No. 1998-68

AN ACT

SB 91

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," providing for automobile insurance issuance, renewal, cancellation and refusal; providing for quality health care accountability and protection, for responsibilities of managed care plans, for disclosure, for utilization review, for complaints and grievances, for departmental powers and duties and for penalties; providing for comprehensive health care for uninsured children; and making repeals.

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 articles to read:

ARTICLE XX.
AUTOMOBILE INSURANCE ISSUANCE, RENEWAL, CANCELLATION AND REFUSAL.

Section 2001. Definitions.—As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Commissioner." The Insurance Commissioner of this Commonwealth.

"Insurer." An insurance company, association or exchange authorized to transact the business of automobile insurance in this Commonwealth.

"Nonpayment of premium." Failure of the named insured to discharge when due any obligation in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension or credit.

"Policy of automobile insurance" or "policy." A policy delivered or issued for delivery in this Commonwealth insuring a natural person as named insured or one or more related individuals resident of the same household and under which the insured vehicles therein designated are of the following types only:

(i) a motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers and is not rented to others; or

(ii) any other four-wheel motor vehicle with a gross weight not exceeding nine thousand pounds which is not principally used in the

occupation, profession or business of the insured other than farming.

"Renewal" or "to renew." To issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same insurer and which provides types and limits of coverage at least equal to those contained in the policy being superseded, or to issue and deliver a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy being extended: Provided, however, That any policy with a policy period or term of less than twelve (12) months or any period with no fixed expiration date shall for the purpose of this article be considered as if written for successive policy periods or terms of twelve (12) months.

Section 2002. Applicability.—(a) This article shall apply only to:

(1) that portion of a policy of automobile insurance providing bodily injury and property damage liability, comprehensive and collision coverages; and

(2) to the policy's provisions, if any, relating to medical payments and uninsured motorists coverage.

(b) This article shall not apply to:

(1) any policy issued under an automobile assigned risk plan;

(2) any policy insuring more than four automobiles; or

(3) any policy covering garage, automobile sales agency repair shop, service station or public parking place operation hazards.

(c) Nothing in this article shall apply:

(1) If the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate or other evidence of renewal or has manifested such intention by any other means.

(2) If the named insured has demonstrated by some overt action to the insurer or its agent that he wishes the policy to be cancelled or that he does not wish the policy to be renewed.

(3) To any policy of automobile insurance which has been in effect less than sixty (60) days, unless it is a renewal policy, except that no insurer shall decline to continue in force such a policy of automobile insurance on the basis of the grounds set forth in section 2003(a) and except that if an insurer cancels a policy of automobile insurance in the first sixty (60) days, the insurer shall supply the insured with a written statement of the reason for cancellation.

Section 2003. Discrimination Prohibited.—(a) An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any of the following reasons:

(1) Age.

(2) Residence or operation of a motor vehicle in a specific geographic area.

(3) Race.

(4) Color.

(5) Creed.

(6) National origin.

(7) Ancestry.

(8) Marital status.

(9) Sex.

(10) Lawful occupation, including military service.

(11) The refusal of another insurer to write a policy or the cancellation or refusal to renew an existing policy by another insurer.

(12) Illness or permanent or temporary disability where the insured can medically document that such illness or disability will not impair his ability to operate a motor vehicle. Failure to provide such documentation shall be proper reason for the insurer to amend the policy of the named insured to exclude such disabled insured from coverage under the policy while operating a motor vehicle after the effective date of such policy amendment but shall not be proper reason to cancel or refuse to write or renew the policy. Nothing in this provision shall be construed to effect such excluded individual's eligibility for coverage under the named insured's policy for any injury sustained while not operating a motor vehicle. Illness or permanent or temporary disability on the part of any insured shall not be proper reason for cancelling the policy of the named insured.

(13) Any accident which occurred under the following circumstances:

(i) automobile lawfully parked (if the parked vehicle rolls from the parked position, then any such accident is charged to the person who parked the automobile);

(ii) the applicant, owner or other resident operator is reimbursed by or on behalf of a person who is responsible for the accident or has judgment against such person;

(iii) automobile is struck in the rear by another vehicle and the applicant or other resident operator has not been convicted of a moving traffic violation in connection with this accident;

(iv) operator of the other automobile involved in the accident was convicted of a moving traffic violation and the applicant or resident operator was not convicted of a moving traffic violation in connection with the accident;

(v) automobile operated by the applicant or any resident operator is struck by a "hit-and-run" vehicle if the accident is reported to the proper authority within twenty-four (24) hours by the applicant or resident operator;

(vi) accident involving damage by contact with animals or fowl;

(vii) accident involving physical damage limited to and caused by flying gravel, missiles or falling objects;

(viii) accident occurring when using automobile in response to any emergency if the operator of the automobile at the time of the accident was a paid or volunteer member of any police or fire department, first aid squad or any law enforcement agency. This exception does not include an

accident occurring after the automobile ceases to be used in response to such emergency; or

(ix) accidents which occurred more than thirty-six (36) months prior to the later of the inception of the insurance policy or the upcoming anniversary date of the policy.

(14) Any claim under the comprehensive portion of the policy unless such loss was intentionally caused by the insured.

(b) An insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of one accident within the thirty-six-month period prior to the upcoming anniversary date of the policy.

(c) For a period twelve (12) months after notice of termination given to an agent:

(1) An insurer may not cancel or refuse to renew existing policies written through the terminated agent because of such termination except as provided in paragraph (2).

(2) An insurer may cancel or refuse to renew only such policies as could have been cancelled or nonrenewed had the agency relationship continued.

(3) An insurer shall be obligated to pay commissions for such policies that are continued or renewed through the terminated agent except where:

(i) the insurer retained ownership of the expirations of such policies; or

(ii) the agent has misappropriated funds or property of the insurer or has failed to remit to the insurer funds due it promptly upon demand or has been terminated for insolvency, abandonment, gross and wilful misconduct or has had his license suspended or revoked.

