SENATE AMENDED
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**THE GENERAL ASSEMBLY OF PENNSYLVANIA**

# HOUSE BILL

## No. 2699 Session of 2006

INTRODUCED BY KENNEY, OLIVER, WATSON, ROSS, BEBKO-JONES, BISHOP, JAMES, KIRKLAND, MYERS, WATERS, ADOLPH, BARRAR, BLACKWELL, BOYD, BUXTON, CALTAGIRONE, CIVERA, COHEN, COSTA, CRAHALLA, CRUZ, DALLY, DERMODY, FABRIZIO, GANNON, GEORGE, GILLESPIE, GODSHALL, GOODMAN, HARHART, HENNESSEY, W. KELLER, KILLION, LEACH, LEDERER, LEVDANSKY, MACKERETH, MAHER, MAITLAND, MANN, McGEEHAN, MICOZZIE, O'BRIEN, PARKER, PETRONE, PHILLIPS, QUIGLEY, RAYMOND, ROEBUCK, RUBLEY, SABATINA, SHAPIRO, SIPTROTH, T. STEVENSON, E. Z. TAYLOR, J. TAYLOR, THOMAS, TIGUE, TRUE, WILLIAMS, YUDICHAK, O'NEILL, SATHER, CORNELL, BENNINGHOFF, PISTELLA, SONNEY, YOUNGBLOOD, BEYER, GINGRICH, McILHINNEY AND PETRI, JUNE 6, 2006

AS AMENDED ON THIRD CONSIDERATION, IN SENATE, OCTOBER 23, 2006

AN ACT

1 ~~Authorizing and directing the Department of Public Welfare to~~ <--
2 ~~establish and maintain a managed health care program for~~
3 ~~medical assistance recipients; requiring actuarially sound~~
4 ~~rates for certain managed care organizations; providing for~~
5 ~~the right of appeal and approval by the General Assembly of~~
6 ~~changes to the Commonwealth medical assistance plan and~~
7 ~~associated waivers; and repealing inconsistent portions of~~
8 ~~other acts.~~
9 AMENDING THE ACT OF MAY 17, 1921 (P.L.682, NO.284), ENTITLED "AN <--
10 ACT RELATING TO INSURANCE; AMENDING, REVISING, AND
11 CONSOLIDATING THE LAW PROVIDING FOR THE INCORPORATION OF
12 INSURANCE COMPANIES, AND THE REGULATION, SUPERVISION, AND
13 PROTECTION OF HOME AND FOREIGN INSURANCE COMPANIES, LLOYDS
14 ASSOCIATIONS, RECIPROCAL AND INTER-INSURANCE EXCHANGES, AND
15 FIRE INSURANCE RATING BUREAUS, AND THE REGULATION AND
16 SUPERVISION OF INSURANCE CARRIED BY SUCH COMPANIES,
17 ASSOCIATIONS, AND EXCHANGES, INCLUDING INSURANCE CARRIED BY
18 THE STATE WORKMEN'S INSURANCE FUND; PROVIDING PENALTIES; AND
19 REPEALING EXISTING LAWS," FURTHER PROVIDING, IN HEALTH CARE
20 INSURANCE INDIVIDUAL ACCESSIBILITY, FOR EXPIRATION;
21 PROVIDING, IN QUALITY HEALTH CARE ACCOUNTABILITY, FOR MANAGED
22 CARE PLANS PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM;
23 FURTHER PROVIDING, IN CHILDREN'S HEALTH CARE, FOR LEGISLATIVE

1 FINDINGS AND INTENT, FOR DEFINITIONS, FOR FREE AND SUBSIDIZED
2 HEALTH CARE, FOR OUTREACH AND FOR PAYOR OF LAST RESORT AND
3 INSURANCE COVERAGE; AND PROVIDING, IN CHILDREN'S HEALTH CARE,
4 FOR FEDERAL WAIVERS AND FOR EXPIRATION.

5 The General Assembly of the Commonwealth of Pennsylvania
6 hereby enacts as follows:
7 ~~Section 1. Short title.~~ <--

8 ~~This act shall be known and may be cited as the Health~~
9 ~~Choices Act.~~
10 ~~Section 2. Legislative intent.~~
11 ~~It is the intent of the General Assembly to:~~
12 ~~(1) Improve the accessibility, continuity and quality of~~
13 ~~health care services for participants in the Commonwealth's~~
14 ~~medical assistance program, while responsibly controlling~~
15 ~~program costs.~~
16 ~~(2) Establish a process for the establishment and~~
17 ~~maintenance of a program to manage the care of participants~~
18 ~~in the medical assistance program.~~
19 ~~(3) Ensure that managed care organizations serving~~
20 ~~medical assistance recipients receive compensation that is~~
21 ~~actuarially sound and otherwise compliant with Federal and~~
22 ~~Commonwealth statutes and regulations and that is determined~~
23 ~~through a transparent process.~~
24 ~~(4) Provide for legislative approval of certain~~
25 ~~amendments to the Commonwealth State plan for the medical~~
26 ~~assistance program.~~
27 ~~(5) Establish procedures by which managed care~~
28 ~~organizations may appeal decisions made by the Department of~~
29 ~~Public Welfare with respect to the calculation of capitation~~
30 ~~rates and payments and other contractual provisions.~~
31 ~~Section 3. Definitions.~~

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1 ~~The following words and phrases when used in this act shall~~
2 ~~have the meanings given to them in this section unless the~~
3 ~~context clearly indicates otherwise:~~
4 ~~"Actuarial standards board." The body established by the~~
5 ~~American Academy of Actuaries to promulgate actuarial standards~~
6 ~~of practice.~~
7 ~~"Actuarially sound rates." With respect to the health~~
8 ~~choices program, capitation rates which:~~
9 ~~(1) Are adequate to cover the reasonably expected~~
10 ~~medical, administrative and assessment expenses, and a~~
11 ~~reasonable level of profit or contingency, associated with~~
12 ~~the fulfillment of a contractor's obligations in the~~
13 ~~applicable contract year.~~
14 ~~(2) Make provision for assumed expense levels, for all~~
15 ~~expenses, that are reasonably attainable by all contractors~~
16 ~~in each geographic zone in the contract year, based primarily~~
17 ~~on the actual expense experience of such contractor during~~
18 ~~prior years and expenses actually expected to be incurred in~~
19 ~~the applicable contract year.~~
20 ~~(3) Are based on assumptions that represent the most~~
21 ~~likely outcomes for costs and utilization expected within the~~
22 ~~range of assumptions developed for the populations and~~
23 ~~benefits covered in each geographic zone.~~
24 ~~(4) Are compliant with all applicable standards,~~
25 ~~statutes, rules and regulations governing the development of~~
26 ~~such rates.~~
27 ~~(5) Are based on methods, considerations and analyses~~
28 ~~that conform to applicable guidelines promulgated by the~~
29 ~~actuarial standards board.~~
30 ~~"Capitation." A fee the Department of Public Welfare~~

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1 ~~periodically pays to a contractor for each recipient enrolled~~
2 ~~under a contract for the provision of medical services, whether~~
3 ~~or not the recipient receives the services during the period~~
4 ~~covered by the fee.~~
5 ~~"CMS." The Centers for Medicare and Medicaid Services of the~~
6 ~~United States Department of Health and Human Services and such~~
7 ~~successor entities which may from time to time discharge the~~
8 ~~duties of CMS with respect to the medical assistance program.~~
9 ~~"Contractor." A managed care organization providing managed~~
10 ~~care services relating to medical care provided to recipients~~

11 ~~under one or more contracts with the Department of Public~~
12 ~~Welfare pursuant to the health choices program. This term shall~~
13 ~~also refer to a managed care organization seeking to enter into~~
14 ~~a contract with the Department of Public Welfare to provide~~
15 ~~services under health choices program.~~
16 ~~"Department." The Department of Public Welfare of the~~
17 ~~Commonwealth.~~
18 ~~"HIPAA." The Health Insurance Portability and Accountability~~
19 ~~Act of 1996 (Public Law 104-191, 110 Stat. 1936) and regulations~~
20 ~~promulgated thereunder.~~
21 ~~"In plan services." Services included in the medical~~
22 ~~assistance program pursuant to the State plan.~~
23 ~~"Managed care organization." A public or private~~
24 ~~organization that is a federally qualified health maintenance~~
25 ~~organization or meets the State plan's definition of a health~~
26 ~~maintenance organization or otherwise qualifies as a managed~~
27 ~~care plan as defined in Article XXI of the act of May 17, 1921~~
28 ~~(P.L.682, No.284), known as The Insurance Company Law of 1921.~~
29 ~~"Medical assistance." The Commonwealth program authorized by~~
30 ~~Subchapter XIX of the Social Security Act (49 Stat. 620, 42~~

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1 ~~U.S.C. 1396 et seq.), known as Medicaid and authorized in this~~
2 ~~Commonwealth under the act of June 13, 1967 (P.L.31, No.21),~~
3 ~~known as the Public Welfare Code, and subject to regulations~~
4 ~~promulgated under such statutes. The term shall also refer to~~
5 ~~any successor program implemented by either the Federal~~
6 ~~Government or the Commonwealth, to the extent a contractor is~~
7 ~~providing services contemplated in this act with respect to such~~
8 ~~program.~~
9 ~~"Program." The Commonwealth's health choices program, as~~
10 ~~provided for in this act, which provides mandatory managed~~
11 ~~health care to recipients in specified areas of this~~
12 ~~Commonwealth through contracts with managed care organizations.~~
13 ~~"Program change." Amendments, revisions or additions to the~~
14 ~~Department of Public Welfare's medical assistance fee schedule,~~
15 ~~State plan or to Federal or Commonwealth regulations, laws,~~
16 ~~guidelines, waivers or policies, insofar as they affect the~~
17 ~~scope or nature of benefits available to eligible persons.~~
18 ~~"Recipient." An individual eligible to receive health care~~
19 ~~or health related services under the medical assistance program.~~
20 ~~"State plan." The document prepared by the Commonwealth in~~
21 ~~the manner required by section 1396a(a) of the Social Security~~
22 ~~Act (49 Stat. 620, 42 U.S.C. § 1396a(a)), as approved by the~~
23 ~~Centers for Medicare and Medicaid Services, that describes the~~
24 ~~nature, scope and operation of the medical assistance program~~
25 ~~and gives assurances that the Commonwealth will administer the~~
26 ~~program in compliance with Federal requirements. The term shall~~
27 ~~also include waivers granted by the Centers for Medicare and~~
28 ~~Medicaid Services not otherwise included in the plan submitted~~
29 ~~by the Commonwealth for Centers for Medicare and Medicaid~~
30 ~~Services approval.~~

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1 ~~"Waiver." A determination made by the Centers for Medicare~~
2 ~~and Medicaid Services under Subchapter XIX of the Social~~
3 ~~Security Act (49 Stat. 620, 42 U.S.C. 1396 et seq.), known as~~
4 ~~Medicaid, and regulations promulgated thereunder, which allows~~
5 ~~the Commonwealth to make modifications in its operation of the~~
6 ~~medical assistance program.~~
7 ~~"Zone." A geographic area, designated as provided in this~~
8 ~~act, within which contractors provide services to recipients.~~
9 ~~Section 4. General provisions regarding program.~~
10 ~~(a) Administration. The Commonwealth, acting by and through~~
11 ~~the department, shall implement and administer the program in~~
12 ~~all areas of this Commonwealth as provided in this act.~~
13 ~~(b) Replacing other law as the means for providing~~
14 ~~assistance. The program shall require the provision of all~~
15 ~~medical assistance covered medical benefits in the amount,~~

16 ~~duration and scope set forth in the act of June 13, 1967~~
17 ~~(P.L.31, No.21), known as the Public Welfare Code, for~~
18 ~~recipients in the following categories:~~
19 ~~(1) Supplemental Security Income.~~
20 ~~(2) Temporary assistance for needy families.~~
21 ~~(3) Healthy beginnings.~~
22 ~~(4) General assistance.~~
23 ~~(5) Successors to the categories listed in paragraphs~~
24 ~~(1), (2), (3) and (4).~~
25 ~~(c) Exclusion. Recipients residing in long term care~~
26 ~~facilities, residential facilities and Commonwealth facilities,~~
27 ~~other than State operated intermediate care facilities for the~~
28 ~~mentally retarded, shall be excluded from participation in the~~
29 ~~program.~~
30 ~~(d) Adding or removing optional benefits. The department~~



