INSURANCE COMPANY LAW OF 1921 - EMERGENCY SERVICE SYSTEM BILLING, COVERAGE OBLIGATIONS OF LOANER VEHICLES AND EXPIRATION

Act of Dec. 20, 2015, P.L. 461, No. 84 Cl. 40

Session of 2015
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HB 857

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in casualty insurance, providing for emergency service system billing; in automobile insurance issuance, renewal, cancellation and refusal, providing for coverage obligations of loaner vehicles; and, in children's health care, further providing for expiration.

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

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding sections to read:

Section 635.7. Billing.--(a) When an EMS agency is dispatched by a public safety answering point as defined in 35 Pa.C.S. § 5302 (relating to definitions) or an EMS agency dispatch center under 35 Pa.C.S. § 8129(i) (relating to emergency medical services agencies) for an emergency and provides medically necessary emergency medical services, a payment made by an insurer for a claim covered under and in accordance with a health insurance policy for an emergency medical service performed by the EMS agency during the call shall be paid directly to the EMS agency.

(b) An insurer must reimburse a nonnetwork EMS agency under the following:

(1) The EMS agency has submitted a completed standardized form to the department requesting nonnetwork direct reimbursement from an insurer an EMS agency has identified. The form must be submitted to the department annually by October 15. The form shall declare the EMS agency's intention to receive direct payment from an insurer identified on the form for the next calendar year. The department shall develop a standardized form, using an EMS agency's assigned license number, to be used by an EMS agency that meets the conditions established under this section. The department shall develop and maintain a publicly accessible electronic registry that indicates which EMS agency has requested nonnetwork direct reimbursement from an insurer identified on the form.

(2) An EMS agency has provided notification to the insurer upon submitting a claim for reimbursement that the EMS agency is registered with the department to receive direct reimbursement as provided for under this section.

(c) An EMS agency may be subject to periodic audits by an insurer to examine claims for direct reimbursement under this section. If, through the audit, the insurer identifies an improper payment, the insurer may deduct the improper payment from future reimbursements.

(d) Where an insurer has reimbursed a nonnetwork EMS agency at the same rate it has established for a network EMS agency, the EMS agency may not bill the insured directly or indirectly or otherwise attempt to collect from the insured for the service provided, except for a billing to recover a copayment, coinsurance or deductible as specified in the health insurance policy.

(e) An EMS agency that submits a form under this section may solicit donations or memberships or conduct fundraising, except that an EMS agency may not promise, suggest or infer to donors that a donation will result in the donor not being billed directly for any payment as provided under this section. Notwithstanding this paragraph, an EMS agency may bill in accordance with subsection (d). A violation of this section shall be considered a violation of the act of December 17, 1968 (P.L.1224, No.387), known as the "Unfair Trade Practices and Consumer Protection Law."

(f) Claims paid under this section shall be subject to section 2166.

(g) This section shall apply only to an EMS agency that is a nonnetwork provider and provides emergency medical services, unless preempted by Federal law.

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

"Department." Department of Health of the Commonwealth.

"EMS agency." As defined in 35 Pa.C.S. § 8103 (relating to definitions).

"Emergency medical services." As defined in 35 Pa.C.S. § 8103 (relating to definitions).

"Insurer." As follows:

(1) An entity that is responsible for providing or paying for all or part of the cost of emergency medical services covered by an insurance policy, contract or plan. The term includes an entity subject to:

(i) section 630, Article XXIV or any other provision of this act;

(ii) the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act; or

(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(2) The term does not include an entity that is responsible for providing or paying under an insurance policy, contract or plan which meets any of the following:

(i) Is a homeowner's insurance policy.

(ii) Provides any of the following types of insurance:

(A) Accident only.

(B) Fixed indemnity.

(C) Limited benefit.

(D) Credit.

(E) Dental.

(F) Vision.

(G) Specified disease.

(H) Medicare supplement.

(I) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

(J) Long-term care.
(K) Disability income.
(L) Workers' compensation.
(M) Automobile medical payment insurance.

Section 2007.1. Coverage obligations of loaner vehicles.--(a) An insurance company authorized to write private passenger automobile insurance within this Commonwealth shall provide, where purchased and within the limits of the insured's policy, primary liability coverage for third-party bodily injury and primary first-party physical damage coverage for a motor vehicle provided by a motor vehicle dealer, when an insured has custody of or is operating that motor vehicle, while a motor vehicle specifically listed or covered under the insured's motor vehicle insurance policy is being transported, serviced, repaired or inspected by the motor vehicle dealer.

(b) An insurance company authorized to do business in this Commonwealth shall provide to a motor vehicle dealer or an agent thereof with custody of or operating a customer's motor vehicle for the purpose of transporting, servicing, repairing or inspecting the vehicle, primary liability coverage for third-party bodily injury and primary first-party physical damage coverage in the amounts set forth in the customer's private passenger automobile insurance policy.

(c) This section shall apply only to the loan of a motor vehicle by a motor vehicle dealer that occurs without financial remuneration in the form of a fee, rental or lease charge paid directly by the insured operating the motor vehicle. Payments made by a third party to a motor vehicle dealer or similar reimbursements shall not be considered payments directly from the insured operating the motor vehicle.

(d) A change in the coverage of a private passenger automobile insurance policy resulting from this section shall not impact the validity of a waiver, selection of benefits or amount of benefits in that policy, beyond the coverage change as a result of this section. An insurer shall file with the Insurance Department any forms or rates revised as a result of this section, along with certification that the revisions are limited to the compliance with this section. The revisions shall be effective ten (10) days after filing.

(e) As used in this section, the term "motor vehicle dealer" shall have the same meaning as "dealer" as defined in section 2 of the act of December 22, 1983 (P.L.306, No.84), known as the "Board of Vehicles Act."

Section 2. Article XXIII of the act is repealed:

[ARTICLE XXIII.
CHILDREN'S HEALTH CARE.
(a) General Provisions.

Section 2301. Short Title.--This article shall be known and may be cited as the "Children's Health Care Act."

