

THE GENERAL ASSEMBLY OF PENNSYLVANIA

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SENATE BILL

No. 507 Session of  
2009

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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

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REFERRED TO BANKING AND INSURANCE, MARCH 2, 2009

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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; prescribing plan benefits; and making an  
7 appropriation.

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  
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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

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1 Adjustment Assistance Reform Act of 2002 (Public Law 107-210,  
2 116 Stat. 933).

3 "State-mandated health insurance benefit." The right,  
4 established by an act of the General Assembly, of an insured

5 under a health insurance policy to receive reimbursement from  
6 the insurer of an expenditure or cost of a medical test,  
7 procedure or service related to the health of the insured, which  
8 test, procedure or service is provided by a medical provider.

9 Section 3. Pennsylvania High-Risk Health Insurance Pool.

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

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

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

19 Section 4. Pool coverage eligibility.

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

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

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

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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

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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) has not had prior coverage with the pool terminated

11 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  
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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; 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  
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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  
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1 one appointment by each of the following: the Majority Leader  
2 of the Senate, the Minority Leader of the Senate, the  
3 Majority Leader of the House of Representatives, the Minority  
4 Leader of the House of Representatives and the Insurance  
5 Commissioner.

6 No elected official may be a member of the board.

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

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

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

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

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

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

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

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

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

28 (g) Plan to be submitted.--

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

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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  
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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  
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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

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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

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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.

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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

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

3 (d) Covered expenses.--

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

8 (i) Hospital services.

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

13 (iii) Drugs requiring a physician's prescription.

14 (iv) Services of a licensed skilled nursing facility  
15 for eligible individuals, ineligible for Medicare, for  
16 not more than 100 calendar days during a policy year, if

17 the services and reimbursements are the type which would  
18 qualify as reimbursable services under Medicare.

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

22 (vi) Use of radium or other radioactive materials.

23 (vii) Oxygen.

24 (viii) Anesthetics.

25 (ix) Prosthesis, other than dental prosthesis.

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

29 (xi) Diagnostic X-rays and laboratory tests.

30 (xii) Oral surgery for partially or completely

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

4 (xiii) Services of a physical therapist.

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

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

11           (xvi) Services for the treatment of alcohol and drug  
12 abuse, but the insured shall be required to make a 50%  
13 copayment, and the payment of the plan shall not exceed  
14 \$4,000.

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

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

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

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

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

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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.

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

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

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

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

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

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

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

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

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

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

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1 underwriting practices.

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

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

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

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

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

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

28 Section 12. Appropriation.

29 The sum of \$4,000,000 is hereby appropriated to the State  
30 Comprehensive Health Insurance Pool Board for deposit into the  
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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. Effective date.

5 This act shall take effect in 60 days.  
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