1 ~~may amend the State plan to add or remove optional medical~~
2 ~~assistance benefits which are not required by this act, the~~
3 ~~Public Welfare Code, other acts of the General Assembly or by~~
4 ~~Subchapter XIX of the Social Security Act (49 Stat. 620, 42~~
5 ~~U.S.C. 1396 et seq.), known as Medicaid, and regulations~~
6 ~~promulgated thereunder to be provided by the Commonwealth to~~
7 ~~recipients, with the exception of pharmaceutical services, which~~
8 ~~shall remain a covered benefit under the program and provided by~~
9 ~~contracts with managed care contractors.~~
10 ~~(e) Mandatory participation exclusion.--Notwithstanding the~~
11 ~~provisions of subsection (b), the department may exclude~~
12 ~~recipients from mandatory participation in the program as a~~
13 ~~result of:~~
14 ~~(1) Determination by the department that the recipient~~
15 ~~is eligible for the Commonwealth's health insurance premium~~
16 ~~payment program.~~
17 ~~(2) The recipient becoming ventilator dependent in an~~
18 ~~acute or rehabilitation hospital for more than 30 consecutive~~
19 ~~days.~~
20 ~~(3) The recipient's enrollment in the Department of~~
21 ~~Aging waiver.~~
22 ~~(4) The recipient's enrollment in the Michael Dallas~~
23 ~~Model waiver.~~
24 ~~(f) Alternative services. Contracts executed by and between~~
25 ~~the department and contractors shall allow contractors to~~
26 ~~provide supplemental and cost effective alternative services to~~
27 ~~recipients in lieu of or in addition to in plan services and to~~
28 ~~take other measures which in the contractor's judgment promote~~
29 ~~quality of care or efficiency, and the process established in~~
30 ~~this act for determination of actuarially sound capitation rates~~



1 ~~shall take the effect of such supplemental and cost effective~~
2 ~~alternative services and other measures into account.~~
3 ~~(g) Allocation of responsibility. Contracts executed by and~~
4 ~~between the department and contractors may provide for the~~
5 ~~allocation of responsibility to provide health care services~~
6 ~~between physical and behavioral health care among contractors.~~
7 ~~Section 5. Program administration.~~
8 ~~(a) Zones. The department shall administer the program for~~
9 ~~both physical health care and behavioral health care in the~~
10 ~~following areas of this Commonwealth, incorporating the~~
11 ~~provisions of this act:~~
12 ~~(1) Southeast zone: Bucks, Chester, Delaware, Montgomery~~
13 ~~and Philadelphia Counties.~~
14 ~~(2) Southwest zone: Allegheny, Armstrong, Beaver,~~
15 ~~Butler, Fayette, Greene, Indiana, Lawrence, Washington and~~
16 ~~Westmoreland Counties.~~
17 ~~(3) Lehigh and Capital zone: Adams, Berks, Cumberland,~~
18 ~~Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and~~
19 ~~York Counties.~~
20 ~~(4) Other zones: Other counties, or groupings of~~

21 ~~counties, which are covered by program contracts in effect as~~
22 ~~of the effective date of this section by and between the~~
23 ~~department and contractors which provide for the provision of~~
24 ~~behavioral health care services to recipients residing in~~
25 ~~such counties.~~
26 ~~(b) Designation. Within 120 days of the effective date of~~
27 ~~this section, the department shall designate groupings of~~
28 ~~counties not included in the groupings described in subsection~~
29 ~~(a) as zones for expansion of the program to counties of this~~
30 ~~Commonwealth not covered by the program. Such determination~~

1 ~~shall be based upon factors, including, but not limited to:~~
2 ~~(1) Population, in terms both of the total number of~~
3 ~~people who live in an area, and population density, as well~~
4 ~~as the number of current and anticipated recipients.~~
5 ~~(2) Multicounty arrangements created under the act of~~
6 ~~October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the~~
7 ~~Mental Health and Mental Retardation Act of 1966, operating~~
8 ~~under other statutes relating to the provision of human~~
9 ~~services or cooperating in contracting with the Commonwealth~~
10 ~~or in the operation of human services programs.~~
11 ~~(3) The department's regions.~~
12 ~~(4) Constraints imposed by geography, transportation and~~
13 ~~health care provider systems.~~
14 ~~(5) Relationships among consumers and providers.~~
15 ~~(6) Managed care organization service areas.~~
16 ~~(c) Residents of seventh or eighth class counties. The~~
17 ~~department may exclude recipients residing in a county of the~~
18 ~~seventh or eighth class, as such classifications are established~~
19 ~~under the act of August 9, 1955 (P.L.323, No.130), known as The~~
20 ~~County Code, from participation in the program upon making a~~
21 ~~finding that population density, availability of providers or~~
22 ~~other factors make inclusion of such recipients in the program~~
23 ~~impracticable.~~
24 ~~Section 6. Program expansion.~~
25 ~~(a) Responsibilities of department.--Within 270 days of the~~
26 ~~effective date of this section, the department shall:~~
27 ~~(1) Issue one or more requests for proposals for the~~
28 ~~expansion of the program to all counties of this Commonwealth~~
29 ~~not covered by one or more program contracts for physical~~
30 ~~health care at that time, based upon the zones created~~

1 ~~pursuant to section 5.~~
2 ~~(2) Review and evaluate responses from managed care~~
3 ~~organizations to the requests for proposals issued pursuant~~
4 ~~to paragraph (1), in accordance with applicable Federal and~~
5 ~~Commonwealth laws and regulations.~~
6 ~~(3) Select contractors for each zone into which the~~
7 ~~program is to be expanded in accordance with the provisions~~
8 ~~of section 7 and this section. The contractors having the~~
9 ~~responsibility to provide services for the benefit of all~~
10 ~~program recipients residing in these zones are subject only~~
11 ~~to the limitations imposed in section 4.~~
12 ~~(4) Negotiate and execute contracts with selected~~
13 ~~contractors for each zone into which the program is to be~~
14 ~~expanded, incorporating terms and conditions in conformance~~
15 ~~with the provisions of this act, including, without~~
16 ~~limitation, actuarially sound capitation rates determined in~~
17 ~~accordance with section 7.~~
18 ~~(5) Seek and make all efforts to obtain any necessary or~~
19 ~~desirable amendments to or approvals of waivers from CMS or~~
20 ~~any other agencies of the Federal Government to allow timely~~
21 ~~implementation of the expansion provided for in this section.~~
22 ~~(b) Selection of contractors. The department shall select~~
23 ~~no fewer than two contractors to provide managed care services~~
24 ~~for each zone into which the program is to be expanded, such~~
25 ~~contractors having the responsibility to provide services for~~

26 the benefit of all program recipients residing in such zone,
27 subject only to the limitations provided in section 4. If the
28 department selects one or more counties to act as contractors to
29 provide managed behavioral health care services to recipients
30 residing in designated counties, the requirement to select more
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1 than one contractor shall not apply as to the provision of
2 behavioral health care services in such counties only.
3 (c) Implementation of expansion. The department may
4 implement the expansion required by this section in phases, but
5 program shall become operational in all zones to the full extent
6 required under this act no later than 24 months after the
7 effective date of this section.
8 Section 7. Capitation rates.
9 (a) Development and determination of rates. The department
10 shall adopt by regulation a methodology for development and
11 determination of actuarially sound capitation rates to be paid
12 to contractors which is in all respects compliant with this act.
13 The methodology shall include a list of all relevant factors
14 which the department shall take into account in the development
15 of such rates.
16 (b) Annual capitation rates.
17 (1) Capitation rates paid by the department to
18 contractors shall be actuarially sound.
19 (2) Capitation rates shall be determined by the
20 department in accordance with the methodology in the
21 regulations adopted pursuant to subsection (a).
22 (3) The department shall use its best efforts to publish
23 final capitation rates for each contractor for the next
24 contract year not less than 120 days prior to the beginning
25 of such contract year and shall advise contractors of any
26 delays in the publication of such rates.
27 (4) The department shall disclose to contractors its
28 application of all factors used in the development of the
29 capitation rates for such contractor and all information
30 submitted to CMS relating to such capitation rates, no later
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1 than the date the department discloses the rates it intends
2 to offer with respect to a contract period. The department
3 shall also provide the contractor with any other such
4 information which it submits to CMS after the initial
5 disclosure contemplated in this subsection within ten days of
6 its submission to CMS.
7 (c) Intrayear adjustments to capitation rates.
8 (1) The department shall adjust capitation rates within
9 a contract year to achieve or maintain actuarially sound
10 capitation rates for contractors to reflect program changes,
11 such adjustments shall cover all applicable portions of the
12 contract year to which such program changes apply and be
13 developed pursuant to the methodology required be established
14 under subsection (a).
15 (2) In considering the need for intrayear capitation
16 rate adjustments, the department shall evaluate the impact of
17 program changes which have been imposed during the course of
18 the contract year in combination with prospective program
19 changes.
20 (3) Other than program changes designated by the
21 department as being emergency program changes or program
22 changes required by changes in Federal law or regulation with
23 an earlier effective date, no program change shall become
24 effective with less than 60 days' notice to the contractor.
25 (4) The department shall disclose to contractors its
26 application of all factors used in the development of the
27 capitation rates with respect to an intrayear adjustment in
28 capitation rates for such contractors and all information
29 submitted to CMS relating to such capitation rates, no later
30 than the date when the department disclosed the rates it

1 ~~intends to offer with respect to such intrayear adjustment.~~
2 ~~The department shall also provide the contractor with any~~
3 ~~other such information which it submits to CMS after the~~
4 ~~initial disclosure contemplated in this subsection within ten~~
5 ~~days of its submission to CMS.~~
6 ~~Section 8. Appeals.~~
7 ~~(a) Claims by contractor. All claims against the department~~
8 ~~relating to any matter regarding any contract relating to the~~
9 ~~program may be filed by the contractor in the Board of Claims~~
10 ~~under 62 Pa.C.S. Ch. 17 Subch. C (relating to Board of Claims),~~
11 ~~including, without limitation, claims relating to the actuarial~~
12 ~~soundness of capitation rates.~~
13 ~~(b) Effect of agreements between contractor and~~
14 ~~department. No provision of any agreement by and between a~~
15 ~~contractor and the department, any request for proposal,~~
16 ~~regulation, bulletin or other statement issued by any agency or~~
17 ~~department of the commonwealth shall foreclose:~~
18 ~~(1) The right of a contractor to file a claim before the~~
19 ~~Board of Claims, including its right to appeal any~~
20 ~~determination by the department as to the actuarial soundness~~
21 ~~of any capitation rate or to appeal a finding by the Board of~~
22 ~~Claims with respect to such claim.~~
23 ~~(2) The right of a contractor to file any other claim or~~
24 ~~appeal in any forum having jurisdiction to consider such~~
25 ~~claim or appeal.~~
26 ~~(3) The right of the contractor to perform at the~~
27 ~~capitation rate accepted by the department during the~~
28 ~~pendency of such claim or appeal. Any such provision shall be~~
29 ~~void and unenforceable against a contractor.~~
30 ~~(c) Notification by contractor. A contractor which desires~~


1 ~~to perform at the capitation rate accepted by the department~~
2 ~~during the pendency of proceedings in the Board of Claims or any~~
3 ~~appeal of a finding by the Board of Claims shall notify the~~
4 ~~department of its intention to file a claim in the Board of~~
5 ~~Claims no later than the date the contractor executes the~~
6 ~~contract incorporating such rate.~~
7 ~~Section 9. Replacement of contractors.~~
8 ~~(a) Requests for proposals. The department may, from time~~
9 ~~to time, determine to issue requests for proposals:~~
10 ~~(1) to expand the number of contractors serving one or~~
11 ~~more zones;~~
12 ~~(2) to replace contractors;~~
13 ~~(3) to assess the qualification or performance of~~
14 ~~current contractors; or~~
15 ~~(4) at the discretion of the department.~~
16 ~~(b) Compliance by department. In the event the department~~
17 ~~exercises its right under this section, it shall comply with the~~
18 ~~provisions of section 7 with respect to the determination of~~
19 ~~capitation rates.~~
20 ~~Section 10. Amendments to the State plan.~~
21 ~~(a) Waiver or amendment submissions. Prior to the~~
22 ~~department submitting a waiver, an amendment to the State plan~~
23 ~~or an amendment to a waiver to CMS for its approval where such~~
24 ~~waiver, State plan amendment or amended waiver would cause a~~
25 ~~change in expenditure of Commonwealth funds of more than $20~~
26 ~~million during any fiscal year, the department shall submit such~~
27 ~~proposed waiver, State plan amendment or waiver amendment for~~
28 ~~review under the provisions of the act of June 25, 1982~~
29 ~~(P.L.633, No.181), known as the Regulatory Review Act.~~
30 ~~(b) Determination of expenditures. In making the~~


