

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 507 Session of
2009

INTRODUCED BY FOLMER, TOMLINSON, BROWNE, ALLOWAY, EARLL, ORIE,
SCARNATI, SMUCKER, ERICKSON, PICCOLA, CORMAN, PILEGGI,
GREENLEAF, WAUGH, WONDERLING, M. WHITE, BAKER AND D. WHITE,
MARCH 2, 2009

SENATOR D. WHITE, BANKING AND INSURANCE, AS AMENDED, APRIL 14,
2010

AN ACT

1 Establishing the Pennsylvania High-Risk Health Insurance Pool,
2 the Pennsylvania High-Risk Health Insurance Pool Fund and the
3 State Comprehensive Health Insurance Pool Board; providing
4 for the powers and duties of the pool and the board, for
5 selection of administering insurer and for payment of plan
6 costs; AND prescribing plan benefits; ~~and making an~~
7 ~~appropriation.~~

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

10 Section 1. Short title.

11 This act shall be known and may be cited as the High-Risk
12 Health Insurance Pool Act.

13 Section 2. Definitions.

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

17 "Board." The State Comprehensive Health Insurance Pool
18 Board.

19 "Commissioner." The Insurance Commissioner of the

1 Commonwealth.

2 "Fund." The Pennsylvania High-Risk Health Insurance Pool
3 Fund.

4 "Health insurance." A hospital or medical expense incurred
5 policy, nonprofit health care services plan contract, health
6 maintenance organization, subscriber contract or any other
7 health care plan or arrangement that pays for or furnishes
8 medical or health care services whether by insurance or
9 otherwise, when sold to an individual or as a group policy. This
10 term does not include short-term, accident, dental-only, fixed
11 indemnity, limited benefit or credit insurance, coverage issued
12 as a supplement to liability insurance, insurance arising out of
13 a workers' compensation or similar law, automobile medical-
14 payment insurance or insurance under which benefits are payable
15 with or without regard to fault and which is statutorily
16 required to be contained in any liability insurance policy or
17 equivalent self-insurance.

18 "Insured." A person who is a legal resident of this
19 Commonwealth and a citizen of the United States who is eligible
20 to receive benefits from the pool. The term includes a dependent
21 and family member.

22 "Insurer." An entity that is authorized in this Commonwealth
23 to write health insurance or that provides health insurance in
24 this Commonwealth. The term includes an insurance company,
25 nonprofit health care services plan, fraternal benefits society,
26 health maintenance organization, third-party administrators,
27 State or local governmental unit, to the extent permitted by
28 Federal law any self-insured arrangement covered by section 3 of
29 the Employee Retirement Income Security Act of 1974 (Public Law
30 93-406, 29 U.S.C. § 1002), that provides health care benefits in

1 this Commonwealth, any other entity providing a plan of health
2 insurance or health benefits subject to State insurance
3 regulation and any reinsurer or stop-loss plan providing
4 reinsurance or stop-loss coverage to a health insurer in this
5 Commonwealth.

6 "Medicare." Coverage under both Parts A and B of Title XVIII
7 of the Social Security Act (42 U.S.C. § 1395 et seq.).

8 "Physician." An individual licensed to practice medicine
9 under the laws of this Commonwealth.

10 "Plan." The Comprehensive Health Insurance Plan as adopted
11 by the State Comprehensive Health Insurance Board.

12 "Pool." The Pennsylvania High-Risk Health Insurance Pool.

13 "Preexisting condition." A condition for which medical
14 advice, care or treatment was recommended or received during the
15 six months prior to effective date of coverage under the pool.
16 Except as otherwise provided in this act, preexisting conditions
17 shall not be covered during the 12 months following the person's
18 effective date of coverage under the plan.

19 "Producer." A person who is licensed to sell health
20 insurance in this Commonwealth.

21 "Resident." Any of the following:

22 (1) An individual who has been legally domiciled in this
23 Commonwealth for a minimum of 90 days for persons eligible
24 for enrollment in the pool.

25 (2) An individual who is legally domiciled in this
26 Commonwealth and is eligible for enrollment in the pool as a
27 result of the Health Insurance Portability and Accountability
28 Act of 1996 (Public Law 104-191, 110 Stat. 1936).