(d) Subsequent to the twelve-month period after notice of termination given to an agent, an insurer may not cancel or refuse to renew existing policies written through the terminated agent without offering each such insured coverage on a direct basis or offering to refer the insured to one or more new agents in the event the terminated agent could not find a suitable insurer acceptable to the policyholder for such business. The offer need not be made if the insurer could have cancelled or nonrenewed the policy had the agency relationship continued. If the insurer retains ownership of the expirations of such policies, the insurer need not offer a new agent.

(e) An insurer may not cancel or refuse to renew a policy of automobile insurance for two or fewer moving violations in any jurisdiction or jurisdictions during a twenty-four-month period when the operator's record indicates that the named insured presently bears five points or fewer, unless:

(1) All five points were incurred from one violation.

(2) The driver's license or motor vehicle registration of the named insured has been suspended or revoked.

(3) If, however, the driver's license has been suspended under 75

Pa.C.S. § 1533 (relating to suspension of operating privilege for failure to respond to citation) and the insured is able to produce proof that he or she has responded to all citations and paid all fines and penalties imposed under that section and that he or she has done so on or before the termination date of the policy, this suspension shall not be grounds for cancellation or for refusal to renew.

(f) The applicability of subsection (e) to one, other than the named insured, who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer to exclude that individual from coverage under the policy but not for cancelling the policy.

(g) As used in subsection (e), "points" shall mean points as set forth in 75 Pa.C.S. Ch. 15[1] (relating to licensing of drivers).

Section 2004. Valid Reasons to Cancel Policy.—An insurer may not cancel a policy except for one or more of the following specified reasons:

(1) Nonpayment of premium.

(2) The driver's license or motor vehicle registration of the named insured has been under suspension or revocation during the policy period; the applicability of this reason to one who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer thereafter excluding such individual from coverage under the policy but not for cancelling the policy.

(3) A determination that the insured has concealed a material fact, or has made a material allegation contrary to fact, or has made a misrepresentation of a material fact and that such concealment, allegation or misrepresentation was material to the acceptance of the risk by the insurer.

Section 2005. Policy Premium Increases.—(a) An insurer may not increase an individual insured's premium or assess a premium surcharge on the basis of any moving traffic violation records, any revocation or suspension records or any accident records if any of the following occurs:

(1) The insured establishes that the records are erroneous or inaccurate.

(2) The citation is imposed under 75 Pa.C.S. § 1533 (relating to suspension of operating privilege for failure to respond to citation) and the insured is able to produce proof that he or she has responded to the citation and paid the fines and penalties imposed under that section. An increase or surcharge imposed prior to the date when an insured provides this proof shall terminate as of the date the insured responded to the citation which is the subject of the increase or surcharge.

(b) At the time an increase or surcharge is applied, the insurer shall notify the insured that the increase or surcharge will be terminated if the insured is able to provide the insurer with proof that the insured has

---

[1] "75 Pa.C.S. § 1501" in enrolled bill.

responded to all citations imposed under 75 Pa.C.S. § 1533 and paid any fines and penalties imposed under that section.

(c) All insurers shall provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of a surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance or as a result of any other factors.

Section 2006. Proper Notification of Intention to Cancel.—A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the named insured at the address shown in the policy a written notice of the cancellation or refusal to renew. The notice shall:

(1) Be in a form acceptable to the Insurance Commissioner.

(2) State the date, not less than sixty (60) days after the date of the mailing or delivery, on which cancellation or refusal to renew shall become effective. When the policy is being cancelled or not renewed for the reasons set forth in section 2004(1) and (2), however, the effective date may be fifteen (15) days from the date of mailing or delivery.

(3) State the specific reason or reasons of the insurer for cancellation or refusal to renew.

(4) Advise the insured of his right to request in writing, within thirty (30) days of the receipt of the notice of cancellation or intention not to renew and of the receipt of the reason or reasons for the cancellation or refusal to renew as stated in the notice of cancellation or of intention not to renew, that the Insurance Commissioner review the action of the insurer.

(5) Either in the notice or in an accompanying statement advise the insured of his possible eligibility for insurance through the automobile assigned risk plan.

(6) Advise the insured that he must obtain compulsory automobile insurance coverage if he operates or registers a motor vehicle in this Commonwealth, that the insurer is notifying the Department of Transportation that the insurance is being cancelled or not renewed and that the insured must notify the Department of Transportation that he has replaced said coverage.

(7) Clearly state that when coverage is to be terminated due to nonresponse to a citation imposed under 75 Pa.C.S. § 1533 (relating to suspension of operating privilege for failure to respond to citation) or nonpayment of a fine or penalty imposed under that section coverage shall not terminate if the insured provides the insurer with proof that the insured has responded to all citations and paid all fines and penalties and that he has done so on or before the termination date of the policy.

Section 2007. Exemption from Liability.—There shall be no liability on the part of and no cause of action of any nature shall arise against the Insurance Commissioner, any insurer, the authorized representatives, agents and employes of either or any firm, person or corporation

furnishing to the insurer information as to reasons for cancellation or refusal to write or renew for any statement made by any of them in complying with this act or for the providing of information pertaining thereto. The insurer must furnish the insured the notification required by the Federal Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.) when such cancellations or refusal to write or renew occur.

Section 2008. Request for Review.—(a) Any insured may, within thirty (30) days of the receipt by the insured of notice of cancellation or notice of intention not to renew and of the receipt of the reason or reasons for the cancellation or refusal to renew as stated in the notice, request in writing to the Insurance Commissioner that the Insurance Commissioner review the action of the insurer in cancelling or refusing to renew the policy of such insured.

(b) Any applicant for a policy who is refused a policy by an insurer shall be given a written notice of refusal to write by the insurer. The notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within thirty (30) days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that the Insurance Commissioner review the action of the insurer in refusing to write a policy for the applicant.

Section 2009. Review Procedure.—(a) On receipt of a request for review, the Insurance Commissioner shall notify the insurer that a review has been requested. The Insurance Commissioner shall review the matter to determine whether the cancellation or refusal to renew or to write was in violation of this article and shall, within forty (40) days of the receipt of such request, either order the policy written or reinstated or uphold the cancellation or refusal to renew.

