
 THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. **857** Session of
2015

INTRODUCED BY PICKETT, QUINN, DeLUCA, LONGIETTI, SCHLOSSBERG, DRISCOLL, SAMUELSON, BISHOP, TOEPEL, KILLION, HICKERNELL, MACKENZIE, SAINATO, SCHREIBER, KOTIK, CONKLIN, JAMES, SCHWEYER, BAKER, MILLARD, MOUL, STEPHENS, READSHAW, HELM, FABRIZIO, SCHLEGEL CULVER, HEFFLEY, GODSHALL, MALONEY, McNEILL, IRVIN, D. COSTA, ENGLISH, A. HARRIS, FARINA, V. BROWN, KAUFFMAN, GRELL, RAPP, ACOSTA, DONATUCCI, COHEN, HAHN, MARSHALL, GINGRICH, SAYLOR, MURT, WATSON, GABLER, McCARTER, GIBBONS, KORTZ, RADER, BARBIN, JOZWIAK, DAVIS, BROWNLEE AND MILNE, MARCH 31, 2015

AS AMENDED ON THIRD CONSIDERATION, IN SENATE, DECEMBER 8, 2015

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," IN CASUALTY INSURANCE, PROVIDING <--
12 FOR EMERGENCY SERVICE SYSTEM BILLING; IN AUTOMOBILE INSURANCE
13 ISSUANCE, RENEWAL, CANCELLATION AND REFUSAL, PROVIDING FOR
14 COVERAGE OBLIGATIONS OF LOANER VEHICLES; AND, in children's
15 health care, further providing for expiration.

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

18 ~~Section 1. Section 2362 of the act of May 17, 1921 (P.L.682, <--~~
19 ~~No.284), known as The Insurance Company Law of 1921, amended~~
20 ~~October 16, 2013 (P.L.634, No.74), is amended to read:~~

1 ~~Section 2362. Expiration. This article shall expire~~
2 ~~December 31, [2015] 2017.~~

3 ~~Section 2. This act shall take effect immediately.~~

4 SECTION 1. THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN <--
5 AS THE INSURANCE COMPANY LAW OF 1921, IS AMENDED BY ADDING
6 SECTIONS TO READ:

7 SECTION 635.7. BILLING.--(A) WHEN AN EMS AGENCY IS
8 DISPATCHED BY A PUBLIC SAFETY ANSWERING POINT AS DEFINED IN 35
9 PA.C.S. § 5302 (RELATING TO DEFINITIONS) OR AN EMS AGENCY
10 DISPATCH CENTER UNDER 35 PA.C.S. § 8129(I) (RELATING TO
11 EMERGENCY MEDICAL SERVICES AGENCIES) FOR AN EMERGENCY AND
12 PROVIDES MEDICALLY NECESSARY EMERGENCY MEDICAL SERVICES, A
13 PAYMENT MADE BY AN INSURER FOR A CLAIM COVERED UNDER AND IN
14 ACCORDANCE WITH A HEALTH INSURANCE POLICY FOR AN EMERGENCY
15 MEDICAL SERVICE PERFORMED BY THE EMS AGENCY DURING THE CALL
16 SHALL BE PAID DIRECTLY TO THE EMS AGENCY.

17 (B) AN INSURER MUST REIMBURSE A NONNETWORK EMS AGENCY UNDER
18 THE FOLLOWING:

19 (1) THE EMS AGENCY HAS SUBMITTED A COMPLETED STANDARDIZED
20 FORM TO THE DEPARTMENT REQUESTING NONNETWORK DIRECT
21 REIMBURSEMENT FROM AN INSURER AN EMS AGENCY HAS IDENTIFIED. THE
22 FORM MUST BE SUBMITTED TO THE DEPARTMENT ANNUALLY BY OCTOBER 15.
23 THE FORM SHALL DECLARE THE EMS AGENCY'S INTENTION TO RECEIVE
24 DIRECT PAYMENT FROM AN INSURER IDENTIFIED ON THE FORM FOR THE
25 NEXT CALENDAR YEAR. THE DEPARTMENT SHALL DEVELOP A STANDARDIZED
26 FORM, USING AN EMS AGENCY'S ASSIGNED LICENSE NUMBER, TO BE USED
27 BY AN EMS AGENCY THAT MEETS THE CONDITIONS ESTABLISHED UNDER
28 THIS SECTION. THE DEPARTMENT SHALL DEVELOP AND MAINTAIN A
29 PUBLICLY ACCESSIBLE ELECTRONIC REGISTRY THAT INDICATES WHICH EMS
30 AGENCY HAS REQUESTED NONNETWORK DIRECT REIMBURSEMENT FROM AN

1 INSURER IDENTIFIED ON THE FORM.

2 (2) AN EMS AGENCY HAS PROVIDED NOTIFICATION TO THE INSURER
3 UPON SUBMITTING A CLAIM FOR REIMBURSEMENT THAT THE EMS AGENCY IS
4 REGISTERED WITH THE DEPARTMENT TO RECEIVE DIRECT REIMBURSEMENT
5 AS PROVIDED FOR UNDER THIS SECTION.

6 (C) AN EMS AGENCY MAY BE SUBJECT TO PERIODIC AUDITS BY AN
7 INSURER TO EXAMINE CLAIMS FOR DIRECT REIMBURSEMENT UNDER THIS
8 SECTION. IF, THROUGH THE AUDIT, THE INSURER IDENTIFIES AN
9 IMPROPER PAYMENT, THE INSURER MAY DEDUCT THE IMPROPER PAYMENT
10 FROM FUTURE REIMBURSEMENTS.

11 (D) WHERE AN INSURER HAS REIMBURSED A NONNETWORK EMS AGENCY
12 AT THE SAME RATE IT HAS ESTABLISHED FOR A NETWORK EMS AGENCY,
13 THE EMS AGENCY MAY NOT BILL THE INSURED DIRECTLY OR INDIRECTLY
14 OR OTHERWISE ATTEMPT TO COLLECT FROM THE INSURED FOR THE SERVICE
15 PROVIDED, EXCEPT FOR A BILLING TO RECOVER A COPAYMENT,
16 COINSURANCE OR DEDUCTIBLE AS SPECIFIED IN THE HEALTH INSURANCE
17 POLICY.

18 (E) AN EMS AGENCY THAT SUBMITS A FORM UNDER THIS SECTION MAY
19 SOLICIT DONATIONS, MEMBERSHIPS OR CONDUCT FUNDRAISING, EXCEPT
20 THAT AN EMS AGENCY MAY NOT PROMISE, SUGGEST OR INFER TO DONORS
21 THAT A DONATION WILL RESULT IN THE DONOR NOT BEING BILLED
22 DIRECTLY FOR ANY PAYMENT AS PROVIDED UNDER THIS SECTION.
23 NOTWITHSTANDING THIS PARAGRAPH, AN EMS AGENCY MAY BILL IN
24 ACCORDANCE WITH SUBSECTION (D). A VIOLATION OF THIS SECTION
25 SHALL BE CONSIDERED A VIOLATION OF THE ACT OF DECEMBER 17, 1968
26 (P.L.1224, NO.387), KNOWN AS THE "UNFAIR TRADE PRACTICES AND
27 CONSUMER PROTECTION LAW."

28 (F) CLAIMS PAID UNDER THIS SECTION SHALL BE SUBJECT TO
29 SECTION 2166.

30 (G) THIS SECTION SHALL APPLY ONLY TO AN EMS AGENCY THAT IS A

1 NONNETWORK PROVIDER AND PROVIDES EMERGENCY MEDICAL SERVICES,
2 UNLESS PREEMPTED BY FEDERAL LAW.

3 (H) THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS
4 SECTION SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SUBSECTION
5 UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

6 "DEPARTMENT." DEPARTMENT OF HEALTH OF THE COMMONWEALTH.

7 "EMS AGENCY." AS DEFINED IN 35 PA.C.S. § 8103 (RELATING TO
8 DEFINITIONS).

9 "EMERGENCY MEDICAL SERVICES." AS DEFINED IN 35 PA.C.S. §
10 8103 (RELATING TO DEFINITIONS).

11 "INSURER." AS FOLLOWS:

12 (1) AN ENTITY THAT IS RESPONSIBLE FOR PROVIDING OR PAYING
13 FOR ALL OR PART OF THE COST OF EMERGENCY MEDICAL SERVICES
14 COVERED BY AN INSURANCE POLICY, CONTRACT OR PLAN. THE TERM
15 INCLUDES AN ENTITY SUBJECT TO:

16 (I) SECTION 630, ARTICLE XXIV OR ANY OTHER PROVISION OF THIS
17 ACT;

18 (II) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN
19 AS THE HEALTH MAINTENANCE ORGANIZATION ACT; OR

20 (III) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
21 CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES
22 PLAN CORPORATIONS).

23 (2) THE TERM DOES NOT INCLUDE AN ENTITY THAT IS RESPONSIBLE
24 FOR PROVIDING OR PAYING UNDER AN INSURANCE POLICY, CONTRACT OR
25 PLAN WHICH MEETS ANY OF THE FOLLOWING:

26 (I) IS A HOMEOWNER'S INSURANCE POLICY.

27 (II) PROVIDES ANY OF THE FOLLOWING TYPES OF INSURANCE:

28 (A) ACCIDENT ONLY.

29 (B) FIXED INDEMNITY.

30 (C) LIMITED BENEFIT.

- 1 (D) CREDIT.
- 2 (E) DENTAL.
- 3 (F) VISION.
- 4 (G) SPECIFIED DISEASE.
- 5 (H) MEDICARE SUPPLEMENT.
- 6 (I) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED
- 7 SERVICES (CHAMPUS) SUPPLEMENT.
- 8 (J) LONG-TERM CARE.
- 9 (K) DISABILITY INCOME.
- 10 (L) WORKERS' COMPENSATION.
- 11 (M) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

12 SECTION 2007.1. COVERAGE OBLIGATIONS OF LOANER VEHICLES.--

13 (A) AN INSURANCE COMPANY AUTHORIZED TO WRITE PRIVATE PASSENGER
14 AUTOMOBILE INSURANCE WITHIN THIS COMMONWEALTH SHALL PROVIDE,
15 WHERE PURCHASED AND WITHIN THE LIMITS OF THE INSURED'S POLICY,
16 PRIMARY LIABILITY COVERAGE FOR THIRD-PARTY BODILY INJURY AND
17 PRIMARY FIRST-PARTY PHYSICAL DAMAGE COVERAGE FOR A MOTOR VEHICLE
18 PROVIDED BY A MOTOR VEHICLE DEALER, WHEN AN INSURED HAS CUSTODY
19 OF OR IS OPERATING THAT MOTOR VEHICLE, WHILE A MOTOR VEHICLE
20 SPECIFICALLY LISTED OR COVERED UNDER THE INSURED'S MOTOR VEHICLE
21 INSURANCE POLICY IS BEING TRANSPORTED, SERVICED, REPAIRED OR
22 INSPECTED BY THE MOTOR VEHICLE DEALER.

23 (B) AN INSURANCE COMPANY AUTHORIZED TO DO BUSINESS IN THIS
24 COMMONWEALTH SHALL PROVIDE TO A MOTOR VEHICLE DEALER OR AN AGENT
25 THEREOF WITH CUSTODY OF OR OPERATING A CUSTOMER'S MOTOR VEHICLE
26 FOR THE PURPOSE OF TRANSPORTING, SERVICING, REPAIRING OR
27 INSPECTING THE VEHICLE, PRIMARY LIABILITY COVERAGE FOR THIRD-
28 PARTY BODILY INJURY AND PRIMARY FIRST-PARTY PHYSICAL DAMAGE
29 COVERAGE IN THE AMOUNTS SET FORTH IN THE CUSTOMER'S PRIVATE
30 PASSENGER AUTOMOBILE INSURANCE POLICY.

1 (C) THIS SECTION SHALL APPLY ONLY TO THE LOAN OF A MOTOR
2 VEHICLE BY A MOTOR VEHICLE DEALER THAT OCCURS WITHOUT FINANCIAL
3 REMUNERATION IN THE FORM OF A FEE, RENTAL OR LEASE CHARGE PAID
4 DIRECTLY BY THE INSURED OPERATING THE MOTOR VEHICLE. PAYMENTS
5 MADE BY A THIRD PARTY TO A MOTOR VEHICLE DEALER OR SIMILAR
6 REIMBURSEMENTS SHALL NOT BE CONSIDERED PAYMENTS DIRECTLY FROM
7 THE INSURED OPERATING THE MOTOR VEHICLE.

8 (D) A CHANGE IN THE COVERAGE OF A PRIVATE PASSENGER
9 AUTOMOBILE INSURANCE POLICY RESULTING FROM THIS SECTION SHALL
10 NOT IMPACT THE VALIDITY OF A WAIVER, SELECTION OF BENEFITS OR
11 AMOUNT OF BENEFITS IN THAT POLICY, BEYOND THE COVERAGE CHANGE AS
12 A RESULT OF THIS SECTION. AN INSURER SHALL FILE WITH THE
13 INSURANCE DEPARTMENT ANY FORMS OR RATES REVISED AS A RESULT OF
14 THIS SECTION, ALONG WITH CERTIFICATION THAT THE REVISIONS ARE
15 LIMITED TO THE COMPLIANCE WITH THIS SECTION. THE REVISIONS SHALL
16 BE EFFECTIVE 10 DAYS AFTER FILING.

17 (E) AS USED IN THIS SECTION, THE TERM "MOTOR VEHICLE DEALER"
18 SHALL HAVE THE SAME MEANING AS "DEALER" AS DEFINED IN SECTION 2
19 OF THE ACT OF DECEMBER 22, 1983 (P.L.306, NO.84), KNOWN AS THE
20 "BOARD OF VEHICLES ACT."

21 SECTION 2. ARTICLE XXIII OF THE ACT IS REPEALED:

22 [ARTICLE XXIII.

23 CHILDREN'S HEALTH CARE.

24 (A) GENERAL PROVISIONS.

25 SECTION 2301. SHORT TITLE.--THIS ARTICLE SHALL BE KNOWN AND
26 MAY BE CITED AS THE "CHILDREN'S HEALTH CARE ACT."

27 SECTION 2302. LEGISLATIVE FINDINGS AND INTENT.--THE GENERAL
28 ASSEMBLY FINDS AND DECLARES AS FOLLOWS:

29 (1) CITIZENS OF THIS COMMONWEALTH SHOULD HAVE ACCESS TO
30 AFFORDABLE AND REASONABLY PRICED HEALTH CARE AND TO

1 NONDISCRIMINATORY TREATMENT BY HEALTH INSURERS AND PROVIDERS.

2 (2) THE UNINSURED HEALTH CARE POPULATION OF THIS
3 COMMONWEALTH IS ESTIMATED TO BE APPROXIMATELY ONE MILLION
4 PERSONS AND MANY THOUSANDS MORE LACK ADEQUATE INSURANCE
5 COVERAGE. IT IS ALSO ESTIMATED THAT APPROXIMATELY TWO-THIRDS OF
6 THE UNINSURED ARE EMPLOYED OR DEPENDENTS OF EMPLOYED PERSONS.