29 (3) An individual who is legally domiciled in the pool
30 and is eligible for enrollment as a result of the Trade

Adjustment Assistance Reform Act of 2002 (Public Law 107-210,
116 Stat. 933).

"State-mandated health insurance benefit." The right,
established by an act of the General Assembly, of an insured
under a health insurance policy to receive reimbursement from
the insurer of an expenditure or cost of a medical test,
procedure or service related to the health of the insured, which
test, procedure or service is provided by a medical provider.

Section 3. Pennsylvania High-Risk Health Insurance Pool.

(a) Establishment.--A nonprofit legal entity to be known as
the Pennsylvania High-Risk Health Insurance Pool is hereby
established.

(b) Availability date for health insurance policies.--Health
insurance policies available in accordance with this act shall
be available for sale within one year from the effective date of
this section.

(c) Fund.--The Pennsylvania High-Risk Health Insurance Pool
Fund is established in the State Treasury.

Section 4. Pool coverage eligibility.

(a) General rule.--Any individual person who is and
continues to be a resident of this Commonwealth and a citizen of
the United States shall be eligible for coverage from the pool
if evidence is provided of one of the following:

(1) (i) A notice of rejection or refusal to issue
substantially similar insurance for health reasons by two
insurers, provided that at least two insurers offer
individual health insurance coverage in this
Commonwealth.

(ii) If only one insurer offers individual market
health insurance coverage in this Commonwealth then one

1 rejection shall be sufficient.

2 (iii) A rejection or refusal by an insurer offering
3 only stop-loss, excess loss or reinsurance coverage with
4 respect to the applicant shall not be sufficient except
5 under this subsection.

6 (2) (i) A refusal by two insurers to issue insurance
7 except at a rate exceeding the pool rate, provided that
8 at least two insurers offer individual health insurance
9 coverage in this Commonwealth.

10 (ii) If only one insurer offers individual market
11 health insurance coverage in this Commonwealth, then one
12 quote that exceeds the pool rate shall be sufficient.

13 (3) A diagnosis of the individual with one of the
14 medical or health conditions listed by the board in
15 accordance with section 6. A person diagnosed with one or
16 more of these conditions shall be eligible for a pool
17 coverage without applying for health insurance coverage.

18 (4) For persons eligible due to eligibility under the
19 Health Insurance Portability and Accountability Act of 1996
20 (Public Law 104-191, 110 Stat. 1936), the maintenance of
21 health insurance coverage for the previous 18 months with no
22 gap in coverage greater than 63 days of which the most recent
23 coverage was through an employer-sponsored plan.

24 (5) For persons eligible as a result of certification
25 for Federal trade adjustment assistance or for pension
26 benefit guarantee corporation assistance as provided by the
27 Trade Adjustment Assistance Reform Act of 2002 (Public Law
28 107-210, 116 Stat. 933), coverage with no preexisting
29 conditions limitation for individuals with three months of
30 prior creditable coverage with a break in coverage of no more

1 than 63 days.

2 (b) Dependents.--Each dependent of a person who is eligible
3 for coverage from the pool shall also be eligible for coverage
4 from the pool. In the instance of a child who is the primary
5 insured, resident family members shall also be eligible for
6 coverage.

7 (c) Preexisting waiting periods.--A person may maintain pool
8 coverage for the period of time the person is satisfying a
9 preexisting waiting period under another health insurance policy
10 or insurance arrangement intended to replace the pool policy.

11 (d) Conditions for ineligibility.--A person is ineligible
12 for coverage from the pool if the person:

13 (1) has in effect on the date pool coverage takes effect
14 health insurance coverage from an insurer or insurance
15 arrangement;

16 (2) is eligible for other health care benefits at the
17 time application is made to the pool, including COBRA
18 continuation except:

19 (i) coverage, including COBRA continuation, other
20 continuation or conversion coverage, maintained for the
21 period of time the person is satisfying any preexisting
22 condition waiting period under a pool policy;

23 (ii) employer group coverage conditioned by the
24 limitations described by subsection (a)(4) and (5); or

25 (iii) individual coverage conditioned by the
26 limitation described by subsection (a)(1), (2) or (3).

