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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2497 Session of 2008

INTRODUCED BY D. EVANS, MAY 8, 2008

REFERRED TO COMMITTEE ON HEALTH AND HUMAN SERVICES, MAY 8, 2008

AN ACT

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," further providing for medical assistance payments for institutional care and for additional services for eligible persons other than the medically needy; providing for payments for readmissions to a hospital paid through diagnosis-related groups and for maximum payment to practitioners for inpatient hospitalization; further providing for time periods; providing for hospital assessments; further providing for third-party liability and for data matching; and providing for Federal law recovery of medical assistance reimbursement.

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

Section 1. Section 443.1(7) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, is amended by adding a subclause to read:

Section 443.1. Medical Assistance Payments for Institutional Care.--The following medical assistance payments shall be made in behalf of eligible persons whose institutional care is prescribed by physicians:

* * *

(7) After June 30, 2007, payments to county and nonpublic

nursing facilities enrolled in the medical assistance program as providers of nursing facility services shall be determined in accordance with the methodologies for establishing payment rates for county and nonpublic nursing facilities specified in the department's regulations and the Commonwealth's approved Title XIX State Plan for nursing facility services in effect after June 30, 2007. The following shall apply:

* * *

(i.1) During the period of July 1, 2008, through June 30, 2011, the department shall apply a revenue adjustment neutrality factor and make adjustments to county and nonpublic nursing facility payment rates for medical assistance nursing facility services in each fiscal year. The revenue adjustment neutrality factor for each fiscal year shall limit the estimated Statewide day-weighted average payment rate for that fiscal year so that the aggregate increase in the Statewide day-weighted average payment rate over the period commencing July 1, 2005, and ending June 30 of the fiscal year in which the factor is applied does not exceed the percentage rate of increase permitted by the funds appropriated for nursing facility services in the General Appropriations Acts for those fiscal years. Application of the revenue adjustment neutrality factor shall be subject to Federal approval of any amendments as may be necessary to the Commonwealth's approved Title XIX State Plan for nursing facility services.

* * *

Section 2. Section 443.4 of the act, amended November 28, 1973 (P.L.364, No.128), is amended to read:

Section 443.4. Additional Services for Eligible Persons [Other Than the Medically Needy].--[Except for the medically

needy, persons] Persons eligible for medical assistance may, pursuant to regulations of the department, also receive dental services, vision care provided by a physician skilled in diseases of the eye or by an optometrist, prescribed medications, prosthetics and appliances, ambulance transportation, skilled nursing home care for an unlimited period of time, and other remedial, palliative or therapeutic services prescribed by or provided under the direction of a physician or podiatrist.

Section 3. The act is amended by adding sections to read:

Section 443.9. Payments for Readmission to a Hospital Paid Through Diagnosis-Related Groups.--All of the following shall apply to eligible recipients readmitted to a hospital within fourteen days of the date of discharge:

(1) If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the department shall make no payment in addition to the hospital's original diagnosis-related group payment. If the combined hospital stay qualifies as an outlier, as set forth under the department's regulations, an outlier payment shall be made.

(2) If the readmission is due to complications of the original diagnosis and the result is a different diagnosis-related group with a higher payment, the department shall pay the higher diagnosis-related group payment rather than the original diagnosis-related group payment.

(3) If the readmission is due to conditions unrelated to the previous admission, the department shall consider the readmission as a new admission for payment purposes.

Section 443.10. Maximum Payment to Practitioners for

Inpatient Hospitalization.--The maximum payment made to a practitioner for all services provided to an eligible recipient during any one period of inpatient hospitalization shall be the lowest of the following:

(1) The practitioner's usual charge to the general public for the same service.

(2) The medical assistance maximum allowable fee for the service.

(3) A maximum payment limit, per recipient per the period of inpatient hospitalization, established by the medical assistance program and published as a notice in the Pennsylvania Bulletin. If the fee for the actual service exceeds the maximum payment limit, the fee for the actual procedure shall be the maximum payment for the period of inpatient hospitalization.

Section 4. Section 811-B of the act, added July 4, 2004 (P.L.528, No.69), is amended to read:

Section 811-B. Time periods.

The assessment authorized in this article shall not be imposed or paid prior to July 1, 2004, or in the absence of Federal financial participation as described in section 803-B. The assessment shall cease on June 30, [2008] 2013, or earlier if required by law.

Section 5. Section 811-C of the act, amended November 29, 2004 (P.L.1272, No.154), is amended to read:

Section 811-C. Time periods.

