospitals which 2 3 qualify for disproportionate share payments shall receive the 4 payments at fixed intervals under the following formula: 5 (1) The department shall multiply each hospital's 6 assigned disproportionate share rank weight by its number of 7 medical assistance cases to obtain a weighted number of 8 medical assistance cases for each hospital. 9 (2) The department shall then divide the total amount of 10 money to be distributed through disproportionate share 11 payments by the total weighted number of medical assistance 12 cases for all hospitals to obtain a unit disproportionate 13 share payment weighted medical assistance case. 14 (3) The department shall then multiply each hospital's 15 weighted number of medical assistance cases by the unit 16 disproportionate share payment per weighted medical 17 assistance case to obtain a disproportionate share payment 18 for each qualifying hospital. 19 (d) Hold harmless payments. Hold harmless payment shall be 20 made to each hospital which qualifies so that for any given 21 fiscal year no hospital receives payments from the Commonwealth 22 under subsections (b), (c) and (d) and payments of Federal funds 23 earned under this section totaling less than 1.05 times the 24 amount the hospital paid into the fund for that year, except as 25 provided in subsections (g) and (h). 26 (e) Funding for expansion of the Pennsylvania Medical 27 Assistance Program. Payments from the fund may be made for the 28 additional costs due to the expansion of the Pennsylvania Medical Assistance Program as is provided for in this act. 29 30 (f) Funding for medical education. Payments from the fund - 15 -19910H0020B2886

may be made to hospitals for direct medical education programs. 1 (g) Total payments. The amount to be paid to each hospital 2 3 under this section shall be set so that the total amounts paid 4 do not exceed the total amount deposited into the fund. 5 (h) Medical assistance program. No payment from this fund shall be made to any hospital that does not ensure that all 6 staff and admitting physicians that directly treat patients are 7 enrolled and actively participating in the Pennsylvania Medical 8 Assistance Program. As a condition of receiving payments from 9 10 the fund, each hospital must establish a physician referral 11 service to assist medical assistance recipients with referrals to primary care and specialist physicians on an equitable, 12 13 rotating basis. 14 (i) Charity care. Commencing with the calendar year 15 beginning January 1, 1994, no payment from this fund shall be 16 made to any hospital that does not provide for the year an 17 amount of uncompensated charity care, as described in section 18 1901, equal to at least 2% of their total revenue for that year. 19 Section 305. Provision of charity care by hospitals. 20 In meeting the charity care requirements under section 21 304(i), all hospitals shall: 22 (1) Spread charity care out over the entire year, if at 23 all possible. 24 (2) Maintain up to date records on the amount of charity 25 care provided. A copy of that record must be provided to any 26 person or group that so requests it within ten business days 27 of the request. 28 (3) Advertise the opportunity to apply for charity care at the hospital in permanent, prominent displays in the 29 30 waiting rooms, reception areas, emergency rooms, lobbies and

19910H0020B2886

- 16 -

1	hilling	/nazmont	aroad	of	+ho	hognital
1	DITITIO,	payment	arcas	OL	CIIC	nospical.

2	(4) Prominently display eligibility guideline pamphlets
3	in the same room or rooms as the announcements of the
4	presence of charity care, and readily accessible to the
5	public without requesting the assistance of any hospital
6	personnel.
7	(5) Advertise the opportunity to apply for charity care
8	in the local community in a manner designed to provide wide
9	exposure for the program.
10	Section 306. Use of fund moneys to reduce costs shifted to
11	other health care payors.
12	(a) Cost reduction. Insofar as some hospitals have been
13	required to increase their hospital charges of other payors to
14	cover a shortfall in funding by the Medicaid program for its
15	costs, such hospitals receiving funding under this chapter shall
16	use their best efforts to proportionally reduce future charges
17	to those payors to whom those costs have been shifted to reflect
18	the increased Medicaid funding under this chapter and the
19	Medicaid program.
20	(b) Compliance report. All hospitals receiving funds under
21	this chapter shall file reports required by the Health Care Cost
22	Containment Council which document the hospitals compliance with
23	sections 304(i) and 306(a).
24	(c) Annual report. The council shall issue an annual report
25	to the General Assembly and the public at the beginning of the
26	calendar year on the following:
27	(1) Whether present medical assistance and Pennsylvania
28	Hospital Fair Share Program funding adequately reimburse
29	efficient hospitals which provide quality acute care for
30	Pennsylvania's medical assistance population.
199	10H0020B2886 - 17 -

19910H0020B2886

- 17 -

1	(2) Pennsylvania hospitals' compliance with sections
2	304(i) and 306(a) and the impact thereon to hospital charges
3	for other payors.
4	(3) Any recommendation for adjustments in the Medical or
5	Pennsylvania Fair Share Program to ensure that these programs
6	appropriately pay the costs for reimbursement to hospitals
7	for the care of medical assistance patients and adjustments
8	that should be made in sections 304(i) and 306(a).
9	CHAPTER 5
10	MEDICAL ASSISTANCE PROGRAM
11	Section 501. Hospital responsibilities under medical assistance
12	program.
13	(a) Necessary care. Each licensed acute care hospital shall
14	not deny necessary and timely health care due to a person's
15	inability to pay in advance from current income or resources for
16	all or part of that care.
17	(b) Installment agreements. Hospitals shall enter into
18	reasonable installment agreements to cover the spend down cost
19	of the care necessary for the person to qualify for medical
20	assistance coverage or insurance. Within six months of the
21	effective date of this act, the department shall issue
22	guidelines to ensure uniformity of this provision and compliance
23	with Federal and State requirements.
24	(c) Prohibitions. It is unlawful for any hospital licensed
25	by the Commonwealth:
26	(1) to require, as a condition of admission or
27	treatment, assurance from the patient or any other person
28	that the patient is not eligible for or will not apply for
29	medical assistance;
30	(2) to deny or delay admission or treatment of a person

19910H0020B2886

- 18 -

because of his current or possible future status as a medical
 assistance recipient;

3 (3) to transfer a patient to another health care
4 provider because of his current or possible status as a
5 medical assistance recipient;

6 (4) to discharge a patient from care because of his
7 current or possible future status as a medical assistance
8 recipient;

9 (5) to charge any amounts in excess of the medical
10 assistance rate for any services covered or which could have
11 been covered by the medical assistance program; or

12 (6) to discourage any person who would be eligible for 13 the medical assistance program from applying or seeking 14 needed health care or needed admission to a health care

15 facility because of his inability to pay for that care.

16 (d) Application for medical assistance. Each hospital shall

17 provide to each prospective uninsured or underinsured patient,

18 assistance in completing an application for medical assistance,

19 within one business day of the prospective patient's first

20 request to be admitted to the hospital.

21 Section 502. Medical assistance outreach.

22 (a) Content of program. The department shall establish and
 23 administer an outreach program to enroll people who are eligible
 24 for Medicaid but have not enrolled. This shall include:

25 (1) Providing for on site applications at all

26 disproportionate share hospitals and Federal qualified health

27 centers.

28 (2) Providing Statewide training to hospital staff on
 29 medical assistance spend down and other eligibility

30 procedures.

(3) Developing a program of public service announcements
 to be aired on television and radio on a regular Statewide
 basis, advising citizens of:

4 (i) expanded medical assistance eligibility for
5 pregnant women, infants, the elderly, the disabled,
6 persons with acquired immune deficiency syndrome (AIDS);
7 and

8 (ii) general eligibility requirements, spend down,
 9 expedited issuance of medical assistance cards, and how
 10 and where to apply.

11 (4) Developing pamphlets and informational services for
 12 medical assistance providers to help providers inform
 13 patients about medical assistance options and eligibility.

14 (5) Providing the General Assembly and the public an 15 annual report for each fiscal year, detailing the outreach and enrollment efforts taken by each county assistance 16 17 office, and reporting by county on the number of citizens 18 enrolled in the medical assistance program and the projected medical assistance eligible population of each county. 19 20 (b) Applications for medical assistance and children's 21 health care plan. Persons taking applications for medical 22 assistance, including persons at sites other than county 23 assistance offices, shall offer to take an application for coverage under the Children's Health Care Plan, as established 24 25 under Chapter 7, for any child. Persons taking applications for 26 the Children's Health Care Plan shall promptly forward the applications to the entity designated by the health service 27 28 corporation and hospital plan corporations to administer the 29 plan. Section 503. Pennsylvania Children's Medical Assistance 30

19910H0020B2886

- 20 -

1	program.
2	(a) Card. Every child in this Commonwealth eligible for
3	coverage under medical assistance shall be given a Pennsylvania
4	Children's Medical Assistance program card.
5	(b) Coverage.
6	(1) The department shall amend its medical assistance
7	regulations to provide all medically necessary health care,
8	diagnostic services, rehabilitative services and treatment
9	for which Federal financial participation is available, to
10	all children enrolled under this section.
11	(2) Health care services shall be provided in sufficient
12	amount, duration and scope, required for each enrolled
13	child's medical condition.
14	(3) Children with chronic health care needs shall have
15	available targeted case management services to assist them
16	with accessing needed health care and services.
17	(c) Enrollment.
18	(1) Every child shall be immediately enrolled in the
19	EPSDT program upon authorization for medical assistance. Any
20	parent wishing not to participate in the EPSDT program must
21	sign a form detailing the health care benefits that are being
22	waived.
23	(2) At time of application for medical assistance for
24	any child, or the addition of a new child, the department or
25	its designee shall assist the parent in making an appointment
26	for the child for a EPSDT screen with the physician of the
27	parent's choice.
28	(3) At each redetermination for eligibility, the county
29	assistance worker shall determine whether the children are
30	current in their screens and if they are in need of
199	10H0020B2886 - 21 -

1 assistance in arranging health, dental, mental health or other treatment. Assistance shall be provided the parent by 2 3 the department or its designee, if needed, in arranging for 4 such care, screen or transportation therefor. 5 (d) Audit. For each county the department shall annually conduct a performance analysis of the following: 6 7 (1) Percentage of potentially eligible children in the 8 county actually enrolled in the medical assistance and EPSDT 9 program. (2) The outreach efforts as schools, day care 10 facilities, hospitals, etc., to enroll children in the 11 12 medical assistance and EPSDT program. 13 (3) Of those children enrolled in medical assistance, 14 the percentage of children current in their screens and for 15 whom needed treatment and services have been obtained. (4) The ease of use, accuracy, completeness and 16 17 readability of county specific handbooks for parents of 18 children on medical assistance, detailing all child health and nutrition services available in the county and 19 20 transportation for medical care. (5) Coordination of MIC, WIC, EPSDT, mental health, drug 21 22 and alcohol, State and county health centers and other 23 services in the county available to children on medical 24 assistance. 25 (e) Noncompliance. Any county assistance office found to be 26 in noncompliance with the provisions of this section or which has failed to take sufficient outreach efforts to enroll that 27 county's eligible children under this section shall be required 28 by the department to immediately file a corrective action plan. 29 The department shall do quarterly on site compliance reviews of 30 - 22 -19910H0020B2886

the noncompliant county assistance office until that office has
 corrected the identified performance deficiencies.

3 (f) Publicity. The department shall develop and widely 4 utilize a media campaign for use on television, radio and local newspapers, advising Pennsylvania's citizens of the availability 5 of health care for low income children under this section. 6 (g) Report to General Assembly. The department shall 7 provide a written annual report to the General Assembly 8 detailing on a county by county basis the findings of the county 9 10 performance audits set forth in this section and evaluating the 11 media campaign used by the department to inform citizens about the availability of health coverage for low income children 12 13 under this section. (h) Advisory committee. The MAAC shall, on a quarterly 14 15 basis, review county assistance and departmental implementation 16 of this section and to advise the department on changes in 17 policy needed to maximize the availability of timely and cost-18 effective health care to Pennsylvania's low income children who 19 depend on medical assistance for their health care. In its 20 review, the MAAC shall seek the advice from the Consumer 21 Subcommittee of the MAAC; the Pennsylvania Chapter of the 22 American Academy of Pediatricians; the Pennsylvania Academy of 23 Family Physicians; the Developmental Disability Planning Council 24 and other interested groups. 25 (i) Reimbursement. Reimbursement under the Pennsylvania 26 Medical Assistance Medical Surgical Fee Schedule shall be no less than the Plan C, Blue Shield rate for: 27 28 (1) primary physician care for children; and 29 (2) prenatal, delivery and postnatal care for pregnant 30 women.

19910H0020B2886

- 23 -

1	CHAPTER 7
2	PRIMARY HEALTH CARE PROGRAMS
3	Section 701. Children's Health Care Plan.
4	(a) Development. The health service corporation and each
5	hospital plan corporation shall jointly develop for operation no
6	later than January 1, 1993, a Statewide primary health care
7	insurance plan for all children of this Commonwealth who are not
8	otherwise eligible for, or covered by, a health insurance plan,
9	a self insurance health plan or the medical assistance program.
10	(b) Department of Health. The Children's Health Care Plan
11	shall be regulated by the Department of Health as to quality of
12	care and scope of services, but at a minimum shall provide
13	preventive care, including routine physical examinations, eye
14	and ear examinations to determine the need for vision and
15	hearing correction, and immunizations, physician office visits
16	when a child is sick, emergency care, diagnostic tests,
17	outpatient surgery, availability of 24 hours a day, 7 days a
18	week access, integration with EPSDT, WIC, MIC Programs,
19	specialist referral requirements and prescription drugs.
20	(c) Contracts with providers. To the fullest extent
21	practicable, the Children's Health Care Plan shall contract with
22	providers to provide primary health care services for enrollees
23	on a basis best calculated to manage costs of the program,
24	including, but not limited to, purchasing health care services
25	on a capitated basis, using managed health care techniques,
26	using generic drugs where appropriate or other cost management
27	methods.
28	(d) Eligibility for enrollment.
29	(1) To the extent funds permit, any parent, guardian or

30 other legal representative of a child residing in this

19910H0020B2886

- 24 -

1	Commonwealth who is not eligible for or covered by a health
2	insurance plan, a self insurance health plan or the medical
3	assistance program shall be eligible for enrollment of their
4	child in the Children's Health Care Plan. However, the plan
5	may permit enrollment by children who are eligible for a
6	health insurance plan or self insurance health plan or
7	medical assistance program but who refuse to accept such
8	coverage if:
9	(i) the premium payment required for such coverage
10	for the child is so expensive relative to the income of
11	that family that it would constitute a severe economic
12	hardship if the family accepted such coverage for the
13	child;
14	(ii) the refusal to accept such coverage was made in
15	good faith; and
16	(iii) providing coverage would be consistent with
17	the purposes of this section.
18	(2) Coverage shall not be denied on the basis of a
19	preexisting medical condition.
20	(e) Inpatient care. Inpatient hospital care shall be
21	provided through the medical assistance program, with primary
22	care physicians making the necessary arrangements for admission
23	to the hospital and necessary specialty care.
24	(f) Uninsured children. The plan shall be free to all
25	uninsured children whose family income is less than or up to
26	150% of the Federal poverty level, and shall be available on a
27	sliding fee basis to children whose family income is more than
28	150% but less than 200% of the Federal poverty level. Those over
29	200% of the Federal poverty level may purchase coverage for
30	children under the plan at cost. There shall be no copayments or
199	10H0020B2886 - 25 -

1 deductibles.

(g) Children temporarily without coverage. The plan shall 2 3 provide for participation in the program by children who are 4 temporarily without coverage by a health insurance plan, selfinsurance health plan or medical assistance. 5 6 (h) Contracts. The plan shall have a contractual arrangement with the Department of Public Welfare to receive 7 Federal and State funding under Title XIX for persons who are 8 eligible for medical assistance, and contract with providers who 9 agree to accept the fee established for provision of primary 10 11 health care to medical assistance recipients as payment in full. 12 (i) Funding. 13 (1) The plan shall be financed by the health service 14 corporation and hospital plan corporations as defined in 40 15 Pa.C.S. (relating to insurance) in partial fulfillment of their obligation to serve low income subscribers. The 16 17 expenses of the plan shall be financed by the health service 18 corporation and hospital plan corporations in proportion to 19 the percentage of premiums of that health service corporation 20 and hospital plan corporations to the total premiums for the 21 Commonwealth health service corporation and hospital plan 22 corporations premiums, but shall not exceed 2% of any health 23 service corporation or hospital plan corporations total 24 annual premiums, excluding administrative costs. 25 Administrative expenses of the plan shall be donated by the 26 respective health service corporation and hospital plan 27 corporations. 28 (2) Any funds appropriated by the General Assembly to 29 the Children's Health Care Plan shall supplement the funding 30 described in paragraph (1), and if such appropriation is

19910H0020B2886

- 26 -

1 sufficient to completely finance the Children's Health Care Plan, the appropriation shall supersede the funding described 2 3 in paragraph (1). 4 (j) Insurance cards. The plan shall provide Blue Cross/Blue 5 Shield cards to those children covered under the plan which shall not specially identify them as low income. 6 7 (k) Physicians. The plan shall ensure that there are 8 adequate primary care physicians throughout this Commonwealth to 9 ensure some choice of physicians, availability within a 10 reasonable and convenient travel distance and Statewide 11 coverage. 12 (1) Contracts with providers. The plan shall contract with 13 any qualified, cost effective provider, including hospital 14 outpatient departments, HMOs, clinics, group practices and 15 individual practitioners. Section 702. Uninsured workers and adults. 16 17 (a) Development. The health service corporation and the 18 hospital plan corporations shall concurrently develop a primary 19 health care insurance plan for adults, equivalent to the 20 Children's Primary Health Care Plan set forth in section 701 for 21 purchase at cost by January 1, 1993. The plan for adults shall 22 make affordable primary health care available to individual 23 Commonwealth residents whose income exceeds medical assistance eligibility guidelines but who are without sufficient means to 24 25 purchase other health care insurance to cover the costs of 26 health care. 27 (b) Rates. The Insurance Commissioner shall review the rates for the Primary Health Care Plan for adults and shall 28 29 ensure that the premium covers all appropriate costs, reserves and administrative costs of the health service corporation and 30

19910H0020B2886

- 27 -

1 the hospital plan corporations.

2 (c) Cost data. The health service corporation and the
3 hospital plan corporations shall keep detailed actuarial data on
4 the costs of the adult plan.