(b) After a review of a cancellation of or refusal to renew a policy, if the Insurance Commissioner finds the insurer not to be in violation of this article, the policy shall remain in effect until the date referred to in section 2006(2) or thirty (30) days following the conclusion of the review provided for in subsection (a), whichever is later. Provided, however, for review of cancellations under section 2004(1), the policy shall terminate as of the date provided in the notice under section 2006(2) unless the policy is reinstated. Nothing in this subsection shall be construed to prevent the insurer, at its discretion, from continuing coverage after the initial review period until such time as the Insurance Commissioner has issued a final order.

(c) After review of a cancellation of or refusal to renew a policy, if the Insurance Commissioner finds the insurer to be in violation of this article and the insurer requests a hearing pursuant to subsection (d), the policy shall remain in effect until such time as the Insurance Commissioner has issued a final order.

(d) If either of the parties shall dispute the Insurance Commissioner's findings, that party shall have the right to a formal hearing. In the event

a hearing is requested, the Insurance Commissioner shall issue notice of the hearing which shall state the time and place for the hearing, which shall not be less than thirty (30) days from the date of notice.

(e) At the time and place fixed for the hearing in the notice, the parties shall have an opportunity to be heard.

(f) Upon good cause shown, the Insurance Commissioner shall permit any person to intervene, appear and be heard at the hearing in person or by counsel.

(g) The Insurance Commissioner may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence and subpoena witnesses, compel their attendance and require the production of books, papers, records or other documents which he deems relevant to the hearing. The Insurance Commissioner shall cause a record to be kept of all evidence and all proceedings at the hearings.

(h) The insurer shall bear the burden at the hearing to prove that the cancellation or refusal to renew complies with this article. However, if the insured requested the hearing and fails to appear at the time and place for the hearing, the Insurance Commissioner may consider a motion to dismiss and shall not be compelled to take evidence at the scheduled hearing. In addition to any remedy in subsection (i), the Insurance Commissioner shall have the authority to order an insurer to cease and desist from acts constituting a violation of this article.

(i) Following the hearing, the Insurance Commissioner shall issue a written order resolving the factual issues presented at the hearing and stating what remedial action, if any, is required. If the Insurance Commissioner finds that the cancellation or refusal to renew violates this article, then the remedial action ordered by the Insurance Commissioner shall include at least one of the following:

(1) That the insurer reimburse the insured for any increase in the cost of insurance and any short-term cancellation fees which are incurred.

(2) That the insurer reinstate the original policy prospectively.

(3) That if an insurer has elected to continue coverage pursuant to subsection (b), the coverage shall remain in full force and effect under the terms of the policy. Reimbursement shall be in the amount incurred by the insured to secure replacement coverage during the pendency of the hearing process, which cost exceeds the cost which would have been incurred had the policy under review remained in effect. The reimbursement shall be based on the difference of the cost of the policies to the extent that the coverage and limits of the replacement coverage does not exceed the original coverage. The insured shall bear the burden to request reimbursement and prove any increase in the cost of insurance. In addition, if a prospective reinstatement of the original policy is ordered, then the reinstatement shall take effect on the next policy anniversary date unless the insured requests that the reinstatement take effect at an earlier date.

(j) The Insurance Commissioner shall send a copy of the order to the

parties participating in the hearing.

(k) All of the actions which may be performed by the Insurance Commissioner in this section may be performed by the Insurance Commissioner's designated representative.

Section 2010. Regulations.—(a) The Insurance Commissioner shall promulgate rules and regulations necessary for the administration of this article.

(b) The Insurance Commissioner may provide in such rules and regulations for the establishment of a filing fee not exceeding fifteen dollars ($15) to accompany the request for review. Should the Insurance Commissioner decide the appeal in favor of the insured, the filing fee shall be returned immediately and the fee shall be paid by the insurer. No part of the review by the Insurance Commissioner shall be subject to the provisions of 2 Pa.C.S. Ch. 5 Subch. A[1] (relating to practice and procedure of Commonwealth agencies).

Section 2011. Appeal.—(a) The decision of the Insurance Commissioner shall be subject to appeal in accordance with 2 Pa.C.S. Ch. 7 Subch. A[2] (relating to judicial review of Commonwealth agency action), but the court hearing an appeal shall not decline to affirm a decision on the ground that the requirements of 2 Pa.C.S. Ch. 5 Subch. A[3] were not fulfilled.

(b) Upon a determination that this article has been violated, the Insurance Commissioner may issue an order requiring the insurer to cease and desist from engaging in such violation.

(c) Whenever a violator fails to comply with an order of the Insurance Commissioner to cease and desist from engaging in such violation, the Insurance Commissioner may cause an action for injunction to be filed in court regardless of whether an insurer is licensed by the Insurance Commissioner.

Section 2012. Information and Report.—Each insurer shall maintain records of the numbers of cancellations and refusals to write or renew policies and the reasons therefor and shall supply this information to the Insurance Commissioner upon his request.

Section 2013. Penalty.—Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars ($5,000).

ARTICLE XXI.
QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION.

(a) Preliminary Provisions.

---

[1] *"2 Pa.C.S. §§ 501 through 508" in enrolled bill.*

[2] *"2 Pa.C.S. §§ 701 through 704" in enrolled bill.*

[3] *"2 Pa.C.S. §§ 501 through 508" in enrolled bill.*

Section 2101. Scope.—This article governs quality health care accountability and protection.

Section 2102. Definitions.—As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Active clinical practice." The practice of clinical medicine by a health care provider for an average of not less than twenty (20) hours per week.

"Ancillary service plans." Any individual or group health insurance plan, subscriber contract or certificate that provides exclusive coverage for dental services or vision services. The term also includes Medicare Supplement Policies subject to section 1882 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395ss) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

"Clean claim." A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

"Complaint." A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan which has not been resolved by the managed care plan and has been filed with the plan or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

"Concurrent utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs during an enrollee's hospital stay or course of treatment and results in a decision to approve or deny payment for the health care service.

"Department." The Department of Health of the Commonwealth.

"Drug formulary." A listing of managed care plan preferred therapeutic drugs.

"Emergency service." Any health care service provided to an enrollee after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

"Enrollee." Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan.