7 (3) APPROXIMATELY FIFTEEN PER CENTUM (15%) OF THE UNINSURED
8 HEALTH CARE POPULATION ARE CHILDREN. UNINSURED CHILDREN ARE OF
9 PARTICULAR CONCERN BECAUSE OF THEIR NEED FOR ONGOING PREVENTIVE
10 AND PRIMARY CARE. MEASURES NOT TAKEN TO CARE FOR SUCH CHILDREN
11 NOW WILL RESULT IN HIGHER HUMAN AND FINANCIAL COSTS LATER.

12 (4) UNINSURED CHILDREN LACK ACCESS TO TIMELY AND APPROPRIATE
13 PRIMARY AND PREVENTIVE CARE. AS A RESULT, HEALTH CARE IS OFTEN
14 DELAYED OR FORGONE, RESULTING IN INCREASED RISK OF DEVELOPING
15 MORE SEVERE CONDITIONS WHICH IN TURN ARE MORE EXPENSIVE TO
16 TREAT. THIS TENDENCY TO DELAY CARE AND TO SEEK AMBULATORY CARE
17 IN HOSPITAL-BASED SETTINGS ALSO CAUSES INEFFICIENCIES IN THE
18 HEALTH CARE SYSTEM.

19 (5) HEALTH CARE MARKETS HAVE BEEN DISTORTED THROUGH COST
20 SHIFTS FOR THE UNCOMPENSATED HEALTH CARE COSTS OF UNINSURED
21 CITIZENS OF THIS COMMONWEALTH WHICH HAS CAUSED DECREASED
22 COMPETITIVE CAPACITY ON THE PART OF THOSE HEALTH CARE PROVIDERS
23 WHO SERVE THE POOR AND INCREASED COSTS OF OTHER HEALTH CARE
24 PAYORS.

25 (6) NO ONE SECTOR CAN ABSORB THE COST OF PROVIDING HEALTH
26 CARE TO CITIZENS OF THIS COMMONWEALTH WHO CANNOT AFFORD HEALTH
27 CARE ON THEIR OWN. THE COST IS TOO LARGE FOR THE PUBLIC SECTOR
28 ALONE TO BEAR AND INSTEAD REQUIRES THE ESTABLISHMENT OF A PUBLIC
29 AND PRIVATE PARTNERSHIP TO SHARE THE COSTS IN A MANNER
30 ECONOMICALLY FEASIBLE FOR ALL INTERESTS. THE MAGNITUDE OF THIS

1 NEED ALSO REQUIRES THAT IT BE DONE ON A TIME-PHASED, COST-
2 MANAGED AND PLANNED BASIS.

3 (7) ELIGIBLE UNINSURED CHILDREN IN THIS COMMONWEALTH SHOULD
4 HAVE ACCESS TO COST-EFFECTIVE, COMPREHENSIVE PRIMARY HEALTH
5 COVERAGE IF THEY ARE UNABLE TO AFFORD COVERAGE OR OBTAIN IT.

6 (8) CARE SHOULD BE PROVIDED IN APPROPRIATE SETTINGS BY
7 EFFICIENT PROVIDERS, CONSISTENT WITH HIGH QUALITY CARE AND AT AN
8 APPROPRIATE STAGE, SOON ENOUGH TO AVERT THE NEED FOR OVERLY
9 EXPENSIVE TREATMENT.

10 (9) EQUITY SHOULD BE ASSURED AMONG HEALTH PROVIDERS AND
11 PAYORS BY PROVIDING A MECHANISM FOR PROVIDERS, EMPLOYERS, THE
12 PUBLIC SECTOR AND PATIENTS TO SHARE IN FINANCING INDIGENT
13 CHILDREN'S HEALTH CARE.

14 SECTION 2303. DEFINITIONS.--AS USED IN THIS ARTICLE, THE
15 FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO
16 THEM IN THIS SECTION:

17 "CHILD." A PERSON UNDER NINETEEN (19) YEARS OF AGE.

18 "CONTRACTOR." AN INSURER AWARDED A CONTRACT UNDER
19 SUBDIVISION (B) TO PROVIDE HEALTH CARE SERVICES UNDER THIS
20 ARTICLE. THE TERM INCLUDES AN ENTITY AND ITS SUBSIDIARY WHICH IS
21 ESTABLISHED UNDER 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
22 CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES
23 PLAN CORPORATIONS); THIS ACT; OR THE ACT OF DECEMBER 29, 1972
24 (P.L.1701, NO.364), KNOWN AS THE "HEALTH MAINTENANCE
25 ORGANIZATION ACT."

26 "COUNCIL." THE CHILDREN'S HEALTH ADVISORY COUNCIL
27 ESTABLISHED IN SECTION 2311(I).

28 "DEPARTMENT." THE INSURANCE DEPARTMENT OF THE COMMONWEALTH.

29 "EPSDT." EARLY AND PERIODIC SCREENING, DIAGNOSIS AND
30 TREATMENT.

1 "FUND." THE CHILDREN'S HEALTH FUND FOR HEALTH CARE FOR
2 INDIGENT CHILDREN ESTABLISHED BY SECTION 1296 OF THE ACT OF
3 MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE "TAX REFORM CODE OF
4 1971."

5 "GROUP." A GROUP FOR WHICH A HEALTH INSURANCE POLICY IS
6 WRITTEN IN THIS COMMONWEALTH.

7 "HEALTH MAINTENANCE ORGANIZATION" OR "HMO." AN ENTITY
8 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972
9 (P.L.1701, NO.364), KNOWN AS THE "HEALTH MAINTENANCE
10 ORGANIZATION ACT."

11 "HEALTH SERVICE CORPORATION." A PROFESSIONAL HEALTH SERVICE
12 CORPORATION AS DEFINED IN 40 PA.C.S. § 6302 (RELATING TO
13 DEFINITIONS).

14 "HEALTHY BEGINNINGS PROGRAM." MEDICAL ASSISTANCE COVERAGE
15 FOR SERVICES TO CHILDREN AS REQUIRED UNDER TITLE XIX OF THE
16 SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 301 ET SEQ.) FOR
17 THE FOLLOWING:

18 (1) CHILDREN FROM BIRTH TO AGE ONE (1) WHOSE FAMILY INCOME
19 IS NO GREATER THAN ONE HUNDRED EIGHTY-FIVE PER CENTUM (185%) OF
20 THE FEDERAL POVERTY LEVEL;

21 (2) CHILDREN ONE (1) THROUGH FIVE (5) YEARS OF AGE WHOSE
22 FAMILY INCOME IS NO GREATER THAN ONE HUNDRED THIRTY-THREE PER
23 CENTUM (133%) OF THE FEDERAL POVERTY LEVEL; AND

24 (3) CHILDREN SIX (6) THROUGH EIGHTEEN (18) YEARS OF AGE
25 WHOSE FAMILY INCOME IS NO GREATER THAN ONE HUNDRED PER CENTUM
26 (100%) OF THE FEDERAL POVERTY LEVEL.

27 "HOSPITAL." AN INSTITUTION HAVING AN ORGANIZED MEDICAL STAFF
28 WHICH IS ENGAGED PRIMARILY IN PROVIDING TO INPATIENTS, BY OR
29 UNDER 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 FACILITIES
2 FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS WITHIN THE SCOPE OF
3 SPECIFIC MEDICAL SPECIALTIES. THE TERM DOES NOT INCLUDE
4 FACILITIES CARING 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 "INSURER." A HEALTH INSURANCE ENTITY LICENSED IN THIS
8 COMMONWEALTH TO ISSUE ANY INDIVIDUAL OR GROUP HEALTH, SICKNESS
9 OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR CERTIFICATE THAT
10 PROVIDES MEDICAL OR HEALTH CARE COVERAGE BY A HEALTH CARE
11 FACILITY OR LICENSED HEALTH CARE PROVIDER THAT IS OFFERED OR
12 GOVERNED UNDER THIS ACT OR ANY OF THE FOLLOWING:

13 (1) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364),
14 KNOWN AS THE "HEALTH MAINTENANCE ORGANIZATION ACT."

15 (2) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS
16 THE "INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM
17 STANDARDS ACT."

18 (3) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
19 CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES
20 PLAN CORPORATIONS).

21 (4) ARTICLE XXIV.

22 "MAAC." THE MEDICAL ASSISTANCE ADVISORY COMMITTEE.

23 "MANAGED CARE ORGANIZATION." HEALTH MAINTENANCE ORGANIZATION
24 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972
25 (P.L.1701, NO.364), KNOWN AS THE "HEALTH MAINTENANCE
26 ORGANIZATION ACT," OR A RISK-ASSUMING PREFERRED PROVIDER
27 ORGANIZATION OR EXCLUSIVE PROVIDER ORGANIZATION, ORGANIZED AND
28 REGULATED UNDER THIS ACT.

29 "MCH." MATERNAL AND CHILD HEALTH.

30 "MEDICAID." THE FEDERAL MEDICAL ASSISTANCE PROGRAM

1 ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT.
2 620, 42 U.S.C. § 1396 ET SEQ.).

3 "MEDICAL ASSISTANCE." THE STATE PROGRAM OF MEDICAL
4 ASSISTANCE ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31,
5 NO.21), KNOWN AS THE "PUBLIC WELFARE CODE."

6 "MID-LEVEL HEALTH PROFESSIONAL." A PHYSICIAN ASSISTANT,
7 CERTIFIED REGISTERED NURSE PRACTITIONER, NURSE PRACTITIONER OR A
8 CERTIFIED NURSE MIDWIFE.

9 "PARENT." A NATURAL PARENT, STEPPARENT, ADOPTIVE PARENT,
10 GUARDIAN OR CUSTODIAN OF A CHILD.

11 "PPO." A PREFERRED PROVIDER ORGANIZATION SUBJECT TO THE
12 PROVISIONS OF SECTION 630.

13 "PREEXISTING CONDITION." A DISEASE OR PHYSICAL CONDITION FOR
14 WHICH MEDICAL ADVICE OR TREATMENT HAS BEEN RECEIVED PRIOR TO THE
15 EFFECTIVE DATE OF COVERAGE.

16 "PREMIUM ASSISTANCE PROGRAM." A COMPONENT OF A SEPARATE
17 CHILD HEALTH PROGRAM, APPROVED UNDER THE STATE PLAN, UNDER WHICH
18 THE COMMONWEALTH PAYS PART OR ALL OF THE PREMIUM FOR AN ENROLLEE
19 OR ENROLLEE'S GROUP HEALTH INSURANCE COVERAGE OR COVERAGE UNDER
20 A GROUP HEALTH PLAN.

21 "PRESCRIPTION DRUG." A CONTROLLED SUBSTANCE, OTHER DRUG OR
22 DEVICE FOR MEDICATION DISPENSED BY ORDER OF AN APPROPRIATELY
23 LICENSED MEDICAL PROFESSIONAL.

24 "SUBGROUP." AN EMPLOYER COVERED UNDER A CONTRACT ISSUED TO A
25 MULTIPLE EMPLOYER TRUST OR TO AN ASSOCIATION.

26 "TERMINATE." INCLUDES CANCELLATION, NONRENEWAL AND
27 RESCISSION.

28 "WAITING PERIOD." A PERIOD OF TIME AFTER THE EFFECTIVE DATE
29 OF ENROLLMENT DURING WHICH AN INSURER EXCLUDES COVERAGE FOR THE
30 DIAGNOSIS OR TREATMENT OF ONE OR MORE MEDICAL CONDITIONS.

1 "WIC." THE FEDERAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN,
2 INFANTS AND CHILDREN.

3 (B) PRIMARY HEALTH CARE PROGRAMS.

4 SECTION 2311. CHILDREN'S HEALTH CARE.-- (A) NOTWITHSTANDING
5 ANY OTHER PROVISION OF LAW, THE DEPARTMENT SHALL TAKE SUCH
6 ACTIONS AS MAY BE NECESSARY TO ENSURE THE RECEIPT OF FEDERAL
7 FINANCIAL PARTICIPATION UNDER TITLE XXI OF THE SOCIAL SECURITY
8 ACT (49 STAT. 620, 42 U.S.C. § 1397AA ET SEQ.) FOR SERVICES
9 PROVIDED UNDER THIS ACT AND TO QUALIFY THE BENEFIT EXPANSION
10 PROVIDED BY SUBSECTION (C) (1.1) FOR AVAILABLE FEDERAL FINANCIAL
11 PARTICIPATION.

12 (B) (1) THE FUND SHALL BE DEDICATED EXCLUSIVELY FOR
13 DISTRIBUTION BY THE DEPARTMENT THROUGH CONTRACTS IN ORDER TO
14 PROVIDE FREE AND SUBSIDIZED HEALTH CARE SERVICES UNDER THIS
15 SECTION, BASED ON AN ACTUARIALLY SOUND AND ADEQUATE REVIEW, AND
16 TO DEVELOP AND IMPLEMENT OUTREACH ACTIVITIES REQUIRED UNDER
17 SECTION 2312.

18 (2) THE FUND, ALONG WITH FEDERAL, STATE AND OTHER MONEY
19 AVAILABLE FOR THE PROGRAM, SHALL BE USED FOR HEALTH CARE
20 COVERAGE FOR CHILDREN AS SPECIFIED IN THIS SECTION. THE
21 DEPARTMENT SHALL ASSURE THAT THE PROGRAM IS IMPLEMENTED
22 STATEWIDE. ALL CONTRACTS AWARDED UNDER THIS SECTION SHALL BE
23 AWARDED THROUGH A COMPETITIVE PROCUREMENT PROCESS. THE
24 DEPARTMENT AND THE DEPARTMENT OF PUBLIC WELFARE SHALL USE THEIR
25 BEST EFFORTS TO ENSURE THAT ELIGIBLE CHILDREN ACROSS THIS
26 COMMONWEALTH HAVE ACCESS TO HEALTH CARE SERVICES TO BE PROVIDED
27 UNDER THIS ARTICLE.

28 (3) NO MORE THAN TEN PER CENTUM (10%) OF THE AMOUNT OF THE
29 CONTRACT MAY BE USED FOR ADMINISTRATIVE EXPENSES OF THE
30 CONTRACTOR. IF ANY CONTRACTOR PRESENTS DOCUMENTED EVIDENCE THAT

1 ADMINISTRATIVE EXPENSES FOR PURPOSES OF EXPANDED OUTREACH AND
2 SYSTEMS AND OPERATIONAL CHANGES ARE IN EXCESS OF TEN PER CENTUM
3 (10%) OF THE AMOUNT OF THE CONTRACT, THE DEPARTMENT SHALL MAKE
4 AN ADDITIONAL ALLOTMENT OF FUNDS, NOT TO EXCEED TWO PER CENTUM
5 (2%) OF THE AMOUNT OF THE CONTRACT, TO THE CONTRACTOR TO THE
6 EXTENT THAT THE DEPARTMENT FINDS THE EXPENSES REASONABLE AND
7 NECESSARY.

8 (4) NO LESS THAN EIGHTY-FOUR PER CENTUM (84%) OF THE
9 CONTRACT SHALL BE USED TO PROVIDE THE HEALTH CARE SERVICES
10 PROVIDED UNDER THIS ARTICLE FOR CHILDREN ELIGIBLE FOR CARE UNDER
11 THIS ARTICLE.