[The assessment authorized in this article shall not be imposed prior to July 1, 2003, for private ICFs/MR and July 1, 2004, for public ICFs/MR and shall cease on June 30, 2009, or earlier if required by law.]

(a) Imposition.--The assessment authorized under this

article shall not be imposed as follows:

(1) Prior to July 1, 2003, for private ICFs/MR.

(2) Prior to July 1, 2004, for public ICFs/MR.

(3) In the absence of Federal financial participation as described under section 803-C.

(b) Cessation.--The assessment authorized under this article shall cease June 30, 2013, or earlier, if required by law.

Section 6. The act is amended by adding an article to read:

ARTICLE VIII-E

HOSPITAL ASSESSMENTS

Section 801-E. Definitions.

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

"Assessment." The fee authorized to be implemented under this article on every general acute care hospital within a municipality.

"Exempt hospital." A hospital that the Secretary of Public Welfare has determined meets one of the following:

(1) Is excluded under 42 C.F.R. § 412.23(a), (b), (d) and (f) (relating to excluded hospitals: classification) as of March 20, 2008, from reimbursement of certain Federal funds under the prospective payment system.

(2) Is a Federal veterans' affairs hospital.

(3) Provides care, including inpatient hospital services, to all patients free of charge.

"General acute care hospital." A hospital other than an exempt hospital.

"Hospital." A facility licensed as a hospital under 28 Pa. Code Pt. IV Subpt. B (relating to general and special hospitals)

and located within a municipality.

"Municipality." A city of the first class.

"Net operating revenue." Gross charges for facilities less any deducted amounts for bad debts, charity care and payer discounts as those terms are applied under 42 C.F.R. § 433.68(d)(1)(iii) (relating to permissible health care-related taxes after the transition period).

"Program." The Commonwealth's medical assistance program as authorized under Article IV.

Section 802-E. Authorization.

In order to generate additional revenues for the purpose of assuring that medical assistance recipients have access to hospital services, and that all citizens have access to emergency department services, a municipality may, by ordinance, impose a monetary assessment on the net operating revenue of each general acute care hospital located in the municipality subject to the conditions and requirements specified under this article. The ordinance may include appropriate administrative provisions including, without limitation, provisions for the collection of interest and penalties. In each year in which the assessment is implemented, the assessment shall be subject to the maximum aggregate amount that may be assessed under 42 CFR § 433.68(f)(3)(i) (relating to permissible health care-related taxes after the transition period) or any other maximum established under Federal law.

Section 803-E. Implementation.

The assessment authorized under this article, once imposed, shall be implemented as a health-care related fee as defined under section 1903(w)(3)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and

may be collected only to the extent and for the periods that the secretary determines that revenues generated by the assessment will qualify as the State share of program expenditures eligible for Federal financial participation.

Section 804-E. Administration.

(a) Remittance.--Upon collection of the funds generated by the assessment authorized under this article, the municipality shall remit a portion of the funds to the Commonwealth for the purposes set forth under section 802-E, except that the municipality may retain funds in an amount necessary to reimburse it for its reasonable costs in the administration and collection of the assessment as set forth in an agreement to be entered into between the municipality and the Commonwealth acting through the secretary.

(b) Establishment.--There is established a restricted account in the General Fund for the receipt and deposit of funds under subsection (a). Funds in the account are hereby appropriated to the department for purposes of making supplemental or increased medical assistance payments for emergency department services to general acute care hospitals within the municipality and to maintain or increase other medical assistance payments to general acute care hospitals within the municipality.

Section 805-E. No hold harmless.

No general acute care hospital shall be directly guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissible health care-related taxes after the transition period), except that in each fiscal year in which an assessment is implemented, the department shall use a portion of the funds received under section 804-E(a) for the purposes

outlined under section 804-E(b) to the extent permissible under Federal and State law or regulation and without creating an indirect guarantee to hold harmless, as those terms are used under 42 CFR 433.68(f)(i). The secretary shall submit any State Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to make the payments authorized under section 804-E(b).

Section 806-E. Federal waiver.

To the extent necessary in order to implement this article, the department shall seek a waiver under 42 CFR 433.68(e) (relating to permissible health care-related taxes after the transition period) from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

Section 807-E. Tax exemption.

Notwithstanding any exemptions granted by any other Federal, State or local tax or other law, including section 204(a)(3) of the act of May 22, 1933 (P.L.853, No.155), known as The General County Assessment Law, no general acute care hospital in the municipality shall be exempt from the assessment.