Section 2302. Legislative Findings and Intent.--The General Assembly finds and declares as follows:

(1) Citizens of this Commonwealth should have access to affordable and reasonably priced health care and to nondiscriminatory treatment by health insurers and providers.

(2) The uninsured health care population of this Commonwealth is estimated to be approximately one million persons and many thousands more lack adequate insurance coverage. It is also estimated that approximately two-thirds of the uninsured are employed or dependents of employed persons.

(3) Approximately fifteen per centum (15%) of the uninsured health care population are children. Uninsured children are of particular concern because of their need for ongoing preventive

and primary care. Measures not taken to care for such children now will result in higher human and financial costs later.

(4) Uninsured children lack access to timely and appropriate primary and preventive care. As a result, health care is often delayed or forgone, resulting in increased risk of developing more severe conditions which in turn are more expensive to treat. This tendency to delay care and to seek ambulatory care in hospital-based settings also causes inefficiencies in the health care system.

(5) Health care markets have been distorted through cost shifts for the uncompensated health care costs of uninsured citizens of this Commonwealth which has caused decreased competitive capacity on the part of those health care providers who serve the poor and increased costs of other health care payors.

(6) No one sector can absorb the cost of providing health care to citizens of this Commonwealth who cannot afford health care on their own. The cost is too large for the public sector alone to bear and instead requires the establishment of a public and private partnership to share the costs in a manner economically feasible for all interests. The magnitude of this need also requires that it be done on a time-phased, cost-managed and planned basis.

(7) Eligible uninsured children in this Commonwealth should have access to cost-effective, comprehensive primary health coverage if they are unable to afford coverage or obtain it.

(8) Care should be provided in appropriate settings by efficient providers, consistent with high quality care and at an appropriate stage, soon enough to avert the need for overly expensive treatment.

(9) Equity should be assured among health providers and payors by providing a mechanism for providers, employers, the public sector and patients to share in financing indigent children's health care.

Section 2303. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Child." A person under nineteen (19) years of age.

"Contractor." An insurer awarded a contract under subdivision (b) to provide health care services under this article. The term includes an entity and its subsidiary which is established under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations); this act; or the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

"Council." The Children's Health Advisory Council established in section 2311(i).

"Department." The Insurance Department of the Commonwealth.

"EPSDT." Early and periodic screening, diagnosis and treatment.

"Fund." The Children's Health Fund for health care for indigent children established by section 1296 of the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971."

"Group." A group for which a health insurance policy is written in this Commonwealth.

"Health maintenance organization" or "HMO." An entity organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

"Health service corporation." A professional health service corporation as defined in 40 Pa.C.S. § 6302 (relating to definitions).

"Healthy Beginnings Program." Medical assistance coverage for services to children as required under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.) for the following:

(1) children from birth to age one (1) whose family income is no greater than one hundred eighty-five per centum (185%) of the Federal poverty level;

(2) children one (1) through five (5) years of age whose family income is no greater than one hundred thirty-three per centum (133%) of the Federal poverty level; and

(3) children six (6) through eighteen (18) years of age whose family income is no greater than one hundred per centum (100%) of the Federal poverty level.

"Hospital." An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill persons. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties. The term does not include facilities caring exclusively for the mentally ill.

"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. § 6101 (relating to definitions).

"Insurer." A health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under this act or any of the following:

(1) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(2) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(4) Article XXIV.

"MAAC." The Medical Assistance Advisory Committee.

"Managed care organization." Health maintenance organization organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," or a risk-assuming preferred provider organization or exclusive provider organization, organized and regulated under this act.

"MCH." Maternal and Child Health.

"Medicaid." The Federal medical assistance program established under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

"Mid-level health professional." A physician assistant, certified registered nurse practitioner, nurse practitioner or a certified nurse midwife.

"Parent." A natural parent, stepparent, adoptive parent, guardian or custodian of a child.

"PPO." A preferred provider organization subject to the provisions of section 630.

"Preexisting condition." A disease or physical condition for which medical advice or treatment has been received prior to the effective date of coverage.

"Premium assistance program." A component of a separate child health program, approved under the State plan, under which the Commonwealth pays part or all of the premium for an enrollee or enrollee's group health insurance coverage or coverage under a group health plan.

"Prescription drug." A controlled substance, other drug or device for medication dispensed by order of an appropriately licensed medical professional.

"Subgroup." An employer covered under a contract issued to a multiple employer trust or to an association.

"Terminate." Includes cancellation, nonrenewal and rescission.

"Waiting period." A period of time after the effective date of enrollment during which an insurer excludes coverage for the diagnosis or treatment of one or more medical conditions.

"WIC." The Federal Supplemental Food Program for Women, Infants and Children.

(b) Primary Health Care Programs.

Section 2311. Children's Health Care.--(a) Notwithstanding any other provision of law, the department shall take such actions as may be necessary to ensure the receipt of Federal financial participation under Title XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1397aa et seq.) for services provided under this act and to qualify the benefit expansion provided by subsection (c)(1.1) for available Federal financial participation.

(b) (1) The fund shall be dedicated exclusively for distribution by the department through contracts in order to provide free and subsidized health care services under this section, based on an actuarially sound and adequate review, and to develop and implement outreach activities required under section 2312.

(2) The fund, along with Federal, State and other money available for the program, shall be used for health care coverage for children as specified in this section. The department shall assure that the program is implemented Statewide. All contracts awarded under this section shall be awarded through a competitive procurement process. The department and the Department of Public Welfare shall use their best efforts to ensure that eligible children across this Commonwealth have access to health care services to be provided under this article.

(3) No more than ten per centum (10%) of the amount of the contract may be used for administrative expenses of the contractor. If any contractor presents documented evidence that administrative expenses for purposes of expanded outreach and systems and operational changes are in excess of ten per centum (10%) of the amount of the contract, the department shall make an additional allotment of funds, not to exceed two per centum (2%) of the amount of the contract, to the contractor to the extent that the department finds the expenses reasonable and necessary.

(4) No less than eighty-four per centum (84%) of the contract shall be used to provide the health care services provided under this article for children eligible for care under this article.

(5) To ensure that inpatient hospital care is provided to eligible children, each primary care provider furnishing primary

care services shall make necessary arrangements for admission to the hospital and for necessary specialty care.

