HOUSE AMENDED
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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1137 Session of 2007

INTRODUCED BY D. WHITE, RAFFERTY, PILEGGI, ORIE, SCARNATI, ROBBINS, ERICKSON, GORDNER, C. WILLIAMS, FONTANA, MADIGAN, ARMSTRONG, PIPPY, FERLO, WONDERLING, WAUGH, BAKER, REGOLA, BROWNE AND BOSCOLA, OCTOBER 23, 2007

AS AMENDED ON THIRD CONSIDERATION, HOUSE OF REPRESENTATIVES, MARCH 17, 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; providing for the Medical Care Availability and~~ <——
19 ~~Reduction of Error (Mcare) FOR PENNSYLVANIANS (MCAP) Reserve~~ <——
20 ~~Fund; and further providing for abatement program, for the~~ <——
21 ~~Health Care Provider Retention Account and for expiration;~~ <——
22 ~~AND PROVIDING FOR EXPIRATION OF CERTAIN SECTIONS.~~ FURTHER <——
23 PROVIDING FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE, FOR
24 THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND AND
25 FOR ACTUARIAL DATA; ESTABLISHING THE PENNSYLVANIA ACCESS TO
26 BASIC CARE (PA ABC) PROGRAM FUND AND THE CONTINUING ACCESS
27 WITH RELIEF FOR EMPLOYERS (CARE) FUND; FURTHER DEFINING
28 "HEALTH CARE PROVIDER"; FURTHER PROVIDING FOR THE HEALTH CARE
29 PROVIDER RETENTION PROGRAM; ESTABLISHING THE SUPPLEMENTAL

ASSISTANCE AND FUNDING ACCOUNT; FURTHER PROVIDING FOR EXPIRATION OF THE HEALTH CARE PROVIDER RETENTION PROGRAM; ESTABLISHING THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM; PROVIDING FOR CONTINUING ACCESS WITH RELIEF FOR EMPLOYERS (CARE) GRANTS, FOR HEALTH CARE COVERAGE FOR CERTAIN ADULTS, INDIVIDUALS, EMPLOYEES AND EMPLOYERS AND FOR EXPIRATION OF CERTAIN SECTIONS; AND REPEALING PROVISIONS OF THE TOBACCO SETTLEMENT ACT.

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

~~Section 1. Sections 711, 712 and 745 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, are amended to read:~~ <——

~~Section 711. Medical professional liability insurance.~~

~~(a) Requirement.--A health care provider providing health care services in this Commonwealth shall:~~

~~(1) purchase medical professional liability insurance from an insurer which is licensed or approved by the department; or~~

~~(2) provide self-insurance.~~

~~(b) Proof of insurance.--A health care provider required by subsection (a) to purchase medical professional liability insurance or provide self-insurance shall submit proof of insurance or self-insurance to the department within 60 days of the policy being issued.~~

~~(c) Failure to provide proof of insurance.--If a health care provider fails to submit the proof of insurance or self-insurance required by subsection (b), the department shall, after providing the health care provider with notice, notify the health care provider's licensing authority. A health care provider's license shall be suspended or revoked by its licensure board or agency if the health care provider fails to comply with any of the provisions of this chapter.~~

1 ~~(d) Basic coverage limits.--A health care provider shall~~
2 ~~insure or self-insure medical professional liability in~~
3 ~~accordance with the following:~~
4 ~~(1) For policies issued or renewed in the calendar year~~
5 ~~2002, the basic insurance coverage shall be:~~
6 ~~(i) $500,000 per occurrence or claim and $1,500,000~~
7 ~~per annual aggregate for a health care provider who~~
8 ~~conducts more than 50% of its health care business or~~
9 ~~practice within this Commonwealth and that is not a~~
10 ~~hospital.~~
11 ~~(ii) $500,000 per occurrence or claim and $1,500,000~~
12 ~~per annual aggregate for a health care provider who~~
13 ~~conducts 50% or less of its health care business or~~
14 ~~practice within this Commonwealth.~~
15 ~~(iii) $500,000 per occurrence or claim and~~
16 ~~$2,500,000 per annual aggregate for a hospital.~~
17 ~~(2) For policies issued or renewed in the calendar years~~
18 ~~2003, 2004 and 2005, the basic insurance coverage shall be:~~
19 ~~(i) $500,000 per occurrence or claim and $1,500,000~~
20 ~~per annual aggregate for a participating health care~~
21 ~~provider that is not a hospital.~~
22 ~~(ii) $1,000,000 per occurrence or claim and~~
23 ~~$3,000,000 per annual aggregate for a nonparticipating~~
24 ~~health care provider.~~
25 ~~(iii) $500,000 per occurrence or claim and~~
26 ~~$2,500,000 per annual aggregate for a hospital.~~
27 ~~(3) Unless the commissioner finds pursuant to section~~
28 ~~745(a) that additional basic insurance coverage capacity is~~
29 ~~not available, for policies issued or renewed in calendar~~
30 ~~year 2006 and each year thereafter subject to paragraph (4),~~

1 the basic insurance coverage shall be:

2 (i) Up to $750,000 per occurrence or claim and

3 $2,250,000 per annual aggregate for a participating

4 health care provider that is not a hospital.

5 (ii) Up to $1,000,000 per occurrence or claim and

6 $3,000,000 per annual aggregate for a nonparticipating

7 health care provider.

8 (iii) Up to $750,000 per occurrence or claim and

9 $3,750,000 per annual aggregate for a hospital.

10 If the commissioner finds pursuant to section 745(a) that

11 additional basic insurance coverage capacity is not

12 available, the basic insurance coverage requirements shall

13 remain at the level required by paragraph (2); and the

14 commissioner shall conduct a study every [two years] year

15 until the commissioner finds that additional basic insurance

16 coverage capacity is available, at which time the

17 commissioner shall increase the required basic insurance

18 coverage in accordance with this paragraph.

19 (4) Unless the commissioner finds pursuant to section

20 745(b) that additional basic insurance coverage capacity is

21 not available, for policies issued or renewed [three] two

22 years after the increase in coverage limits required by

23 paragraph (3) and for each year thereafter, the basic

24 insurance coverage shall be:

25 (i) Up to $1,000,000 per occurrence or claim and

26 $3,000,000 per annual aggregate for a participating

27 health care provider that is not a hospital.

28 (ii) Up to $1,000,000 per occurrence or claim and

29 $3,000,000 per annual aggregate for a nonparticipating

30 health care provider.

1 (iii) Up to $1,000,000 per occurrence or claim and
2 $4,500,000 per annual aggregate for a hospital.
3 If the commissioner finds pursuant to section 745(b) that
4 additional basic insurance coverage capacity is not
5 available, the basic insurance coverage requirements shall
6 remain at the level required by paragraph (3); and the
7 commissioner shall conduct a study every [two years] year
8 until the commissioner finds that additional basic insurance
9 coverage capacity is available, at which time the
10 commissioner shall increase the required basic insurance
11 coverage in accordance with this paragraph.
12 (5) The amount of basic insurance coverage per
13 occurrence or claim under paragraphs (3) and (4) shall be no
14 less than $500,000 and shall be set in $50,000 increments.
15 (6) In no event shall the total coverage for basic
16 primary insurance and the fund, per occurrence or claim, be
17 less than $1,000,000 or less than $3,000,000 per annual
18 aggregate for a participating or nonparticipating health care
19 provider, except hospitals which have total coverage limits
20 of not less than $1,000,000 per occurrence or less than
21 $4,500,000 per annual aggregate.
22 (e) Fund participation.--A participating health care
23 provider shall be required to participate in the fund.
24 (f) Self-insurance.--
25 (1) If a health care provider self-insures its medical
26 professional liability, the health care provider shall submit
27 its self-insurance plan, such additional information as the
28 department may require and the examination fee to the
29 department for approval.
30 (2) The department shall approve the plan if it

~~determines that the plan constitutes protection equivalent to the insurance required of a health care provider under subsection (d).~~

~~(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 health care provider's basic insurance coverage or self-insurance plan, the fund shall be responsible for payment of the claim against the participating health care provider up to the fund liability limits.~~

~~(h) Excess insurance.--~~

~~(1) No insurer providing medical professional liability insurance with liability limits in excess of the fund's liability limits to a participating health care provider shall be liable for payment of a claim against the participating health care provider for a loss or damages in a medical professional liability action except the losses and damages in excess of the fund coverage limits.~~

~~(2) No insurer providing medical professional liability insurance with liability limits in excess of the fund's liability limits to a participating health care provider shall be liable for any loss resulting from the insolvency or dissolution of the fund.~~

1 ~~(i) Governmental entities.--A governmental entity may~~
2 ~~satisfy its obligations under this chapter, as well as the~~
3 ~~obligations of its employees to the extent of their employment,~~
4 ~~by either purchasing medical professional liability insurance or~~
5 ~~assuming an obligation as a self-insurer, and paying the~~
6 ~~assessments under this chapter.~~
7 ~~(j) Exemptions.--The following participating health care~~
8 ~~providers shall be exempt from this chapter:~~
9 ~~(1) A physician who exclusively practices the specialty~~
10 ~~of forensic pathology.~~
11 ~~(2) A participating health care provider who is a member~~
12 ~~of the Pennsylvania military forces while in the performance~~
13 ~~of the member's assigned duty in the Pennsylvania military~~
14 ~~forces under orders.~~
15 ~~(3) A retired licensed participating health care~~
16 ~~provider who provides care only to the provider or the~~
17 ~~provider's immediate family members.~~
18 ~~Section 712. Medical Care Availability and Reduction of Error~~
19 ~~Fund.~~
20 ~~(a) Establishment.--There is hereby established within the~~
21 ~~State Treasury a special fund to be known as the Medical Care~~
22 ~~Availability and Reduction of Error Fund. Money in the fund~~
23 ~~shall be used to pay claims against participating health care~~
24 ~~providers for losses or damages awarded in medical professional~~
25 ~~liability actions against them in excess of the basic insurance~~
26 ~~coverage required by section 711(d), liabilities transferred in~~
27 ~~accordance with subsection (b) and for the administration of the~~
28 ~~fund.~~
29 ~~(b) Transfer of assets and liabilities.--~~
30 ~~(1) (i) The money in the Medical Professional Liability~~

~~Catastrophe Loss Fund established under section 701(d) of the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is transferred to the fund.~~

~~(ii) The rights of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.~~

~~(2) The liabilities and obligations of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.~~

~~(c) Fund liability limits.--~~

~~(1) For calendar year 2002, the limit of liability of the fund created in section 701(d) of the former Health Care Services Malpractice Act for each health care provider that conducts more than 50% of its health care business or practice within this Commonwealth and for each hospital shall be $700,000 for each occurrence and $2,100,000 per annual aggregate.~~

~~(2) The limit of liability of the fund for each participating health care provider shall be as follows:~~

~~(i) For calendar year 2003 and each year thereafter, the limit of liability of the fund shall be $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)~~ or (4) ~~and, notwithstanding subparagraph (i), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund~~

1 shall be [$250,000 for each occurrence and $750,000 per
2 annual aggregate.
3 (iii) If the basic insurance coverage requirement is
4 increased in accordance with section 711(d)(4) and,
5 notwithstanding subparagraphs (i) and (ii), for each
6 calendar year following the increase in the basic
7 insurance coverage requirement, the limit of liability of
8 the fund shall be zero] $1,000,000 per occurrence and
9 $3,000,000 per annual aggregate, except hospitals which
10 shall be $1,000,000 per occurrence and $4,500,000 per
11 annual aggregate, minus the amount the commissioner
12 determines for basic insurance coverage under section
13 711(d)(3) and (4).
14 (d) Assessments.--
15 (1) For calendar year 2003 and for each year thereafter,
16 the fund shall be funded by an assessment on each
17 participating health care provider. Assessments shall be
18 levied by the department on or after January 1 of each year.
19 The assessment shall be based on the prevailing primary
20 premium for each participating health care provider and
21 shall, in the aggregate, produce an amount sufficient to do
22 all of the following:
23 (i) Reimburse the fund for the payment of reported
24 claims which became final during the preceding claims
25 period.
26 (ii) Pay expenses of the fund incurred during the
27 preceding claims period.
28 (iii) Pay principal and interest on moneys
29 transferred into the fund in accordance with section
30 713(c).

1 ~~(iv) Provide a reserve that shall be 10% of the sum~~
2 ~~of subparagraphs (i), (ii) and (iii).~~
3 ~~(2) The department shall notify all basic insurance~~
4 ~~coverage insurers and self-insured participating health care~~
5 ~~providers of the assessment by November 1 for the succeeding~~
6 ~~calendar year. Beginning January 1, 2008, the department~~
7 ~~shall bill and collect the assessment from all participating~~
8 ~~health care providers.~~
9 ~~(3) Any appeal of the assessment shall be filed with the~~
10 ~~department.~~
11 ~~(4) FOR CALENDAR YEAR BEGINNING JANUARY 1, 2008, THE~~ <——
12 ~~DEPARTMENT MAY DELAY OR SUSPEND THE COLLECTION OF ASSESSMENTS~~
13 ~~UNTIL THE REQUIREMENTS UNDER SECTION 752(B) ARE MET.~~
14 ~~(e) Discount on surcharges and assessments.--~~
15 ~~(1) For calendar year 2002, the department shall~~
16 ~~discount the aggregate surcharge imposed under section~~
17 ~~701(e)(1) of the Health Care Services Malpractice Act by 5%~~
18 ~~of the aggregate surcharge imposed under that section for~~
19 ~~calendar year 2001 in accordance with the following:~~
20 ~~(i) Fifty percent of the aggregate discount shall be~~
21 ~~granted equally to hospitals and to participating health~~
22 ~~care providers that were surcharged as members of one of~~
23 ~~the four highest rate classes of the prevailing primary~~
24 ~~premium.~~
25 ~~(ii) Notwithstanding subparagraph (i), 50% of the~~
26 ~~aggregate discount shall be granted equally to all~~
27 ~~participating health care providers.~~
28 ~~(iii) The department shall issue a credit to a~~
29 ~~participating health care provider who, prior to the~~
30 ~~effective date of this section, has paid the surcharge~~

~~imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to the effective date of this section.~~

~~(2) For calendar years 2003 and 2004, the department shall discount the aggregate assessment imposed under subsection (d) for each calendar year by 10% of the aggregate surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2001 in accordance with the following:~~

~~(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were assessed as members of one of the four highest rate classes of the prevailing primary premium.~~

~~(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.~~

~~(3) For calendar years 2005 and thereafter, if the basic insurance coverage requirement is increased in accordance with section 711(d)(3) or (4), the department may discount the aggregate assessment imposed under subsection (d) by an amount not to exceed the aggregate sum to be deposited in the fund in accordance with subsection (m).~~

~~(f) Updated rates.--The joint underwriting association shall file updated rates for all health care providers with the commissioner by May 1 of each year. The department shall review and may adjust the prevailing primary premium in line with any applicable changes which have been approved by the commissioner.~~

~~(g) Additional adjustments of the prevailing primary premium.--The department shall adjust the applicable prevailing~~

1 primary premium of each participating health care provider in
2 accordance with the following:
3 (1) The applicable prevailing primary premium of a
4 participating health care provider which is not a hospital
5 may be adjusted through an increase in the individual
6 participating health care provider's prevailing primary
7 premium not to exceed 20%. Any adjustment shall be based upon
8 the frequency of claims paid by the fund on behalf of the
9 individual participating health care provider during the past
10 five most recent claims periods and shall be in accordance
11 with the following:
12 (i) If three claims have been paid during the past
13 five most recent claims periods by the fund, a 10%
14 increase shall be charged.
15 (ii) If four or more claims have been paid during
16 the past five most recent claims periods by the fund, a
17 20% increase shall be charged.
18 (2) The applicable prevailing primary premium of a
19 participating health care provider which is not a hospital
20 and which has not had an adjustment under paragraph (1) may
21 be adjusted through an increase in the individual
22 participating health care provider's prevailing primary
23 premium not to exceed 20%. Any adjustment shall be based upon
24 the severity of at least two claims paid by the fund on
25 behalf of the individual participating health care provider
26 during the past five most recent claims periods.
27 (3) The applicable prevailing primary premium of a
28 participating health care provider not engaged in direct
29 clinical practice on a full-time basis may be adjusted
30 through a decrease in the individual participating health

~~care provider's prevailing primary premium not to exceed 10%. Any adjustment shall be based upon the lower risk associated with the less-than-full-time direct clinical practice.~~

~~(4) The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent claims periods.~~

~~(h) Self-insured health care providers.--A participating health care provider that has an approved self-insurance plan shall be assessed an amount equal to the assessment imposed on a participating health care provider of like class, size, risk and kind as determined by the department.~~

~~(i) Change in basic insurance coverage.--If a participating health care provider changes the term of its medical professional liability insurance coverage, the assessment shall be calculated on an annual basis and shall reflect the assessment percentages in effect for the period over which the policies are in effect.~~

~~(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on or before December 31 following the August 31 on which they became final.~~

~~(k) Termination.--Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination shall be returned by the department to the participating health care providers who participated in the fund in proportion to their assessments in the preceding~~

