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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

~~Providing a comprehensive plan for health care for the indigent; providing further duties of the Department of Health, the Department of Public Welfare and the Department of Revenue; providing for a hospital payment system and for certain responsibilities under the medical assistance program; providing primary health care programs for children and adults; establishing the Pennsylvania Health Care Fund; providing for certain tax credits; providing for enforcement and civil penalties; providing for certain health care studies; further providing for eligibility for medical assistance; and making repeals.~~ <—

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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. <——

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

~~CHAPTER 1~~ <—

~~GENERAL PROVISIONS~~

~~Section 101. Short title.~~

~~This act shall be known and may be cited as the Health Care Partnership Act.~~

~~Section 102. Legislative findings and intent.~~

~~(a) Declaration.--The General Assembly finds and declares that:~~

~~(1) All citizens of this Commonwealth have a right to affordable and reasonably priced health care and to nondiscriminatory treatment by health insurers and providers.~~

~~(2) The uninsured health care population of this Commonwealth is over one million persons, and many thousands more lack adequate insurance coverage. Approximately two-thirds of the uninsured are employed or dependents of employed persons.~~

~~(3) Over one-third of the uninsured health care population are children. Uninsured children are of particular concern because of their need for ongoing preventative and primary care. Measures not taken to care for such children now will result in higher human and financial costs later.~~

~~Access to timely and appropriate primary care is particularly~~

~~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 and appropriate primary and preventative care. As a result, they often delay or forego health care, with the resulting increased risk of developing more severe conditions, which are more expensive to treat. This tendency of the medically indigent to delay care and to seek ambulatory care in hospital-based settings also causes inefficiencies in the 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 health care payors.~~

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

~~(7) Not-for-profit hospitals which have been granted a tax free status by the State vary greatly in the amount of charitable uncompensated health care they provide and on average provide less than the national average. There has been no uniform definition to determine the amount of charity care provided by these health care institutions.~~

~~(8) Although the proper implementation of spend-down provisions under Medicaid should result in the provision of~~

~~the vast majority of all hospital care for the uninsured through the Medicaid program and hospitals vary widely in their willingness to allow patients to incur expenses so they can qualify for Medicaid.~~

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

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

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

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

~~(1) Ensure access to timely and appropriate health care for all citizens of this Commonwealth by providing for a cost-effective, comprehensive health coverage for low-income citizens of this Commonwealth who are unable to afford coverage or obtain it through their employment.~~

~~(2) Provide incentives for employers to provide health~~

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

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

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

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

~~Section 103. Definitions.~~

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

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

"Bad debt." The difference between the patient pay amount due and the patient pay revenue received.

"Child." A person under 18 years of age.

"Council." The Health Care Cost Containment Council.

"Department." The Department of Public Welfare of the Commonwealth.

"Disproportionate share hospital." Each hospital, including distinct parts, providing a number or percentage of inpatient services paid through the medical assistance program during the previous fiscal year in excess of one of the means of the numbers or percentages of all hospitals, as described in Chapter 3.

"EPSDT." Early periodic screening, diagnostic and testing.

"Fund" or "health care fund." The Pennsylvania Health Care Fund established in Chapter 9.

"Group." Any group for which a health insurance policy is written in the Commonwealth of Pennsylvania.

"Health maintenance organization" or "HMO." An entity organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Health service corporation." A professional health service corporation as defined in 40 Pa.C.S. (relating to insurance).

"Hill-Burton program." The hospital survey and construction program provided in the Hill-Burton Act (60 Stat. 1040, 42 U.S.C. § 291 et seq.).

"Hospital." An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased

~~or sick or mentally ill persons. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, including facilities which provide care and treatment exclusively for the mentally ill and drug or alcohol inpatient detoxification or rehabilitative care. The term does not include inpatient nonhospital activity as described in 28 Pa. Code § 701.1 (relating to general definitions), publicly owned inpatient facilities or skilled or intermediate care nursing facilities. The term also does not include a facility which is operated by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of a religious denomination or a facility providing treatment solely on the basis of prayer or spiritual means.~~

~~"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. (relating to insurance).~~

~~"MAAC." The Medical Assistance Advisory Committee.~~

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

~~"Medicaid." The Federal medical assistance program established under Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.).~~

~~"Medically indigent." Families and individuals who lack sufficient income or financial resources through insurance or other means to pay for necessary health care services.~~

~~"MIC." The Federal Maternal, Infant and Child Care program.~~

~~"Net inpatient revenue." The difference between a hospital's total inpatient revenue and a hospital's total medical assistance inpatient revenue.~~

"Nondisproportionate share hospital." A hospital, including distinct parts, located within this Commonwealth which provided a percentage of inpatient services paid through the medical assistance program during the previous fiscal year below the mean of the percentages of all hospitals, as described in Chapter 3.

"Preexisting condition exclusion." An exclusion of benefits for a specified or indefinite period of time on the basis of one or more physical or mental conditions for which, before the effective date of enrollment:

(1) a person experienced symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(2) a provider of health care services recommended or provided medical advice or treatment to the person.

"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.

"Spend-down." The qualifying procedure for the Pennsylvania Medical Assistance Program set forth in 55 Pa. Code, Chapter 181 (relating to income provisions for categorically needy nonmoney payment (NMP-MA) and medically needy only (MNO-MA) medical assistance (MA)).

"Subgroup." An employer covered under a contract issued to a multiple employer trust or to an association.

"Title XIX." Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.).

"Title XIX medical assistance." Only those aspects of the

medical assistance program established under Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.), for which Federal financial participation is available.

"Waiting period." A period of time after the effective date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of one or more medical conditions.

"WIC." The Federal Women, Infants and Children program.

CHAPTER 3

PENNSYLVANIA HOSPITAL FAIR SHARE PROGRAM

Section 301. Establishment and purpose.

(a) Establishment.--The General Assembly hereby establishes the Pennsylvania Hospital Fair Share Program, to be administered by the department.

(b) Purpose.--The purpose of the program shall be to identify those hospitals in this Commonwealth which provide a disproportionate share of care to the medically indigent and to compensate those hospitals for their services.

Section 302. Computation.

On or before the last day of January 1992, and each year thereafter, the department shall:

(1) Determine the total number of inpatient hospital days of care provided during the previous fiscal year by each hospital which has entered into a medical assistance provider agreement.

(2) Determine the number of inpatient hospital days of care provided by the hospital to all persons eligible for medical assistance and paid through the medical assistance program during the previous fiscal year.

(3) Determine the number of inpatient hospital days of

~~care provided by the hospital to persons eligible for Title XIX medical assistance and paid through the medical assistance program during the previous fiscal year.~~

~~(4) Using the information from paragraphs (1) through (3), calculate the following for each hospital:~~

~~(i) the ratio of Title XIX medical assistance days to total days;~~

~~(ii) the ratio of total medical assistance days to total days;~~

~~(iii) the total number of Title XIX medical assistance days; and~~

~~(iv) the total number of all medical assistance days.~~

~~(5) Using the information from paragraph (4), for all hospitals, determine:~~

~~(i) the mean ratio of Title XIX medical assistance days to total days;~~

~~(ii) the mean ratio of total medical assistance days to total days;~~

~~(iii) the mean of the total number of Title XIX medical assistance days; and~~

~~(iv) the mean of the total number of all medical assistance days.~~

~~Section 303. Disproportionate share hospital.~~

~~A hospital is a disproportionate share hospital if any of its hospital specific results determined under section 302(4) equals or exceeds the corresponding mean Statewide result for all hospitals determined under section 302(5). Disproportionate share hospitals shall be ranked for payment purposes by the ratio of Title XIX medical assistance days to total patient days~~