Section 7. Section 1409 of the act, amended or added July 10, 1980 (P.L.493, No.105), June 16, 1994 (P.L.319, No.49) and July 7, 2005 (P.L.177, No.42), is amended to read:

Section 1409. Third Party Liability.--(a) (1) No person having private health care coverage shall be entitled to receive the same health care furnished or paid for by a publicly funded health care program. For the purposes of this section, "publicly funded health care program" shall mean care for services rendered by a State or local government or any facility thereof, health care services for which payment is made under the medical

assistance program established by the department or by its fiscal intermediary, or by an insurer or organization with which the department has contracted to furnish such services or to pay providers who furnish such services. For the purposes of this section, "privately funded health care" means medical care coverage contained in accident and health insurance policies or subscriber contracts issued by health plan corporations and nonprofit health service plans, certificates issued by fraternal benefit societies, and also any medical care benefits provided by self insurance plan including self insurance trust, as outlined in Pennsylvania insurance laws and related statutes.

(2) If such a person receives health care furnished or paid for by a publicly funded health care program, the insurer of his private health care coverage shall reimburse the publicly funded health care program, the cost incurred in rendering such care to the extent of the benefits provided under the terms of the policy for the services rendered.

(3) Each publicly funded health care program that furnishes or pays for health care services to a recipient having private health care coverage shall be entitled to be subrogated to the rights that such person has against the insurer of such coverage to the extent of the health care services rendered. Such action may be brought within five years from the date that service was rendered such person.

(4) When health care services are provided to a person under this section who at the time the service is provided has any other contractual or legal entitlement to such services, the secretary of the department shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person

entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, health service plan or fraternal society owing such entitlement in the appropriate court in the name of the secretary of the department.

(5) The Commonwealth of Pennsylvania shall not reimburse any local government or any facility thereof, under medical assistance or under any other health program where the Commonwealth pays part or all of the costs, for care provided to a person covered under any disability insurance, health insurance or prepaid health plan.

(6) In local programs fully or partially funded by the Commonwealth, Commonwealth participation shall be reduced in the amount proportionate to the cost of services provided to a person.

(7) When health care services are provided to a dependent of a legally responsible relative, including but not limited to a spouse or a parent of an unemancipated child, such legally responsible relative shall be liable for the cost of health care services furnished to the individual on whose behalf the duty of support is owed. The department shall have the right to recover from such legally responsible relative the charges for such services furnished under the medical assistance program.

(b) (1) When benefits are provided or will be provided to a beneficiary under this section because of an injury for which another person is liable, or for which an insurer is liable in accordance with the provisions of any policy of insurance issued pursuant to Pennsylvania insurance laws and related statutes the

department shall have the right to recover from such person or insurer the reasonable value of benefits so provided. The Attorney General or his designee may, at the request of the department, to enforce such right, institute and prosecute legal proceedings against the third person or insurer who may be liable for the injury in an appropriate court, either in the name of the department or in the name of the injured person, his guardian, personal representative, estate or survivors.

(2) The department may:

(i) compromise, or settle and release any such claims; or

(ii) waive any such claim, in whole or in part, or if the department determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(3) No action taken in behalf of the department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, personal representative, estate, dependents or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(4) Where an action is brought by the department pursuant to this section, it shall be commenced within five years of the date [the cause of action arises] <u>the department receives notice that a third party may be liable for the beneficiary's injuries</u>:

(i) The death of the beneficiary does not abate any right of action established by this section.

(ii) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third

party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the department's claims for reimbursement of the benefits provided to the beneficiary under the medical assistance program.

(iii) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the department's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the services to the beneficiary.

(iv) For the purposes of any statute of limitation or statute of repose, the time during which the department may commence an action shall be tolled during the minority of the beneficiary.

(5) If either the beneficiary or the department brings an action or claim against such third party or insurer, the beneficiary or the department shall within thirty days of filing the action give to the other written notice by personal service, or certified or registered mail of the action or claim. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the department or beneficiary, the other may, at any time before trial on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently. The beneficiary shall include as part of his claim the amount of benefits that have been or will be provided by the medical assistance program, unless the department brings an action or intervenes in an action brought by the beneficiary.

(6) If an action or claim is brought by the department pursuant to subsection (a), written notice to the beneficiary,

guardian, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to recover the reasonable value of the benefits provided.