12 (5) TO ENSURE THAT INPATIENT HOSPITAL CARE IS PROVIDED TO
13 ELIGIBLE CHILDREN, EACH PRIMARY CARE PROVIDER FURNISHING PRIMARY
14 CARE SERVICES SHALL MAKE NECESSARY ARRANGEMENTS FOR ADMISSION TO
15 THE HOSPITAL AND FOR NECESSARY SPECIALTY CARE.

16 (C) (1) ANY INSURER RECEIVING FUNDS FROM THE DEPARTMENT TO
17 PROVIDE COVERAGE OF HEALTH CARE SERVICES SHALL ENROLL, TO THE
18 EXTENT THAT FUNDS ARE AVAILABLE, ANY CHILD WHO MEETS ALL OF THE
19 FOLLOWING:

20 (I) IS A RESIDENT OF THIS COMMONWEALTH.

21 (II) IS NOT COVERED BY A HEALTH INSURANCE PLAN, A SELF-
22 INSURANCE PLAN OR A SELF-FUNDED PLAN OR IS NOT ELIGIBLE FOR OR
23 COVERED BY MEDICAL ASSISTANCE, INCLUDING THE HEALTHY BEGINNINGS
24 PROGRAM.

25 (III) IS QUALIFIED BASED ON INCOME UNDER SUBSECTION (D) OR
26 (E).

27 (IV) MEETS THE CITIZENSHIP REQUIREMENTS OF TITLE XXI OF THE
28 SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1397AA ET SEQ.).

29 (1.1) BEGINNING JANUARY 1, 2007, AND SUBJECT TO THE
30 PROVISIONS OF SECTION 2314, ANY INSURER RECEIVING FUNDS FROM THE

1 DEPARTMENT TO PROVIDE COVERAGE OF HEALTH CARE SERVICES UNDER
2 THIS SECTION SHALL ENROLL, TO THE EXTENT THAT FUNDS ARE
3 AVAILABLE, ANY CHILD WHO MEETS ALL OF THE FOLLOWING:

4 (I) IS A RESIDENT OF THIS COMMONWEALTH.

5 (II) IS NOT COVERED BY A HEALTH INSURANCE PLAN, A SELF-
6 INSURANCE PLAN OR A SELF-FUNDED PLAN, OR IS NOT PROVIDED ACCESS
7 TO HEALTH CARE COVERAGE BY COURT ORDER, OR IS NOT ELIGIBLE FOR
8 OR COVERED BY A MEDICAL ASSISTANCE PROGRAM ADMINISTERED BY THE
9 DEPARTMENT OF PUBLIC WELFARE, INCLUDING THE HEALTHY BEGINNINGS
10 PROGRAM.

11 (III) IS QUALIFIED BASED ON INCOME UNDER SUBSECTION (D),
12 (E.1), (E.2), (E.3) OR (E.4).

13 (IV) MEETS THE CITIZENSHIP REQUIREMENTS OF TITLE XXI OF THE
14 SOCIAL SECURITY ACT.

15 (2) ENROLLMENT MAY NOT BE DENIED ON THE BASIS OF A
16 PREEXISTING CONDITION, NOR MAY DIAGNOSIS OR TREATMENT FOR THE
17 CONDITION BE EXCLUDED BASED ON THE CONDITION'S PREEXISTENCE.

18 (D) THE PROVISION OF HEALTH CARE INSURANCE FOR ELIGIBLE
19 CHILDREN SHALL BE FREE TO A CHILD WHOSE FAMILY INCOME IS NO
20 GREATER THAN TWO HUNDRED PER CENTUM (200%) OF THE FEDERAL
21 POVERTY LEVEL.

22 (E.1) THE PROVISION OF HEALTH CARE INSURANCE FOR AN ELIGIBLE
23 CHILD WHOSE FAMILY INCOME IS GREATER THAN TWO HUNDRED PER CENTUM
24 (200%) OF THE FEDERAL POVERTY LEVEL BUT NO GREATER THAN TWO
25 HUNDRED FIFTY PER CENTUM (250%) OF THE FEDERAL POVERTY LEVEL MAY
26 BE SUBSIDIZED BY THE FUND AT A RATE NOT TO EXCEED SEVENTY-FIVE
27 PER CENTUM (75%) OF THE PER MEMBER PER MONTH PREMIUM COST.

28 (E.2) THE PROVISION OF HEALTH CARE INSURANCE FOR AN ELIGIBLE
29 CHILD WHOSE FAMILY INCOME IS GREATER THAN TWO HUNDRED FIFTY PER
30 CENTUM (250%) OF THE FEDERAL POVERTY LEVEL BUT NO GREATER THAN

1 TWO HUNDRED SEVENTY-FIVE PER CENTUM (275%) OF THE FEDERAL
2 POVERTY LEVEL MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
3 EXCEED SIXTY-FIVE PER CENTUM (65%) OF THE PER MEMBER PER MONTH
4 PREMIUM COST.

5 (E.3) THE PROVISION OF HEALTH CARE INSURANCE FOR AN ELIGIBLE
6 CHILD WHOSE FAMILY INCOME IS GREATER THAN TWO HUNDRED SEVENTY-
7 FIVE PER CENTUM (275%) OF THE FEDERAL POVERTY LEVEL BUT NO
8 GREATER THAN THREE HUNDRED PER CENTUM (300%) OF THE FEDERAL
9 POVERTY LEVEL MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
10 EXCEED SIXTY PER CENTUM (60%) OF THE PER MEMBER PER MONTH
11 PREMIUM COST.

12 (E.4) THE FOLLOWING APPLY:

13 (1) FOR AN ELIGIBLE CHILD WHOSE FAMILY INCOME IS GREATER
14 THAN THE MAXIMUM LEVEL ESTABLISHED UNDER SUBSECTION (O), THE
15 FAMILY MAY PURCHASE THE MINIMUM BENEFIT PACKAGE SET FORTH IN
16 SUBSECTION (L) (6) FOR THAT CHILD AT THE PER MONTH PER MEMBER
17 PREMIUM COST, WHICH COST SHALL BE DERIVED SEPARATELY FROM THE
18 OTHER ELIGIBILITY CATEGORIES IN THE PROGRAM, AS LONG AS THE
19 FAMILY DEMONSTRATES ON AN ANNUAL BASIS AND IN A MANNER
20 DETERMINED BY THE DEPARTMENT EITHER ONE OF THE FOLLOWING:

21 (I) THE FAMILY IS UNABLE TO AFFORD INDIVIDUAL OR GROUP
22 COVERAGE BECAUSE THAT COVERAGE WOULD EXCEED TEN PER CENTUM (10%)
23 OF THE FAMILY INCOME OR BECAUSE THE TOTAL COST OF COVERAGE FOR
24 THE CHILD IS ONE HUNDRED FIFTY PER CENTUM (150%) OF THE GREATER
25 OF:

26 (A) THE PREMIUM COST ESTABLISHED UNDER THIS SUBSECTION FOR
27 THAT SERVICE AREA; OR

28 (B) THE PREMIUM COST ESTABLISHED UNDER THE PROGRAM FOR THAT
29 SERVICE AREA.

30 (II) THE FAMILY HAS BEEN REFUSED COVERAGE BY AN INSURER DUE

1 TO THE CHILD OR A MEMBER OF THAT CHILD'S IMMEDIATE FAMILY HAVING
2 A PREEXISTING CONDITION AND COVERAGE IS NOT AVAILABLE TO THE
3 CHILD.

4 (2) FOR PURPOSES OF THIS SUBSECTION, "COVERAGE" SHALL NOT
5 INCLUDE COVERAGE OFFERED THROUGH ACCIDENT ONLY, FIXED INDEMNITY,
6 LIMITED BENEFIT, CREDIT, DENTAL, VISION, SPECIFIED DISEASE,
7 MEDICARE SUPPLEMENT, CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE
8 UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT, LONG-TERM CARE OR
9 DISABILITY INCOME, WORKERS' COMPENSATION OR AUTOMOBILE MEDICAL
10 PAYMENT INSURANCE.

11 (F.1) (RESERVED).

12 (F.2) FOR ENROLLEES UNDER SUBSECTIONS (E.1), (E.2), (E.3)
13 AND (E.4), THE FOLLOWING APPLY:

14 (1) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO IMPOSE
15 COPAYMENTS FOR THE FOLLOWING SERVICES, EXCEPT AS OTHERWISE
16 PROHIBITED BY LAW:

17 (I) OUTPATIENT VISITS.

18 (II) EMERGENCY ROOM VISITS.

19 (III) PRESCRIPTION MEDICATIONS.

20 (IV) ANY OTHER SERVICE DEFINED BY THE DEPARTMENT.

21 (2) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO ESTABLISH AND
22 ADJUST THE LEVELS OF THESE COPAYMENTS IN ORDER TO IMPOSE
23 REASONABLE COST SHARING AND TO ENCOURAGE APPROPRIATE UTILIZATION
24 OF THESE SERVICES. IN NO EVENT SHALL THE PREMIUMS AND COPAYMENTS
25 FOR ENROLLEES UNDER SUBSECTIONS (E.1), (E.2) AND (E.3) AMOUNT TO
26 MORE THAN THE PER CENTUM OF TOTAL HOUSEHOLD INCOME WHICH IS IN
27 ACCORD WITH THE REQUIREMENTS OF THE CENTERS FOR MEDICARE AND
28 MEDICAID SERVICES.

29 (G) THE DEPARTMENT SHALL:

30 (1) ADMINISTER THE CHILDREN'S HEALTH CARE PROGRAM PURSUANT

1 TO THIS ARTICLE.

2 (2) REVIEW ALL BIDS AND APPROVE AND EXECUTE ALL CONTRACTS
3 FOR THE PURPOSE OF EXPANDING ACCESS TO HEALTH CARE SERVICES FOR
4 ELIGIBLE CHILDREN AS PROVIDED FOR IN THIS SUBDIVISION.

5 (3) CONDUCT MONITORING AND OVERSIGHT OF CONTRACTS ENTERED
6 INTO.

7 (4) ISSUE AN ANNUAL REPORT TO THE GOVERNOR, THE GENERAL
8 ASSEMBLY AND THE PUBLIC FOR EACH CALENDAR YEAR NO LATER THAN
9 MARCH 1 OUTLINING PRIMARY HEALTH SERVICES FUNDED FOR THE YEAR,
10 DETAILING THE OUTREACH AND ENROLLMENT EFFORTS AND REPORTING BY
11 NUMBER OF CHILDREN BY COUNTY AND BY PER CENTUM OF THE FEDERAL
12 POVERTY LEVEL, THE NUMBER OF CHILDREN RECEIVING HEALTH CARE
13 SERVICES; BY COUNTY AND BY PER CENTUM OF THE FEDERAL POVERTY
14 LEVEL, THE PROJECTED NUMBER OF ELIGIBLE CHILDREN; AND THE NUMBER
15 OF ELIGIBLE CHILDREN ON WAITING LISTS FOR ENROLLMENT IN THE
16 HEALTH INSURANCE PROGRAM ESTABLISHED UNDER THIS ACT BY COUNTY
17 AND BY PER CENTUM OF THE FEDERAL POVERTY LEVEL.

18 (5) IN CONSULTATION WITH APPROPRIATE COMMONWEALTH AGENCIES,
19 COORDINATE THE DEVELOPMENT AND SUPERVISION OF THE OUTREACH PLAN
20 REQUIRED UNDER SECTION 2312.

21 (6) IN CONSULTATION WITH APPROPRIATE COMMONWEALTH AGENCIES,
22 MONITOR, REVIEW AND EVALUATE THE ADEQUACY, ACCESSIBILITY AND
23 AVAILABILITY OF SERVICES DELIVERED TO CHILDREN WHO ARE ENROLLED
24 IN THE HEALTH INSURANCE PROGRAM ESTABLISHED UNDER THIS
25 SUBDIVISION.

26 (H) THE DEPARTMENT MAY PROMULGATE REGULATIONS NECESSARY FOR
27 THE IMPLEMENTATION AND ADMINISTRATION OF THIS SUBDIVISION.

28 (I) THE CHILDREN'S HEALTH ADVISORY COUNCIL IS ESTABLISHED
29 WITHIN THE DEPARTMENT AS AN ADVISORY COUNCIL. THE FOLLOWING
30 SHALL APPLY:

1 (1) THE COUNCIL SHALL CONSIST OF FOURTEEN VOTING MEMBERS.
2 MEMBERS PROVIDED FOR IN SUBPARAGRAPHS (IV), (V), (VI), (VII),
3 (VIII), (X) AND (XI) SHALL BE APPOINTED BY THE INSURANCE
4 COMMISSIONER. THE COUNCIL SHALL BE GEOGRAPHICALLY BALANCED ON A
5 STATEWIDE BASIS AND SHALL INCLUDE:

6 (I) THE SECRETARY OF HEALTH EX OFFICIO OR A DESIGNEE.

7 (II) THE INSURANCE COMMISSIONER EX OFFICIO OR A DESIGNEE.

8 (III) THE SECRETARY OF PUBLIC WELFARE EX OFFICIO OR A
9 DESIGNEE.

10 (IV) A REPRESENTATIVE WITH EXPERIENCE IN CHILDREN'S HEALTH
11 FROM A SCHOOL OF PUBLIC HEALTH LOCATED IN THIS COMMONWEALTH.

12 (V) A PHYSICIAN WITH EXPERIENCE IN CHILDREN'S HEALTH
13 APPOINTED FROM A LIST OF THREE QUALIFIED PERSONS RECOMMENDED BY
14 THE PENNSYLVANIA MEDICAL SOCIETY.

15 (VI) A REPRESENTATIVE OF A CHILDREN'S HOSPITAL OR A HOSPITAL
16 WITH A PEDIATRIC OUTPATIENT CLINIC APPOINTED FROM A LIST OF
17 THREE PERSONS SUBMITTED BY THE HOSPITAL ASSOCIATION OF
18 PENNSYLVANIA.

19 (VII) A PARENT OF A CHILD WHO RECEIVES PRIMARY HEALTH CARE
20 COVERAGE FROM THE FUND.

21 (VIII) A MID-LEVEL PROFESSIONAL APPOINTED FROM LISTS OF
22 NAMES RECOMMENDED BY STATEWIDE ASSOCIATIONS REPRESENTING MID-
23 LEVEL HEALTH PROFESSIONALS.

24 (IX) A SENATOR APPOINTED BY THE PRESIDENT PRO TEMPORE OF THE
25 SENATE, A SENATOR APPOINTED BY THE MINORITY LEADER OF THE
26 SENATE, A REPRESENTATIVE APPOINTED BY THE SPEAKER OF THE HOUSE
27 OF REPRESENTATIVES AND A REPRESENTATIVE APPOINTED BY THE
28 MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES.

29 (X) A REPRESENTATIVE FROM A PRIVATE NONPROFIT FOUNDATION.