27 (3) has terminated coverage in the pool within 12 months
28 of the date that application is made to the pool unless the
29 person demonstrates a good faith reason for the termination;

30 (4) is confined in a county jail or imprisoned in a

1 State correctional institution;

2 ~~(5) has premiums that are paid for or reimbursed by any~~ ←
3 ~~third party payer or under any government sponsored program~~
4 ~~or by any government agency or health care provider, except~~
5 ~~as an otherwise qualifying full time employee or dependent~~
6 ~~thereof, of a government agency or health care provider, or~~
7 ~~if the individual receives premium payment assistance through~~
8 ~~the Federal health insurance tax credit established by the~~
9 ~~Trade Adjustment Assistance Reform Act of 2002, or~~

10 ~~(6)~~ (5) has not had prior coverage with the pool ←
11 terminated for nonpayment of premiums or fraud.

12 (e) Waiver of preexisting condition requirements.--Pool
13 preexisting condition requirements shall be waived for the
14 following individuals:

15 (1) an individual for whom, as of the date on which the
16 individual seeks plan coverage, the aggregate of the periods
17 of creditable coverage is 18 months or more and whose most
18 recent prior creditable coverage was under group health
19 insurance coverage offered by a health insurance issuer, a
20 group health plan, a governmental plan, or a church plan, or
21 health insurance coverage offered in connection with any such
22 plans, or any other type of creditable coverage that may be
23 required by the Health Insurance Portability and
24 Accountability Act of 1996, or the regulations under that
25 act;

26 (2) an individual who is eligible for Federal trade
27 adjustment assistance or for pension benefit guarantee
28 corporation assistance, as provided by the Trade Adjustment
29 Assistance Reform Act of 2002, provided that as of the date
30 on which the individual was certified as eligible for Federal

1 trade adjustment assistance, the individual had at least
2 three months of prior creditable coverage with no longer than
3 a 63-day break in coverage as established by the Trade
4 Adjustment Assistance Reform Act of 2002 or the regulations
5 under that act.

6 (f) Termination of pool coverage.--Pool coverage shall
7 terminate:

8 (1) on the date a person is no longer a resident of the
9 person's state, except for a child who is a student under 23
10 years of age and who is financially dependent on a parent, a
11 child for whom a person may be obligated to pay child support
12 or a child of any age who is disabled and dependent on a
13 parent;

14 (2) on the date a person requests coverage to end;

15 (3) on the death of the covered person;

16 (4) on the date State law requires cancellation of the
17 policy;

18 (5) at the option of the pool, 30 days after the pool
19 sends to the person an inquiry concerning the person's
20 eligibility, including an inquiry concerning the person's
21 residence, to which the person does not reply;

22 (6) on the 31st day after the day on which a premium
23 payment for pool coverage becomes due, if the payment is not
24 made before that date;

25 (7) on the date a person reaches the maximum lifetime
26 limit, as provided in ~~section 12~~ THIS ACT; or

27 (8) at such time as the person ceases to meet the
28 eligibility requirements of this section.

29 (g) Termination due to eligibility.--A person who ceases to
30 meet the eligibility requirements of this section may have the



1 person's coverage terminated at the end of the policy period.

2 Section 5. State Comprehensive Health Insurance Pool Board.

3 (a) Establishment.--The State Comprehensive Health Insurance
4 Pool Board is established. The board members shall be appointed
5 as follows:

6 (1) One representative of a domestic insurance company
7 appointed by the President pro tempore of the Senate from a
8 list supplied by the Insurance Federation of Pennsylvania,
9 Inc., or its successor.

10 (2) One representative of a domestic insurance company
11 appointed by the Speaker of the House of Representatives from
12 a list supplied by the Insurance Federation of Pennsylvania,
13 Inc., or its successor.

14 (3) One representative of a nonprofit health care
15 service plan appointed by the President pro tempore of the
16 Senate.

17 (4) One representative of a health maintenance
18 organization appointed by the Speaker of the House of
19 Representatives.