~~provided during the reporting period. The hospital with the highest ratio of Title XIX medical assistance days to total patient days provided during the reporting period shall be assigned a numerical rank equal to the total number of disproportionate share hospitals. The hospital with the lowest ratio of Title XIX medical assistance days to total patient days provided during the reporting period shall be assigned a rank number of one. Each hospital shall be assigned a disproportionate share rank weight equal to one plus the quotient of its numerical rank divided by the total number of disproportionate share hospitals.~~

~~Section 304. Expenditures from fund.~~

~~(a) Purpose.--Moneys deposited in the Pennsylvania Health Care Fund shall be expended on programs established under this act to provide care for the medically indigent, to provide all hospitals with a medical assistance payment rate subsidy, to provide a disproportionate share payment to all hospitals which qualify for such payment, to provide a hold harmless payment to all hospitals eligible to receive such payment, and to provide for Medicaid expansion as set forth in section 3101.~~

~~(b) Medical assistance payment rate.--Amounts paid into the fund shall be used to adjust medical assistance payment rates to hospitals to the most recent rebased figures established by the department. The department shall rebase the medical assistance payment rates at least every 24 months, to reflect current cost data, but such rates shall not exceed the upper limits for Medicaid payment rates established at 42 CFR 447.272 (relating to application of upper payment limits).~~

~~(c) Disproportionate share payments.--Amounts paid into the fund shall also be used to provide disproportionate share~~

~~payments to hospitals. Disproportionate share payments to hospitals shall be in the form of a rate add-on. Hospitals which qualify for disproportionate share payments shall receive the payments at fixed intervals under the following formula:~~

~~(1) The department shall multiply each hospital's assigned disproportionate share rank weight by its number of medical assistance cases to obtain a weighted number of medical assistance cases for each hospital.~~

~~(2) The department shall then divide the total amount of money to be distributed through disproportionate share payments by the total weighted number of medical assistance cases for all hospitals to obtain a unit disproportionate share payment weighted medical assistance case.~~

~~(3) The department shall then multiply each hospital's weighted number of medical assistance cases by the unit disproportionate share payment per weighted medical assistance case to obtain a disproportionate share payment for each qualifying hospital.~~

~~(d) Hold harmless payments.--Hold harmless payment shall be made to each hospital which qualifies so that for any given fiscal year no hospital receives payments from the Commonwealth under subsections (b), (c) and (d) and payments of Federal funds earned under this section totaling less than 1.05 times the amount the hospital paid into the fund for that year, except as provided in subsections (g) and (h).~~

~~(e) Funding for expansion of the Pennsylvania Medical Assistance Program.--Payments from the fund may be made for the additional costs due to the expansion of the Pennsylvania Medical Assistance Program as is provided for in this act.~~

~~(f) Funding for medical education.--Payments from the fund~~

may be made to hospitals for direct medical education programs.

(g) Total payments.--The amount to be paid to each hospital under this section shall be set so that the total amounts paid do not exceed the total amount deposited into the fund.

(h) Medical assistance program.--No payment from this fund shall be made to any hospital that does not ensure that all staff and admitting physicians that directly treat patients are enrolled and actively participating in the Pennsylvania Medical Assistance Program. As a condition of receiving payments from the fund, each hospital must establish a physician referral service to assist medical assistance recipients with referrals to primary care and specialist physicians on an equitable, rotating basis.

(i) Charity care.--Commencing with the calendar year beginning January 1, 1994, no payment from this fund shall be made to any hospital that does not provide for the year an amount of uncompensated charity care, as described in section 1901, equal to at least 2% of their total revenue for that year.

Section 305. Provision of charity care by hospitals.

In meeting the charity care requirements under section 304(i), all hospitals shall:

(1) Spread charity care out over the entire year, if at all possible.

(2) Maintain up-to-date records on the amount of charity care provided. A copy of that record must be provided to any person or group that so requests it within ten business days of the request.

(3) Advertise the opportunity to apply for charity care at the hospital in permanent, prominent displays in the waiting rooms, reception areas, emergency rooms, lobbies and

billing/payment areas of the hospital.

(4) Prominently display eligibility guideline pamphlets in the same room or rooms as the announcements of the presence of charity care, and readily accessible to the public without requesting the assistance of any hospital personnel.

(5) Advertise the opportunity to apply for charity care in the local community in a manner designed to provide wide exposure for the program.

Section 306. Use of fund moneys to reduce costs shifted to other health care payors.

(a) Cost reduction.--Insofar as some hospitals have been required to increase their hospital charges of other payors to cover a shortfall in funding by the Medicaid program for its costs, such hospitals receiving funding under this chapter shall use their best efforts to proportionally reduce future charges to those payors to whom those costs have been shifted to reflect the increased Medicaid funding under this chapter and the Medicaid program.

(b) Compliance report.--All hospitals receiving funds under this chapter shall file reports required by the Health Care Cost Containment Council which document the hospitals compliance with sections 304(i) and 306(a).

(c) Annual report.--The council shall issue an annual report to the General Assembly and the public at the beginning of the calendar year on the following:

(1) Whether present medical assistance and Pennsylvania Hospital Fair Share Program funding adequately reimburse efficient hospitals which provide quality acute care for Pennsylvania's medical assistance population.

~~(2) Pennsylvania hospitals' compliance with sections 304(i) and 306(a) and the impact thereon to hospital charges for other payors.~~

~~(3) Any recommendation for adjustments in the Medical or Pennsylvania Fair Share Program to ensure that these programs appropriately pay the costs for reimbursement to hospitals for the care of medical assistance patients and adjustments that should be made in sections 304(i) and 306(a).~~

~~CHAPTER 5~~

~~MEDICAL ASSISTANCE PROGRAM~~

~~Section 501. Hospital responsibilities under medical assistance program.~~

~~(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 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.~~

~~(c) Prohibitions.--It is unlawful for any hospital licensed by the Commonwealth:~~

~~(1) to require, as a condition of admission or treatment, assurance from the patient or any other person that the patient is not eligible for or will not apply for medical assistance;~~

~~(2) to deny or delay admission or treatment of a person~~

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

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

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

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

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

Section 502. Medical assistance outreach.

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

(1) Providing for on-site applications at all disproportionate share hospitals and Federal qualified health centers.

(2) Providing Statewide training to hospital staff on medical assistance spend-down and other eligibility procedures.

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

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

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

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

~~(5) Providing the General Assembly and the public an annual report for each fiscal year, detailing the outreach and enrollment efforts taken by each county assistance office, and reporting by county on the number of citizens enrolled in the medical assistance program and the projected medical assistance eligible population of each county.~~

~~(b) Applications for medical assistance and children's health care plan.--Persons taking applications for medical assistance, including persons at sites other than county assistance offices, shall offer to take an application for coverage under the Children's Health Care Plan, as established under Chapter 7, for any child. Persons taking applications for the Children's Health Care Plan shall promptly forward the applications to the entity designated by the health service corporation and hospital plan corporations to administer the plan.~~

~~Section 503. Pennsylvania Children's Medical Assistance~~

program.

(a) Card.--Every child in this Commonwealth eligible for coverage under medical assistance shall be given a Pennsylvania Children's Medical Assistance program card.

(b) 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.

(2) Health care services shall be provided in sufficient amount, duration and scope, required for each enrolled child's medical condition.

(3) Children with chronic health care needs shall have available targeted case management services to assist them with accessing needed health care and services.

(c) Enrollment.--

(1) Every child shall be immediately enrolled in the 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.

(2) At time of application for medical assistance for any child, or the addition of a new child, the department or its designee shall assist the parent in making an appointment for the child for a EPSDT screen with the physician of the parent's choice.

