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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2348 Session of 2008

INTRODUCED BY EACHUS, DeLUCA, CARROLL, COHEN, COSTA, CURRY, DePASQUALE, DERMODY, DeWEESE, D. EVANS, FRANKEL, KORTZ, KOTIK, KULA, MANDERINO, McCALL, MUNDY, PARKER, PASHINSKI, SIPTROTH, SURRA, WHEATLEY AND YUDICHAK, MARCH 12, 2008

REFERRED TO COMMITTEE ON INSURANCE, MARCH 12, 2008

AN ACT

1 Amending the act of March 20, 2002 (P.L.154, No.13), entitled
2 "An act reforming the law on medical professional liability;
3 providing for patient safety and reporting; establishing the
4 Patient Safety Authority and the Patient Safety Trust Fund;
5 abrogating regulations; providing for medical professional
6 liability informed consent, damages, expert qualifications,
7 limitations of actions and medical records; establishing the
8 Interbranch Commission on Venue; providing for medical
9 professional liability insurance; establishing the Medical
10 Care Availability and Reduction of Error Fund; providing for
11 medical professional liability claims; establishing the Joint
12 Underwriting Association; regulating medical professional
13 liability insurance; providing for medical licensure
14 regulation; providing for administration; imposing penalties;
15 and making repeals," further providing for medical
16 professional liability insurance, for the Medical Care
17 Availability and Reduction of Error Fund and for actuarial
18 data; establishing the Pennsylvania Access to Basic Care (PA
19 ABC) Program Fund and the Continuing Access with Relief for
20 Employers (CARE) Fund; further defining "health care
21 provider"; further providing for the Health Care Provider
22 Retention Program; establishing the Supplemental Assistance
23 and Funding Account; further providing for expiration of the
24 Health Care Provider Retention Program; establishing the
25 Pennsylvania Access to Basic Care (PA ABC) Program; providing
26 for Continuing Access with Relief for Employers (CARE)
27 Grants, for health care coverage for certain adults,
28 individuals, employees and employers and for expiration of
29 certain sections; and repealing provisions of the Tobacco
30 Settlement Act.

31 The General Assembly of the Commonwealth of Pennsylvania

1 hereby enacts as follows:

2 Section 1. Section 711(d) and (g) of the act of March 20,
3 2002 (P.L.154, No.13), known as the Medical Care Availability
4 and Reduction of Error (Mcare) Act, are amended to read:

5 Section 711. Medical professional liability insurance.

6 * * *

7 (d) Basic coverage limits.--A health care provider shall
8 insure or self-insure medical professional liability in
9 accordance with the following:

10 (1) For policies issued or renewed in the calendar year
11 2002, the basic insurance coverage shall be:

12 (i) $500,000 per occurrence or claim and $1,500,000
13 per annual aggregate for a health care provider who
14 conducts more than 50% of its health care business or
15 practice within this Commonwealth and that is not a
16 hospital.

17 (ii) $500,000 per occurrence or claim and $1,500,000
18 per annual aggregate for a health care provider who
19 conducts 50% or less of its health care business or
20 practice within this Commonwealth.

21 (iii) $500,000 per occurrence or claim and
22 $2,500,000 per annual aggregate for a hospital.

23 (2) For policies issued or renewed in the calendar years
24 2003[, 2004 and 2005] through 2008, the basic insurance
25 coverage shall be:

26 (i) $500,000 per occurrence or claim and $1,500,000
27 per annual aggregate for a participating health care
28 provider that is not a hospital.

29 (ii) $1,000,000 per occurrence or claim and
30 $3,000,000 per annual aggregate for a nonparticipating

health care provider.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

[(3) Unless the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, for policies issued or renewed in calendar year 2006 and each year thereafter subject to paragraph (4), the basic insurance coverage shall be:

(i) $750,000 per occurrence or claim and $2,250,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $750,000 per occurrence or claim and $3,750,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (2); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.

(4) Unless the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, for policies issued or renewed three years after the increase in coverage limits required by paragraph (3) and for each year thereafter, the basic insurance

coverage shall be:

(i) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (3); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.]

(5) For policies issued or renewed in calendar year 2009, the basic insurance coverage shall be:

(i) $550,000 per occurrence or claim and $1,650,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $550,000 per occurrence or claim and $2,700,000 per annual aggregate for a hospital.

(6) For policies issued or renewed in calendar years 2010 and thereafter:

(i) The basic insurance coverage for a participating health care provider that is not a hospital shall increase by $50,000 per occurrence or claim and $150,000 per annual aggregate per year until such time as the basic insurance coverage required shall be $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate.

(ii) The basic insurance coverage for a nonparticipating health care provider shall be $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate.

(iii) The basic insurance coverage for a hospital shall increase by $50,000 per occurrence or claim and $200,000 per annual aggregate until such time as the basic insurance coverage requirement shall be $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate per year.

(7) Basic insurance coverage amounts shall be exclusive of a deductible or any other contribution from the health care provider.

* * *

(g) Basic insurance liability.--

(1) An insurer providing medical professional liability insurance shall not be liable for payment of a claim against a health care provider for any loss or damages awarded in a medical professional liability action in excess of the basic insurance coverage required by subsection (d) unless the health care provider's medical professional liability insurance policy or self-insurance plan provides for a higher limit.

(2) If a claim exceeds the limits of a participating

1 health care provider's basic insurance coverage or self-
2 insurance plan, the fund shall be responsible for payment of
3 the claim against the participating health care provider up
4 to the fund liability limits. The fund shall not be
5 responsible if a claimant has waived collection of any
6 portion of the applicable basic insurance coverage limit.
7 (3) If the health care provider has more than one basic
8 insurance coverage policy with more than one insurer
9 applicable to a claim, the fund shall be liable when the
10 policy with the highest limit has been tendered to the fund.
11 * * *
12 Section 2. Section 712(c), (d), (e), (i), (j) and (m) of the
13 act are amended and the section is amended by adding a
14 subsection to read:
15 Section 712. Medical Care Availability and Reduction of Error
16 Fund.
17 * * *
18 (c) Fund liability limits.--
19 (1) For calendar year 2002, the limit of liability of
20 the fund created in section 701(d) of the former Health Care
21 Services Malpractice Act for each health care provider that
22 conducts more than 50% of its health care business or
23 practice within this Commonwealth and for each hospital shall
24 be $700,000 for each occurrence and $2,100,000 per annual
25 aggregate.
26 (2) The limit of liability of the fund for each
27 participating health care provider shall be [as follows:
28 (i) For] for calendar year 2003 and each year
29 thereafter, the limit of liability of the fund shall be
30 $500,000 for each occurrence and $1,500,000 per annual

aggregate.

[(ii) If the basic insurance coverage requirement is increased in accordance with section 711(d)(3) and, notwithstanding subparagraph (i), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund shall be $250,000 for each occurrence and $750,000 per annual aggregate.

(iii) If the basic insurance coverage requirement is increased in accordance with section 711(d)(4) and, notwithstanding subparagraphs (i) and (ii), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund shall be zero.]

(3) The limit of liability of the fund for each participating health care provider shall be:

(i) For calendar years 2003 through 2008, $500,000 for each occurrence and $1,500,000 per annual aggregate.

(ii) For calendar year 2009, $450,000 per occurrence or claim and $1,350,000 per annual aggregate.