20 (5) One member representing the medical provider
21 community, such as a physician licensed to practice medicine
22 in this Commonwealth or a hospital administrator appointed by
23 the Secretary of Health from lists supplied by the
24 Pennsylvania Medical Society, or its successor, and the
25 Hospital & Healthsystem Association of Pennsylvania, or its
26 successor.

27 (6) Five members of the general public who are not
28 employed by or affiliated with an insurance company or plan,
29 group hospital or other health care provider and are not
30 reasonably expected to qualify for coverage in the pool, with

one appointment by each of the following: the Majority Leader of the Senate, the Minority Leader of the Senate, the Majority Leader of the House of Representatives, the Minority Leader of the House of Representatives and the Insurance Commissioner.

No elected official may be a member of the board.

(b) Special qualification.--In making appointments to the board, efforts shall be made to ensure that at least one person serving on the board is at least 60 years of age.

(c) Terms of board members.--The original members of the board shall be appointed for the following terms:

(1) Three members for a term of one year.

(2) Two members for a term of two year.

(3) Two members for a term of three years.

(4) All terms after the initial term shall be for three years.

(d) Chairman.--The board shall elect one of its members as chairman, who may serve in that capacity only for two years.

(e) Reimbursement of expenses.--Members of the board may be reimbursed from moneys of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be compensated for their services.

(f) Limitation of liability.--Members of the board are not liable for an action or omission performed in good faith in the performance of powers and duties under this act, and no cause of action may arise against a member for the action or omission.

(g) Plan to be submitted.--

(1) The board shall adopt a plan pursuant to this act and submit its articles, bylaws and operating rules to the

1 commissioner for approval.

2 (2) If the board fails to adopt a plan and suitable
3 articles, bylaws and operating rules within 180 days after
4 appointment of the board, the commissioner shall promulgate
5 rules to effectuate the provisions of this act and such rules
6 shall remain in effect until superseded by a plan and
7 articles, bylaws and operating procedures submitted by the
8 board and approved by the commissioner.

9 Section 6. Board duties.

10 The board shall:

11 (1) Operate, supervise and administer the pool.

12 (2) Establish administrative and accounting procedures
13 for the operation of the pool.

14 (3) Establish procedures under which applicants and
15 participants in the plan may have grievances reviewed by an
16 impartial body and reported to the board.

17 (4) Select an administering insurer in accordance with
18 section 8.

19 (5) Require that all policy forms issued by the board
20 conform to standard forms developed by the board. The forms
21 shall be approved by the commissioner.

22 (6) Develop a program to publicize the existence of the
23 plan, the eligibility requirements of the plan, the
24 procedures for enrollment in the plan and shall maintain
25 public awareness of the plan.

26 (7) Promulgate a list of medical or health conditions
27 for which a person shall be eligible for pool coverage
28 without applying for health insurance. The list shall be
29 effective on the first day of the operation of the pool and
30 may be amended from time to time as may be appropriate.

1 (8) No later than June 1 of each year, make an annual
2 report to the Governor, the General Assembly and the
3 commissioner. The report shall summarize the activities of
4 the pool in the preceding calendar year, including
5 information regarding net written and earned premiums, plan
6 enrollment, administration expenses and paid and incurred
7 losses.

8 Section 7. Operation of pool.

9 (a) General rule.--The pool may exercise any of the
10 authority that an insurance company authorized to write health
11 insurance in this Commonwealth may exercise under the laws of
12 this Commonwealth.

13 (b) Specific powers.--As part of its authority, the pool
14 may:

15 (1) Provide health benefits coverage to persons who are
16 eligible for that coverage under this act.

17 (2) Enter into contracts that are necessary to carry out
18 this act, including, with the approval of the commissioner,
19 entering into contracts with similar pools in other states
20 for the joint performance of common administrative functions
21 or with other organizations for the performance of
22 administrative functions.

23 (3) Sue or be sued, including taking any legal actions
24 necessary or proper to recover or collect assessments due the
25 pool.

26 (4) Institute any legal action necessary to avoid
27 payment of improper claims against the pool or the coverage
28 provided by or through the pool, to recover any amounts
29 erroneously or improperly paid by the pool, to recover any
30 amount paid by the pool as a mistake of fact or law and to

1 recover other amounts due the pool.