1 ~~calendar year.~~

2 ~~(l) Sole and exclusive source of funding.--Except as~~

3 ~~provided in subsection (m), the surcharges imposed under section~~

4 ~~701(e)(1) of the Health Care Services Malpractice Act and~~

5 ~~assessments on participating health care providers and any~~

6 ~~income realized by investment or reinvestment shall constitute~~

7 ~~the sole and exclusive sources of funding for the fund. Nothing~~

8 ~~in this subsection shall prohibit the fund from accepting~~

9 ~~contributions from nongovernmental sources. A claim against or a~~

10 ~~liability of the fund shall not be deemed to constitute a debt~~

11 ~~or liability of the Commonwealth or a charge against the General~~

12 ~~Fund.~~

13 ~~(m) Supplemental funding.--Notwithstanding the provisions of~~

14 ~~75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary,~~

15 ~~beginning January 1, 2004, and for a period of nine calendar~~

16 ~~years thereafter, all surcharges levied and collected under 75~~

17 ~~Pa.C.S. § 6506(a) by any division of the unified judicial system~~

18 ~~shall be remitted to the Commonwealth for deposit in the Medical~~

19 ~~Care Availability and Restriction of Error Fund. These funds~~

20 ~~shall be used to reduce surcharges and assessments in accordance~~

21 ~~with subsection (e). Beginning January 1, 2014, and each year~~

22 ~~thereafter, the surcharges levied and collected under 75 Pa.C.S.~~

23 ~~§ 6506(a) shall be deposited into the General Fund.~~

24 ~~(n) Waiver of right to consent to settlement.--A~~

25 ~~participating health care provider may maintain the right to~~

26 ~~consent to a settlement in a basic insurance coverage policy for~~

27 ~~medical professional liability insurance upon the payment of an~~

28 ~~additional premium amount.~~

29 ~~Section 745. Actuarial data.~~

30 ~~(a) Initial study.--The following shall apply:~~

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

1 paragraph (1), the commissioner shall conduct a study
2 regarding the availability of additional basic insurance
3 coverage capacity. The study shall include an estimate of the
4 total change in medical professional liability insurance
5 loss-cost resulting from implementation of this act prepared
6 by an independent actuary. The fee for the independent
7 actuary shall be borne by the fund. In developing the
8 estimate, the independent actuary shall consider all of the
9 following:
10 (i) The most recent accident year and ratemaking
11 data available.
12 (ii) Any other relevant factors including economic
13 considerations within or outside this Commonwealth in
14 accordance with sound actuarial principles.
15 Section 2. Chapter 7 of the act is amended by adding
16 subchapters A SUBCHAPTER to read: <--
17 SUBCHAPTER E <--
18 MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR
19 (MCARE) RESERVE FUND
20 Section 751. Establishment.
21 There is established within the State Treasury a special fund
22 to be known as the Medical Care Availability and Reduction of
23 Error (Mcare) Reserve Fund.
24 Section 752. Allocation.
25 Money in the Medical Care Availability and Reduction of Error
26 (Mcare) Reserve Fund shall be allocated annually as follows:
27 (1) Fifty percent of the total amount in the Medical
28 Care Availability and Reduction of Error (Mcare) Reserve Fund
29 shall remain in the Medical Care Availability and Reduction
30 of Error (Mcare) Reserve Fund for the sole purpose of

1 ~~reducing the unfunded liability of the fund.~~

2 ~~(2) Twenty-five percent of the total amount in the~~
3 ~~Medical Care Availability and Reduction of Error (Mcare)~~
4 ~~Reserve Fund shall be transferred to the Patient Safety Trust~~
5 ~~Fund for use by the Department of Public Welfare for~~
6 ~~implementing section 407.~~

7 ~~(3) Twenty-five percent of the total amount in the~~
8 ~~Medical Care Availability and Reduction of Error (Mcare)~~
9 ~~Reserve Fund shall be transferred to the Medical Safety~~
10 ~~Automation Fund.~~

11 ~~SUBCHAPTER F~~
12 ~~MEDICAL SAFETY AUTOMATION FUND~~

13 ~~Section 762. Medical Safety Automation Fund established.~~

14 ~~There is established within the State Treasury a special fund~~
15 ~~to be known as the Medical Safety Automation Fund. No money in~~
16 ~~the Medical Safety Automation Fund shall be used until~~
17 ~~legislation is enacted for the purpose of providing medical~~
18 ~~safety automation system grants to health care providers under~~
19 ~~the act of July 19, 1979 (P.L.130, No.48), known as the Health~~
20 ~~Care Facilities Act, a group practice or a community-based~~
21 ~~health care provider.~~

22 ~~SUBCHAPTER E~~ <——
23 ~~MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS~~
24 ~~(MCAP) RESERVE FUND~~

25 ~~SECTION 751. ESTABLISHMENT.~~

26 ~~THERE IS ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND~~
27 ~~TO BE KNOWN AS THE MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS~~
28 ~~(MCAP) RESERVE FUND.~~

29 ~~SECTION 752. ALLOCATION.~~

30 ~~(A) ANNUAL ALLOCATION.--MONEY IN THE MEDICAL CARE~~

1 ~~AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND SHALL BE~~
2 ~~ALLOCATED ANNUALLY AS FOLLOWS:~~
3 ~~(1) FIFTY PERCENT OF THE TOTAL AMOUNT IN THE MEDICAL~~
4 ~~CARE AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND~~
5 ~~SHALL REMAIN IN THE MEDICAL CARE AVAILABILITY FOR~~
6 ~~PENNSYLVANIANS (MCAP) RESERVE FUND FOR THE SOLE PURPOSE OF~~
7 ~~REDUCING THE UNFUNDED LIABILITY OF THE FUND.~~
8 ~~(2) FIFTY PERCENT OF THE TOTAL AMOUNT IN THE MEDICAL~~
9 ~~CARE AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND~~
10 ~~SHALL BE DEDICATED TO FUNDING THE PROGRAM ESTABLISHED UNDER~~
11 ~~SUBSECTION (B).~~
12 ~~(B) ENACTMENT OF LEGISLATION.--NO MONEY IN THE MEDICAL CARE~~
13 ~~AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND SHALL BE~~
14 ~~USED UNTIL LEGISLATION IS ENACTED THAT PROVIDES BOTH ASSISTANCE~~
15 ~~TO CERTAIN SMALL BUSINESS EMPLOYERS IN COVERING THEIR LOW WAGE~~
16 ~~UNINSURED AND ACCESS TO AFFORDABLE HEALTH INSURANCE COVERAGE FOR~~
17 ~~UNINSURED LOW-INCOME ADULT PENNSYLVANIANS.~~
18 ~~Section 3. Section 1102 of the act, amended October 27, 2006~~
19 ~~(P.L.1198, No.128), is amended to read:~~
20 ~~Section 1102. Abatement program.~~
21 ~~(a) Establishment.--There is hereby established within the~~
22 ~~Insurance Department a program to be known as the Health Care~~
23 ~~Provider Retention Program. The Insurance Department, in~~
24 ~~conjunction with the Department of Public Welfare, shall~~
25 ~~administer the program. The program shall provide assistance in~~
26 ~~the form of assessment abatements to health care providers for~~
27 ~~calendar years 2003, 2004, 2005, 2006 [and], 2007 and 2008 AND~~ <--
28 ~~2007, except that licensed podiatrists shall not be eligible for~~
29 ~~calendar years 2003 and 2004, and nursing homes shall not be~~
30 ~~eligible for calendar years 2003, 2004 and 2005.~~

1 (b) Other [abatement.--] abatements.--
2 (1) Emergency physicians not employed full time by a
3 trauma center or working under an exclusive contract with a
4 trauma center shall retain eligibility for an abatement
5 pursuant to section 1104(b)(2) for calendar years 2003, 2004,
6 2005 and 2006. Commencing in calendar year 2007, these
7 emergency physicians shall be eligible for an abatement
8 pursuant to section 1104(b)(1).
9 (2) Birth centers shall retain eligibility for abatement
10 pursuant to section 1104(b)(2) for calendar years 2003, 2004,
11 2005, 2006 and 2007. Commencing in calendar year 2008, birth
12 centers shall be eligible for an abatement pursuant to
13 section 1104(b)(1).
14 Section 4. Section 1112 of the act, added December 22, 2005
15 (P.L.458, No.88), is amended to read:
16 Section 1112. Health Care Provider Retention Account.
17 (a) Fund established.--There is established within the
18 General Fund a special account to be known as the Health Care
19 Provider Retention Account. Funds in the account shall be
20 subject to an annual appropriation by the General Assembly to
21 the Department of Public Welfare. The Department of Public
22 Welfare shall administer funds appropriated under this section
23 consistent with its duties under section 201(1) of the act of
24 June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.
25 (b) Transfers from Mcare Fund.--By December 31 of each year,
26 the Secretary of the Budget may transfer from the Medical Care
27 Availability and Reduction of Error (Mcare) Fund established in
28 section 712(a) to the account an amount equal to the difference
29 between the amount deposited under section 712(m) and the amount
30 granted as discounts under section 712(e)(2) for that calendar

1 ~~year.~~

2 ~~(c) Transfers from account.--The Secretary of the Budget may~~
3 ~~annually transfer from the account to the Medical Care~~
4 ~~Availability and Reduction of Error (MCARE) Fund an amount up to~~
5 ~~the aggregate amount of abatements granted by the Insurance~~
6 ~~Department under section 1104(b).~~

7 ~~(c.1) Transfers to the Medical Care Availability and~~ <--
8 ~~Reduction of Error (Mcare) Reserve Fund.--If the Secretary of~~
9 ~~the Budget makes a transfer from the account under subsection~~
10 ~~(c), the remaining funds in the account shall be transferred to~~
11 ~~the Medical Care Availability and Reduction of Error (Mcare)~~
12 ~~Reserve Fund. If the Secretary of the Budget does not make a~~
13 ~~transfer from the account under subsection (c), all of the funds~~
14 ~~in the account shall be transferred to the Medical Care~~
15 ~~Availability and Reduction of Error (Mcare) Reserve Fund.~~

16 ~~(C.1) TRANSFERS TO THE MEDICAL CARE AVAILABILITY FOR~~ <--
17 ~~PENNSYLVANIANS (MCAP) RESERVE FUND.--IF THE SECRETARY OF THE~~
18 ~~BUDGET MAKES A TRANSFER FROM THE ACCOUNT UNDER SUBSECTION (C),~~
19 ~~THE REMAINING FUNDS IN THE ACCOUNT SHALL BE TRANSFERRED TO THE~~
20 ~~MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE~~
21 ~~FUND. IF THE SECRETARY OF THE BUDGET DOES NOT MAKE A TRANSFER~~
22 ~~FROM THE ACCOUNT UNDER SUBSECTION (C), ALL OF THE FUNDS IN THE~~
23 ~~ACCOUNT SHALL BE TRANSFERRED TO THE MEDICAL CARE AVAILABILITY~~
24 ~~FOR PENNSYLVANIANS (MCAP) RESERVE FUND.~~

25 ~~(d) Other deposits.--The Department of Public Welfare may~~
26 ~~deposit any other funds received by the department which it~~
27 ~~deems appropriate in the account.~~

28 ~~(e) Administration assistance.--The Insurance Department~~
29 ~~shall provide assistance to the Department of Public Welfare in~~
30 ~~administering the account.~~

1 ~~Section 5. Section 1115 of the act, amended October 27, 2006~~
2 ~~(P.L.1198, No.128), is amended to read:~~
3 ~~Section 1115. Expiration.~~
4 ~~The Health Care Provider Retention Program established under~~
5 ~~this chapter shall expire December 31, [2008] 2009 2011.~~ <——
6 ~~Section 6. Section 5106 of the act is amended to read:~~
7 ~~Section 5106. Expiration.~~
8 ~~Section 312 shall expire on December 31, [2007] 2008.~~
9 ~~SECTION 7. IF THE REQUIREMENTS OF SECTION 752(B) OF THE ACT~~ <——
10 ~~ARE NOT SATISFIED WITHIN 90 DAYS AFTER ENACTMENT, SECTIONS 711,~~
11 ~~712(D), (E), (G), (H) AND (I) OF THE ACT SHALL EXPIRE JUNE 30,~~
12 ~~2008. IF THESE SECTIONS EXPIRE ON JUNE 30, 2008, THE FUND SHALL~~
13 ~~CONTINUE TO BE RESPONSIBLE FOR PAYMENT OF CLAIMS AGAINST~~
14 ~~PARTICIPATING HEALTH CARE PROVIDERS AS OF JUNE 30, 2008, UP TO~~
15 ~~THE FUND LIABILITY LIMITS AS OF JUNE 30, 2008, TO THE EXTENT THE~~
16 ~~FUND WOULD HAVE BEEN RESPONSIBLE FOR PAYMENT OF SUCH CLAIMS IF~~
17 ~~SECTIONS 711, 712(D), (E), (G), (H) AND (I) OF THE ACT DID NOT~~
18 ~~EXPIRE JUNE 30, 2008.~~
19 ~~Section 7 8. This act shall take effect immediately.~~ <——
20 SECTION 1. SECTION 711(D) AND (G) OF THE ACT OF MARCH 20, <——
21 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY
22 AND REDUCTION OF ERROR (MCARE) ACT, ARE AMENDED TO READ:
23 SECTION 711. MEDICAL PROFESSIONAL LIABILITY INSURANCE.
24 * * *
25 (D) BASIC COVERAGE LIMITS.--A HEALTH CARE PROVIDER SHALL
26 INSURE OR SELF-INSURE MEDICAL PROFESSIONAL LIABILITY IN
27 ACCORDANCE WITH THE FOLLOWING:
28 (1) FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEAR
29 2002, THE BASIC INSURANCE COVERAGE SHALL BE:
30 (I) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000

1 PER ANNUAL AGGREGATE FOR A HEALTH CARE PROVIDER WHO
2 CONDUCTS MORE THAN 50% OF ITS HEALTH CARE BUSINESS OR
3 PRACTICE WITHIN THIS COMMONWEALTH AND THAT IS NOT A
4 HOSPITAL.
5 (II) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000
6 PER ANNUAL AGGREGATE FOR A HEALTH CARE PROVIDER WHO
7 CONDUCTS 50% OR LESS OF ITS HEALTH CARE BUSINESS OR
8 PRACTICE WITHIN THIS COMMONWEALTH.
9 (III) $500,000 PER OCCURRENCE OR CLAIM AND
10 $2,500,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.
11 (2) FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEARS
12 2003[, 2004 AND 2005] THROUGH 2008, THE BASIC INSURANCE
13 COVERAGE SHALL BE:
14 (I) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000
15 PER ANNUAL AGGREGATE FOR A PARTICIPATING HEALTH CARE
16 PROVIDER THAT IS NOT A HOSPITAL.
17 (II) $1,000,000 PER OCCURRENCE OR CLAIM AND
18 $3,000,000 PER ANNUAL AGGREGATE FOR A NONPARTICIPATING
19 HEALTH CARE PROVIDER.
20 (III) $500,000 PER OCCURRENCE OR CLAIM AND
21 $2,500,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.
22 [(3) UNLESS THE COMMISSIONER FINDS PURSUANT TO SECTION
23 745(A) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS
24 NOT AVAILABLE, FOR POLICIES ISSUED OR RENEWED IN CALENDAR
25 YEAR 2006 AND EACH YEAR THEREAFTER SUBJECT TO PARAGRAPH (4),
26 THE BASIC INSURANCE COVERAGE SHALL BE:
27 (I) $750,000 PER OCCURRENCE OR CLAIM AND $2,250,000
28 PER ANNUAL AGGREGATE FOR A PARTICIPATING HEALTH CARE
29 PROVIDER THAT IS NOT A HOSPITAL.
30 (II) $1,000,000 PER OCCURRENCE OR CLAIM AND

1 $3,000,000 PER ANNUAL AGGREGATE FOR A NONPARTICIPATING
2 HEALTH CARE PROVIDER.
3 (III) $750,000 PER OCCURRENCE OR CLAIM AND
4 $3,750,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.
5 IF THE COMMISSIONER FINDS PURSUANT TO SECTION 745(A) THAT
6 ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT
7 AVAILABLE, THE BASIC INSURANCE COVERAGE REQUIREMENTS SHALL
8 REMAIN AT THE LEVEL REQUIRED BY PARAGRAPH (2); AND THE
9 COMMISSIONER SHALL CONDUCT A STUDY EVERY TWO YEARS UNTIL THE
10 COMMISSIONER FINDS THAT ADDITIONAL BASIC INSURANCE COVERAGE
11 CAPACITY IS AVAILABLE, AT WHICH TIME THE COMMISSIONER SHALL
12 INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE
13 WITH THIS PARAGRAPH.
14 (4) UNLESS THE COMMISSIONER FINDS PURSUANT TO SECTION
15 745(B) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS
16 NOT AVAILABLE, FOR POLICIES ISSUED OR RENEWED THREE YEARS
17 AFTER THE INCREASE IN COVERAGE LIMITS REQUIRED BY PARAGRAPH
18 (3) AND FOR EACH YEAR THEREAFTER, THE BASIC INSURANCE
19 COVERAGE SHALL BE:
20 (I) $1,000,000 PER OCCURRENCE OR CLAIM AND
21 $3,000,000 PER ANNUAL AGGREGATE FOR A PARTICIPATING
22 HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL.
23 (II) $1,000,000 PER OCCURRENCE OR CLAIM AND
24 $3,000,000 PER ANNUAL AGGREGATE FOR A NONPARTICIPATING
25 HEALTH CARE PROVIDER.
26 (III) $1,000,000 PER OCCURRENCE OR CLAIM AND
27 $4,500,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.
28 IF THE COMMISSIONER FINDS PURSUANT TO SECTION 745(B) THAT
29 ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT
30 AVAILABLE, THE BASIC INSURANCE COVERAGE REQUIREMENTS SHALL