30 (XI) A REPRESENTATIVE OF BUSINESS WHO IS NOT A CONTRACTOR OR

1 PROVIDER OF PRIMARY HEALTH CARE INSURANCE UNDER THIS
2 SUBDIVISION.

3 (2) IF ANY SPECIFIED ORGANIZATION SHOULD CEASE TO EXIST OR
4 FAIL TO MAKE A RECOMMENDATION WITHIN NINETY (90) DAYS OF A
5 REQUEST TO DO SO, THE COUNCIL SHALL SPECIFY A NEW EQUIVALENT
6 ORGANIZATION TO FULFILL THE RESPONSIBILITIES OF THIS SECTION.

7 (3) THE INSURANCE COMMISSIONER SHALL CHAIR THE COUNCIL. THE
8 MEMBERS OF THE COUNCIL SHALL ANNUALLY ELECT, BY A MAJORITY VOTE
9 OF THE MEMBERS, A VICE CHAIRPERSON FROM AMONG THE MEMBERS OF THE
10 COUNCIL.

11 (4) THE PRESENCE OF EIGHT MEMBERS SHALL CONSTITUTE A QUORUM
12 FOR THE TRANSACTING OF ANY BUSINESS. ANY ACT BY A MAJORITY OF
13 THE MEMBERS PRESENT AT ANY MEETING AT WHICH THERE IS A QUORUM
14 SHALL BE DEEMED TO BE THAT OF THE COUNCIL.

15 (5) ALL MEETINGS OF THE COUNCIL SHALL BE CONDUCTED PURSUANT
16 TO 65 PA.C.S. CH. 7 (RELATING TO OPEN MEETINGS) UNLESS OTHERWISE
17 PROVIDED IN THIS SECTION. THE COUNCIL SHALL MEET AT LEAST TWICE
18 PER YEAR AND MAY PROVIDE FOR SPECIAL MEETINGS AS IT DEEMS
19 NECESSARY. MEETING DATES SHALL BE SET BY A MAJORITY VOTE OF
20 MEMBERS OF THE COUNCIL OR BY CALL OF THE CHAIRPERSON UPON SEVEN

21 (7) DAYS' NOTICE TO ALL MEMBERS. THE COUNCIL SHALL PUBLISH
22 NOTICE OF ITS MEETINGS IN THE PENNSYLVANIA BULLETIN. NOTICE
23 SHALL SPECIFY THE DATE, TIME AND PLACE OF THE MEETING AND SHALL
24 STATE THAT THE COUNCIL'S MEETINGS ARE OPEN TO THE GENERAL
25 PUBLIC. ALL ACTION TAKEN BY THE COUNCIL SHALL BE TAKEN IN OPEN
26 PUBLIC SESSION AND SHALL NOT BE TAKEN EXCEPT UPON A MAJORITY
27 VOTE OF THE MEMBERS PRESENT AT A MEETING AT WHICH A QUORUM IS
28 PRESENT.

29 (6) THE MEMBERS OF THE COUNCIL SHALL NOT RECEIVE A SALARY OR
30 PER DIEM ALLOWANCE FOR SERVING AS MEMBERS OF THE COUNCIL BUT

1 SHALL BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES INCURRED
2 IN THE PERFORMANCE OF THEIR DUTIES.

3 (7) TERMS OF COUNCIL MEMBERS SHALL BE AS FOLLOWS:

4 (I) THE APPOINTED MEMBERS SHALL SERVE FOR A TERM OF THREE
5 (3) YEARS AND SHALL CONTINUE TO SERVE THEREAFTER UNTIL THEIR
6 SUCCESSORS ARE APPOINTED.

7 (II) AN APPOINTED MEMBER SHALL NOT BE ELIGIBLE TO SERVE MORE
8 THAN TWO FULL CONSECUTIVE TERMS OF THREE (3) YEARS. VACANCIES
9 SHALL BE FILLED IN THE SAME MANNER IN WHICH THEY WERE DESIGNATED
10 WITHIN SIXTY (60) DAYS OF THE VACANCY.

11 (III) AN APPOINTED MEMBER MAY BE REMOVED BY THE APPOINTING
12 AUTHORITY FOR JUST CAUSE AND BY A VOTE OF AT LEAST SEVEN MEMBERS
13 OF THE COUNCIL.

14 (8) THE COUNCIL SHALL REVIEW OUTREACH ACTIVITIES AND MAY
15 MAKE RECOMMENDATIONS TO THE DEPARTMENT.

16 (9) THE COUNCIL SHALL REVIEW AND EVALUATE THE ACCESSIBILITY
17 AND AVAILABILITY OF SERVICES DELIVERED TO CHILDREN ENROLLED IN
18 THE PROGRAM.

19 (J) THE DEPARTMENT SHALL SOLICIT BIDS AND AWARD CONTRACTS
20 THROUGH A COMPETITIVE PROCUREMENT PROCESS PURSUANT TO THE
21 FOLLOWING:

22 (1) TO THE FULLEST EXTENT PRACTICABLE, CONTRACTS SHALL BE
23 AWARDED TO INSURERS THAT CONTRACT WITH PROVIDERS TO PROVIDE
24 PRIMARY CARE SERVICES FOR ENROLLEES ON A COST-EFFECTIVE BASIS.
25 THE DEPARTMENT SHALL REQUIRE CONTRACTORS TO USE APPROPRIATE
26 COST-MANAGEMENT METHODS SO THAT BASIC PRIMARY BENEFIT SERVICES
27 CAN BE PROVIDED TO THE MAXIMUM NUMBER OF ELIGIBLE CHILDREN AND,
28 WHENEVER POSSIBLE, TO PURSUE AND UTILIZE AVAILABLE PUBLIC AND
29 PRIVATE FUNDS.

30 (2) TO THE FULLEST EXTENT PRACTICABLE, THE DEPARTMENT SHALL

1 REQUIRE THAT ANY CONTRACTOR COMPLY WITH ALL PROCEDURES RELATING
2 TO COORDINATION OF BENEFITS AS REQUIRED BY THE DEPARTMENT OR THE
3 DEPARTMENT OF PUBLIC WELFARE.

4 (3) CONTRACTS MAY BE FOR A TERM OF UP TO THREE (3) YEARS,
5 WITH THE OPTION TO EXTEND FOR TWO ONE-YEAR PERIODS.

6 (K) UPON RECEIPT OF A SOLICITATION FROM THE DEPARTMENT, EACH
7 HEALTH SERVICE CORPORATION AND HOSPITAL PLAN CORPORATION OR
8 THEIR ENTITIES DOING BUSINESS IN THIS COMMONWEALTH SHALL SUBMIT
9 A BID OR PROPOSAL TO THE DEPARTMENT TO CARRY OUT THE PURPOSES OF
10 THIS SECTION IN THE AREA SERVICED BY THE CORPORATION. ALL OTHER
11 INSURERS MAY SUBMIT A BID OR PROPOSAL TO THE DEPARTMENT TO CARRY
12 OUT THE PURPOSES OF THIS SECTION.

13 (L) A CONTRACTOR WITH WHOM THE DEPARTMENT ENTERS INTO A
14 CONTRACT SHALL DO THE FOLLOWING:

15 (1) ENSURE TO THE MAXIMUM EXTENT POSSIBLE THAT ELIGIBLE
16 CHILDREN HAVE ACCESS TO PRIMARY HEALTH CARE PHYSICIANS AND NURSE
17 PRACTITIONERS WITHIN THE CONTRACTOR'S SERVICE AREA.

18 (2) CONTRACT WITH QUALIFIED, COST-EFFECTIVE PROVIDERS, WHICH
19 MAY INCLUDE PRIMARY HEALTH CARE PHYSICIANS, NURSE PRACTITIONERS,
20 CLINICS AND HEALTH MAINTENANCE ORGANIZATIONS, TO PROVIDE PRIMARY
21 AND PREVENTIVE HEALTH CARE FOR ENROLLEES ON A BASIS BEST
22 CALCULATED TO MANAGE THE COSTS OF THE SERVICES, INCLUDING, BUT
23 NOT LIMITED TO, USING MANAGED HEALTH CARE TECHNIQUES AND OTHER
24 APPROPRIATE MEDICAL COST-MANAGEMENT METHODS.

25 (3) ENSURE THAT THE FAMILY OF A CHILD WHO MAY BE ELIGIBLE
26 FOR MEDICAL ASSISTANCE RECEIVES ASSISTANCE IN APPLYING FOR
27 MEDICAL ASSISTANCE.

28 (4) MAINTAIN WAITING LISTS OF CHILDREN FINANCIALLY ELIGIBLE
29 FOR BENEFITS WHO HAVE APPLIED FOR BENEFITS BUT WHO WERE NOT
30 ENROLLED DUE TO LACK OF FUNDS.

1 (4.1) NOTIFY FAMILIES OF CHILDREN WHO ARE PAYING A PREMIUM
2 OF ANY CHANGES IN SUCH PREMIUM OR COPAYMENT REQUIREMENTS.

3 (4.2) COLLECT SUCH PREMIUMS OR COPAYMENTS FROM THE FAMILY OF
4 ANY CHILD RECEIVING BENEFITS AS MAY BE REQUIRED.

5 (4.3) CANCEL POLICIES FOR NONPAYMENT OF PREMIUM, IN
6 ACCORDANCE WITH ALL OTHER APPLICABLE INSURANCE LAWS.

7 (5) STRONGLY ENCOURAGE ALL PROVIDERS WHO PROVIDE PRIMARY
8 CARE TO ELIGIBLE CHILDREN TO PARTICIPATE IN MEDICAL ASSISTANCE
9 AS QUALIFIED EPSDT PROVIDERS AND TO CONTINUE TO PROVIDE CARE TO
10 CHILDREN WHO BECOME INELIGIBLE FOR COVERAGE UNDER THE PROVISIONS
11 OF THIS ARTICLE BUT WHO QUALIFY FOR MEDICAL ASSISTANCE.

12 (6) SUBJECT TO ANY NECESSARY FEDERAL APPROVAL, PROVIDE THE
13 FOLLOWING MINIMUM BENEFIT PACKAGE FOR ELIGIBLE CHILDREN:

14 (I) PREVENTIVE CARE. THIS SUBPARAGRAPH INCLUDES WELL-CHILD
15 CARE VISITS IN ACCORDANCE WITH THE SCHEDULE ESTABLISHED BY THE
16 AMERICAN ACADEMY OF PEDIATRICS AND THE SERVICES RELATED TO THOSE
17 VISITS, INCLUDING, BUT NOT LIMITED TO, IMMUNIZATIONS, HEALTH
18 EDUCATION, TUBERCULOSIS TESTING AND DEVELOPMENTAL SCREENING IN
19 ACCORDANCE WITH ROUTINE SCHEDULE OF WELL-CHILD VISITS. CARE
20 SHALL ALSO INCLUDE A COMPREHENSIVE PHYSICAL EXAMINATION,
21 INCLUDING X-RAYS IF NECESSARY, FOR ANY CHILD EXHIBITING SYMPTOMS
22 OF POSSIBLE CHILD ABUSE.

23 (II) DIAGNOSIS AND TREATMENT OF ILLNESS OR INJURY, INCLUDING
24 ALL MEDICALLY NECESSARY SERVICES RELATED TO THE DIAGNOSIS AND
25 TREATMENT OF SICKNESS AND INJURY AND OTHER CONDITIONS PROVIDED
26 ON AN AMBULATORY BASIS, SUCH AS LABORATORY TESTS, WOUND DRESSING
27 AND CASTING TO IMMOBILIZE FRACTURES.

28 (III) INJECTIONS AND MEDICATIONS PROVIDED AT THE TIME OF THE
29 OFFICE VISIT OR THERAPY AND OUTPATIENT SURGERY PERFORMED IN THE
30 OFFICE, A HOSPITAL OR FREESTANDING AMBULATORY SERVICE CENTER,

1 INCLUDING ANESTHESIA PROVIDED IN CONJUNCTION WITH SUCH SERVICE
2 OR DURING EMERGENCY MEDICAL SERVICE.

3 (IV) EMERGENCY ACCIDENT AND EMERGENCY MEDICAL CARE.

4 (V) PRESCRIPTION DRUGS.

5 (VI) EMERGENCY, PREVENTIVE AND ROUTINE DENTAL CARE. THIS
6 SUBPARAGRAPH DOES NOT INCLUDE ORTHODONTIA OR COSMETIC SURGERY.

7 (VII) EMERGENCY, PREVENTIVE AND ROUTINE VISION CARE,
8 INCLUDING THE COST OF CORRECTIVE LENSES AND FRAMES, NOT TO
9 EXCEED TWO PRESCRIPTIONS PER YEAR.

10 (VIII) EMERGENCY, PREVENTIVE AND ROUTINE HEARING CARE.

11 (IX) INPATIENT HOSPITALIZATION UP TO NINETY (90) DAYS PER
12 YEAR FOR ELIGIBLE CHILDREN.

13 (6.1) THE DEPARTMENT SHALL IMPLEMENT A PREMIUM ASSISTANCE
14 PROGRAM PERMITTED UNDER FEDERAL REGULATIONS AND AS PERMITTED
15 THROUGH FEDERAL WAIVER OR STATE PLAN AMENDMENT MADE PURSUANT TO
16 THIS ARTICLE. NOTWITHSTANDING ANY OTHER LAW TO THE CONTRARY, IN
17 THE EVENT IT IS MORE COST EFFECTIVE TO PURCHASE HEALTH CARE FROM
18 A PARENT'S EMPLOYER-BASED PROGRAM AND THE EMPLOYER-BASED PROGRAM
19 MEETS THE MINIMUM COVERAGE REQUIREMENTS, EMPLOYER-BASED COVERAGE
20 MAY BE PURCHASED IN PLACE OF ENROLLMENT IN THE HEALTH INSURANCE
21 PROGRAM ESTABLISHED UNDER THIS SUBDIVISION. AN INSURER SHALL
22 HONOR A REQUEST FOR ENROLLMENT AND PURCHASE OF EMPLOYEE GROUP
23 HEALTH INSURANCE REQUESTED ON BEHALF OF AN INDIVIDUAL APPLYING
24 FOR COVERAGE UNDER THIS ARTICLE IF THAT INDIVIDUAL:

25 (I) IS A RESIDENT OF THIS COMMONWEALTH;

26 (II) IS QUALIFIED BASED ON INCOME UNDER SECTION 2311(D),
27 (E.1), (E.2) OR (E.3); AND

28 (III) MEETS THE CITIZENSHIP REQUIREMENTS OF SECTION 2311(C)
29 (1.1)(IV).

30 (6.2) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO REVIEW,

1 AUDIT AND APPROVE ANNUAL ADMINISTRATIVE EXPENSES INCURRED BY
2 CONTRACTORS PURSUANT TO THIS SECTION.

3 (7) EXCEPT FOR CHILDREN COVERED UNDER PARAGRAPH (6.1), EACH
4 CONTRACTOR SHALL PROVIDE AN INSURANCE IDENTIFICATION CARD TO
5 EACH ELIGIBLE CHILD COVERED UNDER CONTRACTS EXECUTED UNDER THIS
6 ARTICLE. THE CARD MUST NOT SPECIFICALLY IDENTIFY THE HOLDER AS
7 LOW INCOME.