5 (d) Premiums. The health service corporation and the hospital plan corporations shall establish a premium structure 6 for enrollment effective January 1, 1993, which shall be 7 adjusted to reflect the incomes of persons seeking to become 8 9 enrollees in the program and shall be structured so that 10 individuals whose incomes are insufficient to pay the full 11 premium can participate in the program. 12 (e) Expiration of section. If prior to January 1, 1993, the 13 Insurance Commissioner approves an adult health care plan by the 14 health service corporation and the hospital plan corporations 15 that meets the intent and purposes of the primary health care plan for adults, the commissioner shall publish a notice of this 16 17 approval in the Pennsylvania Bulletin. This section shall expire 18 upon the date of publication of that notice. 19 Section 703. Outreach and quality assurance. 20 (a) Public information. The health service corporation and 21 the hospital plan corporations shall actively publicize both the 22 children's and adults' primary care health plans and shall 23 solicit the assistance of the Commonwealth, health care 24 providers and others in bringing the program to the attention of 25 prospective enrollees. 26 (b) Quality assurance. The Department of Health shall 27 develop a quality assurance program for the Children's and 28 Adult's Health Care Program within 90 days of the effective date 29 of this act. This quality assurance program shall require 30 arrangements for referral to supplemental health care, including

19910H0020B2886

- 28 -

1	specialty care, rehabilitative services and acute hospital care.
2	(c) Enrollment information. Commencing January 1, 1993, and
3	on an annual basis, all employers who do not provide health care
4	insurance shall provide their employees with enrollment
5	information concerning the Primary Health Care Plan for Adults.
6	CHAPTER 9
7	PENNSYLVANIA HEALTH CARE FUND
8	Section 901. Establishment.
9	There is hereby established in the State Treasury a separate
10	account, to be known as the Pennsylvania Health Care Fund.
11	Section 902. Purpose.
12	Moneys deposited in the fund shall be expended for programs,
13	goods and services which support the provisions of this act for
14	which Federal matching funds are available through Title XIX.
15	Section 903. Administration.
16	The fund shall be administered by the Department of Revenue.
17	The Department of Revenue shall:
18	(1) Collect and distribute the moneys of the fund
19	pursuant to this act.
20	(2) Promulgate rules and regulations for the collection
21	of data and the determination of deposit amounts for the fund
22	and the distribution thereof, as set forth in Chapter 3.
23	Section 904. Assessment.
24	Effective January 1, 1992, every hospital is hereby assessed
25	an amount for the fund, payable at the rate provided in this
26	section. On the last day of September, December, March and June,
27	every hospital shall forward to the Department of Revenue for
28	deposit in the fund an amount equal to one fourth of four
29	percent of the hospital's net inpatient revenue for the
30	preceding quarter.
199	10н0020в2886 - 29 -

1 Section 905. Civil penalty.

Any hospital that fails to comply with section 904 shall be 2 3 liable for a civil penalty of \$1,000 per day for each day after 4 the due date that the funds are not deposited. The Secretary of Revenue may waive this penalty for a period not to exceed 30 5 days. In addition, no hospital shall be eligible to receive 6 7 funds under the Pennsylvania Hospital Fair Share Program until the requirements of this section are met and penalties, if 8 applicable, are paid. Interest on the penalty and the amounts 9 due under section 904 may be applied in accordance with the 10 11 regulations of the Department of Revenue. 12 Section 906. Financial provisions. 13 (a) Appropriations. All moneys in the fund are hereby 14 appropriated to the Department of Public Welfare on a continuing 15 basis to carry out the purposes of the fund as described in this act. Federal funds earned as the result of payments under this 16 chapter are likewise appropriated to the Department of Public 17 18 Welfare on a continuing basis. 19 (b) Reconciliation of payments. The Department of Public 20 Welfare shall reconcile payments to hospitals made under section 21 304(d), as are necessary on an annual basis. The department 22 shall also ensure that within five working days of the hospital 23 assessment in section 904 every hospital assessed shall receive 24 payments at least equal to the amount assessed that hospital 25 under section 904. 26 (c) Fund administration. For the purpose of the orderly 27 administration of payments under this act, in any year in which 28 obligations exceed the balance in the fund, the payment of obligations may be carried forward to the following fiscal year. 29 30 In addition, any funds not expended during a fiscal year shall 19910H0020B2886 - 30 -

1	be retained in the fund and be made available for use during the		
2	following fiscal year.		
3	CHAPTER 11		
4	SMALL BUSINESS HEALTH INSURANCE TAX CREDIT		
5	Section 1101. Eligibility.		
6	An employer shall be eligible for a tax credit against any		
7	tax due under Article II, III, IV, or VI of the act of March 4,		
8	1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, and		
9	against any payment of estimated tax or payment of tentative tax		
10	due on account of said taxes if all of the following conditions		
11	are met:		
12	(1) The employer has a payroll of nine or fewer		
13	employees.		
14	(2) When seeking credit for the cost of providing		
15	employee health care coverage, the employer has not provided		
16	at least 50% of the cost of a health insurance plan which		
17	would have met standards established by the Insurance		
18	Commissioner for any of the employees of the enterprise in		
19	any of the preceding three years, or where seeking credit for		
20	the cost of providing dependent coverage, the employer has		
21	not provided at least 50% of the cost of a health insurance		
22	plan for any of the employees' uninsured dependents in any of		
23	the preceding three years.		
24	(3) The employer provides health care insurance for the		
25	employees, or the employees and their uninsured dependents or		
26	the uninsured dependents of the employees.		
27	(4) The employer provides a health care benefit plan		
28	that meets minimum standards established by the Insurance		
29	Commissioner.		
30	(5) The employer's health insurance expenditure for the		
199	19910Н0020В2886 - 31 -		

1	coverage for which credit is so	ught equals at least 50% of		
2	the total cost of the health insurance coverage.			
3	Section 1102. Calculation of credit.			
4	(a) Beneficiaries. An eligible employer shall receive a tax			
5	credit of a portion of the amount of employers' expenditure for			
6	health insurance costs initiated or expanded coverage only for			
7	the following beneficiaries:			
8	(1) Employees whose average annualized wage is less than			
9	150% of the Federal poverty level for a family of four, as			
10	published by the United States Department of Health and Human			
11	Services.			
12	(2) Employees whose average annualized wage is less than			
13	150% of the Federal poverty level and their uninsured			
14	dependents.			
15	(3) Uninsured dependents of employees whose average			
16	annualized wage is less than 150% of the Federal poverty			
17	level, when coverage previously included only the employees.			
18	(b) Credit schedule. The credit may be claimed in			
19	accordance with the following schedule:			
20	Percentage of amount	Tax year in which		
21	of employer's	such expenditure was made,		
22	expenditure for	and for which the tax		
23	health insurance	credit is claimed		
24	costs			
25	40%	The tax year commencing on		
26		or after January 1, 1993.		
27	30%	The tax year commencing on		
28		or after January 1, 1994.		
29	20%	The tax year commencing on		
30		or after January 1, 1995.		
199	19910Н0020В2886 - 32 -			

1 (c) Availability of credit. Tax credits shall be available in years following the first year in which coverage is initiated 2 3 or expanded, only if the employer continues to offer it in the 4 following two years. No employer shall be eligible for a tax credit for more than the three tax years specified in subsection 5 6 (b). Section 1103. Rules and regulations. 7 8 The Department of Revenue and the Insurance Department shall: 9 (1) Promulgate any rules and regulations which may be 10 required to implement this chapter. 11 (2) Publish as a notice in the Pennsylvania Bulletin, no 12 later than January 1, of the year following the effective 13 date of this act, forms upon which taxpayers may apply for 14 the tax credit authorized by this chapter. 15 Section 1104. Reports to General Assembly. 16 Within five months after the close of any tax year for which 17 tax credits granted pursuant to this chapter were used, the 18 Insurance Department and the Department of Revenue shall furnish 19 to the General Assembly a report providing the number of 20 employers who used credits during the preceding tax year, the 21 number of employees and dependents receiving new health care 22 coverage and the amount of tax credits granted. 23 CHAPTER 13 2.4 ACCESS TO HEALTH CARE 25 Section 1301. Health maintenance organizations. 26 (a) Fair share of medical assistance subscribers. Within six months of the effective date of this act, each health 27 28 maintenance organization shall enter into an agreement with the 29 department to enroll as subscribers individuals who are eligible to receive medical assistance benefits. A health maintenance 30 - 33 -19910H0020B2886

organization that receives its certificate of authority after 1 the effective date of this act shall enter into an agreement 2 3 with the department under this section before the end of the 4 health maintenance organization's second year of operation in 5 this Commonwealth. All health maintenance organizations shall agree to accept as enrollees a fair share of medical assistance 6 recipients. A "fair share" of medical assistance subscribers for 7 purposes of this section shall be defined as the same ratio of 8 9 medical assistance recipients to general population in the 10 health maintenance organization's service area as enrolled 11 medical assistance subscribers to the total health maintenance organization enrollment or 25%, whichever is less. Within three 12 years of the effective date of the contract between the 13 14 department and the health maintenance organization, the health 15 maintenance organization shall have enrolled or have attempted to enroll its fair share of medical assistance subscribers. 16 (b) County percentages. The department shall publish 17 18 annually in the Pennsylvania Bulletin notice of the county 19 percentage of medical assistance recipients for each county and 20 shall assist health maintenance organizations in determining the number of medical assistance subscribers necessary to constitute 21 its fair share. 22 23 (c) Approval of capitated rate. The capitated rate 24 contained in the agreement between the health maintenance 25 organization and the department is subject to the approval of 26 the Insurance Commissioner in accordance with section 10 of the act of December 29, 1972 (P.L.1701, No.364), known as the Health 27 Maintenance Organization Act. The rate shall not exceed 100% of 28 the fee for service medical assistance cost in each county 29 served by the health maintenance organization. In the event the 30 19910H0020B2886 - 34 -

Insurance Commissioner finds that the proposed rate is 1 insufficient to meet the costs of the health maintenance 2 3 organization, the Secretary of Public Welfare shall waive the 4 limit on the capitation rate, renegotiate the agreement with the 5 health maintenance organization to address the concerns of the Insurance Commissioner or grant an exception to the health 6 7 maintenance organization from the fair share requirements of 8 this act.

9 (d) Separate systems. Unless authorized by the department, 10 after consultation with the Medical Assistance Advisory 11 Committee, a health maintenance organization shall not establish separate systems of care for its medical assistance subscribers. 12 13 (e) Waiver of requirements. The department may grant a 14 waiver of the requirements of this section if it finds that the 15 health maintenance organization has made and continues to make a good faith effort to obtain a fair share of medical assistance 16 17 subscribers, but is unable to reach or maintain that percentage. 18 The department may also grant a waiver of the requirements of 19 this section upon demonstration by the health maintenance 20 organization that this section would result in insolvency of the 21 health maintenance organization. 22 Section 1302. Continuity on replacement of a group policy. 23 (a) Policies subject to this section. This section applies to all group health insurance policies, except group long-term 24 25 care policies or group long term disability policies, issued by 26 insurers or health maintenance organizations doing business in 27 this Commonwealth to policyholders who are obtaining coverage to 28 replace coverage under a different contract or policy. 29 (b) Continuity of coverage. The replacement policy issued 30 to replace the prior contract or policy shall provide continuity - 35 -19910H0020B2886

of coverage to all persons who were covered under the replaced 1 contract or policy at any time during the 90 days before the 2 3 discontinuance of the replaced contract or policy. 4 (c) Prohibition against discontinuity. In a replacement 5 policy subject to this section, an insurer or health maintenance organization may not, for any person described in section 1304: 6 7 (1) request that the person provide or otherwise seek to 8 obtain evidence of insurability; (2) decline to enroll the person on the basis of 9 10 evidence of insurability if the person is otherwise eligible 11 for coverage; or (3) impose a preexisting condition exclusion period or 12 13 waiting period on that person, except as provided in the 14 section. 15 (d) Person covered for fewer than 90 continuous days. 16 Notwithstanding subsection (c), a person who was covered under the replaced contract or policy for fewer than 90 continuous 17 18 days may be subject to a preexisting condition exclusion or 19 waiting period in the replacement policy, provided the period is 20 not longer than 90 days, and credit is given for satisfaction or 21 partial satisfaction of the same or similar provisions under the 22 replaced contract or policy. 23 (e) Liability after discontinuance. The entity, insurer or 24 health maintenance organization that issued the replaced 25 contract or policy is liable after discontinuance of that 26 contract or policy only to the extent of its accrued liabilities and extensions of benefits. 27 28 Section 1303. Extension of benefits for disabled persons. 29 (a) Policies subject to this section. This section applies 30 to all group health insurance policies, except group long term

19910H0020B2886

- 36 -

care policies or group long term disability policies, or group
 policies providing coverage only for dental expense issued by
 insurers, professional health service corporations, nonprofit
 hospital plans or health maintenance organizations doing

5 business in this Commonwealth.

(b) Requirement. Every group policy subject to this section 6 must provide a reasonable extension of benefits for a person, 7 including a dependent child covered under the policy, who is 8 totally disabled on the date the group policy is discontinued, 9 10 or on the date coverage for a subgroup in the policy is 11 discontinued. A person may not be charged during the period of extension. An extension of benefits provision is reasonable if 12 13 it provides benefits for covered expenses directly relating to 14 the condition causing total disability for at least six months 15 following the effective date of discontinuance.

16 (c) Description of benefits extension. The extension of 17 benefits provision must be described in all policies and group 18 certificates. The benefits payable during any period of 19 extension are subject to the regular benefit limits under the 20 policy.

21 (d) Liability after discontinuance. After discontinuance of 22 a policy, the insurer, professional health service corporation, 23 nonprofit hospital plan corporation or health maintenance organization remains liable only to the extent of its accrued 24 25 liabilities and extensions of benefits. The liability of the 26 insurer or health maintenance organization is the same whether 27 the group policyholder or other entity secures replacement 28 coverage from any insurer, professional health service corporation, nonprofit hospital plan corporation or health 29 30 maintenance organization, self insures or foregoes the provision - 37 -19910H0020B2886

1 of coverage.

2	(e) Definition of term. The Secretary of Health shall in
3	the manner provided by law, promulgate a regulation defining
4	"total disability" for purposes of this section. The definition
5	must identify persons who are unable, as a result of disability,
6	to obtain comparable alternative coverage through comparable
7	employment or otherwise. The regulations promulgated under this
8	subsection shall not be subject to the act of June 25, 1982
9	(P.L.633, No.181), known as the Regulatory Review Act.
10	Section 1304. Continuity for individual who changes groups.
11	(a) Application. This section applies to all group health
12	policies issued by insurers or health maintenance organizations,
13	except group long term care policies and group disability
14	coverage.
15	(b) Persons provided continuity of coverage. This section
16	provides continuity of coverage for a person who seeks coverage
17	under a group insurance or health maintenance organization
18	policy if:
19	(1) That person was covered under an individual or group
20	contract or policy issued by an insurer, health maintenance
21	organization, or governmental program such as Medicaid or
22	Medicare or any program established by this act.
23	(2) Coverage under the prior contract or policy
24	terminated within three months before the date the person
25	enrolls or is eligible to enroll in the succeeding policy. A
26	period of ineligibility for any health plan imposed by terms
27	of employment may not be considered in determining whether
28	the coverage ended within three months of the date the person
29	enrolls or would otherwise be eligible to enroll.
30	(c) Prohibition against discontinuity. Except as provided
199	

in this section, in a group policy subject to this section, an 1 insurer or health maintenance organization must, for any person 2 described in subsection (b), waive any medical underwriting or 3 preexisting conditions exclusion to the extent that benefits 4 5 would have been payable under a prior contract or policy if the prior contract or policy were still in effect. The succeeding 6 policy is not required to duplicate any benefits covered by the 7 prior contract or policy. 8

9 (d) Determination of benefits. When a determination of 10 benefit under the prior contract or policy is required, the 11 issuer of the prior contract or policy shall, at the request of the issuer of the succeeding policy, furnish a statement of 12 13 benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination 14 15 itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior contract or policy are 16 17 determined in accordance with the definitions, conditions and 18 covered expense provisions of that contract or policy rather 19 than those of the succeeding policy. The benefit determination 20 must be made as if coverage had not been replaced. 21 Section 1305. Limitations on exclusions and waiting periods. 22 (a) Application. This section applies to any individual or group health insurance policy or contract either with an insurer 23 24 or health maintenance organization, except long term care

25 policies or long term disability policies.

26 (b) Exclusions for certain factors. No group or individual 27 health insurance policy written in this Commonwealth may exclude 28 or use waivers or riders of any kind to exclude, limit or reduce 29 coverage or benefits for a specifically named or described 30 preexisting disease or physical condition, beyond the waiting 19910H0020B2886 - 39 - 1 period defined in this act.

2	(c) Preexisting conditions. No group health policy,
3	contract or certificate shall exclude a member of that group who
4	has applied for coverage, except that coverage can be denied for
5	a preexisting condition within the waiting period for new
6	enrollees, as is defined in section 1306, for those not
7	qualifying for continuity of benefits under this act.
8	(d) Permitted exclusion. An individual policy issued by an
9	insurer may not impose a preexisting condition exclusion or
10	waiting period except as defined in section 1306.
11	Section 1306. Waiting period for preexisting conditions.
12	No group or individual health policy, certificate or contract
13	may deny coverage for an enrollee for a preexisting condition
14	except as follows:
15	(1) Preexisting medical conditions occurring three
16	months prior to the effective date of coverage or enrollment
17	in the group.
18	(2) Preexisting medical conditions for which the
19	enrollee has received treatment three months prior to the
20	effective date of coverage on the enrollee or enrollment in
21	the group.
22	(3) In no event may there be an exclusion of coverage
23	for a group or individual enrollee for any condition or
24	disease covered by the policy, certificate or contract after
25	that enrollee or insured has been enrolled or insured for 12
26	continuous months.
27	Section 1307. Enforcement.
28	(a) Civil penalty.
29	(1) Any health maintenance organization that violates

30 the provisions of this chapter shall be subject to a civil 19910H0020B2886 - 40 -

1 penalty equal to 2% of the annual premiums of the HMO or the HMO's average rate per member multiplied by the number of 2 3 individuals that the HMO has failed to enroll under the fair 4 share provisions of this chapter, whichever is greater. This 5 penalty shall be deposited in the Pennsylvania Health Care Fund. The penalty shall be levied by the department, 6 annually, when it concludes that the HMO did not make a good 7 8 faith effort to enroll the minimum number of medical assistance subscribers required by this chapter. 9 10 (2) Any HMO found to have violated the provisions of 11 this chapter shall have the right to appeal such a 12 determination to the Secretary of Public Welfare in the 13 manner provided in Title 2 of the Pennsylvania Consolidated 14 Statutes (relating to administrative law and procedure). 15 (b) Civil action. Any individual alleging discrimination under this chapter may file a civil cause of action in a court 16 17 of competent jurisdiction against a health maintenance 18 organization or group insurers alleged to be in violation of 19 this chapter. If the health maintenance organization or group 20 insurers is found to have violated this chapter the court may 21 assess attorney fees, cost and penalties against the health 22 maintenance organization or group insurers in addition to any 23 monetary compensation to the plaintiff. A judgment against a health maintenance organization or group insurers shall be 24 25 referred by the court to the appropriate professional licensing 26 authority or regulatory agency. 27 CHAPTER 15 28 STUDIES AND HEARINGS ON HEALTH CARE 29 Section 1501. Hospital uncompensated charity care study. (a) Charity care data. The Health Care Cost Containment 30

19910H0020B2886

- 41 -

Council shall collect each year commencing with the calendar 1 year beginning January 1, 1993, the following charity care data 2 3 from all acute care hospitals licensed in this Commonwealth: 4 (1) Catastrophic inpatient and outpatient costs which 5 are defined as the allowable audited costs of services provided to persons above 150% of the poverty level, with an 6 7 unpaid personal liability greater than annual family income, 8 less an amount equivalent to 150% of the Federal poverty 9 level. Such amount must be net, following reasonable 10 collection procedures, consistently applied, and may not 11 include any costs or services for which reimbursement could 12 have been secured from the medical assistance or Medicare 13 program or other third party payor, nor any costs or services 14 rendered by a hospital in fulfillment of any charity care 15 obligation funding from foundations or Federal or State 16 sources including funding under the Hill Burton program. 17 (2) Medical assistance which is defined as the inpatient 18 and outpatient patient pay amount for medical assistance 19 recipients which has been unable to be collected following 20 reasonable collection procedures, consistently applied. 21 (3) Underinsured inpatient charity care which is defined 22 as the allowable audited cost of services provided to 23 uninsured persons below 150% of the Federal poverty level, 24 following reasonable collection procedures, consistently 25 applied. Such amount may not include payment for goods or 26 services which could have been reimbursed under the Medicaid 27 or Medicare program or other third party payor, nor any costs 28 or services rendered by a hospital in fulfillment of any 29 charity care obligation funding from foundations or Federal 30 or State sources including funding under the Hill Burton - 42 -19910H0020B2886

1 program.