1 REMAIN AT THE LEVEL REQUIRED BY PARAGRAPH (3); AND THE
2 COMMISSIONER SHALL CONDUCT A STUDY EVERY TWO YEARS UNTIL THE
3 COMMISSIONER FINDS THAT ADDITIONAL BASIC INSURANCE COVERAGE
4 CAPACITY IS AVAILABLE, AT WHICH TIME THE COMMISSIONER SHALL
5 INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE
6 WITH THIS PARAGRAPH.]
7 (5) FOR POLICIES ISSUED OR RENEWED IN CALENDAR YEAR
8 2009, THE BASIC INSURANCE COVERAGE SHALL BE:
9 (I) $550,000 PER OCCURRENCE OR CLAIM AND $1,650,000
10 PER ANNUAL AGGREGATE FOR A PARTICIPATING HEALTH CARE
11 PROVIDER THAT IS NOT A HOSPITAL.
12 (II) $1,000,000 PER OCCURRENCE OR CLAIM AND
13 $3,000,000 PER ANNUAL AGGREGATE FOR A NONPARTICIPATING
14 HEALTH CARE PROVIDER.
15 (III) $550,000 PER OCCURRENCE OR CLAIM AND
16 $2,700,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.
17 (6) FOR POLICIES ISSUED OR RENEWED IN CALENDAR YEARS
18 2010 AND THEREAFTER:
19 (I) THE BASIC INSURANCE COVERAGE FOR A PARTICIPATING
20 HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL SHALL
21 INCREASE BY $50,000 PER OCCURRENCE OR CLAIM AND $150,000
22 PER ANNUAL AGGREGATE PER YEAR UNTIL SUCH TIME AS THE
23 BASIC INSURANCE COVERAGE REQUIRED SHALL BE $1,000,000 PER
24 OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL AGGREGATE.
25 (II) THE BASIC INSURANCE COVERAGE FOR A
26 NONPARTICIPATING HEALTH CARE PROVIDER SHALL BE $1,000,000
27 PER OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL
28 AGGREGATE.
29 (III) THE BASIC INSURANCE COVERAGE FOR A HOSPITAL
30 SHALL INCREASE BY $50,000 PER OCCURRENCE OR CLAIM AND

1 $200,000 PER ANNUAL AGGREGATE UNTIL SUCH TIME AS THE
2 BASIC INSURANCE COVERAGE REQUIREMENT SHALL BE $1,000,000
3 PER OCCURRENCE OR CLAIM AND $4,500,000 PER ANNUAL
4 AGGREGATE PER YEAR.
5 (7) BASIC INSURANCE COVERAGE AMOUNTS SHALL BE EXCLUSIVE
6 OF A DEDUCTIBLE OR ANY OTHER CONTRIBUTION FROM THE HEALTH
7 CARE PROVIDER.
8 * * *
9 (G) BASIC INSURANCE LIABILITY.--
10 (1) AN INSURER PROVIDING MEDICAL PROFESSIONAL LIABILITY
11 INSURANCE SHALL NOT BE LIABLE FOR PAYMENT OF A CLAIM AGAINST
12 A HEALTH CARE PROVIDER FOR ANY LOSS OR DAMAGES AWARDED IN A
13 MEDICAL PROFESSIONAL LIABILITY ACTION IN EXCESS OF THE BASIC
14 INSURANCE COVERAGE REQUIRED BY SUBSECTION (D) UNLESS THE
15 HEALTH CARE PROVIDER'S MEDICAL PROFESSIONAL LIABILITY
16 INSURANCE POLICY OR SELF-INSURANCE PLAN PROVIDES FOR A HIGHER
17 LIMIT.
18 (2) IF A CLAIM EXCEEDS THE LIMITS OF A PARTICIPATING
19 HEALTH CARE PROVIDER'S BASIC INSURANCE COVERAGE OR SELF-
20 INSURANCE PLAN, THE FUND SHALL BE RESPONSIBLE FOR PAYMENT OF
21 THE CLAIM AGAINST THE PARTICIPATING HEALTH CARE PROVIDER UP
22 TO THE FUND LIABILITY LIMITS. THE FUND SHALL NOT BE
23 RESPONSIBLE IF A CLAIMANT HAS WAIVED COLLECTION OF ANY
24 PORTION OF THE APPLICABLE BASIC INSURANCE COVERAGE LIMIT.
25 (3) IF THE HEALTH CARE PROVIDER HAS MORE THAN ONE BASIC
26 INSURANCE COVERAGE POLICY WITH MORE THAN ONE INSURER
27 APPLICABLE TO A CLAIM, THE FUND SHALL BE LIABLE WHEN THE
28 POLICY WITH THE HIGHEST LIMIT HAS BEEN TENDERED TO THE FUND.
29 * * *
30 SECTION 2. SECTION 712(C), (D), (E), (I), (J) AND (M) OF THE

1 ACT ARE AMENDED AND THE SECTION IS AMENDED BY ADDING A
2 SUBSECTION TO READ:
3 SECTION 712. MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR
4 FUND.
5 * * *
6 (C) FUND LIABILITY LIMITS.--
7 (1) FOR CALENDAR YEAR 2002, THE LIMIT OF LIABILITY OF
8 THE FUND CREATED IN SECTION 701(D) OF THE FORMER HEALTH CARE
9 SERVICES MALPRACTICE ACT FOR EACH HEALTH CARE PROVIDER THAT
10 CONDUCTS MORE THAN 50% OF ITS HEALTH CARE BUSINESS OR
11 PRACTICE WITHIN THIS COMMONWEALTH AND FOR EACH HOSPITAL SHALL
12 BE $700,000 FOR EACH OCCURRENCE AND $2,100,000 PER ANNUAL
13 AGGREGATE.
14 (2) THE LIMIT OF LIABILITY OF THE FUND FOR EACH
15 PARTICIPATING HEALTH CARE PROVIDER SHALL BE [AS FOLLOWS:
16 (I) FOR] FOR CALENDAR YEAR 2003 AND EACH YEAR
17 THEREAFTER, THE LIMIT OF LIABILITY OF THE FUND SHALL BE
18 $500,000 FOR EACH OCCURRENCE AND $1,500,000 PER ANNUAL
19 AGGREGATE.
20 [(II) IF THE BASIC INSURANCE COVERAGE REQUIREMENT IS
21 INCREASED IN ACCORDANCE WITH SECTION 711(D)(3) AND,
22 NOTWITHSTANDING SUBPARAGRAPH (I), FOR EACH CALENDAR YEAR
23 FOLLOWING THE INCREASE IN THE BASIC INSURANCE COVERAGE
24 REQUIREMENT, THE LIMIT OF LIABILITY OF THE FUND SHALL BE
25 $250,000 FOR EACH OCCURRENCE AND $750,000 PER ANNUAL
26 AGGREGATE.
27 (III) IF THE BASIC INSURANCE COVERAGE REQUIREMENT IS
28 INCREASED IN ACCORDANCE WITH SECTION 711(D)(4) AND,
29 NOTWITHSTANDING SUBPARAGRAPHS (I) AND (II), FOR EACH
30 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 PROVIDER. ASSESSMENTS SHALL BE LEVIED BY THE DEPARTMENT ON OR AFTER JANUARY 1 OF EACH YEAR. THE ASSESSMENT SHALL BE BASED ON THE PREVAILING PRIMARY PREMIUM FOR EACH PARTICIPATING HEALTH CARE PROVIDER AND SHALL, IN THE AGGREGATE, PRODUCE AN AMOUNT SUFFICIENT TO DO ALL OF THE FOLLOWING:

(I) REIMBURSE THE FUND FOR THE PAYMENT OF REPORTED CLAIMS WHICH BECAME FINAL DURING THE PRECEDING CLAIMS PERIOD.

(II) PAY EXPENSES OF THE FUND INCURRED DURING THE PRECEDING CLAIMS PERIOD.

(III) PAY PRINCIPAL AND INTEREST ON MONEYS TRANSFERRED INTO THE FUND IN ACCORDANCE WITH SECTION

713(C).

(IV) PROVIDE A RESERVE THAT SHALL BE 10% OF THE SUM OF SUBPARAGRAPHS (I), (II) AND (III).

(2) THE DEPARTMENT SHALL NOTIFY ALL BASIC INSURANCE COVERAGE INSURERS AND SELF-INSURED PARTICIPATING HEALTH CARE PROVIDERS OF THE ASSESSMENT BY NOVEMBER 1 FOR THE SUCCEEDING CALENDAR YEAR.

(3) ANY APPEAL OF THE ASSESSMENT SHALL BE FILED WITH THE DEPARTMENT.

[(E) DISCOUNT ON SURCHARGES AND ASSESSMENTS.--

(1) FOR CALENDAR YEAR 2002, THE DEPARTMENT SHALL DISCOUNT THE AGGREGATE SURCHARGE IMPOSED UNDER SECTION 701(E)(1) OF THE HEALTH CARE SERVICES MALPRACTICE ACT BY 5% OF THE AGGREGATE SURCHARGE IMPOSED UNDER THAT SECTION FOR CALENDAR YEAR 2001 IN ACCORDANCE WITH THE FOLLOWING:

(I) FIFTY PERCENT OF THE AGGREGATE DISCOUNT SHALL BE GRANTED EQUALLY TO HOSPITALS AND TO PARTICIPATING HEALTH CARE PROVIDERS THAT WERE SURCHARGED AS MEMBERS OF ONE OF THE FOUR HIGHEST RATE CLASSES OF THE PREVAILING PRIMARY PREMIUM.

(II) NOTWITHSTANDING SUBPARAGRAPH (I), 50% OF THE AGGREGATE DISCOUNT SHALL BE GRANTED EQUALLY TO ALL PARTICIPATING HEALTH CARE PROVIDERS.

(III) THE DEPARTMENT SHALL ISSUE A CREDIT TO A PARTICIPATING HEALTH CARE PROVIDER WHO, PRIOR TO THE EFFECTIVE DATE OF THIS SECTION, HAS PAID THE SURCHARGE IMPOSED UNDER SECTION 701(E)(1) OF THE FORMER HEALTH CARE SERVICES MALPRACTICE ACT FOR CALENDAR YEAR 2002 PRIOR TO THE EFFECTIVE DATE OF THIS SECTION.

(2) FOR CALENDAR YEARS 2003 AND 2004, THE DEPARTMENT

1 SHALL DISCOUNT THE AGGREGATE ASSESSMENT IMPOSED UNDER
2 SUBSECTION (D) FOR EACH CALENDAR YEAR BY 10% OF THE AGGREGATE
3 SURCHARGE IMPOSED UNDER SECTION 701(E)(1) OF THE FORMER
4 HEALTH CARE SERVICES MALPRACTICE ACT FOR CALENDAR YEAR 2001
5 IN ACCORDANCE WITH THE FOLLOWING:
6 (I) FIFTY PERCENT OF THE AGGREGATE DISCOUNT SHALL BE
7 GRANTED EQUALLY TO HOSPITALS AND TO PARTICIPATING HEALTH
8 CARE PROVIDERS THAT WERE ASSESSED AS MEMBERS OF ONE OF
9 THE FOUR HIGHEST RATE CLASSES OF THE PREVAILING PRIMARY
10 PREMIUM.
11 (II) NOTWITHSTANDING SUBPARAGRAPH (I), 50% OF THE
12 AGGREGATE DISCOUNT SHALL BE GRANTED EQUALLY TO ALL
13 PARTICIPATING HEALTH CARE PROVIDERS.
14 (3) FOR CALENDAR YEARS 2005 AND THEREAFTER, IF THE BASIC
15 INSURANCE COVERAGE REQUIREMENT IS INCREASED IN ACCORDANCE
16 WITH SECTION 711(D)(3) OR (4), THE DEPARTMENT MAY DISCOUNT
17 THE AGGREGATE ASSESSMENT IMPOSED UNDER SUBSECTION (D) BY AN
18 AMOUNT NOT TO EXCEED THE AGGREGATE SUM TO BE DEPOSITED IN THE
19 FUND IN ACCORDANCE WITH SUBSECTION (M).]
20 * * *
21 (I) CHANGE IN BASIC INSURANCE COVERAGE.--IF A PARTICIPATING
22 HEALTH CARE PROVIDER CHANGES THE TERM OF ITS MEDICAL
23 PROFESSIONAL LIABILITY INSURANCE COVERAGE, THE ASSESSMENT SHALL
24 BE CALCULATED ON AN ANNUAL BASIS AND SHALL REFLECT THE
25 ASSESSMENT PERCENTAGES IN EFFECT FOR THE PERIOD OVER WHICH THE
26 POLICIES ARE IN EFFECT. A POLICY PERIOD LESS THAN 12 MONTHS MAY
27 RESULT IN A PRORATED REDUCTION IN THE MCARE ANNUAL AGGREGATE
28 LIMIT.
29 (J) PAYMENT OF CLAIMS.--CLAIMS WHICH BECAME FINAL DURING THE
30 PRECEDING CLAIMS PERIOD SHALL BE PAID ON [OR BEFORE] DECEMBER 31

OR THE LAST BUSINESS DAY OF THE YEAR FOLLOWING THE AUGUST 31 ON WHICH THEY BECAME FINAL.

* * *

(M) SUPPLEMENTAL FUNDING.--NOTWITHSTANDING THE PROVISIONS OF 75 PA.C.S. § 6506(B) (RELATING TO SURCHARGE) TO THE CONTRARY, BEGINNING JANUARY 1, 2004, [AND FOR A PERIOD OF NINE CALENDAR YEARS THEREAFTER,] THROUGH JUNE 30, 2018, ALL SURCHARGES LEVIED AND COLLECTED UNDER 75 PA.C.S. § 6506(A) BY ANY DIVISION OF THE UNIFIED JUDICIAL SYSTEM SHALL BE REMITTED TO THE COMMONWEALTH FOR DEPOSIT IN THE MEDICAL CARE AVAILABILITY AND [RESTRICTION] REDUCTION OF ERROR FUND. **[**THESE FUNDS SHALL BE USED TO REDUCE SURCHARGES AND ASSESSMENTS IN ACCORDANCE WITH SUBSECTION (E).**]** BEGINNING [JANUARY 1, 2014] JULY 1, 2018, AND EACH YEAR THEREAFTER, THE SURCHARGES LEVIED AND COLLECTED UNDER 75 PA.C.S. § 6506(A) SHALL BE DEPOSITED INTO THE [GENERAL FUND.] HEALTH CARE PROVIDER RETENTION ACCOUNT.