8 (M) THE DEPARTMENT MAY GRANT A WAIVER OF THE MINIMUM BENEFIT
9 PACKAGE OF SUBSECTION (L) (6) UPON DEMONSTRATION BY THE APPLICANT
10 THAT IT IS PROVIDING HEALTH CARE SERVICES FOR ELIGIBLE CHILDREN
11 THAT MEET THE PURPOSES AND INTENT OF THIS SECTION.

12 (N) AFTER THE FIRST YEAR OF OPERATION AND PERIODICALLY
13 THEREAFTER, THE DEPARTMENT IN CONSULTATION WITH APPROPRIATE
14 COMMONWEALTH AGENCIES SHALL REVIEW ENROLLMENT PATTERNS FOR BOTH
15 THE FREE INSURANCE PROGRAM AND THE SUBSIDIZED INSURANCE PROGRAM.
16 THE DEPARTMENT SHALL CONSIDER THE RELATIONSHIP, IF ANY, AMONG
17 ENROLLMENT, ENROLLMENT FEES, INCOME LEVELS AND FAMILY
18 COMPOSITION. BASED ON THE RESULTS OF THIS STUDY AND THE
19 AVAILABILITY OF FUNDS, THE DEPARTMENT IS AUTHORIZED TO ADJUST
20 THE MAXIMUM INCOME CEILING FOR FREE INSURANCE AND THE MAXIMUM
21 INCOME CEILING FOR SUBSIDIZED INSURANCE BY REGULATION. IN NO
22 EVENT, HOWEVER, SHALL THE MAXIMUM INCOME CEILING FOR FREE
23 INSURANCE BE RAISED ABOVE TWO HUNDRED PER CENTUM (200%) OF THE
24 FEDERAL POVERTY LEVEL.

25 (O) NOTWITHSTANDING SUBSECTION (N), BEGINNING JANUARY 1,
26 2007, AND THEREAFTER, AND SUBJECT TO THE PROVISIONS OF SECTION
27 2314, THE MAXIMUM INCOME CEILING FOR SUBSIDIZED INSURANCE SHALL
28 NOT BE RAISED ABOVE THREE HUNDRED PER CENTUM (300%) OF THE
29 FEDERAL POVERTY LEVEL.

30 SECTION 2312. OUTREACH.-- (A) THE DEPARTMENT, IN

1 CONSULTATION WITH APPROPRIATE COMMONWEALTH AGENCIES, SHALL
2 COORDINATE THE DEVELOPMENT OF AN OUTREACH PLAN TO INFORM
3 POTENTIAL CONTRACTORS, PROVIDERS AND ENROLLEES REGARDING
4 ELIGIBILITY AND AVAILABLE BENEFITS. THE PLAN SHALL INCLUDE
5 PROVISIONS FOR REACHING SPECIAL POPULATIONS, INCLUDING NONWHITE
6 AND NON-ENGLISH-SPEAKING CHILDREN AND CHILDREN WITH
7 DISABILITIES; FOR REACHING DIFFERENT GEOGRAPHIC AREAS, INCLUDING
8 RURAL AND INNER-CITY AREAS; AND FOR ASSURING THAT SPECIAL
9 EFFORTS ARE COORDINATED WITHIN THE OVERALL OUTREACH ACTIVITIES
10 THROUGHOUT THIS COMMONWEALTH.

11 (B) THE COUNCIL SHALL REVIEW THE OUTREACH ACTIVITIES AND
12 RECOMMEND CHANGES AS IT DEEMS IN THE BEST INTERESTS OF THE
13 CHILDREN TO BE SERVED.

14 SECTION 2313. PAYOR OF LAST RESORT; INSURANCE COVERAGE.--THE
15 CONTRACTOR SHALL NOT PAY ANY CLAIM ON BEHALF OF AN ENROLLED
16 CHILD UNLESS ALL OTHER FEDERAL, STATE, LOCAL OR PRIVATE
17 RESOURCES AVAILABLE TO THE CHILD OR THE CHILD'S FAMILY ARE
18 UTILIZED FIRST. THE DEPARTMENT, IN COOPERATION WITH THE
19 DEPARTMENT OF PUBLIC WELFARE, SHALL DETERMINE IF ANY OTHER
20 INSURANCE COVERAGE IS AVAILABLE TO THE CHILD THROUGH A CUSTODIAL
21 OR NONCUSTODIAL PARENT ON AN EMPLOYMENT-RELATED OR OTHER GROUP
22 BASIS. IF SUCH INSURANCE COVERAGE IS AVAILABLE, THE CHILD'S
23 ELIGIBILITY UNDER SECTION 2311 SHALL BE REEVALUATED, AS SHALL
24 THE MOST COST-EFFECTIVE MEANS OF PROVIDING COVERAGE FOR THAT
25 CHILD.

26 SECTION 2314. STATE PLAN.--THE DEPARTMENT, IN COOPERATION
27 WITH THE DEPARTMENT OF PUBLIC WELFARE, SHALL AMEND THE STATE
28 PLAN AS DEEMED NECESSARY TO CARRY OUT THE PROVISIONS OF THIS
29 ARTICLE. THE REPEAL OF SECTION 2311 (E) AND (F) AND THE EXPANSION
30 OF FINANCIAL ELIGIBILITY UNDER SECTION 2311 (E.1), (E.2) AND

1 (E.3) SHALL BE CONTINGENT UPON FEDERAL APPROVAL.

2 (C) (RESERVED) .

3 (D) (RESERVED) .

4 (E) (RESERVED) .

5 (F) (RESERVED) .

6 (G) MISCELLANEOUS PROVISIONS.

7 SECTION 2361. LIMITATION ON EXPENDITURE OF FUNDS.--IN NO
8 CASE SHALL THE TOTAL AMOUNT OF ANNUAL CONTRACT AWARDS AUTHORIZED
9 IN SUBDIVISION (B) EXCEED THE AMOUNT OF CIGARETTE TAX RECEIPTS
10 ANNUALLY DEPOSITED INTO THE FUND PURSUANT TO SECTION 1296 OF THE
11 ACT OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE "TAX REFORM
12 CODE OF 1971," AND ANY OTHER FEDERAL OR STATE FUNDS RECEIVED
13 THROUGH THE FUND. THE PROVISION OF CHILDREN'S HEALTH CARE
14 THROUGH THE FUND SHALL IN NO WAY CONSTITUTE AN ENTITLEMENT
15 DERIVED FROM THE COMMONWEALTH OR A CLAIM ON ANY OTHER FUNDS OF
16 THE COMMONWEALTH.

17 SECTION 2362. EXPIRATION.--THIS ARTICLE SHALL EXPIRE
18 DECEMBER 31, 2015.]

19 SECTION 3. THE ACT IS AMENDED BY ADDING AN ARTICLE TO READ:

20 ARTICLE XXIII-A
21 COMPREHENSIVE HEALTH CARE
22 FOR UNINSURED CHILDREN

23 SECTION 2301-A. DEFINITIONS.

24 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ARTICLE
25 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
26 CONTEXT CLEARLY INDICATES OTHERWISE:

27 "CHILD." AN INDIVIDUAL UNDER 19 YEARS OF AGE.

28 "CONTRACTOR." AN INSURER AWARDED A CONTRACT UNDER SECTION
29 2304-A TO PROVIDE HEALTH CARE SERVICES UNDER THIS ARTICLE. THE
30 TERM INCLUDES AN ENTITY AND AN ENTITY'S SUBSIDIARY WHICH IS

1 ESTABLISHED UNDER THIS ACT, 40 PA.C.S. CH. 61 (RELATING TO
2 HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL
3 HEALTH SERVICES PLAN CORPORATIONS), OR THE ACT OF DECEMBER 29,
4 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE
5 ORGANIZATION ACT.

6 "COUNCIL." THE CHILDREN'S HEALTH ADVISORY COUNCIL
7 ESTABLISHED IN SECTION 2303-A .

8 "DEPARTMENT." THE DEPARTMENT OF HUMAN SERVICES OF THE
9 COMMONWEALTH.

10 "EPSDT." EARLY AND PERIODIC SCREENING, DIAGNOSIS AND
11 TREATMENT.

12 "EXPRESS LANE ELIGIBILITY." A PROCESS WHICH PERMITS THE USE
13 OF FINDINGS FOR ELIGIBILITY FACTORS, INCLUDING INCOME AND
14 HOUSEHOLD SIZE FROM AN EXPRESS LANE PARTNER ADMINISTERING A
15 GOVERNMENT PROGRAM.

16 "EXPRESS LANE PARTNER." AN AGENCY DETERMINING ELIGIBILITY
17 FOR ASSISTANCE FOR ANY OF THE FOLLOWING PROGRAMS:

18 (1) SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP).

19 (2) CHILD CARE PROVIDED UNDER THE CHILD CARE AND
20 DEVELOPMENT BLOCK GRANT ACT OF 1990 (PUBLIC LAW 101-508, 42
21 U.S.C. § 9858 ET SEQ.).

22 "FUND." THE CHILDREN'S HEALTH FUND.

23 "GROUP." A GROUP FOR WHICH A HEALTH INSURANCE POLICY IS
24 WRITTEN IN THIS COMMONWEALTH.

25 "HEALTH SERVICE CORPORATION." A PROFESSIONAL HEALTH SERVICE
26 CORPORATION AS DEFINED IN SECTION 2302-A.

27 "HEALTHY BEGINNINGS PROGRAM." MEDICAL ASSISTANCE COVERAGE
28 FOR SERVICES TO CHILDREN AS REQUIRED UNDER TITLE XIX FOR THE
29 FOLLOWING:

30 (1) CHILDREN FROM BIRTH TO ONE YEAR OF AGE WHOSE FAMILY

1 INCOME IS NOT GREATER THAN 185% OF THE FEDERAL POVERTY LEVEL.

2 (2) CHILDREN ONE THROUGH FIVE YEARS OF AGE WHOSE FAMILY
3 INCOME IS NOT GREATER THAN 133% OF THE FEDERAL POVERTY LEVEL.

4 (3) CHILDREN 6 THROUGH 18 YEARS OF AGE WHOSE FAMILY
5 INCOME IS NOT GREATER THAN 133% OF THE FEDERAL POVERTY LEVEL.

6 "HMO." AN ENTITY ORGANIZED AND REGULATED UNDER THE HEALTH
7 MAINTENANCE ORGANIZATION ACT.

8 "HOSPITAL." AN INSTITUTION HAVING AN ORGANIZED MEDICAL STAFF
9 WHICH IS ENGAGED PRIMARILY IN PROVIDING TO INPATIENTS, BY OR
10 UNDER THE SUPERVISION OF PHYSICIANS, DIAGNOSTIC AND THERAPEUTIC
11 SERVICES FOR THE CARE OF INJURED, DISABLED, PREGNANT, DISEASED
12 OR SICK OR MENTALLY ILL INDIVIDUALS. THE TERM INCLUDES
13 FACILITIES FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS WITHIN
14 THE SCOPE OF SPECIFIC MEDICAL SPECIALTIES. THE TERM DOES NOT
15 INCLUDE FACILITIES CARING EXCLUSIVELY FOR THE MENTALLY ILL.

16 "HOSPITAL PLAN CORPORATION." A HOSPITAL PLAN CORPORATION AS
17 DEFINED IN 40 PA.C.S. § 6101 (RELATING TO DEFINITIONS).

18 "INSURER." A HEALTH INSURANCE ENTITY LICENSED IN THIS
19 COMMONWEALTH TO ISSUE ANY INDIVIDUAL OR GROUP HEALTH, SICKNESS
20 OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR CERTIFICATE THAT
21 PROVIDES MEDICAL OR HEALTH CARE COVERAGE BY A HEALTH CARE
22 FACILITY OR LICENSED HEALTH CARE PROVIDER THAT IS OFFERED OR
23 GOVERNED UNDER ANY OF THE FOLLOWING:

24 (1) THIS ACT.

25 (2) THE HEALTH MAINTENANCE ORGANIZATION ACT.

26 (3) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS
27 THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM
28 STANDARDS ACT.

29 (4) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
30 CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES

1 PLAN CORPORATIONS).

2 "MEDICAID." THE FEDERAL MEDICAL ASSISTANCE PROGRAM
3 ESTABLISHED UNDER TITLE XIX.

4 "MEDICAL ASSISTANCE." THE STATE PROGRAM OF MEDICAL
5 ASSISTANCE ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31,
6 NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

7 "MID-LEVEL HEALTH PROFESSIONAL." A PHYSICIAN ASSISTANT,
8 CERTIFIED REGISTERED NURSE PRACTITIONER, NURSE PRACTITIONER OR
9 CERTIFIED NURSE MIDWIFE.

10 "PARENT." A NATURAL PARENT, STEPPARENT, ADOPTIVE PARENT,
11 GUARDIAN OR CUSTODIAN OF A CHILD.

12 "PREMIUM ASSISTANCE PROGRAM." A COMPONENT OF A SEPARATE
13 CHILD HEALTH PROGRAM, APPROVED UNDER THE STATE PLAN, UNDER WHICH
14 THE COMMONWEALTH PAYS PART OR ALL OF THE PREMIUM FOR AN ENROLLEE
15 OR ENROLLEE'S GROUP HEALTH INSURANCE COVERAGE OR COVERAGE UNDER
16 A GROUP HEALTH PLAN.

17 "PRESCRIPTION DRUG." A CONTROLLED SUBSTANCE, OTHER DRUG OR
18 DEVICE FOR MEDICATION DISPENSED BY ORDER OF AN APPROPRIATELY
19 LICENSED MEDICAL PROFESSIONAL.

20 "SECRETARY." THE SECRETARY OF HUMAN SERVICES OF THE
21 COMMONWEALTH.

22 "TERMINATE." THE TERM INCLUDES CANCELLATION, NONRENEWAL AND
23 RESCISSION.

24 "TITLE XIX." TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT.
25 620, 42 U.S.C. § 301 ET SEQ.).

26 "TITLE XXI." TITLE XXI OF THE SOCIAL SECURITY ACT.
27 SECTION 2302-A. CHILDREN'S HEALTH CARE.

28 (A) FEDERAL FUNDS.--NOTWITHSTANDING ANY OTHER PROVISION OF
29 LAW, THE DEPARTMENT SHALL ENSURE THE RECEIPT OF FEDERAL
30 FINANCIAL PARTICIPATION UNDER TITLE XXI FOR SERVICES PROVIDED

1 UNDER THIS CHAPTER.

2 (B) GENERAL CARE.--TO ENSURE THAT INPATIENT HOSPITAL CARE IS
3 PROVIDED TO ELIGIBLE CHILDREN, EACH PRIMARY CARE PROVIDER
4 FURNISHING PRIMARY CARE SERVICES SHALL MAKE NECESSARY
5 ARRANGEMENTS FOR ADMISSION TO THE HOSPITAL AND FOR NECESSARY
6 SPECIALTY CARE.