1 ~~determination of Commonwealth expenditures required by~~
2 ~~subsection (a), the department shall take into account all~~
3 ~~waivers, State plan amendments and amended waivers then proposed~~
4 ~~or in effect, in combination with all waivers, State plan~~

5 ~~amendments and waiver amendments expected to be requested for~~
6 ~~the remainder of the then current fiscal year.~~
7 ~~Section 11. General provisions.~~
8 ~~In discharging its responsibilities under this act, the~~
9 ~~department shall be subject to the provisions of the act of June~~
10 ~~21, 1957 (P.L.390, No.212), referred to as the Right to Know~~
11 ~~Law. The department shall not make available any information:~~
12 ~~(1) in violation of the provisions of HIPAA; or~~
13 ~~(2) disclosing capitation rates for individual managed~~
14 ~~care organizations, including, without limitation, financial~~
15 ~~and actuarial information provided by a managed care~~
16 ~~organization or a managed care organization contractor to the~~
17 ~~department for the purpose of negotiating or determining~~
18 ~~capitation rates to be paid for health care services on~~
19 ~~behalf of recipients.~~
20 ~~Section 12. Report to General Assembly.~~
21 ~~(a) Officials to receive report. Within 12 months following~~
22 ~~the effective date of this section, and annually thereafter, the~~
23 ~~department shall deliver a report on the implementation and~~
24 ~~operation of the program to:~~
25 ~~(1) The Speaker of the House of Representatives.~~
26 ~~(2) The minority leader of the House of Representatives.~~
27 ~~(3) The chairman of the Appropriations Committee of the~~
28 ~~House of Representatives.~~
29 ~~(4) The minority chairman of the Appropriations~~
30 ~~Committee of the House of Representatives.~~

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1 ~~(5) The chairman of the Health and Human Services~~
2 ~~Committee of the House of Representatives.~~
3 ~~(6) The minority chairman of the Health and Human~~
4 ~~Services Committee of the House of Representatives.~~
5 ~~(7) The President pro tempore of the Senate.~~
6 ~~(8) The minority leader of the Senate.~~
7 ~~(9) The chairman of the Appropriations Committee of~~
8 ~~Senate.~~
9 ~~(10) The minority chairman of the Appropriations~~
10 ~~Committee of the Senate.~~
11 ~~(11) The chairman of the Public Health and Welfare~~
12 ~~Committee of the Senate.~~
13 ~~(12) The minority chairman of the Public Health and~~
14 ~~Welfare Committee of the Senate.~~
15 ~~(b) Content of report. This report shall include:~~
16 ~~(1) The number of applicants per service per county,~~
17 ~~separated by those served and those denied.~~
18 ~~(2) The total cost or savings to the Commonwealth by~~
19 ~~contractors, itemized by county per service provided.~~
20 ~~(3) The number of doctors in each county, separated by~~
21 ~~those who accept medical assistance and those who do not~~
22 ~~accept medical assistance.~~
23 ~~(4) The percentage change of each of the categories~~
24 ~~above since the implementation of the act.~~
25 ~~(5) Policy recommendations.~~
26 ~~Section 13. Repeals.~~
27 ~~All acts, including without limitation, the act of December~~
28 ~~3, 2002 (P.L.1147, No.142), are repealed to the extent they are~~
29 ~~inconsistent with this act.~~
30 ~~Section 14. Effective date.~~

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1 ~~This act shall take effect as follows:~~
2 ~~(1) Section 7 shall take effect immediately.~~
3 ~~(2) The remainder of this act shall take effect in 60~~
4 ~~days.~~
5 SECTION 1. SECTION 1012-A OF THE ACT OF MAY 17, 1921 <--
6 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921,
7 AMENDED DECEMBER 23, 2003 (P.L.358, NO.50), IS AMENDED TO READ:
8 [SECTION 1012-A. EXPIRATION.--THIS ARTICLE SHALL EXPIRE ON
9 DECEMBER 31, 2006.]

10 SECTION 2. THE ACT IS AMENDED BY ADDING A SECTION TO READ:
11 SECTION 2194. MANAGED CARE PLANS PARTICIPATING IN THE
12 MEDICAL ASSISTANCE PROGRAM.--(A) THE GENERAL ASSEMBLY FINDS
13 THAT:
14 (1) ACCESSIBILITY TO HEALTH CARE SERVICES RECEIVED BY
15 PARTICIPANTS IN THE COMMONWEALTH'S MEDICAL ASSISTANCE PROGRAM
16 MUST BE MAINTAINED THROUGHOUT THIS COMMONWEALTH.
17 (2) THE QUALITY AND CONTINUITY OF THESE SERVICES MUST BE
18 ASSURED IN A MANNER THAT RESPONSIBLY AND EFFECTIVELY CONTROLS
19 MEDICAL ASSISTANCE COSTS.
20 (3) MANAGED CARE PLANS CONTRACTING WITH THE DEPARTMENT OF
21 PUBLIC WELFARE FOR PURPOSES OF PARTICIPATION IN THE MEDICAL
22 ASSISTANCE PROGRAM HAVE DEVELOPED ACROSS THIS COMMONWEALTH AND
23 PROVIDE VITAL HEALTH CARE SERVICES, INCLUDING PHARMACEUTICALS,
24 TO THE MEDICAL ASSISTANCE POPULATION OF THIS COMMONWEALTH.
25 (4) A REVIEW OF THE DELIVERY OF SERVICES PROVIDED BY THESE
26 MANAGED CARE PLANS IS NECESSARY TO ENABLE THE DEPARTMENT OF
27 PUBLIC WELFARE, IN CONSULTATION WITH THE DEPARTMENT, TO
28 FORMULATE A STRATEGY THAT PROPERLY UTILIZES COST CONTROL
29 MECHANISMS THAT PRODUCE AVAILABLE SAVINGS TO THE COMMONWEALTH IF
30 AN EFFECTIVE AND RESPONSIVE HEALTH CARE NETWORK IS TO BE



1 MAINTAINED ACROSS THIS COMMONWEALTH, ESPECIALLY DUE TO
2 CONTINUING CHANGES AT THE FEDERAL LEVEL.
3 (B) THE LEGISLATIVE BUDGET AND FINANCE COMMITTEE SHALL
4 CONDUCT A REVIEW OF AND ISSUE A REPORT ON THE DELIVERY AND
5 QUALITY OF HEALTH CARE SERVICES PROVIDED THROUGH THE CURRENT
6 FEE-FOR-SERVICE PROGRAM, AS WELL AS BY MANAGED CARE PLANS
7 PARTICIPATING IN THE COMMONWEALTH'S MEDICAL ASSISTANCE PROGRAM.
8 THE REPORT SHALL INCLUDE THE FOLLOWING FOR EACH SERVICE DELIVERY
9 SYSTEM:
10 (1) INFORMATION REGARDING THE NUMBER OF MEDICAL ASSISTANCE
11 PARTICIPANTS PER SERVICE PER COUNTY, SEPARATED BY THOSE SERVED
12 AND THOSE DENIED.
13 (2) THE TOTAL COST OR SAVINGS ACCRUED TO THE COMMONWEALTH
14 ITEMIZED BY COUNTY PER SERVICE PROVIDED, INCLUDING
15 PHARMACEUTICALS.
16 (3) RECOMMENDATIONS FOR REVISIONS IN PRACTICES USED BY THE
17 DEPARTMENT OF PUBLIC WELFARE TO CONTRACT AND PROVIDE FOR ALL
18 HEALTH CARE SERVICES AVAILABLE THROUGH THE MEDICAL ASSISTANCE
19 PROGRAM.
20 (4) ANY OTHER RECOMMENDATIONS THAT WILL PROMOTE MEDICAL
21 ASSISTANCE PROGRAM SAVINGS.
22 (C) THE DEPARTMENT OF PUBLIC WELFARE AND ALL OTHER AFFECTED
23 STATE AGENCIES SHALL COOPERATE FULLY WITH THE LEGISLATIVE BUDGET
24 AND FINANCE COMMITTEE IN PROVIDING ANY AND ALL INFORMATION
25 NECESSARY TO CONDUCT ITS REVIEW AND PREPARE ITS REPORT.
26 (D) THE LEGISLATIVE BUDGET AND FINANCE COMMITTEE SHALL
27 REPORT ITS FINDINGS AND RECOMMENDATIONS NO LATER THAN MARCH 1,
28 2007, TO THE GOVERNOR, THE SECRETARY OF PUBLIC WELFARE, THE
29 INSURANCE COMMISSIONER, THE CHAIRMAN AND MINORITY CHAIRMAN OF
30 THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE, THE



1 CHAIRMAN AND MINORITY CHAIRMAN OF THE HEALTH AND HUMAN SERVICES
2 COMMITTEE OF THE HOUSE OF REPRESENTATIVES, THE CHAIRMAN AND
3 MINORITY CHAIRMAN OF THE BANKING AND INSURANCE COMMITTEE OF THE
4 SENATE AND THE CHAIRMAN AND MINORITY CHAIRMAN OF THE INSURANCE
5 COMMITTEE OF THE HOUSE OF REPRESENTATIVES.
6 (E) FOR PURPOSES OF THIS SECTION, "MEDICAL ASSISTANCE" SHALL
7 BE DEFINED AS THE STATE PROGRAM OF MEDICAL ASSISTANCE
8 ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31, NO.21),
9 KNOWN AS THE "PUBLIC WELFARE CODE."
10 SECTION 3. SECTIONS 2302, 2303, 2311, 2312 AND 2313 OF THE
11 ACT, ADDED JUNE 17, 1998 (P.L.464, NO.68), ARE AMENDED TO READ:
12 SECTION 2302. LEGISLATIVE FINDINGS AND INTENT.--THE GENERAL
13 ASSEMBLY FINDS AND DECLARES AS FOLLOWS:
14 (1) [ALL CITIZENS] CITIZENS OF THIS COMMONWEALTH SHOULD HAVE

15 ACCESS TO AFFORDABLE AND REASONABLY PRICED HEALTH CARE AND TO
16 NONDISCRIMINATORY TREATMENT BY HEALTH INSURERS AND PROVIDERS.
17 (2) THE UNINSURED HEALTH CARE POPULATION OF THIS
18 COMMONWEALTH IS ESTIMATED TO BE [OVER] APPROXIMATELY ONE MILLION
19 PERSONS AND MANY THOUSANDS MORE LACK ADEQUATE INSURANCE
20 COVERAGE. IT IS ALSO ESTIMATED THAT APPROXIMATELY TWO-THIRDS OF
21 THE UNINSURED ARE EMPLOYED OR DEPENDENTS OF EMPLOYED PERSONS.
22 (3) [OVER ONE-THIRD] APPROXIMATELY FIFTEEN PER CENTUM (15%)
23 OF THE UNINSURED HEALTH CARE POPULATION ARE CHILDREN. UNINSURED
24 CHILDREN ARE OF PARTICULAR CONCERN BECAUSE OF THEIR NEED FOR
25 ONGOING PREVENTIVE AND PRIMARY CARE. MEASURES NOT TAKEN TO CARE
26 FOR SUCH CHILDREN NOW WILL RESULT IN HIGHER HUMAN AND FINANCIAL
27 COSTS LATER.
28 (4) UNINSURED CHILDREN LACK ACCESS TO TIMELY AND APPROPRIATE
29 PRIMARY AND PREVENTIVE CARE. AS A RESULT, HEALTH CARE IS OFTEN
30 DELAYED OR FORGONE, RESULTING IN INCREASED RISK OF DEVELOPING