* * *

(O) COVERAGE OF CLAIMS IN RELATION TO PAYMENT OF CERTAIN 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,

1 SELF-INSURED PARTICIPATING HEALTH CARE PROVIDER OR RISK
2 RETENTION GROUP SHALL PAY TO THE DEPARTMENT A PENALTY
3 EQUAL TO 10% PER ANNUM OF EACH UNTIMELY ASSESSMENT
4 ACCRUING FROM THE 61ST DAY AFTER THE INCEPTION OR RENEWAL
5 DATE OF THE PRIMARY POLICY UNTIL THE REMITTANCE IS
6 RECEIVED BY THE DEPARTMENT.
7 (II) IN ADDITION TO THE PROVISIONS OF SUBPARAGRAPH
8 (I), IF THE DEPARTMENT FINDS THAT THERE HAS BEEN A
9 PATTERN OR PRACTICE OF NOT COMPLYING WITH THIS SECTION,
10 THE BASIC INSURANCE COVERAGE INSURER, SELF-INSURED
11 PARTICIPATING HEALTH CARE PROVIDER OR RISK RETENTION
12 GROUP SHALL BE SUBJECT TO THE PENALTIES AND PROCESS SET
13 FORTH IN THE ACT OF JULY 22, 1974 (P.L.589, NO.205),
14 KNOWN AS THE UNFAIR INSURANCE PRACTICES ACT.
15 (III) IF THE BASIC INSURANCE COVERAGE INSURER, SELF-
16 INSURER OR RISK RETENTION GROUP RECEIVES THE ASSESSMENT
17 FROM A HEALTH CARE PROVIDER, PROFESSIONAL CORPORATION OR
18 PROFESSIONAL ASSOCIATION WITH LESS THAN 30 DAYS TO MAKE
19 THE REMITTANCE TIMELY AS PROVIDED UNDER THIS SUBSECTION,
20 THE BASIC INSURANCE COVERAGE INSURER, SELF-INSURER OR
21 RISK RETENTION GROUP REMITTANCE PERIOD SHALL BE EXTENDED
22 BY 30 DAYS FROM THE DATE OF RECEIPT UPON PROVIDING
23 REASONABLE EVIDENCE TO THE DEPARTMENT REGARDING THE DATE
24 OF RECEIPT AND SHALL NOT BE SUBJECT TO THE PENALTIES
25 PROVIDED FOR UNDER THIS SECTION.
26 (IV) IF THE BASIC INSURANCE COVERAGE INSURER, SELF-
27 INSURER OR RISK RETENTION GROUP RECEIVES AN ASSESSMENT
28 AFTER 60 DAYS OF THE INCEPTION OR RENEWAL DATE OF THE
29 PRIMARY PROFESSIONAL LIABILITY POLICY AND REMITS THE
30 ASSESSMENT WITHIN 30 DAYS FROM THE DATE OF RECEIPT, THE

1 BASIC INSURANCE COVERAGE INSURER, SELF-INSURER OR RISK
2 RETENTION GROUP SHALL NOT BE SUBJECT TO THE PENALTIES
3 PROVIDED FOR UNDER THIS SECTION. REMITTANCES TO THE
4 DEPARTMENT BEYOND THE 30-DAY PERIOD SHALL BE SUBJECT TO
5 THE PENALTIES PROVIDED FOR UNDER THIS SECTION.
6 (V) (A) A HEALTH CARE PROVIDER OR PROFESSIONAL
7 CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP
8 SHALL BE PROVIDED COVERAGE FROM THE INCEPTION OR
9 RENEWAL DATE OF THE PRIMARY PROFESSIONAL LIABILITY
10 POLICY IF THE BILLED ASSESSMENT IS PAID TO THE BASIC
11 INSURANCE COVERAGE INSURER, SELF-INSURER OR RISK
12 RETENTION GROUP WITHIN 60 DAYS OF THE INCEPTION OR
13 RENEWAL DATE OF THE PRIMARY PROFESSIONAL LIABILITY
14 POLICY.
15 (B) A HEALTH CARE PROVIDER OR PROFESSIONAL
16 CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP
17 THAT FAILS TO PAY THE BILLED ASSESSMENT TO ITS BASIC
18 INSURANCE COVERAGE INSURER, SELF-INSURER OR RISK
19 RETENTION GROUP WITHIN 60 DAYS OF POLICY INCEPTION OR
20 RENEWAL AND BEFORE RECEIVING NOTICE OF A CLAIM SHALL
21 NOT HAVE COVERAGE FOR THAT CLAIM.
22 (C) IF A HEALTH CARE PROVIDER OR PROFESSIONAL
23 CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP
24 IS BILLED BY THE BASIC INSURANCE COVERAGE INSURER,
25 SELF-INSURER OR RISK RETENTION GROUP LATER THAN 30
26 DAYS AFTER THE POLICY INCEPTION OR RENEWAL DATE AND
27 THE HEALTH CARE PROVIDER OR PROFESSIONAL CORPORATION,
28 PROFESSIONAL ASSOCIATION OR PARTNERSHIP PAYS THE
29 BASIC INSURANCE COVERAGE INSURER, SELF-INSURER OR
30 RISK RETENTION GROUP WITHIN 30 DAYS FROM THE DATE OF

1 RECEIPT OF THE BILL AND THE BASIC INSURANCE COVERAGE
2 INSURER, SELF-INSURER OR RISK RETENTION GROUP CARRIER
3 REMITS THE ASSESSMENT TO THE DEPARTMENT WITHIN 30
4 DAYS FROM THE DATE OF RECEIPT, THE HEALTH CARE
5 PROVIDER SHALL BE PROVIDED COVERAGE AS OF THE
6 INCEPTION OR RENEWAL DATE OF THE PRIMARY POLICY.
7 COVERAGE SHALL ALSO BE PROVIDED TO THE HEALTH CARE
8 PROVIDER OR PROFESSIONAL CORPORATION, PROFESSIONAL
9 ASSOCIATION OR PARTNERSHIP FOR ALL PROFESSIONAL
10 LIABILITY CLAIMS MADE AFTER PAYMENT OF THE
11 ASSESSMENT.
12 (VI) EXCEPT AS TO PROVISIONS IN CONFLICT WITH THIS
13 SECTION, NOTHING IN THIS SECTION SHALL BE CONSTRUED TO
14 AFFECT EXISTING REGULATIONS SAVED BY SECTION 5107(A), AND
15 ALL EXISTING REGULATIONS SHALL REMAIN IN FULL FORCE AND
16 EFFECT.
17 SECTION 3. SECTION 745 OF THE ACT IS REPEALED:
18 [SECTION 745. ACTUARIAL DATA.
19 (A) INITIAL STUDY.--THE FOLLOWING SHALL APPLY:
20 (1) NO LATER THAN APRIL 1, 2005, EACH INSURER PROVIDING
21 MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THIS COMMONWEALTH
22 SHALL FILE LOSS DATA AS REQUIRED BY THE COMMISSIONER. FOR
23 FAILURE TO COMPLY, THE COMMISSIONER SHALL IMPOSE AN
24 ADMINISTRATIVE PENALTY OF $1,000 FOR EVERY DAY THAT THIS DATA
25 IS NOT PROVIDED IN ACCORDANCE WITH THIS PARAGRAPH.
26 (2) BY JULY 1, 2005, THE COMMISSIONER SHALL CONDUCT A
27 STUDY REGARDING THE AVAILABILITY OF ADDITIONAL BASIC
28 INSURANCE COVERAGE CAPACITY. THE STUDY SHALL INCLUDE AN
29 ESTIMATE OF THE TOTAL CHANGE IN MEDICAL PROFESSIONAL
30 LIABILITY INSURANCE LOSS-COST RESULTING FROM IMPLEMENTATION

1 OF THIS ACT PREPARED BY AN INDEPENDENT ACTUARY. THE FEE FOR
2 THE INDEPENDENT ACTUARY SHALL BE BORNE BY THE FUND. IN
3 DEVELOPING THE ESTIMATE, THE INDEPENDENT ACTUARY SHALL
4 CONSIDER ALL OF THE FOLLOWING:
5 (I) THE MOST RECENT ACCIDENT YEAR AND RATEMAKING
6 DATA AVAILABLE.
7 (II) ANY OTHER RELEVANT FACTORS WITHIN OR OUTSIDE
8 THIS COMMONWEALTH IN ACCORDANCE WITH SOUND ACTUARIAL
9 PRINCIPLES.
10 (B) ADDITIONAL STUDY.--THE FOLLOWING SHALL APPLY:
11 (1) THREE YEARS FOLLOWING THE INCREASE OF THE BASIC
12 INSURANCE COVERAGE REQUIREMENT IN ACCORDANCE WITH SECTION
13 711(D)(3), EACH INSURER PROVIDING MEDICAL PROFESSIONAL
14 LIABILITY INSURANCE IN THIS COMMONWEALTH SHALL FILE LOSS DATA
15 WITH THE COMMISSIONER UPON REQUEST. FOR FAILURE TO COMPLY,
16 THE COMMISSIONER SHALL IMPOSE AN ADMINISTRATIVE PENALTY OF
17 $1,000 FOR EVERY DAY THAT THIS DATA IS NOT PROVIDED IN
18 ACCORDANCE WITH THIS PARAGRAPH.
19 (2) THREE MONTHS FOLLOWING THE REQUEST MADE UNDER
20 PARAGRAPH (1), THE COMMISSIONER SHALL CONDUCT A STUDY
21 REGARDING THE AVAILABILITY OF ADDITIONAL BASIC INSURANCE
22 COVERAGE CAPACITY. THE STUDY SHALL INCLUDE AN ESTIMATE OF THE
23 TOTAL CHANGE IN MEDICAL PROFESSIONAL LIABILITY INSURANCE
24 LOSS-COST RESULTING FROM IMPLEMENTATION OF THIS ACT PREPARED
25 BY AN INDEPENDENT ACTUARY. THE FEE FOR THE INDEPENDENT
26 ACTUARY SHALL BE BORNE BY THE FUND. IN DEVELOPING THE
27 ESTIMATE, THE INDEPENDENT ACTUARY SHALL CONSIDER ALL OF THE
28 FOLLOWING:
29 (I) THE MOST RECENT ACCIDENT YEAR AND RATEMAKING
30 DATA AVAILABLE.

1 (II) ANY OTHER RELEVANT FACTORS WITHIN OR OUTSIDE
2 THIS COMMONWEALTH IN ACCORDANCE WITH SOUND ACTUARIAL
3 PRINCIPLES.]
4 SECTION 4. CHAPTER 7 OF THE ACT IS AMENDED BY ADDING
5 SUBCHAPTERS TO READ:
6 SUBCHAPTER E
7 PENNSYLVANIA ACCESS TO BASIC CARE
8 (PA ABC) PROGRAM FUND
9 SECTION 751. ESTABLISHMENT.
10 THERE IS ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND
11 TO BE KNOWN AS THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
12 PROGRAM FUND.
13 SECTION 752. ALLOCATION.
14 MONEY IN THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
15 PROGRAM FUND IS HEREBY APPROPRIATED UPON APPROVAL OF THE
16 GOVERNOR FOR HEALTH CARE COVERAGE AND SERVICES UNDER CHAPTER 13.
17 SUBCHAPTER F
18 CONTINUING ACCESS WITH RELIEF FOR
19 EMPLOYERS (CARE) FUND
20 SECTION 761. ESTABLISHMENT.
21 THERE IS ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND
22 TO BE KNOWN AS THE CONTINUING ACCESS WITH RELIEF FOR EMPLOYERS
23 (CARE) FUND.
24 SECTION 762. ALLOCATION.
25 MONEY IN THE CONTINUING ACCESS WITH RELIEF FOR EMPLOYERS
26 (CARE) FUND IS HEREBY APPROPRIATED ON A CONTINUING BASIS TO THE
27 DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT AND SHALL BE
28 DEDICATED TO ASSISTING CERTAIN EMPLOYERS THAT CURRENTLY OFFER
29 AND MAINTAIN HEALTH CARE COVERAGE FOR THEIR EMPLOYEES IN
30 COMPLIANCE WITH THE REQUIREMENTS UNDER SECTION 1308.

1 SECTION 5. THE DEFINITION OF "HEALTH CARE PROVIDER" IN
2 SECTION 1101 OF THE ACT, ADDED DECEMBER 22, 2005 (P.L.458,
3 NO.88), IS AMENDED TO READ:
4 SECTION 1101. DEFINITIONS.
5 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS CHAPTER
6 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
7 CONTEXT CLEARLY INDICATES OTHERWISE:
8 * * *
9 "HEALTH CARE PROVIDER." [AN INDIVIDUAL WHO IS ALL OF THE
10 FOLLOWING:
11 (1) A PHYSICIAN, LICENSED PODIATRIST, CERTIFIED NURSE
12 MIDWIFE OR NURSING HOME.
13 (2) A PARTICIPATING HEALTH CARE PROVIDER AS DEFINED IN
14 SECTION 702.] ANY OF THE FOLLOWING:
15 (1) A NURSING HOME OR BIRTH CENTER THAT IS A
16 PARTICIPATING HEALTH CARE PROVIDER AS DEFINED IN SECTION 702.
17 (2) AN INDIVIDUAL WHO IS A PHYSICIAN, LICENSED
18 PODIATRIST OR CERTIFIED NURSE MIDWIFE.
19 * * *
20 SECTION 6. SECTION 1102 OF THE ACT, AMENDED OCTOBER 27, 2006
21 (P.L.1198, NO.128), IS AMENDED TO READ:
22 SECTION 1102. ABATEMENT PROGRAM.
23 (A) ESTABLISHMENT.--THERE IS HEREBY ESTABLISHED WITHIN THE
24 INSURANCE DEPARTMENT A PROGRAM TO BE KNOWN AS THE HEALTH CARE
25 PROVIDER RETENTION PROGRAM. THE INSURANCE DEPARTMENT, IN
26 CONJUNCTION WITH THE DEPARTMENT OF PUBLIC WELFARE, SHALL
27 ADMINISTER THE PROGRAM. THE PROGRAM SHALL PROVIDE ASSISTANCE IN
28 THE FORM OF ASSESSMENT ABATEMENTS TO HEALTH CARE PROVIDERS FOR
29 CALENDAR YEARS [2003, 2004, 2005, 2006 AND 2007] BEGINNING 2003
30 AND ENDING 2017, EXCEPT THAT LICENSED PODIATRISTS SHALL NOT BE

1 ELIGIBLE FOR CALENDAR YEARS 2003 AND 2004, AND NURSING HOMES
2 SHALL NOT BE ELIGIBLE FOR CALENDAR YEARS 2003, 2004 AND 2005.
3 (B) OTHER [ABATEMENT.--] ABATEMENTS.--
4 (1) EMERGENCY PHYSICIANS NOT EMPLOYED FULL TIME BY A
5 TRAUMA CENTER OR WORKING UNDER AN EXCLUSIVE CONTRACT WITH A
6 TRAUMA CENTER SHALL RETAIN ELIGIBILITY FOR AN ABATEMENT
7 PURSUANT TO SECTION 1104(B)(2) FOR CALENDAR YEARS 2003, 2004,
8 2005 AND 2006. COMMENCING IN CALENDAR YEAR 2007, THESE
9 EMERGENCY PHYSICIANS SHALL BE ELIGIBLE FOR AN ABATEMENT
10 PURSUANT TO SECTION 1104(B)(1).
11 (2) BIRTH CENTERS SHALL RETAIN ELIGIBILITY FOR ABATEMENT
12 PURSUANT TO SECTION 1104(B)(2) FOR CALENDAR YEARS 2003, 2004,
13 2005, 2006 AND 2007. COMMENCING IN CALENDAR YEAR 2008, BIRTH
14 CENTERS SHALL BE ELIGIBLE FOR ABATEMENT PURSUANT TO SECTION
15 1104(B)(1).
16 SECTION 7. SECTION 1103 OF THE ACT, ADDED DECEMBER 22, 2005
17 (P.L.458, NO.88), IS AMENDED BY ADDING PARAGRAPHS TO READ:
18 SECTION 1103. ELIGIBILITY.
19 A HEALTH CARE PROVIDER SHALL NOT BE ELIGIBLE FOR [ASSESSMENT]
20 ABATEMENT UNDER THE PROGRAM IF ANY OF THE FOLLOWING APPLY:
21 * * *
22 (6) THE HEALTH CARE PROVIDER HAS REFUSED TO BE AN ACTIVE
23 PROVIDER IN THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
24 PROGRAM IN THE HEALTH CARE PROVIDER'S SERVICE AREA.
25 (7) THE ACTIVE HEALTH CARE PROVIDER IS AN ACTIVE
26 PROVIDER IN THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
27 PROGRAM AND PLACES RESTRICTIONS ON BENEFITS FOR PATIENTS
28 ENROLLED IN THAT PROGRAM.
29 (8) THE HEALTH CARE PROVIDER HAS REFUSED TO BE AN ACTIVE
30 PROVIDER IN THE CHILDREN'S HEALTH INSURANCE PROGRAM

1 ESTABLISHED UNDER ARTICLE XXIII OF THE ACT OF MAY 17, 1921
2 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF
3 1921.
4 (9) THE ACTIVE HEALTH CARE PROVIDER IS AN ACTIVE
5 PROVIDER IN THE CHILDREN'S HEALTH INSURANCE PROGRAM AND
6 PLACES RESTRICTIONS ON BENEFITS FOR PATIENTS ENROLLED IN THE
7 CHILDREN'S HEALTH INSURANCE PROGRAM.
8 (10) THE DEPARTMENT OF REVENUE HAS DETERMINED THAT THE
9 HEALTH CARE PROVIDER HAS NOT FILED ALL REQUIRED STATE TAX
10 REPORTS AND RETURNS FOR ALL APPLICABLE TAXABLE YEARS OR HAS
11 NOT PAID ANY BALANCE OF STATE TAX DUE AS DETERMINED AT
12 SETTLEMENT, ASSESSMENT OR DETERMINATION BY THE DEPARTMENT OF
13 REVENUE THAT ARE NOT SUBJECT TO A TIMELY PERFECTED
14 ADMINISTRATIVE OR JUDICIAL APPEAL OR SUBJECT TO A DULY
15 AUTHORIZED DEFERRED PAYMENT PLAN AS OF THE DATE OF
16 APPLICATION. NOTWITHSTANDING THE PROVISIONS OF SECTION 353(F)
17 OF THE ACT OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE TAX
18 REFORM CODE OF 1971, THE DEPARTMENT OF REVENUE SHALL SUPPLY
19 THE INSURANCE DEPARTMENT WITH INFORMATION CONCERNING THE
20 STATUS OF DELINQUENT TAXES OWED BY A HEALTH CARE PROVIDER FOR
21 PURPOSES OF THIS PARAGRAPH.
22 (11) (I) THE HEALTH CARE PROVIDER HAS NOT ATTENDED AT
23 LEAST ONE COMMONWEALTH-SPONSORED INDEPENDENT DRUG
24 INFORMATION SERVICE SESSION, EITHER IN PERSON OR BY
25 VIDEOCONFERENCE.
26 (II) THIS PARAGRAPH DOES NOT APPLY IF THE
27 COMMONWEALTH HAS NOT MADE A COMMONWEALTH-SPONSORED
28 INDEPENDENT DRUG INFORMATION SERVICE SESSION AVAILABLE TO
29 THE HEALTH CARE PROVIDER PRIOR TO THE DATE THAT THE
30 HEALTH CARE PROVIDER'S APPLICATION IS SUBMITTED UNDER