(3) At each redetermination for eligibility, the county assistance worker shall determine whether the children are current in their screens and if they are in need of

~~assistance in arranging health, dental, mental health or other treatment. Assistance shall be provided the parent by the department or its designee, if needed, in arranging for such care, screen or transportation therefor.~~

~~(d) Audit.--For each county the department shall annually conduct a performance analysis of the following:~~

~~(1) Percentage of potentially eligible children in the county actually enrolled in the medical assistance and EPSDT program.~~

~~(2) The outreach efforts as schools, day-care facilities, hospitals, etc., to enroll children in the medical assistance and EPSDT program.~~

~~(3) 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.~~

~~(4) The ease of use, accuracy, completeness and readability of county specific handbooks for parents of children on medical assistance, detailing all child health and nutrition services available in the county and transportation for medical care.~~

~~(5) Coordination of MIC, WIC, EPSDT, mental health, drug and alcohol, State and county health centers and other services in the county available to children on medical assistance.~~

~~(e) Noncompliance.--Any county assistance office found to be in noncompliance with the provisions of this section or which has failed to take sufficient outreach efforts to enroll that county's eligible children under this section shall be required by the department to immediately file a corrective action plan. The department shall do quarterly on-site compliance reviews of~~

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

~~(f) Publicity.--The department shall develop and widely utilize a media campaign for use on television, radio and local newspapers, advising Pennsylvania's citizens of the availability of health care for low-income children under this section.~~

~~(g) Report to General Assembly.--The department shall provide a written annual report to the General Assembly detailing on a county by county basis the findings of the county performance audits set forth in this section and evaluating the media campaign used by the department to inform citizens about the availability of health coverage for low-income children under this section.~~

~~(h) Advisory committee.--The MAAC shall, on a quarterly basis, review county assistance and departmental implementation of this section and to advise the department on changes in policy needed to maximize the availability of timely and cost-effective health care to Pennsylvania's low-income children who depend on medical assistance for their health care. In its review, the MAAC shall seek the advice from the Consumer Subcommittee of the MAAC; the Pennsylvania Chapter of the American Academy of Pediatricians; the Pennsylvania Academy of Family Physicians; the Developmental Disability Planning Council and other interested groups.~~

~~(i) Reimbursement.--Reimbursement under the Pennsylvania Medical ASsistance Medical-Surgical Fee Schedule shall be no less than the Plan C, Blue Shield rate for:~~

~~(1) primary physician care for children; and~~

~~(2) prenatal, delivery and postnatal care for pregnant women.~~

~~CHAPTER 7~~

~~PRIMARY HEALTH CARE PROGRAMS~~

~~Section 701. Children's Health Care Plan.~~

~~(a) Development.--The health service corporation and each hospital plan corporation shall jointly develop for operation no later than January 1, 1993, a Statewide primary health care insurance plan for all children of this Commonwealth who are not otherwise eligible for, or covered by, a health insurance plan, a self-insurance health plan or the medical assistance program.~~

~~(b) Department of Health.--The Children's Health Care Plan shall be regulated by the Department of Health as to quality of care and scope of services, but at a minimum shall provide preventive care, including routine physical examinations, eye and ear examinations to determine the need for vision and hearing correction, and immunizations, physician office visits when a child is sick, emergency care, diagnostic tests, outpatient surgery, availability of 24-hours-a-day, 7-days-a-week-access, integration with EPSDT, WIC, MIC Programs, specialist referral requirements and prescription drugs.~~

~~(c) Contracts with providers.--To the fullest extent practicable, the Children's Health Care Plan shall contract with providers to provide primary health care services for enrollees on a basis best calculated to manage costs of the program, including, but not limited to, purchasing health care services on a capitated basis, using managed health care techniques, using generic drugs where appropriate or other cost management methods.~~

~~(d) Eligibility for enrollment.--~~

~~(1) To the extent funds permit, any parent, guardian or other legal representative of a child residing in this~~

~~Commonwealth who is not eligible for or covered by a health insurance plan, a self-insurance health plan or the medical assistance program shall be eligible for enrollment of their child in the Children's Health Care Plan. However, the plan may permit enrollment by children who are eligible for a health insurance plan or self-insurance health plan or medical assistance program but who refuse to accept such coverage if:~~

~~(i) the premium payment required for such coverage for the child is so expensive relative to the income of that family that it would constitute a severe economic hardship if the family accepted such coverage for the child;~~

~~(ii) the refusal to accept such coverage was made in good faith; and~~

~~(iii) providing coverage would be consistent with the purposes of this section.~~

~~(2) Coverage shall not be denied on the basis of a preexisting medical condition.~~

~~(e) Inpatient care.--Inpatient hospital care shall be provided through the medical assistance program, with primary care physicians making the necessary arrangements for admission to the hospital and necessary specialty care.~~

~~(f) Uninsured children.--The plan shall be free to all uninsured children whose family income is less than or up to 150% of the Federal poverty level, and shall be available on a sliding fee basis to children whose family income is more than 150% but less than 200% of the Federal poverty level. Those over 200% of the Federal poverty level may purchase coverage for children under the plan at cost. There shall be no copayments or~~

~~deductibles.~~

~~(g) Children temporarily without coverage.--The plan shall provide for participation in the program by children who are temporarily without coverage by a health insurance plan, self-insurance health plan or medical assistance.~~

~~(h) Contracts.--The plan shall have a contractual arrangement with the Department of Public Welfare to receive Federal and State funding under Title XIX for persons who are eligible for medical assistance, and contract with providers who agree to accept the fee established for provision of primary health care to medical assistance recipients as payment in full.~~

~~(i) Funding.--~~

~~(1) The plan shall be financed by the health service corporation and hospital plan corporations as defined in 40 Pa.C.S. (relating to insurance) in partial fulfillment of their obligation to serve low-income subscribers. The expenses of the plan shall be financed by the health service corporation and hospital plan corporations in proportion to the percentage of premiums of that health service corporation and hospital plan corporations to the total premiums for the Commonwealth health service corporation and hospital plan corporations premiums, but shall not exceed 2% of any health service corporation or hospital plan corporations total annual premiums, excluding administrative costs. Administrative expenses of the plan shall be donated by the respective health service corporation and hospital plan corporations.~~

~~(2) Any funds appropriated by the General Assembly to the Children's Health Care Plan shall supplement the funding described in paragraph (1), and if such appropriation is~~

~~sufficient to completely finance the Children's Health Care Plan, the appropriation shall supersede the funding described in paragraph (1).~~

~~(j) Insurance cards.--The plan shall provide Blue Cross/Blue Shield cards to those children covered under the plan which shall not specially identify them as low income.~~

~~(k) Physicians.--The plan shall ensure that there are adequate primary care physicians throughout this Commonwealth to ensure some choice of physicians, availability within a reasonable and convenient travel distance and Statewide coverage.~~

~~(l) Contracts with providers.--The plan shall contract with any qualified, cost-effective provider, including hospital outpatient departments, HMOs, clinics, group practices and individual practitioners.~~

~~Section 702. Uninsured workers and adults.~~

~~(a) Development.--The health service corporation and the hospital plan corporations shall concurrently develop a primary health care insurance plan for adults, equivalent to the Children's Primary Health Care Plan set forth in section 701 for purchase at cost by January 1, 1993. The plan for adults shall make affordable primary health care available to individual Commonwealth residents whose income exceeds medical assistance eligibility guidelines but who are without sufficient means to purchase other health care insurance to cover the costs of health care.~~

~~(b) Rates.--The Insurance Commissioner shall review the rates for the Primary Health Care Plan for adults and shall ensure that the premium covers all appropriate costs, reserves and administrative costs of the health service corporation and~~

~~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.~~

~~(e) Expiration of section.--If prior to January 1, 1993, the Insurance Commissioner approves an adult health care plan by the health service corporation and the hospital plan corporations that meets the intent and purposes of the primary health care plan for adults, the commissioner shall publish a notice of this approval in the Pennsylvania Bulletin. This section shall expire upon the date of publication of that notice.~~

~~Section 703. Outreach and quality assurance.~~

~~(a) Public information.--The health service corporation and the hospital plan corporations shall actively publicize both the children's and adults' primary care health plans and shall solicit the assistance of the Commonwealth, health care providers and others in bringing the program to the attention of prospective enrollees.~~