(c) (1) Any insurer receiving funds from the department to provide coverage of health care services shall enroll, to the extent that funds are available, any child who meets all of the following:

(i) Is a resident of this Commonwealth.

(ii) Is not covered by a health insurance plan, a self-insurance plan or a self-funded plan or is not eligible for or covered by medical assistance, including the Healthy Beginnings Program.

(iii) Is qualified based on income under subsection (d) or (e).

(iv) Meets the citizenship requirements of Title XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1397aa et seq.).

(1.1) Beginning January 1, 2007, and subject to the provisions of section 2314, any insurer receiving funds from the department to provide coverage of health care services under this section shall enroll, to the extent that funds are available, any child who meets all of the following:

(i) Is a resident of this Commonwealth.

(ii) Is not covered by a health insurance plan, a self-insurance plan or a self-funded plan, or is not provided access to health care coverage by court order, or is not eligible for or covered by a medical assistance program administered by the Department of Public Welfare, including the Healthy Beginnings Program.

(iii) Is qualified based on income under subsection (d), (e.1), (e.2), (e.3) or (e.4).

(iv) Meets the citizenship requirements of Title XXI of the Social Security Act.

(2) Enrollment may not be denied on the basis of a preexisting condition, nor may diagnosis or treatment for the condition be excluded based on the condition's preexistence.

(d) The provision of health care insurance for eligible children shall be free to a child whose family income is no greater than two hundred per centum (200%) of the Federal poverty level.

(e.1) The provision of health care insurance for an eligible child whose family income is greater than two hundred per centum (200%) of the Federal poverty level but no greater than two hundred fifty per centum (250%) of the Federal poverty level may be subsidized by the fund at a rate not to exceed seventy-five per centum (75%) of the per member per month premium cost.

(e.2) The provision of health care insurance for an eligible child whose family income is greater than two hundred fifty per centum (250%) of the Federal poverty level but no greater than two hundred seventy-five per centum (275%) of the Federal poverty level may be subsidized by the fund at a rate not to exceed sixty-five per centum (65%) of the per member per month premium cost.

(e.3) The provision of health care insurance for an eligible child whose family income is greater than two hundred seventy-five per centum (275%) of the Federal poverty level but no greater than three hundred per centum (300%) of the Federal poverty level may be subsidized by the fund at a rate not to exceed sixty per centum (60%) of the per member per month premium cost.

(e.4) The following apply:

(1) For an eligible child whose family income is greater than the maximum level established under subsection (o), the

family may purchase the minimum benefit package set forth in subsection (l)(6) for that child at the per month per member premium cost, which cost shall be derived separately from the other eligibility categories in the program, as long as the family demonstrates on an annual basis and in a manner determined by the department either one of the following:

(i) The family is unable to afford individual or group coverage because that coverage would exceed ten per centum (10%) of the family income or because the total cost of coverage for the child is one hundred fifty per centum (150%) of the greater of:

(A) the premium cost established under this subsection for that service area; or

(B) the premium cost established under the program for that service area.

(ii) The family has been refused coverage by an insurer due to the child or a member of that child's immediate family having a preexisting condition and coverage is not available to the child.

(2) For purposes of this subsection, "coverage" shall not include coverage offered through accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

(f.1) (Reserved).

(f.2) For enrollees under subsections (e.1), (e.2), (e.3) and (e.4), the following apply:

(1) The department shall have the authority to impose copayments for the following services, except as otherwise prohibited by law:

(i) Outpatient visits.

(ii) Emergency room visits.

(iii) Prescription medications.

(iv) Any other service defined by the department.

(2) The department shall have the authority to establish and adjust the levels of these copayments in order to impose reasonable cost sharing and to encourage appropriate utilization of these services. In no event shall the premiums and copayments for enrollees under subsections (e.1), (e.2) and (e.3) amount to more than the per centum of total household income which is in accord with the requirements of the Centers for Medicare and Medicaid Services.

(g) The department shall:

(1) Administer the children's health care program pursuant to this article.

(2) Review all bids and approve and execute all contracts for the purpose of expanding access to health care services for eligible children as provided for in this subdivision.

(3) Conduct monitoring and oversight of contracts entered into.

(4) Issue an annual report to the Governor, the General Assembly and the public for each calendar year no later than March 1 outlining primary health services funded for the year, detailing the outreach and enrollment efforts and reporting by number of children by county and by per centum of the Federal poverty level, the number of children receiving health care services; by county and by per centum of the Federal poverty level, the projected number of eligible children; and the number of eligible children on waiting lists for enrollment in the

health insurance program established under this act by county and by per centum of the Federal poverty level.

(5) In consultation with appropriate Commonwealth agencies, coordinate the development and supervision of the outreach plan required under section 2312.

(6) In consultation with appropriate Commonwealth agencies, monitor, review and evaluate the adequacy, accessibility and availability of services delivered to children who are enrolled in the health insurance program established under this subdivision.

(h) The department may promulgate regulations necessary for the implementation and administration of this subdivision.

(i) The Children's Health Advisory Council is established within the department as an advisory council. The following shall apply:

(1) The council shall consist of fourteen voting members. Members provided for in subparagraphs (iv), (v), (vi), (vii), (viii), (x) and (xi) shall be appointed by the Insurance Commissioner. The council shall be geographically balanced on a Statewide basis and shall include:

(i) The Secretary of Health ex officio or a designee.

(ii) The Insurance Commissioner ex officio or a designee.

(iii) The Secretary of Public Welfare ex officio or a designee.

(iv) A representative with experience in children's health from a school of public health located in this Commonwealth.

(v) A physician with experience in children's health appointed from a list of three qualified persons recommended by the Pennsylvania Medical Society.

(vi) A representative of a children's hospital or a hospital with a pediatric outpatient clinic appointed from a list of three persons submitted by the Hospital Association of Pennsylvania.

(vii) A parent of a child who receives primary health care coverage from the fund.

(viii) A mid-level professional appointed from lists of names recommended by Statewide associations representing mid-level health professionals.