2	(4) Uninsured inpatient charity care which is defined as
3	the allowable audited cost of services provided to persons
4	without public or private insurance coverage, with income
5	below 150% of the poverty level, following reasonable
6	collection procedures, consistently applied. Such amount may
7	not include payment for goods or services which could have
8	been reimbursed under the Medicaid or Medicare program or
9	other third party payor, nor any costs or services rendered
10	by a hospital in fulfillment of any charity care obligation
11	funding from foundations or Federal or State sources
12	including funding under the Hill Burton program.
13	(5) Additional data that the council believes is
14	necessary in determining charity care provided by acute care
15	hospitals.
16	(b) Recommendations to General Assembly. Commencing March
17	1, 1994, and every March 1 thereafter, the council shall submit
18	recommendations to the Governor and the General Assembly as to
19	whether a source of funding is required for uncompensated
20	charity care provided by acute care hospitals in this
21	Commonwealth. These recommendations shall be based on data
22	collection for uncompensated charity care as defined in this
23	section for the preceding calendar year.
24	(c) Annual hearings of the General Assembly. The Health and
25	Welfare Committee of the House of Representatives and the Public
26	Health and Welfare Committee of the Senate shall hold annual
27	joint public hearings in each region to review the council's
28	recommendations for the level of funding required for charity
29	care.
30	Section 1502. Medicaid reimbursement.

19910H0020B2886

- 43 -

1 (a) Joint hearings. The Health and Welfare Committee of the House of Representatives and the Public Health and Welfare 2 3 Committee of the Senate shall hold joint public hearings in each 4 region of this Commonwealth to review the adequacy of payments to providers under the medical assistance program. 5 (b) Joint Select Committee on Medicaid Reimbursement 6 Procedures. The President pro tempore of the Senate and the 7 Speaker of the House of Representatives shall appoint members to 8 9 a Joint Select Committee to study the feasibility of 10 implementing material improvements in the processing of claims 11 for medical assistance reimbursements to providers, and in the use of Pennsylvania Medical Assistance by it's low income 12 13 citizens. The study shall include, but not be limited to, the following: 14 (1) The cost effectiveness of contracting the entire 15 16 Medicaid reimbursement process to a fiscal intermediary, such as Blue Cross/Blue Shield. 17 18 (2) Explanation sections in all claim forms so that they 19 contain a clear description in English of the applicable 20 codes and messages in order that providers and recipient's 21 can respond to or complete the form. 22 (3) Additional staffing of the 800 telephone number so 23 that providers and beneficiaries can verify eligibility to receive benefits, inquire as to applicable eligibility 24 25 requirements and coverage restrictions, and receive a 26 verification number as to preclude denial for reasons 27 inconsistent with the information received by telephone. 28 (4) Development of a special training for providers, 29 identifying those parts of the claim forms with the greatest 30 incidence of error and explaining how to avoid such errors. 19910H0020B2886 - 44 -

1	(5) Submission of claims by providers on floppy disks,
2	tape to tape billing or telecommunications.
3	(6) Development of computer software that will
4	automatically identify errors by validity edit which verifies
5	that the data entered into any field or claim line on a claim
6	is appropriate for that field or claim line.
7	(7) Rewriting the provider handbook and reorganizing
8	provider bulletins on a regular basis to make these documents
9	more understandable and usable.
10	(c) Reports. Each committee shall issue a report by
11	December 31, 1992, and the General Assembly shall enact
12	legislation, if necessary, to adjust medical assistance provider
13	reimbursement to comply with Federal requirements and to
14	implement changes in Medicaid reimbursement procedures.
15	Section 1503. Cost of mandated health benefits.
16	(a) Content of study. The Health Care Cost Containment
17	Council, through its Mandated Benefits Review Panel, is directed
18	to study the costs and effectiveness of existing mandated health
19	benefits to businesses. For each of the existing mandated health
20	benefits, the review panel shall determine the financial impact
21	and health care effectiveness of the existing benefit, including
22	at least:
23	(1) The number of persons utilizing the existing
24	benefit.
25	(2) The extent to which elimination of the existing
26	benefit as a mandated health benefit would result in
27	inadequate health care for the population of this
28	Commonwealth.
29	(3) The cost effectiveness of the existing benefit in
30	reducing further more costly medical procedures.

19910H0020B2886

- 45 -

1	(4) The impact of the existing benefit on the total cost
2	of health care within this Commonwealth.
3	(5) The impact of the existing benefit on health
4	insurance costs of health care purchasers.
5	(6) The impact of the existing benefit on administrative
6	expenses of health care insurers.
7	(7) The extent to which elimination of the existing
8	benefit as a mandated health benefit would result in
9	increased medical assistance expenditures and charity care.
10	(8) The extent to which elimination of the existing
11	benefit as a mandated health benefit could be paid for by the
12	person receiving the existing benefit.
13	(9) The impact of the existing benefit on the ability of
14	small businesses to purchase health insurance for their
15	employees and on the ability of self employed persons to
16	purchase health insurance.
17	(b) Findings and recommendations. The review panel shall
18	issue a report to the council by June 30, 1993, outlining their
19	findings on the costs and effectiveness of the existing mandated
20	health benefits. After review of the panel's report, the council
21	shall submit a final report to the Governor and the General
22	Assembly by December 31, 1993, outlining their findings on the
23	costs and effectiveness of the existing mandated health benefits
24	and recommendations as to whether any or all existing mandated
25	health benefits should be eliminated.
26	Section 1504. Physician acceptance of medical assistance
27	patients.
28	The council shall, for all providers within this Commonwealth
29	and within the appropriate regions and subregions within this
30	Commonwealth, prepare and issue quarterly reports that provide
199	- 46 -

1	information on the number of physicians, by specialty, on the
2	staff of each hospital or ambulatory service facility and the
3	number and names of those physicians, by specialty, on the staff
4	that accept medical assistance patients.
5	Section 1505. Subsidies provided by health service corporation
6	and hospital plan corporations.
7	The health service corporation and hospital plan corporations
8	presently are exempt from paying the 2% premium tax. In lieu of
9	this exemption, and as part of their obligation to serve low-
10	income subscribers, the health service corporation and hospital
11	plan corporations shall submit annually, commencing on January
12	31, 1993, to the Department of Health and the Department of
13	Insurance data documenting their subsidies to health care
14	purchasers that they provide in lieu of their exemption from the
15	2% premium tax. In submitting this data, the health service
16	corporation and hospital plan corporations shall indicate which
17	subsidies are based on the income of the health care purchaser
18	or beneficiary.
19	CHAPTER 31
20	MISCELLANEOUS PROVISIONS
21	Section 3101. Persons eligible for medical assistance.
22	(a) General rule. In addition to those persons described in
23	section 441.1(1) and (2) of the act of June 13, 1967 (P.L.31,
24	No.21), known as the Public Welfare Code, the medical assistance
25	eligibility for all groups shall be set at the highest
26	eligibility limit permitted under Title XIX of the Social
27	Security Act.
28	(b) Additional eligibility. For purposes of this section
29	and section 441.1 of the Public Welfare Code, all recipients
30	(including medically needy recipients) and recipients of the

19910H0020B2886

State blind pension shall be entitled to all the medical 1 assistance benefits available to persons deemed categorically 2 needy as provided for in section 441.1(1) of the Public Welfare 3 4 Code except dental care. The Healthy Horizon resource level shall be increased to the maximum permitted under Federal law. 5 Section 3102. Mandated coverage. 6 7 (a) Health care providers. All insurance companies writing 8 group accident and sickness insurance in this Commonwealth shall by January 1, 1993, offer in every area in which they write such 9 10 insurance, a policy or policies meeting all State mandated 11 coverage. In selecting the health care providers, the insurance 12 companies shall utilize the date produced by the council and 13 other relevant data to design the insurance products. 14 (b) Approval. All such policies shall be approved by the 15 Department of Health and the Insurance Department to assure that 16 the policies provide for adequate urgent and emergency care from 17 other health providers, should that be needed and to ensure 18 sufficient numbers and types of health care providers. 19 Section 3103. Group accident and sickness insurance. 20 In addition to the provisions of section 621.2(a)(3) of the 21 act of May 17, 1921 (P.L.682, No.284), known as The Insurance 22 Company Law of 1921, group accident and sickness insurance shall 23 also include insurance under policies issued to the trustees of a fund established by any two or more employers or by an insurer 24 25 licensed in this Commonwealth. 26 Section 3104. Construction and application of Chapters 3 and 9. 27 (a) Construction of chapters. 28 (1) Chapters 3 and 9 shall not be construed to create 29 any legally enforceable right or entitlement to payment for 30 services on the part of any medically indigent person or any

- 48 -

19910H0020B2886

1	right of entitlement to payment of any particular rate by any	
2	hospital, other provider of medical services or other person.	
3	(2) Chapters 3 and 9 shall not be construed to relieve	
4	any hospital of its obligations under the Hill Burton Act (60	
5	Stat. 1040, 42 U.S.C. § 291 et seq.) or under any other	
6	similar Federal or State law or agreement to provide	
7	unreimbursed care to medically indigent persons.	
8	(b) Application of chapters. Chapters 3 and 9 shall apply	
9	only upon publication of notice in the Pennsylvania Bulletin by	
10	the Secretary of Public Welfare that the United States	
11	Department of Health and Human Services has approved the	
12	amendment of Pennsylvania's State Plan for Medical Assistance as	
13	set forth by the provisions of this act.	
14	Section 3105. Repeals.	
15	(a) Specific. Section 441.1(3) of the act of June 13, 1967	
16	(P.L.31, No.21), known as the Public Welfare Code, is repealed.	
17	(b) General. All other acts and parts of acts are repealed	
18	insofar as they are inconsistent with this act.	
19	Section 3106. Expiration.	
20	This act shall expire December 31, 1999, unless reenacted by	
21	the General Assembly.	
22	Section 3107. Effective date.	
23	This act shall take effect in 60 days.	
24	CHAPTER 1	<—
25	GENERAL PROVISIONS	
26	SECTION 101. SHORT TITLE.	
27	THIS ACT SHALL BE KNOWN AND MAY BE CITED AS THE HEALTH CARE	
28	PARTNERSHIP ACT.	
29	SECTION 102. LEGISLATIVE FINDINGS AND INTENT.	
30	(A) DECLARATIONTHE GENERAL ASSEMBLY FINDS AND DECLARES	
199	10H0020B2886 - 49 -	

1 THAT:

2 (1) ALL CITIZENS OF THIS COMMONWEALTH HAVE A RIGHT TO
3 ACCESS TO AFFORDABLE AND REASONABLY PRICED HEALTH CARE AND TO
4 NONDISCRIMINATORY TREATMENT BY HEALTH INSURERS AND PROVIDERS.

5 (2) THE UNINSURED HEALTH CARE POPULATION OF THIS
6 COMMONWEALTH IS OVER ONE MILLION PERSONS, AND MANY THOUSANDS
7 MORE LACK ADEQUATE INSURANCE COVERAGE. APPROXIMATELY TWO8 THIRDS OF THE UNINSURED ARE EMPLOYED OR DEPENDENTS OF
9 EMPLOYED PERSONS.

(3) OVER ONE-THIRD OF THE UNINSURED HEALTH CARE 10 11 POPULATION ARE CHILDREN. UNINSURED CHILDREN ARE OF PARTICULAR 12 CONCERN BECAUSE OF THEIR NEED FOR ONGOING PREVENTATIVE AND 13 PRIMARY CARE. MEASURES NOT TAKEN TO CARE FOR SUCH CHILDREN 14 NOW WILL RESULT IN HIGHER HUMAN AND FINANCIAL COSTS LATER. 15 ACCESS TO TIMELY AND APPROPRIATE PRIMARY CARE IS PARTICULARLY 16 SERIOUS FOR WOMEN WHO RECEIVE LATE OR NO PRENATAL CARE WHICH 17 INCREASES THE RISK OF LOW BIRTH WEIGHTS AND INFANT MORTALITY.

18 (4) THE UNINSURED AND UNDERINSURED LACK ACCESS TO TIMELY 19 AND APPROPRIATE PRIMARY AND PREVENTATIVE CARE. AS A RESULT, THEY OFTEN DELAY OR FOREGO HEALTH CARE, WITH THE RESULTING 20 21 INCREASED RISK OF DEVELOPING MORE SEVERE CONDITIONS, WHICH 22 ARE MORE EXPENSIVE TO TREAT. THIS TENDENCY OF THE MEDICALLY 23 INDIGENT TO DELAY CARE AND TO SEEK AMBULATORY CARE IN HOSPITAL-BASED SETTINGS ALSO CAUSES INEFFICIENCIES IN THE 24 25 HEALTH CARE SYSTEM.

(5) HEALTH MARKETS HAVE BEEN DISTORTED THROUGH COST
 SHIFTS FOR THE UNCOMPENSATED HEALTH CARE COSTS OF UNINSURED
 CITIZENS OF THIS COMMONWEALTH WHICH HAS CAUSED DECREASED
 COMPETITIVE CAPACITY ON THE PART OF THOSE HEALTH CARE
 PROVIDERS WHO SERVE THE POOR, AND INCREASED COSTS OF OTHER
 19910H0020B2886 - 50 -

1 HEALTH CARE PAYORS.

2 (6) NOT-FOR-PROFIT HOSPITALS WHICH HAVE BEEN GRANTED A
3 TAX FREE STATUS BY THE STATE VARY GREATLY IN THE AMOUNT OF
4 CHARITABLE UNCOMPENSATED HEALTH CARE THEY PROVIDE AND ON
5 AVERAGE PROVIDE LESS THAN THE NATIONAL AVERAGE. THERE HAS
6 BEEN NO UNIFORM DEFINITION TO DETERMINE THE AMOUNT OF CHARITY
7 CARE PROVIDED BY THESE HEALTH CARE INSTITUTIONS.

8 (7) ALTHOUGH THE PROPER IMPLEMENTATION BY HOSPITALS OF 9 SPEND-DOWN PROVISIONS UNDER MEDICAL ASSISTANCE SHOULD RESULT 10 IN THE PROVISION OF THE VAST MAJORITY OF ALL HOSPITAL CARE 11 FOR THE UNINSURED THROUGH THE MEDICAL ASSISTANCE PROGRAM, 12 HOSPITALS VARY WIDELY IN THEIR WILLINGNESS TO ALLOW PATIENTS 13 TO INCUR EXPENSES SO THEY CAN QUALIFY FOR MEDICAL ASSISTANCE.

14 (8) THE PROFESSIONAL HEALTH SERVICE PLAN CORPORATION AND
15 THE HOSPITAL PLAN CORPORATIONS WHICH ARE GRANTED AN EXEMPTION
16 FROM THE PREMIUM TAX HAVE VARIED GREATLY IN THE AMOUNT OF
17 HEALTH SERVICES THEY PROVIDE TO LOW-INCOME CITIZENS OF THIS
18 COMMONWEALTH AND THE MANNER IN WHICH THEY HAVE TARGETED THEIR
19 SUBSIDIES.

20 (9) MANY HEALTH MAINTENANCE ORGANIZATIONS HAVE BEEN
21 UNWILLING TO REACH AN AGREEMENT WITH THE DEPARTMENT OF PUBLIC
22 WELFARE, TO ENROLL AS SUBSCRIBERS, INDIVIDUALS PARTICIPATING
23 IN OR ELIGIBLE FOR MEDICAL ASSISTANCE.

(10) NO ONE SECTOR CAN ABSORB THE COST OF PROVIDING 24 25 HEALTH CARE TO ALL CITIZENS OF THIS COMMONWEALTH WHO CANNOT 26 AFFORD HEALTH CARE ON THEIR OWN. THE COST IS TOO LARGE FOR THE PUBLIC SECTOR ALONE TO BEAR AND INSTEAD REQUIRES THE 27 28 ESTABLISHMENT OF A PUBLIC/PRIVATE PARTNERSHIP TO SHARE THE COSTS IN A MANNER ECONOMICALLY FEASIBLE FOR ALL INTERESTS. 29 30 THE MAGNITUDE OF THIS NEED ALSO REQUIRES THAT IT BE DONE ON A 19910H0020B2886 - 51 -

1 TIME-PHASED, COST-MANAGED AND PLANNED BASIS.

(B) INTENT.--IT IS THE INTENT OF THE GENERAL ASSEMBLY AND 2 3 THE PURPOSE OF THIS ACT THAT:

4 (1) ELIGIBLE CITIZENS OF THIS COMMONWEALTH HAVE ACCESS 5 TO COST-EFFECTIVE, COMPREHENSIVE HEALTH COVERAGE WHEN THEY 6 ARE UNABLE TO AFFORD COVERAGE OR OBTAIN IT THROUGH THEIR 7 EMPLOYMENT.

8 (2) CARE BE PROVIDED IN APPROPRIATE SETTINGS BY 9 EFFICIENT PROVIDERS, CONSISTENT WITH HIGH QUALITY CARE AND AT 10 AN APPROPRIATE STAGE, SOON ENOUGH TO AVERT THE NEED FOR 11 OVERLY EXPENSIVE TREATMENT.

12 (3) EQUITY BE ASSURED AMONG HEALTH PROVIDERS AND PAYORS 13 BY PROVIDING A MECHANISM FOR PROVIDERS, EMPLOYERS, THE PUBLIC 14 SECTOR AND PATIENTS TO SHARE IN FINANCING INDIGENT HEALTH 15 CARE.

16 SECTION 103. DEFINITIONS.

17 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ACT SHALL 18 HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE 19 CONTEXT CLEARLY INDICATES OTHERWISE:

20 "BAD DEBT." THE DIFFERENCE BETWEEN THE PATIENT PAY AMOUNT 21 DUE AND THE PATIENT PAY REVENUE RECEIVED.

22 "CHILD." A PERSON UNDER 18 YEARS OF AGE.

23 "COUNCIL." THE HEALTH CARE COST CONTAINMENT COUNCIL.

"DEPARTMENT." THE DEPARTMENT OF PUBLIC WELFARE OF THE 24

25 COMMONWEALTH.

26 "DISPROPORTIONATE SHARE HOSPITAL." EACH HOSPITAL, INCLUDING 27 DISTINCT PARTS, PROVIDING A CERTAIN NUMBER OR PERCENTAGE OF 28 INPATIENT SERVICES PAID THROUGH THE MEDICAL ASSISTANCE PROGRAM, 29 AS DEFINED IN REGULATIONS OF THE DEPARTMENT OF PUBLIC WELFARE 30 AND THE FEDERALLY APPROVED MEDICAL ASSISTANCE STATE PLAN. 19910H0020B2886

- 52 -

"EPSDT." EARLY AND PERIODIC SCREENING, DIAGNOSIS AND
 TREATMENT.