(iii) For calendar years 2010 and thereafter, the limit of liability shall decrease by $50,000 per occurrence or claim and $150,000 per annual aggregate per year until such time as the fund limit of liability shall be zero dollars per occurrence or claim and zero dollars per annual aggregate.

(d) Assessments.--

(1) For calendar [year 2003 and for each year thereafter,] years 2003 through 2017, the fund shall be funded by an assessment on each participating health care

1 provider. Assessments shall be levied by the department on or
2 after January 1 of each year. The assessment shall be based
3 on the prevailing primary premium for each participating
4 health care provider and shall, in the aggregate, produce an
5 amount sufficient to do all of the following:
6 (i) Reimburse the fund for the payment of reported
7 claims which became final during the preceding claims
8 period.
9 (ii) Pay expenses of the fund incurred during the
10 preceding claims period.
11 (iii) Pay principal and interest on moneys
12 transferred into the fund in accordance with section
13 713(c).
14 (iv) Provide a reserve that shall be 10% of the sum
15 of subparagraphs (i), (ii) and (iii).
16 (2) The department shall notify all basic insurance
17 coverage insurers and self-insured participating health care
18 providers of the assessment by November 1 for the succeeding
19 calendar year.
20 (3) Any appeal of the assessment shall be filed with the
21 department.
22 [(e) Discount on surcharges and assessments.--
23 (1) For calendar year 2002, the department shall
24 discount the aggregate surcharge imposed under section
25 701(e)(1) of the Health Care Services Malpractice Act by 5%
26 of the aggregate surcharge imposed under that section for
27 calendar year 2001 in accordance with the following:
28 (i) Fifty percent of the aggregate discount shall be
29 granted equally to hospitals and to participating health
30 care providers that were surcharged as members of one of

1 the four highest rate classes of the prevailing primary
2 premium.
3 (ii) Notwithstanding subparagraph (i), 50% of the
4 aggregate discount shall be granted equally to all
5 participating health care providers.
6 (iii) The department shall issue a credit to a
7 participating health care provider who, prior to the
8 effective date of this section, has paid the surcharge
9 imposed under section 701(e)(1) of the former Health Care
10 Services Malpractice Act for calendar year 2002 prior to
11 the effective date of this section.
12 (2) For calendar years 2003 and 2004, the department
13 shall discount the aggregate assessment imposed under
14 subsection (d) for each calendar year by 10% of the aggregate
15 surcharge imposed under section 701(e)(1) of the former
16 Health Care Services Malpractice Act for calendar year 2001
17 in accordance with the following:
18 (i) Fifty percent of the aggregate discount shall be
19 granted equally to hospitals and to participating health
20 care providers that were assessed as members of one of
21 the four highest rate classes of the prevailing primary
22 premium.
23 (ii) Notwithstanding subparagraph (i), 50% of the
24 aggregate discount shall be granted equally to all
25 participating health care providers.
26 (3) For calendar years 2005 and thereafter, if the basic
27 insurance coverage requirement is increased in accordance
28 with section 711(d)(3) or (4), the department may discount
29 the aggregate assessment imposed under subsection (d) by an
30 amount not to exceed the aggregate sum to be deposited in the

1 fund in accordance with subsection (m).]
2 * * *
3 (i) Change in basic insurance coverage.--If a participating
4 health care provider changes the term of its medical
5 professional liability insurance coverage, the assessment shall
6 be calculated on an annual basis and shall reflect the
7 assessment percentages in effect for the period over which the
8 policies are in effect. <u>A policy period less than 12 months may</u>
9 <u>result in a prorated reduction in the Mcare annual aggregate</u>
10 <u>limit.</u>
11 (j) Payment of claims.--Claims which became final during the
12 preceding claims period shall be paid on [or before] December 31
13 <u>or the last business day of the year</u> following the August 31 on
14 which they became final.
15 * * *
16 (m) Supplemental funding.--Notwithstanding the provisions of
17 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary,
18 beginning January 1, 2004, [and for a period of nine calendar
19 years thereafter,] <u>through June 30, 2018,</u> all surcharges levied
20 and collected under 75 Pa.C.S. § 6506(a) by any division of the
21 unified judicial system shall be remitted to the Commonwealth
22 for deposit in the Medical Care Availability and [Restriction]
23 <u>Reduction</u> of Error Fund. These funds shall be used to reduce
24 surcharges and assessments in accordance with subsection (e).
25 Beginning [January 1, 2014] <u>July 1, 2018</u>, and each year
26 thereafter, the surcharges levied and collected under 75 Pa.C.S.
27 § 6506(a) shall be deposited into the [General Fund.] <u>Health</u>
28 <u>Care Provider Retention Account.</u>
29 * * *
30 <u>(o) Coverage of claims in relation to payment of certain</u>

late assessments.--

(1) All basic insurance coverage insurers, self-insured participating health care providers and risk retention groups shall bill, collect and remit the assessment to the department within 60 days of the inception or renewal date of the primary professional liability policy.

(2) All basic insurance coverage insurers, self-insured participating health care providers and risk retention groups shall be subject to the following:

(i) For assessments remitted to the department in excess of 60 days after the inception or renewal date of the primary policy, the basic insurance coverage insurer, self-insured participating health care provider or risk retention group shall pay to the department a penalty equal to 10% per annum of each untimely assessment accruing from the 61st day after the inception or renewal date of the primary policy until the remittance is received by the department.

(ii) In addition to the provisions of subparagraph (i), if the department finds that there has been a pattern or practice of not complying with this section, the basic insurance coverage insurer, self-insured participating health care provider or risk retention group shall be subject to the penalties and process set forth in the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

(iii) If the basic insurance coverage insurer, self-insurer or risk retention group receives the assessment from a health care provider, professional corporation or professional association with less than 30 days to make

the remittance timely as provided under this subsection, the basic insurance coverage insurer, self-insurer or risk retention group remittance period shall be extended by 30 days from the date of receipt upon providing reasonable evidence to the department regarding the date of receipt and shall not be subject to the penalties provided for under this section.

(iv) If the basic insurance coverage insurer, self-insurer or risk retention group receives an assessment after 60 days of the inception or renewal date of the primary professional liability policy and remits the assessment within 30 days from the date of receipt, the basic insurance coverage insurer, self-insurer or risk retention group shall not be subject to the penalties provided for under this section. Remittances to the department beyond the 30-day period shall be subject to the penalties provided for under this section.

(v) (A) A health care provider or professional corporation, professional association or partnership shall be provided coverage from the inception or renewal date of the primary professional liability policy if the billed assessment is paid to the basic insurance coverage insurer, self-insurer or risk retention group within 60 days of the inception or renewal date of the primary professional liability policy.

(B) A health care provider or professional corporation, professional association or partnership that fails to pay the billed assessment to its basic insurance coverage insurer, self-insurer or risk

1 retention group within 60 days of policy inception or
2 renewal and before receiving notice of a claim shall
3 not have coverage for that claim.
4 (C) If a health care provider or professional
5 corporation, professional association or partnership
6 is billed by the basic insurance coverage insurer,
7 self-insurer or risk retention group later than 30
8 days after the policy inception or renewal date and
9 the health care provider or professional corporation,
10 professional association or partnership pays the
11 basic insurance coverage insurer, self-insurer or
12 risk retention group within 30 days from the date of
13 receipt of the bill and the basic insurance coverage
14 insurer, self-insurer or risk retention group carrier
15 remits the assessment to the department within 30
16 days from the date of receipt, the health care
17 provider shall be provided coverage as of the
18 inception or renewal date of the primary policy.
19 Coverage shall also be provided to the health care
20 provider or professional corporation, professional
21 association or partnership for all professional
22 liability claims made after payment of the
23 assessment.
24 (vi) Except as to provisions in conflict with this
25 section, nothing in this section shall be construed to
26 affect existing regulations saved by section 5107(a), and
27 all existing regulations shall remain in full force and
28 effect.
29 Section 3. Section 745 of the act is repealed:
30 [Section 745. Actuarial data.