(ix) A senator appointed by the President pro tempore of the Senate, a senator appointed by the minority leader of the Senate, a representative appointed by the Speaker of the House of Representatives and a representative appointed by the minority leader of the House of Representatives.

(x) A representative from a private nonprofit foundation.

(xi) A representative of business who is not a contractor or provider of primary health care insurance under this subdivision.

(2) If any specified organization should cease to exist or fail to make a recommendation within ninety (90) days of a request to do so, the council shall specify a new equivalent organization to fulfill the responsibilities of this section.

(3) The Insurance Commissioner shall chair the council. The members of the council shall annually elect, by a majority vote of the members, a vice chairperson from among the members of the council.

(4) The presence of eight members shall constitute a quorum for the transacting of any business. Any act by a majority of the members present at any meeting at which there is a quorum shall be deemed to be that of the council.

(5) All meetings of the council shall be conducted pursuant to 65 Pa.C.S. Ch. 7 (relating to open meetings) unless otherwise provided in this section. The council shall meet at least twice

per year and may provide for special meetings as it deems necessary. Meeting dates shall be set by a majority vote of members of the council or by call of the chairperson upon seven (7) days' notice to all members. The council shall publish notice of its meetings in the Pennsylvania Bulletin. Notice shall specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public. All action taken by the council shall be taken in open public session and shall not be taken except upon a majority vote of the members present at a meeting at which a quorum is present.

(6) The members of the council shall not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

(7) Terms of council members shall be as follows:

(i) The appointed members shall serve for a term of three (3) years and shall continue to serve thereafter until their successors are appointed.

(ii) An appointed member shall not be eligible to serve more than two full consecutive terms of three (3) years. Vacancies shall be filled in the same manner in which they were designated within sixty (60) days of the vacancy.

(iii) An appointed member may be removed by the appointing authority for just cause and by a vote of at least seven members of the council.

(8) The council shall review outreach activities and may make recommendations to the department.

(9) The council shall review and evaluate the accessibility and availability of services delivered to children enrolled in the program.

(j) The department shall solicit bids and award contracts through a competitive procurement process pursuant to the following:

(1) To the fullest extent practicable, contracts shall be awarded to insurers that contract with providers to provide primary care services for enrollees on a cost-effective basis. The department shall require contractors to use appropriate cost-management methods so that basic primary benefit services can be provided to the maximum number of eligible children and, whenever possible, to pursue and utilize available public and private funds.

(2) To the fullest extent practicable, the department shall require that any contractor comply with all procedures relating to coordination of benefits as required by the department or the Department of Public Welfare.

(3) Contracts may be for a term of up to three (3) years, with the option to extend for two one-year periods.

(k) Upon receipt of a solicitation from the department, each health service corporation and hospital plan corporation or their entities doing business in this Commonwealth shall submit a bid or proposal to the department to carry out the purposes of this section in the area serviced by the corporation. All other insurers may submit a bid or proposal to the department to carry out the purposes of this section.

(l) A contractor with whom the department enters into a contract shall do the following:

(1) Ensure to the maximum extent possible that eligible children have access to primary health care physicians and nurse practitioners within the contractor's service area.

(2) Contract with qualified, cost-effective providers, which may include primary health care physicians, nurse practitioners,

clinics and health maintenance organizations, to provide primary and preventive health care for enrollees on a basis best calculated to manage the costs of the services, including, but not limited to, using managed health care techniques and other appropriate medical cost-management methods.

(3) Ensure that the family of a child who may be eligible for medical assistance receives assistance in applying for medical assistance.

(4) Maintain waiting lists of children financially eligible for benefits who have applied for benefits but who were not enrolled due to lack of funds.

(4.1) Notify families of children who are paying a premium of any changes in such premium or copayment requirements.

(4.2) Collect such premiums or copayments from the family of any child receiving benefits as may be required.

(4.3) Cancel policies for nonpayment of premium, in accordance with all other applicable insurance laws.

(5) Strongly encourage all providers who provide primary care to eligible children to participate in medical assistance as qualified EPSDT providers and to continue to provide care to children who become ineligible for coverage under the provisions of this article but who qualify for medical assistance.

(6) Subject to any necessary Federal approval, provide the following minimum benefit package for eligible children:

(i) Preventive care. This subparagraph includes well-child care visits in accordance with the schedule established by the American Academy of Pediatrics and the services related to those visits, including, but not limited to, immunizations, health education, tuberculosis testing and developmental screening in accordance with routine schedule of well-child visits. Care shall also include a comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child abuse.

(ii) Diagnosis and treatment of illness or injury, including all medically necessary services related to the diagnosis and treatment of sickness and injury and other conditions provided on an ambulatory basis, such as laboratory tests, wound dressing and casting to immobilize fractures.

(iii) Injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital or freestanding ambulatory service center, including anesthesia provided in conjunction with such service or during emergency medical service.

(iv) Emergency accident and emergency medical care.

(v) Prescription drugs.

(vi) Emergency, preventive and routine dental care. This subparagraph does not include orthodontia or cosmetic surgery.

(vii) Emergency, preventive and routine vision care, including the cost of corrective lenses and frames, not to exceed two prescriptions per year.

(viii) Emergency, preventive and routine hearing care.

(ix) Inpatient hospitalization up to ninety (90) days per year for eligible children.

(6.1) The department shall implement a premium assistance program permitted under Federal regulations and as permitted through Federal waiver or State plan amendment made pursuant to this article. Notwithstanding any other law to the contrary, in the event it is more cost effective to purchase health care from a parent's employer-based program and the employer-based program meets the minimum coverage requirements, employer-based coverage may be purchased in place of enrollment in the health

insurance program established under this subdivision. An insurer shall honor a request for enrollment and purchase of employe group health insurance requested on behalf of an individual applying for coverage under this article if that individual:

(i) is a resident of this Commonwealth;

(ii) is qualified based on income under section 2311(d), (e.1), (e.2) or (e.3); and

(iii) meets the citizenship requirements of section 2311(c)(1.1)(iv).

(6.2) The department shall have the authority to review, audit and approve annual administrative expenses incurred by contractors pursuant to this section.