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1 MORE SEVERE CONDITIONS WHICH IN TURN ARE MORE EXPENSIVE TO
2 TREAT. THIS TENDENCY TO DELAY CARE AND TO SEEK AMBULATORY CARE
3 IN HOSPITAL-BASED SETTINGS ALSO CAUSES INEFFICIENCIES IN THE
4 HEALTH CARE SYSTEM.
5 (5) HEALTH CARE MARKETS HAVE BEEN DISTORTED THROUGH COST
6 SHIFTS FOR THE UNCOMPENSATED HEALTH CARE COSTS OF UNINSURED
7 CITIZENS OF THIS COMMONWEALTH WHICH HAS CAUSED DECREASED
8 COMPETITIVE CAPACITY ON THE PART OF THOSE HEALTH CARE PROVIDERS
9 WHO SERVE THE POOR AND INCREASED COSTS OF OTHER HEALTH CARE
10 PAYORS.
11 (6) NO ONE SECTOR CAN ABSORB THE COST OF PROVIDING HEALTH
12 CARE TO CITIZENS OF THIS COMMONWEALTH WHO CANNOT AFFORD HEALTH
13 CARE ON THEIR OWN. THE COST IS TOO LARGE FOR THE PUBLIC SECTOR
14 ALONE TO BEAR AND INSTEAD REQUIRES THE ESTABLISHMENT OF A PUBLIC
15 AND PRIVATE PARTNERSHIP TO SHARE THE COSTS IN A MANNER
16 ECONOMICALLY FEASIBLE FOR ALL INTERESTS. THE MAGNITUDE OF THIS
17 NEED ALSO REQUIRES THAT IT BE DONE ON A TIME-PHASED, COST-
18 MANAGED AND PLANNED BASIS.
19 (7) ELIGIBLE UNINSURED CHILDREN IN THIS COMMONWEALTH SHOULD
20 HAVE ACCESS TO COST-EFFECTIVE, COMPREHENSIVE PRIMARY HEALTH
21 COVERAGE IF THEY ARE UNABLE TO AFFORD COVERAGE OR OBTAIN IT.
22 (8) CARE SHOULD BE PROVIDED IN APPROPRIATE SETTINGS BY
23 EFFICIENT PROVIDERS, CONSISTENT WITH HIGH QUALITY CARE AND AT AN
24 APPROPRIATE STAGE, SOON ENOUGH TO AVERT THE NEED FOR OVERLY
25 EXPENSIVE TREATMENT.
26 (9) EQUITY SHOULD BE ASSURED AMONG HEALTH PROVIDERS AND
27 PAYORS BY PROVIDING A MECHANISM FOR PROVIDERS, EMPLOYERS, THE
28 PUBLIC SECTOR AND PATIENTS TO SHARE IN FINANCING INDIGENT
29 CHILDREN'S HEALTH CARE.
30 SECTION 2303. DEFINITIONS.--AS USED IN THIS ARTICLE, THE

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1 FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO
2 THEM IN THIS SECTION:
3 "CHILD." A PERSON UNDER NINETEEN (19) YEARS OF AGE.
4 ["CHILDREN'S MEDICAL ASSISTANCE." MEDICAL ASSISTANCE
5 SERVICES TO CHILDREN AS REQUIRED UNDER TITLE XIV OF THE SOCIAL
6 SECURITY ACT (49 STAT. 620, 42 U.S.C. § 301 ET SEQ.), INCLUDING
7 EPSDT SERVICES.]
8 "CONTRACTOR." AN [ENTITY] INSURER AWARDED A CONTRACT UNDER
9 SUBDIVISION (B) TO PROVIDE HEALTH CARE SERVICES UNDER THIS
10 ARTICLE. THE TERM INCLUDES AN ENTITY AND ITS SUBSIDIARY WHICH IS
11 ESTABLISHED UNDER 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
12 CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES
13 PLAN CORPORATIONS); THIS ACT; OR THE ACT OF DECEMBER 29, 1972
14 (P.L.1701, NO.364), KNOWN AS THE "HEALTH MAINTENANCE
15 ORGANIZATION ACT."
16 "COUNCIL." THE CHILDREN'S HEALTH ADVISORY COUNCIL
17 ESTABLISHED IN SECTION 2311(I).
18 "DEPARTMENT." THE INSURANCE DEPARTMENT OF THE COMMONWEALTH.
19 "EPSDT." EARLY AND PERIODIC SCREENING, DIAGNOSIS AND

20 TREATMENT.
21 "FUND." THE CHILDREN'S HEALTH FUND FOR HEALTH CARE FOR
22 INDIGENT CHILDREN ESTABLISHED BY SECTION 1296 OF THE ACT OF
23 MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE "TAX REFORM CODE OF
24 1971."
25 ["GENETIC STATUS." THE PRESENCE OF A PHYSICAL CONDITION IN
26 AN INDIVIDUAL WHICH IS A RESULT OF AN INHERITED TRAIT.]
27 "GROUP." A GROUP FOR WHICH A HEALTH INSURANCE POLICY IS
28 WRITTEN IN THIS COMMONWEALTH.
29 "HEALTH MAINTENANCE ORGANIZATION" OR "HMO." AN ENTITY
30 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972



1 (P.L.1701, NO.364), KNOWN AS THE "HEALTH MAINTENANCE
2 ORGANIZATION ACT."
3 "HEALTH SERVICE CORPORATION." A PROFESSIONAL HEALTH SERVICE
4 CORPORATION AS DEFINED IN 40 PA.C.S. § 6302 (RELATING TO
5 DEFINITIONS).
6 "HEALTHY BEGINNINGS PROGRAM." MEDICAL ASSISTANCE COVERAGE
7 FOR SERVICES TO CHILDREN AS REQUIRED UNDER TITLE XIX OF THE
8 SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 301 ET SEQ.) FOR
9 THE FOLLOWING:
10 (1) CHILDREN FROM BIRTH TO AGE ONE (1) WHOSE FAMILY INCOME
11 IS NO GREATER THAN ONE HUNDRED EIGHTY-FIVE PER CENTUM (185%) OF
12 THE FEDERAL POVERTY LEVEL;
13 (2) CHILDREN ONE (1) THROUGH FIVE (5) YEARS OF AGE WHOSE
14 FAMILY INCOME IS NO GREATER THAN ONE HUNDRED THIRTY-THREE PER
15 CENTUM (133%) OF THE FEDERAL POVERTY LEVEL; AND
16 (3) CHILDREN SIX (6) THROUGH EIGHTEEN (18) YEARS OF AGE
17 WHOSE FAMILY INCOME IS NO GREATER THAN ONE HUNDRED PER CENTUM
18 (100%) OF THE FEDERAL POVERTY LEVEL.
19 "HOSPITAL." AN INSTITUTION HAVING AN ORGANIZED MEDICAL STAFF
20 WHICH IS ENGAGED PRIMARILY IN PROVIDING TO INPATIENTS, BY OR
21 UNDER THE SUPERVISION OF PHYSICIANS, DIAGNOSTIC AND THERAPEUTIC
22 SERVICES FOR THE CARE OF INJURED, DISABLED, PREGNANT, DISEASED
23 OR SICK OR MENTALLY ILL PERSONS. THE TERM INCLUDES FACILITIES
24 FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS WITHIN THE SCOPE OF
25 SPECIFIC MEDICAL SPECIALTIES. THE TERM DOES NOT INCLUDE
26 FACILITIES CARING EXCLUSIVELY FOR THE MENTALLY ILL.
27 "HOSPITAL PLAN CORPORATION." A HOSPITAL PLAN CORPORATION AS
28 DEFINED IN 40 PA.C.S. § 6101 (RELATING TO DEFINITIONS).
29 ["INSURER." ANY INSURANCE COMPANY, ASSOCIATION, RECIPROCAL,
30 NONPROFIT HOSPITAL PLAN CORPORATION, NONPROFIT PROFESSIONAL



1 HEALTH SERVICE PLAN, HEALTH MAINTENANCE ORGANIZATION, FRATERNAL
2 BENEFITS SOCIETY OR A RISK-BEARING PPO OR NONRISK-BEARING PPO
3 NOT GOVERNED AND REGULATED UNDER THE EMPLOYEE RETIREMENT INCOME
4 SECURITY ACT OF 1974 (PUBLIC LAW 93-406, 29 U.S.C. § 1001 ET
5 SEQ.).]
6 "INSURER." A HEALTH INSURANCE ENTITY LICENSED IN THIS
7 COMMONWEALTH TO ISSUE ANY INDIVIDUAL OR GROUP HEALTH, SICKNESS
8 OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR CERTIFICATE THAT
9 PROVIDES MEDICAL OR HEALTH CARE COVERAGE BY A HEALTH CARE
10 FACILITY OR LICENSED HEALTH CARE PROVIDER THAT IS OFFERED OR
11 GOVERNED UNDER THIS ACT OR ANY OF THE FOLLOWING:
12 (1) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364),
13 KNOWN AS THE "HEALTH MAINTENANCE ORGANIZATION ACT."
14 (2) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS
15 THE "INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM
16 STANDARDS ACT."
17 (3) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
18 CORPORATIONS), 63 (RELATING TO PROFESSIONAL HEALTH SERVICES
19 PLAN CORPORATIONS) OR 65 (RELATING TO FRATERNAL BENEFIT
20 SOCIETIES).
21 "MAAC." THE MEDICAL ASSISTANCE ADVISORY COMMITTEE.
22 "MANAGED CARE ORGANIZATION." HEALTH MAINTENANCE ORGANIZATION
23 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972
24 (P.L.1701, NO.364), KNOWN AS THE "HEALTH MAINTENANCE

25 ORGANIZATION ACT," OR A RISK-ASSUMING PREFERRED PROVIDER
26 ORGANIZATION OR EXCLUSIVE PROVIDER ORGANIZATION, ORGANIZED AND
27 REGULATED UNDER THIS ACT.
28 "MCH." MATERNAL AND CHILD HEALTH.
29 "MEDICAID." THE FEDERAL MEDICAL ASSISTANCE PROGRAM
30 ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT.



1 620, 42 U.S.C. § 1396 ET SEQ.).
2 "MEDICAL ASSISTANCE." THE STATE PROGRAM OF MEDICAL
3 ASSISTANCE ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31,
4 NO.21), KNOWN AS THE "PUBLIC WELFARE CODE."
5 "MID-LEVEL HEALTH PROFESSIONAL." A PHYSICIAN ASSISTANT,
6 CERTIFIED REGISTERED NURSE PRACTITIONER, NURSE PRACTITIONER OR A
7 CERTIFIED NURSE MIDWIFE.
8 "PARENT." A NATURAL PARENT, STEPPARENT, ADOPTIVE PARENT,
9 GUARDIAN OR CUSTODIAN OF A CHILD.
10 "PPO." A PREFERRED PROVIDER ORGANIZATION SUBJECT TO THE
11 PROVISIONS OF SECTION 630.
12 "PREEXISTING CONDITION." A DISEASE OR PHYSICAL CONDITION FOR
13 WHICH MEDICAL ADVICE OR TREATMENT HAS BEEN RECEIVED PRIOR TO THE
14 EFFECTIVE DATE OF COVERAGE.
15 "PREMIUM ASSISTANCE PROGRAM." A COMPONENT OF A SEPARATE
16 CHILD HEALTH PROGRAM, APPROVED UNDER THE STATE PLAN, UNDER WHICH
17 THE COMMONWEALTH PAYS PART OR ALL OF THE PREMIUM FOR AN ENROLLEE
18 OR ENROLLEES' GROUP HEALTH INSURANCE COVERAGE OR COVERAGE UNDER
19 A GROUP HEALTH PLAN.
20 "PRESCRIPTION DRUG." A CONTROLLED SUBSTANCE, OTHER DRUG OR
21 DEVICE FOR MEDICATION DISPENSED BY ORDER OF AN APPROPRIATELY
22 LICENSED MEDICAL PROFESSIONAL.
23 "SUBGROUP." AN EMPLOYER COVERED UNDER A CONTRACT ISSUED TO A
24 MULTIPLE EMPLOYER TRUST OR TO AN ASSOCIATION.
25 "TERMINATE." INCLUDES CANCELLATION, NONRENEWAL AND
26 RESCISSION.
27 "UNINSURED PERIOD." EXCEPT FOR CHILDREN TWO YEARS OF AGE OR
28 LESS, A CONTINUOUS PERIOD OF TIME OF NOT LESS THAN SIX (6)
29 CONSECUTIVE MONTHS IMMEDIATELY PRECEDING ENROLLMENT, DURING
30 WHICH A CHILD HAS BEEN WITHOUT HEALTH CARE INSURANCE COVERAGE IN