7 (C) ENROLLMENT.--SUBJECT TO THE PROVISIONS OF SECTION 2304-
8 A, AN INSURER RECEIVING FUNDS FROM THE DEPARTMENT TO PROVIDE
9 COVERAGE OF HEALTH CARE SERVICES UNDER THIS SECTION SHALL
10 ENROLL, TO THE EXTENT THAT FUNDS ARE AVAILABLE, ANY CHILD WHO
11 MEETS ALL OF THE FOLLOWING:

12 (1) IS A RESIDENT OF THIS COMMONWEALTH.

13 (2) IS NOT:

14 (I) COVERED BY A HEALTH INSURANCE PLAN.

15 (II) COVERED BY A SELF-INSURANCE PLAN.

16 (III) COVERED BY A SELF-FUNDED PLAN.

17 (IV) PROVIDED ACCESS TO HEALTH CARE COVERAGE BY
18 COURT ORDER.

19 (V) ELIGIBLE FOR OR COVERED BY A MEDICAL ASSISTANCE
20 PROGRAM ADMINISTERED BY THE DEPARTMENT, INCLUDING THE
21 HEALTHY BEGINNINGS PROGRAM.

22 (3) IS QUALIFIED BASED ON INCOME UNDER SUBSECTIONS (D)
23 AND (E).

24 (4) MEETS THE CITIZENSHIP REQUIREMENTS OF TITLE XXI.

25 (D) INCOME LEVELS.--THE PROVISION OF HEALTH CARE INSURANCE
26 FOR ELIGIBLE CHILDREN SHALL BE IN ACCORDANCE WITH THE FOLLOWING:

27 (1) FREE TO A CHILD WHOSE FAMILY INCOME IS NO GREATER
28 THAN 200% OF THE FEDERAL POVERTY LEVEL.

29 (2) MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
30 EXCEED 75% OF THE PER MEMBER PER MONTH PREMIUM COST FOR A

1 CHILD WHOSE FAMILY INCOME IS GREATER THAN 200% OF THE FEDERAL
2 POVERTY LEVEL BUT NOT GREATER THAN 250% OF THE FEDERAL
3 POVERTY LEVEL.

4 (3) MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
5 EXCEED 65% OF THE PER MEMBER PER MONTH PREMIUM COST FOR A
6 CHILD WHOSE FAMILY INCOME IS GREATER THAN 250% OF THE FEDERAL
7 POVERTY LEVEL BUT NOT GREATER THAN 275% OF THE FEDERAL
8 POVERTY LEVEL.

9 (4) MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
10 EXCEED 60% OF THE PER MEMBER PER MONTH PREMIUM FOR A CHILD
11 WHOSE FAMILY INCOME IS GREATER THAN 275% OF THE FEDERAL
12 POVERTY LEVEL BUT NOT GREATER THAN 300% OF THE FEDERAL
13 POVERTY LEVEL.

14 (5) NOTWITHSTANDING PARAGRAPHS (1), (2), (3) AND (4),
15 FOR PURPOSES OF DETERMINING COST SHARING OBLIGATIONS OF A
16 FAMILY WITH INCOME LEVELS SPECIFIED UNDER PARAGRAPHS (2), (3)
17 AND (4), THE PER MEMBER PER MONTH PREMIUM SHALL EXCLUDE THE
18 COST RELATED TO AN ASSESSMENT IMPOSED ON A CONTRACTOR
19 RELATING TO MANAGED CARE ORGANIZATION ASSESSMENTS UNDER THE
20 ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS THE PUBLIC
21 WELFARE CODE.

22 (E) INCOME EXCEEDING LIMITS.--THE FOLLOWING APPLY:

23 (1) FOR AN ELIGIBLE CHILD WHOSE FAMILY INCOME IS GREATER
24 THAN THE MAXIMUM LEVEL ESTABLISHED UNDER SECTION 2304-A(H),
25 THE FAMILY MAY PURCHASE THE MINIMUM COVERAGE PACKAGE UNDER
26 2304-A(E) (9) FOR THAT CHILD AT THE PER MEMBER PER MONTH
27 PREMIUM COST. THE COST SHALL BE DERIVED SEPARATELY FROM THE
28 OTHER ELIGIBILITY CATEGORIES IN THE PROGRAM. THE FAMILY MAY
29 PURCHASE THE MINIMUM COVERAGE PACKAGE IF THE FAMILY
30 DEMONSTRATES ON AN ANNUAL BASIS AND IN A MANNER DETERMINED BY

1 THE DEPARTMENT THAT THE FAMILY IS UNABLE TO AFFORD INDIVIDUAL
2 OR GROUP COVERAGE BECAUSE OF ONE OF THE FOLLOWING REASONS:

3 (I) THE COVERAGE WOULD EXCEED 10% OF THE FAMILY
4 INCOME.

5 (II) THE TOTAL COST OF COVERAGE FOR THE CHILD IS
6 150% OF THE GREATER OF:

7 (A) THE PREMIUM COST ESTABLISHED UNDER THIS
8 SUBSECTION FOR THAT SERVICE AREA; OR

9 (B) THE PREMIUM COST ESTABLISHED UNDER THE
10 PROGRAM FOR THAT SERVICE AREA.

11 (2) FOR PURPOSES OF THIS SUBSECTION, THE PER MEMBER PER
12 MONTH PREMIUM COST SHALL EXCLUDE THE COST RELATED TO THE
13 MANAGED CARE ORGANIZATION ASSESSMENT IMPOSED ON A CONTRACTOR
14 UNDER THE PUBLIC WELFARE CODE.

15 (3) FOR PURPOSES OF THIS SUBSECTION, THE TERM "COVERAGE"
16 MAY NOT INCLUDE COVERAGE OFFERED THROUGH ACCIDENT ONLY, FIXED
17 INDEMNITY, LIMITED BENEFIT, CREDIT, DENTAL, VISION, SPECIFIED
18 DISEASE, MEDICARE SUPPLEMENT, CIVILIAN HEALTH AND MEDICAL
19 PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT, LONG-
20 TERM CARE OR DISABILITY INCOME, WORKERS' COMPENSATION OR
21 AUTOMOBILE MEDICAL PAYMENT INSURANCE.

22 (F) POWERS AND DUTIES.--

23 (1) FOR ENROLLEES UNDER SUBSECTION (D) (2), (3) OR (4) OR
24 (E), THE FOLLOWING APPLY:

25 (I) THE DEPARTMENT MAY IMPOSE COPAYMENTS FOR THE
26 FOLLOWING SERVICES, EXCEPT AS OTHERWISE PROHIBITED BY
27 LAW:

28 (A) OUTPATIENT VISITS.

29 (B) EMERGENCY ROOM VISITS.

30 (C) PRESCRIPTION MEDICATIONS.

1 (D) ANY OTHER SERVICE DEFINED BY THE DEPARTMENT.

2 (II) THE DEPARTMENT MAY ESTABLISH AND ADJUST THE
3 LEVELS OF THESE COPAYMENTS IN ORDER TO IMPOSE REASONABLE
4 COST SHARING AND TO ENCOURAGE APPROPRIATE UTILIZATION OF
5 THESE SERVICES. THE PREMIUMS AND COPAYMENTS FOR ENROLLEES
6 UNDER SUBSECTION (D) (2), (3) OR (4) MAY NOT AMOUNT TO
7 MORE THAN THE PERCENT OF TOTAL HOUSEHOLD INCOME WHICH IS
8 IN ACCORDANCE WITH THE REQUIREMENTS OF THE CENTERS FOR
9 MEDICARE AND MEDICAID SERVICES.

10 (2) THE DEPARTMENT SHALL:

11 (I) ADMINISTER THE CHILDREN'S HEALTH INSURANCE
12 PROGRAM IN ACCORDANCE WITH THIS CHAPTER.

13 (II) REVIEW ALL BIDS AND APPROVE AND EXECUTE ALL
14 CONTRACTS FOR THE PURPOSE OF EXPANDING ACCESS TO HEALTH
15 CARE SERVICES FOR ELIGIBLE CHILDREN AS PROVIDED FOR IN
16 THIS ARTICLE.

17 (III) CONDUCT MONITORING AND OVERSIGHT OF CONTRACTS.

18 (IV) ISSUE AN ANNUAL REPORT TO THE GOVERNOR, THE
19 GENERAL ASSEMBLY AND THE PUBLIC FOR EACH CALENDAR YEAR NO
20 LATER THAN MARCH 1 OF EACH YEAR PROVIDING FOR THE
21 FOLLOWING:

22 (A) THE PRIMARY HEALTH SERVICES FUNDED FOR THE
23 YEAR.

24 (B) THE OUTREACH AND ENROLLMENT EFFORTS AND THE
25 NUMBER OF CHILDREN BY COUNTY AND BY PERCENT OF THE
26 FEDERAL POVERTY LEVEL WHO ARE RECEIVING HEALTH CARE
27 SERVICES.

28 (C) THE PROJECTED NUMBER OF ELIGIBLE CHILDREN BY
29 COUNTY AND BY PERCENT OF THE FEDERAL POVERTY LEVEL.

30 (D) THE NUMBER OF ELIGIBLE CHILDREN ON WAITING

1 LISTS FOR ENROLLMENT IN THE CHILDREN'S HEALTH
2 INSURANCE PROGRAM ESTABLISHED UNDER THIS ARTICLE BY
3 COUNTY AND BY PERCENT OF THE FEDERAL POVERTY LEVEL.

4 (E) THE DETAILS OF THE DEPARTMENT'S EFFORTS ON
5 THE IMPLEMENTATION OF EXPRESS LANE ELIGIBILITY.

6 (V) IN CONSULTATION WITH APPROPRIATE COMMONWEALTH
7 AGENCIES, COORDINATE THE DEVELOPMENT AND SUPERVISION OF
8 THE OUTREACH PLAN REQUIRED UNDER SECTION 2305-A.

9 (VI) IN CONSULTATION WITH APPROPRIATE COMMONWEALTH
10 AGENCIES, MONITOR, REVIEW AND EVALUATE THE ADEQUACY,
11 ACCESSIBILITY AND AVAILABILITY OF SERVICES DELIVERED TO
12 CHILDREN WHO ARE ENROLLED IN THE CHILDREN'S HEALTH
13 INSURANCE PROGRAM ESTABLISHED UNDER THIS ARTICLE.

14 (VII) ENTER INTO ARRANGEMENTS, INCLUDING MEMORANDA
15 OF UNDERSTANDING, WITH THE INSURANCE DEPARTMENT AND OTHER
16 APPROPRIATE FEDERAL OR STATE AGENCIES, AS MAY BE
17 NECESSARY TO CARRY OUT THE DEPARTMENT'S DUTIES UNDER THIS
18 ARTICLE.

19 (3) THE DEPARTMENT MAY PROMULGATE REGULATIONS NECESSARY
20 FOR THE IMPLEMENTATION AND ADMINISTRATION OF THIS ARTICLE.

21 SECTION 2303-A. CHILDREN'S HEALTH ADVISORY COUNCIL.

22 THE CHILDREN'S HEALTH ADVISORY COUNCIL IS ESTABLISHED WITHIN
23 THE DEPARTMENT AS AN ADVISORY COUNCIL. THE FOLLOWING APPLY:

24 (1) THE COUNCIL SHALL CONSIST OF 16 VOTING MEMBERS.
25 MEMBERS PROVIDED FOR IN SUBPARAGRAPHS (IV), (V), (VI), (VII),
26 (VIII), (XIII), (XIV), (XV) AND (XVI) SHALL BE APPOINTED BY
27 THE SECRETARY. THE COUNCIL SHALL BE GEOGRAPHICALLY BALANCED
28 ON A STATEWIDE BASIS AND SHALL INCLUDE:

29 (I) THE SECRETARY OF HEALTH EX OFFICIO OR A
30 DESIGNEE.

1 (II) THE INSURANCE COMMISSIONER EX OFFICIO OR A
2 DESIGNEE.

3 (III) THE SECRETARY EX OFFICIO OR A DESIGNEE.

4 (IV) A REPRESENTATIVE WITH EXPERIENCE IN CHILDREN'S
5 HEALTH FROM A SCHOOL OF PUBLIC HEALTH LOCATED IN THIS
6 COMMONWEALTH.

7 (V) A PHYSICIAN WITH EXPERIENCE IN CHILDREN'S HEALTH
8 APPOINTED FROM A LIST OF THREE QUALIFIED PERSONS
9 RECOMMENDED BY THE PENNSYLVANIA MEDICAL SOCIETY.

10 (VI) A REPRESENTATIVE OF A CHILDREN'S HOSPITAL OR A
11 HOSPITAL WITH A PEDIATRIC OUTPATIENT CLINIC APPOINTED
12 FROM A LIST OF THREE PERSONS SUBMITTED BY THE HOSPITAL
13 ASSOCIATION OF PENNSYLVANIA.

14 (VII) A PARENT OF A CHILD WHO RECEIVES PRIMARY
15 HEALTH CARE COVERAGE FROM THE FUND.

16 (VIII) A MID-LEVEL PROFESSIONAL APPOINTED FROM LISTS
17 OF NAMES RECOMMENDED BY STATEWIDE ASSOCIATIONS
18 REPRESENTING MID-LEVEL HEALTH PROFESSIONALS.

19 (IX) A SENATOR APPOINTED BY THE PRESIDENT PRO
20 TEMPORE OF THE SENATE.

21 (X) A SENATOR APPOINTED BY THE MINORITY LEADER OF
22 THE SENATE.

23 (XI) A REPRESENTATIVE APPOINTED BY THE SPEAKER OF
24 THE HOUSE OF REPRESENTATIVES.

25 (XII) A REPRESENTATIVE APPOINTED BY THE MINORITY
26 LEADER OF THE HOUSE OF REPRESENTATIVES.

27 (XIII) A REPRESENTATIVE FROM A PRIVATE NONPROFIT
28 FOUNDATION.

29 (XIV) A REPRESENTATIVE OF BUSINESS WHO IS NOT A
30 CONTRACTOR OR PROVIDER OF PRIMARY HEALTH CARE INSURANCE

1 UNDER THIS ARTICLE.

2 (XV) A REPRESENTATIVE OF A NONPROFIT BUSINESS WHO IS
3 A CONTRACTOR OR PROVIDER OF PRIMARY HEALTH INSURANCE
4 UNDER THIS ARTICLE.

5 (XVI) A REPRESENTATIVE OF A FOR PROFIT BUSINESS WHO
6 IS A CONTRACTOR OR PROVIDER OF PRIMARY HEALTH INSURANCE
7 UNDER THIS ARTICLE.

8 (2) IF A SPECIFIED ORGANIZATION CEASES TO EXIST OR FAILS
9 TO MAKE A RECOMMENDATION WITHIN 90 DAYS OF A REQUEST, THE
10 COUNCIL SHALL SPECIFY A NEW EQUIVALENT ORGANIZATION TO
11 FULFILL THE RESPONSIBILITIES OF THIS SECTION.

12 (3) THE SECRETARY SHALL SERVE AS CHAIRPERSON OF THE
13 COUNCIL. THE MEMBERS OF THE COUNCIL SHALL ANNUALLY ELECT, BY
14 A MAJORITY VOTE OF THE MEMBERS, A VICE CHAIRPERSON FROM AMONG
15 THE MEMBERS OF THE COUNCIL.