(7) [In] Except as provided under section 1409.1, in the event of judgment, award or settlement in a suit or claim against such third party or insurer:

(i) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of such expenses and attorney's fees the court or agency shall, on the application of the department, allow as a first lien against the amount of such judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(ii) If the action or claim is prosecuted both by the beneficiary and the department, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of such expenses and attorney's fees, the court or agency shall apply out of the balance of such judgment or award an amount of benefits paid on behalf of the beneficiary under the medical assistance program reduced by the department's pro rata share of attorney fees and costs in an amount not to exceed twenty-five percent of the department's claim.

(iii) With respect to claims against third parties for the cost of medical assistance services delivered through a managed care organization contract, the department shall recover the actual payment to the hospital or other medical provider for the service. If no specific payment is identified by the managed care organization for the service, the department shall recover its fee schedule amount for the service.

(8) [Upon] Except as provided under section 1409.1, upon application of the department, the court or agency shall allow a lien against any third party payment or trust fund resulting from a judgment, award or settlement in the amount of any expenditures in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the medical assistance program, when such benefits were provided or became payable subsequent to the date of the judgment, award or settlement.

(9) Unless otherwise directed by the department, no payment or distribution shall be made to a claimant or a claimant's designee of the proceeds of any action, claim or settlement where the department has an interest without first satisfying or assuring satisfaction of the interest of the Commonwealth. Any person who, after receiving notice of the department's interest, knowingly fails to comply with the obligations established under this clause shall be liable to the department, and the department may sue to recover from the person.

(10) When the department has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the medical assistance program, the department shall be entitled to a writ of execution as lien claimant to

enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the department shall be entitled to a writ of execution against such beneficiary to the extent of the department's lien, with interest and other accruing costs as in the cost of other executions.

(11) Except as otherwise provided in this act, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the department's claim for reimbursement of the benefits provided any lien filed pursuant thereto, but in no event shall the department's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

(12) In the event that the beneficiary, his guardian, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this act shall be given to the secretary (or his designee) in Harrisburg except in cases where the secretary specifies that notice shall be given to the Attorney General. <u>Notice of settlement shall be provided by the beneficiary at least thirty days before the settlement becomes legally binding upon the parties.</u> All such notices shall be given by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, personal representative, estate or survivors, if no attorney is retained.

(13) The following special definitions apply to this subsection [(b)]:

"Beneficiary" means any person, including a minor, who has received benefits or will be provided benefits under this act because of an injury for which another person may be liable. It includes such beneficiary's guardian, conservator, or other personal representative, his estate or survivors.

"Insurer" includes any insurer as defined in the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," including any insurer authorized under the Laws of this Commonwealth to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement of coverage pursuant to the act of July 19, 1974 (P.L.489, No.176), known as the "Pennsylvania No-fault Motor Vehicle Insurance Act."

(c) (1) Following notice and hearing, the department may administratively impose a penalty of up to one thousand dollars ($1,000) per violation upon any person who wilfully fails to comply with the obligations imposed under this section.

(2) If a beneficiary fails to comply with the obligations imposed under this section, the resolution of any action or claim brought by the beneficiary, whether by verdict or settlement, shall not extinguish or in any way affect the department's claim. Notwithstanding the resolution, the department may bring an action under subsection (b)(1) within the period provided under subsection (b)(4) or five years from the date of the department's discovery of the verdict or

settlement, whichever is later. In any action by the department under subsection (b), a prior settlement for monetary damages by the defendant for an amount in excess of five thousand dollars ($5,000) with the injured beneficiary shall be deemed an admission of liability by the settling defendants, notwithstanding anything to the contrary in the settlement agreement, and the only issue shall be the department's damages.

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

Section 1409.1. Federal Law Recovery of Medical Assistance Reimbursement.--(a) To the extent that Federal law limits the department's recovery of medical assistance reimbursement to the medical portion of a beneficiary's judgment, award or settlement in a claim against a third party, the provisions of this section shall apply.

(b) In the event of judgment, award or settlement in a suit or claim against a third party or insurer:

(1) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of the action or claim, together with reasonable attorney fees. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall allow the department a first lien against the medical portion of the judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program reduced by the department's pro rata share of attorney fees and the costs, in an amount not to exceed twenty-five percent of the department's claim.

(2) If the action or claim is prosecuted both by the

beneficiary and the department, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney fees based solely on the services rendered for the benefit of the beneficiary. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall make an award to the department out of the medical portion of the judgment or award the amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(3) The department shall be given reasonable advance notice and an opportunity to participate before the court makes any allocation of a judgment or award under this section.