1 SECTION 1104.

2 SECTION 8. SECTION 1104(B) OF THE ACT, AMENDED DECEMBER 22,
3 2005 (P.L.458, NO.88), IS AMENDED TO READ:

4 SECTION 1104. PROCEDURE.

5 * * *

6 (B) REVIEW.--UPON RECEIPT OF A COMPLETED APPLICATION, THE
7 INSURANCE DEPARTMENT SHALL REVIEW THE APPLICANT'S INFORMATION
8 AND GRANT THE APPLICABLE ABATEMENT OF THE ASSESSMENT FOR THE
9 PREVIOUS CALENDAR YEAR SPECIFIED ON THE APPLICATION IN
10 ACCORDANCE WITH ALL OF THE FOLLOWING:

11 (1) THE INSURANCE DEPARTMENT SHALL NOTIFY THE DEPARTMENT
12 OF PUBLIC WELFARE THAT THE APPLICANT HAS SELF-CERTIFIED AS
13 ELIGIBLE AND WAS NOT DISQUALIFIED FOR AN ABATEMENT UNDER
14 SECTION 1103(6), (7), (8), (9), (10) AND (11) FOR A 100%
15 ABATEMENT OF THE IMPOSED ASSESSMENT IF THE HEALTH CARE
16 PROVIDER WAS ASSESSED UNDER SECTION 712(D) AS:

17 (I) A PHYSICIAN WHO IS ASSESSED AS A MEMBER OF ONE
18 OF THE FOUR HIGHEST RATE CLASSES OF THE PREVAILING
19 PRIMARY PREMIUM;

20 (II) AN EMERGENCY PHYSICIAN;

21 (III) A PHYSICIAN WHO ROUTINELY PROVIDES OBSTETRICAL
22 SERVICES IN RURAL AREAS AS DESIGNATED BY THE INSURANCE
23 DEPARTMENT; [OR]

24 (IV) A CERTIFIED NURSE MIDWIFE[.]; OR

25 (V) A BIRTH CENTER.

26 (2) THE INSURANCE DEPARTMENT SHALL NOTIFY THE DEPARTMENT
27 OF PUBLIC WELFARE THAT THE APPLICANT HAS SELF-CERTIFIED AS
28 ELIGIBLE AND WAS NOT DISQUALIFIED FOR AN ABATEMENT UNDER
29 SECTION 1103(6), (7), (8), (9), (10) AND (11) FOR A 50%
30 ABATEMENT OF THE IMPOSED ASSESSMENT IN CALENDAR YEARS 2008

1 THROUGH 2012, A 56.5% ABATEMENT IN CALENDAR YEAR 2013, A
2 63.5% ABATEMENT IN CALENDAR YEAR 2014, A 70% ABATEMENT IN
3 CALENDAR YEAR 2015, A 78% ABATEMENT IN CALENDAR YEAR 2016, AN
4 88% ABATEMENT IN CALENDAR YEAR 2017 AND A 100% ABATEMENT IN
5 CALENDAR YEAR 2018 IF THE HEALTH CARE PROVIDER WAS ASSESSED
6 UNDER SECTION 712(D) AS:
7 (I) A PHYSICIAN BUT IS A PHYSICIAN WHO DOES NOT
8 QUALIFY FOR ABATEMENT UNDER PARAGRAPH (1);
9 (II) A LICENSED PODIATRIST; [OR]
10 (III) A NURSING HOME[.]; OR
11 (IV) A BIRTH CENTER.
12 * * *
13 SECTION 9. SECTION 1112(C) AND (E) OF THE ACT, ADDED
14 DECEMBER 22, 2005 (P.L.458, NO.88), ARE AMENDED AND THE SECTION
15 IS AMENDED BY ADDING SUBSECTIONS TO READ:
16 SECTION 1112. HEALTH CARE PROVIDER RETENTION ACCOUNT.
17 * * *
18 (A.1) SUPPLEMENTAL ASSISTANCE AND FUNDING ACCOUNT.--THERE IS
19 ESTABLISHED WITHIN THE HEALTH CARE PROVIDER RETENTION ACCOUNT A
20 SPECIAL ACCOUNT TO BE KNOWN AS THE SUPPLEMENTAL ASSISTANCE AND
21 FUNDING ACCOUNT. FUNDS IN THIS ACCOUNT SHALL BE USED ANNUALLY TO
22 SUPPLEMENT THE FUNDING OF THE PENNSYLVANIA ACCESS TO BASIC CARE
23 (PA ABC) PROGRAM.
24 * * *
25 (C) TRANSFERS FROM ACCOUNT.--
26 (1) THE SECRETARY OF THE BUDGET MAY ANNUALLY TRANSFER
27 FROM THE ACCOUNT TO THE MEDICAL CARE AVAILABILITY AND
28 REDUCTION OF ERROR (MCARE) FUND AN AMOUNT UP TO THE AGGREGATE
29 AMOUNT OF ABATEMENTS GRANTED BY THE INSURANCE DEPARTMENT
30 UNDER SECTION 1104(B).

1 (2) IN ADDITION TO THE TRANSFERS SPECIFIED IN PARAGRAPH
2 (1), THE SECRETARY OF THE BUDGET MAY ALSO TRANSFER FUNDS FROM
3 THE ACCOUNT TO THE MEDICAL CARE AVAILABILITY AND REDUCTION OF
4 ERROR (MCARE) FUND FOR THE PURPOSE OF PAYING CLAIMS AND
5 OPERATING EXPENSES COMING DUE AFTER JANUARY 1, 2018.
6 (3) THE SECRETARY OF THE BUDGET MAY TRANSFER FUNDS FROM
7 THE ACCOUNT TO THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
8 PROGRAM FUND.
9 (4) THE SECRETARY OF THE BUDGET SHALL ANNUALLY TRANSFER
10 FROM THE ACCOUNT TO THE CONTINUING ACCESS RELIEF FOR
11 EMPLOYERS (CARE) FUND AN AMOUNT AT LEAST EQUAL TO THE AMOUNT
12 DEPOSITED UNDER SECTION 712(M).
13 (C.1) TRANSFERS FROM THE SUPPLEMENTAL ASSISTANCE AND FUNDING
14 ACCOUNT.--THE SECRETARY OF THE BUDGET SHALL ANNUALLY TRANSFER
15 FUNDS FROM THE SUPPLEMENTAL ASSISTANCE AND FUNDING ACCOUNT
16 ESTABLISHED UNDER SUBSECTION (A.1) TO THE PENNSYLVANIA ACCESS TO
17 BASIC CARE (PA ABC) PROGRAM FUND.
18 * * *
19 [(E) ADMINISTRATION ASSISTANCE.--THE INSURANCE DEPARTMENT
20 SHALL PROVIDE ASSISTANCE TO THE DEPARTMENT OF PUBLIC WELFARE IN
21 ADMINISTERING THE ACCOUNT.]
22 SECTION 10. SECTION 1115 OF THE ACT, AMENDED OCTOBER 27,
23 2006 (P.L.1198, NO.128), IS AMENDED TO READ:
24 SECTION 1115. EXPIRATION.
25 THE HEALTH CARE PROVIDER RETENTION PROGRAM ESTABLISHED UNDER
26 THIS CHAPTER SHALL EXPIRE DECEMBER 31, [2008] 2018.
27 SECTION 11. THE ACT IS AMENDED BY ADDING A CHAPTER TO READ:
28 CHAPTER 13
29 PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM
30 SECTION 1301. SCOPE.

1 THIS CHAPTER RELATES TO OFFERING HEALTH CARE COVERAGE TO
2 ELIGIBLE ADULTS, INDIVIDUALS, EMPLOYEES AND EMPLOYERS.
3 SECTION 1302. DEFINITIONS.
4 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS CHAPTER
5 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
6 CONTEXT CLEARLY INDICATES OTHERWISE:
7 "ADULTBASIC PROGRAM." THE ADULT BASIC COVERAGE INSURANCE
8 PROGRAM ESTABLISHED UNDER SECTION 1303 OF THE ACT OF JUNE 26,
9 2001 (P.L.755, NO.77), KNOWN AS THE TOBACCO SETTLEMENT ACT.
10 "AVERAGE ANNUAL WAGE." THE TOTAL ANNUAL WAGES PAID BY AN
11 EMPLOYER DIVIDED BY THE NUMBER OF THE EMPLOYER'S FULL-TIME
12 EQUIVALENT EMPLOYEES.
13 "BEHAVIORAL HEALTH SERVICES." MENTAL HEALTH OR SUBSTANCE
14 ABUSE SERVICES.
15 "CHILDREN'S HEALTH INSURANCE PROGRAM." THE CHILDREN'S HEALTH
16 CARE PROGRAM ESTABLISHED UNDER ARTICLE XXIII OF THE ACT OF MAY
17 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW
18 OF 1921.
19 "CHRONIC DISEASE MANAGEMENT PROGRAM." A PROGRAM THAT ALLOWS
20 A PATIENT, WITH THE SUPPORT OF A HEALTH CARE TEAM, TO PLAY AN
21 ACTIVE ROLE IN THE PATIENT'S CARE AND ASSURES THAT THERE IS AN
22 INFRASTRUCTURE TO ENSURE COMPLIANCE WITH ESTABLISHED PRACTICE
23 GUIDELINES.
24 "COMMUNITY HEALTH REINVESTMENT AGREEMENT." THE AGREEMENT ON
25 COMMUNITY HEALTH REINVESTMENT ENTERED INTO FEBRUARY 2, 2005, BY
26 THE INSURANCE DEPARTMENT AND CAPITAL BLUE CROSS, HIGHMARK INC.,
27 HOSPITAL SERVICE ASSOCIATION OF NORTHEASTERN PENNSYLVANIA AND
28 INDEPENDENCE BLUE CROSS AND PUBLISHED IN THE PENNSYLVANIA
29 BULLETIN AT 35 PA.B. 4155.
30 "CONTRACTOR." AN INSURER AWARDED A CONTRACT TO PROVIDE

1 HEALTH CARE SERVICES UNDER THIS CHAPTER. THE TERM INCLUDES AN
2 ENTITY AND ITS SUBSIDIARY WHICH IS ESTABLISHED UNDER 40 PA.C.S.
3 CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING
4 TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS), THE ACT OF
5 MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY
6 LAW OF 1921, OR THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364),
7 KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.
8 "DEPARTMENT." THE INSURANCE DEPARTMENT OF THE COMMONWEALTH.
9 "ELIGIBLE ADULT." AN INDIVIDUAL WHO MEETS ALL OF THE
10 FOLLOWING:
11 (1) IS AT LEAST 19 YEARS OF AGE BUT NOT MORE THAN 64
12 YEARS OF AGE.
13 (2) LEGALLY RESIDES WITHIN THE UNITED STATES.
14 (3) HAS BEEN DOMICILED IN THIS COMMONWEALTH FOR AT LEAST
15 90 DAYS PRIOR TO APPLICATION TO THE PROGRAM.
16 (4) IS INELIGIBLE TO RECEIVE CONTINUOUS ELIGIBILITY
17 COVERAGE UNDER TITLE XIX OR XXI OF THE SOCIAL SECURITY ACT
18 (49 STAT. 620, 42 U.S.C. § 301 ET SEQ.), EXCEPT FOR BENEFITS
19 AUTHORIZED UNDER A WAIVER GRANTED BY THE UNITED STATES
20 DEPARTMENT OF HEALTH AND HUMAN SERVICES TO IMPLEMENT THE
21 PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM.
22 (5) IS INELIGIBLE FOR MEDICAL ASSISTANCE OR MEDICARE.
23 (6) MAY CURRENTLY BE ENROLLED IN THE ADULTBASIC PROGRAM
24 OR IS ON THE WAITING LIST FOR THAT PROGRAM ON THE EFFECTIVE
25 DATE OF THIS SECTION.
26 (7) SUBJECT TO THE PROVISIONS OF SECTION 1305, HAS A
27 HOUSEHOLD INCOME THAT IS NO GREATER THAN 300% OF THE FEDERAL
28 POVERTY LEVEL AT THE TIME OF APPLICATION.
29 (8) HAS NOT BEEN COVERED BY ANY HEALTH INSURANCE PLAN OR
30 PROGRAM FOR AT LEAST 180 DAYS IMMEDIATELY PRECEDING THE DATE

1 OF APPLICATION, EXCEPT THAT THE 180-DAY PERIOD SHALL NOT
2 APPLY TO AN ELIGIBLE ADULT WHO MEETS ONE OF THE FOLLOWING:
3 (I) IS ELIGIBLE TO RECEIVE BENEFITS UNDER THE ACT OF
4 DECEMBER 5, 1936 (2ND SP.SESS., 1937 P.L.2897, NO.1),
5 KNOWN AS THE UNEMPLOYMENT COMPENSATION LAW;
6 (II) WAS COVERED UNDER A HEALTH INSURANCE PLAN OR
7 PROGRAM PROVIDED BY AN EMPLOYER, BUT AT THE TIME OF
8 APPLICATION IS NO LONGER COVERED BECAUSE OF A CHANGE IN
9 THE INDIVIDUAL'S EMPLOYMENT STATUS AND IS INELIGIBLE TO
10 RECEIVE BENEFITS UNDER THE UNEMPLOYMENT COMPENSATION LAW;
11 (III) LOST COVERAGE AS A RESULT OF DIVORCE OR
12 SEPARATION FROM A COVERED INDIVIDUAL, THE DEATH OF A
13 COVERED INDIVIDUAL OR A CHANGE IN EMPLOYMENT STATUS OF A
14 COVERED INDIVIDUAL; OR
15 (IV) IS TRANSFERRING FROM ANOTHER GOVERNMENT-
16 SUBSIDIZED HEALTH INSURANCE PROGRAM, INCLUDING A TRANSFER
17 THAT OCCURS AS A RESULT OF FAILURE TO MEET INCOME
18 ELIGIBILITY REQUIREMENTS.
19 "ELIGIBLE EMPLOYEE." AN ELIGIBLE ADULT OR AN EMPLOYEE WHO
20 MEETS ALL THE REQUIREMENTS OF AN ELIGIBLE ADULT OR EMPLOYEE AT
21 THE TIME THE ELIGIBLE EMPLOYER MAKES APPLICATION TO THE PROGRAM.
22 "ELIGIBLE EMPLOYER." AN EMPLOYER THAT MEETS ALL OF THE
23 FOLLOWING:
24 (1) HAS AT LEAST TWO BUT NOT MORE THAN 50 FULL-TIME
25 EQUIVALENT EMPLOYEES.
26 (2) HAS NOT OFFERED HEALTH CARE COVERAGE THROUGH ANY
27 PLAN OR PROGRAM DURING THE 180 DAYS IMMEDIATELY PRECEDING THE
28 DATE OF APPLICATION FOR PARTICIPATION IN THE PENNSYLVANIA
29 ACCESS TO BASIC CARE (PA ABC) PROGRAM.
30 (3) HAS NOT PROVIDED REMUNERATION IN ANY FORM TO AN

1 EMPLOYEE ON PAYROLL FOR THE PURCHASE OF HEALTH CARE COVERAGE
2 DURING THE 180 DAYS IMMEDIATELY PRECEDING THE DATE ON WHICH
3 THE EMPLOYER APPLIES FOR PARTICIPATION IN THE PROGRAM.
4 (4) PAYS AN AVERAGE ANNUAL WAGE THAT IS LESS THAN 300%
5 OF THE FEDERAL POVERTY LEVEL FOR AN INDIVIDUAL.
6 "EMPLOYEE." AN INDIVIDUAL WHO IS EMPLOYED FOR MORE THAN 20
7 HOURS IN A SINGLE WEEK AND FROM WHOSE WAGES AN EMPLOYER IS
8 REQUIRED UNDER THE INTERNAL REVENUE CODE OF 1986 (PUBLIC LAW 99-
9 514, 26 U.S.C. § 1 ET SEQ.) TO WITHHOLD FEDERAL INCOME TAX.
10 "EMPLOYER." THE TERM SHALL INCLUDE:
11 (1) ANY OF THE FOLLOWING WHO OR WHICH EMPLOYS TWO BUT
12 NOT MORE THAN 50 EMPLOYEES TO PERFORM SERVICES FOR
13 REMUNERATION:
14 (I) AN INDIVIDUAL, PARTNERSHIP, ASSOCIATION,
15 DOMESTIC OR FOREIGN CORPORATION OR OTHER ENTITY;
16 (II) THE LEGAL REPRESENTATIVE, TRUSTEE IN
17 BANKRUPTCY, RECEIVER OR TRUSTEE OF ANY INDIVIDUAL,
18 PARTNERSHIP, ASSOCIATION OR CORPORATION OR OTHER ENTITY;
19 OR
20 (III) THE LEGAL REPRESENTATIVE OF A DECEASED
21 INDIVIDUAL.
22 (2) AN INDIVIDUAL WHO IS SELF-EMPLOYED.
23 (3) THE EXECUTIVE, LEGISLATIVE AND JUDICIAL BRANCHES OF
24 THE COMMONWEALTH AND ANY ONE OF ITS POLITICAL SUBDIVISIONS.
25 "FUND." THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
26 PROGRAM FUND.
27 "HEALTH BENEFIT PLAN." AN INSURANCE COVERAGE PLAN THAT
28 PROVIDES THE BENEFITS SET FORTH UNDER SECTION 1313. THE TERM
29 DOES NOT INCLUDE ANY OF THE FOLLOWING:
30 (1) AN ACCIDENT-ONLY POLICY.