3 "GROUP." ANY GROUP FOR WHICH A HEALTH INSURANCE POLICY IS4 WRITTEN IN THE COMMONWEALTH OF PENNSYLVANIA.

5 "HEALTH MAINTENANCE ORGANIZATION" OR "HMO." AN ENTITY
6 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972
7 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION
8 ACT.

9 "HEALTH SERVICE CORPORATION." A PROFESSIONAL HEALTH SERVICE 10 CORPORATION AS DEFINED IN 40 PA.C.S. (RELATING TO INSURANCE). 11 "HILL-BURTON PROGRAM." THE HOSPITAL SURVEY AND CONSTRUCTION 12 PROGRAM PROVIDED IN THE HILL-BURTON ACT (60 STAT. 1040, 42 13 U.S.C. § 291 ET SEQ.).

14 "HOSPITAL." AN INSTITUTION HAVING AN ORGANIZED MEDICAL STAFF 15 WHICH IS ENGAGED PRIMARILY IN PROVIDING TO INPATIENTS, BY OR 16 UNDER THE SUPERVISION OF PHYSICIANS, DIAGNOSTIC AND THERAPEUTIC 17 SERVICES FOR THE CARE OF INJURED, DISABLED, PREGNANT, DISEASED 18 OR SICK OR MENTALLY ILL PERSONS. THE TERM INCLUDES FACILITIES 19 FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS WITHIN THE SCOPE OF 20 SPECIFIC MEDICAL SPECIALTIES, INCLUDING FACILITIES WHICH PROVIDE 21 CARE AND TREATMENT EXCLUSIVELY FOR THE MENTALLY ILL AND DRUG OR 22 ALCOHOL INPATIENT DETOXIFICATION OR REHABILITATIVE CARE. THE 23 TERM DOES NOT INCLUDE INPATIENT NONHOSPITAL ACTIVITY AS 24 DESCRIBED IN 28 PA. CODE § 701.1 (RELATING TO GENERAL 25 DEFINITIONS), PUBLICLY OWNED INPATIENT FACILITIES OR SKILLED OR 26 INTERMEDIATE CARE NURSING FACILITIES. THE TERM ALSO DOES NOT 27 INCLUDE A FACILITY WHICH IS OPERATED BY A RELIGIOUS ORGANIZATION 28 FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES EXCLUSIVELY TO 29 CLERGYMEN OR OTHER PERSONS IN A RELIGIOUS PROFESSION WHO ARE 30 MEMBERS OF A RELIGIOUS DENOMINATION OR A FACILITY PROVIDING 19910H0020B2886 - 53 -

1 TREATMENT SOLELY ON THE BASIS OF PRAYER OR SPIRITUAL MEANS.

2 "HOSPITAL PLAN CORPORATION." A HOSPITAL PLAN CORPORATION AS3 DEFINED IN 40 PA.C.S. (RELATING TO INSURANCE).

4 "INSURER." AN ENTITY SUBJECT TO THE ACT OF MAY 17, 1921 5 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921. 6 "MAAC." THE MEDICAL ASSISTANCE ADVISORY COMMITTEE. 7 "MANAGED CARE ORGANIZATION." A HEALTH MAINTENANCE ORGANIZATION ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 8 9 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE 10 ORGANIZATION ACT; A RISK-ASSUMING PREFERRED PROVIDER 11 ORGANIZATION OR EXCLUSIVE PROVIDER ORGANIZATION, ORGANIZED AND 12 REGULATED UNDER THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN 13 AS THE INSURANCE COMPANY LAW OF 1921; OR A PREFERRED PROVIDER 14 WITH A HEALTH MANAGEMENT/"GATEKEEPER" ROLE FOR PRIMARY CARE 15 PHYSICIANS ORGANIZED AND REGULATED AS A HEALTH SERVICES 16 CORPORATION UNDER 40 PA.C.S. CH. 63 (RELATING TO PROFESSIONAL

17 HEALTH SERVICES PLAN CORPORATIONS).

18 "MEDICAL ASSISTANCE." THE STATE PROGRAM OF MEDICAL 19 ASSISTANCE ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31, 20 NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

21 "MEDICAID." THE FEDERAL MEDICAL ASSISTANCE PROGRAM
22 ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (PUBLIC
23 LAW 74-271, 42 U.S.C. § 301 ET SEQ.).

24 "MEDICALLY INDIGENT." FAMILIES AND INDIVIDUALS WHO LACK
25 SUFFICIENT INCOME OR FINANCIAL RESOURCES THROUGH INSURANCE OR
26 OTHER MEANS TO PAY FOR NECESSARY HEALTH CARE SERVICES.

27 "MIC." THE FEDERAL MATERNAL, INFANT AND CHILD CARE PROGRAM.
28 "PREEXISTING CONDITION." A DISEASE OR PHYSICAL CONDITION FOR
29 WHICH MEDICAL ADVICE OF TREATMENT HAS BEEN RECEIVED WITHIN 90
30 DAYS IMMEDIATELY PRIOR TO THE EFFECTIVE DATE OF COVERAGE.

19910H0020B2886

- 54 -

"SPECIALTY AND SUPPLEMENTAL HEALTH SERVICES." SERVICES NOT
 INCLUDED AS PRIMARY HEALTH SERVICES, SUCH AS HOSPITAL CARE, HOME
 HEALTH SERVICES, REHABILITATIVE SERVICES, MENTAL HEALTH
 SERVICES, DRUG AND ALCOHOL SERVICES AND AMBULATORY SURGICAL
 SERVICES.

6 "SPEND-DOWN." THE QUALIFYING PROCEDURE FOR THE PENNSYLVANIA
7 MEDICAL ASSISTANCE PROGRAM SET FORTH IN 55 PA. CODE, CH. 181
8 (RELATING TO INCOME PROVISIONS FOR CATEGORICALLY NEEDY NONMONEY
9 PAYMENT (NMP-MA) AND MEDICALLY NEEDY ONLY (MNO-MA) MEDICAL
10 ASSISTANCE (MA)).

11 "SUBGROUP." AN EMPLOYER COVERED UNDER A CONTRACT ISSUED TO A12 MULTIPLE EMPLOYER TRUST OR TO AN ASSOCIATION.

13 "TITLE XIX." TITLE XIX OF THE SOCIAL SECURITY ACT (PUBLIC 14 LAW 74-271, 42 U.S.C. § 301 ET SEQ.).

15 "WAITING PERIOD." A PERIOD OF TIME AFTER THE EFFECTIVE DATE 16 OF ENROLLMENT DURING WHICH A HEALTH INSURANCE PLAN EXCLUDES 17 COVERAGE FOR THE DIAGNOSIS OR TREATMENT OF ONE OR MORE MEDICAL 18 CONDITIONS.

19 "WIC." THE FEDERAL WOMEN, INFANTS AND CHILDREN PROGRAM.

20

21 MEDICAL ASSISTANCE PROGRAM

22 SECTION 501. HOSPITAL RESPONSIBILITIES UNDER MEDICAL ASSISTANCE23 PROGRAM.

CHAPTER 5

(A) NECESSARY CARE.--EACH LICENSED ACUTE CARE HOSPITAL SHALL
NOT DENY NECESSARY AND TIMELY HEALTH CARE DUE TO A PERSON'S
INABILITY TO PAY IN ADVANCE FROM CURRENT INCOME OR RESOURCES FOR
ALL OR PART OF THAT CARE.

(B) INSTALLMENT AGREEMENTS. --HOSPITALS SHALL ENTER INTO
 REASONABLE INSTALLMENT AGREEMENTS TO COVER THE SPEND-DOWN COST
 OF THE CARE NECESSARY FOR THE PERSON TO QUALIFY FOR MEDICAL
 19910H0020B2886 - 55 -

ASSISTANCE COVERAGE OR INSURANCE. WITHIN SIX MONTHS OF THE
 EFFECTIVE DATE OF THIS ACT, THE DEPARTMENT SHALL ISSUE
 GUIDELINES TO ENSURE UNIFORMITY OF THIS PROVISION AND COMPLIANCE
 WITH FEDERAL AND STATE REQUIREMENTS.

5 (C) PROHIBITIONS.--IT IS UNLAWFUL FOR ANY HOSPITAL LICENSED6 BY THE COMMONWEALTH:

7 (1) TO REQUIRE, AS A CONDITION OF ADMISSION OR
8 TREATMENT, ASSURANCE FROM THE PATIENT OR ANY OTHER PERSON
9 THAT THE PATIENT IS NOT ELIGIBLE FOR OR WILL NOT APPLY FOR
10 MEDICAL ASSISTANCE;

11 (2) TO DENY OR DELAY ADMISSION OR TREATMENT OF A PERSON
12 BECAUSE OF HIS CURRENT OR POSSIBLE FUTURE STATUS AS A MEDICAL
13 ASSISTANCE RECIPIENT;

14 (3) TO TRANSFER A PATIENT TO ANOTHER HEALTH CARE
15 PROVIDER BECAUSE OF HIS CURRENT OR POSSIBLE STATUS AS A
16 MEDICAL ASSISTANCE RECIPIENT;

17 (4) TO DISCHARGE A PATIENT FROM CARE BECAUSE OF HIS
18 CURRENT OR POSSIBLE FUTURE STATUS AS A MEDICAL ASSISTANCE
19 RECIPIENT; OR

20 (5) TO DISCOURAGE ANY PERSON WHO WOULD BE ELIGIBLE FOR
21 THE MEDICAL ASSISTANCE PROGRAM FROM APPLYING OR SEEKING
22 NEEDED HEALTH CARE OR NEEDED ADMISSION TO A HEALTH CARE
23 FACILITY BECAUSE OF HIS INABILITY TO PAY FOR THAT CARE.

(D) APPLICATION FOR MEDICAL ASSISTANCE.--EACH HOSPITAL SHALL
PROVIDE TO EACH PROSPECTIVE UNINSURED OR UNDERINSURED PATIENT,
ASSISTANCE IN COMPLETING AN APPLICATION FOR MEDICAL ASSISTANCE,
WITHIN ONE BUSINESS DAY OF THE PROSPECTIVE PATIENT'S FIRST
REQUEST TO BE ADMITTED TO THE HOSPITAL.

(E) ACCESS TO ALL SERVICES. -- EACH HOSPITAL SHALL ENSURE THAT
 30 ALL MEDICAL ASSISTANCE RECIPIENTS HAVE FULL ACCESS TO ALL
 19910H0020B2886 - 56 -

AVAILABLE SERVICES, PHYSICIAN SPECIALISTS AND ANY DEPARTMENT OF
 THE FACILITY. EACH HOSPITAL SHALL ESTABLISH A PHYSICIAN REFERRAL
 SERVICE TO ASSIST MEDICAL ASSISTANCE RECIPIENTS WITH REFERRALS
 TO PRIMARY CARE AND SPECIALIST PHYSICIANS ON AN EQUITABLE,

5 ROTATING BASIS.

6 SECTION 502. MEDICAL ASSISTANCE OUTREACH.

7 (A) CONTENT OF PROGRAM. --THE DEPARTMENT SHALL ESTABLISH AND
8 ADMINISTER AN OUTREACH PROGRAM TO ENROLL PEOPLE WHO ARE ELIGIBLE
9 FOR MEDICAL ASSISTANCE BUT HAVE NOT ENROLLED. THIS SHALL

10 INCLUDE:

11 (1) PROVIDING FOR ON-SITE APPLICATIONS AT ALL

12 DISPROPORTIONATE SHARE HOSPITALS AND FEDERAL QUALIFIED HEALTH 13 CENTERS.

14 (2) DEVELOPING A PROGRAM OF PUBLIC SERVICE ANNOUNCEMENTS
15 TO BE AIRED ON TELEVISION AND RADIO ON A REGULAR STATEWIDE
16 BASIS, ADVISING CITIZENS OF:

17 (I) EXPANDED MEDICAL ASSISTANCE ELIGIBILITY FOR
18 PREGNANT WOMEN, INFANTS, THE ELDERLY, THE DISABLED,
19 PERSONS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS);

20 (II) GENERAL ELIGIBILITY REQUIREMENTS, SPEND-DOWN,
21 EXPEDITED ISSUANCE OF MEDICAL ASSISTANCE CARDS, AND HOW
22 AND WHERE TO APPLY; AND

23 (III) AVAILABILITY OF PRIMARY AND SPECIALTY CARE
24 PHYSICIANS WHO ACCEPT MEDICAL ASSISTANCE.

25 (3) PROVIDING TO MEDICAL ASSISTANCE RECIPIENTS PERIODIC
26 NOTIFICATION OF PRIMARY AND SPECIALTY CARE PHYSICIAN
27 AVAILABILITY, PROCEDURE TO ACCESS PHYSICIANS, COMPLAINT
28 PROCEDURES AND CONSUMER RIGHTS.

29 (4) DEVELOPING PAMPHLETS AND INFORMATIONAL SERVICES FOR 30 MEDICAL ASSISTANCE PROVIDERS TO HELP PROVIDERS INFORM 19910H0020B2886 - 57 - 1 PATIENTS ABOUT MEDICAL ASSISTANCE OPTIONS AND ELIGIBILITY.

2 (5) PROVIDING THE GENERAL ASSEMBLY AND THE PUBLIC AN 3 ANNUAL REPORT FOR EACH FISCAL YEAR, DETAILING THE OUTREACH 4 AND ENROLLMENT EFFORTS TAKEN BY EACH COUNTY ASSISTANCE 5 OFFICE, AND REPORTING BY COUNTY ON THE NUMBER OF CITIZENS 6 ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM AND THE PROJECTED 7 MEDICAL ASSISTANCE ELIGIBLE POPULATION OF EACH COUNTY. 8 (B) APPLICATIONS FOR MEDICAL ASSISTANCE AND CHILDREN'S 9 HEALTH CARE PLAN. -- PERSONS TAKING APPLICATIONS FOR MEDICAL 10 ASSISTANCE, INCLUDING PERSONS AT SITES OTHER THAN COUNTY 11 ASSISTANCE OFFICES, SHALL OFFER TO TAKE AN APPLICATION FOR 12 COVERAGE UNDER THE CHILDREN'S HEALTH CARE PLAN, AS ESTABLISHED 13 UNDER CHAPTER 7, FOR ANY CHILD. PERSONS TAKING APPLICATIONS FOR 14 THE CHILDREN'S HEALTH CARE PLAN SHALL PROMPTLY FORWARD THE 15 APPLICATIONS TO THE ENTITY DESIGNATED BY THE HEALTH SERVICE 16 CORPORATION AND HOSPITAL PLAN CORPORATIONS TO ADMINISTER THE 17 PLAN.

18 SECTION 503. PENNSYLVANIA CHILDREN'S MEDICAL ASSISTANCE

PROGRAM.

19

20

(A) COVERAGE.--

(1) THE DEPARTMENT SHALL AMEND ITS MEDICAL ASSISTANCE
REGULATIONS TO PROVIDE ALL MEDICALLY NECESSARY HEALTH CARE,
DIAGNOSTIC SERVICES, REHABILITATIVE SERVICES AND TREATMENT
FOR WHICH FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE, TO
ALL CHILDREN ENROLLED UNDER THIS SECTION.

26 (2) HEALTH CARE SERVICES SHALL BE PROVIDED IN SUFFICIENT
27 AMOUNT, DURATION AND SCOPE, REQUIRED FOR EACH ENROLLED
28 CHILD'S MEDICAL CONDITION.

29 (B) ENROLLMENT.--

30 (1) EVERY CHILD SHALL BE IMMEDIATELY ENROLLED IN THE 19910H0020B2886 - 58 - EPSDT PROGRAM UPON AUTHORIZATION FOR MEDICAL ASSISTANCE. ANY
 PARENT WISHING NOT TO PARTICIPATE IN THE EPSDT PROGRAM MUST
 SIGN A FORM DETAILING THE HEALTH CARE BENEFITS THAT ARE BEING
 WAIVED.

5 (2) AT TIME OF AUTHORIZATION, OR SHORTLY THEREAFTER, FOR 6 MEDICAL ASSISTANCE FOR ANY CHILD, OR THE ADDITION OF A NEW 7 CHILD, THE DEPARTMENT OR ITS DESIGNEE SHALL ASSIST THE PARENT 8 IN MAKING AN APPOINTMENT FOR THE CHILD FOR A EPSDT SCREEN 9 WITH THE PHYSICIAN OF THE PARENT'S CHOICE.

10 (3) PERIODICALLY, THE DEPARTMENT OR ITS DESIGNEE SHALL
11 DETERMINE WHETHER THE CHILDREN ARE CURRENT IN THEIR SCREENS
12 AND IF THEY ARE IN NEED OF ASSISTANCE IN ARRANGING HEALTH,
13 DENTAL, MENTAL HEALTH OR OTHER TREATMENT. ASSISTANCE SHALL BE
14 PROVIDED THE PARENT BY THE DEPARTMENT OR ITS DESIGNEE, IF
15 NEEDED, IN ARRANGING FOR SUCH CARE, SCREEN OR TRANSPORTATION
16 THEREFOR.

17 (C) AUDIT.--THE DEPARTMENT SHALL ANNUALLY CONDUCT A 18 PERFORMANCE ANALYSIS OF THE EPSDT PROGRAM, INCLUDING THE 19 FOLLOWING:

(1) THE OUTREACH EFFORTS AS SCHOOLS, DAY-CARE
 FACILITIES, HOSPITALS, ETC., TO ENROLL CHILDREN IN THE
 MEDICAL ASSISTANCE AND EPSDT PROGRAM.

(2) OF THOSE CHILDREN ENROLLED IN MEDICAL ASSISTANCE,
THE PERCENTAGE OF CHILDREN CURRENT IN THEIR SCREENS AND FOR
WHOM NEEDED TREATMENT AND SERVICES HAVE BEEN OBTAINED.

26 (3) COORDINATION OF MIC, WIC, EPSDT, MENTAL HEALTH, DRUG
27 AND ALCOHOL, STATE AND COUNTY HEALTH CENTERS AND OTHER
28 SERVICES IN THE COUNTY AVAILABLE TO CHILDREN ON MEDICAL
29 ASSISTANCE.

30 (D) NONCOMPLIANCE.--IF THE EPSDT PROGRAM IS FOUND TO BE IN 19910H0020B2886 - 59 - NONCOMPLIANCE WITH THE PROVISIONS OF THIS SECTION OR HAS FAILED
 TO TAKE SUFFICIENT OUTREACH EFFORTS TO ENROLL ANY COUNTY'S
 ELIGIBLE CHILDREN UNDER THIS SECTION, THE DEPARTMENT SHALL
 IMMEDIATELY FILE A CORRECTIVE ACTION PLAN. THE DEPARTMENT SHALL
 DO QUARTERLY COMPLIANCE REVIEWS OF THE EPSDT PROGRAM UNTIL IT
 HAS CORRECTED THE IDENTIFIED PERFORMANCE DEFICIENCIES.