(7) Except for children covered under paragraph (6.1), each contractor shall provide an insurance identification card to each eligible child covered under contracts executed under this article. The card must not specifically identify the holder as low income.

(m) The department may grant a waiver of the minimum benefit package of subsection (l)(6) upon demonstration by the applicant that it is providing health care services for eligible children that meet the purposes and intent of this section.

(n) After the first year of operation and periodically thereafter, the department in consultation with appropriate Commonwealth agencies shall review enrollment patterns for both the free insurance program and the subsidized insurance program. The department shall consider the relationship, if any, among enrollment, enrollment fees, income levels and family composition. Based on the results of this study and the availability of funds, the department is authorized to adjust the maximum income ceiling for free insurance and the maximum income ceiling for subsidized insurance by regulation. In no event, however, shall the maximum income ceiling for free insurance be raised above two hundred per centum (200%) of the Federal poverty level.

(o) Notwithstanding subsection (n), beginning January 1, 2007, and thereafter, and subject to the provisions of section 2314, the maximum income ceiling for subsidized insurance shall not be raised above three hundred per centum (300%) of the Federal poverty level.

Section 2312. Outreach.--(a) The department, in consultation with appropriate Commonwealth agencies, shall coordinate the development of an outreach plan to inform potential contractors, providers and enrollees regarding eligibility and available benefits. The plan shall include provisions for reaching special populations, including nonwhite and non-English-speaking children and children with disabilities; for reaching different geographic areas, including rural and inner-city areas; and for assuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

(b) The council shall review the outreach activities and recommend changes as it deems in the best interests of the children to be served.

Section 2313. Payor of Last Resort; Insurance Coverage.--The contractor shall not pay any claim on behalf of an enrolled child unless all other Federal, State, local or private resources available to the child or the child's family are utilized first. The department, in cooperation with the Department of Public Welfare, shall determine if any other insurance coverage is available to the child through a custodial or noncustodial parent on an employment-related or other group basis. If such insurance coverage is available, the child's

eligibility under section 2311 shall be reevaluated, as shall the most cost-effective means of providing coverage for that child.

Section 2314. State Plan.--The department, in cooperation with the Department of Public Welfare, shall amend the State plan as deemed necessary to carry out the provisions of this article. The repeal of section 2311(e) and (f) and the expansion of financial eligibility under section 2311(e.1), (e.2) and (e.3) shall be contingent upon Federal approval.

(c) (Reserved).

(d) (Reserved).

(e) (Reserved).

(f) (Reserved).

(g) Miscellaneous Provisions.

Section 2361. Limitation on Expenditure of Funds.--In no case shall the total amount of annual contract awards authorized in subdivision (b) exceed the amount of cigarette tax receipts annually deposited into the fund pursuant to section 1296 of the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971," and any other Federal or State funds received through the fund. The provision of children's health care through the fund shall in no way constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

Section 2362. Expiration.--This article shall expire December 31, 2015.]

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

ARTICLE XXIII-A

COMPREHENSIVE HEALTH CARE

FOR UNINSURED CHILDREN

Section 2301-A. Definitions.

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

"Child." An individual under 19 years of age.

"Contractor." An insurer awarded a contract under section 2304-A to provide health care services under this article. The term includes an entity and an entity's subsidiary which is established under this act, 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations) or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Council." The Children's Health Advisory Council established in section 2303-A .

"Department." The Department of Human Services of the Commonwealth.

"EPSDT." Early and periodic screening, diagnosis and treatment.

"Express lane eligibility." A process which permits the use of findings for eligibility factors, including income and household size from an express lane partner administering a government program.

"Express lane partner." An agency determining eligibility for assistance for any of the following programs:

(1) Supplemental Nutrition Assistance Program (SNAP).

(2) Child care provided under the Child Care and Development Block Grant Act of 1990 (Public Law 101-508, 42 U.S.C. § 9858 et seq.).

"Fund." The Children's Health Fund.

"Group." A group for which a health insurance policy is written in this Commonwealth.

"Health service corporation." A professional health service corporation as defined in section 2302-A.

"Healthy Beginnings Program." Medical assistance coverage for services to children as required under Title XIX for the following:

(1) Children from birth to one year of age whose family income is not greater than 185% of the Federal poverty level.

(2) Children one through five years of age whose family income is not greater than 133% of the Federal poverty level.

(3) Children 6 through 18 years of age whose family income is not greater than 133% of the Federal poverty level.

"HMO." An entity organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Hospital." An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill individuals. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties. The term does not include facilities caring exclusively for the mentally ill.

"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. § 6101 (relating to definitions).

"Insurer." A health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under any of the following:

(1) This act.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Medicaid." The Federal medical assistance program established under Title XIX.

"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Mid-level health professional." A physician assistant, certified registered nurse practitioner, nurse practitioner or certified nurse midwife.

"Parent." A natural parent, stepparent, adoptive parent, guardian or custodian of a child.

"Premium assistance program." A component of a separate child health program, approved under the State plan, under which the Commonwealth pays part or all of the premium for an enrollee or enrollee's group health insurance coverage or coverage under a group health plan.

"Prescription drug." A controlled substance, other drug or device for medication dispensed by order of an appropriately licensed medical professional.

"Secretary." The Secretary of Human Services of the Commonwealth.

"Terminate." The term includes cancellation, nonrenewal and rescission.

"Title XIX." Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.).

"Title XXI." Title XXI of the Social Security Act.

Section 2302-A. Children's health care.

(a) Federal funds.--Notwithstanding any other provision of law, the department shall ensure the receipt of Federal financial participation under Title XXI for services provided under this chapter.

(b) General care.--To ensure that inpatient hospital care is provided to eligible children, each primary care provider furnishing primary care services shall make necessary arrangements for admission to the hospital and for necessary specialty care.

(c) Enrollment.--Subject to the provisions of section 2304-A, an insurer receiving funds from the department to provide coverage of health care services under this section shall enroll, to the extent that funds are available, any child who meets all of the following:

(1) Is a resident of this Commonwealth.

(2) Is not:

(i) Covered by a health insurance plan.

(ii) Covered by a self-insurance plan.

(iii) Covered by a self-funded plan.