1 ACCORDANCE WITH THE REQUIREMENTS OF THIS ARTICLE.
2 "WAITING PERIOD." A PERIOD OF TIME AFTER THE EFFECTIVE DATE
3 OF ENROLLMENT DURING WHICH [A HEALTH INSURANCE PLAN] AN INSURER
4 EXCLUDES COVERAGE FOR THE DIAGNOSIS OR TREATMENT OF ONE OR MORE
5 MEDICAL CONDITIONS.
6 "WIC." THE FEDERAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN,
7 INFANTS AND CHILDREN.
8 SECTION 2311. CHILDREN'S HEALTH CARE.--(A) NOTWITHSTANDING
9 ANY OTHER PROVISION OF LAW, THE DEPARTMENT SHALL TAKE SUCH
10 ACTIONS AS MAY BE NECESSARY TO ENSURE THE RECEIPT OF FEDERAL
11 FINANCIAL PARTICIPATION UNDER TITLE XXI OF THE SOCIAL SECURITY
12 ACT (49 STAT. 620, 42 U.S.C. § 1397AA ET SEQ.) FOR SERVICES
13 PROVIDED UNDER THIS ACT, AND TO QUALIFY THE BENEFIT EXPANSION
14 PROVIDED BY SUBSECTION (C)(1.1) FOR AVAILABLE FEDERAL FINANCIAL
15 PARTICIPATION.
16 (B) (1) THE FUND SHALL BE DEDICATED EXCLUSIVELY FOR
17 DISTRIBUTION BY THE [INSURANCE DEPARTMENT] DEPARTMENT THROUGH
18 CONTRACTS IN ORDER TO PROVIDE FREE AND SUBSIDIZED HEALTH CARE
19 SERVICES UNDER THIS SECTION, BASED ON AN ACTUARIALLY SOUND AND
20 ADEQUATE REVIEW, AND TO DEVELOP AND IMPLEMENT OUTREACH
21 ACTIVITIES REQUIRED UNDER SECTION 2312.
22 [(B) (1)] (2) THE FUND, ALONG WITH FEDERAL, STATE AND OTHER
23 MONEY AVAILABLE FOR THE PROGRAM, SHALL BE USED [TO FUND] FOR
24 HEALTH CARE [SERVICES] COVERAGE FOR CHILDREN AS SPECIFIED IN
25 THIS SECTION. THE [INSURANCE DEPARTMENT] DEPARTMENT SHALL ASSURE
26 THAT THE PROGRAM IS IMPLEMENTED STATEWIDE. ALL CONTRACTS AWARDED
27 UNDER THIS SECTION SHALL BE AWARDED THROUGH A COMPETITIVE
28 PROCUREMENT PROCESS. THE [INSURANCE DEPARTMENT SHALL USE ITS]
29 DEPARTMENT AND THE DEPARTMENT OF PUBLIC WELFARE SHALL USE THEIR

30 BEST EFFORTS TO ENSURE THAT ELIGIBLE CHILDREN ACROSS THIS
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1 COMMONWEALTH HAVE ACCESS TO HEALTH CARE SERVICES TO BE PROVIDED
2 UNDER THIS ARTICLE.
3 [(2)] (3) NO MORE THAN [SEVEN AND ONE-HALF PER CENTUM (7
4 1/2%)] TEN PER CENTUM (10%) OF THE AMOUNT OF THE CONTRACT MAY BE
5 USED FOR ADMINISTRATIVE EXPENSES OF THE CONTRACTOR. IF [AFTER
6 THE FIRST THREE (3) FULL YEARS OF OPERATION] ANY CONTRACTOR
7 PRESENTS DOCUMENTED EVIDENCE THAT ADMINISTRATIVE EXPENSES FOR
8 PURPOSES OF EXPANDED OUTREACH AND SYSTEMS AND OPERATIONAL
9 CHANGES ARE IN EXCESS OF [SEVEN AND ONE-HALF PER CENTUM (7
10 1/2%)] TEN PER CENTUM (10%) OF THE AMOUNT OF THE CONTRACT, THE
11 [INSURANCE DEPARTMENT MAY] DEPARTMENT SHALL MAKE AN ADDITIONAL
12 ALLOTMENT OF FUNDS, NOT TO EXCEED [TWO AND ONE-HALF PER CENTUM
13 (2 1/2%)] TWO PER CENTUM (2%) OF THE AMOUNT OF THE CONTRACT,
14 [FOR FUTURE ADMINISTRATIVE EXPENSES] TO THE CONTRACTOR TO THE
15 EXTENT THAT THE [INSURANCE DEPARTMENT] DEPARTMENT FINDS THE
16 EXPENSES REASONABLE AND NECESSARY.
17 [(3)] (4) NO LESS THAN [SEVENTY PER CENTUM (70%)] EIGHTY-
18 FOUR PER CENTUM (84%) OF THE [FUND] CONTRACT SHALL BE USED TO
19 PROVIDE THE HEALTH CARE SERVICES PROVIDED UNDER THIS ARTICLE FOR
20 CHILDREN ELIGIBLE FOR [FREE] CARE UNDER [SUBSECTION (D)] THIS
21 ARTICLE. [WHEN THE INSURANCE DEPARTMENT DETERMINES THAT SEVENTY
22 PER CENTUM (70%) OF THE FUND IS NOT NEEDED IN ORDER TO ACHIEVE
23 MAXIMUM ENROLLMENT OF CHILDREN ELIGIBLE FOR FREE CARE AND
24 PROMULGATES A FINAL FORM REGULATION WITH PROPOSED RULEMAKING
25 OMITTED, THIS PARAGRAPH SHALL EXPIRE.]
26 [(4)] (5) TO ENSURE THAT INPATIENT HOSPITAL CARE IS PROVIDED
27 TO ELIGIBLE CHILDREN, EACH PRIMARY CARE [PHYSICIAN PROVIDING]
28 PROVIDER FURNISHING PRIMARY CARE SERVICES SHALL MAKE NECESSARY
29 ARRANGEMENTS FOR ADMISSION TO THE HOSPITAL AND FOR NECESSARY
30 SPECIALTY CARE.
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1 (C) (1) ANY [ORGANIZATION OR CORPORATION] INSURER RECEIVING
2 FUNDS FROM THE [INSURANCE DEPARTMENT] DEPARTMENT TO PROVIDE
3 COVERAGE OF HEALTH CARE SERVICES SHALL ENROLL, TO THE EXTENT
4 THAT FUNDS ARE AVAILABLE, ANY CHILD WHO MEETS ALL OF THE
5 FOLLOWING:
6 (I) [EXCEPT FOR NEWBORNS, HAS BEEN] IS A RESIDENT OF THIS
7 COMMONWEALTH [FOR AT LEAST THIRTY (30) DAYS PRIOR TO
8 ENROLLMENT].
9 (II) IS NOT COVERED BY A HEALTH INSURANCE PLAN, A SELF-
10 INSURANCE PLAN OR A SELF-FUNDED PLAN OR IS NOT ELIGIBLE FOR OR
11 COVERED BY MEDICAL ASSISTANCE, INCLUDING THE HEALTHY BEGINNINGS
12 PROGRAM.
13 (III) IS QUALIFIED BASED ON INCOME UNDER SUBSECTION (D) OR
14 (E).
15 (IV) MEETS THE CITIZENSHIP REQUIREMENTS OF [THE MEDICAID
16 PROGRAM ADMINISTERED BY THE DEPARTMENT OF PUBLIC WELFARE.] TITLE
17 XXI OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1397AA
18 ET SEQ.).
19 (1.1) BEGINNING JANUARY 1, 2007, AND SUBJECT TO THE
20 PROVISIONS OF SECTION 2314, ANY INSURER RECEIVING FUNDS FROM THE
21 DEPARTMENT TO PROVIDE COVERAGE OF HEALTH CARE SERVICES UNDER
22 THIS SECTION SHALL ENROLL, TO THE EXTENT THAT FUNDS ARE
23 AVAILABLE, ANY CHILD WHO MEETS ALL OF THE FOLLOWING:
24 (I) IS A RESIDENT OF THIS COMMONWEALTH.
25 (II) IS NOT COVERED BY A HEALTH INSURANCE PLAN, A SELF-
26 INSURANCE PLAN OR A SELF-FUNDED PLAN, OR IS NOT PROVIDED ACCESS
27 TO HEALTH CARE COVERAGE BY COURT ORDER, OR IS NOT ELIGIBLE FOR
28 OR COVERED BY A MEDICAL ASSISTANCE PROGRAM ADMINISTERED BY THE
29 DEPARTMENT OF PUBLIC WELFARE, INCLUDING THE HEALTHY BEGINNINGS
30 PROGRAM.
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1 (III) IS QUALIFIED BASED ON INCOME UNDER SUBSECTION (D),
2 (E.1), (E.2), (E.3) OR (E.4) AND MEETS THE UNINSURED PERIOD
3 REQUIREMENTS AS PROVIDED IN SUBSECTION (F.1).

4 (IV) MEETS THE CITIZENSHIP REQUIREMENTS OF TITLE XXI OF THE
5 SOCIAL SECURITY ACT (42 U.S.C. § 1397AA ET SEQ.).
6 (2) ENROLLMENT MAY NOT BE DENIED ON THE BASIS OF A
7 PREEXISTING CONDITION, NOR MAY DIAGNOSIS OR TREATMENT FOR THE
8 CONDITION BE EXCLUDED BASED ON THE CONDITION'S PREEXISTENCE.
9 (D) THE PROVISION OF HEALTH CARE INSURANCE FOR ELIGIBLE
10 CHILDREN SHALL BE FREE TO A CHILD [UNDER NINETEEN (19) YEARS OF
11 AGE] WHOSE FAMILY INCOME IS NO GREATER THAN TWO HUNDRED PER
12 CENTUM (200%) OF THE FEDERAL POVERTY LEVEL.
13 [(E) (1) THE PROVISION OF HEALTH CARE INSURANCE FOR AN
14 ELIGIBLE CHILD WHO IS UNDER NINETEEN (19) YEARS OF AGE AND WHOSE
15 FAMILY INCOME IS GREATER THAN TWO HUNDRED PER CENTUM (200%) OF
16 THE FEDERAL POVERTY LEVEL BUT NO GREATER THAN TWO HUNDRED
17 THIRTY-FIVE PER CENTUM (235%) OF THE FEDERAL POVERTY LEVEL MAY
18 BE SUBSIDIZED BY THE FUND AT A RATE NOT TO EXCEED FIFTY PER
19 CENTUM (50%).
20 (2) THE DIFFERENCE BETWEEN THE PURE PREMIUM OF THE MINIMUM
21 BENEFIT PACKAGE IN SUBSECTION (L)(6) AND THE SUBSIDY PROVIDED
22 UNDER THIS SUBSECTION SHALL BE THE AMOUNT PAID BY THE FAMILY OF
23 THE ELIGIBLE CHILD PURCHASING THE MINIMUM BENEFIT PACKAGE.
24 (F) THE FAMILY OF AN ELIGIBLE CHILD WHOSE FAMILY INCOME
25 MAKES THE CHILD ELIGIBLE FOR FREE OR SUBSIDIZED CARE BUT WHO
26 CANNOT RECEIVE CARE DUE TO LACK OF FUNDS IN THE FUND MAY
27 PURCHASE COVERAGE FOR THE CHILD AT COST.]
28 (E.1) THE PROVISION OF HEALTH CARE INSURANCE FOR AN ELIGIBLE
29 CHILD WHOSE FAMILY INCOME IS GREATER THAN TWO HUNDRED PER CENTUM
30 (200%) OF THE FEDERAL POVERTY LEVEL BUT NO GREATER THAN TWO