1 (a) Initial study.--The following shall apply:
2 (1) No later than April 1, 2005, each insurer providing
3 medical professional liability insurance in this Commonwealth
4 shall file loss data as required by the commissioner. For
5 failure to comply, the commissioner shall impose an
6 administrative penalty of $1,000 for every day that this data
7 is not provided in accordance with this paragraph.
8 (2) By July 1, 2005, the commissioner shall conduct a
9 study regarding the availability of additional basic
10 insurance coverage capacity. The study shall include an
11 estimate of the total change in medical professional
12 liability insurance loss-cost resulting from implementation
13 of this act prepared by an independent actuary. The fee for
14 the independent actuary shall be borne by the fund. In
15 developing the estimate, the independent actuary shall
16 consider all of the following:
17 (i) The most recent accident year and ratemaking
18 data available.
19 (ii) Any other relevant factors within or outside
20 this Commonwealth in accordance with sound actuarial
21 principles.
22 (b) Additional study.--The following shall apply:
23 (1) Three years following the increase of the basic
24 insurance coverage requirement in accordance with section
25 711(d)(3), each insurer providing medical professional
26 liability insurance in this Commonwealth shall file loss data
27 with the commissioner upon request. For failure to comply,
28 the commissioner shall impose an administrative penalty of
29 $1,000 for every day that this data is not provided in
30 accordance with this paragraph.

1 (2) Three months following the request made under
2 paragraph (1), the commissioner shall conduct a study
3 regarding the availability of additional basic insurance
4 coverage capacity. The study shall include an estimate of the
5 total change in medical professional liability insurance
6 loss-cost resulting from implementation of this act prepared
7 by an independent actuary. The fee for the independent
8 actuary shall be borne by the fund. In developing the
9 estimate, the independent actuary shall consider all of the
10 following:
11 (i) The most recent accident year and ratemaking
12 data available.
13 (ii) Any other relevant factors within or outside
14 this Commonwealth in accordance with sound actuarial
15 principles.]
16 Section 4. Chapter 7 of the act is amended by adding
17 subchapters to read:
18 SUBCHAPTER E
19 PENNSYLVANIA ACCESS TO BASIC CARE
20 (PA ABC) PROGRAM FUND
21 Section 751. Establishment.
22 There is established within the State Treasury a special fund
23 to be known as the Pennsylvania Access to Basic Care (PA ABC)
24 Program Fund.
25 Section 752. Allocation.
26 Money in the Pennsylvania Access to Basic Care (PA ABC)
27 Program Fund is hereby appropriated upon approval of the
28 Governor for health care coverage and services under Chapter 13.
29 SUBCHAPTER F
30 CONTINUING ACCESS WITH RELIEF FOR

EMPLOYERS (CARE) FUND

Section 761. Establishment.

There is established within the State Treasury a special fund to be known as the Continuing Access with Relief for Employers (CARE) Fund.

Section 762. Allocation.

Money in the Continuing Access with Relief for Employers (CARE) Fund is hereby appropriated on a continuing basis to the Department of Community and Economic Development and shall be dedicated to assisting certain employers that currently offer and maintain health care coverage for their employees in compliance with the requirements under section 1308.

Section 5. The definition of "health care provider" in section 1101 of the act, added December 22, 2005 (P.L.458, No.88), is amended to read:

Section 1101. Definitions.

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

* * *

"Health care provider." [An individual who is all of the following:

(1) A physician, licensed podiatrist, certified nurse midwife or nursing home.

(2) A participating health care provider as defined in section 702.] Any of the following:

(1) A nursing home or birth center that is a participating health care provider as defined in section 702.

(2) An individual who is a physician, licensed podiatrist or certified nurse midwife.

* * *

Section 6. Section 1102 of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read:

Section 1102. Abatement program.

(a) Establishment.--There is hereby established within the Insurance Department a program to be known as the Health Care Provider Retention Program. The Insurance Department, in conjunction with the Department of Public Welfare, shall administer the program. The program shall provide assistance in the form of assessment abatements to health care providers for calendar years [2003, 2004, 2005, 2006 and 2007] beginning 2003 and ending 2017, except that licensed podiatrists shall not be eligible for calendar years 2003 and 2004, and nursing homes shall not be eligible for calendar years 2003, 2004 and 2005.

(b) Other [abatement.--] abatements.--

(1) Emergency physicians not employed full time by a trauma center or working under an exclusive contract with a trauma center shall retain eligibility for an abatement pursuant to section 1104(b)(2) for calendar years 2003, 2004, 2005 and 2006. Commencing in calendar year 2007, these emergency physicians shall be eligible for an abatement pursuant to section 1104(b)(1).

(2) Birth centers shall retain eligibility for abatement pursuant to section 1104(b)(2) for calendar years 2003, 2004, 2005, 2006 and 2007. Commencing in calendar year 2008, birth centers shall be eligible for abatement pursuant to section 1104(b)(1).

Section 7. Section 1103 of the act, added December 22, 2005 (P.L.458, No.88), is amended by adding paragraphs to read:

Section 1103. Eligibility.

1 A health care provider shall not be eligible for [assessment]
2 abatement under the program if any of the following apply:
3 * * *
4 (6) The health care provider has refused to be an active
5 provider in the Pennsylvania Access to Basic Care (PA ABC)
6 Program in the health care provider's service area.
7 (7) The active health care provider is an active
8 provider in the Pennsylvania Access to Basic Care (PA ABC)
9 Program and places restrictions on benefits for patients
10 enrolled in that program.
11 (8) The health care provider has refused to be an active
12 provider in the children's health insurance program
13 established under Article XXIII of the act of May 17, 1921
14 (P.L.682, No.284), known as The Insurance Company Law of
15 1921.
16 (9) The active health care provider is an active
17 provider in the children's health insurance program and
18 places restrictions on benefits for patients enrolled in the
19 children's health insurance program.
20 (10) The Department of Revenue has determined that the
21 health care provider has not filed all required State tax
22 reports and returns for all applicable taxable years or has
23 not paid any balance of State tax due as determined at
24 settlement, assessment or determination by the Department of
25 Revenue that are not subject to a timely perfected
26 administrative or judicial appeal or subject to a duly
27 authorized deferred payment plan as of the date of
28 application. Notwithstanding the provisions of section 353(f)
29 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax
30 Reform Code of 1971, the Department of Revenue shall supply

the Insurance Department with information concerning the status of delinquent taxes owed by a health care provider for purposes of this paragraph.

(11) (i) The health care provider has not attended at least one Commonwealth-sponsored independent drug information service session, either in person or by videoconference.

(ii) This paragraph does not apply if the Commonwealth has not made a Commonwealth-sponsored independent drug information service session available to the health care provider prior to the date that the health care provider's application is submitted under section 1104.