(iv) Provided access to health care coverage by court order.

(v) Eligible for or covered by a medical assistance program administered by the department, including the Healthy Beginnings Program.

(3) Is qualified based on income under subsections (d) and (e).

(4) Meets the citizenship requirements of Title XXI.

(d) Income levels.--The provision of health care insurance for eligible children shall be in accordance with the following:

(1) Free to a child whose family income is no greater than 200% of the Federal poverty level.

(2) May be subsidized by the fund at a rate not to exceed 75% of the per member per month premium cost for a child whose family income is greater than 200% of the Federal poverty level but not greater than 250% of the Federal poverty level.

(3) May be subsidized by the fund at a rate not to exceed 65% of the per member per month premium cost for a child whose family income is greater than 250% of the Federal poverty level but not greater than 275% of the Federal poverty level.

(4) May be subsidized by the fund at a rate not to exceed 60% of the per member per month premium for a child whose family income is greater than 275% of the Federal poverty level but not greater than 300% of the Federal poverty level.

(5) Notwithstanding paragraphs (1), (2), (3) and (4), for purposes of determining cost-sharing obligations of a family with income levels specified under paragraphs (2), (3) and (4), the per member per month premium shall exclude the cost related to an assessment imposed on a contractor relating to managed care organization assessments under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(e) Income exceeding limits.--The following apply:

(1) For an eligible child whose family income is greater than the maximum level established under section 2304-A(h), the family may purchase the minimum coverage package under

2304-A(e)(9) for that child at the per member per month premium cost. The cost shall be derived separately from the other eligibility categories in the program. The family may purchase the minimum coverage package if the family demonstrates on an annual basis and in a manner determined by the department that the family is unable to afford individual or group coverage because of one of the following reasons:

(i) The coverage would exceed 10% of the family income.

(ii) The total cost of coverage for the child is 150% of the greater of:

(A) the premium cost established under this subsection for that service area; or

(B) the premium cost established under the program for that service area.

(2) For purposes of this subsection, the per member per month premium cost shall exclude the cost related to the managed care organization assessment imposed on a contractor under the Public Welfare Code.

(3) For purposes of this subsection, the term "coverage" may not include coverage offered through accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

(f) Powers and duties.--

(1) For enrollees under subsection (d)(2), (3) or (4) or (e), the following apply:

(i) The department may impose copayments for the following services, except as otherwise prohibited by law:

(A) Outpatient visits.

(B) Emergency room visits.

(C) Prescription medications.

(D) Any other service defined by the department.

(ii) The department may establish and adjust the levels of these copayments in order to impose reasonable cost sharing and to encourage appropriate utilization of these services. The premiums and copayments for enrollees under subsection (d)(2), (3) or (4) may not amount to more than the percent of total household income which is in accordance with the requirements of the Centers for Medicare and Medicaid Services.

(2) The department shall:

(i) Administer the children's health insurance program in accordance with this chapter.

(ii) Review all bids and approve and execute all contracts for the purpose of expanding access to health care services for eligible children as provided for in this article.

(iii) Conduct monitoring and oversight of contracts.

(iv) Issue an annual report to the Governor, the General Assembly and the public for each calendar year no later than March 1 of each year providing for the following:

(A) The primary health services funded for the year.

(B) The outreach and enrollment efforts and the number of children by county and by percent of the

Federal poverty level who are receiving health care services.

(C) The projected number of eligible children by county and by percent of the Federal poverty level.

(D) The number of eligible children on waiting lists for enrollment in the children's health insurance program established under this article by county and by percent of the Federal poverty level.

(E) The details of the department's efforts on the implementation of express lane eligibility.

(v) In consultation with appropriate Commonwealth agencies, coordinate the development and supervision of the outreach plan required under section 2305-A.

(vi) In consultation with appropriate Commonwealth agencies, monitor, review and evaluate the adequacy, accessibility and availability of services delivered to children who are enrolled in the children's health insurance program established under this article.

(vii) Enter into arrangements, including memoranda of understanding, with the Insurance Department and other appropriate Federal or State agencies, as may be necessary to carry out the department's duties under this article.

(3) The department may promulgate regulations necessary for the implementation and administration of this article.

Section 2303-A. Children's Health Advisory Council.

The Children's Health Advisory Council is established within the department as an advisory council. The following apply:

(1) The council shall consist of 16 voting members. Members provided for in subparagraphs (iv), (v), (vi), (vii), (viii), (xiii), (xiv), (xv) and (xvi) shall be appointed by the secretary. The council shall be geographically balanced on a Statewide basis and shall include:

(i) The Secretary of Health ex officio or a designee.

(ii) The Insurance Commissioner ex officio or a designee.

(iii) The secretary ex officio or a designee.

(iv) A representative with experience in children's health from a school of public health located in this Commonwealth.

(v) A physician with experience in children's health appointed from a list of three qualified persons recommended by the Pennsylvania Medical Society.

(vi) A representative of a children's hospital or a hospital with a pediatric outpatient clinic appointed from a list of three persons submitted by the Hospital Association of Pennsylvania.

(vii) A parent of a child who receives primary health care coverage from the fund.

(viii) A mid-level professional appointed from lists of names recommended by Statewide associations representing mid-level health professionals.

(ix) A senator appointed by the President pro tempore of the Senate.

(x) A senator appointed by the Minority Leader of the Senate.

(xi) A representative appointed by the Speaker of the House of Representatives.

(xii) A representative appointed by the Minority Leader of the House of Representatives.

(xiii) A representative from a private nonprofit foundation.

(xiv) A representative of business who is not a contractor or provider of primary health care insurance under this article.

(xv) A representative of a nonprofit business who is a contractor or provider of primary health insurance under this article.

(xvi) A representative of a for-profit business who is a contractor or provider of primary health insurance under this article.

(2) If a specified organization ceases to exist or fails to make a recommendation within 90 days of a request, the council shall specify a new equivalent organization to fulfill the responsibilities of this section.

(3) The secretary shall serve as chairperson of the council. The members of the council shall annually elect, by a majority vote of the members, a vice chairperson from among the members of the council.