"Grievance." As provided in subdivision (i), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

(1) disapproves full or partial payment for a requested health care service;

(2) approves the provision of a requested health care service for a lesser scope or duration than requested; or

(3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

The term does not include a complaint.

"Health care provider." A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

"Health care service." Any covered treatment, admission, procedure, medical supplies and equipment or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

"Managed care plan." A health care plan that uses a gatekeeper to manage the utilization of health care services, integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:

(1) Section 630.

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

(3) The act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. The term does not include ancillary service plans or an indemnity arrangement which is primarily fee

for service.

"Plan." A managed care plan.

"Primary care provider." A health care provider who, within the scope of the provider's practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to an enrollee, initiates enrollee referral for specialist care and maintains continuity of enrollee care.

"Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Provider network." The health care providers designated by a managed care plan to provide health care services.

"Referral." A prior authorization from a managed care plan or a participating health care provider that allows an enrollee to have one or more appointments with a health care provider for a health care service.

"Retrospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Service area." The geographic area for which the managed care plan is licensed or has been issued a certificate of authority.

"Specialist." A health care provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, has board certification or practices in a licensed specialized area of health care. The term includes a health care provider who is not classified by a plan solely as a primary care provider.

"Utilization review." A system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee. The term does not include any of the following:

(1) Requests for clarification of coverage, eligibility or health care service verification.

(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of a managed care plan.

(b) Managed Care Plan Requirements.

Section 2111. Responsibilities of Managed Care Plans.—A managed care plan shall do all of the following:

(1) Assure availability and accessibility of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services.

(2) Consult with health care providers in active clinical practice regarding professional qualifications and necessary specialists to be included in the plan.

(3) Adopt and maintain a definition of medical necessity used by the plan in determining health care services.

(4) Ensure that emergency services are provided twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for emergency services.

(5) Adopt and maintain procedures by which an enrollee can obtain health care services outside the plan's service area.

(6) Adopt and maintain procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the plan's established standards are met, be permitted to receive:

(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

The referral to or designation of a specialist shall be pursuant to a treatment plan approved by the managed care plan in consultation with the primary care provider, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a health care provider participating in the plan.

(7) Provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the plan to obtain maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological care, without prior approval from a primary care provider. The health care services shall be within the scope of practice of the selected health care provider. The selected health care provider shall inform the enrollee's primary care provider of all health care services provided.

(8) Adopt and maintain a complaint process as set forth in subdivision (g).

(9) Adopt and maintain a grievance process as set forth in subdivision (i).

(10) Adopt and maintain credentialing standards for health care providers as set forth in subdivision (d).

(11) Ensure that there are participating health care providers that are physically accessible to people with disabilities and can communicate with individuals with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990 (Public Law 101-336, 42 U.S.C. § 12181 et seq.).

(12) Provide a list of health care providers participating in the plan to the department every two (2) years or as may otherwise be required by the

department. The list shall include the extent to which health care providers in the plan are accepting new enrollees.

(13) Report to the department and the Insurance Department in accordance with the requirements of this article. Such information shall include the number, type and disposition of all complaints and grievances filed with the plan.

Section 2112. Financial Incentives Prohibition.—No managed care plan shall use any financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee. Nothing in this section shall be deemed to prohibit a managed care plan from using a capitated payment arrangement or other risk-sharing arrangement.

Section 2113. Medical Gag Clause Prohibition.—(a) No managed care plan may penalize or restrict a health care provider from discussing:

(1) the process that the plan or any entity contracting with the plan uses or proposes to use to deny payment for a health care service;

(2) medically necessary and appropriate care with or on behalf of an enrollee, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or

(3) the decision of any managed care plan to deny payment for a health care service.

(b) A provision to prohibit or restrict disclosure of medically necessary and appropriate health care information contained in a contract with a health care provider is contrary to public policy and shall be void and unenforceable.

(c) No managed care plan shall terminate the employment of or a contract with a health care provider for any of the following:

(1) Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.

(2) Filing a grievance pursuant to the procedures set forth in this article.

(3) Protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide medically necessary and appropriate health care.

(d) Nothing in this section shall:

(1) Prohibit a managed care plan from making a determination not to pay for a particular medical treatment, supply or service, enforcing reasonable peer review or utilization review protocols or making a determination that a health care provider has or has not complied with

appropriate protocols.

(2) Be construed as requiring a managed care plan to provide, reimburse for or cover counseling, referral or other health care services if the plan:

(i) objects to the provision of that service on moral or religious grounds; and

(ii) makes available information on its policies regarding such health care services to enrollees and prospective enrollees.

(c) Medical Services.

Section 2116. Emergency Services.—If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. The emergency health care provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary.

Section 2117. Continuity of Care.—(a) Except as provided under subsection (b), if a managed care plan initiates termination of its contract with a participating health care provider, an enrollee may continue an ongoing course of treatment with that health care provider at the enrollee's option for a transitional period of up to sixty (60) days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.

(b) If the plan terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the plan, the plan shall not be responsible for health care services provided to the enrollee following the date of termination.

(c) If the plan terminates the contract of a participating primary care

provider, the plan shall notify every enrollee served by that provider of the plan's termination of its contract and shall request that the enrollee select another primary care provider.

(d) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment in a managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.

(e) A plan may require a nonparticipating health care provider whose health care services are covered under this section to meet the same terms and conditions as a participating health care provider.

(f) Nothing in this section shall require a managed care plan to provide health care services that are not otherwise covered under the terms and conditions of the plan.

(d) Provider Credentialing.

Section 2121. Procedures.—(a) A managed care plan shall establish a credentialing process to enroll qualified health care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.

(b) The department shall establish credentialing standards for managed care plans. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for managed care plans.

(c) A managed care plan shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.

(d) A managed care plan shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the plan's provider network. A managed care plan shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of a managed care plan shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

(e) No managed care plan shall exclude or terminate a health care provider from participation in the plan due to any of the following:

(1) The health care provider engaged in any of the activities set forth in section 2113(c).

(2) The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.

(3) The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.