~~(b) Quality assurance.--The Department of Health shall develop a quality assurance program for the Children's and Adult's Health Care Program within 90 days of the effective date of this act. This quality assurance program shall require arrangements for referral to supplemental health care, including~~

~~specialty care, rehabilitative services and acute hospital care.~~

~~(c) Enrollment information.--Commencing January 1, 1993, and on an annual basis, all employers who do not provide health care insurance shall provide their employees with enrollment information concerning the Primary Health Care Plan for Adults.~~

~~CHAPTER 9~~

~~PENNSYLVANIA HEALTH CARE FUND~~

~~Section 901. Establishment.~~

~~There is hereby established in the State Treasury a separate account, to be known as the Pennsylvania Health Care Fund.~~

~~Section 902. Purpose.~~

~~Moneys deposited in the fund shall be expended for programs, goods and services which support the provisions of this act for which Federal matching funds are available through Title XIX.~~

~~Section 903. Administration.~~

~~The fund shall be administered by the Department of Revenue. The Department of Revenue shall:~~

~~(1) Collect and distribute the moneys of the fund pursuant to this act.~~

~~(2) Promulgate rules and regulations for the collection of data and the determination of deposit amounts for the fund and the distribution thereof, as set forth in Chapter 3.~~

~~Section 904. Assessment.~~

~~Effective January 1, 1992, every hospital is hereby assessed an amount for the fund, payable at the rate provided in this section. On the last day of September, December, March and June, every hospital shall forward to the Department of Revenue for deposit in the fund an amount equal to one-fourth of four percent of the hospital's net inpatient revenue for the preceding quarter.~~

Section 905. Civil penalty.

Any hospital that fails to comply with section 904 shall be liable for a civil penalty of $1,000 per day for each day after the due date that the funds are not deposited. The Secretary of Revenue may waive this penalty for a period not to exceed 30 days. In addition, no hospital shall be eligible to receive funds under the Pennsylvania Hospital Fair Share Program until the requirements of this section are met and penalties, if applicable, are paid. Interest on the penalty and the amounts due under section 904 may be applied in accordance with the regulations of the Department of Revenue.

Section 906. Financial provisions.

(a) Appropriations.--All moneys in the fund are hereby appropriated to the Department of Public Welfare on a continuing basis to carry out the purposes of the fund as described in this act. Federal funds earned as the result of payments under this chapter are likewise appropriated to the Department of Public Welfare on a continuing basis.

(b) Reconciliation of payments.--The Department of Public Welfare shall reconcile payments to hospitals made under section 304(d), as are necessary on an annual basis. The department shall also ensure that within five working days of the hospital assessment in section 904 every hospital assessed shall receive payments at least equal to the amount assessed that hospital under section 904.

(c) Fund administration.--For the purpose of the orderly administration of payments under this act, in any year in which obligations exceed the balance in the fund, the payment of obligations may be carried forward to the following fiscal year. In addition, any funds not expended during a fiscal year shall

be retained in the fund and be made available for use during the following fiscal year.

CHAPTER 11

SMALL BUSINESS HEALTH INSURANCE TAX CREDIT

Section 1101. Eligibility.

An employer shall be eligible for a tax credit against any tax due under Article II, III, IV, or VI of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, and against any payment of estimated tax or payment of tentative tax due on account of said taxes if all of the following conditions are met:

(1) The employer has a payroll of nine or fewer employees.

(2) When seeking credit for the cost of providing employee health care coverage, the employer has not provided at least 50% of the cost of a health insurance plan which would have met standards established by the Insurance Commissioner for any of the employees of the enterprise in any of the preceding three years, or where seeking credit for the cost of providing dependent coverage, the employer has not provided at least 50% of the cost of a health insurance plan for any of the employees' uninsured dependents in any of the preceding three years.

(3) The employer provides health care insurance for the employees, or the employees and their uninsured dependents or the uninsured dependents of the employees.

(4) The employer provides a health care benefit plan that meets minimum standards established by the Insurance Commissioner.

(5) The employer's health insurance expenditure for the

coverage for which credit is sought equals at least 50% of the total cost of the health insurance coverage.

Section 1102. Calculation of credit.

(a) Beneficiaries.--An eligible employer shall receive a tax credit of a portion of the amount of employers' expenditure for health insurance costs initiated or expanded coverage only for the following beneficiaries:

(1) Employees whose average annualized wage is less than 150% of the Federal poverty level for a family of four, as published by the United States Department of Health and Human Services.

(2) Employees whose average annualized wage is less than 150% of the Federal poverty level and their uninsured dependents.

(3) Uninsured dependents of employees whose average annualized wage is less than 150% of the Federal poverty level, when coverage previously included only the employees.

(b) Credit schedule.--The credit may be claimed in accordance with the following schedule:

Percentage of amount of employer's expenditure for health insurance costs	Tax year in which such expenditure was made, and for which the tax credit is claimed
40%	The tax year commencing on or after January 1, 1993.
30%	The tax year commencing on or after January 1, 1994.
20%	The tax year commencing on or after January 1, 1995.

~~(c) Availability of credit.--Tax credits shall be available in years following the first year in which coverage is initiated or expanded, only if the employer continues to offer it in the following two years. No employer shall be eligible for a tax credit for more than the three tax years specified in subsection (b).~~

~~Section 1103. Rules and regulations.~~

~~The Department of Revenue and the Insurance Department shall:~~

~~(1) Promulgate any rules and regulations which may be required to implement this chapter.~~

~~(2) Publish as a notice in the Pennsylvania Bulletin, no later than January 1, of the year following the effective date of this act, forms upon which taxpayers may apply for the tax credit authorized by this chapter.~~

~~Section 1104. Reports to General Assembly.~~

~~Within five months after the close of any tax year for which tax credits granted pursuant to this chapter were used, the Insurance Department and the Department of Revenue shall furnish to the General Assembly a report providing the number of employers who used credits during the preceding tax year, the number of employees and dependents receiving new health care coverage and the amount of tax credits granted.~~

~~CHAPTER 13~~

~~ACCESS TO HEALTH CARE~~

~~Section 1301. Health maintenance organizations.~~

~~(a) Fair share of medical assistance subscribers.--Within six months of the effective date of this act, each health maintenance organization shall enter into an agreement with the department to enroll as subscribers individuals who are eligible to receive medical assistance benefits. A health maintenance~~

~~organization that receives its certificate of authority after the effective date of this act shall enter into an agreement with the department under this section before the end of the health maintenance organization's second year of operation in this Commonwealth. All health maintenance organizations shall agree to accept as enrollees a fair share of medical assistance recipients. A "fair share" of medical assistance subscribers for purposes of this section shall be defined as the same ratio of medical assistance recipients to general population in the health maintenance organization's service area as enrolled medical assistance subscribers to the total health maintenance organization enrollment or 25%, whichever is less. Within three years of the effective date of the contract between the department and the health maintenance organization, the health maintenance organization shall have enrolled or have attempted to enroll its fair share of medical assistance 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 health maintenance organizations in determining the number of medical assistance subscribers necessary to constitute its fair share.~~

~~(c) Approval of capitated rate.--The capitated rate contained in the agreement between the health maintenance organization and the department is subject to the approval of the Insurance Commissioner in accordance with section 10 of the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act. The rate shall not exceed 100% of the fee-for-service medical assistance cost in each county served by the health maintenance organization. In the event the~~

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

~~(d) Separate systems.--Unless authorized by the department, after consultation with the Medical Assistance Advisory Committee, a health maintenance organization shall not establish separate systems of care for its medical assistance subscribers.~~