1 (2) A CREDIT-ONLY POLICY.
2 (3) A LONG-TERM OR DISABILITY INCOME POLICY.
3 (4) A SPECIFIED DISEASE POLICY.
4 (5) A MEDICARE SUPPLEMENT POLICY.
5 (6) A CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE
6 UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT POLICY.
7 (7) A FIXED INDEMNITY POLICY.
8 (8) A DENTAL-ONLY POLICY.
9 (9) A VISION-ONLY POLICY.
10 (10) A WORKERS' COMPENSATION POLICY.
11 (11) AN AUTOMOBILE MEDICAL PAYMENT POLICY PURSUANT TO 75
12 PA.C.S. (RELATING TO VEHICLES).
13 (12) SUCH OTHER SIMILAR POLICIES PROVIDING FOR LIMITED
14 BENEFITS.
15 "HEALTH CARE COVERAGE." A HEALTH BENEFIT PLAN OR OTHER FORM
16 OF HEALTH CARE COVERAGE THAT IS APPROVED BY THE DEPARTMENT OF
17 COMMUNITY AND ECONOMIC DEVELOPMENT IN CONSULTATION WITH THE
18 INSURANCE DEPARTMENT. THE TERM DOES NOT INCLUDE COVERAGE UNDER
19 THE PA ABC PROGRAM.
20 "HEALTH MAINTENANCE ORGANIZATION" OR "HMO." AN ENTITY
21 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972
22 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION
23 ACT.
24 "HEALTH SAVINGS ACCOUNT." AN ACCOUNT ESTABLISHED BY AN
25 EMPLOYER UNDER SECTION 1307 ON BEHALF OF AN EMPLOYEE WHOSE
26 INCOME IS GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL.
27 "HOSPITAL." AN INSTITUTION THAT HAS AN ORGANIZED MEDICAL
28 STAFF ENGAGED PRIMARILY IN PROVIDING TO INPATIENTS, BY OR UNDER
29 THE SUPERVISION OF PHYSICIANS, DIAGNOSTIC AND THERAPEUTIC
30 SERVICES FOR THE CARE OF INJURED, DISABLED, PREGNANT, DISEASED

1 OR SICK OR MENTALLY ILL PERSONS. THE TERM INCLUDES A FACILITY
2 FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS WITHIN THE SCOPE OF
3 SPECIFIC MEDICAL SPECIALTIES. THE TERM DOES NOT INCLUDE A
4 FACILITY THAT CARES EXCLUSIVELY FOR THE MENTALLY ILL.
5 "HOSPITAL PLAN CORPORATION." A HOSPITAL PLAN CORPORATION AS
6 DEFINED IN 40 PA.C.S. § 6101 (RELATING TO DEFINITIONS).
7 "INDIVIDUAL." A PERSON WHO MEETS ALL THE REQUIREMENTS OF AN
8 ELIGIBLE ADULT BUT WHOSE HOUSEHOLD INCOME IS GREATER THAN 300%
9 OF THE FEDERAL POVERTY LEVEL.
10 "INSURER." A COMPANY OR HEALTH INSURANCE ENTITY LICENSED IN
11 THIS COMMONWEALTH TO ISSUE AN INDIVIDUAL OR GROUP HEALTH,
12 SICKNESS OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR
13 CERTIFICATE OR PLAN THAT PROVIDES MEDICAL OR HEALTH CARE
14 COVERAGE BY A HEALTH CARE FACILITY OR LICENSED HEALTH CARE
15 PROVIDER AND THAT IS OFFERED OR GOVERNED UNDER THIS ACT OR ANY
16 OF THE FOLLOWING:
17 (1) THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS
18 THE INSURANCE COMPANY LAW OF 1921.
19 (2) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364),
20 KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.
21 (3) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS
22 THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM
23 STANDARDS ACT.
24 (4) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
25 CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES
26 PLAN CORPORATIONS).
27 "MEDICAL ASSISTANCE." THE STATE PROGRAM OF MEDICAL
28 ASSISTANCE ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31,
29 NO.21), KNOWN AS THE PUBLIC WELFARE CODE.
30 "MEDICAL LOSS RATIO." THE RATIO OF PAID MEDICAL CLAIM COSTS

1 TO EARNED PREMIUMS.

2 "MEDICARE." THE FEDERAL PROGRAM ESTABLISHED UNDER TITLE
3 XVIII OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395
4 ET SEQ.).

5 "OFFEROR." AN INSURER THAT SUBMITS A BID OR PROPOSAL UNDER
6 SECTION 1311 IN RESPONSE TO THE DEPARTMENT'S PROCUREMENT
7 SOLICITATION.

8 "PREEXISTING CONDITION." A DISEASE OR PHYSICAL CONDITION FOR
9 WHICH MEDICAL ADVICE OR TREATMENT HAS BEEN RECEIVED PRIOR TO THE
10 EFFECTIVE DATE OF COVERAGE.

11 "PRESCRIPTION DRUG." A CONTROLLED SUBSTANCE, OTHER DRUG OR
12 DEVICE FOR MEDICATION DISPENSED BY ORDER OF AN APPROPRIATELY
13 LICENSED MEDICAL PROFESSIONAL.

14 "PROFESSIONAL HEALTH SERVICES PLAN CORPORATION." A NOT-FOR-
15 PROFIT CORPORATION OPERATING UNDER THE PROVISIONS OF 40 PA.C.S.
16 CH. 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN
17 CORPORATIONS).

18 "PROGRAM." THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC)
19 PROGRAM ESTABLISHED UNDER THIS CHAPTER.

20 "QUALIFYING HEALTH CARE COVERAGE." A HEALTH BENEFIT PLAN OR
21 OTHER FORM OF HEALTH CARE COVERAGE ACTUARIALLY EQUIVALENT TO THE
22 BENEFITS IN SECTION 1313 AND APPROVED BY THE INSURANCE
23 DEPARTMENT.

24 "TERMINATE." THE TERM INCLUDES CANCELLATION, NONRENEWAL AND
25 RESCISSION.

26 "UNEMPLOYMENT COMPENSATION LAW." THE ACT OF DECEMBER 5, 1936
27 (2ND SP.SESS., 1937 P.L.2897, NO.1), KNOWN AS THE UNEMPLOYMENT
28 COMPENSATION LAW.

29 "UNINSURED PERIOD." A CONTINUOUS PERIOD OF TIME OF NOT LESS
30 THAN 180 CONSECUTIVE DAYS IMMEDIATELY PRECEDING ENROLLMENT

1 APPLICATION DURING WHICH AN ADULT HAS BEEN WITHOUT HEALTH CARE
2 COVERAGE IN ACCORDANCE WITH THE REQUIREMENTS OF THIS CHAPTER.
3 SECTION 1303. ESTABLISHMENT OF PROGRAM.
4 THE PENNSYLVANIA ACCESS TO BASIC CARE (PA ABC) PROGRAM IS
5 ESTABLISHED IN THE DEPARTMENT.
6 SECTION 1304. FUNDING.
7 (A) SOURCES.--THE FOLLOWING ARE THE SOURCES OF MONEY FOR THE
8 PROGRAM:
9 (1) MONEY RECEIVED FROM THE SUPPLEMENTAL ASSISTANCE AND
10 FUNDING ACCOUNT ESTABLISHED UNDER SECTION 1112(A.1).
11 (2) MONEY RECEIVED FROM THE FEDERAL GOVERNMENT OR OTHER
12 SOURCES.
13 (3) MONEY REQUIRED TO BE DEPOSITED PURSUANT TO OTHER
14 PROVISIONS OF THIS CHAPTER OR ANY OTHER LAW OF THIS
15 COMMONWEALTH.
16 (4) UPON IMPLEMENTATION OF THE PROGRAM:
17 (I) ONLY THOSE FUNDS APPROPRIATED FOR HEALTH
18 INVESTMENT INSURANCE UNDER SECTION 306(B)(1)(VI) OF THE
19 ACT OF JUNE 26, 2001 (P.L.755, NO.77), KNOWN AS THE
20 TOBACCO SETTLEMENT ACT, AND DESIGNATED FOR THE ADULTBASIC
21 PROGRAM.
22 (II) MONEY CURRENTLY REQUIRED TO BE DEDICATED TO THE
23 ADULTBASIC PROGRAM OR ANY ALTERNATIVE PROGRAM TO BENEFIT
24 PERSONS OF LOW INCOME UNDER THE COMMUNITY HEALTH
25 REINVESTMENT AGREEMENT WITHIN THE RESPECTIVE SERVICE
26 AREAS FOR EACH PARTY TO THAT AGREEMENT. MONEY UNDER THIS
27 SUBPARAGRAPH SHALL BE USED ONLY TO DEFRAY THE COST OF THE
28 PROGRAM AND SUBSIDIES APPROVED UNDER SECTIONS 1305 AND
29 1306.
30 (5) ANY MONEYS DERIVED FROM WHATEVER SOURCES AND

1 DESIGNATED SPECIFICALLY TO FUND THE PROGRAM.
2 (6) RETURN ON INVESTMENTS IN THE FUND.
3 SECTION 1305. PURCHASE BY ELIGIBLE ADULTS AND INDIVIDUALS.
4 (A) ELIGIBLE ADULTS.--AN ELIGIBLE ADULT WHO SEEKS TO
5 PURCHASE COVERAGE UNDER THE PROGRAM MUST:
6 (1) SUBMIT AN APPLICATION TO THE DEPARTMENT OR ITS
7 CONTRACTOR.
8 (2) PAY TO THE DEPARTMENT OR ITS CONTRACTOR THE AMOUNT
9 OF THE PREMIUM SPECIFIED.
10 (3) BE RESPONSIBLE FOR ANY REQUIRED COPAYMENTS FOR
11 HEALTH CARE SERVICES RENDERED UNDER THE HEALTH BENEFIT PLAN
12 IN SECTION 1313 SUBJECT TO FEDERAL WAIVER REQUIREMENTS.
13 (4) NOTIFY THE DEPARTMENT OR ITS CONTRACTOR OF ANY
14 CHANGE IN THE ELIGIBLE ADULT'S OR INDIVIDUAL'S HOUSEHOLD
15 INCOME.
16 (B) MONTHLY PREMIUMS.--EXCEPT TO THE EXTENT THAT CHANGES MAY
17 BE NECESSARY TO MEET FEDERAL REQUIREMENTS UNDER SECTION 1317 OR
18 TO ENCOURAGE ELIGIBLE EMPLOYER PARTICIPATION, SUBSIDIES FOR THE
19 2008-2009 FISCAL YEAR AND EACH FISCAL YEAR THEREAFTER SHALL
20 RESULT IN THE FOLLOWING PREMIUM AMOUNT BASED ON HOUSEHOLD INCOME
21 FOR A HEALTH BENEFIT PLAN:
22 (1) FOR AN ELIGIBLE ADULT WHOSE HOUSEHOLD INCOME IS NOT
23 GREATER THAN 150% OF THE FEDERAL POVERTY LEVEL, NO MONTHLY
24 PREMIUM.
25 (2) FOR AN ELIGIBLE ADULT WHOSE HOUSEHOLD INCOME IS
26 GREATER THAN 150% BUT NOT GREATER THAN 175% OF THE FEDERAL
27 POVERTY LEVEL, A MONTHLY PREMIUM OF $40.
28 (3) FOR AN ELIGIBLE ADULT WHOSE HOUSEHOLD INCOME IS
29 GREATER THAN 175% BUT NOT GREATER THAN 200% OF THE FEDERAL
30 POVERTY LEVEL, A MONTHLY PREMIUM OF $50.

1 (4) FOR AN ELIGIBLE ADULT WHOSE HOUSEHOLD INCOME IS
2 GREATER THAN 200%, A MONTHLY PREMIUM MAY BE ESTABLISHED BASED
3 UPON FEDERAL REQUIREMENTS AND IN ACCORDANCE WITH FEDERAL
4 WAIVERS, IF APPLICABLE, BY THE COMMISSIONER.
5 (C) OTHER ELIGIBLE ADULTS.--AN ELIGIBLE ADULT WHOSE
6 HOUSEHOLD INCOME IS GREATER THAN 200% OF THE FEDERAL POVERTY
7 LEVEL MAY PURCHASE UNDER THE PROGRAM EITHER THE BENEFIT PACKAGE
8 UNDER SECTION 1313 OR OTHER QUALIFYING HEALTH CARE COVERAGE AT
9 THE PER-MEMBER, PER-MONTH PREMIUM COST.
10 (D) INDIVIDUALS.--FOR AN INDIVIDUAL WHOSE HOUSEHOLD INCOME
11 IS GREATER THAN 300% OF THE FEDERAL POVERTY LEVEL, AN INDIVIDUAL
12 MAY PURCHASE THE BENEFIT PACKAGE UNDER SECTION 1313 AT THE PER-
13 MEMBER, PER-MONTH PREMIUM COST AS LONG AS THE INDIVIDUAL
14 DEMONSTRATES, ON AN ANNUAL BASIS AND IN A MANNER DETERMINED BY
15 THE DEPARTMENT, EITHER ONE OF THE FOLLOWING:
16 (1) THE INDIVIDUAL IS UNABLE TO AFFORD INDIVIDUAL OR
17 GROUP COVERAGE BECAUSE THAT COVERAGE WOULD EXCEED 10% OF THE
18 INDIVIDUAL'S HOUSEHOLD INCOME OR BECAUSE THE TOTAL COST OF
19 COVERAGE FOR THE INDIVIDUAL IS 150% OF THE PREMIUM COST
20 ESTABLISHED UNDER THIS SECTION FOR THAT SERVICE AREA.
21 (2) THE INDIVIDUAL HAS BEEN REFUSED COVERAGE BY AN
22 INSURER BECAUSE THE INDIVIDUAL OR A MEMBER OF THAT
23 INDIVIDUAL'S IMMEDIATE FAMILY HAS A PREEXISTING CONDITION AND
24 COVERAGE IS NOT AVAILABLE TO THE INDIVIDUAL.
25 (E) ESTABLISHING PREMIUMS.--FOR EACH FISCAL YEAR BEGINNING
26 AFTER JUNE 30, 2009, THE DEPARTMENT MAY ADJUST THE PREMIUM
27 AMOUNTS UNDER SUBSECTION (B) TO REFLECT CHANGES IN THE COST OF
28 MEDICAL SERVICES AND SHALL FORWARD NOTICE OF THE NEW PREMIUM
29 AMOUNTS TO THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION AS A
30 NOTICE IN THE PENNSYLVANIA BULLETIN.