Section 8. Section 1104(b) of the act, amended December 22, 2005 (P.L.458, No.88), is amended to read:

Section 1104. Procedure.

* * *

(b) Review.--Upon receipt of a completed application, the Insurance Department shall review the applicant's information and grant the applicable abatement of the assessment for the previous calendar year specified on the application in accordance with all of the following:

(1) The Insurance Department shall notify the Department of Public Welfare that the applicant has self-certified as eligible and was not disqualified for an abatement under section 1103(6), (7), (8), (9), (10) and (11) for a 100% abatement of the imposed assessment if the health care provider was assessed under section 712(d) as:

(i) a physician who is assessed as a member of one of the four highest rate classes of the prevailing

1 primary premium;

2 (ii) an emergency physician;

3 (iii) a physician who routinely provides obstetrical

4 services in rural areas as designated by the Insurance

5 Department; [or]

6 (iv) a certified nurse midwife[.]; or

7 (v) a birth center.

8 (2) The Insurance Department shall notify the Department

9 of Public Welfare that the applicant has self-certified as

10 eligible and was not disqualified for an abatement under

11 section 1103(6), (7), (8), (9), (10) and (11) for a 50%

12 abatement of the imposed assessment in calendar years 2008

13 through 2012, a 56.5% abatement in calendar year 2013, a

14 63.5% abatement in calendar year 2014, a 70% abatement in

15 calendar year 2015, a 78% abatement in calendar year 2016, an

16 88% abatement in calendar year 2017 and a 100% abatement in

17 calendar year 2018 if the health care provider was assessed

18 under section 712(d) as:

19 (i) a physician but is a physician who does not

20 qualify for abatement under paragraph (1);

21 (ii) a licensed podiatrist; [or]

22 (iii) a nursing home[.]; or

23 (iv) a birth center.

24 * * *

25 Section 9. Section 1112(c) and (e) of the act, added

26 December 22, 2005 (P.L.458, No.88), are amended and the section

27 is amended by adding subsections to read:

28 Section 1112. Health Care Provider Retention Account.

29 * * *

30 (a.1) Supplemental Assistance and Funding Account.--There is

established within the Health Care Provider Retention Account a special account to be known as the Supplemental Assistance and Funding Account. Funds in this account shall be used annually to supplement the funding of the Pennsylvania Access to Basic Care (PA ABC) Program.

* * *

(c) Transfers from account.--

(1) The Secretary of the Budget may annually transfer from the account to the Medical Care Availability and Reduction of Error (Mcare) Fund an amount up to the aggregate amount of abatements granted by the Insurance Department under section 1104(b).

(2) In addition to the transfers specified in paragraph (1), the Secretary of the Budget may also transfer funds from the account to the Medical Care Availability and Reduction of Error (Mcare) Fund for the purpose of paying claims and operating expenses coming due after January 1, 2018.

(3) The Secretary of the Budget may transfer funds from the account to the Pennsylvania Access to Basic Care (PA ABC) Program Fund.

(4) The Secretary of the Budget shall annually transfer from the account to the Continuing Access Relief for Employers (CARE) Fund an amount at least equal to the amount deposited under section 712(m).

(c.1) Transfers from the Supplemental Assistance and Funding Account.--The Secretary of the Budget shall annually transfer funds from the Supplemental Assistance and Funding Account established under subsection (a.1) to the Pennsylvania Access to Basic Care (PA ABC) Program Fund.

* * *

1 [(e) Administration assistance.--The Insurance Department
2 shall provide assistance to the Department of Public Welfare in
3 administering the account.]
4 Section 10. Section 1115 of the act, amended October 27,
5 2006 (P.L.1198, No.128), is amended to read:
6 Section 1115. Expiration.
7 The Health Care Provider Retention Program established under
8 this chapter shall expire December 31, [2008] 2018.
9 Section 11. The act is amended by adding a chapter to read:
10 CHAPTER 13
11 PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM
12 Section 1301. Scope.
13 This chapter relates to offering health care coverage to
14 eligible adults, individuals, employees and employers.
15 Section 1302. Definitions.
16 The following words and phrases when used in this chapter
17 shall have the meanings given to them in this section unless the
18 context clearly indicates otherwise:
19 "AdultBasic Program." The adult basic coverage insurance
20 program established under section 1303 of the act of June 26,
21 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.
22 "Average annual wage." The total annual wages paid by an
23 employer divided by the number of the employer's full-time
24 equivalent employees.
25 "Behavioral health services." Mental health or substance
26 abuse services.
27 "Children's health insurance program." The children's health
28 care program established under Article XXIII of the act of May
29 17, 1921 (P.L.682, No.284), known as The Insurance Company Law
30 of 1921.

"Chronic disease management program." A program that allows a patient, with the support of a health care team, to play an active role in the patient's care and assures that there is an infrastructure to ensure compliance with established practice guidelines.

"Community Health Reinvestment Agreement." The Agreement on Community Health Reinvestment entered into February 2, 2005, by the Insurance Department and Capital Blue Cross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross and published in the Pennsylvania Bulletin at 35 Pa.B. 4155.

"Contractor." An insurer awarded a contract to provide health care services under this chapter. The term includes an entity and its subsidiary which is established under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Department." The Insurance Department of the Commonwealth.

"Eligible adult." An individual who meets all of the following:

(1) Is at least 19 years of age but not more than 64 years of age.

(2) Legally resides within the United States.

(3) Has been domiciled in this Commonwealth for at least 90 days prior to application to the program.

(4) Is ineligible to receive continuous eligibility coverage under Title XIX or XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), except for benefits

1 authorized under a waiver granted by the United States
2 Department of Health and Human Services to implement the
3 Pennsylvania Access to Basic Care (PA ABC) Program.
4 (5) Is ineligible for medical assistance or Medicare.
5 (6) May currently be enrolled in the AdultBasic Program
6 or is on the waiting list for that program on the effective
7 date of this section.
8 (7) Subject to the provisions of section 1305, has a
9 household income that is no greater than 300% of the Federal
10 poverty level at the time of application.
11 (8) Has not been covered by any health insurance plan or
12 program for at least 180 days immediately preceding the date
13 of application, except that the 180-day period shall not
14 apply to an eligible adult who meets one of the following:
15 (i) is eligible to receive benefits under the act of
16 December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1),
17 known as the Unemployment Compensation Law;
18 (ii) was covered under a health insurance plan or
19 program provided by an employer, but at the time of
20 application is no longer covered because of a change in
21 the individual's employment status and is ineligible to
22 receive benefits under the Unemployment Compensation Law;
23 (iii) lost coverage as a result of divorce or
24 separation from a covered individual, the death of a
25 covered individual or a change in employment status of a
26 covered individual; or
27 (iv) is transferring from another government-
28 subsidized health insurance program, including a transfer
29 that occurs as a result of failure to meet income
30 eligibility requirements.

"Eligible employee." An eligible adult or an employee who meets all the requirements of an eligible adult or employee at the time the eligible employer makes application to the program.

"Eligible employer." An employer that meets all of the following:

(1) Has at least two but not more than 50 full-time equivalent employees.

(2) Has not offered health care coverage through any plan or program during the 180 days immediately preceding the date of application for participation in the Pennsylvania Access to Basic Care (PA ABC) Program.