7 (E) PUBLICITY.--THE DEPARTMENT SHALL DEVELOP AND WIDELY 8 UTILIZE A MEDIA CAMPAIGN FOR USE ON TELEVISION, RADIO AND LOCAL 9 NEWSPAPERS, ADVISING PENNSYLVANIA'S CITIZENS OF THE AVAILABILITY 10 OF HEALTH CARE FOR LOW-INCOME CHILDREN UNDER THIS SECTION. 11 (F) REPORT TO GENERAL ASSEMBLY.--THE DEPARTMENT SHALL 12 PROVIDE A WRITTEN ANNUAL REPORT TO THE GENERAL ASSEMBLY 13 DETAILING ON A COUNTY BY COUNTY BASIS THE FINDINGS OF THE 14 PERFORMANCE AUDITS SET FORTH IN THIS SECTION AND EVALUATING THE 15 MEDIA CAMPAIGN USED BY THE DEPARTMENT TO INFORM CITIZENS ABOUT 16 THE AVAILABILITY OF HEALTH COVERAGE FOR LOW-INCOME CHILDREN 17 UNDER THIS SECTION.

18 (G) ADVISORY COMMITTEE. -- THE MAAC SHALL, ON A QUARTERLY 19 BASIS, REVIEW COUNTY ASSISTANCE AND DEPARTMENTAL IMPLEMENTATION 20 OF THIS SECTION AND TO ADVISE THE DEPARTMENT ON CHANGES IN POLICY NEEDED TO MAXIMIZE THE AVAILABILITY OF TIMELY AND COST-21 22 EFFECTIVE HEALTH CARE TO PENNSYLVANIA'S LOW-INCOME CHILDREN WHO 23 DEPEND ON MEDICAL ASSISTANCE FOR THEIR HEALTH CARE. IN ITS 24 REVIEW, THE MAAC SHALL SEEK THE ADVICE FROM THE CONSUMER 25 SUBCOMMITTEE OF THE MAAC; THE PENNSYLVANIA CHAPTER OF THE 26 AMERICAN ACADEMY OF PEDIATRICIANS; THE PENNSYLVANIA ACADEMY OF 27 FAMILY PHYSICIANS; THE DEVELOPMENTAL DISABILITY PLANNING COUNCIL 28 AND OTHER INTERESTED GROUPS.

29

30

CHAPTER 7

PRIMARY HEALTH CARE PROGRAMS

19910H0020B2886

- 60 -

1 SECTION 701. CHILDREN'S HEALTH CARE.

2 (A) THE CHILDREN'S HEALTH FUND AUTHORITY.--THE CHILDREN'S
3 HEALTH FUND AUTHORITY IS ESTABLISHED AS AN AGENCY OF THE
4 COMMONWEALTH, EXERCISING PUBLIC POWERS, INCLUDING ALL POWERS
5 NECESSARY OR APPROPRIATE TO CARRY OUT AND EFFECTUATE THE
6 PURPOSES AND PROVISIONS OF THIS SECTION.

7 (1) THE CHILDREN'S HEALTH FUND AUTHORITY SHALL CONSIST
8 OF 17 VOTING MEMBERS, COMPOSED OF AND APPOINTED IN ACCORDANCE
9 WITH THE FOLLOWING:

10

(I) THE SECRETARY OF HEALTH.

11 (II) THE SECRETARY OF PUBLIC WELFARE.

12 (III) THE INSURANCE COMMISSIONER.

13 (IV) ONE REPRESENTATIVE FROM THE PENNSYLVANIA
14 CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, APPOINTED
15 BY THE GOVERNOR FROM A LIST OF THREE QUALIFIED PERSONS
16 RECOMMENDED BY THE ACADEMY.

17 (V) ONE REPRESENTATIVE FROM THE PENNSYLVANIA ACADEMY
18 OF FAMILY PHYSICIANS, APPOINTED BY THE GOVERNOR FROM A
19 LIST OF THREE QUALIFIED PERSONS RECOMMENDED BY THE
20 ACADEMY.

(VI) A REPRESENTATIVE FROM THE DEVELOPMENTAL
DISABILITY COUNCIL, APPOINTED BY THE GOVERNOR FROM A LIST
OF THREE QUALIFIED PERSONS RECOMMENDED BY THE COUNCIL.

24 (VII) A REPRESENTATIVE APPOINTED BY THE CHILD HEALTH
25 SUBCOMMITTEE OF THE MEDICAL ASSISTANCE ADVISORY
26 COMMITTEE.

27 (VIII) ONE REPRESENTATIVE APPOINTED BY THE MATERNAL28 AND INFANT ADVISORY COUNCIL.

(IX) A PARENT OF A CHILD WHO RECEIVES PRIMARY HEALTH
 CARE FUNDED BY THE AUTHORITY, APPOINTED BY THE GOVERNOR
 19910H0020B2886 - 61 -

1 FROM A LIST OF PARENT APPLICANTS.

2 (X) THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN
3 OF THE APPROPRIATIONS COMMITTEE OF THE SENATE AND THE
4 MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF THE
5 APPROPRIATIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES

6 (XI) THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN 7 OF THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE 8 AND THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF 9 THE HEALTH AND WELFARE COMMITTEE OF THE HOUSE OF 10 REPRESENTATIVES.

11 (2) ALL INITIAL APPOINTMENTS TO THE AUTHORITY SHALL BE 12 MADE BY WITHIN 60 DAYS OF THE EFFECTIVE DATE OF THIS ACT, AND 13 THE AUTHORITY SHALL COMMENCE OPERATIONS IMMEDIATELY THEREAFTER. IF ANY SPECIFIED ORGANIZATION SHOULD CEASE TO 14 15 EXIST OR FAIL TO MAKE A RECOMMENDATION WITHIN 90 DAYS OF A 16 REQUEST TO DO SO, THE AUTHORITY SHALL SPECIFY A NEW 17 EQUIVALENT ORGANIZATION TO FULFILL THE RESPONSIBILITIES OF 18 THIS SECTION.

19 (3) THE MEMBERS OF THE AUTHORITY SHALL ANNUALLY ELECT,
20 BY A MAJORITY VOTE OF THE MEMBERS, A CHAIRPERSON AND VICE
21 CHAIRPERSON FROM AMONG THE MEMBERS OF THE AUTHORITY.

22 (4) THE AUTHORITY MAY APPOINT STAFF NECESSARY TO CARRY23 OUT ITS FUNCTIONS.

(5) NINE MEMBERS SHALL CONSTITUTE A QUORUM FOR THE
TRANSACTING OF ANY BUSINESS. ANY ACT BY A MAJORITY OF THE
MEMBERS PRESENT AT ANY MEETING AT WHICH THERE IS A QUORUM
SHALL BE DEEMED TO BE THAT OF THE AUTHORITY.

28 (6) ALL MEETINGS OF THE AUTHORITY SHALL BE ADVERTISED
29 PURSUANT TO THE ACT OF JULY 3, 1986 (P.L.388, NO.84), KNOWN
30 AS THE SUNSHINE ACT, UNLESS OTHERWISE PROVIDED IN THIS

19910H0020B2886

- 62 -

1 SECTION. THE AUTHORITY SHALL MEET AT LEAST QUARTERLY AND MAY 2 PROVIDE FOR SPECIAL MEETINGS AS IT DEEMS NECESSARY. MEETING 3 DATES SHALL BE SET BY A MAJORITY VOTE OF MEMBERS OF THE 4 AUTHORITY OR BY CALL OF THE CHAIRPERSON UPON SEVEN DAYS' 5 NOTICE TO ALL MEMBERS. THE AUTHORITY SHALL PUBLISH A SCHEDULE 6 OF ITS MEETINGS IN THE PENNSYLVANIA BULLETIN AND AT LEAST 7 FOUR NEWSPAPERS OF GENERAL CIRCULATION IN THIS COMMONWEALTH. 8 NOTICE SHALL BE PUBLISHED AT LEAST ONCE IN EACH CALENDAR 9 OUARTER AND SHALL LIST A SCHEDULE OF MEETINGS OF THE 10 AUTHORITY TO BE HELD IN THE SUBSEQUENT CALENDAR QUARTER. 11 NOTICE SHALL SPECIFY THE DATE, TIME AND PLACE OF THE MEETING 12 AND SHALL STATE THAT THE AUTHORITY'S MEETINGS ARE OPEN TO THE 13 GENERAL PUBLIC. ALL ACTION TAKEN BY THE AUTHORITY SHALL BE 14 TAKEN IN OPEN PUBLIC SESSION AND SHALL NOT BE TAKEN EXCEPT 15 UPON A MAJORITY VOTE OF THE MEMBERS PRESENT AT A MEETING AT 16 WHICH A QUORUM IS PRESENT.

17 (7) THE AUTHORITY SHALL ADOPT REGULATIONS NOT18 INCONSISTENT WITH THIS SECTION.

19 (8) THE MEMBERS OF THE AUTHORITY SHALL NOT RECEIVE A
20 SALARY OR PER DIEM ALLOWANCE FOR SERVING AS MEMBERS OF THE
21 AUTHORITY BUT SHALL BE REIMBURSED FOR ACTUAL AND NECESSARY
22 EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES.

23

(9) TERMS OF AUTHORITY MEMBERS SHALL BE AS FOLLOWS:

(I) THE TERMS OF THE SECRETARY OF HEALTH AND THE
SECRETARY OF PUBLIC WELFARE AND INSURANCE COMMISSIONER
SHALL BE CONCURRENT WITH THEIR HOLDING OF PUBLIC OFFICE.
THE TERMS OF LEGISLATIVE MEMBERS SHALL BE CONCURRENT WITH
THE LEGISLATIVE SESSION IN WHICH THEY BECAME MEMBERS. THE
SIX APPOINTED AUTHORITY MEMBERS SHALL SERVE FOR A TERM OF
THREE YEARS AND SHALL CONTINUE TO SERVE THEREAFTER UNTIL

19910H0020B2886

- 63 -

1 THEIR SUCCESSORS ARE APPOINTED.

2 (II) AN APPOINTED MEMBER SHALL NOT BE ELIGIBLE TO
3 SERVE MORE THAN TWO FULL CONSECUTIVE TERMS OF THREE
4 YEARS. VACANCIES ON THE AUTHORITY SHALL BE FILLED IN THE
5 SAME MANNER IN WHICH THEY WERE DESIGNATED WITHIN 60 DAYS
6 OF THE VACANCY.

7 (III) A MEMBER MAY BE REMOVED FOR JUST CAUSE BY THE
8 APPOINTING AUTHORITY OR BY A VOTE OF AT LEAST NINE
9 MEMBERS OF THE AUTHORITY.

(B) DISTRIBUTION OF FUNDS.--THE AUTHORITY SHALL PROVIDE FOR
THE EXPANDED ACCESS TO PRIMARY HEALTH CARE FOR ELIGIBLE CHILDREN
THROUGH THE DISTRIBUTION OF THE CHILDREN'S HEALTH FUND FOR
HEALTH CARE FOR INDIGENT CHILDREN AS ESTABLISHED BY SECTION 1296
OF THE ACT OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE TAX
REFORM CODE OF 1971.

16 (1) NO LESS THAN 80% OF THE FUNDS FROM THE CHILDREN'S
17 HEALTH FUND SHALL BE USED TO FUND THOSE PRIMARY HEALTH CARE
18 PROGRAMS DEFINED IN SUBSECTION (D) AND ESTABLISHED UNDER 40
19 PA.C.S. CHS. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) AND
20 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN
21 CORPORATIONS).

(I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II), NO MORE
THAN 15% OF THE AMOUNT STATED IN THIS PARAGRAPH SHALL BE
USED FOR ADMINISTRATION EXPENSES, INCLUDING OUTREACH, IN
PROVIDING THOSE PRIMARY HEALTH CARE PROGRAMS DEFINED IN
SUBSECTION (E).

(II) IF A HOSPITAL SERVICE CORPORATION OR A HEALTH
 SERVICE CORPORATION PRESENTS DOCUMENTED EVIDENCE THAT
 ADMINISTRATIVE EXPENSES ARE IN EXCESS OF THE MAXIMUM SET
 FORTH IN SUBPARAGRAPH (I), THE INSURANCE COMMISSIONER
 19910H0020B2886 - 64 -

SHALL ADVISE THE AUTHORITY TO MAKE AN ADDITIONAL
 ALLOTMENT OF FUNDS FOR ADMINISTRATIVE EXPENSES TO THE
 EXTENT THE INSURANCE COMMISSIONER FINDS SUCH EXPENSES
 REASONABLE AND NECESSARY.

5 (2) THE AUTHORITY MAY GRANT START-UP FUNDS PURSUANT TO 6 THIS SUBSECTION FOR ANY QUALIFYING CORPORATION NEEDING SUCH 7 FUNDS TO ESTABLISH A FOUNDATION ELIGIBLE TO RECEIVE GRANTS 8 FROM THE AUTHORITY.

9 (3) ALL GRANTS MADE PURSUANT TO THIS SUBSECTION SHALL BE 10 ON AN EQUITABLE BASIS BASED ON THE NUMBER OF ENROLLED 11 ELIGIBLE CHILDREN OR ELIGIBLE CHILDREN ANTICIPATED TO BE 12 ENROLLED. THE AUTHORITY SHALL USE ITS BEST EFFORTS TO PROVIDE 13 GRANTS THAT ENSURE THAT ELIGIBLE CHILDREN HAVE ACCESS TO 14 BASIC PRIMARY HEALTH CARE SERVICES TO BE PROVIDED UNDER THIS 15 SECTION ON AN EQUITABLE STATEWIDE BASIS.

16 (C) LIMITATIONS.--

17 (1) NO MORE THAN 1% OF THE FUNDS FROM THE CHILDREN'S
18 HEALTH FUND MAY BE USED FOR EXPENSES OF MEMBERS OF THE
19 AUTHORITY AND FOR ADMINISTRATION.

20 (2) NO MORE THAN 20% OF THE FUNDS FROM THE CHILDREN'S HEALTH FUND MAY BE USED FOR DEMONSTRATION PROJECTS TO LINK 21 22 PRIMARY HEALTH CARE SERVICES WITH DENTAL, HEARING AND VISION 23 CARE FOR ELIGIBLE CHILDREN. ALL GRANTS MADE PURSUANT TO THIS 24 SUBSECTION SHALL BE TO ANY ORGANIZATION OR CORPORATION 25 PROVIDING PRIMARY HEALTH SERVICES OR WILLING TO PROVIDE 26 PRIMARY HEALTH SERVICES IN ACCORDANCE WITH SUBSECTION (E) FOR 27 ELIGIBLE CHILDREN.

(D) GRANT CRITERIA. --THE CHILDREN'S HEALTH FUND AUTHORITY
 SHALL ANNUALLY ACCEPT APPLICATIONS FOR GRANTS TO BE MADE
 PURSUANT TO THIS SECTION BY THE AUTHORITY PURSUANT TO THE
 19910H0020B2886 - 65 -

1 FOLLOWING:

(1) TO THE FULLEST EXTENT PRACTICABLE, GRANTS SHALL BE 2 3 MADE TO APPLICANTS THAT CONTRACT WITH PROVIDERS TO PROVIDE 4 PRIMARY CARE SERVICES FOR ENROLLEES ON A BASIS BEST 5 CALCULATED TO MANAGE COSTS OF THE PROGRAM, INCLUDING, BUT NOT 6 LIMITED TO, PURCHASING HEALTH CARE SERVICES ON A CAPITATED 7 BASIS, USING MANAGED HEALTH CARE TECHNIQUES AND, WHERE 8 APPROPRIATE, OTHER COST MANAGEMENT METHODS. THE AUTHORITY 9 SHALL REQUIRE GRANTEES TO USE APPROPRIATE COST MANAGEMENT 10 METHODS SO THAT THE CHILDREN'S HEALTH FUND CAN BE USED TO 11 PROVIDE THE BASIC PRIMARY BENEFIT SERVICES TO THE MAXIMUM NUMBER OF ELIGIBLE CHILDREN. THIS SHALL INCLUDE CONTRACTING 12 13 WITH QUALIFIED, COST-EFFECTIVE PROVIDERS, INCLUDING HOSPITAL 14 OUTPATIENT DEPARTMENTS, HMOS, CLINICS, GROUP PRACTICES AND 15 INDIVIDUAL PRACTITIONERS.

16 (2) TO THE FULLEST EXTENT PRACTICABLE, THE AUTHORITY
17 SHALL ENSURE THAT ELIGIBLE CHILDREN HAVE ACCESS TO PRIMARY
18 HEALTH CARE PROVIDED BY THE CHILDREN'S HEALTH FUND THAT HAS
19 ADEQUATE PRIMARY CARE PHYSICIANS AND THAT PROVIDES ADEQUATE
20 FREEDOM OF CHOICE OF PHYSICIANS WITHIN A REASONABLE AND
21 CONVENIENT TRAVEL DISTANCE.

(3) TO THE FULLEST EXTENT PRACTICABLE, THE AUTHORITY
SHALL ENSURE THAT ANY GRANTEE WHO DETERMINES THAT A CHILD IS
NOT ELIGIBLE BECAUSE THE CHILD IS ELIGIBLE FOR MEDICAL
ASSISTANCE PROVIDE IN WRITING TO THE FAMILY OF THE CHILD THE
TELEPHONE NUMBER OF THE COUNTY ASSISTANCE OFFICE OF THE
DEPARTMENT WHERE THE FAMILY CAN CALL TO APPLY FOR MEDICAL
ASSISTANCE.

29 (E) ELIGIBLE PRIMARY HEALTH CARE COVERAGE FOR FUNDING.--ALL
 30 GRANTEES FUNDED SHALL INCLUDE THE FOLLOWING MINIMUM BENEFIT
 19910H0020B2886 - 66 -

1 PACKAGE FOR ELIGIBLE CHILDREN:

(1) PREVENTIVE CARE, WHICH SHALL INCLUDE WELL-CHILD CARE
VISITS IN ACCORDANCE WITH THE SCHEDULE ESTABLISHED BY THE
AMERICAN ACADEMY OF PEDIATRICS AND THE SERVICES RELATED TO
THOSE VISITS, INCLUDING, BUT NOT LIMITED TO, IMMUNIZATIONS,
WELL-CHILD CARE, HEALTH EDUCATION, TUBERCULOSIS TESTING AND
DEVELOPMENTAL SCREENING IN ACCORDANCE WITH ROUTINE SCHEDULE
OF WELL-CHILD VISITS.

9 (2) DIAGNOSIS AND TREATMENT OF ILLNESS OR INJURY, 10 INCLUDING ALL SERVICES RELATED TO THE DIAGNOSIS AND TREATMENT 11 OF SICKNESS AND INJURY AND OTHER CONDITIONS PROVIDED ON AN 12 AMBULATORY BASIS, SUCH AS WOUND DRESSING AND CASTING TO 13 IMMOBILIZE FRACTURES.

14 (3) INJECTIONS AND MEDICATIONS PROVIDED AT THE TIME OF
15 THE OFFICE VISIT OR THERAPY, OUTPATIENT SURGERY PERFORMED IN
16 THE OFFICE OR FREESTANDING AMBULATORY SERVICE CENTER,
17 INCLUDING ANESTHESIA PROVIDED IN CONJUNCTION WITH SUCH
18 SERVICE, AND EMERGENCY MEDICAL SERVICE.

19 (4) EMERGENCY ACCIDENT AND EMERGENCY MEDICAL CARE.