(4) The presence of nine members shall constitute a quorum for the transacting of any business. An act by a majority of the members present at a meeting at which there is a quorum shall be deemed to be that of the council.

(5) All meetings of the council shall be conducted in accordance with 65 Pa.C.S. Ch. 7 (relating to open meetings), except as provided in this section. Meetings must be in accordance with the following:

(i) The council shall meet at least twice per year and may provide for special meetings as the council deems necessary.

(ii) Meeting dates shall be set by a majority vote of members of the council or by call of the chairperson upon seven days' notice to all members.

(iii) The council shall publish notice of the council's meetings in the Pennsylvania Bulletin. The notice must specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public.

(iv) All action taken by the council shall be taken in open public session and may not be taken except upon a majority vote of the members present at a meeting at which a quorum is present.

(6) The members of the council may not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses incurred in the performance of the members' duties.

(7) Terms of council members shall be as follows:

(i) The appointed members shall serve for a term of three years and shall continue to serve until a successor is appointed.

(ii) An appointed member may not be eligible to serve more than two full consecutive terms of three years. Vacancies shall be filled in the same manner as the original appointment within 60 days of the vacancy.

(iii) An appointed member may be removed by the appointing authority for just cause and by a vote of at least seven members of the council.

(8) The council shall review outreach activities and may make recommendations to the department.

(9) The council shall review and evaluate the accessibility and availability of services delivered to children enrolled in the program.

Section 2304-A. Contracts and coverage packages.

(a) Paid from fund.--In addition to any other requirements provided by law, the fund shall be operated in accordance with the following:

(1) The fund must be dedicated exclusively for distribution by the department through contracts in order to provide free and subsidized health care services under this article, based on an actuarially sound and adequate review, and to develop and implement outreach activities required under section 2305-A.

(2) The fund, along with Federal, State and other funds available for the program, must be used for health care coverage for children as specified in this article. The department shall ensure that the program is implemented Statewide.

(3) The department must award contracts paid from the fund in accordance with the following:

(i) All contracts awarded under this subsection must be awarded through a competitive procurement process. The department and the Insurance Department must use their best efforts to ensure that eligible children across this Commonwealth have access to health care services to be provided under this article.

(ii) No more than 10% of the amount of the contract may be used for administrative expenses of the contractor. If a contractor presents documented evidence that administrative expenses for purposes of expanded outreach and systems and operational changes are in excess of 10% of the amount of the contract, the department shall make an additional allotment of funds, not to exceed 2% of the amount of the contract, to the contractor to the extent that the department finds the expenses reasonable and necessary.

(iii) At least 84% of the amount of the contract shall be used to provide health care services for children eligible for care under this article.

(iv) In determining the amount of the contract which may be used for the purposes specified in subparagraphs (ii) and (iii), any Federal and State taxes that would be deducted from premium revenue in determining an issuer's medical loss ratio under 45 CFR 158.221 (relating to formula for calculating an issuer's medical loss ratio), including a managed care organization assessment imposed on a contractor under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, shall be excluded.

(b) Solicitation of contracts.--The department must solicit bids and award contracts through a competitive procurement process in accordance with the following:

(1) To the fullest extent practicable, contracts shall be awarded to insurers that contract with providers to provide primary care services for enrollees on a cost-effective basis. The department shall require contractors to use appropriate cost-management methods so that basic primary coverage services can be provided to the maximum number of eligible children and, if possible, to pursue and utilize available public and private funds.

(2) To the fullest extent practicable, the department must require that a contractor comply with all procedures relating to coordination of health care services as required by the department or the Insurance Department.

(3) Contracts may be for a term of up to three years, with the option to extend for two one-year periods.

(c) Bidding.--Upon receipt of a solicitation from the department, each health service corporation and hospital plan corporation or their entities doing business in this Commonwealth shall submit a bid or proposal to the department to carry out the purposes of this article in the area serviced by the corporation.

(d) Bidding by other insurers.--All other insurers may submit a bid or proposal to the department to carry out the purposes of this article.

(e) Duties of contractor.--A contractor with whom the department enters into a contract shall do the following:

(1) Ensure to the maximum extent possible that eligible children have access to primary health care physicians and nurse practitioners within the contractor's service area.

(2) Contract with qualified, cost-effective providers, which may include primary health care physicians, nurse practitioners, clinics and HMOs, to provide primary and preventive health care for enrollees on a basis best calculated to manage the costs of the services, including, but not limited to, using managed health care techniques and other appropriate medical cost-management methods.

(3) Ensure that the family of a child who may be eligible for medical assistance receives assistance in applying for medical assistance.

(4) Maintain waiting lists of children financially eligible for coverage who have applied for coverage but who were not enrolled due to lack of funds.

(5) Notify families of children who are paying a premium of any changes in such premium or copayment requirements.

(6) Collect premiums or copayments from the family of a child receiving coverage as may be required.

(7) Cancel coverage for nonpayment of premium, in accordance with all applicable insurance laws.

(8) Strongly encourage all providers who provide primary care to eligible children to participate in medical assistance as qualified EPSDT providers and to continue to provide care to children who become ineligible for coverage under the provisions of this article but who qualify for medical assistance.

(9) Subject to any necessary Federal approval, provide the following minimum coverage package, which may not conflict with Federal law, regulation or guidance, for eligible children:

(i) Preventive care. This subparagraph shall include:

(A) Well-child care visits in accordance with the schedule established by the American Academy of Pediatrics and the services related to the visits, including immunizations, health education, tuberculosis testing and developmental screening in accordance with the routine schedule of well-child care visits.

(B) A comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child abuse.

(ii) Diagnosis and treatment of illness or injury, including all medically necessary services related to the diagnosis and treatment of sickness and injury and other conditions provided on an ambulatory basis, such

as laboratory tests, wound dressing and casting to immobilize fractures.

(iii) Injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital or freestanding ambulatory service center, including anesthesia provided in conjunction with such service or during emergency medical service.

(iv) Emergency accident and emergency medical care.

(v) Prescription drugs.

(vi) Emergency, preventive and routine dental care. This subparagraph does not include orthodontia or cosmetic surgery.