1 HUNDRED FIFTY PER CENTUM (250%) OF THE FEDERAL POVERTY LEVEL MAY
2 BE SUBSIDIZED BY THE FUND AT A RATE NOT TO EXCEED SEVENTY-FIVE
3 PER CENTUM (75%) OF THE PER MEMBER PER MONTH PREMIUM COST.
4 (E.2) THE PROVISION OF HEALTH CARE INSURANCE FOR AN ELIGIBLE
5 CHILD WHOSE FAMILY INCOME IS GREATER THAN TWO HUNDRED FIFTY PER
6 CENTUM (250%) OF THE FEDERAL POVERTY LEVEL BUT NO GREATER THAN
7 TWO HUNDRED SEVENTY-FIVE PER CENTUM (275%) OF THE FEDERAL
8 POVERTY LEVEL MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
9 EXCEED SIXTY-FIVE PER CENTUM (65%) OF THE PER MEMBER PER MONTH
10 PREMIUM COST.
11 (E.3) THE PROVISION OF HEALTH CARE INSURANCE FOR AN ELIGIBLE
12 CHILD WHOSE FAMILY INCOME IS GREATER THAN TWO HUNDRED SEVENTY-
13 FIVE PER CENTUM (275%) OF THE FEDERAL POVERTY LEVEL, BUT NO
14 GREATER THAN THREE HUNDRED PER CENTUM (300%) OF THE FEDERAL
15 POVERTY LEVEL MAY BE SUBSIDIZED BY THE FUND AT A RATE NOT TO
16 EXCEED SIXTY PER CENTUM (60%) OF THE PER MEMBER PER MONTH
17 PREMIUM COST.
18 (E.4) THE FOLLOWING APPLY:
19 (1) FOR AN ELIGIBLE CHILD WHOSE FAMILY INCOME IS GREATER
20 THAN THE MAXIMUM LEVEL ESTABLISHED UNDER SUBSECTION (O), THE
21 FAMILY MAY PURCHASE THE MINIMUM BENEFIT PACKAGE SET FORTH IN
22 SUBSECTION (L)(6) FOR THAT CHILD AT THE PER MONTH PER MEMBER
23 PREMIUM COST, WHICH (COST) SHALL BE DERIVED SEPARATELY FROM THE
24 OTHER ELIGIBILITY CATEGORIES IN THE PROGRAM, AS LONG AS THE
25 FAMILY DEMONSTRATES ON AN ANNUAL BASIS AND IN A MANNER
26 DETERMINED BY THE DEPARTMENT EITHER ONE OF THE FOLLOWING:
27 (I) THE FAMILY IS UNABLE TO AFFORD INDIVIDUAL OR GROUP
28 COVERAGE BECAUSE THAT COVERAGE WOULD EXCEED TEN PER CENTUM (10%)
29 OF THE FAMILY INCOME OR BECAUSE THE TOTAL COST OF COVERAGE FOR
30 THE CHILD IS ONE HUNDRED FIFTY PER CENTUM (150%) OF THE GREATER



1 OF:
2 (A) THE PREMIUM COST ESTABLISHED UNDER THIS SUBSECTION FOR
3 THAT SERVICE AREA; OR
4 (B) THE PREMIUM COST ESTABLISHED UNDER THE PROGRAM FOR THAT
5 SERVICE AREA.
6 (II) THE FAMILY HAS BEEN REFUSED COVERAGE BY AN INSURER DUE
7 TO THE CHILD OR A MEMBER OF THAT CHILD'S IMMEDIATE FAMILY HAVING
8 A PRE-EXISTING CONDITION AND COVERAGE IS NOT AVAILABLE TO THE

9 CHILD.
10 (2) FOR PURPOSES OF THIS SUBSECTION, "COVERAGE" SHALL NOT
11 INCLUDE COVERAGE OFFERED THROUGH ACCIDENT ONLY, FIXED INDEMNITY,
12 LIMITED BENEFIT, CREDIT, DENTAL, VISION, SPECIFIED DISEASE,
13 MEDICARE SUPPLEMENT, CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE
14 UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT, LONG-TERM CARE OR
15 DISABILITY INCOME, WORKERS' COMPENSATION OR AUTOMOBILE MEDICAL
16 PAYMENT INSURANCE.
17 (F.1) TO BE ELIGIBLE FOR COVERAGE UNDER SUBSECTIONS (E.1),
18 (E.2), (E.3) AND (E.4), A CHILD OVER TWO (2) YEARS OF AGE MUST
19 HAVE BEEN UNINSURED FOR THE UNINSURED PERIOD UNLESS:
20 (1) THE CHILD'S PARENT IS ELIGIBLE TO RECEIVE BENEFITS
21 PURSUANT TO THE ACT OF DECEMBER 5, 1936 (2ND SP.SESS., 1937
22 P.L.2897, NO.1), KNOWN AS THE "UNEMPLOYMENT COMPENSATION LAW";
23 (2) THE CHILD'S PARENT WAS COVERED BY A HEALTH INSURANCE
24 PLAN, A SELF-INSURANCE PLAN OR A SELF-FUNDED PLAN BUT, AT THE
25 TIME OF APPLICATION FOR COVERAGE, IS NO LONGER EMPLOYED AND IS
26 INELIGIBLE TO RECEIVE BENEFITS UNDER THE "UNEMPLOYMENT
27 COMPENSATION LAW"; OR
28 (3) A CHILD IS TRANSFERRING FROM ONE GOVERNMENT-SUBSIDIZED
29 HEALTH CARE PROGRAM TO ANOTHER.
30 (F.2) FOR ENROLLEES UNDER SUBSECTIONS (E.1), (E.2), (E.3)



1 AND (E.4), THE FOLLOWING APPLY:
2 (1) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO IMPOSE
3 COPAYMENTS FOR THE FOLLOWING SERVICES, EXCEPT AS OTHERWISE
4 PROHIBITED BY LAW:
5 (I) OUTPATIENT VISITS.
6 (II) EMERGENCY ROOM VISITS.
7 (III) PRESCRIPTION MEDICATIONS.
8 (IV) ANY OTHER SERVICE DEFINED BY THE DEPARTMENT.
9 (2) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO ESTABLISH AND
10 ADJUST THE LEVELS OF THESE COPAYMENTS IN ORDER TO IMPOSE
11 REASONABLE COST SHARING AND TO ENCOURAGE APPROPRIATE UTILIZATION
12 OF THESE SERVICES. IN NO EVENT SHALL THE PREMIUMS AND COPAYMENTS
13 FOR ENROLLEES UNDER SUBSECTIONS (E.1), (E.2) AND (E.3) AMOUNT TO
14 MORE THAN THE PER CENTUM OF TOTAL HOUSEHOLD INCOME WHICH IS IN
15 ACCORD WITH THE REQUIREMENTS OF THE CENTERS FOR MEDICARE AND
16 MEDICAID SERVICES.
17 (G) THE [INSURANCE DEPARTMENT] DEPARTMENT SHALL:
18 (1) ADMINISTER THE CHILDREN'S HEALTH CARE PROGRAM PURSUANT
19 TO THIS ARTICLE.
20 (2) REVIEW ALL BIDS AND APPROVE AND EXECUTE ALL CONTRACTS
21 FOR THE PURPOSE OF EXPANDING ACCESS TO HEALTH CARE SERVICES FOR
22 ELIGIBLE CHILDREN AS PROVIDED FOR IN THIS SUBDIVISION.
23 (3) CONDUCT MONITORING AND OVERSIGHT OF CONTRACTS ENTERED
24 INTO.
25 (4) ISSUE AN ANNUAL REPORT TO THE GOVERNOR, THE GENERAL
26 ASSEMBLY AND THE PUBLIC FOR EACH [FISCAL] CALENDAR YEAR NO LATER
27 THAN MARCH 1 OUTLINING PRIMARY HEALTH SERVICES FUNDED FOR THE
28 YEAR, DETAILING THE OUTREACH AND ENROLLMENT EFFORTS AND
29 REPORTING BY NUMBER OF CHILDREN BY COUNTY AND BY PER CENTUM OF
30 THE FEDERAL POVERTY LEVEL, THE NUMBER OF CHILDREN RECEIVING



1 HEALTH CARE SERVICES [FROM THE FUND,] BY COUNTY AND BY PER
2 CENTUM OF THE FEDERAL POVERTY LEVEL, THE PROJECTED NUMBER OF
3 ELIGIBLE CHILDREN AND THE NUMBER OF ELIGIBLE CHILDREN ON WAITING
4 LISTS FOR [HEALTH CARE SERVICES] ENROLLMENT IN THE HEALTH
5 INSURANCE PROGRAM ESTABLISHED UNDER THIS ACT BY COUNTY AND BY
6 PER CENTUM OF THE FEDERAL POVERTY LEVEL.
7 (5) IN CONSULTATION WITH APPROPRIATE COMMONWEALTH AGENCIES,
8 COORDINATE THE DEVELOPMENT AND SUPERVISION OF THE OUTREACH PLAN
9 REQUIRED UNDER SECTION 2312.
10 (6) IN CONSULTATION WITH APPROPRIATE COMMONWEALTH AGENCIES,
11 MONITOR, REVIEW AND EVALUATE THE ADEQUACY, ACCESSIBILITY AND
12 AVAILABILITY OF SERVICES DELIVERED TO CHILDREN WHO ARE ENROLLED
13 IN THE HEALTH INSURANCE PROGRAM ESTABLISHED UNDER THIS

14 SUBDIVISION.
15 (H) THE [INSURANCE DEPARTMENT] DEPARTMENT MAY PROMULGATE
16 REGULATIONS NECESSARY FOR THE IMPLEMENTATION AND ADMINISTRATION
17 OF THIS SUBDIVISION.
18 (I) THE CHILDREN'S HEALTH ADVISORY COUNCIL IS ESTABLISHED
19 WITHIN THE [INSURANCE DEPARTMENT] DEPARTMENT AS AN ADVISORY
20 COUNCIL. THE FOLLOWING SHALL APPLY:
21 (1) THE COUNCIL SHALL CONSIST OF FOURTEEN VOTING MEMBERS.
22 MEMBERS PROVIDED FOR IN SUBPARAGRAPHS (IV), (V), (VI), (VII),
23 (VIII), (X) AND (XI) SHALL BE APPOINTED BY THE INSURANCE
24 COMMISSIONER. THE COUNCIL SHALL BE GEOGRAPHICALLY BALANCED ON A
25 STATEWIDE BASIS AND SHALL INCLUDE:
26 (I) THE SECRETARY OF HEALTH EX OFFICIO OR A DESIGNEE.
27 (II) THE INSURANCE COMMISSIONER EX OFFICIO OR A DESIGNEE.
28 (III) THE SECRETARY OF PUBLIC WELFARE EX OFFICIO OR A
29 DESIGNEE.
30 (IV) A REPRESENTATIVE WITH EXPERIENCE IN CHILDREN'S HEALTH



1 FROM A SCHOOL OF PUBLIC HEALTH LOCATED IN THIS COMMONWEALTH.
2 (V) A PHYSICIAN WITH EXPERIENCE IN CHILDREN'S HEALTH
3 APPOINTED FROM A LIST OF THREE QUALIFIED PERSONS RECOMMENDED BY
4 THE PENNSYLVANIA MEDICAL SOCIETY.
5 (VI) A REPRESENTATIVE OF A CHILDREN'S HOSPITAL OR A HOSPITAL
6 WITH A PEDIATRIC OUTPATIENT CLINIC APPOINTED FROM A LIST OF
7 THREE PERSONS SUBMITTED BY THE HOSPITAL ASSOCIATION OF
8 PENNSYLVANIA.
9 (VII) A PARENT OF A CHILD WHO RECEIVES PRIMARY HEALTH CARE
10 COVERAGE FROM THE FUND.
11 (VIII) A MID-LEVEL PROFESSIONAL APPOINTED FROM LISTS OF
12 NAMES RECOMMENDED BY STATEWIDE ASSOCIATIONS REPRESENTING MID-
13 LEVEL HEALTH PROFESSIONALS.
14 (IX) A SENATOR APPOINTED BY THE PRESIDENT PRO TEMPORE OF THE
15 SENATE, A SENATOR APPOINTED BY THE MINORITY LEADER OF THE
16 SENATE, A REPRESENTATIVE APPOINTED BY THE SPEAKER OF THE HOUSE
17 OF REPRESENTATIVES AND A REPRESENTATIVE APPOINTED BY THE
18 MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES.
19 (X) A REPRESENTATIVE FROM A PRIVATE NONPROFIT FOUNDATION.
20 (XI) A REPRESENTATIVE OF BUSINESS WHO IS NOT A CONTRACTOR OR
21 PROVIDER OF PRIMARY HEALTH CARE INSURANCE UNDER THIS
22 SUBDIVISION.
23 (2) IF ANY SPECIFIED ORGANIZATION SHOULD CEASE TO EXIST OR
24 FAIL TO MAKE A RECOMMENDATION WITHIN NINETY (90) DAYS OF A
25 REQUEST TO DO SO, THE COUNCIL SHALL SPECIFY A NEW EQUIVALENT
26 ORGANIZATION TO FULFILL THE RESPONSIBILITIES OF THIS SECTION.
27 (3) THE INSURANCE COMMISSIONER SHALL CHAIR THE COUNCIL. THE
28 MEMBERS OF THE COUNCIL SHALL ANNUALLY ELECT, BY A MAJORITY VOTE
29 OF THE MEMBERS, A VICE CHAIRPERSON FROM AMONG THE MEMBERS OF THE
30 COUNCIL.