20 (5) AVAILABILITY OF 24-HOUR-A-DAY, 7 DAY-A-WEEK ACCESS
21 TO THE SERVICES IN THIS SUBSECTION.

(F) WAIVER.--THE AUTHORITY MAY GRANT A WAIVER OF THE MINIMUM
BENEFIT PACKAGE OF SUBSECTION (E) UPON DEMONSTRATION BY THE
APPLICANT THAT THEY ARE PROVIDING PRIMARY HEALTH CARE SERVICES
FOR ELIGIBLE CHILDREN THAT MEET THE PURPOSE AND INTENT OF THIS
SECTION.

(G) INPATIENT HOSPITAL CARE.--TO ENSURE THAT INPATIENT
 HOSPITAL CARE IS PROVIDED TO ELIGIBLE CHILDREN, ALL PRIMARY CARE
 PHYSICIANS PROVIDING PRIMARY CARE SERVICES TO ELIGIBLE CHILDREN
 UNDER THIS CHAPTER SHALL MAKE THE NECESSARY ARRANGEMENTS THROUGH
 19910H0020B2886 - 67 -

THE SPEND-DOWN PROVISIONS OF MEDICAL ASSISTANCE FOR ADMISSION TO
 THE HOSPITAL AND FOR THE NECESSARY SPECIALTY CARE FOR A CHILD
 NEEDING SUCH CARE AND SHALL CONTINUE TO CARE FOR THE CHILD AS A
 MEDICAL ASSISTANCE PROVIDER IN THE HOSPITAL AS APPROPRIATE.

5 (H) ELIGIBILITY FOR ENROLLMENT IN PROGRAMS RECEIVING FUNDING
6 THROUGH THE CHILDREN'S HEALTH FUND AUTHORITY.--

7 (1) ANY ORGANIZATION OR CORPORATION RECEIVING FUNDS FROM
8 THE CHILDREN'S HEALTH FUND AUTHORITY SHALL ENROLL ANY CHILD
9 WHO MEETS ALL OF THE FOLLOWING:

10

(I) IS UNDER 19 YEARS OF AGE.

11 (II) IS A RESIDENT OF THIS COMMONWEALTH AND OF A
12 COUNTY SERVED BY THE ORGANIZATION OR CORPORATION.

13 (III) IS NOT ELIGIBLE FOR NOR COVERED BY A HEALTH
14 INSURANCE PLAN, A SELF-INSURANCE PLAN OR THE MEDICAL
15 ASSISTANCE PROGRAM.

16

(IV) IS QUALIFIED UNDER SUBSECTION (I).

17 (2) COVERAGE SHALL NOT BE DENIED ON THE BASIS OF A
18 PREEXISTING CONDITION.

19 (3) THE AUTHORITY MAY PERMIT ENROLLMENT BY CHILDREN WITH 20 HEALTH INSURANCE COVERAGE FOR INPATIENT HOSPITAL CARE, BUT 21 LITTLE OR NO COVERAGE FOR THE PRIMARY HEALTH CARE SERVICES 22 FUNDED BY THE AUTHORITY IF, AFTER THE FIRST YEAR OF 23 OPERATION, THERE APPEARS TO BE SUFFICIENT REVENUE TO DO SO. 24 (I) FREE CARE.--THE PROVISION OF PRIMARY HEALTH SERVICES FOR 25 ELIGIBLE CHILDREN SHALL BE FREE TO ALL CHILDREN WHOSE FAMILY 26 INCOME IS LESS THAN OR UP TO 150% OF THE FEDERAL POVERTY LEVEL 27 AND SHALL BE AVAILABLE ON A SLIDING FEE BASIS TO CHILDREN WHOSE 28 FAMILY INCOME IS MORE THAN 150% BUT LESS THAN OR UP TO 200% OF 29 THE FEDERAL POVERTY LEVEL. THE SLIDING SCALE FEE SHALL NOT 30 EXCEED \$25 PER CHILD PER YEAR AND \$100 PER FAMILY PER YEAR. - 68 -19910H0020B2886

THOSE FAMILIES WITH INCOME HIGHER THAN 200% OF THE FEDERAL
 POVERTY LEVEL MAY PURCHASE COVERAGE FOR THEIR CHILDREN AT COST.
 THERE SHALL BE NO COPAYMENTS OR DEDUCTIBLES OF ANY KIND FOR
 UNINSURED CHILDREN WHOSE FAMILY INCOME IS LESS THAN 100% OF THE
 FEDERAL POVERTY LEVEL; AND, IN NO CASE, MAY THE COPAYMENTS OR
 DEDUCTIBLES EXCEED .1% OF THE FAMILY INCOME.

(J) ANNUAL REPORT.--THE AUTHORITY SHALL PROVIDE THE GENERAL
ASSEMBLY AND THE PUBLIC WITH AN ANNUAL REPORT FOR EACH FISCAL
YEAR, OUTLINING PRIMARY HEALTH SERVICES FUNDED FOR THE YEAR,
DETAILING THE OUTREACH AND ENROLLMENT EFFORTS BY EACH GRANTEE
AND REPORTING BY COUNTY THE NUMBER OF CHILDREN FOR WHOM PRIMARY
CARE IS FUNDED BY THE AUTHORITY AND THE PROJECTED ELIGIBLE
CHILDREN.

14 (K) ROLE OF THE HEALTH SERVICE CORPORATION AND HOSPITAL PLAN 15 CORPORATIONS.--BY JANUARY 1, 1993, EACH HEALTH SERVICE 16 CORPORATION AND HOSPITAL PLAN CORPORATION DOING BUSINESS IN THIS 17 COMMONWEALTH SHALL FILE A LETTER OF INTENT WITH THE AUTHORITY TO 18 APPLY FOR FUNDS FROM THE AUTHORITY IN THE AREA SERVICED BY THE 19 CORPORATION. EACH HEALTH SERVICE CORPORATION AND HOSPITAL PLAN 20 CORPORATION SHALL PROVIDE INSURANCE IDENTIFICATION CARDS TO 21 THOSE ELIGIBLE CHILDREN COVERED UNDER PROGRAMS RECEIVING GRANTS 22 FROM THE AUTHORITY. THE CARD SHALL NOT SPECIFICALLY IDENTIFY THE 23 HOLDER AS LOW INCOME.

(L) RATE FILING REQUEST INFORMATION.--THE INSURANCE
COMMISSIONER SHALL MAKE A COPY AND FORWARD TO THE AUTHORITY ALL
RELEVANT INFORMATION AND DATA FILED BY EACH HEALTH SERVICE
CORPORATION AND HOSPITAL PLAN CORPORATION DOING BUSINESS IN THIS
COMMONWEALTH AS PART OF ANY RATE FILING REQUEST FOR PROGRAMS
RECEIVING GRANTS UNDER THIS SECTION BY THE CORPORATION.

30 (M) DEDICATED FUNDING.--THE CHILDREN'S HEALTH FUND FOR 19910H0020B2886 - 69 - HEALTH CARE FOR INDIGENT CHILDREN, AS ESTABLISHED BY SECTION
 1296 OF THE TAX REFORM CODE OF 1971 SHALL BE DEDICATED
 EXCLUSIVELY FOR DISTRIBUTION BY THE CHILDREN'S HEALTH FUND
 AUTHORITY PURSUANT TO THIS SECTION.

5 SECTION 702. UNINSURED WORKERS AND ADULTS.

6 (A) DEVELOPMENT.--THE HEALTH SERVICE CORPORATION AND THE 7 HOSPITAL PLAN CORPORATIONS SHALL CONCURRENTLY DEVELOP A PRIMARY 8 HEALTH CARE INSURANCE PLAN FOR ADULTS, EQUIVALENT TO THE 9 CHILDREN'S PRIMARY HEALTH CARE PLAN SET FORTH IN SECTION 701 FOR 10 PURCHASE AT COST BY JANUARY 1, 1993. THE PLAN FOR ADULTS SHALL 11 MAKE AFFORDABLE PRIMARY HEALTH CARE AVAILABLE TO INDIVIDUAL 12 COMMONWEALTH RESIDENTS WHOSE INCOME EXCEEDS MEDICAL ASSISTANCE 13 ELIGIBILITY GUIDELINES BUT WHO ARE WITHOUT SUFFICIENT MEANS TO 14 PURCHASE OTHER HEALTH CARE INSURANCE TO COVER THE COSTS OF 15 HEALTH CARE.

16 (B) RATES.--THE INSURANCE COMMISSIONER SHALL REVIEW THE
17 RATES FOR THE PRIMARY HEALTH CARE PLAN FOR ADULTS AND SHALL
18 ENSURE THAT THE PREMIUM COVERS ALL APPROPRIATE COSTS, RESERVES
19 AND ADMINISTRATIVE COSTS OF THE HEALTH SERVICE CORPORATION AND
20 THE HOSPITAL PLAN CORPORATIONS.

(C) COST DATA.--THE HEALTH SERVICE CORPORATION AND THE
HOSPITAL PLAN CORPORATIONS SHALL KEEP DETAILED ACTUARIAL DATA ON
THE COSTS OF THE ADULT PLAN.

(D) PREMIUMS.--THE HEALTH SERVICE CORPORATION AND THE
HOSPITAL PLAN CORPORATIONS SHALL ESTABLISH A PREMIUM STRUCTURE
FOR ENROLLMENT EFFECTIVE JANUARY 1, 1993, WHICH SHALL BE
ADJUSTED TO REFLECT THE INCOMES OF PERSONS SEEKING TO BECOME
ENROLLEES IN THE PROGRAM AND SHALL BE STRUCTURED SO THAT
INDIVIDUALS WHOSE INCOMES ARE INSUFFICIENT TO PAY THE FULL
PREMIUM CAN PARTICIPATE IN THE PROGRAM.

19910H0020B2886

- 70 -

1 (E) EXPIRATION OF SECTION.--IF PRIOR TO JANUARY 1, 1993, THE 2 INSURANCE COMMISSIONER APPROVES AN ADULT HEALTH CARE PLAN BY THE 3 HEALTH SERVICE CORPORATION AND THE HOSPITAL PLAN CORPORATIONS 4 THAT MEETS THE INTENT AND PURPOSES OF THE PRIMARY HEALTH CARE 5 PLAN FOR ADULTS, THE COMMISSIONER SHALL PUBLISH A NOTICE OF THIS 6 APPROVAL IN THE PENNSYLVANIA BULLETIN. THIS SECTION SHALL EXPIRE 7 UPON THE DATE OF PUBLICATION OF THAT NOTICE.

8 SECTION 703. OUTREACH AND QUALITY ASSURANCE.

9 (A) PUBLIC INFORMATION.--THE HEALTH SERVICE CORPORATION AND 10 THE HOSPITAL PLAN CORPORATIONS SHALL ACTIVELY PUBLICIZE BOTH THE 11 CHILDREN'S AND ADULTS' PRIMARY CARE HEALTH PLANS AND SHALL 12 SOLICIT THE ASSISTANCE OF THE COMMONWEALTH, HEALTH CARE 13 PROVIDERS AND OTHERS IN BRINGING THE PROGRAM TO THE ATTENTION OF 14 PROSPECTIVE ENROLLEES.

15 (B) ENROLLMENT INFORMATION.--COMMENCING JANUARY 1, 1993, AND 16 ON AN ANNUAL BASIS, ALL EMPLOYERS WHO DO NOT PROVIDE HEALTH CARE 17 INSURANCE SHALL PROVIDE THEIR EMPLOYEES WITH ENROLLMENT

18 INFORMATION CONCERNING THE PRIMARY HEALTH CARE PLAN FOR ADULTS.

19

CHAPTER 11

20 ACCESS TO HEALTH CARE

21 SECTION 1101. MANAGED CARE ORGANIZATIONS.

22 (A) FAIR SHARE OF MEDICAL ASSISTANCE SUBSCRIBERS. --WITHIN SIX MONTHS OF THE EFFECTIVE DATE OF THIS ACT, EACH MANAGED CARE 23 24 ORGANIZATION SHALL ENTER INTO AN AGREEMENT WITH THE DEPARTMENT 25 TO ENROLL AS SUBSCRIBERS INDIVIDUALS WHO ARE ELIGIBLE TO RECEIVE 26 MEDICAL ASSISTANCE BENEFITS. A MANAGED CARE ORGANIZATION THAT 27 RECEIVES ITS CERTIFICATE OF AUTHORITY AFTER THE EFFECTIVE DATE 28 OF THIS ACT SHALL ENTER INTO AN AGREEMENT WITH THE DEPARTMENT 29 UNDER THIS SECTION BEFORE THE END OF THE MANAGED CARE 30 ORGANIZATION'S SECOND YEAR OF OPERATION IN THIS COMMONWEALTH. 19910H0020B2886 - 71 -

1 ALL MANAGED CARE ORGANIZATIONS SHALL AGREE TO ACCEPT AS 2 ENROLLEES A FAIR SHARE OF MEDICAL ASSISTANCE RECIPIENTS. A "FAIR 3 SHARE" OF MEDICAL ASSISTANCE SUBSCRIBERS FOR PURPOSES OF THIS 4 SECTION SHALL BE DEFINED AS THE SAME RATIO OF MEDICAL ASSISTANCE 5 RECIPIENTS TO GENERAL POPULATION IN THE MANAGED CARE ORGANIZATION'S SERVICE AREA AS ENROLLED MEDICAL ASSISTANCE 6 7 SUBSCRIBERS TO THE TOTAL MANAGED CARE ORGANIZATION ENROLLMENT OR 25%, WHICHEVER IS LESS. WITHIN THREE YEARS OF THE EFFECTIVE DATE 8 9 OF THE CONTRACT BETWEEN THE DEPARTMENT AND THE MANAGED CARE 10 ORGANIZATION, THE MANAGED CARE ORGANIZATION SHALL HAVE ENROLLED 11 OR HAVE ATTEMPTED TO ENROLL ITS FAIR SHARE OF MEDICAL ASSISTANCE 12 SUBSCRIBERS.

(B) COUNTY PERCENTAGES.--THE DEPARTMENT SHALL PUBLISH
ANNUALLY IN THE PENNSYLVANIA BULLETIN NOTICE OF THE COUNTY
PERCENTAGE OF MEDICAL ASSISTANCE RECIPIENTS FOR EACH COUNTY AND
SHALL ASSIST MANAGED CARE ORGANIZATIONS IN DETERMINING THE
NUMBER OF MEDICAL ASSISTANCE SUBSCRIBERS NECESSARY TO CONSTITUTE
ITS FAIR SHARE.

19 (C) SEPARATE SYSTEMS. -- UNLESS AUTHORIZED BY THE DEPARTMENT, 20 AFTER CONSULTATION WITH THE MEDICAL ASSISTANCE ADVISORY 21 COMMITTEE, A MANAGED CARE ORGANIZATION SHALL NOT ESTABLISH 22 SEPARATE SYSTEMS OF CARE FOR ITS MEDICAL ASSISTANCE SUBSCRIBERS. 23 THIS SUBSECTION SHALL NOT PRECLUDE ENTITIES OPERATING AS MEDICAL 24 ASSISTANCE SUBCONTRACTORS TO A HEALTH MAINTENANCE ORGANIZATION 25 PRIOR TO JULY 1, 1991, FROM MAINTAINING THEIR CURRENT CONTRACTS 26 OR ENTERING INTO NEW CONTRACTS WITH HEALTH MAINTENANCE 27 ORGANIZATIONS. THESE ENTITIES MUST STILL COMPLY WITH ALL 28 APPLICABLE PROVISIONS FOR QUALITY ASSURANCE CONTAINED IN THIS 29 ACT.

30 (D) WAIVER OF REQUIREMENTS.--THE DEPARTMENT MAY GRANT A 19910H0020B2886 - 72 -

WAIVER OF THE REQUIREMENTS OF THIS SECTION IF IT FINDS THAT THE 1 MANAGED CARE ORGANIZATION HAS MADE AND CONTINUES TO MAKE A GOOD 2 3 FAITH EFFORT TO OBTAIN A FAIR SHARE OF MEDICAL ASSISTANCE 4 SUBSCRIBERS, BUT IS UNABLE TO REACH OR MAINTAIN THAT PERCENTAGE. 5 THE DEPARTMENT MAY ALSO GRANT A WAIVER OF THE REQUIREMENTS OF 6 THIS SECTION UPON DEMONSTRATION BY THE MANAGED CARE ORGANIZATION 7 THAT THIS SECTION WOULD RESULT IN INSOLVENCY OF THE MANAGED CARE 8 ORGANIZATION.

9 SECTION 1102. ENFORCEMENT.

10 (A) CIVIL PENALTY.--

11 (1) ANY HEALTH MAINTENANCE ORGANIZATION THAT VIOLATES 12 THE PROVISIONS OF THIS CHAPTER SHALL BE SUBJECT TO A CIVIL 13 PENALTY EQUAL TO 2% OF THE ANNUAL PREMIUMS OF THE HMO OR THE 14 HMO'S AVERAGE RATE PER MEMBER MULTIPLIED BY THE NUMBER OF 15 INDIVIDUALS THAT THE HMO HAS FAILED TO ENROLL UNDER THE FAIR 16 SHARE PROVISIONS OF THIS CHAPTER, WHICHEVER IS GREATER. THIS 17 PENALTY SHALL BE DEPOSITED IN THE GENERAL FUND FOR 18 AUGMENTATION OF THE MEDICAL ASSISTANCE APPROPRIATION. THE 19 PENALTY SHALL BE LEVIED BY THE DEPARTMENT, ANNUALLY, WHEN IT 20 CONCLUDES THAT THE HMO DID NOT MAKE A GOOD FAITH EFFORT TO 21 ENROLL THE MINIMUM NUMBER OF MEDICAL ASSISTANCE SUBSCRIBERS 22 REQUIRED BY THIS CHAPTER.

23 (2) ANY HMO FOUND TO HAVE VIOLATED THE PROVISIONS OF THIS CHAPTER SHALL HAVE THE RIGHT TO APPEAL SUCH A 24 25 DETERMINATION TO THE SECRETARY OF PUBLIC WELFARE IN THE 26 MANNER PROVIDED IN TITLE 2 OF THE PENNSYLVANIA CONSOLIDATED 27 STATUTES (RELATING TO ADMINISTRATIVE LAW AND PROCEDURE). 28 (B) CIVIL ACTION. -- ANY INDIVIDUAL ALLEGING DISCRIMINATION 29 UNDER THIS CHAPTER MAY FILE A CIVIL CAUSE OF ACTION IN A COURT 30 OF COMPETENT JURISDICTION AGAINST A HEALTH MAINTENANCE - 73 -19910H0020B2886

ORGANIZATION OR GROUP INSURERS ALLEGED TO BE IN VIOLATION OF 1 2 THIS CHAPTER. IF THE HEALTH MAINTENANCE ORGANIZATION OR GROUP 3 INSURERS IS FOUND TO HAVE VIOLATED THIS CHAPTER THE COURT MAY 4 ASSESS ATTORNEY FEES, COST AND PENALTIES AGAINST THE HEALTH 5 MAINTENANCE ORGANIZATION OR GROUP INSURERS IN ADDITION TO ANY MONETARY COMPENSATION TO THE PLAINTIFF. A JUDGMENT AGAINST A 6 7 HEALTH MAINTENANCE ORGANIZATION OR GROUP INSURERS SHALL BE REFERRED BY THE COURT TO THE APPROPRIATE PROFESSIONAL LICENSING 8 9 AUTHORITY OR REGULATORY AGENCY.