~~(e) Waiver of requirements.--The department may grant a waiver of the requirements of this section if it finds that the health maintenance organization has made and continues to make a good faith effort to obtain a fair share of medical assistance subscribers, but is unable to reach or maintain that percentage. The department may also grant a waiver of the requirements of this section upon demonstration by the health maintenance organization that this section would result in insolvency of the health maintenance organization.~~

~~Section 1302. Continuity on replacement of a group policy.~~

~~(a) Policies subject to this section.--This section applies to all group health insurance policies, except group long-term care policies or group long-term disability policies, issued by insurers or health maintenance organizations doing business in this Commonwealth to policyholders who are obtaining coverage to replace coverage under a different contract or policy.~~

~~(b) Continuity of coverage.--The replacement policy issued to replace the prior contract or policy shall provide continuity~~

~~of coverage to all persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.~~

~~(c) Prohibition against discontinuity.--In a replacement policy subject to this section, an insurer or health maintenance organization may not, for any person described in section 1304:~~

~~(1) request that the person provide or otherwise seek to obtain evidence of insurability;~~

~~(2) decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; or~~

~~(3) impose a preexisting condition exclusion period or waiting period on that person, except as provided in the section.~~

~~(d) Person covered for fewer than 90 continuous days.--Notwithstanding subsection (c), a person who was covered under the replaced contract or policy for fewer than 90 continuous days may be subject to a preexisting condition exclusion or waiting period in the replacement policy, provided the period is not longer than 90 days, and credit is given for satisfaction or partial satisfaction of the same or similar provisions under the replaced contract or policy.~~

~~(e) Liability after discontinuance.--The entity, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.~~

~~Section 1303. Extension of benefits for disabled persons.~~

~~(a) Policies subject to this section.--This section applies to all group health insurance policies, except group long-term~~

~~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 business in this Commonwealth.~~

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

~~(d) Liability after discontinuance.--After discontinuance of a policy, the insurer, professional health service corporation, nonprofit hospital plan corporation or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits. The liability of the insurer or health maintenance organization is the same whether the group policyholder or other entity secures replacement coverage from any insurer, professional health service corporation, nonprofit hospital plan corporation or health maintenance organization, self-insures or foregoes the provision~~

~~of coverage.~~

~~(e) Definition of term.--The Secretary of Health shall in the manner provided by law, promulgate a regulation defining "total disability" for purposes of this section. The definition must identify persons who are unable, as a result of disability, to obtain comparable alternative coverage through comparable employment or otherwise. The regulations promulgated under this subsection shall not be subject to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.~~

~~Section 1304. Continuity for individual who changes groups.~~

~~(a) Application.--This section applies to all group health policies issued by insurers or health maintenance organizations, except group long-term care policies and group disability coverage.~~

~~(b) Persons provided continuity of coverage.--This section provides continuity of coverage for a person who seeks coverage under a group insurance or health maintenance organization policy if:~~

~~(1) That person was covered under an individual or group contract or policy issued by an insurer, health maintenance organization, or governmental program such as Medicaid or Medicare or any program established by this act.~~

~~(2) Coverage under the prior contract or policy terminated within three months before the date the person enrolls or is eligible to enroll in the succeeding policy. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within three months of the date the person enrolls or would otherwise be eligible to enroll.~~

~~(c) Prohibition against discontinuity.--Except as provided~~

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

~~(d) Determination of benefits.--When a determination of benefit under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.~~

~~Section 1305. Limitations on exclusions and waiting periods.~~

~~(a) Application.--This section applies to any individual or group health insurance policy or contract either with an insurer or health maintenance organization, except long-term care policies or long-term disability policies.~~

~~(b) Exclusions for certain factors.--No group or individual health insurance policy written in this Commonwealth may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for a specifically named or described preexisting disease or physical condition, beyond the waiting~~

~~period defined in this act.~~

~~(c) Preexisting conditions.--No group health policy, contract or certificate shall exclude a member of that group who has applied for coverage, except that coverage can be denied for a preexisting condition within the waiting period for new enrollees, as is defined in section 1306, for those not qualifying for continuity of benefits under this act.~~

~~(d) Permitted exclusion.--An individual policy issued by an insurer may not impose a preexisting condition exclusion or waiting period except as defined in section 1306.~~

~~Section 1306. Waiting period for preexisting conditions.~~

~~No group or individual health policy, certificate or contract may deny coverage for an enrollee for a preexisting condition except as follows:~~

~~(1) Preexisting medical conditions occurring three months prior to the effective date of coverage or enrollment in the group.~~

~~(2) Preexisting medical conditions for which the enrollee has received treatment three months prior to the effective date of coverage on the enrollee or enrollment in the group.~~

~~(3) In no event may there be an exclusion of coverage for a group or individual enrollee for any condition or disease covered by the policy, certificate or contract after that enrollee or insured has been enrolled or insured for 12 continuous months.~~

~~Section 1307. Enforcement.~~

~~(a) Civil penalty.--~~

~~(1) Any health maintenance organization that violates the provisions of this chapter shall be subject to a civil~~

penalty equal to 2% of the annual premiums of the HMO or the HMO's average rate per member multiplied by the number of individuals that the HMO has failed to enroll under the fair share provisions of this chapter, whichever is greater. This penalty shall be deposited in the Pennsylvania Health Care Fund. The penalty shall be levied by the department, annually, when it concludes that the HMO did not make a good faith effort to enroll the minimum number of medical assistance subscribers required by this chapter.

(2) Any HMO found to have violated the provisions of this chapter shall have the right to appeal such a determination to the Secretary of Public Welfare in the manner provided in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

(b) Civil action.--Any individual alleging discrimination under this chapter may file a civil cause of action in a court of competent jurisdiction against a health maintenance organization or group insurers alleged to be in violation of this chapter. If the health maintenance organization or group insurers is found to have violated this chapter the court may assess attorney fees, cost and penalties against the health maintenance organization or group insurers in addition to any monetary compensation to the plaintiff. A judgment against a health maintenance organization or group insurers shall be referred by the court to the appropriate professional licensing authority or regulatory agency.

CHAPTER 15

STUDIES AND HEARINGS ON HEALTH CARE

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 unpaid personal liability greater than annual family income, less an amount equivalent to 150% of the Federal poverty level. Such amount must be net, following reasonable collection procedures, consistently applied, and may not include any costs or services for which reimbursement could have been secured from 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.~~

~~(2) Medical assistance which is defined as the inpatient and outpatient patient-pay amount for medical assistance recipients which has been unable to be collected following reasonable collection procedures, consistently applied.~~

~~(3) Underinsured inpatient charity care which is defined as the allowable audited cost of services provided to uninsured persons below 150% of the Federal poverty level, following reasonable collection procedures, consistently applied. Such amount may not include payment for goods or services which could have been reimbursed under the Medicaid 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.~~

~~(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 been reimbursed under the Medicaid 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.~~

~~(5) Additional data that the council believes is necessary in determining charity care provided by acute care hospitals.~~

~~(b) Recommendations to General Assembly.--Commencing March 1, 1994, and every March 1 thereafter, the council shall submit recommendations to the Governor and the General Assembly as to whether a source of funding is required for uncompensated charity care provided by acute care hospitals in this Commonwealth. These recommendations shall be based on data collection for uncompensated charity care as defined in this section for the preceding calendar year.~~

~~(c) Annual hearings of the General Assembly.--The Health and Welfare Committee of the House of Representatives and the Public Health and Welfare Committee of the Senate shall hold annual joint public hearings in each region to review the council's recommendations for the level of funding required for charity care.~~

~~Section 1502. Medicaid 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.~~

~~(b) Joint Select Committee on Medicaid Reimbursement Procedures.--The President pro tempore of the 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 it's low-income citizens. The study shall include, but not be limited to, the following:~~

~~(1) The cost-effectiveness of contracting the entire Medicaid reimbursement process to a fiscal intermediary, such as Blue Cross/Blue Shield.~~