1 (4) THE PRESENCE OF EIGHT MEMBERS SHALL CONSTITUTE A QUORUM
2 FOR THE TRANSACTING OF ANY BUSINESS. ANY ACT BY A MAJORITY OF
3 THE MEMBERS PRESENT AT ANY MEETING AT WHICH THERE IS A QUORUM
4 SHALL BE DEEMED TO BE THAT OF THE COUNCIL.
5 (5) ALL MEETINGS OF THE COUNCIL SHALL BE CONDUCTED PURSUANT
6 TO [THE ACT OF JULY 3, 1986 (P.L.388, NO.84), KNOWN AS THE
7 "SUNSHINE ACT,"] 65 PA.C.S. CH. 7 (RELATING TO OPEN MEETINGS)
8 UNLESS OTHERWISE PROVIDED IN THIS SECTION. THE COUNCIL SHALL
9 MEET AT LEAST ANNUALLY AND MAY PROVIDE FOR SPECIAL MEETINGS AS
10 IT DEEMS NECESSARY. MEETING DATES SHALL BE SET BY A MAJORITY
11 VOTE OF MEMBERS OF THE COUNCIL OR BY CALL OF THE CHAIRPERSON
12 UPON SEVEN (7) DAYS' NOTICE TO ALL MEMBERS. THE COUNCIL SHALL
13 PUBLISH NOTICE OF ITS MEETINGS IN THE PENNSYLVANIA BULLETIN.
14 NOTICE SHALL SPECIFY THE DATE, TIME AND PLACE OF THE MEETING AND
15 SHALL STATE THAT THE COUNCIL'S MEETINGS ARE OPEN TO THE GENERAL
16 PUBLIC. ALL ACTION TAKEN BY THE COUNCIL SHALL BE TAKEN IN OPEN
17 PUBLIC SESSION AND SHALL NOT BE TAKEN EXCEPT UPON A MAJORITY
18 VOTE OF THE MEMBERS PRESENT AT A MEETING AT WHICH A QUORUM IS

19 PRESENT.
20 (6) THE MEMBERS OF THE COUNCIL SHALL NOT RECEIVE A SALARY OR
21 PER DIEM ALLOWANCE FOR SERVING AS MEMBERS OF THE COUNCIL BUT
22 SHALL BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES INCURRED
23 IN THE PERFORMANCE OF THEIR DUTIES.
24 (7) TERMS OF COUNCIL MEMBERS SHALL BE AS FOLLOWS:
25 (I) THE APPOINTED MEMBERS SHALL SERVE FOR A TERM OF THREE
26 (3) YEARS AND SHALL CONTINUE TO SERVE THEREAFTER UNTIL THEIR
27 SUCCESSORS ARE APPOINTED.
28 (II) AN APPOINTED MEMBER SHALL NOT BE ELIGIBLE TO SERVE MORE
29 THAN TWO FULL CONSECUTIVE TERMS OF THREE (3) YEARS. VACANCIES
30 SHALL BE FILLED IN THE SAME MANNER IN WHICH THEY WERE DESIGNATED



1 WITHIN SIXTY (60) DAYS OF THE VACANCY.
2 (III) AN APPOINTED MEMBER MAY BE REMOVED BY THE APPOINTING
3 AUTHORITY FOR JUST CAUSE AND BY A VOTE OF AT LEAST SEVEN MEMBERS
4 OF THE COUNCIL.
5 (8) THE COUNCIL SHALL REVIEW OUTREACH ACTIVITIES AND MAY
6 MAKE RECOMMENDATIONS TO THE [INSURANCE DEPARTMENT] DEPARTMENT.
7 (9) THE COUNCIL SHALL REVIEW AND EVALUATE THE ACCESSIBILITY
8 AND AVAILABILITY OF SERVICES DELIVERED TO CHILDREN ENROLLED IN
9 THE PROGRAM.
10 (J) THE [INSURANCE DEPARTMENT] DEPARTMENT SHALL SOLICIT BIDS
11 AND AWARD CONTRACTS THROUGH A COMPETITIVE PROCUREMENT PROCESS
12 PURSUANT TO THE FOLLOWING:
13 (1) TO THE FULLEST EXTENT PRACTICABLE, CONTRACTS SHALL BE
14 AWARDED TO [ENTITIES] INSURERS THAT CONTRACT WITH PROVIDERS TO
15 PROVIDE PRIMARY CARE SERVICES FOR ENROLLEES ON A COST-EFFECTIVE
16 BASIS. THE [INSURANCE DEPARTMENT] DEPARTMENT SHALL REQUIRE
17 CONTRACTORS TO USE APPROPRIATE COST-MANAGEMENT METHODS SO THAT
18 [THE FUND CAN BE USED TO PROVIDE THE] BASIC PRIMARY BENEFIT
19 SERVICES CAN BE PROVIDED TO THE MAXIMUM NUMBER OF ELIGIBLE
20 CHILDREN AND, WHENEVER POSSIBLE, TO PURSUE AND UTILIZE AVAILABLE
21 PUBLIC AND PRIVATE FUNDS.
22 (2) TO THE FULLEST EXTENT PRACTICABLE, THE [INSURANCE
23 DEPARTMENT] DEPARTMENT SHALL REQUIRE THAT ANY CONTRACTOR COMPLY
24 WITH ALL PROCEDURES RELATING TO COORDINATION OF BENEFITS AS
25 REQUIRED BY THE [INSURANCE DEPARTMENT] DEPARTMENT OR THE
26 DEPARTMENT OF PUBLIC WELFARE.
27 (3) CONTRACTS MAY BE FOR A TERM OF UP TO THREE (3) YEARS[.],
28 WITH THE OPTION TO EXTEND FOR TWO ONE-YEAR PERIODS.
29 (K) UPON RECEIPT OF A [REQUEST FOR PROPOSAL] SOLICITATION
30 FROM THE [INSURANCE DEPARTMENT] DEPARTMENT, EACH [HEALTH PLAN



1 CORPORATION OR ITS] HEALTH SERVICE CORPORATION AND HOSPITAL PLAN
2 CORPORATION OR THEIR ENTITIES DOING BUSINESS IN THIS
3 COMMONWEALTH SHALL SUBMIT A BID OR PROPOSAL TO THE [INSURANCE
4 DEPARTMENT] DEPARTMENT TO CARRY OUT THE PURPOSES OF THIS SECTION
5 IN THE AREA SERVICED BY THE CORPORATION. ALL OTHER INSURERS MAY
6 SUBMIT A BID OR PROPOSAL TO THE DEPARTMENT TO CARRY OUT THE
7 PURPOSES OF THIS SECTION.
8 (L) A CONTRACTOR WITH WHOM THE [INSURANCE DEPARTMENT]
9 DEPARTMENT ENTERS INTO A CONTRACT SHALL DO THE FOLLOWING:
10 (1) ENSURE TO THE MAXIMUM EXTENT POSSIBLE THAT ELIGIBLE
11 CHILDREN HAVE ACCESS TO PRIMARY HEALTH CARE PHYSICIANS AND NURSE
12 PRACTITIONERS [ON AN EQUITABLE STATEWIDE BASIS] WITHIN THE
13 CONTRACTOR'S SERVICE AREA.
14 (2) CONTRACT WITH QUALIFIED, COST-EFFECTIVE PROVIDERS, WHICH
15 MAY INCLUDE PRIMARY HEALTH CARE PHYSICIANS, NURSE PRACTITIONERS,
16 CLINICS AND HEALTH MAINTENANCE ORGANIZATIONS, TO PROVIDE PRIMARY
17 AND PREVENTIVE HEALTH CARE FOR ENROLLEES ON A BASIS BEST
18 CALCULATED TO MANAGE THE COSTS OF THE SERVICES, INCLUDING, BUT
19 NOT LIMITED TO, USING MANAGED HEALTH CARE TECHNIQUES AND OTHER
20 APPROPRIATE MEDICAL COST-MANAGEMENT METHODS.
21 (3) ENSURE THAT THE FAMILY OF A CHILD WHO MAY BE ELIGIBLE
22 FOR MEDICAL ASSISTANCE RECEIVES ASSISTANCE IN APPLYING FOR
23 MEDICAL ASSISTANCE.[, INCLUDING, AT A MINIMUM, WRITTEN NOTICE OF

24 THE TELEPHONE NUMBER AND ADDRESS OF THE COUNTY ASSISTANCE OFFICE
25 WHERE THE FAMILY CAN APPLY FOR MEDICAL ASSISTANCE.]
26 (4) MAINTAIN WAITING LISTS OF CHILDREN FINANCIALLY ELIGIBLE
27 FOR BENEFITS WHO HAVE APPLIED FOR BENEFITS BUT WHO WERE NOT
28 ENROLLED DUE TO LACK OF FUNDS.
29 (4.1) NOTIFY FAMILIES OF CHILDREN WHO ARE PAYING A PREMIUM
30 OF ANY CHANGES IN SUCH PREMIUM OR COPAYMENT REQUIREMENTS.



1 (4.2) COLLECT SUCH PREMIUMS OR COPAYMENTS FROM THE FAMILY OF
2 ANY CHILD RECEIVING BENEFITS AS MAY BE REQUIRED.
3 (4.3) CANCEL POLICIES FOR NONPAYMENT OF PREMIUM, IN
4 ACCORDANCE WITH ALL OTHER APPLICABLE INSURANCE LAWS.
5 (5) STRONGLY ENCOURAGE ALL PROVIDERS WHO PROVIDE PRIMARY
6 CARE TO ELIGIBLE CHILDREN TO PARTICIPATE IN MEDICAL ASSISTANCE
7 AS QUALIFIED EPSDT PROVIDERS AND TO CONTINUE TO PROVIDE CARE TO
8 CHILDREN WHO BECOME INELIGIBLE FOR [PAYMENT] COVERAGE UNDER THE
9 [FUND] PROVISIONS OF THIS ARTICLE, BUT WHO QUALIFY FOR MEDICAL
10 ASSISTANCE.
11 (6) [PROVIDE] SUBJECT TO ANY NECESSARY FEDERAL APPROVAL,
12 PROVIDE THE FOLLOWING MINIMUM BENEFIT PACKAGE FOR ELIGIBLE
13 CHILDREN:
14 (I) PREVENTIVE CARE. THIS SUBPARAGRAPH INCLUDES WELL-CHILD
15 CARE VISITS IN ACCORDANCE WITH THE SCHEDULE ESTABLISHED BY THE
16 AMERICAN ACADEMY OF PEDIATRICS AND THE SERVICES RELATED TO THOSE
17 VISITS, INCLUDING, BUT NOT LIMITED TO, IMMUNIZATIONS, HEALTH
18 EDUCATION, TUBERCULOSIS TESTING AND DEVELOPMENTAL SCREENING IN
19 ACCORDANCE WITH ROUTINE SCHEDULE OF WELL-CHILD VISITS. CARE
20 SHALL ALSO INCLUDE A COMPREHENSIVE PHYSICAL EXAMINATION,
21 INCLUDING X-RAYS IF NECESSARY, FOR ANY CHILD EXHIBITING SYMPTOMS
22 OF POSSIBLE CHILD ABUSE.
23 (II) DIAGNOSIS AND TREATMENT OF ILLNESS OR INJURY, INCLUDING
24 ALL MEDICALLY NECESSARY SERVICES RELATED TO THE DIAGNOSIS AND
25 TREATMENT OF SICKNESS AND INJURY AND OTHER CONDITIONS PROVIDED
26 ON AN AMBULATORY BASIS, SUCH AS LABORATORY TESTS, WOUND DRESSING
27 AND CASTING TO IMMOBILIZE FRACTURES.
28 (III) INJECTIONS AND MEDICATIONS PROVIDED AT THE TIME OF THE
29 OFFICE VISIT OR THERAPY AND OUTPATIENT SURGERY PERFORMED IN THE
30 OFFICE, A HOSPITAL OR FREESTANDING AMBULATORY SERVICE CENTER,