10

11

CHAPTER 13

HEALTH INSURANCE REFORMS

12 SECTION 1301. CONTINUITY ON REPLACEMENT OF A GROUP CONTRACT OR13 POLICY.

(A) CONTRACTS AND POLICIES SUBJECT TO THIS SECTION.-15 NOTWITHSTANDING ANY OTHER PROVISION OF LAW, THIS SECTION APPLIES
16 TO ALL GROUP HEALTH INSURANCE CONTRACTS, EXCEPT GROUP LONG-TERM
17 CARE POLICIES, ISSUED BY ANY INSURER, NONPROFIT HOSPITAL PLAN OR
18 PROFESSIONAL HEALTH SERVICE CORPORATION AND TO CONTRACTS FOR THE
19 PROVISION OR MANAGEMENT OF HEALTH CARE ISSUED BY A MANAGED CARE
20 ORGANIZATION.

21 (B) PERSONS PROTECTED BY THIS SECTION. -- ANY PERSON WHO HAD 22 BEEN COVERED UNDER A REPLACED CONTRACT OR POLICY FOR AT LEAST 90 23 DAYS BEFORE DISCONTINUANCE OR TERMINATION OF THE REPLACED 24 CONTRACT SHALL BE ENTITLED TO THE PROTECTIONS OF THIS SECTION. 25 PROTECTED INDIVIDUALS INCLUDE THE DEPENDENT OF AN EMPLOYEE WHERE 26 THE EMPLOYEE AND THE DEPENDENT HAD BEEN COVERED UNDER THE 27 REPLACED CONTRACT OR POLICY. PERSONS COVERED FOR LESS THAN 90 28 DAYS BEFORE DISCONTINUANCE OR TERMINATION OF THE REPLACED 29 CONTRACT SHALL BE ENTITLED TO THE PROTECTIONS OF THIS SECTION; 30 HOWEVER, A PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING - 74 -19910H0020B2886

PERIOD MAY BE IMPOSED IF IT IS NOT LONGER THAN 90 DAYS AND IF
 THE PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD OF
 THE REPLACEMENT CONTRACT OR POLICY IS NOT IMPOSED FOR A PERIOD
 EXCLEDING THE PERIOD OF TIME THAT WOULD BE REMAINING ON SUCH
 EXCLUSION PERIOD OR WAITING PERIOD OF THE REPLACED POLICY WERE
 IT STILL IN EFFECT.

7 (C) PROTECTIONS.--NO INSURER, NONPROFIT HOSPITAL PLAN,
8 PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE
9 ORGANIZATION MAY DO ANY OF THE FOLLOWING:

10 (1) REQUEST OR REQUIRE A PERSON PROTECTED BY THIS
11 SECTION TO PROVIDE OR OTHERWISE SEEK TO OBTAIN EVIDENCE OF
12 HEALTH OR GENETIC STATUS OR HISTORY AS A CONDITION OF
13 ENROLLING THE PERSON IN A REPLACEMENT CONTRACT OR POLICY
14 SUBJECT TO THIS SECTION.

15 (2) DECLINE TO ENROLL ANY PERSON PROTECTED BY THIS
16 SECTION IN A REPLACEMENT CONTRACT OR POLICY SUBJECT TO THIS
17 SECTION BASED ON HEALTH OR GENETIC STATUS OR HISTORY IF THE
18 PERSON IS OTHERWISE ELIGIBLE TO BE ENROLLED.

19 (3) IMPOSE A PREEXISTING CONDITION EXCLUSION PERIOD OR 20 WAITING PERIOD UPON A PERSON PROTECTED BY THIS SECTION FOR ANY CONDITION EXCEPT TO THE EXTENT THAT THERE IS A 21 22 PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD FROM 23 THE REPLACED CONTRACT OR POLICY THAT REMAINS UNEXPIRED. IN 24 THIS EVENT, THE PREEXISTING CONDITION EXCLUSION PERIOD OR 25 WAITING PERIOD OF THE REPLACEMENT CONTRACT OR POLICY MAY BE 26 IMPOSED FOR A PERIOD NOT TO EXCEED THE PERIOD OF TIME THAT 27 WOULD BE REMAINING ON THE EXCLUSION PERIOD OR WAITING PERIOD 28 OF THE REPLACED POLICY WERE IT STILL IN EFFECT.

29 (D) DETERMINATION OF WAITING PERIOD.--IF A DETERMINATION OF 30 THE EXISTENCE OF A PREEXISTING CONDITION EXCLUSION PERIOD OR 19910H0020B2886 - 75 -

WAITING PERIOD UNDER THE REPLACED CONTRACT OR POLICY IS REQUIRED 1 2 FOR THE INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH 3 SERVICE CORPORATION OR MANAGED CARE ORGANIZATION ISSUING OR 4 ENTERING INTO A REPLACEMENT CONTRACT OR POLICY TO COMPLY WITH 5 THIS SECTION, THE ISSUER OF THE REPLACED CONTRACT OR POLICY SHALL, AT THE REQUEST OF THE ISSUER OF THE REPLACEMENT CONTRACT 6 7 OR POLICY, FURNISH A STATEMENT AS TO THE EXISTENCE AND TERMS OF 8 ANY PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD 9 UNDER THE REPLACED CONTRACT OR POLICY. IF AN EXCLUSION PERIOD OR 10 A WAITING PERIOD EXISTS UNDER THE REPLACED CONTRACT OR POLICY, 11 THE ISSUER OF THE REPLACEMENT CONTRACT OR POLICY SHALL CALCULATE THE AMOUNT OF TIME REMAINING ON THE PERIOD BASED ON THE TERMS OF 12 13 THE REPLACED CONTRACT OR POLICY.

14 (E) LIMITED LIABILITY AFTER DISCONTINUANCE.--THE INSURER,
15 NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION
16 OR MANAGED CARE ORGANIZATION THAT ISSUED THE REPLACED CONTRACT
17 OR POLICY IS LIABLE AFTER DISCONTINUANCE OF THAT CONTRACT OR
18 POLICY ONLY TO THE EXTENT OF ITS ACCRUED LIABILITIES AND
19 EXTENSIONS OF BENEFITS.

(F) DUPLICATION.--NOTHING IN THIS SECTION SHALL BE CONSTRUED
AS REQUIRING ANY EMPLOYER OR ANY INSURER, NONPROFIT HOSPITAL
PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE
ORGANIZATION ISSUING OR ENTERING INTO A REPLACEMENT CONTRACT OR
POLICY TO PROVIDE THE SAME OR SIMILAR TYPE OF EXTENT OF COVERAGE
AS THE REPLACED CONTRACT OR POLICY. NOTHING IN THIS SECTION
SHALL REQUIRE AN EMPLOYER TO PROVIDE ANY HEALTH INSURANCE TO
EMPLOYEES.

28 SECTION 1302. CONTINUITY OF COVERAGE FOR INDIVIDUAL WHO CHANGES 29 GROUPS.

30 (A) CONTRACTS AND POLICIES SUBJECT TO THIS SECTION.--THIS 19910H0020B2886 - 76 - SECTION APPLIES TO ALL CONTRACTS AND POLICIES SET FORTH IN
 SECTION 1301(A).

3 (B) PERSONS PROTECTED BY THIS SECTION. --THE PROTECTIONS OF
4 THIS SECTION APPLY TO ANY PERSON WHO SEEKS COVERAGE UNDER OR
5 ENROLLMENT IN A GROUP CONTRACT OR POLICY ISSUED BY ANY INSURER,
6 NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION
7 OR MANAGED CARE ORGANIZATION IF ALL OF THE FOLLOWING APPLY:

8 (1) THE PERSON WAS COVERED UNDER AN INDIVIDUAL OR GROUP 9 CONTRACT OR POLICY ISSUED BY ANY INSURER, NONPROFIT HOSPITAL 10 PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE 11 ORGANIZATION OR WAS COVERED UNDER A GOVERNMENTAL HEALTH 12 FINANCING PROGRAM SUCH AS MEDICAL ASSISTANCE, MEDICARE OR ANY 13 PROGRAM ESTABLISHED BY THIS ACT.

14 (2) THE COVERAGE UNDER THE PRIOR CONTRACT, POLICY OR 15 GOVERNMENTAL PROGRAM TERMINATED WITH THREE MONTHS BEFORE THE PERSON ENROLLED OR WAS ELIGIBLE TO ENROLL IN THE SUCCEEDING 16 17 CONTRACT OR POLICY. A PERIOD OF INELIGIBILITY FOR ANY HEALTH 18 PLAN IMPOSED BY TERMS OF EMPLOYMENT MAY NOT BE CONSIDERED IN 19 DETERMINING WHETHER THE COVERAGE ENDED WITHIN THREE MONTHS OF 20 THE DATE THE PERSON ENROLLED OR WAS ELIGIBLE TO ENROLL. 21 (C) PROTECTIONS. -- ANY INSURER, NONPROFIT HOSPITAL PLAN, 22 PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE 23 ORGANIZATION MAY NOT DO ANY OF THE FOLLOWING:

(1) REQUEST OR REQUIRE A PERSON PROTECTED BY THIS
SECTION TO PROVIDE OR OTHERWISE SEEK TO OBTAIN EVIDENCE OF
HEALTH OR GENETIC STATUS OR HISTORY AS A CONDITION OF
ENROLLING THE PERSON IN A CONTRACT OR POLICY SUBJECT TO THIS
SECTION.

29 (2) DECLINE TO ENROLL ANY PERSON PROTECTED BY THIS
 30 SECTION IN A CONTRACT OR POLICY SUBJECT TO THIS SECTION BASED
 19910H0020B2886 - 77 -

ON HEALTH OR GENETIC STATUS OR HISTORY IF THE PERSON IS
 OTHERWISE ELIGIBLE TO BE ENROLLED.

3 (3) IMPOSE A PREEXISTING CONDITION EXCLUSION PERIOD OR 4 WAITING PERIOD UPON A PERSON PROTECTED BY THIS SECTION FOR 5 ANY CONDITION EXCEPT TO THE EXTENT THAT THERE IS A 6 PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD FROM 7 THE PRIOR CONTRACT OR POLICY THAT REMAINS UNEXPIRED. IN THIS 8 EVENT, THE PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING 9 PERIOD OF THE REPLACEMENT CONTRACT OR POLICY MAY BE IMPOSED 10 FOR A PERIOD NOT TO EXCEED THE PERIOD OF TIME THAT WOULD BE 11 REMAINING ON THE EXCLUSION PERIOD OR WAITING PERIOD OF THE PRIOR POLICY WERE IT STILL IN EFFECT. 12

13 (D) DETERMINATION OF WAITING PERIOD. -- IF A DETERMINATION OF 14 THE EXISTENCE OF A PREEXISTING CONDITION EXCLUSION PERIOD OR 15 WAITING PERIOD UNDER THE PRIOR CONTRACT OR POLICY IS REQUIRED 16 FOR THE INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH 17 SERVICE CORPORATION OR MANAGED CARE ORGANIZATION ISSUING OR 18 ENTERING INTO A SUCCEEDING CONTRACT OR POLICY TO COMPLY WITH 19 THIS SECTION, THE ISSUER OF THE PRIOR CONTRACT OR POLICY SHALL, 20 AT THE REQUEST OF THE ISSUER OF THE SUCCEEDING CONTRACT OR 21 POLICY, FURNISH A STATEMENT AS TO THE EXISTENCE AND TERMS OF ANY 22 PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD UNDER 23 THE PRIOR CONTRACT OR POLICY. IF AN EXCLUSION PERIOD OR A 24 WAITING PERIOD EXISTS UNDER THE REPLACED CONTRACT OR POLICY, THE 25 ISSUER OF THE SUBSEQUENT CONTRACT OR POLICY SHALL CALCULATE THE 26 AMOUNT OF TIME REMAINING ON THE PERIOD BASED ON THE TERMS OF THE 27 PRIOR CONTRACT OF POLICY.

(E) DUPLICATION. -- NOTHING IN THIS SECTION SHALL BE CONSTRUED
 AS REQUIRING ANY EMPLOYER OR ANY INSURER, NONPROFIT HOSPITAL
 PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE
 19910H0020B2886 - 78 -

ORGANIZATION ISSUING OR ENTERING INTO A SUCCEEDING CONTRACT OR
 POLICY TO PROVIDE THE SAME OR SIMILAR TYPE OR EXTENT OF COVERAGE
 AS THE PRIOR CONTRACT OR POLICY. NOTHING IN THIS SECTION SHALL
 REQUIRE AN EMPLOYER TO PROVIDE ANY HEALTH INSURANCE TO

5 EMPLOYEES.

6 SECTION 1303. EXTENSION OF BENEFITS FOR DISABLED PERSONS.

7 (A) POLICIES SUBJECT TO THIS SECTION.--THIS SECTION APPLIES 8 TO ALL GROUP HEALTH INSURANCE POLICIES, EXCEPT GROUP LONG-TERM 9 CARE POLICIES OR GROUP LONG-TERM DISABILITY POLICIES, OR GROUP 10 POLICIES PROVIDING COVERAGE ONLY FOR DENTAL EXPENSE ISSUED BY 11 INSURERS, PROFESSIONAL HEALTH SERVICE CORPORATIONS, NONPROFIT 12 HOSPITAL PLANS OR HEALTH MAINTENANCE ORGANIZATIONS DOING 13 BUSINESS IN THIS COMMONWEALTH.

14 (B) REQUIREMENT. -- EVERY GROUP POLICY SUBJECT TO THIS SECTION 15 MUST PROVIDE A REASONABLE EXTENSION OF BENEFITS FOR A PERSON, 16 INCLUDING A DEPENDENT CHILD COVERED UNDER THE POLICY, WHO IS 17 TOTALLY DISABLED ON THE DATE THE GROUP POLICY IS DISCONTINUED, 18 OR ON THE DATE COVERAGE FOR A SUBGROUP IN THE POLICY IS 19 DISCONTINUED. A PERSON MAY NOT BE CHARGED DURING THE PERIOD OF 20 EXTENSION. AN EXTENSION OF BENEFITS PROVISION IS REASONABLE IF 21 IT PROVIDES BENEFITS FOR COVERED EXPENSES DIRECTLY RELATING TO 22 THE CONDITION CAUSING TOTAL DISABILITY FOR AT LEAST SIX MONTHS 23 FOLLOWING THE EFFECTIVE DATE OF DISCONTINUANCE.

(C) DESCRIPTION OF BENEFITS EXTENSION.--THE EXTENSION OF
BENEFITS PROVISION MUST BE DESCRIBED IN ALL POLICIES AND GROUP
CERTIFICATES. THE BENEFITS PAYABLE DURING ANY PERIOD OF
EXTENSION ARE SUBJECT TO THE REGULAR BENEFIT LIMITS UNDER THE
POLICY.

29 (D) LIABILITY AFTER DISCONTINUANCE.--AFTER DISCONTINUANCE OF 30 A POLICY, THE INSURER, PROFESSIONAL HEALTH SERVICE CORPORATION, 19910H0020B2886 - 79 -

NONPROFIT HOSPITAL PLAN CORPORATION OR HEALTH MAINTENANCE 1 ORGANIZATION REMAINS LIABLE ONLY TO THE EXTENT OF ITS ACCRUED 2 3 LIABILITIES AND EXTENSIONS OF BENEFITS. THE LIABILITY OF THE 4 INSURER OR HEALTH MAINTENANCE ORGANIZATION IS THE SAME WHETHER 5 THE GROUP POLICYHOLDER OR OTHER ENTITY SECURES REPLACEMENT COVERAGE FROM ANY INSURER, PROFESSIONAL HEALTH SERVICE 6 7 CORPORATION, NONPROFIT HOSPITAL PLAN CORPORATION OR HEALTH MAINTENANCE ORGANIZATION, SELF-INSURES OR FOREGOES THE PROVISION 8 9 OF COVERAGE.

10 (E) DEFINITION OF TERM. -- THE SECRETARY OF HEALTH SHALL IN 11 THE MANNER PROVIDED BY LAW, PROMULGATE A REGULATION DEFINING "TOTAL DISABILITY" FOR PURPOSES OF THIS SECTION. THE DEFINITION 12 13 MUST IDENTIFY PERSONS WHO ARE UNABLE, AS A RESULT OF DISABILITY, 14 TO OBTAIN COMPARABLE ALTERNATIVE COVERAGE THROUGH COMPARABLE 15 EMPLOYMENT OR OTHERWISE. THE REGULATIONS PROMULGATED UNDER THIS 16 SUBSECTION SHALL NOT BE SUBJECT TO THE ACT OF JUNE 25, 1982 17 (P.L.633, NO.181), KNOWN AS THE REGULATORY REVIEW ACT.

18 SECTION 1304. PREEXISTING CONDITIONS.

19 (A) DISEASE OR CONDITION SPECIFIC CONDITION EXCLUSION 20 LIMITED. -- NOTWITHSTANDING ANY OTHER PROVISION OF LAW, IT SHALL 21 BE UNLAWFUL FOR ANY INSURER, NONPROFIT HOSPITAL PLAN, 22 PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE 23 ORGANIZATION TO EXCLUDE, LIMIT OR REDUCE COVERAGE OR BENEFITS IN 24 A GROUP CONTRACT OR POLICY BEYOND THE WAITING PERIODS PERMITTED 25 UNDER THIS ACT FOR A SPECIFICALLY NAMED OR DESCRIBED PREEXISTING 26 DISEASE, CONDITION OR GENETIC PREDISPOSITION ON THE BASIS OF ITS 27 PREEXISTENCE.

(B) MANDATED OFFER TO ALL GROUP MEMBERS.--WHEN OFFERING A
 CONTRACT OR POLICY TO A GROUP, ANY INSURER, PROFESSIONAL HEALTH
 SERVICE CORPORATION, NONPROFIT HOSPITAL PLAN CORPORATION OR
 19910H0020B2886 - 80 -

MANAGED CARE ORGANIZATION SHALL ALSO OFFER COVERAGE OF ALL
 MEMBERS OF THE GROUP WHO RESIDE WITHIN THE SERVICE AREA OF THE
 INSURERS' CORPORATION OR ORGANIZATION. THIS REQUIREMENT MAY BE
 MET BY OFFERING COVERAGE ON AN INDIVIDUAL BASIS FOR SOME GROUP
 MEMBERS. NOTHING IN THIS SECTION SHALL BE CONSTRUED AS REQUIRING
 ANY EMPLOYER TO ACCEPT ANY SUCH OFFER.

7 (C) LIMITATION ON PREEXISTING CONDITION WAITING PERIODS.--8 NOTWITHSTANDING ANY OTHER PROVISION OF LAW, IT SHALL BE UNLAWFUL 9 FOR ANY INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH 10 SERVICE CORPORATION OR MANAGED CARE ORGANIZATION TO INCLUDE IN A 11 GROUP CONTRACT OR POLICY A PREEXISTING CONDITION EXCLUSION 12 PERIOD OR WAITING PERIOD WHICH IS LONGER THAN SIX MONTHS.

