No. 2006-136

AN ACT

HB 2699

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," further providing, in health care insurance individual accessibility, for expiration; providing, in quality health care accountability, for managed care plans participating in the medical assistance program; further providing, in children's health care, for legislative findings and intent, for definitions, for free and subsidized health care, for outreach and for payor of last resort and insurance coverage; and providing, in children's health care, for Federal waivers and for expiration.

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

Section 1. Section 1012-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, amended December 23, 2003 (P.L.358, No.50), is amended to read:

[Section 1012-A. Expiration.—This article shall expire on December 31, 2006.]

Section 2. The act is amended by adding a section to read:

Section 2194. Managed Care Plans Participating in the Medical Assistance Program.—(a) The General Assembly finds that:

(1) Accessibility to health care services received by participants in the Commonwealth's medical assistance program must be maintained throughout this Commonwealth.

(2) The quality and continuity of these services must be assured in a manner that responsibly and effectively controls medical assistance costs.

(3) Managed care plans contracting with the Department of Public Welfare for purposes of participation in the medical assistance program have developed across this Commonwealth and provide vital health care services, including pharmaceuticals, to the medical assistance population of this Commonwealth.

(4) A review of the delivery of services provided by these managed care plans is necessary to enable the Department of Public Welfare, in consultation with the department, to formulate a strategy that properly utilizes cost control mechanisms that produce available savings to the Commonwealth if an effective and responsive health care network is to be maintained across this Commonwealth, especially due to continuing changes at the Federal level.

(b) The Legislative Budget and Finance Committee shall conduct a review of and issue a report on the delivery and quality of health care services provided through the current fee-for-service program as well as by managed care plans participating in the Commonwealth's medical assistance program. The report shall include the following for each service delivery system:

(1) Information regarding the number of medical assistance participants per service per county, separated by those served and those denied.

(2) The total cost or savings accrued to the Commonwealth itemized by county per service provided, including pharmaceuticals.

(3) Recommendations for revisions in practices used by the Department of Public Welfare to contract and provide for all health care services available through the medical assistance program.

(4) Any other recommendations that will promote medical assistance program savings.

(c) The Department of Public Welfare and all other affected State agencies shall cooperate fully with the Legislative Budget and Finance Committee in providing any and all information necessary to conduct its review and prepare its report.

(d) The Legislative Budget and Finance Committee shall report its findings and recommendations no later than March 1, 2007, to the Governor, the Secretary of Public Welfare, the Insurance Commissioner, the chairman and minority chairman of the Public Health and Welfare Committee of the Senate, the chairman and minority chairman of the Health and Human Services Committee of the House of Representatives, the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives.

(e) For purposes of this section, "medical assistance" shall be defined as 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."

Section 3. Sections 2302, 2303, 2311, 2312 and 2313 of the act, added June 17, 1998 (P.L.464, No.68), are amended to read:

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

(1) **[All citizens]** ***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]** ***approximately*** one million persons and many thousands more lack adequate insurance coverage. It is also estimated that approximately two-thirds of the uninsured are employed or dependents of employed persons.

(3) **[Over one-third]** ***Approximately fifteen per centum (15%)*** of the uninsured health care population are children. Uninsured children are of particular concern because of their need for ongoing preventive and primary care. Measures not taken to care for such children now will result in higher human and financial costs later.

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

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

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

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

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

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

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

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

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

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

"Department." The Insurance Department of the Commonwealth.

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

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

["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).

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

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

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

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

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

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

["Insurer." 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.).]

"Insurer." A health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or

subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under this act or any of the following:

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

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).[1]

(4) Article XXIV.[2]

"MAAC." The Medical Assistance Advisory Committee.

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

"MCH." Maternal and Child Health.

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

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

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

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

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

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

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

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[1] "(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations) or 65 (relating to fraternal benefit societies)." in enrolled bill. Chapter 65 is repealed, and the subject matter is now contained in Article XXIV of The Insurance Company Law of 1921.

[2] "(4) Article XXIV." omitted in enrolled bill.

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

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

"Terminate." Includes cancellation, nonrenewal and rescission.

"Uninsured period." Except for children two years of age or less, a continuous period of time of not less than six (6) consecutive months immediately preceding enrollment during which a child has been without health care insurance coverage in accordance with the requirements of this article.

"Waiting period." A period of time after the effective date of enrollment during which **[a health insurance plan]** ***an insurer*** excludes coverage for the diagnosis or treatment of one or more medical conditions.

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

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

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

[(b) (1)] ***(2)*** The fund, ***along with Federal, State and other money available for the program,*** shall be used **[to fund]** ***for*** health care **[services]** ***coverage*** for children as specified in this section. The **[Insurance Department]** ***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]** ***department and the Department of Public Welfare shall use their*** best efforts to ensure that eligible children across this Commonwealth have access to health care services to be provided under this article.

[(2)] ***(3)*** No more than **[seven and one-half per centum (7 1/2%)]** ***ten per centum (10%)*** 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 ***for purposes of expanded outreach and systems and operational changes*** are in excess of **[seven and one-half per centum (7 1/2%)]** ***ten per centum (10%)*** of the amount of the contract, the **[Insurance Department may]** ***department shall*** make an additional

allotment of funds, not to exceed **[two and one-half per centum (2 1/2%)]** ***two per centum (2%)*** of the amount of the contract, **[for future administrative expenses]** to the contractor to the extent that the **[Insurance Department]** ***department*** finds the expenses reasonable and necessary.