(f) If a managed care plan denies enrollment or renewal of credentials to a health care provider, the managed care plan shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.

(e) Confidentiality.

Section 2131. Confidentiality.—(a) A managed care plan and a utilization review entity shall adopt and maintain procedures to ensure that all identifiable information regarding enrollee health, diagnosis and treatment is adequately protected and remains confidential in compliance with all applicable Federal and State laws and regulations and professional ethical standards.

(b) To the extent a managed care plan maintains medical records, the plan shall adopt and maintain procedures to ensure that enrollees have timely access to their medical records unless prohibited by Federal or State law or regulation.

(c) (1) Information regarding an enrollee's health or treatment shall be available to the enrollee, the enrollee's designee or as necessary to prevent death or serious injury.

(2) Nothing in this section shall:

(i) Prevent disclosure necessary to determine coverage, review complaints or grievances, conduct utilization review or facilitate payment of a claim.

(ii) Deny the department, the Insurance Department or the Department of Public Welfare access to records for purposes of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with this article and other laws of this Commonwealth. Records shall be accessible only to department employes or agents with direct responsibilities under the provisions of this subparagraph.

(iii) Deny access to information necessary for a utilization review entity to conduct a review under this article.

(iv) Deny access to the managed care plan for internal quality review, including reviews conducted as part of the plan's quality oversight process. During such reviews, enrollees shall remain anonymous to the greatest extent possible.

(v) Deny access to managed care plans, health care providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For this purpose, enrollees shall provide consent and shall remain anonymous to the greatest extent possible.

(f) Information for Enrollees.

Section 2136. Required Disclosure.—(a) A managed care plan shall

supply each enrollee and, upon written request, each prospective enrollee or health care provider with the following written information. Such information shall be easily understandable by the layperson and shall include, but not be limited to:

(1) A description of coverage, benefits and benefit maximums, including benefit limitations and exclusions of coverage, health care services and the definition of medical necessity used by the plan in determining whether these benefits will be covered. The following statement shall be included in all marketing materials in boldface type:

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

The notice shall be followed by a telephone number to contact the plan.

(2) A description of all necessary prior authorizations or other requirements for nonemergency health care services.

(3) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, copayments, deductibles and other charges, annual limits on an enrollee's financial responsibility and caps on payments for health care services provided under the plan.

(4) An explanation of an enrollee's financial responsibility for payment when a health care service is provided by a nonparticipating health care provider, when a health care service is provided by any health care provider without required authorization or when the care rendered is not covered by the plan.

(5) A description of how the managed care plan addresses the needs of non-English-speaking enrollees.

(6) A notice of mailing addresses and telephone numbers necessary to enable an enrollee to obtain approval or authorization of a health care service or other information regarding the plan.

(7) A summary of the plan's utilization review policies and procedures.

(8) A summary of all complaint and grievance procedures used to resolve disputes between the managed care plan and an enrollee or a health care provider, including:

(i) The procedure to file a complaint or grievance as set forth in this article, including a toll-free telephone number to obtain information regarding the filing and status of a complaint or grievance.

(ii) The right to appeal a decision relating to a complaint or grievance.

(iii) The enrollee's right to designate a representative to participate in the complaint or grievance process as set forth in this article.

(iv) A notice that all disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice and that all notices of decisions will include information regarding the basis for the determination.

(9) A description of the procedure for providing emergency services twenty-four (24) hours a day. The description shall include:

(i) A definition of emergency services as set forth in this article.

(ii) Notice that emergency services are not subject to prior approval.

(iii) The enrollee's financial and other responsibilities regarding emergency services, including the receipt of these services outside the managed care plan's service area.

(10) A description of the procedures for enrollees to select a participating health care provider, including how to determine whether a participating health care provider is accepting new enrollees.

(11) A description of the procedures for changing primary care providers and specialists.

(12) A description of the procedures by which an enrollee may obtain a referral to a health care provider outside the provider network when that provider network does not include a health care provider with appropriate training and experience to meet the health care service needs of an enrollee.

(13) A description of the procedures that an enrollee with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:

(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

(14) A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at least annually.

(15) A list of the information available to enrollees or prospective enrollees, upon written request, under subsection (b).

(b) Each managed care plan shall, upon written request of an enrollee or prospective enrollee, provide the following written information:

(1) A list of the names, business addresses and official positions of the membership of the board of directors or officers of the managed care plan.

(2) The procedures adopted to protect the confidentiality of medical records and other enrollee information.

(3) A description of the credentialing process for health care providers.

(4) A list of the participating health care providers affiliated with participating hospitals.

(5) Whether a specifically identified drug is included or excluded from coverage.

(6) A description of the process by which a health care provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

(7) A description of the procedures followed by the managed care plan

to make decisions about the experimental nature of individual drugs, medical devices or treatments.

(8) A summary of the methodologies used by the managed care plan to reimburse for health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a managed care plan and a health care provider.

(9) A description of the procedures used in the managed care plan's quality assurance program.

(10) Other information as may be required by the department or the Insurance Department.

(g) Complaints.

Section 2141. Internal Complaint Process.—(a) A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan.

(b) The complaint process shall consist of an initial review to include all of the following:

(1) A review by an initial review committee consisting of one or more employes of the managed care plan.

(2) The allowance of a written or oral complaint.

(3) The allowance of written data or other information.

(4) A review or investigation of the complaint which shall be completed within thirty (30) days of receipt of the complaint.

(5) A written notification to the enrollee regarding the decision of the initial review committee within five (5) business days of the decision. Notice shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee.

(c) The complaint process shall include a second level review that includes all of the following:

(1) A review of the decision of the initial review committee by a second level review committee consisting of three or more individuals who did not participate in the initial review. At least one third of the second level review committee shall not be employed by the managed care plan.

(2) A written notification to the enrollee of the right to appear before the second level review committee.

(3) A requirement that the second level review be completed within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis for the decision and the procedure for appealing the decision to the department or the Insurance Department.

Section 2142. Appeal of Complaint.—(a) An enrollee shall have fifteen (15) days from receipt of the notice of the decision from the second level

review committee to appeal the decision to the department or the Insurance Department, as appropriate.