(D) PREEXISTING CONDITION WAITING PERIODS FOR INDIVIDUAL
POLICIES.--ANY INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL
HEALTH SERVICE CORPORATION, OR MANAGED CARE ORGANIZATION THAT
OFFERS INDIVIDUAL OR NONGROUP CONTRACTS OR POLICIES SHALL ALSO
OFFER POLICIES TO INDIVIDUALS AND NONGROUP SUBSCRIBERS THAT DO
NOT CONTAIN A PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING
PERIOD WHICH IS LONGER THAN SIX MONTHS.

20

CHAPTER 15

21 STUDIES AND HEARINGS ON HEALTH CARE

22 SECTION 1501. HOSPITAL UNCOMPENSATED CHARITY CARE STUDY.

(A) CHARITY CARE DATA.--THE HEALTH CARE COST CONTAINMENT
COUNCIL SHALL COLLECT EACH YEAR COMMENCING WITH THE CALENDAR
YEAR BEGINNING JANUARY 1, 1993, THE FOLLOWING CHARITY CARE DATA
FROM ALL ACUTE CARE HOSPITALS LICENSED IN THIS COMMONWEALTH:
(1) CATASTROPHIC INPATIENT AND OUTPATIENT COSTS WHICH
ARE DEFINED AS THE ALLOWABLE AUDITED COSTS OF SERVICES
PROVIDED TO PERSONS ABOVE 150% OF THE POVERTY LEVEL, WITH AN

30 UNPAID PERSONAL LIABILITY GREATER THAN ANNUAL FAMILY INCOME,

19910H0020B2886

- 81 -

1 LESS AN AMOUNT EQUIVALENT TO 150% OF THE FEDERAL POVERTY 2 LEVEL. SUCH AMOUNT MUST BE NET, FOLLOWING REASONABLE 3 COLLECTION PROCEDURES, CONSISTENTLY APPLIED, AND MAY NOT 4 INCLUDE ANY COSTS OR SERVICES FOR WHICH REIMBURSEMENT COULD 5 HAVE BEEN SECURED FROM THE MEDICAL ASSISTANCE OR MEDICARE 6 PROGRAM OR OTHER THIRD-PARTY PAYOR, NOR ANY COSTS OR SERVICES 7 RENDERED BY A HOSPITAL IN FULFILLMENT OF ANY CHARITY CARE 8 OBLIGATION FUNDING FROM FOUNDATIONS OR FEDERAL OR STATE 9 SOURCES INCLUDING FUNDING UNDER THE HILL-BURTON PROGRAM.

10 (2) MEDICAL ASSISTANCE WHICH IS DEFINED AS THE INPATIENT
 11 AND OUTPATIENT PATIENT-PAY AMOUNT FOR MEDICAL ASSISTANCE
 12 RECIPIENTS WHICH HAS BEEN UNABLE TO BE COLLECTED FOLLOWING
 13 REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED.

(3) UNDERINSURED INPATIENT CHARITY CARE WHICH IS DEFINED 14 15 AS THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO UNDERINSURED PERSONS BELOW 150% OF THE FEDERAL POVERTY LEVEL, 16 17 FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY 18 APPLIED. SUCH AMOUNT MAY NOT INCLUDE PAYMENT FOR GOODS OR 19 SERVICES WHICH COULD HAVE BEEN REIMBURSED UNDER THE MEDICAL 20 ASSISTANCE OR MEDICARE PROGRAM OR OTHER THIRD-PARTY PAYOR, 21 NOR ANY COSTS OR SERVICES RENDERED BY A HOSPITAL IN 22 FULFILLMENT OF ANY CHARITY CARE OBLIGATION FUNDING FROM 23 FOUNDATIONS OR FEDERAL OR STATE SOURCES INCLUDING FUNDING 24 UNDER THE HILL-BURTON PROGRAM.

(4) UNINSURED INPATIENT CHARITY CARE WHICH IS DEFINED AS
THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO PERSONS
WITHOUT PUBLIC OR PRIVATE INSURANCE COVERAGE, WITH INCOME
BELOW 150% OF THE POVERTY LEVEL, FOLLOWING REASONABLE
COLLECTION PROCEDURES, CONSISTENTLY APPLIED. SUCH AMOUNT MAY
NOT INCLUDE PAYMENT FOR GOODS OR SERVICES WHICH COULD HAVE
19910H0020B2886 - 82 -

BEEN REIMBURSED UNDER THE MEDICAL ASSISTANCE OR MEDICARE
 PROGRAM OR OTHER THIRD-PARTY PAYOR, NOR ANY COSTS OR SERVICES
 RENDERED BY A HOSPITAL IN FULFILLMENT OF ANY CHARITY CARE
 OBLIGATION FUNDING FROM FOUNDATIONS OR FEDERAL OR STATE
 SOURCES INCLUDING FUNDING UNDER THE HILL-BURTON PROGRAM.

6 (5) ADDITIONAL DATA THAT THE COUNCIL BELIEVES IS
7 NECESSARY IN DETERMINING CHARITY CARE PROVIDED BY ACUTE CARE
8 HOSPITALS.

9 (B) RECOMMENDATIONS TO GENERAL ASSEMBLY. -- COMMENCING MARCH 10 1, 1994, AND EVERY MARCH 1 THEREAFTER, THE COUNCIL SHALL SUBMIT 11 RECOMMENDATIONS TO THE GOVERNOR AND THE GENERAL ASSEMBLY AS TO WHETHER A SOURCE OF FUNDING IS REQUIRED FOR UNCOMPENSATED 12 13 CHARITY CARE PROVIDED BY ACUTE CARE HOSPITALS IN THIS 14 COMMONWEALTH. THESE RECOMMENDATIONS SHALL BE BASED ON DATA 15 COLLECTION FOR UNCOMPENSATED CHARITY CARE AS DEFINED IN THIS 16 SECTION FOR THE PRECEDING CALENDAR YEAR.

17 (C) ANNUAL HEARINGS OF THE GENERAL ASSEMBLY.--THE HEALTH AND
18 WELFARE COMMITTEE OF THE HOUSE OF REPRESENTATIVES AND THE PUBLIC
19 HEALTH AND WELFARE COMMITTEE OF THE SENATE SHALL HOLD ANNUAL
20 JOINT PUBLIC HEARINGS IN EACH REGION TO REVIEW THE COUNCIL'S
21 RECOMMENDATIONS FOR THE LEVEL OF FUNDING REQUIRED FOR CHARITY
22 CARE.

23 SECTION 1502. MEDICAL ASSISTANCE REIMBURSEMENT.

(A) JOINT HEARINGS.--THE HEALTH AND WELFARE COMMITTEE OF THE
HOUSE OF REPRESENTATIVES AND THE PUBLIC HEALTH AND WELFARE
COMMITTEE OF THE SENATE SHALL HOLD JOINT PUBLIC HEARINGS IN EACH
REGION OF THIS COMMONWEALTH TO REVIEW THE ADEQUACY OF PAYMENTS
TO PROVIDERS UNDER THE MEDICAL ASSISTANCE PROGRAM.

29 (B) JOINT SELECT COMMITTEE ON MEDICAL ASSISTANCE
30 REIMBURSEMENT PROCEDURES.--THE PRESIDENT PRO TEMPORE OF THE
19910H0020B2886 - 83 -

SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL
 APPOINT MEMBERS TO A JOINT SELECT COMMITTEE TO STUDY THE
 FEASIBILITY OF IMPLEMENTING MATERIAL IMPROVEMENTS IN THE
 PROCESSING OF CLAIMS FOR MEDICAL ASSISTANCE REIMBURSEMENTS TO
 PROVIDERS, AND IN THE USE OF PENNSYLVANIA MEDICAL ASSISTANCE BY
 ITS LOW-INCOME CITIZENS. THE STUDY SHALL INCLUDE, BUT NOT BE
 LIMITED TO, THE FOLLOWING:

8 (1) THE COST-EFFECTIVENESS OF CONTRACTING THE ENTIRE
9 MEDICAL ASSISTANCE REIMBURSEMENT PROCESS TO A FISCAL
10 INTERMEDIARY, SUCH AS BLUE CROSS/BLUE SHIELD.

11 (2) EXPLANATION SECTIONS IN ALL CLAIM FORMS SO THAT THEY
12 CONTAIN A CLEAR DESCRIPTION IN ENGLISH OF THE APPLICABLE
13 CODES AND MESSAGES IN ORDER THAT PROVIDERS AND RECIPIENT'S
14 CAN RESPOND TO OR COMPLETE THE FORM.

15 (3) ADDITIONAL STAFFING OF THE 800 TELEPHONE NUMBER SO
16 THAT PROVIDERS AND BENEFICIARIES CAN VERIFY ELIGIBILITY TO
17 RECEIVE BENEFITS, INQUIRE AS TO APPLICABLE ELIGIBILITY
18 REQUIREMENTS AND COVERAGE RESTRICTIONS, AND RECEIVE A
19 VERIFICATION NUMBER AS TO PRECLUDE DENIAL FOR REASONS
20 INCONSISTENT WITH THE INFORMATION RECEIVED BY TELEPHONE.

(4) DEVELOPMENT OF A SPECIAL TRAINING FOR PROVIDERS,
 IDENTIFYING THOSE PARTS OF THE CLAIM FORMS WITH THE GREATEST
 INCIDENCE OF ERROR AND EXPLAINING HOW TO AVOID SUCH ERRORS.

24 (5) SUBMISSION OF CLAIMS BY PROVIDERS ON FLOPPY DISKS,
25 TAPE TO TAPE BILLING OR TELECOMMUNICATIONS.

26 (6) DEVELOPMENT OF COMPUTER SOFTWARE THAT WILL
27 AUTOMATICALLY IDENTIFY ERRORS BY VALIDITY EDIT WHICH VERIFIES
28 THAT THE DATA ENTERED INTO ANY FIELD OR CLAIM LINE ON A CLAIM
29 IS APPROPRIATE FOR THAT FIELD OR CLAIM LINE.

30 (7) REWRITING THE PROVIDER HANDBOOK AND REORGANIZING 19910H0020B2886 - 84 - PROVIDER BULLETINS ON A REGULAR BASIS TO MAKE THESE DOCUMENTS
 MORE UNDERSTANDABLE AND USABLE.

3 (C) REPORTS.--EACH COMMITTEE SHALL ISSUE A REPORT BY
4 DECEMBER 31, 1992, AND THE GENERAL ASSEMBLY SHALL ENACT
5 LEGISLATION, IF NECESSARY, TO ADJUST MEDICAL ASSISTANCE PROVIDER
6 REIMBURSEMENT TO COMPLY WITH FEDERAL REQUIREMENTS AND TO
7 IMPLEMENT CHANGES IN MEDICAL ASSISTANCE REIMBURSEMENT

8 PROCEDURES.

9 SECTION 1503. COST OF MANDATED HEALTH BENEFITS.

(A) CONTENT OF STUDY.--THE HEALTH CARE COST CONTAINMENT
COUNCIL, THROUGH ITS MANDATED BENEFITS REVIEW PANEL, IS DIRECTED
TO STUDY THE COSTS AND EFFECTIVENESS OF EXISTING MANDATED HEALTH
BENEFITS TO BUSINESSES. FOR EACH OF THE EXISTING MANDATED HEALTH
BENEFITS, THE REVIEW PANEL SHALL DETERMINE THE FINANCIAL IMPACT
AND HEALTH CARE EFFECTIVENESS OF THE EXISTING BENEFIT, INCLUDING
AT LEAST:

17 (1) THE NUMBER OF PERSONS UTILIZING THE EXISTING18 BENEFIT.

19 (2) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING
20 BENEFIT AS A MANDATED HEALTH BENEFIT WOULD RESULT IN
21 INADEQUATE HEALTH CARE FOR THE POPULATION OF THIS
22 COMMONWEALTH.

23 (3) THE COST-EFFECTIVENESS OF THE EXISTING BENEFIT IN
 24 REDUCING FURTHER MORE COSTLY MEDICAL PROCEDURES.

25 (4) THE IMPACT OF THE EXISTING BENEFIT ON THE TOTAL COST
26 OF HEALTH CARE WITHIN THIS COMMONWEALTH.

27 (5) THE IMPACT OF THE EXISTING BENEFIT ON HEALTH
28 INSURANCE COSTS OF HEALTH CARE PURCHASERS.

29 (6) THE IMPACT OF THE EXISTING BENEFIT ON ADMINISTRATIVE
30 EXPENSES OF HEALTH CARE INSURERS.

19910H0020B2886

- 85 -

(7) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING
 BENEFIT AS A MANDATED HEALTH BENEFIT WOULD RESULT IN
 INCREASED MEDICAL ASSISTANCE EXPENDITURES AND CHARITY CARE.

4 (8) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING
5 BENEFIT AS A MANDATED HEALTH BENEFIT COULD BE PAID FOR BY THE
6 PERSON RECEIVING THE EXISTING BENEFIT.

7 (9) THE IMPACT OF THE EXISTING BENEFIT ON THE ABILITY OF
8 SMALL BUSINESSES TO PURCHASE HEALTH INSURANCE FOR THEIR
9 EMPLOYEES AND ON THE ABILITY OF SELF-EMPLOYED PERSONS TO
10 PURCHASE HEALTH INSURANCE.

11 (B) FINDINGS AND RECOMMENDATIONS. -- THE REVIEW PANEL SHALL ISSUE A REPORT TO THE COUNCIL BY JUNE 30, 1993, OUTLINING THEIR 12 13 FINDINGS ON THE COSTS AND EFFECTIVENESS OF THE EXISTING MANDATED 14 HEALTH BENEFITS. AFTER REVIEW OF THE PANEL'S REPORT, THE COUNCIL 15 SHALL SUBMIT A FINAL REPORT TO THE GOVERNOR AND THE GENERAL 16 ASSEMBLY BY DECEMBER 31, 1993, OUTLINING THEIR FINDINGS ON THE 17 COSTS AND EFFECTIVENESS OF THE EXISTING MANDATED HEALTH BENEFITS 18 AND RECOMMENDATIONS AS TO WHETHER ANY OR ALL EXISTING MANDATED 19 HEALTH BENEFITS SHOULD BE ELIMINATED.

20 SECTION 1504. PHYSICIAN ACCEPTANCE OF MEDICAL ASSISTANCE

21

PATIENTS.

THE COUNCIL SHALL, FOR ALL PROVIDERS WITHIN THIS COMMONWEALTH AND WITHIN THE APPROPRIATE REGIONS AND SUBREGIONS WITHIN THIS COMMONWEALTH, PREPARE AND ISSUE QUARTERLY REPORTS THAT PROVIDE INFORMATION ON THE NUMBER OF PHYSICIANS, BY SPECIALTY, ON THE STAFF OF EACH HOSPITAL OR AMBULATORY SERVICE FACILITY AND THE NUMBER AND NAMES OF THOSE PHYSICIANS, BY SPECIALTY, ON THE STAFF THAT ACCEPT MEDICAL ASSISTANCE PATIENTS.

29 SECTION 1505. SUBSIDIES PROVIDED BY HEALTH SERVICE CORPORATION30 AND HOSPITAL PLAN CORPORATIONS.

19910H0020B2886

- 86 -

1 THE HEALTH SERVICE CORPORATION AND HOSPITAL PLAN CORPORATIONS PRESENTLY ARE EXEMPT FROM PAYING THE 2% PREMIUM TAX. IN LIEU OF 2 3 THIS EXEMPTION, AND AS PART OF THEIR OBLIGATION TO SERVE LOW-4 INCOME SUBSCRIBERS, THE HEALTH SERVICE CORPORATION AND HOSPITAL 5 PLAN CORPORATIONS SHALL SUBMIT ANNUALLY, COMMENCING ON JANUARY 31, 1993, TO THE DEPARTMENT OF HEALTH AND THE DEPARTMENT OF 6 7 INSURANCE DATA DOCUMENTING THEIR SUBSIDIES TO HEALTH CARE 8 PURCHASERS THAT THEY PROVIDE IN LIEU OF THEIR EXEMPTION FROM THE 9 2% PREMIUM TAX. IN SUBMITTING THIS DATA, THE HEALTH SERVICE 10 CORPORATION AND HOSPITAL PLAN CORPORATIONS SHALL INDICATE WHICH 11 SUBSIDIES ARE BASED ON THE INCOME OF THE HEALTH CARE PURCHASER 12 OR BENEFICIARY.

13

CHAPTER 31

14 MISCELLANEOUS PROVISIONS

15 SECTION 3101. MANDATED COVERAGE.

(A) HEALTH CARE PROVIDERS.--ALL INSURANCE COMPANIES WRITING
GROUP ACCIDENT AND SICKNESS INSURANCE IN THIS COMMONWEALTH SHALL
BY JANUARY 1, 1993, OFFER IN EVERY AREA IN WHICH THEY WRITE SUCH
INSURANCE, A POLICY OR POLICIES MEETING ALL STATE MANDATED
COVERAGE. IN SELECTING THE HEALTH CARE PROVIDERS, THE INSURANCE
COMPANIES SHALL UTILIZE THE DATA PRODUCED BY THE COUNCIL AND
OTHER RELEVANT DATA TO DESIGN THE INSURANCE PRODUCTS.

(B) APPROVAL.--ALL SUCH POLICIES SHALL BE APPROVED BY THE
INSURANCE DEPARTMENT TO ASSURE THAT THE POLICIES PROVIDE FOR
ADEQUATE URGENT AND EMERGENCY CARE FROM OTHER HEALTH PROVIDERS,
SHOULD THAT BE NEEDED AND TO ENSURE SUFFICIENT NUMBERS AND TYPES
OF HEALTH CARE PROVIDERS.

28 SECTION 3102. GROUP ACCIDENT AND SICKNESS INSURANCE.

29 IN ADDITION TO THE PROVISIONS OF SECTION 621.2(A)(3) OF THE 30 ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE 19910H0020B2886 - 87 - COMPANY LAW OF 1921, GROUP ACCIDENT AND SICKNESS INSURANCE SHALL
 ALSO INCLUDE INSURANCE UNDER POLICIES ISSUED TO THE TRUSTEES OF
 A FUND ESTABLISHED BY ANY TWO OR MORE EMPLOYERS OR BY AN INSURER
 LICENSED IN THIS COMMONWEALTH.

5 SECTION 3103. SEVERABILITY.

6 THE PROVISIONS OF THIS ACT ARE SEVERABLE. IF ANY PROVISION OF 7 THIS ACT OR ITS APPLICATION TO ANY PERSON OR CIRCUMSTANCE IS 8 HELD INVALID, THE INVALIDITY SHALL NOT AFFECT OTHER PROVISIONS 9 OR APPLICATIONS OF THIS ACT WHICH CAN BE GIVEN EFFECT WITHOUT 10 THE INVALID PROVISION OR APPLICATION.

11 SECTION 3104. REPEALS.

12 ALL ACTS AND PARTS OF ACTS ARE REPEALED INSOFAR AS THEY ARE13 INCONSISTENT WITH THIS ACT.

14 SECTION 3105. EXPIRATION.

15 THIS ACT SHALL EXPIRE DECEMBER 31, 1999, UNLESS REENACTED BY 16 THE GENERAL ASSEMBLY.

17 SECTION 3106. EFFECTIVE DATE.

18 THIS ACT SHALL TAKE EFFECT SEPTEMBER 1, 1992, OR IMMEDIATELY, 19 WHICHEVER IS LATER.