16 (4) THE PRESENCE OF NINE MEMBERS SHALL CONSTITUTE A
17 QUORUM FOR THE TRANSACTING OF ANY BUSINESS. AN ACT BY A
18 MAJORITY OF THE MEMBERS PRESENT AT A MEETING AT WHICH THERE
19 IS A QUORUM SHALL BE DEEMED TO BE THAT OF THE COUNCIL.

20 (5) ALL MEETINGS OF THE COUNCIL SHALL BE CONDUCTED IN
21 ACCORDANCE WITH 65 PA.C.S. CH. 7 (RELATING TO OPEN MEETINGS),
22 EXCEPT AS PROVIDED IN THIS SECTION. MEETINGS MUST BE IN
23 ACCORDANCE WITH THE FOLLOWING:

24 (I) THE COUNCIL SHALL MEET AT LEAST TWICE PER YEAR
25 AND MAY PROVIDE FOR SPECIAL MEETINGS AS THE COUNCIL DEEMS
26 NECESSARY.

27 (II) MEETING DATES SHALL BE SET BY A MAJORITY VOTE
28 OF MEMBERS OF THE COUNCIL OR BY CALL OF THE CHAIRPERSON
29 UPON SEVEN DAYS' NOTICE TO ALL MEMBERS.

30 (III) THE COUNCIL SHALL PUBLISH NOTICE OF THE

1 COUNCIL'S MEETINGS IN THE PENNSYLVANIA BULLETIN. THE
2 NOTICE MUST SPECIFY THE DATE, TIME AND PLACE OF THE
3 MEETING AND SHALL STATE THAT THE COUNCIL'S MEETINGS ARE
4 OPEN TO THE GENERAL PUBLIC.

5 (IV) ALL ACTION TAKEN BY THE COUNCIL SHALL BE TAKEN
6 IN OPEN PUBLIC SESSION AND MAY NOT BE TAKEN EXCEPT UPON A
7 MAJORITY VOTE OF THE MEMBERS PRESENT AT A MEETING AT
8 WHICH A QUORUM IS PRESENT.

9 (6) THE MEMBERS OF THE COUNCIL MAY NOT RECEIVE A SALARY
10 OR PER DIEM ALLOWANCE FOR SERVING AS MEMBERS OF THE COUNCIL
11 BUT SHALL BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES
12 INCURRED IN THE PERFORMANCE OF THE MEMBERS' DUTIES.

13 (7) TERMS OF COUNCIL MEMBERS SHALL BE AS FOLLOWS:

14 (I) THE APPOINTED MEMBERS SHALL SERVE FOR A TERM OF
15 THREE YEARS AND SHALL CONTINUE TO SERVE UNTIL A SUCCESSOR
16 IS APPOINTED.

17 (II) AN APPOINTED MEMBER MAY NOT BE ELIGIBLE TO
18 SERVE MORE THAN TWO FULL CONSECUTIVE TERMS OF THREE
19 YEARS. VACANCIES SHALL BE FILLED IN THE SAME MANNER AS
20 THE ORIGINAL APPOINTMENT WITHIN 60 DAYS OF THE VACANCY.

21 (III) AN APPOINTED MEMBER MAY BE REMOVED BY THE
22 APPOINTING AUTHORITY FOR JUST CAUSE AND BY A VOTE OF AT
23 LEAST SEVEN MEMBERS OF THE COUNCIL.

24 (8) THE COUNCIL SHALL REVIEW OUTREACH ACTIVITIES AND MAY
25 MAKE RECOMMENDATIONS TO THE DEPARTMENT.

26 (9) THE COUNCIL SHALL REVIEW AND EVALUATE THE
27 ACCESSIBILITY AND AVAILABILITY OF SERVICES DELIVERED TO
28 CHILDREN ENROLLED IN THE PROGRAM.

29 SECTION 2304-A. CONTRACTS AND COVERAGE PACKAGES.

30 (A) PAID FROM FUND.--IN ADDITION TO ANY OTHER REQUIREMENTS

1 PROVIDED BY LAW, THE FUND SHALL BE OPERATED IN ACCORDANCE WITH
2 THE FOLLOWING:

3 (1) THE FUND MUST BE DEDICATED EXCLUSIVELY FOR
4 DISTRIBUTION BY THE DEPARTMENT THROUGH CONTRACTS IN ORDER TO
5 PROVIDE FREE AND SUBSIDIZED HEALTH CARE SERVICES UNDER THIS
6 ARTICLE, BASED ON AN ACTUARIALLY SOUND AND ADEQUATE REVIEW,
7 AND TO DEVELOP AND IMPLEMENT OUTREACH ACTIVITIES REQUIRED
8 UNDER SECTION 2305-A.

9 (2) THE FUND, ALONG WITH FEDERAL, STATE AND OTHER FUNDS
10 AVAILABLE FOR THE PROGRAM, MUST BE USED FOR HEALTH CARE
11 COVERAGE FOR CHILDREN AS SPECIFIED IN THIS ARTICLE. THE
12 DEPARTMENT SHALL ENSURE THAT THE PROGRAM IS IMPLEMENTED
13 STATEWIDE.

14 (3) THE DEPARTMENT MUST AWARD CONTRACTS PAID FROM THE
15 FUND IN ACCORDANCE WITH THE FOLLOWING:

16 (I) ALL CONTRACTS AWARDED UNDER THIS SUBSECTION MUST
17 BE AWARDED THROUGH A COMPETITIVE PROCUREMENT PROCESS. THE
18 DEPARTMENT AND THE INSURANCE DEPARTMENT MUST USE THEIR
19 BEST EFFORTS TO ENSURE THAT ELIGIBLE CHILDREN ACROSS THIS
20 COMMONWEALTH HAVE ACCESS TO HEALTH CARE SERVICES TO BE
21 PROVIDED UNDER THIS ARTICLE.

22 (II) NO MORE THAN 10% OF THE AMOUNT OF THE CONTRACT
23 MAY BE USED FOR ADMINISTRATIVE EXPENSES OF THE
24 CONTRACTOR. IF A CONTRACTOR PRESENTS DOCUMENTED EVIDENCE
25 THAT ADMINISTRATIVE EXPENSES FOR PURPOSES OF EXPANDED
26 OUTREACH AND SYSTEMS AND OPERATIONAL CHANGES ARE IN
27 EXCESS OF 10% OF THE AMOUNT OF THE CONTRACT, THE
28 DEPARTMENT SHALL MAKE AN ADDITIONAL ALLOTMENT OF FUNDS,
29 NOT TO EXCEED 2% OF THE AMOUNT OF THE CONTRACT, TO THE
30 CONTRACTOR TO THE EXTENT THAT THE DEPARTMENT FINDS THE

1 EXPENSES REASONABLE AND NECESSARY.

2 (III) AT LEAST 84% OF THE AMOUNT OF THE CONTRACT
3 SHALL BE USED TO PROVIDE HEALTH CARE SERVICES FOR
4 CHILDREN ELIGIBLE FOR CARE UNDER THIS ARTICLE.

5 (IV) IN DETERMINING THE AMOUNT OF THE CONTRACT WHICH
6 MAY BE USED FOR THE PURPOSES SPECIFIED IN SUBPARAGRAPHS
7 (II) AND (III), ANY FEDERAL AND STATE TAXES THAT WOULD BE
8 DEDUCTED FROM PREMIUM REVENUE IN DETERMINING AN ISSUER'S
9 MEDICAL LOSS RATIO UNDER 45 CFR 158.221 (RELATING TO
10 FORMULA FOR CALCULATING AN ISSUER'S MEDICAL LOSS RATIO),
11 INCLUDING A MANAGED CARE ORGANIZATION ASSESSMENT IMPOSED
12 ON A CONTRACTOR UNDER THE ACT OF JUNE 13, 1967 (P.L.31,
13 NO.21), KNOWN AS THE PUBLIC WELFARE CODE, SHALL BE
14 EXCLUDED.

15 (B) SOLICITATION OF CONTRACTS.--THE DEPARTMENT MUST SOLICIT
16 BIDS AND AWARD CONTRACTS THROUGH A COMPETITIVE PROCUREMENT
17 PROCESS IN ACCORDANCE WITH THE FOLLOWING:

18 (1) TO THE FULLEST EXTENT PRACTICABLE, CONTRACTS SHALL
19 BE AWARDED TO INSURERS THAT CONTRACT WITH PROVIDERS TO
20 PROVIDE PRIMARY CARE SERVICES FOR ENROLLEES ON A COST-
21 EFFECTIVE BASIS. THE DEPARTMENT SHALL REQUIRE CONTRACTORS TO
22 USE APPROPRIATE COST-MANAGEMENT METHODS SO THAT BASIC PRIMARY
23 COVERAGE SERVICES CAN BE PROVIDED TO THE MAXIMUM NUMBER OF
24 ELIGIBLE CHILDREN AND, IF POSSIBLE, TO PURSUE AND UTILIZE
25 AVAILABLE PUBLIC AND PRIVATE FUNDS.

26 (2) TO THE FULLEST EXTENT PRACTICABLE, THE DEPARTMENT
27 MUST REQUIRE THAT A CONTRACTOR COMPLY WITH ALL PROCEDURES
28 RELATING TO COORDINATION OF HEALTH CARE SERVICES AS REQUIRED
29 BY THE DEPARTMENT OR THE INSURANCE DEPARTMENT.

30 (3) CONTRACTS MAY BE FOR A TERM OF UP TO THREE YEARS,

1 WITH THE OPTION TO EXTEND FOR TWO ONE-YEAR PERIODS.

2 (C) BIDDING.--UPON RECEIPT OF A SOLICITATION FROM THE
3 DEPARTMENT, EACH HEALTH SERVICE CORPORATION AND HOSPITAL PLAN
4 CORPORATION OR THEIR ENTITIES DOING BUSINESS IN THIS
5 COMMONWEALTH SHALL SUBMIT A BID OR PROPOSAL TO THE DEPARTMENT TO
6 CARRY OUT THE PURPOSES OF THIS ARTICLE IN THE AREA SERVICED BY
7 THE CORPORATION.

8 (D) BIDDING BY OTHER INSURERS.--ALL OTHER INSURERS MAY
9 SUBMIT A BID OR PROPOSAL TO THE DEPARTMENT TO CARRY OUT THE
10 PURPOSES OF THIS ARTICLE.

11 (E) DUTIES OF CONTRACTOR.--A CONTRACTOR WITH WHOM THE
12 DEPARTMENT ENTERS INTO A CONTRACT SHALL DO THE FOLLOWING:

13 (1) ENSURE TO THE MAXIMUM EXTENT POSSIBLE THAT ELIGIBLE
14 CHILDREN HAVE ACCESS TO PRIMARY HEALTH CARE PHYSICIANS AND
15 NURSE PRACTITIONERS WITHIN THE CONTRACTOR'S SERVICE AREA.

16 (2) CONTRACT WITH QUALIFIED, COST-EFFECTIVE PROVIDERS,
17 WHICH MAY INCLUDE PRIMARY HEALTH CARE PHYSICIANS, NURSE
18 PRACTITIONERS, CLINICS AND HMOS, TO PROVIDE PRIMARY AND
19 PREVENTIVE HEALTH CARE FOR ENROLLEES ON A BASIS BEST
20 CALCULATED TO MANAGE THE COSTS OF THE SERVICES, INCLUDING,
21 BUT NOT LIMITED TO, USING MANAGED HEALTH CARE TECHNIQUES AND
22 OTHER APPROPRIATE MEDICAL COST-MANAGEMENT METHODS.

23 (3) ENSURE THAT THE FAMILY OF A CHILD WHO MAY BE
24 ELIGIBLE FOR MEDICAL ASSISTANCE RECEIVES ASSISTANCE IN
25 APPLYING FOR MEDICAL ASSISTANCE.

26 (4) MAINTAIN WAITING LISTS OF CHILDREN FINANCIALLY
27 ELIGIBLE FOR COVERAGE WHO HAVE APPLIED FOR COVERAGE BUT WHO
28 WERE NOT ENROLLED DUE TO LACK OF FUNDS.

29 (5) NOTIFY FAMILIES OF CHILDREN WHO ARE PAYING A PREMIUM
30 OF ANY CHANGES IN SUCH PREMIUM OR COPAYMENT REQUIREMENTS.

1 (6) COLLECT PREMIUMS OR COPAYMENTS FROM THE FAMILY OF A
2 CHILD RECEIVING COVERAGE AS MAY BE REQUIRED.

3 (7) CANCEL COVERAGE FOR NONPAYMENT OF PREMIUM, IN
4 ACCORDANCE WITH ALL APPLICABLE INSURANCE LAWS.

5 (8) STRONGLY ENCOURAGE ALL PROVIDERS WHO PROVIDE PRIMARY
6 CARE TO ELIGIBLE CHILDREN TO PARTICIPATE IN MEDICAL
7 ASSISTANCE AS QUALIFIED EPSDT PROVIDERS AND TO CONTINUE TO
8 PROVIDE CARE TO CHILDREN WHO BECOME INELIGIBLE FOR COVERAGE
9 UNDER THE PROVISIONS OF THIS ARTICLE BUT WHO QUALIFY FOR
10 MEDICAL ASSISTANCE.

11 (9) SUBJECT TO ANY NECESSARY FEDERAL APPROVAL, PROVIDE
12 THE FOLLOWING MINIMUM COVERAGE PACKAGE, WHICH MAY NOT
13 CONFLICT WITH FEDERAL LAW, REGULATION OR GUIDANCE, FOR
14 ELIGIBLE CHILDREN:

15 (I) PREVENTIVE CARE. THIS SUBPARAGRAPH SHALL
16 INCLUDE:

17 (A) WELL-CHILD CARE VISITS IN ACCORDANCE WITH
18 THE SCHEDULE ESTABLISHED BY THE AMERICAN ACADEMY OF
19 PEDIATRICS AND THE SERVICES RELATED TO THE VISITS,
20 INCLUDING IMMUNIZATIONS, HEALTH EDUCATION,
21 TUBERCULOSIS TESTING AND DEVELOPMENTAL SCREENING IN
22 ACCORDANCE WITH THE ROUTINE SCHEDULE OF WELL-CHILD
23 CARE VISITS.

24 (B) A COMPREHENSIVE PHYSICAL EXAMINATION,
25 INCLUDING X-RAYS IF NECESSARY, FOR ANY CHILD
26 EXHIBITING SYMPTOMS OF POSSIBLE CHILD ABUSE.

27 (II) DIAGNOSIS AND TREATMENT OF ILLNESS OR INJURY,
28 INCLUDING ALL MEDICALLY NECESSARY SERVICES RELATED TO THE
29 DIAGNOSIS AND TREATMENT OF SICKNESS AND INJURY AND OTHER
30 CONDITIONS PROVIDED ON AN AMBULATORY BASIS, SUCH AS

1 LABORATORY TESTS, WOUND DRESSING AND CASTING TO
2 IMMOBILIZE FRACTURES.

3 (III) INJECTIONS AND MEDICATIONS PROVIDED AT THE
4 TIME OF THE OFFICE VISIT OR THERAPY AND OUTPATIENT
5 SURGERY PERFORMED IN THE OFFICE, A HOSPITAL OR
6 FREESTANDING AMBULATORY SERVICE CENTER, INCLUDING
7 ANESTHESIA PROVIDED IN CONJUNCTION WITH SUCH SERVICE OR
8 DURING EMERGENCY MEDICAL SERVICE.