(c) Upon application of the department, the court or agency shall allow a lien against the medical portion of any third party payment or trust fund resulting from a judgment, award or settlement in the amount of any expenditures in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the medical assistance program, if the benefits were provided or became payable subsequent to the date of the judgment, award or settlement.

(d) No settlement of a claim in which the department has an interest shall be valid unless, prior to settling the claim, the parties jointly notify the department and attempt to determine by agreement with the department the portion of the settlement that is due the department as reimbursement for benefits provided. If a settlement conference or mediation session is held on such a claim by the court or under its auspices, the

department shall be notified and invited to participate. If no agreement on payment of its claim is reached with the department, the parties shall notify the department if they choose to settle the case without the department's agreement and subject to section 1409(c)(2). Within fifteen days of receipt of the notice, the department shall send written notice to the parties and the court indicating that no agreement with the department has been reached and that the department asserts a claim against the settlement. Within ten days of the date of issuance of the letter by the department, any party may either petition the court in which the action is pending for an allocation of the settlement or, if no action is pending, file a request for an allocation hearing with the department's Bureau of Hearings and Appeals. If no petition or request for hearing is filed, then the settlement amount shall, as a matter of law, include the entire amount of the department's claim up to the amount of the settlement.

Section 9. Section 1413 of the act, added July 7, 2005 (P.L.177, No.42), is amended to read:

Section 1413. Data Matching.--(a) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall provide such information on coverage and benefits, as the department may specify, for any recipient of medical assistance or child support services identified by the department by name and either policy number or Social Security number. The information the department may specify in its request may include information needed to determine during what period individuals or their spouses or their dependents may be or may have been covered by the entity and the nature of the coverage that is or was provided by the

entity, including the name, address and identifying number of the plan.

(b) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall accept the department's right of recovery and the assignment to the department of any right of an individual or any other entity to payment for an item or service for which payment has been made by the medical assistance program and shall receive, process and pay claims for reimbursement submitted by the department or its authorized contractor with respect to medical assistance recipients who have coverage for such claims.

(c) To the maximum extent permitted by Federal law and notwithstanding any policy or plan provision to the contrary, a claim by the department for reimbursement of medical assistance shall be deemed timely filed with the entity providing health insurance or health care coverage and shall not be denied solely on the basis of the date of submission of the claim, the type or format of the claim or a failure to present proper documentation at the point of sale that is the basis of the claim, if it is filed as follows:

(1) within five years of the date of service for all dates of service occurring on or before June 30, 2007; or

(2) within three years of the date of service for all dates of service occurring on or after July 1, 2007.

(c.1) Any action by the department to enforce its rights with respect to a claim submitted by the department under this section must be commenced within six years of the department's submission of the claim. All entities providing health care coverage within this Commonwealth shall respond within forty-five days to any inquiry by the department regarding a claim for

payment for any health care item or service that is submitted not later than three years after the date of provision of the health care item of service.

(d) The department is authorized to enter into agreements with entities providing health insurance and health care coverage for the purpose of carrying out the provisions of this section. The agreement shall provide for the electronic exchange of data between the parties at a mutually agreed-upon frequency, but no less frequently than [once every two months] monthly, and may also allow for payment of a fee by the department to the entity providing health insurance or health care coverage.

(e) Following notice and hearing, the department may impose a penalty of up to one thousand dollars ($1,000) per violation upon any entity that wilfully fails to comply with the obligations imposed by this section.

(e.1) It is a condition of doing business in this Commonwealth that every entity subject to this section comply with the provisions of this section and agree not to deny a claim submitted by the department on the basis of a plan or contract provision that is inconsistent with subsection (c).

(f) This section shall apply to every entity providing health insurance or health care coverage within this Commonwealth, including, but not limited to, plans, policies, contracts or certificates issued by:

(1) A stock insurance company incorporated for any of the purposes set forth in section 202(c) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) A mutual insurance company incorporated for any of the purposes set forth in section 202(d) of "The Insurance Company Law of 1921."

(3) A professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(4) A health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(5) A fraternal benefit society as defined in section 2403 of "The Insurance Company Law of 1921."

(6) A person who sells or issues contracts or certificates of insurance which meet the requirements of this act.

(7) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(8) Health care plans subject to the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829), self-insured plans, service benefit plans, managed care organizations, pharmacy benefit managers and every other organization that is, by statute, contract or agreement, legally responsible for the payment of a claim for a health care service or item to the maximum extent permitted by Federal law.

Section 10. This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) The addition of Article VIII-E of the act.

(ii) This section.

(2) The remainder of the act shall take effect in 60 days.