(3) Has not provided remuneration in any form to an employee on payroll for the purchase of health care coverage during the 180 days immediately preceding the date on which the employer applies for participation in the program.

(4) Pays an average annual wage that is less than 300% of the Federal poverty level for an individual.

"Employee." An individual who is employed for more than 20 hours in a single week and from whose wages an employer is required under the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.) to withhold Federal income tax.

"Employer." The term shall include:

(1) Any of the following who or which employs two but not more than 50 employees to perform services for remuneration:

(i) an individual, partnership, association, domestic or foreign corporation or other entity;

(ii) the legal representative, trustee in bankruptcy, receiver or trustee of any individual, partnership, association or corporation or other entity;

or

(iii) the legal representative of a deceased individual.

(2) An individual who is self-employed.

(3) The executive, legislative and judicial branches of the Commonwealth and any one of its political subdivisions.

"Fund." The Pennsylvania Access to Basic Care (PA ABC) Program Fund.

"Health benefit plan." An insurance coverage plan that provides the benefits set forth under section 1313. The term does not include any of the following:

(1) An accident-only policy.

(2) A credit-only policy.

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

(4) A specified disease policy.

(5) A Medicare supplement policy.

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

(7) A fixed indemnity policy.

(8) A dental-only policy.

(9) A vision-only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy pursuant to 75 Pa.C.S. (relating to vehicles).

(12) Such other similar policies providing for limited benefits.

"Health care coverage." A health benefit plan or other form of health care coverage that is approved by the Department of Community and Economic Development in consultation with the Insurance Department. The term does not include coverage under

1 the PA ABC program.
2 "Health maintenance organization" or "HMO." An entity
3 organized and regulated under the act of December 29, 1972
4 (P.L.1701, No.364), known as the Health Maintenance Organization
5 Act.
6 "Health savings account." An account established by an
7 employer under section 1307 on behalf of an employee whose
8 income is greater than 200% of the Federal poverty level.
9 "Hospital." An institution that has an organized medical
10 staff engaged primarily in providing to inpatients, by or under
11 the supervision of physicians, diagnostic and therapeutic
12 services for the care of injured, disabled, pregnant, diseased
13 or sick or mentally ill persons. The term includes a facility
14 for the diagnosis and treatment of disorders within the scope of
15 specific medical specialties. The term does not include a
16 facility that cares exclusively for the mentally ill.
17 "Hospital plan corporation." A hospital plan corporation as
18 defined in 40 Pa.C.S. § 6101 (relating to definitions).
19 "Individual." A person who meets all the requirements of an
20 eligible adult but whose household income is greater than 300%
21 of the Federal poverty level.
22 "Insurer." A company or health insurance entity licensed in
23 this Commonwealth to issue an individual or group health,
24 sickness or accident policy or subscriber contract or
25 certificate or plan that provides medical or health care
26 coverage by a health care facility or licensed health care
27 provider and that is offered or governed under this act or any
28 of the following:
29 (1) The act of May 17, 1921 (P.L.682, No.284), known as
30 The Insurance Company Law of 1921.

1 (2) The act of December 29, 1972 (P.L.1701, No.364),
2 known as the Health Maintenance Organization Act.
3 (3) The act of May 18, 1976 (P.L.123, No.54), known as
4 the Individual Accident and Sickness Insurance Minimum
5 Standards Act.
6 (4) 40 Pa.C.S. Ch. 61 (relating to hospital plan
7 corporations) or 63 (relating to professional health services
8 plan corporations).
9 "Medical assistance." The State program of medical
10 assistance established under the act of June 13, 1967 (P.L.31,
11 No.21), known as the Public Welfare Code.
12 "Medical loss ratio." The ratio of paid medical claim costs
13 to earned premiums.
14 "Medicare." The Federal program established under Title
15 XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395
16 et seq.).
17 "Offeror." An insurer that submits a bid or proposal under
18 section 1311 in response to the department's procurement
19 solicitation.
20 "Preexisting condition." A disease or physical condition for
21 which medical advice or treatment has been received prior to the
22 effective date of coverage.
23 "Prescription drug." A controlled substance, other drug or
24 device for medication dispensed by order of an appropriately
25 licensed medical professional.
26 "Professional health services plan corporation." A not-for-
27 profit corporation operating under the provisions of 40 Pa.C.S.
28 Ch. 63 (relating to professional health services plan
29 corporations).
30 "Program." The Pennsylvania Access to Basic Care (PA ABC)

1 Program established under this chapter.
2 "Qualifying health care coverage." A health benefit plan or
3 other form of health care coverage actuarially equivalent to the
4 benefits in section 1313 and approved by the Insurance
5 Department.
6 "Terminate." The term includes cancellation, nonrenewal and
7 rescission.
8 "Unemployment Compensation Law." The act of December 5, 1936
9 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment
10 Compensation Law.
11 "Uninsured period." A continuous period of time of not less
12 than 180 consecutive days immediately preceding enrollment
13 application during which an adult has been without health care
14 coverage in accordance with the requirements of this chapter.
15 Section 1303. Establishment of program.
16 The Pennsylvania Access to Basic Care (PA ABC) Program is
17 established in the department.
18 Section 1304. Funding.
19 (a) Sources.--The following are the sources of money for the
20 program:
21 (1) Money received from the Supplemental Assistance and
22 Funding Account established under section 1112(a.1).
23 (2) Money received from the Federal Government or other
24 sources.
25 (3) Money required to be deposited pursuant to other
26 provisions of this chapter or any other law of this
27 Commonwealth.
28 (4) Upon implementation of the program:
29 (i) Only those funds appropriated for health
30 investment insurance under section 306(b)(1)(vi) of the

1 act of June 26, 2001 (P.L.755, No.77), known as the
2 Tobacco Settlement Act, and designated for the AdultBasic
3 Program.
4 (ii) Money currently required to be dedicated to the
5 AdultBasic Program or any alternative program to benefit
6 persons of low income under the Community Health
7 Reinvestment Agreement within the respective service
8 areas for each party to that agreement. Money under this
9 subparagraph shall be used only to defray the cost of the
10 program and subsidies approved under sections 1305 and
11 1306.
12 (5) Any moneys derived from whatever sources and
13 designated specifically to fund the program.
14 (6) Return on investments in the fund.
15 Section 1305. Purchase by eligible adults and individuals.
16 (a) Eligible adults.--An eligible adult who seeks to
17 purchase coverage under the program must:
18 (1) Submit an application to the department or its
19 contractor.
20 (2) Pay to the department or its contractor the amount
21 of the premium specified.
22 (3) Be responsible for any required copayments for
23 health care services rendered under the health benefit plan
24 in section 1313 subject to Federal waiver requirements.
25 (4) Notify the department or its contractor of any
26 change in the eligible adult's or individual's household
27 income.
28 (b) Monthly premiums.--Except to the extent that changes may
29 be necessary to meet Federal requirements under section 1317 or
30 to encourage eligible employer participation, subsidies for the

2008-2009 fiscal year and each fiscal year thereafter shall result in the following premium amount based on household income for a health benefit plan:

(1) For an eligible adult whose household income is not greater than 150% of the Federal poverty level, no monthly premium.

(2) For an eligible adult whose household income is greater than 150% but not greater than 175% of the Federal poverty level, a monthly premium of $40.

(3) For an eligible adult whose household income is greater than 175% but not greater than 200% of the Federal poverty level, a monthly premium of $50.