[(3)] ***(4)*** No less than **[seventy per centum (70%)]** ***eighty-four per centum (84%)*** of the **[fund]** ***contract*** shall be used to provide the health care services provided under this article for children eligible for **[free]** care under **[subsection (d)]** ***this article***. **[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)] ***(5)*** To ensure that inpatient hospital care is provided to eligible children, each primary care **[physician providing]** ***provider furnishing*** primary care services shall make necessary arrangements for admission to the hospital and for necessary specialty care.

(c) (1) Any **[organization or corporation]** ***insurer*** receiving funds from the **[Insurance Department]** ***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]** ***Is*** 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, ***including the Healthy Beginnings Program.***

(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.]** ***Title XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1397aa et seq.).***

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

(i) Is a resident of this Commonwealth.

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

(iii) Is qualified based on income under subsection (d), (e.1), (e.2), (e.3) or (e.4) and meets the uninsured period requirements as provided in subsection (f.1).

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

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

(d) The provision of health care insurance for eligible children shall be free to a child **[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.]

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

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

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

(e.4) The following apply:

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

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

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

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

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

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

(f.1) To be eligible for coverage under subsections (e.1), (e.2), (e.3) and (e.4), a child over two (2) years of age must have been uninsured for the uninsured period unless:

(1) the child's parent is eligible to receive benefits pursuant to the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the "Unemployment Compensation Law";

(2) the child's parent was covered by a health insurance plan, a self-insurance plan or a self-funded plan but, at the time of application for coverage, is no longer employed and is ineligible to receive benefits under the "Unemployment Compensation Law"; or

(3) a child is transferring from one government-subsidized health care program to another.

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

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

(i) Outpatient visits.

(ii) Emergency room visits.

(iii) Prescription medications.

(iv) Any other service defined by the department.

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

(g) The **[Insurance Department]** *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]** ***calendar*** year ***no later than March 1*** outlining primary health services funded for the year, detailing the outreach and enrollment efforts and reporting by ***number of children by*** county ***and by per centum of the Federal poverty level,*** the number of children receiving health care services **[from the fund,]**; ***by county and by per centum of the Federal poverty level,*** the projected number of eligible children; and the number of eligible children on waiting lists for **[health care services]** ***enrollment in the health insurance program established under this act by county and by per centum of the Federal poverty level.***

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

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

(h) The **[Insurance Department]** ***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]** ***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,"]** ***65 Pa.C.S. Ch. 7 (relating to open meetings)*** 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]** ***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]** ***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]** ***insurers*** that contract with providers to provide primary care services for enrollees on a cost-effective basis. The **[Insurance Department]** ***department*** shall require contractors to use appropriate cost-management methods so that **[the fund can be used to provide the]** basic primary benefit services ***can be provided*** to the maximum number of eligible children and, whenever possible, to pursue and utilize available public and private funds.

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

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

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

(l) A contractor with whom the **[Insurance Department]** ***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]** ***within the contractor's service area.***

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

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

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

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

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

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

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

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

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

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

(iv) Emergency accident and emergency medical care.

(v) Prescription drugs.

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

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

(viii) Emergency, preventive and routine hearing care.

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

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

requirements, employer-based coverage may be purchased in place of enrollment in the health insurance program established under this subdivision. An insurer shall honor a request for enrollment and purchase of employe group health insurance requested on behalf of an individual applying for coverage under this article if that individual:

(i) is a resident of this Commonwealth;

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

(iii) meets the uninsured period, except that any delay due to an enrollment restriction, which may not exceed ninety (90) days, or due to the length of the department's cost effectiveness determination shall be counted towards calculating the uninsured period; and

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

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

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

(m) The **[Insurance Department]** ***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]** ***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]** ***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]** ***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."]**

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

Section 2312. Outreach.—(a) The **[Insurance Department]** ***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]** ***department***, in cooperation with the Department of Public Welfare, shall determine **[that no]** ***if any*** other insurance coverage is available to the child through a custodial or noncustodial parent on an employment-related or other group basis. If such insurance coverage is available, the **[Insurance Department shall reevaluate the]** child's eligibility under section 2311**[.]** ***shall be reevaluated, as shall the most cost-effective means of providing coverage for that child.***

Section 4. The act is amended by adding sections to read:

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

Section 2362. Expiration.—This article shall expire December 31, 2010.

Section 5. When the department receives Federal approval of the State plan amendments requested under section 2314 of the act, it shall transmit notice of that fact to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

Section 6. This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) The amendment of section 1012-A of the act.

(ii) The addition of section 2194 of the act.

(iii) The addition of section 2314 of the act.

(iv) The addition of section 2362 of the act.

(v) Section 5 of this act.

(vi) This section.

(2) The remainder of this act shall take effect on the later of:

(i) 30 days after the date of publication of the notice under section 5 of this act; or

(ii) January 1, 2007.

APPROVED—The 2nd day of November, A.D. 2006.

EDWARD G. RENDELL