1 (F) PURCHASE OF HEALTH BENEFIT PLAN.--AN ELIGIBLE ADULT'S OR
2 INDIVIDUAL'S PAYMENT TO THE DEPARTMENT OR ITS CONTRACTOR UNDER
3 SUBSECTION (B) SHALL BE USED TO PURCHASE THE BENEFIT HEALTH PLAN
4 ESTABLISHED UNDER SECTION 1313 AND MUST BE REMITTED IN A TIMELY
5 MANNER.
6 (G) SUBSIDY.--FUNDING FOR THE PROGRAM SHALL BE USED BY THE
7 DEPARTMENT TO PAY THE DIFFERENCE BETWEEN THE TOTAL MONTHLY COST
8 OF THE HEALTH BENEFIT PLAN AND THE ELIGIBLE ADULT'S PREMIUM.
9 SUBSIDIZATION OF THE HEALTH BENEFIT PLAN IS CONTINGENT UPON THE
10 AMOUNT OF THE FUNDING FOR THE PROGRAM AND IS LIMITED TO ELIGIBLE
11 ADULTS IN COMPLIANCE WITH THIS SECTION.
12 SECTION 1306. PARTICIPATION BY ELIGIBLE EMPLOYERS AND ELIGIBLE
13 EMPLOYEES.
14 (A) ELIGIBLE EMPLOYERS.--AN ELIGIBLE EMPLOYER THAT SEEKS TO
15 PARTICIPATE IN THE PROGRAM SHALL:
16 (1) OFFER TO ALL ELIGIBLE EMPLOYEES THE OPPORTUNITY TO
17 PARTICIPATE IN THE PROGRAM AND ENROLL AT LEAST ONE-HALF OF
18 THE ELIGIBLE EMPLOYEES.
19 (2) COMPLY WITH THE APPLICATION PROCESS ESTABLISHED BY
20 THE DEPARTMENT OR ITS CONTRACTOR.
21 (3) REMIT TO THE DEPARTMENT OR ITS CONTRACTOR ANY
22 PREMIUM AMOUNTS REQUIRED UNDER SUBSECTIONS (C) AND (D).
23 (4) ALLOW HEALTH INSURANCE PREMIUMS TO BE PAID BY
24 ELIGIBLE EMPLOYEES ON A PRETAX BASIS AND INFORM ITS EMPLOYEES
25 OF THE AVAILABILITY OF SUCH PROGRAM.
26 (5) NOTIFY THE DEPARTMENT OR ITS CONTRACTOR OF ANY
27 CHANGE IN THE ELIGIBLE EMPLOYEE'S INCOME.
28 (B) ELIGIBLE EMPLOYEES.--AN ELIGIBLE EMPLOYEE WHO SEEKS TO
29 PARTICIPATE WITH AN ELIGIBLE EMPLOYER UNDER THE PROGRAM MUST:
30 (1) SUBMIT AN APPLICATION WITH THE ELIGIBLE EMPLOYER TO

1 THE DEPARTMENT OR ITS CONTRACTOR.
2 (2) BE RESPONSIBLE FOR ANY REQUIRED COPAYMENTS FOR
3 HEALTH CARE SERVICES RENDERED UNDER THE HEALTH BENEFIT PLAN
4 IN SECTION 1313.
5 (C) PREMIUMS FOR EMPLOYERS.--
6 (1) IN ADDITION TO REMITTING THE ELIGIBLE EMPLOYEE
7 PORTION UNDER SUBSECTIONS (A) AND (D), AN ELIGIBLE EMPLOYER
8 SHALL PAY THE EMPLOYER SHARE OF THE TOTAL MONTHLY COST FOR
9 EACH PARTICIPATING EMPLOYEE TO THE DEPARTMENT OR ITS
10 CONTRACTOR EACH MONTH.
11 (2) IN ADDITION TO REMITTING THE ELIGIBLE EMPLOYEE
12 PORTION UNDER PARAGRAPH (1), AN ELIGIBLE EMPLOYER'S PREMIUM
13 PAYMENT TO THE DEPARTMENT OR ITS CONTRACTOR SHALL BE AT LEAST
14 50% OF THE TOTAL MONTHLY COST FOR EACH ELIGIBLE EMPLOYEE BUT
15 NOT LESS THAN $150.
16 (D) PREMIUMS FOR ELIGIBLE EMPLOYEES.--THE PREMIUM FOR
17 ELIGIBLE EMPLOYEES SHALL BE THE SAME AS THE PREMIUM REQUIRED TO
18 BE PAID BY ELIGIBLE ADULTS UNDER SECTION 1305(B).
19 (E) PURCHASE BY CERTAIN ELIGIBLE EMPLOYEES.--AN ELIGIBLE
20 EMPLOYEE WHOSE HOUSEHOLD INCOME IS GREATER THAN 200% OF THE
21 FEDERAL POVERTY LEVEL MAY PURCHASE EITHER THE BENEFIT PACKAGE
22 UNDER SECTION 1313 OR OTHER QUALIFYING HEALTH CARE COVERAGE
23 UNDER SECTION 1307 AT THE PER-MEMBER, PER-MONTH PREMIUM COST
24 MINUS ANY AMOUNT REMITTED BY THE EMPLOYER UNDER SUBSECTION (C).
25 (F) PUBLISHING PREMIUM AMOUNTS.--FOR EACH FISCAL YEAR
26 BEGINNING AFTER JUNE 30, 2009, THE DEPARTMENT MAY ESTABLISH
27 DIFFERENT PREMIUM AMOUNTS FOR ELIGIBLE EMPLOYEES AND ELIGIBLE
28 EMPLOYERS AS REQUIRED UNDER THIS SECTION AND SHALL FORWARD
29 NOTICE OF THE NEW PREMIUM AMOUNTS TO THE LEGISLATIVE REFERENCE
30 BUREAU FOR PUBLICATION AS A NOTICE IN THE PENNSYLVANIA BULLETIN.

(G) PURCHASE OF COVERAGE.--A PREMIUM PAYMENT MADE BY AN ELIGIBLE EMPLOYER TO THE DEPARTMENT OR ITS CONTRACTOR SHALL BE USED TO PURCHASE THE HEALTH BENEFIT PLAN AND MUST BE REMITTED IN A TIMELY MANNER.

(H) ALTERNATIVE COVERAGE.--

(1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, EMPLOYER-BASED COVERAGE MAY, IN THE COMMISSIONER'S SOLE DISCRETION, BE PURCHASED IN PLACE OF PARTICIPATION IN THE PROGRAM OR MAY BE PURCHASED IN CONJUNCTION WITH ANY PORTION OF THE PROGRAM PROVIDED OUTSIDE THE SCOPE OF THE PROGRAM CONTRACTS BY THE COMMONWEALTH PAYING THE EMPLOYEE'S SHARE OF THE PREMIUM TO THE EMPLOYER IF IT IS MORE COST EFFECTIVE FOR THE COMMONWEALTH TO PURCHASE HEALTH CARE COVERAGE FROM AN EMPLOYEE'S EMPLOYER-BASED PROGRAM THAN TO PAY THE COMMONWEALTH'S SHARE OF A SUBSIDIZED PREMIUM.

(2) THIS SECTION SHALL APPLY TO ANY EMPLOYER-BASED PROGRAM, WHETHER INDIVIDUAL OR FAMILY, SUCH THAT IF THE 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 (1) AND WHETHER THAT HEALTH CARE COVERAGE IS FOR THE EMPLOYEE
2 OR THE EMPLOYEE AND THE EMPLOYEE'S SPOUSE AND/OR DEPENDENTS.
3 (3) THE NAMES AND ADDRESSES OF THE INSURANCE CARRIERS OR
4 UNDERWRITERS THAT RECEIVED PAYMENT FROM THE EMPLOYER FOR THE
5 HEALTH CARE COVERAGE PROVIDED UNDER PARAGRAPH (2).
6 (D) COMPUTATION.--AN EMPLOYER WHO QUALIFIES UNDER SUBSECTION
7 (B) SHALL RECEIVE A GRANT LIMITED TO ACTUAL EMPLOYER HEALTH CARE
8 EXPENSES PAID FOR THE PREVIOUS 12 CONSECUTIVE MONTHS IN
9 ACCORDANCE WITH THE FOLLOWING:
10 (1) NO GREATER THAN 25% OF THE EMPLOYER'S HEALTH CARE
11 EXPENSE TO MAINTAIN HEALTH CARE COVERAGE FOR THE EMPLOYEE.
12 (2) NO GREATER THAN 50% OF THE EMPLOYER'S HEALTH CARE
13 EXPENSE TO MAINTAIN HEALTH CARE COVERAGE FOR THE EMPLOYEE,
14 THE EMPLOYEE'S SPOUSE AND/OR DEPENDENTS.
15 (3) THE TOTAL AMOUNT OF PARAGRAPHS (1) AND (2) SHALL NOT
16 EXCEED THE TAX LIABILITY OWED BY THE EMPLOYER FOR THE YEAR
17 APPLICATION IS MADE FOR THE CARE GRANT.
18 (4) IF NO TAX LIABILITY IS OWED BY THE EMPLOYER THEN THE
19 EMPLOYER MAY NOT APPLY FOR A CARE GRANT.
20 (E) DUTIES OF DEPARTMENT.--THE DEPARTMENT HAS THE FOLLOWING
21 DUTIES:
22 (1) ADMINISTER THE PROGRAM.
23 (2) IN CONSULTATION WITH OTHER APPROPRIATE COMMONWEALTH
24 AGENCIES:
25 (I) DEVELOP AN APPLICATION FOR THE COLLECTION OF
26 INFORMATION THAT IS CONSISTENT WITH THE REQUIREMENTS OF
27 THIS SECTION AND THAT CONTAINS ANY OTHER INFORMATION THAT
28 MAY BE NECESSARY TO AWARD CARE GRANTS.
29 (II) DEVELOP A PROCESS TO DETERMINE THE VALIDITY OF
30 INFORMATION COLLECTED BY THE DEPARTMENT FROM THE

1 APPLICATION WITH INFORMATION FILED BY THE EMPLOYER, THE
2 EMPLOYEE OR INSURERS WITH ANY OTHER AGENCY. THIS PROCESS
3 SHALL INCLUDE GUARANTEEING CONFIDENTIALITY OF EMPLOYER
4 AND EMPLOYEE INFORMATION THAT IS CONSISTENT WITH FEDERAL
5 AND STATE LAWS.
6 (F) COORDINATION.--THE DEPARTMENT SHALL COORDINATE WITH
7 OTHER DEPARTMENTS IN THE IMPLEMENTATION OF THIS SECTION.
8 (G) LIMITATION ON GRANTS.--THE TOTAL AMOUNT OF GRANTS
9 APPROVED BY THE DEPARTMENT SHALL NOT EXCEED THE AMOUNT OF
10 FUNDING DESIGNATED UNDER SECTION 762. ANY APPLICATION FILED BY
11 AN EMPLOYER WHEN FUNDING IS NOT AVAILABLE SHALL NOT BE
12 CONSIDERED AND CANNOT BE CARRIED FORWARD FOR CONSIDERATION IN
13 ANY SUCCEEDING FISCAL YEAR.
14 (H) LAPSE.--FUNDS NOT USED BY THE DEPARTMENT FOR CARE GRANTS
15 AT THE END OF THE FISCAL YEAR SHALL LAPSE BACK TO THE HEALTH
16 CARE PROVIDER RETENTION ACCOUNT AND BE DESIGNATED TO THE PA ABC
17 PROGRAM.
18 (I) REPORT TO GENERAL ASSEMBLY.--THE DEPARTMENT SHALL SUBMIT
19 AN ANNUAL REPORT TO THE GENERAL ASSEMBLY INDICATING THE
20 EFFECTIVENESS OF THE PROGRAM PROVIDED UNDER THIS SECTION NO
21 LATER THAN MARCH 15, 2010. THE REPORT SHALL INCLUDE THE NAMES OF
22 ALL THE EMPLOYERS THAT RECEIVED A CARE GRANT AS OF THE DATE OF
23 THE REPORT AND THE AMOUNT OF EACH CARE GRANT APPROVED. THE
24 REPORT MAY ALSO INCLUDE ANY RECOMMENDATIONS FOR CHANGES IN THE
25 CALCULATION OR ADMINISTRATION OF THE CARE GRANT.
26 (J) SUNSET.--THIS SECTION SHALL SUNSET JANUARY 1, 2018.
27 (K) DEFINITIONS.--AS USED IN THIS SECTION, THE FOLLOWING
28 WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS
29 SUBSECTION:
30 "CARE GRANT." A CONTINUING ACCESS WITH RELIEF FOR EMPLOYERS

1 (CARE) GRANT PROVIDED BY THE DEPARTMENT OF COMMUNITY AND
2 ECONOMIC DEVELOPMENT.
3 "COVERAGE." HEALTH CARE COVERAGE THAT IS MAINTAINED BY AN
4 EMPLOYER FOR AN EMPLOYEE, THE EMPLOYEE'S SPOUSE AND/OR
5 DEPENDENTS FOR 12 CONSECUTIVE MONTHS.
6 "DEPARTMENT." THE DEPARTMENT OF COMMUNITY AND ECONOMIC
7 DEVELOPMENT OF THE COMMONWEALTH.
8 "EMPLOYEE." AN INDIVIDUAL WHO MEETS THE FOLLOWING:
9 (1) IS EMPLOYED FOR MORE THAN 20 HOURS IN A SINGLE WEEK
10 AND FROM WHOSE WAGES AN EMPLOYER IS REQUIRED UNDER THE
11 INTERNAL REVENUE CODE OF 1986 (PUBLIC LAW 99-514, 26 U.S.C.
12 §1 ET SEQ.) TO WITHHOLD FEDERAL INCOME TAX.
13 (2) IS AT LEAST 19 YEARS OF AGE BUT NO OLDER THAN 64
14 YEARS OF AGE.
15 (3) LEGALLY RESIDES WITHIN THE UNITED STATES.
16 (4) HAS BEEN DOMICILED IN THIS COMMONWEALTH FOR AT LEAST
17 90 DAYS PRIOR TO ENROLLMENT.
18 (5) HAS A HOUSEHOLD INCOME THAT IS NO GREATER THAN 300%
19 OF THE FEDERAL POVERTY LEVEL AT THE TIME OF APPLICATION.
20 "EMPLOYER." AN EMPLOYER THAT MEETS ALL OF THE FOLLOWING:
21 (1) HAS AT LEAST TWO, BUT NOT MORE THAN 50 FULL-TIME
22 EQUIVALENT EMPLOYEES.
23 (2) PAYS AN AVERAGE ANNUAL WAGE THAT IS NOT GREATER THAN
24 300% OF THE FEDERAL POVERTY LIMIT FOR AN INDIVIDUAL.
25 "HEALTH CARE COVERAGE." A HEALTH BENEFIT PLAN OR OTHER FORM
26 OF HEALTH CARE COVERAGE THAT IS APPROVED BY THE DEPARTMENT OF
27 COMMUNITY AND ECONOMIC DEVELOPMENT IN CONSULTATION WITH THE
28 INSURANCE DEPARTMENT. THE TERM DOES NOT INCLUDE COVERAGE UNDER
29 THE PA ABC PROGRAM.
30 "HEALTH CARE EXPENSE." A PAYMENT MADE BY AN EMPLOYER TO

1 MAINTAIN HEALTH CARE COVERAGE FOR AN EMPLOYEE, THE EMPLOYEE'S
2 SPOUSE AND/OR DEPENDENTS.
3 "PROGRAM." THE CONTINUING ACCESS WITH RELIEF FOR EMPLOYERS
4 (CARE) GRANT PROGRAM ESTABLISHED UNDER THIS SECTION.
5 "TAX LIABILITY." LIABILITY UNDER ARTICLE III, IV OR VI OF
6 THE ACT OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE TAX REFORM
7 CODE OF 1971.
8 SECTION 1309. PROGRAM REQUIREMENTS.
9 (A) RATES.--RATES FOR THE PROGRAM SHALL BE APPROVED ANNUALLY
10 BY THE DEPARTMENT AND MAY VARY BY REGION AND CONTRACTOR. RATES
11 SHALL BE BASED ON AN ACTUARIALLY SOUND AND ADEQUATE REVIEW.
12 (B) ANNUAL PREMIUMS REVIEW.--PREMIUMS FOR THE PROGRAM SHALL
13 BE ESTABLISHED ANNUALLY BY THE DEPARTMENT.
14 (C) USE OF FUNDING.--FUNDING SHALL BE USED BY THE DEPARTMENT
15 TO PAY THE DIFFERENCE BETWEEN THE TOTAL MONTHLY COST OF THE
16 HEALTH BENEFIT PLAN AND THE PREMIUM PAYMENTS BY THE ELIGIBLE
17 EMPLOYEE, THE ELIGIBLE EMPLOYER OR THE ELIGIBLE ADULT.
18 (D) MONTHLY INCREASES.--WITH RESPECT TO A CONTINUOUS PERIOD
19 OF ELIGIBILITY FOR AN ELIGIBLE EMPLOYER TO APPLY FOR
20 PARTICIPATION IN THE PROGRAM AND IN ADDITION TO THE REQUIREMENTS
21 OF SECTION 1306(D), AN ELIGIBLE EMPLOYER SHALL BE SUBJECT TO A
22 1% INCREASE IN THE BASE PREMIUM FOR EACH MONTH AFTER THE LATTER
23 OF THE FOLLOWING:
24 (1) TWELVE MONTHS FROM THE DATE OF THE EFFECTIVE DATE OF
25 THIS SECTION; OR
26 (2) TWELVE MONTHS FROM THE DATE THE ELIGIBLE EMPLOYER
27 FILES FOR A FEDERAL OR STATE TAX IDENTIFICATION NUMBER.
28 (E) FUNDING CONTINGENCY FOR SUBSIDIZATION.--SUBSIDIZATION OF
29 PREMIUMS PAID UNDER SECTIONS 1305 AND 1306 IS CONTINGENT UPON
30 THE AMOUNT OF THE FUNDING AVAILABLE TO THE PROGRAM, THE FEDERAL