(4) For an eligible adult whose household income is greater than 200%, a monthly premium may be established based upon Federal requirements and in accordance with Federal waivers, if applicable, by the commissioner.

(c) Other eligible adults.--An eligible adult whose household income is greater than 200% of the Federal poverty level may purchase under the program either the benefit package under section 1313 or other qualifying health care coverage at the per-member, per-month premium cost.

(d) Individuals.--For an individual whose household income is greater than 300% of the Federal poverty level, an individual may purchase the benefit package under section 1313 at the per-member, per-month premium cost as long as the individual demonstrates, on an annual basis and in a manner determined by the department, either one of the following:

(1) The individual is unable to afford individual or group coverage because that coverage would exceed 10% of the individual's household income or because the total cost of

coverage for the individual is 150% of the premium cost established under this section for that service area.

(2) The individual has been refused coverage by an insurer because the individual or a member of that individual's immediate family has a preexisting condition and coverage is not available to the individual.

(e) Establishing premiums.--For each fiscal year beginning after June 30, 2009, the department may adjust the premium amounts under subsection (b) to reflect changes in the cost of medical services and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(f) Purchase of health benefit plan.--An eligible adult's or individual's payment to the department or its contractor under subsection (b) shall be used to purchase the benefit health plan established under section 1313 and must be remitted in a timely manner.

(g) Subsidy.--Funding for the program shall be used by the department to pay the difference between the total monthly cost of the health benefit plan and the eligible adult's premium. Subsidization of the health benefit plan is contingent upon the amount of the funding for the program and is limited to eligible adults in compliance with this section.

Section 1306. Participation by eligible employers and eligible employees.

(a) Eligible employers.--An eligible employer that seeks to participate in the program shall:

(1) Offer to all eligible employees the opportunity to participate in the program and enroll at least one-half of the eligible employees.

1 (2) Comply with the application process established by
2 the department or its contractor.
3 (3) Remit to the department or its contractor any
4 premium amounts required under subsections (c) and (d).
5 (4) Allow health insurance premiums to be paid by
6 eligible employees on a pretax basis and inform its employees
7 of the availability of such program.
8 (5) Notify the department or its contractor of any
9 change in the eligible employee's income.
10 (b) Eligible employees.--An eligible employee who seeks to
11 participate with an eligible employer under the program must:
12 (1) Submit an application with the eligible employer to
13 the department or its contractor.
14 (2) Be responsible for any required copayments for
15 health care services rendered under the health benefit plan
16 in section 1313.
17 (c) Premiums for employers.--
18 (1) In addition to remitting the eligible employee
19 portion under subsections (a) and (d), an eligible employer
20 shall pay the employer share of the total monthly cost for
21 each participating employee to the department or its
22 contractor each month.
23 (2) In addition to remitting the eligible employee
24 portion under paragraph (1), an eligible employer's premium
25 payment to the department or its contractor shall be at least
26 50% of the total monthly cost for each eligible employee but
27 not less than $150.
28 (d) Premiums for eligible employees.--The premium for
29 eligible employees shall be the same as the premium required to
30 be paid by eligible adults under section 1305(b).

1 (e) Purchase by certain eligible employees.--An eligible
2 employee whose household income is greater than 200% of the
3 Federal poverty level may purchase either the benefit package
4 under section 1313 or other qualifying health care coverage
5 under section 1307 at the per-member, per-month premium cost
6 minus any amount remitted by the employer under subsection (c).
7 (f) Publishing premium amounts.--For each fiscal year
8 beginning after June 30, 2009, the department may establish
9 different premium amounts for eligible employees and eligible
10 employers as required under this section and shall forward
11 notice of the new premium amounts to the Legislative Reference
12 Bureau for publication as a notice in the Pennsylvania Bulletin.
13 (g) Purchase of coverage.--A premium payment made by an
14 eligible employer to the department or its contractor shall be
15 used to purchase the health benefit plan and must be remitted in
16 a timely manner.
17 (h) Alternative coverage.--
18 (1) Notwithstanding any other provision of law to the
19 contrary, employer-based coverage may, in the commissioner's
20 sole discretion, be purchased in place of participation in
21 the program or may be purchased in conjunction with any
22 portion of the program provided outside the scope of the
23 program contracts by the Commonwealth paying the employee's
24 share of the premium to the employer if it is more cost
25 effective for the Commonwealth to purchase health care
26 coverage from an employee's employer-based program than to
27 pay the Commonwealth's share of a subsidized premium.
28 (2) This section shall apply to any employer-based
29 program, whether individual or family, such that if the
30 Commonwealth's share for the employee plus its share for any

spouse under the program or children under the children's health insurance program is greater than the employee's premium share for family coverage under the employer-based program, the Commonwealth may choose to pay the latter alone or in combination with providing any benefit the Commonwealth does not provide through its program contracts.

(i) Termination of employment.--An eligible employee who is terminated from employment shall be eligible to continue participating in the program if the eligible employee continues to meet the requirements as an eligible adult and pays any increased premium required.

Section 1307. Health savings accounts.

The department shall permit the establishment of health savings accounts that are actuarially equivalent to the benefits in section 1313 for employees who enroll in the program. Health savings accounts established under the program shall meet the requirements as defined in section 223(d) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(d)).

Section 1308. Continuing Access with Relief for Employers (CARE) grants.

(a) General rule.--A Continuing Access with Relief for Employers (CARE) grant shall be provided to employers that meet the requirements of this section.

(b) Eligibility.--An employer is eligible to receive a CARE grant if that employer meets the following:

(1) has maintained coverage for at least 12 consecutive months prior to the effective date of this act; or

(2) (i) has maintained coverage for at least 12 consecutive months prior to applying for the CARE grant;

(ii) has incurred a health care expense in this

Commonwealth; and

(iii) has a tax liability for the year in which application is made for the CARE grant.

(c) Application.--Beginning July 1, 2009, and for each year thereafter, an employer seeking to receive a CARE grant shall submit an application to the department containing, at a minimum, the following information:

(1) A statement of the aggregate health care expense made by the employer to provide coverage during the previous 12 consecutive months to employees.

(2) The names, addresses and Social Security numbers of the employees provided health care coverage under paragraph (1) and whether that health care coverage is for the employee or the employee and the employee's spouse and/or dependents.

(3) The names and addresses of the insurance carriers or underwriters that received payment from the employer for the health care coverage provided under paragraph (2).

(d) Computation.--An employer who qualifies under subsection (b) shall receive a grant limited to actual employer health care expenses paid for the previous 12 consecutive months in accordance with the following:

(1) No greater than 25% of the employer's health care expense to maintain health care coverage for the employee.

(2) No greater than 50% of the employer's health care expense to maintain health care coverage for the employee, the employee's spouse and/or dependents.

(3) The total amount of paragraphs (1) and (2) shall not exceed the tax liability owed by the employer for the year application is made for the CARE grant.