~~(2) Explanation sections in all claim forms so that they contain a clear description in English of the applicable codes and messages in order that providers and recipient's can respond to or complete the form.~~

~~(3) Additional staffing of the 800 telephone number so that providers and beneficiaries can verify eligibility to receive benefits, inquire as to applicable eligibility requirements and coverage restrictions, and receive a verification number as to preclude denial for reasons 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.~~

~~(5) Submission of claims by providers on floppy disks, tape to tape billing or telecommunications.~~

~~(6) Development of computer software that will automatically identify errors by validity edit which verifies that the data entered into any field or claim line on a claim is appropriate for that field or claim line.~~

~~(7) Rewriting the provider handbook and reorganizing provider bulletins on a regular basis to make these documents more understandable and usable.~~

~~(c) Reports.--Each committee shall issue a report by December 31, 1992, and the General Assembly shall enact legislation, if necessary, to adjust medical assistance provider reimbursement to comply with Federal requirements and to implement changes in Medicaid reimbursement procedures.~~

~~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:~~

~~(1) The number of persons utilizing the existing benefit.~~

~~(2) The extent to which elimination of the existing benefit as a mandated health benefit would result in inadequate health care for the population of this Commonwealth.~~

~~(3) The cost-effectiveness of the existing benefit in reducing further more costly medical procedures.~~

~~(4) The impact of the existing benefit on the total cost of health care within this Commonwealth.~~

~~(5) The impact of the existing benefit on health insurance costs of health care purchasers.~~

~~(6) The impact of the existing benefit on administrative expenses of health care insurers.~~

~~(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.~~

~~(8) The extent to which elimination of the existing benefit as a mandated health benefit could be paid for by the person receiving the existing benefit.~~

~~(9) The impact of the existing benefit on the ability of small businesses to purchase health insurance for their employees and on the ability of self-employed persons to purchase health insurance.~~

~~(b) Findings and recommendations.--The review panel shall issue a report to the council by June 30, 1993, outlining their findings on the costs and effectiveness of the existing mandated health benefits. After review of the panel's report, the council shall submit a final report to the Governor and the General Assembly by December 31, 1993, outlining their findings on the costs and effectiveness of the existing mandated health benefits and recommendations as to whether any or all existing mandated health benefits should be eliminated.~~

~~Section 1504. Physician acceptance of medical assistance 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.~~

~~Section 1505. Subsidies provided by health service corporation and hospital plan corporations.~~

~~The health service corporation and hospital plan corporations presently are exempt from paying the 2% premium tax. In lieu of this exemption, and as part of their obligation to serve low-income subscribers, the health service corporation and hospital plan corporations shall submit annually, commencing on January 31, 1993, to the Department of Health and the Department of Insurance data documenting their subsidies to health care purchasers that they provide in lieu of their exemption from the 2% premium tax. In submitting this data, the health service corporation and hospital plan corporations shall indicate which subsidies are based on the income of the health care purchaser or beneficiary.~~

~~CHAPTER 31~~

~~MISCELLANEOUS PROVISIONS~~

~~Section 3101. Persons eligible for medical assistance.~~

~~(a) General rule.--In addition to those persons described in section 441.1(1) and (2) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, the medical assistance eligibility for all groups shall be set at the highest eligibility limit permitted under Title XIX of the Social Security Act.~~

~~(b) Additional eligibility.--For purposes of this section and section 441.1 of the Public Welfare Code, all recipients (including medically needy recipients) and recipients of the~~

~~State blind pension shall be entitled to all the medical assistance benefits available to persons deemed categorically needy as provided for in section 441.1(1) of the Public Welfare Code except dental care. The Healthy Horizon resource level shall be increased to the maximum permitted under Federal law.~~

~~Section 3102. 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 date produced by the council and other relevant data to design the insurance products.~~

~~(b) Approval.--All such policies shall be approved by the Department of Health and 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.~~

~~Section 3103. Group accident and sickness insurance.~~

~~In addition to the provisions of section 621.2(a)(3) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance 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.~~

~~Section 3104. Construction and application of Chapters 3 and 9.~~

~~(a) Construction of chapters.--~~

~~(1) Chapters 3 and 9 shall not be construed to create any legally enforceable right or entitlement to payment for services on the part of any medically indigent person or any~~

~~right of entitlement to payment of any particular rate by any hospital, other provider of medical services or other person.~~

~~(2) Chapters 3 and 9 shall not be construed to relieve any hospital of its obligations under the Hill-Burton Act (60 Stat. 1040, 42 U.S.C. § 291 et seq.) or under any other similar Federal or State law or agreement to provide unreimbursed care to medically indigent persons.~~

~~(b) Application of chapters.--Chapters 3 and 9 shall apply only upon publication of notice in the Pennsylvania Bulletin by the Secretary of Public Welfare that the United States Department of Health and Human Services has approved the amendment of Pennsylvania's State Plan for Medical Assistance as set forth by the provisions of this act.~~

~~Section 3105. Repeals.~~

~~(a) Specific.--Section 441.1(3) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, is repealed.~~

~~(b) General.--All other acts and parts of acts are repealed insofar as they are inconsistent with this act.~~

~~Section 3106. Expiration.~~

~~This act shall expire December 31, 1999, unless reenacted by the General Assembly.~~

~~Section 3107. Effective date.~~

~~This act shall take effect in 60 days.~~

CHAPTER 1 <—

GENERAL PROVISIONS

SECTION 101. SHORT TITLE.

THIS ACT SHALL BE KNOWN AND MAY BE CITED AS THE HEALTH CARE PARTNERSHIP ACT.

SECTION 102. LEGISLATIVE FINDINGS AND INTENT.

(A) DECLARATION.--THE GENERAL ASSEMBLY FINDS AND DECLARES

THAT:

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

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

(3) OVER ONE-THIRD OF THE UNINSURED HEALTH CARE POPULATION ARE CHILDREN. UNINSURED CHILDREN ARE OF PARTICULAR CONCERN BECAUSE OF THEIR NEED FOR ONGOING PREVENTATIVE AND PRIMARY CARE. MEASURES NOT TAKEN TO CARE FOR SUCH CHILDREN NOW WILL RESULT IN HIGHER HUMAN AND FINANCIAL COSTS LATER. ACCESS TO TIMELY AND APPROPRIATE PRIMARY CARE IS PARTICULARLY 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 AND APPROPRIATE PRIMARY AND PREVENTATIVE CARE. AS A RESULT, THEY OFTEN DELAY OR FOREGO HEALTH CARE, WITH THE RESULTING INCREASED RISK OF DEVELOPING MORE SEVERE CONDITIONS, WHICH ARE MORE EXPENSIVE TO TREAT. THIS TENDENCY OF THE MEDICALLY INDIGENT TO DELAY CARE AND TO SEEK AMBULATORY CARE IN HOSPITAL-BASED SETTINGS ALSO CAUSES INEFFICIENCIES IN THE 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

HEALTH CARE PAYORS.

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

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

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

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

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

TIME-PHASED, COST-MANAGED AND PLANNED BASIS.

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

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

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

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

SECTION 103. DEFINITIONS.

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

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

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

"COUNCIL." THE HEALTH CARE COST CONTAINMENT COUNCIL.

"DEPARTMENT." THE DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH.

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

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

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

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

"HEALTH SERVICE CORPORATION." A PROFESSIONAL HEALTH SERVICE CORPORATION AS DEFINED IN 40 PA.C.S. (RELATING TO INSURANCE).

"HILL-BURTON PROGRAM." THE HOSPITAL SURVEY AND CONSTRUCTION PROGRAM PROVIDED IN THE HILL-BURTON ACT (60 STAT. 1040, 42 U.S.C. § 291 ET SEQ.).

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

TREATMENT SOLELY ON THE BASIS OF PRAYER OR SPIRITUAL MEANS.

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

"INSURER." AN ENTITY SUBJECT TO THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

"MAAC." THE MEDICAL ASSISTANCE ADVISORY COMMITTEE.