(b) All records from the initial review and second level review shall be transmitted to the appropriate department in the manner prescribed. The enrollee, the health care provider or the managed care plan may submit additional materials related to the complaint.

(c) The enrollee may be represented by an attorney or other individual before the appropriate department.

(d) The appropriate department shall determine whether a violation of this article has occurred and may impose any penalties authorized by this article.

Section 2143. Complaint Resolution.—Nothing in this subdivision shall prevent the department or the Insurance Department from communicating with the enrollee, the health care provider or the managed care plan as appropriate to assist in the resolution of a complaint. Such communication may occur at any time during the complaint process.

(h) Utilization Review.

Section 2151. Certification.—(a) A utilization review entity may not review health care services delivered or proposed to be delivered in this Commonwealth unless the entity is certified by the department to perform utilization review. A utilization review entity operating in this Commonwealth on or before the effective date of this article shall have one year from the effective date of this article to apply for certification.

(b) The department shall grant certification to a utilization review entity that meets the requirements of this section. Certification shall be renewed every three years unless otherwise subject to additional review, suspension or revocation by the department.

(c) The department may adopt a nationally recognized accrediting body's standards to certify utilization review entities to the extent the standards meet or exceed the standards set forth in this article.

(d) The department may prescribe application and renewal fees for certification. The fees shall reflect the administrative costs of certification and shall be deposited in the General Fund.

(e) A licensed insurer or a managed care plan with a certificate of authority shall comply with the standards and procedures of this subdivision but shall not be required to obtain separate certification as a utilization review entity.

Section 2152. Operational Standards.—(a) A utilization review entity shall do all of the following:

(1) Respond to inquiries relating to utilization review determinations by:

(i) providing toll-free telephone access at least forty (40) hours per week during normal business hours;

(ii) maintaining a telephone answering service or recording system during nonbusiness hours; and

(iii) responding to each telephone call received by the answering service

or recording system regarding a utilization review determination within one (1) business day of the receipt of the call.

(2) Protect the confidentiality of enrollee medical records as set forth in section 2131.

(3) Ensure that a health care provider is able to verify that an individual requesting information on behalf of the managed care plan is a legitimate representative of the plan.

(4) Conduct utilization reviews based on the medical necessity and appropriateness of the health care service being reviewed and provide notification within the following time frames:

(i) A prospective utilization review decision shall be communicated within two (2) business days of the receipt of all supporting information reasonably necessary to complete the review.

(ii) A concurrent utilization review decision shall be communicated within one (1) business day of the receipt of all supporting information reasonably necessary to complete the review.

(iii) A retrospective utilization review decision shall be communicated within thirty (30) days of the receipt of all supporting information reasonably necessary to complete the review.

(5) Ensure that personnel conducting a utilization review have current licenses in good standing or other required credentials, without restrictions, from the appropriate agency.

(6) Provide all decisions in writing to include the basis and clinical rationale for the decision.

(7) Notify the health care provider of additional facts or documents required to complete the utilization review within forty-eight (48) hours of receipt of the request for review.

(8) Maintain a written record of utilization review decisions adverse to enrollees for not less than three (3) years, including a detailed justification and all required notifications to the health care provider and the enrollee.

(b) Compensation to any person or entity performing utilization review may not contain incentives, direct or indirect, for the person or entity to approve or deny payment for the delivery of any health care service.

(c) Utilization review that results in a denial of payment for a health care service shall be made by a licensed physician, except as provided in subsection (d).

(d) A licensed psychologist may perform a utilization review for behavioral health care services within the psychologist's scope of practice if the psychologist's clinical experience provides sufficient experience to review that specific behavioral health care service. The use of a licensed psychologist to perform a utilization review of a behavioral health care service shall be approved by the department as part of the certification process under section 2151. A licensed psychologist shall not review the denial of payment for a health care service involving inpatient care or a prescription drug.

(i) Grievances.

Section 2161. Internal Grievance Process.—(a) A managed care plan shall establish and maintain an internal grievance process with two levels of review and an expedited internal grievance process by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service. An enrollee who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.

(b) The internal grievance process shall consist of an initial review that includes all of the following:

(1) A review by one or more persons selected by the managed care plan who did not previously participate in the decision to deny payment for the health care service.

(2) The completion of the review within thirty (30) days of receipt of the grievance.

(3) A written notification to the enrollee and health care provider regarding the decision within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure to file a request for a second level review of the decision.

(c) The grievance process shall include a second level review that includes all of the following:

(1) A review of the decision issued pursuant to subsection (b) by a second level review committee consisting of three or more persons who did not previously participate in any decision to deny payment for the health care service.

(2) A written notification to the enrollee or the health care provider of the right to appear before the second level review committee.

(3) The completion of the second level review within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee and health care provider regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure for appealing the decision.

(d) Any initial review or second level review conducted under this section shall include a licensed physician, or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service.

(e) Should the enrollee's life, health or ability to regain maximum function be in jeopardy, an expedited internal grievance process shall be available which shall include a requirement that a decision with appropriate notification to the enrollee and health care provider be made within forty-eight (48) hours of the filing of the expedited grievance.

Section 2162. External Grievance Process.—(a) A managed care plan shall establish and maintain an external grievance process by which an

enrollee or a health care provider with the written consent of the enrollee may appeal the denial of a grievance following completion of the internal grievance process. The external grievance process shall be conducted by an independent utilization review entity not directly affiliated with ~~the managed~~ care plan.

(b) To conduct external grievances filed under this section:

(1) The department shall randomly assign a utilization review entity on a rotational basis from the list maintained under subsection (d) and notify the assigned utilization review entity and the managed care ~~plan within two~~ (2) business days of receiving the request. If the department fails to select a utilization review entity under this subsection, the managed care plan shall designate and notify a certified utilization review entity ~~to conduct the~~ external grievance.

(2) The managed care plan shall notify the enrollee or health care provider of the name, address and telephone number of the utilization review entity assigned under this subsection within two (2) business days.