(4) If no tax liability is owed by the employer then the

1 employer may not apply for a CARE grant.
2 (e) Duties of department.--The department has the following
3 duties:
4 (1) Administer the program.
5 (2) In consultation with other appropriate Commonwealth
6 agencies:
7 (i) Develop an application for the collection of
8 information that is consistent with the requirements of
9 this section and that contains any other information that
10 may be necessary to award CARE grants.
11 (ii) Develop a process to determine the validity of
12 information collected by the department from the
13 application with information filed by the employer, the
14 employee or insurers with any other agency. This process
15 shall include guaranteeing confidentiality of employer
16 and employee information that is consistent with Federal
17 and State laws.
18 (f) Coordination.--The department shall coordinate with
19 other departments in the implementation of this section.
20 (g) Limitation on grants.--The total amount of grants
21 approved by the department shall not exceed the amount of
22 funding designated under section 762. Any application filed by
23 an employer when funding is not available shall not be
24 considered and cannot be carried forward for consideration in
25 any succeeding fiscal year.
26 (h) Lapse.--Funds not used by the department for CARE grants
27 at the end of the fiscal year shall lapse back to the Health
28 Care Provider Retention Account and be designated to the PA ABC
29 Program.
30 (i) Report to General Assembly.--The department shall submit

an annual report to the General Assembly indicating the effectiveness of the program provided under this section no later than March 15, 2010. The report shall include the names of all the employers that received a CARE grant as of the date of the report and the amount of each CARE grant approved. The report may also include any recommendations for changes in the calculation or administration of the CARE grant.

(j) Sunset.--This section shall sunset January 1, 2018.

(k) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"CARE grant." A Continuing Access with Relief for Employers (CARE) grant provided by the Department of Community and Economic Development.

"Coverage." Health care coverage that is maintained by an employer for an employee, the employee's spouse and/or dependents for 12 consecutive months.

"Department." The Department of Community and Economic Development of the Commonwealth.

"Employee." An individual who meets the following:

(1) Is employed for more than 20 hours in a single week and from whose wages an employer is required under the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. §1 et seq.) to withhold Federal income tax.

(2) Is at least 19 years of age but no older than 64 years of age.

(3) Legally resides within the United States.

(4) Has been domiciled in this Commonwealth for at least 90 days prior to enrollment.

(5) Has a household income that is no greater than 300%

of the Federal poverty level at the time of application.

"Employer." An employer that meets all of the following:

(1) Has at least two, but not more than 50 full-time equivalent employees.

(2) Pays an average annual wage that is not greater than 300% of the Federal poverty limit for an individual.

"Health care coverage." A health benefit plan or other form of health care coverage that is approved by the Department of Community and Economic Development in consultation with the Insurance Department. The term does not include coverage under the PA ABC program.

"Health care expense." A payment made by an employer to maintain health care coverage for an employee, the employee's spouse and/or dependents.

"Program." The Continuing Access with Relief for Employers (CARE) Grant Program established under this section.

"Tax liability." Liability under Article III, IV or VI of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

Section 1309. Program requirements.

(a) Rates.--Rates for the program shall be approved annually by the department and may vary by region and contractor. Rates shall be based on an actuarially sound and adequate review.

(b) Annual premiums review.--Premiums for the program shall be established annually by the department.

(c) Use of funding.--Funding shall be used by the department to pay the difference between the total monthly cost of the health benefit plan and the premium payments by the eligible employee, the eligible employer or the eligible adult.

(d) Monthly increases.--With respect to a continuous period

of eligibility for an eligible employer to apply for participation in the program and in addition to the requirements of section 1306(d), an eligible employer shall be subject to a 1% increase in the base premium for each month after the latter of the following:

(1) twelve months from the date of the effective date of this section; or

(2) twelve months from the date the eligible employer files for a Federal or State tax identification number.

(e) Funding contingency for subsidization.--Subsidization of premiums paid under sections 1305 and 1306 is contingent upon the amount of the funding available to the program, the Federal poverty levels approved by the Federal waiver or State plan amendments granted under section 1317 and is limited to eligible adults and eligible employees who are in compliance with the requirements under this chapter.

(f) Limit on subsidy.--At no time shall the subsidy paid by the Commonwealth from funds other than Federal moneys for the premium of eligible employees be more than 40% of the total cost of the health benefit plan purchased in each region or with each contractor.

Section 1310. Duties of department.

The department has the following duties:

(1) Administer the program on a Statewide basis.

(2) Solicit bids or proposals and award contracts as follows:

(i) The department shall solicit bids or proposals and award contracts for the basic benefit package under section 1313 through a competitive procurement process in accordance with 62 Pa.C.S. (relating to procurement) and

1 subsection (g). The department may award contracts on a
2 multiple-award basis as described in 62 Pa.C.S. § 517
3 (relating to multiple awards).
4 (ii) (A) In order to effectuate the program
5 promptly upon receipt of all applicable waivers and
6 approvals from the Federal Government, the department
7 may amend such contracts as currently exist to
8 provide benefits under either the AdultBasic Program
9 or the Public Welfare Code, or may otherwise procure
10 services outside of the competitive procurement
11 process of 62 Pa.C.S.
12 (B) This subparagraph shall expire at such time
13 as there are effective contracts awarded under this
14 section in every county of this Commonwealth, but not
15 later than 18 months after the effective date of this
16 section.
17 (3) Subject to Federal requirements, impose reasonable
18 cost-sharing arrangements and encourage appropriate use by
19 contractors of cost-effective health care providers who will
20 provide quality health care by establishing and adjusting
21 copayments to be incorporated into the program by
22 contractors. The department shall forward changes of
23 copayments to the Legislative Reference Bureau for
24 publication as notices in the Pennsylvania Bulletin. The
25 changes shall be implemented by contractors as soon as
26 practicable following publication, but in no event more than
27 120 days following publication.
28 (4) In consultation with other appropriate Commonwealth
29 agencies, conduct monitoring and oversight of contracts
30 entered into with contractors.

1 (5) In consultation with other appropriate Commonwealth
2 agencies, monitor, review and evaluate the adequacy,
3 accessibility and availability of services delivered to
4 eligible adults or eligible employees.
5 (6) In consultation with other appropriate Commonwealth
6 agencies, establish and coordinate the development,
7 implementation and supervision of an outreach plan to ensure
8 that all those who may be eligible are aware of the program.
9 The outreach plan shall include provisions for:
10 (i) Reaching special populations, including nonwhite
11 and non-English speaking individuals and individuals with
12 disabilities.
13 (ii) Reaching different geographic areas, including
14 rural and inner-city areas.
15 (iii) Assuring that special efforts are coordinated
16 within the overall outreach activities throughout this
17 Commonwealth.
18 (7) At the request of an eligible adult, eligible
19 employee or eligible employer, facilitate the payment on a
20 pretax basis of premiums:
21 (i) for the program and dependents covered under the
22 program; or
23 (ii) if applicable, for the children's health
24 insurance program.
25 (8) Establish penalties for eligible adults, eligible
26 employees or eligible employers who enroll in the program,
27 drop enrollment and subsequently re-enroll for the purpose of
28 avoiding the ongoing payment of premiums. The commissioner
29 shall forward notice of these penalties to the Legislative
30 Reference Bureau for publication as a notice in the

Pennsylvania Bulletin.

(9) Coordinate with the Department of Public Welfare in the implementation of this chapter and may designate the Department of Public Welfare to perform any duties that are appropriate under this chapter.

Section 1311. Submission of proposals and award of contracts.

(a) Corporations required to submit.--Each professional health services plan corporation and hospital plan corporation and their subsidiaries and affiliates doing business in this Commonwealth shall submit a bid or proposal to the department to carry out the purposes of this section in the geographic area serviced by the corporation. All other insurers may submit a bid or proposal to the department to carry out the purposes of this section.