"MANAGED CARE ORGANIZATION." A HEALTH MAINTENANCE ORGANIZATION ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT; A RISK-ASSUMING PREFERRED PROVIDER ORGANIZATION OR EXCLUSIVE PROVIDER ORGANIZATION, ORGANIZED AND REGULATED UNDER THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921; OR A PREFERRED PROVIDER WITH A HEALTH MANAGEMENT/"GATEKEEPER" ROLE FOR PRIMARY CARE PHYSICIANS ORGANIZED AND REGULATED AS A HEALTH SERVICES CORPORATION UNDER 40 PA.C.S. CH. 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

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

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

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

"MIC." THE FEDERAL MATERNAL, INFANT AND CHILD CARE PROGRAM.

"PREEXISTING CONDITION." A DISEASE OR PHYSICAL CONDITION FOR WHICH MEDICAL ADVICE OF TREATMENT HAS BEEN RECEIVED WITHIN 90 DAYS IMMEDIATELY PRIOR TO THE EFFECTIVE DATE OF COVERAGE.

"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.

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

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

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

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

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

CHAPTER 5

MEDICAL ASSISTANCE PROGRAM

SECTION 501. HOSPITAL RESPONSIBILITIES UNDER MEDICAL ASSISTANCE PROGRAM.

(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

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.

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

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

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

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

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

(5) TO DISCOURAGE ANY PERSON WHO WOULD BE ELIGIBLE FOR THE MEDICAL ASSISTANCE PROGRAM FROM APPLYING OR SEEKING NEEDED HEALTH CARE OR NEEDED ADMISSION TO A HEALTH CARE 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 ALL MEDICAL ASSISTANCE RECIPIENTS HAVE FULL ACCESS TO ALL

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, ROTATING BASIS.

SECTION 502. MEDICAL ASSISTANCE OUTREACH.

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

(1) PROVIDING FOR ON-SITE APPLICATIONS AT ALL DISPROPORTIONATE SHARE HOSPITALS AND FEDERAL QUALIFIED HEALTH CENTERS.

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

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

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

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

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

(4) DEVELOPING PAMPHLETS AND INFORMATIONAL SERVICES FOR MEDICAL ASSISTANCE PROVIDERS TO HELP PROVIDERS INFORM

PATIENTS ABOUT MEDICAL ASSISTANCE OPTIONS AND ELIGIBILITY.

(5) PROVIDING THE GENERAL ASSEMBLY AND THE PUBLIC AN ANNUAL REPORT FOR EACH FISCAL YEAR, DETAILING THE OUTREACH AND ENROLLMENT EFFORTS TAKEN BY EACH COUNTY ASSISTANCE OFFICE, AND REPORTING BY COUNTY ON THE NUMBER OF CITIZENS ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM AND THE PROJECTED MEDICAL ASSISTANCE ELIGIBLE POPULATION OF EACH COUNTY.

(B) APPLICATIONS FOR MEDICAL ASSISTANCE AND CHILDREN'S HEALTH CARE PLAN.--PERSONS TAKING APPLICATIONS FOR MEDICAL ASSISTANCE, INCLUDING PERSONS AT SITES OTHER THAN COUNTY ASSISTANCE OFFICES, SHALL OFFER TO TAKE AN APPLICATION FOR COVERAGE UNDER THE CHILDREN'S HEALTH CARE PLAN, AS ESTABLISHED UNDER CHAPTER 7, FOR ANY CHILD. PERSONS TAKING APPLICATIONS FOR THE CHILDREN'S HEALTH CARE PLAN SHALL PROMPTLY FORWARD THE APPLICATIONS TO THE ENTITY DESIGNATED BY THE HEALTH SERVICE CORPORATION AND HOSPITAL PLAN CORPORATIONS TO ADMINISTER THE PLAN.

SECTION 503. PENNSYLVANIA CHILDREN'S MEDICAL ASSISTANCE PROGRAM.

(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.

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

(B) ENROLLMENT.--

(1) EVERY CHILD SHALL BE IMMEDIATELY ENROLLED IN THE

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.

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

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

(C) AUDIT.--THE DEPARTMENT SHALL ANNUALLY CONDUCT A PERFORMANCE ANALYSIS OF THE EPSDT PROGRAM, INCLUDING THE 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.

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

(D) NONCOMPLIANCE.--IF THE EPSDT PROGRAM IS FOUND TO BE IN

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.

(E) PUBLICITY.--THE DEPARTMENT SHALL DEVELOP AND WIDELY UTILIZE A MEDIA CAMPAIGN FOR USE ON TELEVISION, RADIO AND LOCAL NEWSPAPERS, ADVISING PENNSYLVANIA'S CITIZENS OF THE AVAILABILITY OF HEALTH CARE FOR LOW-INCOME CHILDREN UNDER THIS SECTION.

(F) REPORT TO GENERAL ASSEMBLY.--THE DEPARTMENT SHALL PROVIDE A WRITTEN ANNUAL REPORT TO THE GENERAL ASSEMBLY DETAILING ON A COUNTY BY COUNTY BASIS THE FINDINGS OF THE PERFORMANCE AUDITS SET FORTH IN THIS SECTION AND EVALUATING THE MEDIA CAMPAIGN USED BY THE DEPARTMENT TO INFORM CITIZENS ABOUT THE AVAILABILITY OF HEALTH COVERAGE FOR LOW-INCOME CHILDREN UNDER THIS SECTION.

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

CHAPTER 7

PRIMARY HEALTH CARE PROGRAMS

SECTION 701. CHILDREN'S HEALTH CARE.

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

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

(I) THE SECRETARY OF HEALTH.

(II) THE SECRETARY OF PUBLIC WELFARE.

(III) THE INSURANCE COMMISSIONER.

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

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

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

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

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

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

FROM A LIST OF PARENT APPLICANTS.

(X) THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF THE APPROPRIATIONS COMMITTEE OF THE SENATE AND THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF THE APPROPRIATIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES

(XI) THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE AND THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF THE HEALTH AND WELFARE COMMITTEE OF THE HOUSE OF REPRESENTATIVES.

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

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

(4) THE AUTHORITY MAY APPOINT STAFF NECESSARY TO CARRY 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.

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

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

(7) THE AUTHORITY SHALL ADOPT REGULATIONS NOT INCONSISTENT WITH THIS SECTION.

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

(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

THEIR SUCCESSORS ARE APPOINTED.

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

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

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

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.

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

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

(C) LIMITATIONS.--

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

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

FOLLOWING:

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

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

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

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.

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

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

(4) EMERGENCY ACCIDENT AND EMERGENCY MEDICAL CARE.

(5) AVAILABILITY OF 24-HOUR-A-DAY, 7 DAY-A-WEEK ACCESS 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

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.

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

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

(I) IS UNDER 19 YEARS OF AGE.

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

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

(IV) IS QUALIFIED UNDER SUBSECTION (I).

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

(3) THE AUTHORITY MAY PERMIT ENROLLMENT BY CHILDREN WITH HEALTH INSURANCE COVERAGE FOR INPATIENT HOSPITAL CARE, BUT LITTLE OR NO COVERAGE FOR THE PRIMARY HEALTH CARE SERVICES FUNDED BY THE AUTHORITY IF, AFTER THE FIRST YEAR OF OPERATION, THERE APPEARS TO BE SUFFICIENT REVENUE TO DO SO.

(I) FREE CARE.--THE PROVISION OF PRIMARY HEALTH SERVICES FOR ELIGIBLE CHILDREN SHALL BE FREE TO ALL CHILDREN WHOSE FAMILY INCOME IS LESS THAN OR UP TO 150% OF THE FEDERAL POVERTY LEVEL AND SHALL BE AVAILABLE ON A SLIDING FEE BASIS TO CHILDREN WHOSE FAMILY INCOME IS MORE THAN 150% BUT LESS THAN OR UP TO 200% OF THE FEDERAL POVERTY LEVEL. THE SLIDING SCALE FEE SHALL NOT EXCEED $25 PER CHILD PER YEAR AND $100 PER FAMILY PER YEAR.