2 (5) Establish appropriate rates, rate schedules, rate
3 adjustments, expense allowance, agents' referral fees and
4 claim reserve formulas and perform any actuarial function
5 appropriate to the operation of the pool.

6 (6) Adopt policy forms, endorsements and riders and
7 applications for coverage.

8 (7) Issue insurance policies subject to this act and the
9 plan of operation.

10 (8) Appoint appropriate legal, actuarial and other
11 committees that are necessary to provide technical assistance
12 in operating the pool and performing any of the functions of
13 the pool.

14 (9) Employ and set the compensation of any persons
15 necessary to assist the pool in carrying out its
16 responsibilities and functions.

17 (10) Contract for stop-loss insurance for risks incurred
18 by the pool.

19 (11) Borrow money as necessary to implement the purposes
20 of the pool.

21 (12) Issue additional types of health insurance policies
22 to provide optional coverage which comply with applicable
23 provisions of Federal and State law, including Medicare
24 supplemental health insurance.

25 (13) Provide for and employ cost containment measures
26 and requirements, including, but not limited to, preadmission
27 screening, second surgical opinion and concurrent utilization
28 case management for the purpose of making the benefit plans
29 more cost effective.

30 (14) Design, utilize, contract or otherwise arrange for

1 delivery of cost-effective health care services, including
2 establishing or contracting with preferred provider
3 organizations and health maintenance organizations.

4 (15) Provide for reinsurance on either a facultative or
5 treaty basis, or both.

6 Section 8. Selection of administering insurer.

7 (a) General rule.--The board shall select an insurer,
8 through a competitive bidding process, to administer the plan.

9 The board shall evaluate the bids submitted under this
10 subsection based on criteria established by the board, which
11 criteria shall include, but not be limited to, the following:

12 (1) The insurer's proven ability to handle large group
13 accident and health policies insurance.

14 (2) The efficiency of the insurer's claims-paying
15 procedures.

16 (3) An estimate of total charges for administering the
17 plan.

18 (b) Term of contract.--

19 (1) The administering insurer must enter into a contract
20 with the board. The term of the contract shall be for a
21 period of three years.

22 (2) At least one year prior to the expiration of each
23 three-year period of service by an administering insurer, the
24 board shall invite all insurers, including the current
25 administering insurer, to submit bids to serve as the
26 administering insurer for the succeeding three-year period.

27 (3) The selection of the administering insurer for the
28 succeeding three-year period shall be made at least six
29 months prior to the end of the current three-year period.

30 (c) Duties of administering insurer.--The administering

1 insurer shall:

2 (1) Perform all eligibility and administrative claims-
3 payment functions relating to the plan.

4 (2) Pay an agent's referral fee as established by the
5 board to each agent who refers an applicant to the plan, if
6 the applicant is accepted. The selling or marketing of plans
7 shall not be limited to the administering insurer or its
8 agents. The referral fees shall be paid by the administering
9 insurer from moneys received as premiums for the plan.

10 (3) Establish a premium billing procedure for collection
11 of premiums from persons insured under the plan.

12 (4) Perform all necessary functions to assure timely
13 payment of benefits to covered persons under the plan,
14 including, but not limited to, the following:

15 (i) Making available information relating to the
16 proper manner of submitting a claim for benefits under
17 the plan and distributing forms upon which submissions
18 will be made.

19 (ii) Evaluating the eligibility of each claim for
20 payment under the plan.

21 (iii) Notifying each claimant within 30 days after
22 receiving a properly completed and executed proof of
23 loss, whether the claim is accepted, rejected or
24 compromised.

25 (5) Submit regular reports to the board regarding the
26 operation of the plan. The frequency, content and form of the
27 reports shall be determined by the board.

28 (6) Following the close of each calendar year, determine
29 net premiums, reinsurance premiums less administrative
30 expenses allowance, the expense of administration pertaining

1 to the reinsurance operations of the pool and the incurred
2 losses for the year, and report this information to the board
3 and the commissioner.

4 (7) Pay claims expenses from the premium payments
5 received from or on behalf of covered persons under the plan.