(vii) Emergency, preventive and routine vision care, including the cost of corrective lenses and frames, not to exceed two prescriptions per year.

(viii) Emergency, preventive and routine hearing care.

(ix) Inpatient hospitalization.

(10) The department may implement a premium assistance program permitted under Federal regulations and as permitted through Federal waiver or State plan amendment made pursuant to this article. Notwithstanding any other law to the contrary, if it is more cost effective to purchase health care from a parent's employer-based program and the employer-based program meets the minimum coverage requirements, employer-based coverage may be purchased in place of enrollment in the children's health insurance program established under this article. An insurer must honor a request for enrollment and purchase of employee group health insurance requested on behalf of an individual applying for coverage under this chapter if the individual:

(i) is a resident of this Commonwealth;

(ii) is qualified based on income under section 2302-A; and

(iii) meets the citizenship requirements of section 2302-A(c)(1)(iv).

(11) The department shall have the authority to review, audit and approve annual administrative expenses incurred by contractors under this section.

(12) Except for children covered under paragraph (10), each contractor shall provide a coverage identification card to each eligible child covered under contracts executed under this article. The card must not specifically identify the holder as low income.

(f) Waiver of minimum.--The department may grant a waiver of the minimum coverage package of subsection (e)(9) upon demonstration by the applicant that the applicant is providing health care services for eligible children that meet the purposes and intent of this article.

(g) Review.--

(1) The department, in consultation with appropriate Commonwealth agencies, shall review enrollment patterns for both the free coverage program and the subsidized coverage program. The department shall consider the relationship, if any, among enrollment, enrollment fees, income levels and family composition.

(2) Based on the results of this study and the availability of funds, the department may adjust the maximum income ceiling for free coverage and the maximum income ceiling for subsidized coverage by regulation. The maximum

income ceiling for free coverage may not be raised above 200% of the Federal poverty level.

(h) Limit.--Notwithstanding subsection (g) and subject to section 2307-A, the maximum income ceiling for subsidized coverage under section 2302-A(d)(2), (3) or (4) may not be raised above 300% of the Federal poverty level.

Section 2305-A. Outreach.

(a) Plan.--The department, in consultation with appropriate Commonwealth agencies, must coordinate the development of an outreach plan to inform potential contractors, providers and enrollees regarding eligibility and available coverage. The plan must include provisions for all of the following:

(1) Reaching special populations, including nonwhite and non-English-speaking children and children with disabilities.

(2) Reaching different geographic areas, including rural and inner-city areas.

(3) Ensuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

(4) Comparing children enrolled in child care provided under the Child Care and Development Block Grant Act of 1990 (Public law 101-508, 42 U.S.C. § 9858 et seq.) or enrolled in the Supplemental Nutrition Assistance Program in the determination of a child's eligibility for coverage under this article and implement express lane eligibility as appropriate. The department is authorized to expand the agencies identified as express lane partners by the issuance of a statement of policy.

(5) Notice of the existence of and eligibility for the program shall be prepared by the department and provided to the Department of Education for dissemination to nonpublic and public schools electronically, on an annual basis, not later than August 15.

(b) Review.--The council shall review the outreach activities and recommend changes as the council deems to be in the best interests of the children to be served.

Section 2306-A. Payor of last resort and insurance coverage.

The contractor may not pay a claim on behalf of an enrolled child unless all other Federal, State, local or private resources available to the child or the child's family are utilized first. The department, in cooperation with the Insurance Department, shall determine if insurance coverage is available to the child through a custodial or noncustodial parent on an employment-related or other group basis. If insurance coverage is available, the child's eligibility under section 2302-A and the most cost-effective means of providing coverage for that child must be reevaluated.

Section 2307-A. State plan.

The department may amend the State plan as necessary to carry out the provisions of this article.

Section 2308-A. Limitation on expenditure of funds.

The total amount of annual contract awards authorized under this article may not exceed the amount of cigarette tax receipts annually deposited into the fund under section 1296 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, and any other Federal or State funds received through the fund. The provision of children's health care through the fund may not constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

Section 2309-A. Expiration.

(a) General rule.--This article shall expire on the earlier of:

(1) December 31, 2017; or

(2) ninety days after the date on which Federal funding for the program ceases to be available.

(b) Notice.--If the chapter expires under subsection (a)(2), as determined by the department, the department shall transmit notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

Section 4. The addition of Article XXIII-A of the act is a continuation of former Article XXIII of the act. The following apply:

(1) Except as otherwise provided in Article XXIII-A of the act, all activities initiated under former Article XXIII of the act shall continue and remain in full force and effect and may be completed under Article XXIII-A. Orders, regulations, rules and decisions which were made under former Article XXIII and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under Article XXIII-A. Contracts and obligations entered into under former Article XXIII are not affected nor impaired by the repeal of Article XXIII.

(2) Except as set forth in paragraph (3), any difference in language between Article XXIII-A and former Article XXIII is intended only to conform to style and is not intended to change or affect the legislative intent, judicial construction or administration and implementation of former Article XXIII.

(3) Paragraph (2) does not apply to the addition of the following provisions:

(i) The change in the definition of "department" in section 2301-A of the act.

(ii) The provisions for arrangements with other agencies under section 2302-A(f)(2)(vii) of the act.

(iii) The expiration provision under section 2309-A of the act.

(iv) The addition of paragraphs (d)(5) and (e)(3) of section 2302-A of the act regarding the exclusion of costs related to the managed care organization assessments under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(v) The addition of subparagraph (a)(3)(iv) of section 2304-A of the act regarding the determination of the amount of the contract.

(4) All entities receiving grants under former Article XXIII on the effective date of this section shall continue to receive funds and provide services as required under former Article XXIII until notice from the Department of Human Services is published in the Pennsylvania Bulletin.

Section 5. The addition of section 2007.1 of the act shall apply to all policies issued or renewed on or after 180 days after the effective date of this section.

Section 6. This act shall take effect as follows:

(1) The addition of section 635.7 of the act shall take effect January 1, 2016, or immediately, whichever is later.

(2) The remainder of this act shall take effect immediately.

APPROVED--The 20th day of December, A.D. 2015.

TOM WOLF