(c) The external grievance process shall meet all of the following requirements:

(1) Any external grievance shall be filed with the managed care plan within fifteen (15) days of receipt of a notice of denial resulting from the internal grievance process. The filing of the external grievance shall include any material justification and all reasonably necessary supporting information. Within five (5) business days of the filing of an external grievance, the managed care plan shall notify the enrollee or the health care provider, the utilization review entity that conducted the internal grievance and the department that an external grievance has been filed.

(2) The utilization review entity that conducted the internal grievance shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within fifteen (15) days of receipt of notice that the external grievance was filed. Any additional written information may be submitted by the enrollee or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.

(3) The utilization review entity conducting the external grievance ~~shall~~ review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the enrollee or the health care provider.

(4) An external grievance decision shall be made by:

(i) one or more licensed physicians or approved licensed psychologists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; or

(ii) one or more physicians currently certified by a board approved by

the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.

(5) Within sixty (60) days of the filing of the external grievance, the utilization review entity conducting the external grievance shall issue a written decision to the managed care plan, the enrollee and the health care provider, including the basis and clinical rationale for the decision. The standard of review shall be whether the health care service denied by the internal grievance process was medically necessary and appropriate under the terms of the plan. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the external grievance decision. There shall be a rebuttable presumption in favor of the decision of the utilization review entity conducting the external grievance.

(6) The managed care plan shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under paragraph (5) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.

(7) All fees and costs related to an external grievance shall be paid by the nonprevailing party if the external grievance was filed by the health care provider. The health care provider and the utilization review entity or managed care plan shall each place in escrow an amount equal to one-half of the estimated costs of the external grievance process. If the external grievance was filed by the enrollee, all fees and costs related thereto shall be paid by the managed care plan. For purposes of this paragraph, fees and costs shall not include attorney fees.

(d) The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this article. The department may remove a utilization review entity from the list if such an entity is incapable of performing its responsibilities in a reasonable manner, charges excessive fees or violates this article.

(e) A fee may be imposed by a managed care plan for filing an external grievance pursuant to this article which shall not exceed twenty-five ($25) dollars.

(f) Written contracts between managed care plans and health care providers may provide an alternative dispute resolution system to the external grievance process set forth in this article if the department approves the contract. The alternative dispute resolution system shall be impartial, include specific time limitations to initiate appeals, receive written information, conduct hearings and render decisions and otherwise satisfy the requirements of this section. A written decision pursuant to an alternative dispute resolution system shall be final and binding on all parties. An alternative dispute resolution system shall not be utilized for any external grievance filed by an enrollee.

Section 2163. Records.—Records regarding grievances filed under this subdivision that result in decisions adverse to enrollees shall be maintained by the plan for not less than three (3) years. These records shall be provided to the department, if requested, in accordance with section 2131(c)(2)(ii).

(j) Prompt Payment.

Section 2166. Prompt Payment of Claims.—(a) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

(b) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars.

(k) Health Care Provider and Managed Care Plan Protection.

Section 2171. Health Care Provider and Managed Care Plan Protection.—(a) A managed care plan shall not exclude, discriminate against or penalize any health care provider for its refusal to allow, perform, participate in or refer for health care services when the refusal of the health care provider is based on moral or religious grounds and that provider makes adequate information available to enrollees or, if applicable, prospective enrollees.

(b) No public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan or operating, expanding or improving an existing plan because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other plans when the refusal is based on moral or religious grounds.

(l) Enforcement.

Section 2181. Departmental Powers and Duties.—(a) The department shall require that records and documents submitted to a managed care plan or utilization review entity as part of any complaint or grievance be made available to the department, upon request, for purposes of enforcement or compliance with this article.

(b) The department shall compile data received from a managed care plan on an annual basis regarding the number, type and disposition of complaints and grievances filed with a managed care plan under this article.

(c) The department shall issue guidelines identifying those provisions of this article that exceed or are not included in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance. These guidelines shall be published in

the Pennsylvania Bulletin and updated as necessary. Copies of the guidelines shall be made available to managed care plans, health care providers and enrollees upon request.

(d) The department and the Insurance Department shall ensure compliance with this article. The appropriate department shall investigate potential violations of the article based upon information received from enrollees, health care providers and other sources in order to ensure compliance with this article.

(e) The department and the Insurance Department shall promulgate such regulations as may be necessary to carry out the provisions of this article.

(f) The department in cooperation with the Insurance Department shall submit an annual report to the General Assembly regarding the implementation, operation and enforcement of this article.

Section 2182. Penalties and Sanctions.—(a) The department or the Insurance Department, as appropriate, may impose a civil penalty of up to five thousand ($5,000) dollars for a violation of this article.

(b) A managed care plan shall be subject to the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

(c) The department or the Insurance Department may maintain an action in the name of the Commonwealth for an injunction to prohibit any activity which violates the provisions of this article.

(d) The department may issue an order temporarily prohibiting a managed care plan which violates this article from enrolling new members.

(e) The department may require a managed care plan to develop and adhere to a plan of correction approved by the department. The department shall monitor compliance with the plan of correction. The plan of correction shall be available to enrollees of the managed care plan upon request.

(f) In no event shall the department and the Insurance Department impose a penalty for the same violation.

Section 2183. Administrative Review.—The provisions of this article shall be subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies).

(m) Miscellaneous.

Section 2191. Compliance with National Accrediting Standards.—Notwithstanding any other provision of this article to the contrary, the department shall give consideration to a managed care plan's demonstrated compliance with the standards and requirements set forth in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance or other department-approved quality review organizations in determining compliance with the same or similar provisions of this article. The managed care plan, however, shall remain subject to and shall comply with any other provisions of this article that exceed or are not included in the standards

of the National Committee for Quality Assurance or other department-approved quality review organizations.

Section 2192. Exceptions.—This article shall not apply to any of the following:

(1) The act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act."

(2) The act of July 1, 1937 (P.L.2532, No.470), known as the "Workers' Compensation Security Fund Act."

(3) Peer review, utilization review or mental or physical examinations performed under 75 Pa.C.S. Ch. 17 (relating to financial responsibility).