1 INCLUDING ANESTHESIA PROVIDED IN CONJUNCTION WITH SUCH SERVICE
2 OR DURING EMERGENCY MEDICAL SERVICE.
3 (IV) EMERGENCY ACCIDENT AND EMERGENCY MEDICAL CARE.
4 (V) PRESCRIPTION DRUGS.
5 (VI) EMERGENCY, PREVENTIVE AND ROUTINE DENTAL CARE. THIS
6 SUBPARAGRAPH DOES NOT INCLUDE ORTHODONTIA OR COSMETIC SURGERY.
7 (VII) EMERGENCY, PREVENTIVE AND ROUTINE VISION CARE,
8 INCLUDING THE COST OF CORRECTIVE LENSES AND FRAMES, NOT TO
9 EXCEED TWO PRESCRIPTIONS PER YEAR.
10 (VIII) EMERGENCY, PREVENTIVE AND ROUTINE HEARING CARE.
11 (IX) INPATIENT HOSPITALIZATION UP TO NINETY (90) DAYS PER
12 YEAR FOR ELIGIBLE CHILDREN.
13 (6.1) THE DEPARTMENT SHALL IMPLEMENT A PREMIUM ASSISTANCE
14 PROGRAM PERMITTED UNDER FEDERAL REGULATIONS AND AS PERMITTED
15 THROUGH FEDERAL WAIVER OR STATE PLAN AMENDMENT MADE PURSUANT TO
16 THIS ARTICLE. NOTWITHSTANDING ANY OTHER LAW TO THE CONTRARY, IN
17 THE EVENT IT IS MORE COST EFFECTIVE TO PURCHASE HEALTH CARE FROM
18 A PARENT'S EMPLOYER-BASED PROGRAM AND THE EMPLOYER-BASED PROGRAM
19 MEETS THE MINIMUM COVERAGE REQUIREMENTS, EMPLOYER-BASED COVERAGE
20 MAY BE PURCHASED IN PLACE OF ENROLLMENT IN THE HEALTH INSURANCE
21 PROGRAM ESTABLISHED UNDER THIS SUBDIVISION. AN INSURER SHALL
22 HONOR A REQUEST FOR ENROLLMENT AND PURCHASE OF EMPLOYE GROUP
23 HEALTH INSURANCE REQUESTED ON BEHALF OF AN INDIVIDUAL APPLYING
24 FOR COVERAGE UNDER THIS ARTICLE IF THAT INDIVIDUAL:
25 (I) IS A RESIDENT OF THIS COMMONWEALTH;
26 (II) IS QUALIFIED BASED ON INCOME UNDER SECTION 2311(D),
27 (E.1), (E.2) OR (E.3);
28 (III) MEETS THE UNINSURED PERIOD, EXCEPT THAT ANY DELAY DUE

29 TO AN ENROLLMENT RESTRICTION, WHICH MAY NOT EXCEED NINETY (90)
30 DAYS, OR DUE TO THE LENGTH OF THE DEPARTMENT'S COST
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1 EFFECTIVENESS DETERMINATION SHALL BE COUNTED TOWARDS CALCULATING
2 THE UNINSURED PERIOD; AND
3 (IV) MEETS THE CITIZENSHIP REQUIREMENTS OF SECTION
4 2311(C)(1.1)(IV).
5 (6.2) THE DEPARTMENT SHALL HAVE THE AUTHORITY TO REVIEW,
6 AUDIT AND APPROVE ANNUAL ADMINISTRATIVE EXPENSES INCURRED BY
7 CONTRACTORS PURSUANT TO THIS SECTION.
8 (7) [EACH] EXCEPT FOR CHILDREN COVERED UNDER PARAGRAPH
9 (6.1), EACH CONTRACTOR SHALL PROVIDE AN INSURANCE IDENTIFICATION
10 CARD TO EACH ELIGIBLE CHILD COVERED UNDER CONTRACTS EXECUTED
11 UNDER THIS ARTICLE. THE CARD MUST NOT SPECIFICALLY IDENTIFY THE
12 HOLDER AS LOW INCOME.
13 (M) THE [INSURANCE DEPARTMENT] DEPARTMENT MAY GRANT A WAIVER
14 OF THE MINIMUM BENEFIT PACKAGE OF SUBSECTION (L)(6) UPON
15 DEMONSTRATION BY THE APPLICANT THAT IT IS PROVIDING HEALTH CARE
16 SERVICES FOR ELIGIBLE CHILDREN THAT MEET THE PURPOSES AND INTENT
17 OF THIS SECTION.
18 (N) AFTER THE FIRST YEAR OF OPERATION AND PERIODICALLY
19 THEREAFTER, THE [INSURANCE DEPARTMENT] DEPARTMENT IN
20 CONSULTATION WITH APPROPRIATE COMMONWEALTH AGENCIES SHALL REVIEW
21 ENROLLMENT PATTERNS FOR BOTH THE FREE INSURANCE PROGRAM AND THE
22 SUBSIDIZED INSURANCE PROGRAM. THE [INSURANCE DEPARTMENT]
23 DEPARTMENT SHALL CONSIDER THE RELATIONSHIP, IF ANY, AMONG
24 ENROLLMENT, ENROLLMENT FEES, INCOME LEVELS AND FAMILY
25 COMPOSITION. BASED ON THE RESULTS OF THIS STUDY AND THE
26 AVAILABILITY OF FUNDS, THE [INSURANCE DEPARTMENT] DEPARTMENT IS
27 AUTHORIZED TO ADJUST THE MAXIMUM INCOME CEILING FOR FREE
28 INSURANCE AND THE MAXIMUM INCOME CEILING FOR SUBSIDIZED
29 INSURANCE BY REGULATION. IN NO EVENT, HOWEVER, SHALL THE MAXIMUM
30 INCOME CEILING FOR FREE INSURANCE BE RAISED ABOVE TWO HUNDRED
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1 PER CENTUM (200%) OF THE FEDERAL POVERTY LEVEL.[, NOR SHALL THE
2 MAXIMUM INCOME CEILING FOR SUBSIDIZED INSURANCE BE RAISED ABOVE
3 TWO HUNDRED THIRTY-FIVE PER CENTUM (235%) OF THE FEDERAL POVERTY
4 LEVEL. CHANGES IN THE MAXIMUM INCOME CEILING SHALL BE
5 PROMULGATED AS A FINAL-FORM REGULATION WITH PROPOSED RULEMAKING
6 OMITTED IN ACCORDANCE WITH THE ACT OF JUNE 25, 1982 (P.L.633,
7 NO.181), KNOWN AS THE "REGULATORY REVIEW ACT."]
8 (O) NOTWITHSTANDING SUBSECTION (N), BEGINNING JANUARY 1,
9 2007, AND THEREAFTER, AND SUBJECT TO THE PROVISIONS OF SECTION
10 2314, THE MAXIMUM INCOME CEILING FOR SUBSIDIZED INSURANCE SHALL
11 NOT BE RAISED ABOVE THREE HUNDRED PER CENTUM (300%) OF THE
12 FEDERAL POVERTY LEVEL.
13 SECTION 2312. OUTREACH.--(A) THE [INSURANCE DEPARTMENT]
14 DEPARTMENT, IN CONSULTATION WITH APPROPRIATE COMMONWEALTH
15 AGENCIES, SHALL COORDINATE THE DEVELOPMENT OF AN OUTREACH PLAN
16 TO INFORM POTENTIAL CONTRACTORS, PROVIDERS AND ENROLLEES
17 REGARDING ELIGIBILITY AND AVAILABLE BENEFITS. THE PLAN SHALL
18 INCLUDE PROVISIONS FOR REACHING SPECIAL POPULATIONS, INCLUDING
19 NONWHITE AND NON-ENGLISH-SPEAKING CHILDREN AND CHILDREN WITH
20 DISABILITIES; FOR REACHING DIFFERENT GEOGRAPHIC AREAS, INCLUDING
21 RURAL AND INNER-CITY AREAS; AND FOR ASSURING THAT SPECIAL
22 EFFORTS ARE COORDINATED WITHIN THE OVERALL OUTREACH ACTIVITIES
23 THROUGHOUT THIS COMMONWEALTH.
24 (B) THE COUNCIL SHALL REVIEW THE OUTREACH ACTIVITIES AND
25 RECOMMEND CHANGES AS IT DEEMS IN THE BEST INTERESTS OF THE
26 CHILDREN TO BE SERVED.
27 SECTION 2313. PAYOR OF LAST RESORT; INSURANCE COVERAGE.--THE
28 CONTRACTOR SHALL NOT PAY ANY CLAIM ON BEHALF OF AN ENROLLED
29 CHILD UNLESS ALL OTHER FEDERAL, STATE, LOCAL OR PRIVATE
30 RESOURCES AVAILABLE TO THE CHILD OR THE CHILD'S FAMILY ARE
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1 UTILIZED FIRST. THE [INSURANCE DEPARTMENT] DEPARTMENT, IN
2 COOPERATION WITH THE DEPARTMENT OF PUBLIC WELFARE, SHALL

3 DETERMINE [THAT NO] IF ANY OTHER INSURANCE COVERAGE IS AVAILABLE
4 TO THE CHILD THROUGH A CUSTODIAL OR NONCUSTODIAL PARENT ON AN
5 EMPLOYMENT-RELATED OR OTHER GROUP BASIS. IF SUCH INSURANCE
6 COVERAGE IS AVAILABLE, THE [INSURANCE DEPARTMENT SHALL
7 REEVALUATE THE] CHILD'S ELIGIBILITY UNDER SECTION 2311[.] SHALL
8 BE REEVALUATED, AS SHALL THE MOST COST-EFFECTIVE MEANS OF
9 PROVIDING COVERAGE FOR THAT CHILD.
10 SECTION 4. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:
11 SECTION 2314. STATE PLAN.--THE DEPARTMENT, IN COOPERATION
12 WITH THE DEPARTMENT OF PUBLIC WELFARE, SHALL AMEND THE STATE
13 PLAN AS DEEMED NECESSARY TO CARRY OUT THE PROVISIONS OF THIS
14 ARTICLE. THE REPEAL OF SECTION 2311(E) AND (F) AND THE EXPANSION
15 OF FINANCIAL ELIGIBILITY UNDER SECTION 2311(E.1), (E.2) AND
16 (E.3) SHALL BE CONTINGENT UPON FEDERAL APPROVAL.
17 SECTION 2362. EXPIRATION.--THIS ARTICLE SHALL EXPIRE
18 DECEMBER 31, 2010.
19 SECTION 5. WHEN THE DEPARTMENT RECEIVES FEDERAL APPROVAL OF
20 THE STATE PLAN AMENDMENTS REQUESTED UNDER SECTION 2314 OF THE
21 ACT, IT SHALL TRANSMIT NOTICE OF THAT FACT TO THE LEGISLATIVE
22 REFERENCE BUREAU FOR PUBLICATION AS A NOTICE IN THE PENNSYLVANIA
23 BULLETIN.
24 SECTION 6. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:
25 (1) THE FOLLOWING PROVISIONS SHALL TAKE EFFECT
26 IMMEDIATELY:
27 (I) THE AMENDMENT OF SECTION 1012-A OF THE ACT.
28 (II) THE ADDITION OF SECTION 2194 OF THE ACT.
29 (III) THE ADDITION OF SECTION 2314 OF THE ACT.
30 (IV) THE ADDITION OF SECTION 2362 OF THE ACT.



1 (V) SECTION 5 OF THIS ACT.
2 (VI) THIS SECTION.
3 (2) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT ON THE
4 LATER OF:
5 (I) 30 DAYS AFTER THE DATE OF PUBLICATION OF THE
6 NOTICE UNDER SECTION 5 OF THIS ACT; OR
7 (II) JANUARY 1, 2007.