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.

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

(M) DEDICATED FUNDING.--THE CHILDREN'S HEALTH FUND FOR

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.

SECTION 702. UNINSURED WORKERS AND ADULTS.

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

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

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

SECTION 703. OUTREACH AND QUALITY ASSURANCE.

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

(B) ENROLLMENT INFORMATION.--COMMENCING JANUARY 1, 1993, AND ON AN ANNUAL BASIS, ALL EMPLOYERS WHO DO NOT PROVIDE HEALTH CARE INSURANCE SHALL PROVIDE THEIR EMPLOYEES WITH ENROLLMENT INFORMATION CONCERNING THE PRIMARY HEALTH CARE PLAN FOR ADULTS.

CHAPTER 11

ACCESS TO HEALTH CARE

SECTION 1101. MANAGED CARE ORGANIZATIONS.

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

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

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

(D) WAIVER OF REQUIREMENTS.--THE DEPARTMENT MAY GRANT A

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

SECTION 1102. ENFORCEMENT.

(A) CIVIL PENALTY.--

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

(2) ANY HMO FOUND TO HAVE VIOLATED THE PROVISIONS OF THIS CHAPTER SHALL HAVE THE RIGHT TO APPEAL SUCH A DETERMINATION TO THE SECRETARY OF PUBLIC WELFARE IN THE MANNER PROVIDED IN TITLE 2 OF THE PENNSYLVANIA CONSOLIDATED STATUTES (RELATING TO ADMINISTRATIVE LAW AND PROCEDURE).

(B) CIVIL ACTION.--ANY INDIVIDUAL ALLEGING DISCRIMINATION UNDER THIS CHAPTER MAY FILE A CIVIL CAUSE OF ACTION IN A COURT OF COMPETENT JURISDICTION AGAINST A HEALTH MAINTENANCE

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

CHAPTER 13

HEALTH INSURANCE REFORMS

SECTION 1301. CONTINUITY ON REPLACEMENT OF A GROUP CONTRACT OR POLICY.

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

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

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 EXCEEDING THE PERIOD OF TIME THAT WOULD BE REMAINING ON SUCH EXCLUSION PERIOD OR WAITING PERIOD OF THE REPLACED POLICY WERE IT STILL IN EFFECT.

(C) PROTECTIONS.--NO INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE ORGANIZATION MAY 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 REPLACEMENT CONTRACT OR POLICY SUBJECT TO THIS SECTION.

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

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

(D) DETERMINATION OF WAITING PERIOD.--IF A DETERMINATION OF THE EXISTENCE OF A PREEXISTING CONDITION EXCLUSION PERIOD OR

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

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

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

(A) CONTRACTS AND POLICIES SUBJECT TO THIS SECTION.--THIS

SECTION APPLIES TO ALL CONTRACTS AND POLICIES SET FORTH IN SECTION 1301(A).

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

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

(2) THE COVERAGE UNDER THE PRIOR CONTRACT, POLICY OR GOVERNMENTAL PROGRAM TERMINATED WITH THREE MONTHS BEFORE THE PERSON ENROLLED OR WAS ELIGIBLE TO ENROLL IN THE SUCCEEDING CONTRACT OR POLICY. A PERIOD OF INELIGIBILITY FOR ANY HEALTH PLAN IMPOSED BY TERMS OF EMPLOYMENT MAY NOT BE CONSIDERED IN DETERMINING WHETHER THE COVERAGE ENDED WITHIN THREE MONTHS OF THE DATE THE PERSON ENROLLED OR WAS ELIGIBLE TO ENROLL.

(C) PROTECTIONS.--ANY INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE 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.

(2) DECLINE TO ENROLL ANY PERSON PROTECTED BY THIS SECTION IN A CONTRACT OR POLICY SUBJECT TO THIS SECTION BASED

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

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

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

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 EMPLOYEES.

SECTION 1303. EXTENSION OF BENEFITS FOR DISABLED PERSONS.

(A) POLICIES SUBJECT TO THIS SECTION.--THIS SECTION APPLIES TO ALL GROUP HEALTH INSURANCE POLICIES, EXCEPT GROUP LONG-TERM 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 BUSINESS IN THIS COMMONWEALTH.

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

(D) LIABILITY AFTER DISCONTINUANCE.--AFTER DISCONTINUANCE OF A POLICY, THE INSURER, PROFESSIONAL HEALTH SERVICE CORPORATION,

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

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

SECTION 1304. PREEXISTING CONDITIONS.

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

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.

(C) LIMITATION ON PREEXISTING CONDITION WAITING PERIODS.--NOTWITHSTANDING ANY OTHER PROVISION OF LAW, IT SHALL BE UNLAWFUL FOR ANY INSURER, NONPROFIT HOSPITAL PLAN, PROFESSIONAL HEALTH SERVICE CORPORATION OR MANAGED CARE ORGANIZATION TO INCLUDE IN A GROUP CONTRACT OR POLICY A PREEXISTING CONDITION EXCLUSION 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.

CHAPTER 15

STUDIES AND HEARINGS ON HEALTH CARE

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 UNPAID PERSONAL LIABILITY GREATER THAN ANNUAL FAMILY INCOME,

LESS AN AMOUNT EQUIVALENT TO 150% OF THE FEDERAL POVERTY LEVEL. SUCH AMOUNT MUST BE NET, FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED, AND MAY NOT INCLUDE ANY COSTS OR SERVICES FOR WHICH REIMBURSEMENT COULD HAVE BEEN SECURED FROM 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.

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

(3) UNDERINSURED INPATIENT CHARITY CARE WHICH IS DEFINED AS THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO UNDERINSURED PERSONS BELOW 150% OF THE FEDERAL POVERTY LEVEL, FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED. SUCH AMOUNT MAY NOT INCLUDE PAYMENT FOR GOODS OR SERVICES WHICH COULD HAVE 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.

(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

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.

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

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

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

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.

(B) JOINT SELECT COMMITTEE ON MEDICAL ASSISTANCE REIMBURSEMENT PROCEDURES.--THE PRESIDENT PRO TEMPORE OF THE

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:

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

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

(3) ADDITIONAL STAFFING OF THE 800 TELEPHONE NUMBER SO THAT PROVIDERS AND BENEFICIARIES CAN VERIFY ELIGIBILITY TO RECEIVE BENEFITS, INQUIRE AS TO APPLICABLE ELIGIBILITY REQUIREMENTS AND COVERAGE RESTRICTIONS, AND RECEIVE A VERIFICATION NUMBER AS TO PRECLUDE DENIAL FOR REASONS 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.

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

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

(7) REWRITING THE PROVIDER HANDBOOK AND REORGANIZING

PROVIDER BULLETINS ON A REGULAR BASIS TO MAKE THESE DOCUMENTS MORE UNDERSTANDABLE AND USABLE.

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

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:

(1) THE NUMBER OF PERSONS UTILIZING THE EXISTING BENEFIT.

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

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

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

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

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

(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.

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

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

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

SECTION 1504. PHYSICIAN ACCEPTANCE OF MEDICAL ASSISTANCE 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.

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

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

CHAPTER 31

MISCELLANEOUS PROVISIONS

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.

SECTION 3102. GROUP ACCIDENT AND SICKNESS INSURANCE.

IN ADDITION TO THE PROVISIONS OF SECTION 621.2(A)(3) OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE

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.

SECTION 3103. SEVERABILITY.

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

SECTION 3104. REPEALS.

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

SECTION 3105. EXPIRATION.

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

SECTION 3106. EFFECTIVE DATE.

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