(4) The fee-for-service programs operated by the Department of Public Welfare under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

Section 2193. Preemption.—Nothing in this article shall regulate or authorize regulation which would be ineffective by reason of the State law preemption provisions of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

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) All 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 over 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) Over one-third 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 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.

"Children's Medical Assistance." Medical assistance services to children as required under Title XIV of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), including EPSDT services.

"Contractor." An entity 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).

"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."

"Genetic status." The presence of a physical condition in an individual which is a result of an inherited trait.

"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).

"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." Any insurance company, association, reciprocal, nonprofit hospital plan corporation, nonprofit professional health service plan, health maintenance organization, fraternal benefits society or a risk-bearing PPO or nonrisk-bearing PPO not governed and regulated under the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.).

"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.

"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 a health insurance plan 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) The fund shall be dedicated exclusively for distribution by the Insurance Department through contracts in order to provide free and subsidized health care services under this section and to develop and implement outreach activities required under section 2312.

(b) (1) The fund shall be used to fund health care services for children as specified in this section. The Insurance Department shall assure that the program is implemented Statewide. All contracts awarded under this section shall be awarded through a competitive procurement process. The Insurance Department shall use its best efforts to ensure that eligible children across this Commonwealth have access to health care services to be provided under this article.

(2) No more than seven and one-half per centum (7 1/2%) of the amount of the contract may be used for administrative expenses of the contractor. If after the first three (3) full years of operation any contractor presents documented evidence that administrative expenses are in excess of seven and one-half per centum (7 1/2%) of the amount of the contract, the Insurance Department may make an additional allotment of funds, not to exceed two and one-half per centum (2 1/2%) of the amount of the contract, for future administrative expenses to the contractor to the extent that the Insurance Department finds the expenses reasonable and necessary.

(3) No less than seventy per centum (70%) of the fund shall be used to provide the health care services provided under this article for children eligible for free care under subsection (d). When the Insurance Department determines that seventy per centum (70%) of the fund is not needed in order to achieve maximum enrollment of children eligible for free care and promulgates a final form regulation with proposed rulemaking omitted, this paragraph shall expire.

(4) To ensure that inpatient hospital care is provided to eligible children, each primary care physician providing primary care services shall make necessary arrangements for admission to the hospital and for necessary specialty care.

(c) (1) Any organization or corporation receiving funds from the Insurance 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) Except for newborns, has been a resident of this Commonwealth for at least thirty (30) days prior to enrollment.

(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.

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

(iv) Meets the citizenship requirements of the Medicaid program administered by the Department of Public Welfare.

(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 under nineteen (19) years of age 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 who is under nineteen (19) years of age and whose family income is greater than two hundred per centum (200%) of the Federal poverty level but no greater than two hundred thirty-five per centum (235%) of the Federal poverty level may be subsidized by the fund at a rate not to exceed fifty per centum (50%).

(2) The difference between the pure premium of the minimum benefit package in subsection (l)(6) and the subsidy provided under this subsection shall be the amount paid by the family of the eligible child purchasing the minimum benefit package.

(f) The family of an eligible child whose family income makes the child eligible for free or subsidized care but who cannot receive care due to lack of funds in the fund may purchase coverage for the child at cost.

(g) The Insurance 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 fiscal year outlining primary health services funded for the year, detailing the outreach and enrollment efforts and reporting by county the number of children receiving health care services from the fund, the projected number of eligible children and the number of eligible children on waiting lists for health care services.

(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 Insurance Department may promulgate regulations necessary for the implementation and administration of this subdivision.

(i) The Children's Health Advisory Council is established within the Insurance 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 the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act," unless otherwise provided in this section. The council shall meet at least annually 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 Insurance Department.

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

(j) The Insurance 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 entities that contract with providers to provide primary care services for enrollees on a cost-effective basis. The Insurance Department shall require contractors to use appropriate cost-management methods so that the fund can be used to provide the basic primary benefit services 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 Insurance Department shall require that any contractor comply with all procedures relating to coordination of benefits as required by the Insurance Department or the Department of Public Welfare.

(3) Contracts may be for a term of up to three (3) years.

(k) Upon receipt of a request for proposal from the Insurance Department, each health plan corporation or its entities doing business in this Commonwealth shall submit a bid to the Insurance Department to carry out the purposes of this section in the area serviced by the corporation.

(l) A contractor with whom the Insurance 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 on an equitable Statewide basis.

(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, including, at a minimum, written notice of the telephone number and address of the county assistance office where the family can apply 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.

(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 payment under the fund but who qualify for medical assistance.

(6) 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.

(7) 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 Insurance 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 Insurance Department in consultation with appropriate Commonwealth agencies shall review enrollment patterns for both the free insurance program and the subsidized insurance program. The Insurance 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 Insurance 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, nor shall the maximum income ceiling for subsidized insurance be raised above two hundred thirty-five per centum (235%) of the Federal poverty level. Changes in the maximum income ceiling shall be promulgated as a final-form regulation with proposed rulemaking omitted in accordance with the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

Section 2312. Outreach.—(a) The Insurance 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 Insurance Department, in cooperation with the Department of Public Welfare, shall determine that no 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 Insurance Department shall reevaluate the child's eligibility under section 2311.

(c) through (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 2. All entities receiving grants under the act of December 2, 1992 (P.L.741, No.113), known as the Children's Health Care Act, on the effective date of this section shall continue to receive funds and provide services as required under that act until notice is received from the Insurance Department.

Section 3. The following acts and parts of acts are repealed:

(1) Act of June 5, 1968 (P.L.140, No.78), entitled "An act regulating the writing, cancellation of or refusal to renew policies of automobile insurance; and imposing powers and duties on the Insurance Commissioner therefor."

(2) Sections 102, 701, 702, 703, 3101, 3102, 3103 and 3105 of the act of December 2, 1992 (P.L.741, No.113), known as the Children's Health Care Act.

Section 4. This act shall take effect as follows:

(1) The addition of Article XXI of the act shall take effect January 1, 1999.

(2) The following provisions shall take effect in 60 days:

(i) The addition of Article XX of the act.

(ii) Section 3(1) of this act.

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

APPROVED—The 17th day of June, A.D. 1998.

THOMAS J. RIDGE