6 Section 9. Payment of plan costs.

7 (a) General rule.--The board shall pay plan costs, excluding
8 any premium, deductible and copayment subsidies, first from
9 Federal funds, if any, that are transferred to the fund under
10 subsection (b) and that exceed premium, deductible and copayment
11 subsidy costs in a policy year. The remainder of the plan costs,
12 excluding premium, deductible and copayment subsidy costs, shall
13 be paid as follows:

14 (1) 66 2/3% from premiums paid by eligible persons.

15 (2) 33 1/3% from transfers or appropriations to the
16 fund.

17 (b) Application for Federal funds.--The board shall make
18 application for any Federal grants or other sources under which
19 the plan may be eligible to receive moneys. To the extent
20 allowable, the board shall use any moneys received from a
21 Federal grant or other source to offset plan deficits before
22 drawing from any alternative funding sources ~~authorized under~~
23 ~~this section.~~ ←

24 (c) Surplus funds.--

25 (1) If grants, assessments and other receipts by the
26 pool exceed the actual losses and administrative expenses of
27 the plan, the excess shall be held at interest and used by
28 the board to offset future losses or to reduce premiums.

29 (2) As used in this subsection, the term "future losses"
30 include reserves for claims incurred but not reported.

1 Section 10. Direct insurance by pool.

2 The coverage provided by the plan shall be directly insured
3 by the pool and the policies administered through the
4 administering insurer.

5 Section 11. Plan benefits.

6 (a) General rule.--The plan shall offer in an annually
7 renewable policy the coverage specified in this section for each
8 eligible person. In approving any of the benefit plans to be
9 offered by the plan, the board shall establish such benefit
10 levels, deductibles, coinsurance factors, exclusions and
11 limitations as it may deem appropriate and that it believes to
12 be generally reflective of and commensurate with individual
13 market health insurance that is provided in the individual
14 health insurance market in this Commonwealth.

15 (b) High deductible health plan option.--Notwithstanding any
16 other provisions of this section, the plan shall provide every
17 eligible person the option of selecting a health plan option
18 from at least one high deductible health plan that would qualify
19 to be used in conjunction with a health savings account under
20 section 223 of the Internal Revenue Code of 1986 (Public Law
21 99-514, 26 U.S.C. § 1 et seq.). In conjunction with such a high
22 deductible health plan, the plan shall provide for the
23 establishment and administration of health savings accounts on
24 behalf of eligible persons who chose to be covered by a high
25 deductible health plan under this section.

26 (c) Major medical expense coverage.--The plan shall offer
27 major medical expense coverage to every eligible person who is
28 not eligible for Medicare. Major medical expense coverage
29 offered under the plan shall pay an eligible person's covered
30 expenses, subject to ~~the limits on the deductible and~~



~~coinsurance payments authorized under subsection (f) to a~~
lifetime limit of \$1,000,000 per covered individual.

(d) Covered expenses.--

(1) The usual customary charges or negotiable reimbursement for the following services and articles, when prescribed by a physician and medically necessary, shall be covered expenses:

(i) Hospital services.

(ii) Professional services for the diagnosis or treatment of injuries, illness or conditions, other than dental, which are rendered by a physician or by others at his direction.

(iii) Drugs requiring a physician's prescription.

(iv) Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than 100 calendar days during a policy year, if the services and reimbursements are the type which would qualify as reimbursable services under Medicare.

(v) Services of a home health agency, which services are of a type that would qualify reimbursable services under Medicare.

(vi) Use of radium or other radioactive materials.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prosthesis, other than dental prosthesis.

(x) Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids.

(xi) Diagnostic X-rays and laboratory tests.

(xii) Oral surgery for partially or completely

erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(xiii) Services of a physical therapist.

(xiv) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat a condition.

(xv) Processing of blood, including, but not limited to, collecting, testing, fractioning and distributing blood.

(xvi) Services for the treatment of alcohol and drug abuse, but the insured shall be required to make a 50% copayment, and the payment of the plan shall not exceed \$4,000.

(xvii) As an option, made available at an additional premium, services provided by a duly licensed chiropractor.

(e) Excluded expenses.--Covered expenses shall not include the following:

(1) A charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions.