9 (IV) EMERGENCY ACCIDENT AND EMERGENCY MEDICAL CARE.

10 (V) PRESCRIPTION DRUGS.

11 (VI) EMERGENCY, PREVENTIVE AND ROUTINE DENTAL CARE.

12 THIS SUBPARAGRAPH DOES NOT INCLUDE ORTHODONTIA OR
13 COSMETIC SURGERY.

14 (VII) EMERGENCY, PREVENTIVE AND ROUTINE VISION CARE,
15 INCLUDING THE COST OF CORRECTIVE LENSES AND FRAMES, NOT
16 TO EXCEED TWO PRESCRIPTIONS PER YEAR.

17 (VIII) EMERGENCY, PREVENTIVE AND ROUTINE HEARING
18 CARE.

19 (IX) INPATIENT HOSPITALIZATION.

20 (10) THE DEPARTMENT MAY IMPLEMENT A PREMIUM ASSISTANCE
21 PROGRAM PERMITTED UNDER FEDERAL REGULATIONS AND AS PERMITTED
22 THROUGH FEDERAL WAIVER OR STATE PLAN AMENDMENT MADE PURSUANT
23 TO THIS ARTICLE. NOTWITHSTANDING ANY OTHER LAW TO THE
24 CONTRARY, IF IT IS MORE COST EFFECTIVE TO PURCHASE HEALTH
25 CARE FROM A PARENT'S EMPLOYER-BASED PROGRAM AND THE EMPLOYER-
26 BASED PROGRAM MEETS THE MINIMUM COVERAGE REQUIREMENTS,
27 EMPLOYER-BASED COVERAGE MAY BE PURCHASED IN PLACE OF
28 ENROLLMENT IN THE CHILDREN'S HEALTH INSURANCE PROGRAM
29 ESTABLISHED UNDER THIS ARTICLE. AN INSURER MUST HONOR A
30 REQUEST FOR ENROLLMENT AND PURCHASE OF EMPLOYEE GROUP HEALTH

1 INSURANCE REQUESTED ON BEHALF OF AN INDIVIDUAL APPLYING FOR
2 COVERAGE UNDER THIS CHAPTER IF THE INDIVIDUAL:

3 (I) IS A RESIDENT OF THIS COMMONWEALTH;

4 (II) IS QUALIFIED BASED ON INCOME UNDER SECTION
5 2302-A; AND

6 (III) MEETS THE CITIZENSHIP REQUIREMENTS OF SECTION
7 2302-A(C) (1) (IV).

8 (11) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO REVIEW,
9 AUDIT AND APPROVE ANNUAL ADMINISTRATIVE EXPENSES INCURRED BY
10 CONTRACTORS UNDER THIS SECTION.

11 (12) EXCEPT FOR CHILDREN COVERED UNDER PARAGRAPH (10),
12 EACH CONTRACTOR SHALL PROVIDE A COVERAGE IDENTIFICATION CARD
13 TO EACH ELIGIBLE CHILD COVERED UNDER CONTRACTS EXECUTED UNDER
14 THIS ARTICLE. THE CARD MUST NOT SPECIFICALLY IDENTIFY THE
15 HOLDER AS LOW INCOME.

16 (F) WAIVER OF MINIMUM.--THE DEPARTMENT MAY GRANT A WAIVER OF
17 THE MINIMUM COVERAGE PACKAGE OF SUBSECTION (E) (9) UPON
18 DEMONSTRATION BY THE APPLICANT THAT THE APPLICANT IS PROVIDING
19 HEALTH CARE SERVICES FOR ELIGIBLE CHILDREN THAT MEET THE
20 PURPOSES AND INTENT OF THIS ARTICLE.

21 (G) REVIEW.--

22 (1) THE DEPARTMENT, IN CONSULTATION WITH APPROPRIATE
23 COMMONWEALTH AGENCIES, SHALL REVIEW ENROLLMENT PATTERNS FOR
24 BOTH THE FREE COVERAGE PROGRAM AND THE SUBSIDIZED COVERAGE
25 PROGRAM. THE DEPARTMENT SHALL CONSIDER THE RELATIONSHIP, IF
26 ANY, AMONG ENROLLMENT, ENROLLMENT FEES, INCOME LEVELS AND
27 FAMILY COMPOSITION.

28 (2) BASED ON THE RESULTS OF THIS STUDY AND THE
29 AVAILABILITY OF FUNDS, THE DEPARTMENT MAY ADJUST THE MAXIMUM
30 INCOME CEILING FOR FREE COVERAGE AND THE MAXIMUM INCOME

1 CEILING FOR SUBSIDIZED COVERAGE BY REGULATION. THE MAXIMUM
2 INCOME CEILING FOR FREE COVERAGE MAY NOT BE RAISED ABOVE 200%
3 OF THE FEDERAL POVERTY LEVEL.

4 (H) LIMIT.--NOTWITHSTANDING SUBSECTION (G) AND SUBJECT TO
5 SECTION 2307-A, THE MAXIMUM INCOME CEILING FOR SUBSIDIZED
6 COVERAGE UNDER SECTION 2302-A(D) (2), (3) OR (4) MAY NOT BE
7 RAISED ABOVE 300% OF THE FEDERAL POVERTY LEVEL.
8 SECTION 2305-A. OUTREACH.

9 (A) PLAN.--THE DEPARTMENT, IN CONSULTATION WITH APPROPRIATE
10 COMMONWEALTH AGENCIES, MUST COORDINATE THE DEVELOPMENT OF AN
11 OUTREACH PLAN TO INFORM POTENTIAL CONTRACTORS, PROVIDERS AND
12 ENROLLEES REGARDING ELIGIBILITY AND AVAILABLE COVERAGE. THE PLAN
13 MUST INCLUDE PROVISIONS FOR ALL OF THE FOLLOWING:

14 (1) REACHING SPECIAL POPULATIONS, INCLUDING NONWHITE AND
15 NON-ENGLISH-SPEAKING CHILDREN AND CHILDREN WITH DISABILITIES.

16 (2) REACHING DIFFERENT GEOGRAPHIC AREAS, INCLUDING RURAL
17 AND INNER-CITY AREAS.

18 (3) ENSURING THAT SPECIAL EFFORTS ARE COORDINATED WITHIN
19 THE OVERALL OUTREACH ACTIVITIES THROUGHOUT THIS COMMONWEALTH.

20 (4) COMPARING CHILDREN ENROLLED IN CHILD CARE PROVIDED
21 UNDER THE CHILD CARE AND DEVELOPMENT BLOCK GRANT ACT OF 1990
22 (PUBLIC LAW 101-508, 42 U.S.C. § 9858 ET SEQ.) OR ENROLLED IN
23 THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM IN THE
24 DETERMINATION OF A CHILD'S ELIGIBILITY FOR COVERAGE UNDER
25 THIS ARTICLE AND IMPLEMENT EXPRESS LANE ELIGIBILITY AS
26 APPROPRIATE. THE DEPARTMENT IS AUTHORIZED TO EXPAND THE
27 AGENCIES IDENTIFIED AS EXPRESS LANE PARTNERS BY THE ISSUANCE
28 OF A STATEMENT OF POLICY.

29 (5) NOTICE OF THE EXISTENCE OF AND ELIGIBILITY FOR THE
30 PROGRAM SHALL BE PREPARED BY THE DEPARTMENT AND PROVIDED TO

1 THE DEPARTMENT OF EDUCATION FOR DISSEMINATION TO NONPUBLIC
2 AND PUBLIC SCHOOLS ELECTRONICALLY, ON AN ANNUAL BASIS, NOT
3 LATER THAN AUGUST 15.

4 (B) REVIEW.--THE COUNCIL SHALL REVIEW THE OUTREACH
5 ACTIVITIES AND RECOMMEND CHANGES AS THE COUNCIL DEEMS TO BE IN
6 THE BEST INTERESTS OF THE CHILDREN TO BE SERVED.

7 SECTION 2306-A. PAYOR OF LAST RESORT AND INSURANCE COVERAGE.

8 THE CONTRACTOR MAY NOT PAY A CLAIM ON BEHALF OF AN ENROLLED
9 CHILD UNLESS ALL OTHER FEDERAL, STATE, LOCAL OR PRIVATE
10 RESOURCES AVAILABLE TO THE CHILD OR THE CHILD'S FAMILY ARE
11 UTILIZED FIRST. THE DEPARTMENT, IN COOPERATION WITH THE
12 INSURANCE DEPARTMENT, SHALL DETERMINE IF INSURANCE COVERAGE IS
13 AVAILABLE TO THE CHILD THROUGH A CUSTODIAL OR NONCUSTODIAL
14 PARENT ON AN EMPLOYMENT-RELATED OR OTHER GROUP BASIS. IF
15 INSURANCE COVERAGE IS AVAILABLE, THE CHILD'S ELIGIBILITY UNDER
16 SECTION 2302-A AND THE MOST COST-EFFECTIVE MEANS OF PROVIDING
17 COVERAGE FOR THAT CHILD MUST BE REEVALUATED.

18 SECTION 2307-A. STATE PLAN.

19 THE DEPARTMENT MAY AMEND THE STATE PLAN AS NECESSARY TO CARRY
20 OUT THE PROVISIONS OF THIS ARTICLE.

21 SECTION 2308-A. LIMITATION ON EXPENDITURE OF FUNDS.

22 THE TOTAL AMOUNT OF ANNUAL CONTRACT AWARDS AUTHORIZED UNDER
23 THIS ARTICLE MAY NOT EXCEED THE AMOUNT OF CIGARETTE TAX RECEIPTS
24 ANNUALLY DEPOSITED INTO THE FUND UNDER SECTION 1296 OF THE ACT
25 OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE TAX REFORM CODE OF
26 1971, AND ANY OTHER FEDERAL OR STATE FUNDS RECEIVED THROUGH THE
27 FUND. THE PROVISION OF CHILDREN'S HEALTH CARE THROUGH THE FUND
28 MAY NOT CONSTITUTE AN ENTITLEMENT DERIVED FROM THE COMMONWEALTH
29 OR A CLAIM ON ANY OTHER FUNDS OF THE COMMONWEALTH.

30 SECTION 2309-A. EXPIRATION.

1 (A) GENERAL RULE.--THIS ARTICLE SHALL EXPIRE ON THE EARLIER
2 OF:

3 (1) DECEMBER 31, 2017; OR

4 (2) NINETY DAYS AFTER THE DATE ON WHICH FEDERAL FUNDING
5 FOR THE PROGRAM CEASES TO BE AVAILABLE.

6 (B) NOTICE.--IF THE CHAPTER EXPIRES UNDER SUBSECTION (A) (2),
7 AS DETERMINED BY THE DEPARTMENT, THE DEPARTMENT SHALL TRANSMIT
8 NOTICE TO THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION IN
9 THE PENNSYLVANIA BULLETIN.

10 SECTION 4. THE ADDITION OF ARTICLE XXIII-A OF THE ACT IS A
11 CONTINUATION OF FORMER ARTICLE XXIII OF THE ACT.

12 THE FOLLOWING APPLY:

13 (1) EXCEPT AS OTHERWISE PROVIDED IN ARTICLE XXIII-A OF
14 THE ACT, ALL ACTIVITIES INITIATED UNDER FORMER ARTICLE XXIII
15 OF THE ACT SHALL CONTINUE AND REMAIN IN FULL FORCE AND EFFECT
16 AND MAY BE COMPLETED UNDER ARTICLE XXIII-A. ORDERS,
17 REGULATIONS, RULES AND DECISIONS WHICH WERE MADE UNDER FORMER
18 ARTICLE XXIII AND WHICH ARE IN EFFECT ON THE EFFECTIVE DATE
19 OF THIS SECTION SHALL REMAIN IN FULL FORCE AND EFFECT UNTIL
20 REVOKED, VACATED OR MODIFIED UNDER ARTICLE XXIII-A .

21 CONTRACTS AND OBLIGATIONS ENTERED INTO UNDER FORMER ARTICLE
22 XXIII ARE NOT AFFECTED NOR IMPAIRED BY THE REPEAL OF ARTICLE
23 XXIII.

24 (2) EXCEPT AS SET FORTH IN PARAGRAPH (3), ANY DIFFERENCE
25 IN LANGUAGE BETWEEN ARTICLE XXIII-A AND FORMER ARTICLE XXIII
26 IS INTENDED ONLY TO CONFORM TO STYLE AND IS NOT INTENDED TO
27 CHANGE OR AFFECT THE LEGISLATIVE INTENT, JUDICIAL
28 CONSTRUCTION OR ADMINISTRATION AND IMPLEMENTATION OF FORMER
29 ARTICLE XXIII.

30 (3) PARAGRAPH (2) DOES NOT APPLY TO THE ADDITION OF THE

1 FOLLOWING PROVISIONS:

2 (I) THE CHANGE IN THE DEFINITION OF "DEPARTMENT" IN
3 SECTION 2301-A OF THE ACT.

4 (II) THE PROVISIONS FOR ARRANGEMENTS WITH OTHER
5 AGENCIES UNDER SECTION 2302-A(F) (2) (VII) OF THE ACT.

6 (III) THE EXPIRATION PROVISION UNDER SECTION 2309-A
7 OF THE ACT.

8 (IV) THE ADDITION OF PARAGRAPHS (D) (5) AND (E) (3) OF
9 SECTION 2302-A OF THE ACT REGARDING THE EXCLUSION OF
10 COSTS RELATED TO THE MANAGED CARE ORGANIZATION
11 ASSESSMENTS UNDER THE ACT OF JUNE 13, 1967 (P.L.31,
12 NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

13 (V) THE ADDITION OF SUBPARAGRAPH (A) (3) (IV) OF
14 SECTION 2304-A OF THE ACT REGARDING THE DETERMINATION OF
15 THE AMOUNT OF THE CONTRACT.

16 (4) ALL ENTITIES RECEIVING GRANTS UNDER FORMER ARTICLE
17 XXIII ON THE EFFECTIVE DATE OF THIS SECTION SHALL CONTINUE TO
18 RECEIVE FUNDS AND PROVIDE SERVICES AS REQUIRED UNDER FORMER
19 ARTICLE XXIII UNTIL NOTICE FROM THE DEPARTMENT OF HUMAN
20 SERVICES IS PUBLISHED IN THE PENNSYLVANIA BULLETIN.

21 SECTION 5. THE ADDITION OF SECTION 2007.1 OF THE ACT SHALL
22 APPLY TO ALL POLICIES ISSUED OR RENEWED ON OR AFTER 180 DAYS
23 AFTER THE EFFECTIVE DATE OF THIS SECTION.

24 SECTION 6. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

25 (1) THE ADDITION OF SECTION 635.7 OF THE ACT SHALL TAKE
26 EFFECT JANUARY 1, 2016, OR IMMEDIATELY, WHICHEVER IS LATER.

27 (2) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT
28 IMMEDIATELY.