1 POVERTY LEVELS APPROVED BY THE FEDERAL WAIVER OR STATE PLAN
2 AMENDMENTS GRANTED UNDER SECTION 1317 AND IS LIMITED TO ELIGIBLE
3 ADULTS AND ELIGIBLE EMPLOYEES WHO ARE IN COMPLIANCE WITH THE
4 REQUIREMENTS UNDER THIS CHAPTER.
5 (F) LIMIT ON SUBSIDY.--AT NO TIME SHALL THE SUBSIDY PAID BY
6 THE COMMONWEALTH FROM FUNDS OTHER THAN FEDERAL MONEYS FOR THE
7 PREMIUM OF ELIGIBLE EMPLOYEES BE MORE THAN 40% OF THE TOTAL COST
8 OF THE HEALTH BENEFIT PLAN PURCHASED IN EACH REGION OR WITH EACH
9 CONTRACTOR.
10 SECTION 1310. DUTIES OF DEPARTMENT.
11 THE DEPARTMENT HAS THE FOLLOWING DUTIES:
12 (1) ADMINISTER THE PROGRAM ON A STATEWIDE BASIS.
13 (2) SOLICIT BIDS OR PROPOSALS AND AWARD CONTRACTS AS
14 FOLLOWS:
15 (I) THE DEPARTMENT SHALL SOLICIT BIDS OR PROPOSALS
16 AND AWARD CONTRACTS FOR THE BASIC BENEFIT PACKAGE UNDER
17 SECTION 1313 THROUGH A COMPETITIVE PROCUREMENT PROCESS IN
18 ACCORDANCE WITH 62 PA.C.S. (RELATING TO PROCUREMENT) AND
19 SECTION 1311. THE DEPARTMENT MAY AWARD CONTRACTS ON A
20 MULTIPLE-AWARD BASIS AS DESCRIBED IN 62 PA.C.S. § 517
21 (RELATING TO MULTIPLE AWARDS).
22 (II) (A) IN ORDER TO EFFECTUATE THE PROGRAM
23 PROMPTLY UPON RECEIPT OF ALL APPLICABLE WAIVERS AND
24 APPROVALS FROM THE FEDERAL GOVERNMENT, THE DEPARTMENT
25 MAY AMEND SUCH CONTRACTS AS CURRENTLY EXIST TO
26 PROVIDE BENEFITS UNDER EITHER THE ADULTBASIC PROGRAM
27 OR THE PUBLIC WELFARE CODE, OR MAY OTHERWISE PROCURE
28 SERVICES OUTSIDE OF THE COMPETITIVE PROCUREMENT
29 PROCESS OF 62 PA.C.S.
30 (B) THIS SUBPARAGRAPH SHALL EXPIRE AT SUCH TIME

1 AS THERE ARE EFFECTIVE CONTRACTS AWARDED UNDER THIS
2 SECTION IN EVERY COUNTY OF THIS COMMONWEALTH, BUT NOT
3 LATER THAN 18 MONTHS AFTER THE EFFECTIVE DATE OF THIS
4 SECTION.
5 (3) SUBJECT TO FEDERAL REQUIREMENTS, IMPOSE REASONABLE
6 COST-SHARING ARRANGEMENTS AND ENCOURAGE APPROPRIATE USE BY
7 CONTRACTORS OF COST-EFFECTIVE HEALTH CARE PROVIDERS WHO WILL
8 PROVIDE QUALITY HEALTH CARE BY ESTABLISHING AND ADJUSTING
9 COPAYMENTS TO BE INCORPORATED INTO THE PROGRAM BY
10 CONTRACTORS. THE DEPARTMENT SHALL FORWARD CHANGES OF
11 COPAYMENTS TO THE LEGISLATIVE REFERENCE BUREAU FOR
12 PUBLICATION AS NOTICES IN THE PENNSYLVANIA BULLETIN. THE
13 CHANGES SHALL BE IMPLEMENTED BY CONTRACTORS AS SOON AS
14 PRACTICABLE FOLLOWING PUBLICATION, BUT IN NO EVENT MORE THAN
15 120 DAYS FOLLOWING PUBLICATION.
16 (4) IN CONSULTATION WITH OTHER APPROPRIATE COMMONWEALTH
17 AGENCIES, CONDUCT MONITORING AND OVERSIGHT OF CONTRACTS
18 ENTERED INTO WITH CONTRACTORS.
19 (5) IN CONSULTATION WITH OTHER APPROPRIATE COMMONWEALTH
20 AGENCIES, MONITOR, REVIEW AND EVALUATE THE ADEQUACY,
21 ACCESSIBILITY AND AVAILABILITY OF SERVICES DELIVERED TO
22 ELIGIBLE ADULTS OR ELIGIBLE EMPLOYEES.
23 (6) IN CONSULTATION WITH OTHER APPROPRIATE COMMONWEALTH
24 AGENCIES, ESTABLISH AND COORDINATE THE DEVELOPMENT,
25 IMPLEMENTATION AND SUPERVISION OF AN OUTREACH PLAN TO ENSURE
26 THAT ALL THOSE WHO MAY BE ELIGIBLE ARE AWARE OF THE PROGRAM.
27 THE OUTREACH PLAN SHALL INCLUDE PROVISIONS FOR:
28 (I) REACHING SPECIAL POPULATIONS, INCLUDING NONWHITE
29 AND NON-ENGLISH SPEAKING INDIVIDUALS AND INDIVIDUALS WITH
30 DISABILITIES.

1 (II) REACHING DIFFERENT GEOGRAPHIC AREAS, INCLUDING
2 RURAL AND INNER-CITY AREAS.
3 (III) ASSURING THAT SPECIAL EFFORTS ARE COORDINATED
4 WITHIN THE OVERALL OUTREACH ACTIVITIES THROUGHOUT THIS
5 COMMONWEALTH.
6 (7) AT THE REQUEST OF AN ELIGIBLE ADULT, ELIGIBLE
7 EMPLOYEE OR ELIGIBLE EMPLOYER, FACILITATE THE PAYMENT ON A
8 PRETAX BASIS OF PREMIUMS:
9 (I) FOR THE PROGRAM AND DEPENDENTS COVERED UNDER THE
10 PROGRAM; OR
11 (II) IF APPLICABLE, FOR THE CHILDREN'S HEALTH
12 INSURANCE PROGRAM.
13 (8) ESTABLISH PENALTIES FOR ELIGIBLE ADULTS, ELIGIBLE
14 EMPLOYEES OR ELIGIBLE EMPLOYERS WHO ENROLL IN THE PROGRAM,
15 DROP ENROLLMENT AND SUBSEQUENTLY RE-ENROLL FOR THE PURPOSE OF
16 AVOIDING THE ONGOING PAYMENT OF PREMIUMS. THE COMMISSIONER
17 SHALL FORWARD NOTICE OF THESE PENALTIES TO THE LEGISLATIVE
18 REFERENCE BUREAU FOR PUBLICATION AS A NOTICE IN THE
19 PENNSYLVANIA BULLETIN.
20 (9) COORDINATE WITH THE DEPARTMENT OF PUBLIC WELFARE IN
21 THE IMPLEMENTATION OF THIS CHAPTER AND MAY DESIGNATE THE
22 DEPARTMENT OF PUBLIC WELFARE TO PERFORM ANY DUTIES THAT ARE
23 APPROPRIATE UNDER THIS CHAPTER.
24 SECTION 1311. SUBMISSION OF PROPOSALS AND AWARD OF CONTRACTS.
25 (A) CORPORATIONS REQUIRED TO SUBMIT.--EACH PROFESSIONAL
26 HEALTH SERVICES PLAN CORPORATION AND HOSPITAL PLAN CORPORATION
27 AND THEIR SUBSIDIARIES AND AFFILIATES DOING BUSINESS IN THIS
28 COMMONWEALTH SHALL SUBMIT A BID OR PROPOSAL TO THE DEPARTMENT TO
29 CARRY OUT THE PURPOSES OF THIS SECTION IN THE GEOGRAPHIC AREA
30 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.

1 (D) COPAYMENTS.--THE DEPARTMENT MAY ESTABLISH A COPAYMENT
2 FOR ANY OF THE SERVICES PROVIDED IN THE HEALTH BENEFIT PLAN AS
3 LONG AS THE COPAYMENT MEETS ANY FEDERAL REQUIREMENTS UNDER
4 SECTION 1317. THE DEPARTMENT SHALL FORWARD NOTICE OF THE
5 COPAYMENT AMOUNTS TO THE LEGISLATIVE REFERENCE BUREAU FOR
6 PUBLICATION AS A NOTICE IN THE PENNSYLVANIA BULLETIN.
7 SECTION 1314. DATA MATCHING.
8 (A) COVERED INDIVIDUALS.--ALL ENTITIES PROVIDING HEALTH
9 INSURANCE OR HEALTH CARE COVERAGE WITHIN THIS COMMONWEALTH
10 SHALL, NOT LESS FREQUENTLY THAN ONCE EVERY MONTH, PROVIDE THE
11 NAMES, IDENTIFYING INFORMATION AND ANY ADDITIONAL INFORMATION ON
12 COVERAGE AND BENEFITS AS THE DEPARTMENT MAY SPECIFY FOR ALL
13 INDIVIDUALS FOR WHOM THE ENTITIES PROVIDE INSURANCE OR COVERAGE.
14 (B) USE OF INFORMATION.--
15 (1) THE DEPARTMENT SHALL USE INFORMATION OBTAINED IN
16 SUBSECTION (A) TO DETERMINE WHETHER ANY PORTION OF AN
17 ELIGIBLE ADULT'S, ELIGIBLE EMPLOYEE'S OR ELIGIBLE EMPLOYER'S
18 PREMIUM IS BEING PAID FROM ANY OTHER SOURCE AND TO DETERMINE
19 WHETHER ANOTHER ENTITY HAS PRIMARY LIABILITY FOR ANY HEALTH
20 CARE CLAIMS PAID UNDER ANY PROGRAM ADMINISTERED BY THE
21 DEPARTMENT.
22 (2) IF A DETERMINATION IS MADE THAT AN ELIGIBLE ADULT'S,
23 ELIGIBLE EMPLOYEE'S OR ELIGIBLE EMPLOYER'S PREMIUM IS BEING
24 PAID FROM ANOTHER SOURCE, THE DEPARTMENT MAY NOT MAKE ANY
25 ADDITIONAL PAYMENTS TO THE INSURER FOR THE ELIGIBLE ADULT,
26 ELIGIBLE EMPLOYEE OR ELIGIBLE EMPLOYER.
27 (C) EXCESS PAYMENT.--IF A PAYMENT HAS BEEN MADE TO AN
28 INSURER BY THE DEPARTMENT FOR AN ELIGIBLE ADULT, ELIGIBLE
29 EMPLOYEE OR ELIGIBLE EMPLOYER FOR WHOM ANY PORTION OF THE
30 PREMIUM PAID BY THE DEPARTMENT IS BEING PAID FROM ANOTHER

1 SOURCE, THE INSURER SHALL REIMBURSE THE DEPARTMENT THE AMOUNT OF
2 ANY EXCESS PAYMENT OR PAYMENTS.
3 (D) REIMBURSEMENT.--THE DEPARTMENT MAY SEEK REIMBURSEMENT
4 FROM AN ENTITY THAT PROVIDES HEALTH INSURANCE OR HEALTH CARE
5 COVERAGE THAT IS PRIMARY TO THE COVERAGE PROVIDED UNDER ANY
6 PROGRAM ADMINISTERED BY THE DEPARTMENT.
7 (E) TIMELINESS.--TO THE MAXIMUM EXTENT PERMITTED BY LAW AND
8 NOTWITHSTANDING ANY POLICY OR PLAN PROVISION TO THE CONTRARY, A
9 CLAIM BY THE DEPARTMENT FOR REIMBURSEMENT UNDER SUBSECTION (C)
10 OR (D) SHALL BE DEEMED TIMELY FILED IF IT IS FILED WITH THE
11 INSURER OR ENTITY WITHIN THREE YEARS FOLLOWING THE DATE OF
12 PAYMENT.
13 (F) AGREEMENTS.--THE DEPARTMENT MAY ENTER INTO AGREEMENTS
14 WITH ENTITIES THAT PROVIDE HEALTH INSURANCE AND HEALTH CARE
15 COVERAGE FOR THE PURPOSE OF CARRYING OUT THE PROVISIONS OF THIS
16 SECTION. THE AGREEMENTS SHALL PROVIDE FOR THE ELECTRONIC
17 EXCHANGE OF DATA BETWEEN THE PARTIES AT A MUTUALLY AGREED UPON
18 FREQUENCY, BUT NOT LESS THAN MONTHLY, AND MAY ALSO ALLOW FOR
19 PAYMENT OF A FEE BY THE DEPARTMENT TO THE ENTITY PROVIDING
20 HEALTH INSURANCE OR HEALTH CARE COVERAGE.
21 (G) OTHER COVERAGE.--
22 (1) THE DEPARTMENT SHALL DETERMINE WHETHER ANY OTHER
23 HEALTH CARE COVERAGE IS AVAILABLE TO AN ELIGIBLE ADULT,
24 ELIGIBLE EMPLOYEE OR ELIGIBLE EMPLOYER THROUGH AN ALIMONY
25 AGREEMENT OR AN EMPLOYMENT-RELATED OR OTHER GROUP BASIS.
26 (2) IF OTHER HEALTH CARE COVERAGE IS AVAILABLE, THE
27 DEPARTMENT SHALL REEVALUATE THE ENROLLEE'S ELIGIBILITY UNDER
28 THIS CHAPTER.
29 (H) PENALTY.--
30 (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 FROM THE FEDERAL GOVERNMENT AND SHALL SEEK APPROVAL TO AMEND THE STATE PLAN AS NECESSARY TO CARRY OUT THE PROVISIONS OF THIS CHAPTER.

(2) IF THE DEPARTMENT OF PUBLIC WELFARE RECEIVES APPROVAL OF A WAIVER OR APPROVAL OF A STATE PLAN AMENDMENT AS REQUIRED BY THIS SECTION, IT SHALL NOTIFY THE DEPARTMENT AND TRANSMIT NOTICE OF THE WAIVER OR STATE PLAN AMENDMENT APPROVALS TO THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION AS A NOTICE IN THE PENNSYLVANIA BULLETIN.

(3) THE DEPARTMENT MAY CHANGE THE BENEFITS UNDER SECTION 1313 AND THE PREMIUM AND COPAYMENT AMOUNTS PAYABLE UNDER SECTIONS 1305 AND 1306 AND ELIGIBILITY REQUIREMENTS IN ORDER

1 FOR THE PROGRAM TO MEET FEDERAL REQUIREMENTS.
2 SECTION 1318. FEDERAL FUNDS.
3 NOTWITHSTANDING ANY OTHER PROVISION OF LAW, THE DEPARTMENT OF
4 PUBLIC WELFARE, IN COOPERATION WITH THE DEPARTMENT, SHALL TAKE
5 ANY ACTION NECESSARY TO DO ALL OF THE FOLLOWING:
6 (1) ENSURE THE RECEIPT OF FEDERAL FINANCIAL
7 PARTICIPATION UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (49
8 STAT. 620, 42 U.S.C. § 1396 ET SEQ.) FOR COVERAGE AND FOR
9 SERVICES PROVIDED UNDER THIS CHAPTER.
10 (2) QUALIFY FOR AVAILABLE FEDERAL FINANCIAL
11 PARTICIPATION UNDER TITLE XIX OF THE SOCIAL SECURITY ACT.
12 SECTION 12. THE INSURANCE DEPARTMENT SHALL PUBLISH A NOTICE
13 IN THE PENNSYLVANIA BULLETIN WHEN A LAW IS ENACTED THAT PROVIDES
14 FOR OR DESIGNATES AT LEAST $120,000,000 FOR THE SUPPLEMENTAL
15 ASSISTANCE AND FUNDING ACCOUNT.
16 SECTION 13. REPEALS ARE AS FOLLOWS:
17 (1) THE GENERAL ASSEMBLY DECLARES THAT THE REPEAL UNDER
18 PARAGRAPH (2) IS NECESSARY TO EFFECTUATE THIS ACT.
19 (2) CHAPTER 13 OF THE ACT OF JUNE 26, 2001 (P.L.755,
20 NO.77), KNOWN AS THE TOBACCO SETTLEMENT ACT, IS REPEALED.
21 (3) ALL OTHER ACTS AND PARTS OF ACTS ARE REPEALED
22 INSOFAR AS THEY ARE INCONSISTENT WITH THIS ACT.
23 SECTION 14. THE AMENDMENT OF SECTION 712(E) OF THE ACT SHALL
24 APPLY RETROACTIVELY TO DECEMBER 31, 2007.
25 SECTION 15. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:
26 (1) THE FOLLOWING PROVISIONS SHALL TAKE EFFECT JULY 1,
27 2008, OR IMMEDIATELY, WHICHEVER IS LATER:
28 (I) THE AMENDMENT OF SECTION 712(E) AND (M) OF THE
29 ACT.
30 (II) THE AMENDMENT OF THE DEFINITION OF "HEALTH CARE

1 PROVIDER" IN SECTION 1101 OF THE ACT.

2 (III) THE AMENDMENT OF SECTION 1112 OF THE ACT.

3 (IV) SECTION 12 OF THIS ACT.

4 (2) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT UPON

5 PUBLICATION OF THE NOTICE SPECIFIED UNDER SECTION 12 OF THIS

6 ACT.