(2) A charge for care which is primarily for custodial or domiciliary purposes which does not qualify as an eligible service under Medicaid.

(3) A charge for confinement in a private room, to the extent that the charge is in excess of the charge by the institution for its most common semiprivate room unless a private room is prescribed as medically necessary by a physician.

1 (4) Any part of a charge for services or articles
2 rendered or provided by a physician or other health care
3 personnel that exceeds the prevailing charge in the locality
4 where the service is provided or any charge for services or
5 articles not medically necessary.

6 (5) A charge for services or articles the provision of
7 which is not within the authorized scope of practice of the
8 institution or individual providing the services or articles.

9 (6) An expense incurred prior to the effective date of
10 the coverage under the plan for the person on whose behalf
11 the expense was incurred.

12 (7) A charge for routine physical examinations.

13 (8) A charge for the services of blood donors and any
14 fee for the failure to replace the first three pints of blood
15 provided to an eligible person annually.

16 (9) A charge for personal services or supplies provided
17 by a hospital or nursing home or any other nonmedical or
18 nonprescribed services or supplies.

19 ~~(f) Mandatory covered benefit expiration.~~



20 ~~(1) Notwithstanding any other provision of law to the~~
21 ~~contrary, the State mandated health care insurance benefits~~
22 ~~under the following provisions of law shall be inapplicable~~
23 ~~on and after January 1, 2008, as to coverage offered by the~~
24 ~~plan:~~

25 ~~Sections 602-A, 603-A and 2111(4) and (7) of the act of~~
26 ~~May 17, 1921 (P.L.682, No.284), known as The Insurance~~
27 ~~Company Law of 1921.~~

28 ~~Section 4 of the act of May 18, 1976 (P.L.123, No.54),~~
29 ~~known as the Individual Accident and Sickness Insurance~~
30 ~~Minimum Standards Act.~~

~~Section 4 of the act of December 19, 1986 (P.L.1737, No. 209), known as the Insurance Payment to Registered Nurse Law.~~

~~Section 3 of the act of May 21, 1992 (P.L.239, No.35), known as the Childhood Immunization Insurance Act.~~

~~Section 4 of the act of April 22, 1994 (P.L.136, No.20), known as the Women's Preventative Health Services Act.~~

~~Section 3 of the act of July 2, 1996 (P.L.514, No.85), known as the Health Security Act.~~

~~Section 4 of the act of December 20, 1996 (P.L.1492, No. 191), known as the Medical Foods Insurance Coverage Act.~~

~~(2) Any act or part of an act of the General Assembly that is enacted after the effective date of this section and provides for the imposition of a State mandated health care insurance benefit on the plan shall expire five years after the effective date of such act or part of the act.~~

~~(g)~~ (F) Annual deductible choices.--The board shall provide for at least two choices of annual deductibles for major medical expenses, plus the benefits payable under any other type of insurance coverage or workers' compensation, provided that if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

~~(h)~~ (G) Schedule of premium rates to be determined.--

(1) The board shall annually determine the schedule of premium rates for each benefit plan option offered by the pool.

(2) Rates and rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and

underwriting practices.

(3) (i) The board shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage.

(ii) The initial pool rate may not be less than 150% and may not exceed 200% of rates established as applicable for individual standard rates.

(iii) Subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves and any other cost factors subject to the limitations described in this subsection.

(iv) In no event shall pool rates exceed 200% of rates applicable to individual standard risks.

(4) All rates and rate schedules shall be submitted to the commissioner for approval, and the pool may not use them unless the commissioner approves the rates and rate schedules. The commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided by this section.

~~(i)~~ (H) Last payer of benefits.--The board shall provide that the pool shall be the last payer of benefits whenever any other benefit or source of third party payment is available.

~~Section 12. Appropriation.~~

~~The sum of \$4,000,000 is hereby appropriated to the State Comprehensive Health Insurance Pool Board for deposit into the~~



1 ~~Pennsylvania High Risk Health Insurance Pool Fund to carry out~~
2 ~~the provisions of this act. This appropriation is subject to~~
3 ~~section 9(a).~~

4 Section 20 12. Effective date.

5 This act shall take effect in 60 days.