(b) Review and scoring of bids or proposals.--The department shall review and score the bids or proposals on the basis of all the requirements for the program. The department may include other criteria in the solicitation and in the scoring and selection of the bids or proposals that the department, in the exercise of its duties under section 1310, deems necessary. The department shall do all of the following:

(1) Select, to the greatest extent practicable, offerors that contract with health care providers to provide health care services on a cost-effective basis. The department shall select offerors that use appropriate cost-management methods, including the chronic care and prevention measures, which will enable the program to provide coverage to the maximum number of enrollees.

(2) Select, to the greatest extent practicable, only offerors that comply with all procedures relating to

coordination of benefits as required by the department and the Department of Public Welfare.

(c) Contract terms.--Contracts may be for an initial term of up to five years, with options to extend for five one-year periods.

(d) Duties of contractors.--A contractor that contracts with the department to provide a health benefit plan to eligible adults or eligible employees:

(1) Shall process claims for the coverage.

(2) May not deny coverage to an eligible adult or eligible employee who has been approved by the department to participate in the program.

Section 1312. Rates and charges.

(a) Medical loss ratio.--The medical loss ratio for a contract shall be not less than 85%.

(b) Limitation on fees.--No eligible adult or eligible employee shall be charged a fee, other than those specified in this chapter, as a requirement for participating in the program.

Section 1313. Health benefit plan.

(a) Benefits.--The health benefit plan to be offered under the program shall be of the scope and duration as the department determines and shall provide for all of the following, which may be as limited or unlimited as the department may determine:

(1) Preliminary and annual health assessments.

(2) Emergency care.

(3) Inpatient and outpatient care.

(4) Prescription drugs, medical supplies and equipment.

(5) Emergency dental care.

(6) Maternity care.

(7) Skilled nursing.

(8) Home health and hospice care.

(9) Chronic disease management.

(10) Preventive and wellness care.

(11) Inpatient and outpatient behavioral health services.

(b) Commonwealth election.--The Commonwealth may elect to provide any benefit independently and outside the scope of the program contracts.

(c) Enrollment.--Enrollment in the program may not be prohibited based upon a preexisting condition, nor may a program health benefit plan exclude a diagnosis or treatment for a condition based upon its preexistence.

(d) Copayments.--The department may establish a copayment for any of the services provided in the health benefit plan as long as the copayment meets any Federal requirements under section 1317. The department shall forward notice of the copayment amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

Section 1314. Data matching.

(a) Covered individuals.--All entities providing health insurance or health care coverage within this Commonwealth shall, not less frequently than once every month, provide the names, identifying information and any additional information on coverage and benefits as the department may specify for all individuals for whom the entities provide insurance or coverage.

(b) Use of information.--

(1) The department shall use information obtained in subsection (a) to determine whether any portion of an eligible adult's, eligible employee's or eligible employer's premium is being paid from any other source and to determine

whether another entity has primary liability for any health care claims paid under any program administered by the department.

(2) If a determination is made that an eligible adult's, eligible employee's or eligible employer's premium is being paid from another source, the department may not make any additional payments to the insurer for the eligible adult, eligible employee or eligible employer.

(c) Excess payment.--If a payment has been made to an insurer by the department for an eligible adult, eligible employee or eligible employer for whom any portion of the premium paid by the department is being paid from another source, the insurer shall reimburse the department the amount of any excess payment or payments.

(d) Reimbursement.--The department may seek reimbursement from an entity that provides health insurance or health care coverage that is primary to the coverage provided under any program administered by the department.

(e) Timeliness.--To the maximum extent permitted by law and notwithstanding any policy or plan provision to the contrary, a claim by the department for reimbursement under subsection (c) or (d) shall be deemed timely filed if it is filed with the insurer or entity within three years following the date of payment.

(f) Agreements.--The department may enter into agreements with entities that provide health insurance and health care coverage for the purpose of carrying out the provisions of this section. The agreements shall provide for the electronic exchange of data between the parties at a mutually agreed upon frequency, but not less than monthly, and may also allow for

payment of a fee by the department to the entity providing
health insurance or health care coverage.

(g) Other coverage.--

(1) The department shall determine whether any other health care coverage is available to an eligible adult, eligible employee or eligible employer through an alimony agreement or an employment-related or other group basis.

(2) If other health care coverage is available, the department shall reevaluate the enrollee's eligibility under this chapter.

(h) Penalty.--

(1) The department may impose a penalty of up to $1,000 per violation on any insurer that fails to comply with the obligations imposed by this chapter.

(2) All moneys collected under this subsection shall be deposited into the fund.

Section 1315. Entitlements and claims.

Nothing in this chapter shall be construed as an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth. The Department of Public Welfare, in conjunction with the department, shall establish a waiting list and State plan amendments and revisions to Federal waivers as are necessary to ensure that expenditures in the program do not exceed available funding.

Section 1316. Regulations.

The department may promulgate regulations for the implementation and administration of this chapter.

Section 1317. Federal waivers.

(1) The Department of Public Welfare, in cooperation with the department, shall apply for all applicable waivers

1 from the Federal Government and shall seek approval to amend
2 the State plan as necessary to carry out the provisions of
3 this chapter.
4 (2) If the Department of Public Welfare receives
5 approval of a waiver or approval of a State plan amendment as
6 required by this section, it shall notify the department and
7 transmit notice of the waiver or State plan amendment
8 approvals to the Legislative Reference Bureau for publication
9 as a notice in the Pennsylvania Bulletin.
10 (3) The department may change the benefits under section
11 1313 and the premium and copayment amounts payable under
12 sections 1305 and 1306 and eligibility requirements in order
13 for the program to meet Federal requirements.
14 Section 1318. Federal funds.
15 Notwithstanding any other provision of law, the Department of
16 Public Welfare, in cooperation with the department, shall take
17 any action necessary to do all of the following:
18 (1) Ensure the receipt of Federal financial
19 participation under Title XIX of the Social Security Act (49
20 Stat. 620, 42 U.S.C. § 1396 et seq.) for coverage and for
21 services provided under this chapter.
22 (2) Qualify for available Federal financial
23 participation under Title XIX of the Social Security Act.
24 Section 12. The Insurance Department shall publish a notice
25 in the Pennsylvania Bulletin when a law is enacted that provides
26 for or designates at least $120,000,000 for the Supplemental
27 Assistance and Funding Account.
28 Section 13. Repeals are as follows:
29 (1) The General Assembly declares that the repeal under
30 paragraph (2) is necessary to effectuate this act.

1 (2) Chapter 13 of the act of June 26, 2001 (P.L.755,
2 No.77), known as the Tobacco Settlement Act.
3 (3) All other acts and parts of acts are repealed
4 insofar as they are inconsistent with this act.
5 Section 14. The amendment of section 712(e) of the act shall
6 apply retroactively to December 31, 2007.
7 Section 15. This act shall take effect as follows:
8 (1) The following provisions shall take effect July 1,
9 2008, or immediately, whichever is later:
10 (i) The amendment of section 712(e) and (m) of the
11 act.
12 (ii) The amendment of the definition of "health care
13 provider" in section 1101 of the act.
14 (iii) The amendment of section 1112 of the act.
15 (iv) Section 12 of this act.
16 (2) The remainder of this act shall take effect upon
17 publication of the notice specified under section 12 of this
18 act.