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TITLE 40
INSURANCE

Part
I. Preliminary Provisions
II. Regulation of Insurers and Related Persons Generally
III. Special Provisions Relating to Particular Classes of Insurers
IV. Standard Valuation
V. Health Insurance Market Oversight

Enactment. Unless otherwise noted, the provisions of Title 40 were added November 15, 1972, P.L.1063, No.271, effective in 90 days.

PART I
PRELIMINARY PROVISIONS

Chapter
1. General Provisions

Enactment. Part I was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

CHAPTER 1
GENERAL PROVISIONS

Sec.
101. Definitions.

Enactment. Chapter 1 was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

§ 101. Definitions.

Subject to additional definitions contained in subsequent provisions of this title which are applicable to specific parts, articles, chapters or other provisions of this title, the following words and phrases when used in this title shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Beneficial society." A corporation subject to regulation under the act of June 4, 1937 (P.L.1643, No.342).

"Certificate of authority." An instrument in writing issued by the department authorizing an insurer or proposed insurer to engage in the business of insurance, or some specified line, branch or part thereof, in this Commonwealth.

"Corporation not-for-profit." A corporation not-for-profit as defined in Title 15 (relating to corporations and unincorporated associations).

"Department." The Insurance Department of the Commonwealth.

"Foreign." Not incorporated or organized under the laws of this Commonwealth.

"Uncertificated." Not holding an unsuspended or unrevoked certificate of authority authorizing the relevant line, branch or part of the business of insurance.

PART II
REGULATION OF INSURERS AND RELATED PERSONS GENERALLY

Chapter

33. Compliance with Federal Health Care Legislation
35. Medical Professional Liability Reciprocal Exchange-to-Stock Conversion
37. Unclaimed Life Insurance Benefits
38. Retroactive Denial of Reimbursements
39. Corporate Governance Annual Disclosure
40. Medication Synchronization
43. Mental Health Parity and Access to Addiction Treatment
45. Insurance Data Security

Enactment. Part II (Reserved) was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

Part Heading. The heading of Part II (Reserved) was amended June 17, 2013, P.L.43, No.13, effective in 60 days.

CHAPTER 33
COMPLIANCE WITH FEDERAL HEALTH CARE LEGISLATION

Sec.

3301. Definitions.
3302. Opt-out for abortion.

Enactment. Chapter 33 was added June 17, 2013, P.L.43, No.13, effective in 60 days.

§ 3301. Definitions.

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

"Abortion." The term shall have the same meaning given to it in 18 Pa.C.S. § 3203 (relating to definitions).

"Complication." The term shall have the same meaning given to it in 18 Pa.C.S. § 3203 (relating to definitions).

"Health insurance exchange." The term shall mean an insurance system established to comply with section 1311(b) or 1321(c) of the Patient Protection and Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18031(b) or 18041(c)).

§ 3302. Opt-out for abortion.

(a) Prohibition.--The Commonwealth of Pennsylvania hereby elects pursuant to the authority granted the states under section 1303(a) of the Patient Protection and Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18023(a)) to prohibit certain abortion coverage in qualified health plans offered through the health insurance exchange under subsection (b).

(b) Included coverage prohibition.--No qualified health plan offered in this Commonwealth through the health insurance exchange shall include coverage for the performance of any abortion unless the reason the abortion is performed is one for which the expenditure of public funds would be permitted under 18 Pa.C.S. § 3215(c) (relating to publicly owned facilities; public officials and public funds).

(c) Excluded coverage prohibited.--No qualified health plan offered in this Commonwealth through a health insurance exchange shall exclude coverage for:

(1) Treatment of any postabortion complication.

(2) Treatment of any miscarriage or any complication related to a miscarriage.

(d) Option.--Nothing in this section shall prohibit an individual from purchasing optional supplemental abortion coverage provided the individual pays a separate premium for the coverage and obtains the coverage outside of the health insurance exchange.

CHAPTER 35
MEDICAL PROFESSIONAL LIABILITY
RECIPROCAL EXCHANGE-TO-STOCK CONVERSION

Sec.

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3503. Contents of plan of conversion.
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3505. Alternative plan of conversion.
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3508. Corporate existence.
3509. Conflict of interest.
3510. Failure to give notice.
3511. Limitation on actions.
3512. Reciprocal insurer insolvent or in hazardous financial condition.
3513. Rules and regulations.
3514. Laws applicable to stock company.
3515. Licensing of stock company and commencement of business as an insurance company.
3516. Amendment of policies.
3517. Prohibition on acquisitions of control.

Enactment. Chapter 35 was added May 13, 2015, P.L.3, No.2, effective in 60 days.

§ 3501. Definitions.

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

"Attorney." The person that manages and acts as the attorney-in-fact for the reciprocal insurer.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Eligible subscriber." A subscriber of a reciprocal insurer whose policy is in force on at least one of the following dates:

(1) the date the reciprocal insurer or its attorney adopts a plan of conversion; or

(2) if a different date, on the record date for establishing subscribers eligible to vote on the plan of conversion.

"Participating policy." A policy that grants a holder the right to receive dividends if, as and when declared by the reciprocal insurer.

"Person." An individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a similar entity or a combination of the foregoing acting in concert.

"Plan of conversion" or "plan." A plan adopted under this chapter to convert the reciprocal insurer into a stock company by the subscribers' advisory committee or an equivalent governing body of the reciprocal insurer or, in the absence of a governing body, by the board of directors or governing body of the attorney for the reciprocal insurer.

"Policy." An insurance policy issued by the reciprocal insurer.

"Reciprocal insurer." A Pennsylvania-domiciled reciprocal and inter-insurance exchange, as established in Article X of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, that is authorized to write medical professional liability insurance and at least 50% of its direct written premium in the calendar year preceding adoption of the plan of conversion consisted of medical professional liability insurance.

"Stock company." An insurance company that:

(1) meets the requirements for admission to do business as a domestic Pennsylvania insurer;

(2) is formed at the direction of the reciprocal insurer or attorney; and

(3) shall be the successor of the reciprocal insurer by the merger of the reciprocal insurer with and into the stock company or by another means approved by the commissioner.

§ 3502. Adoption of plan of conversion.

(a) Plan of conversion.--The following shall apply:

(1) A plan of conversion may not become effective unless the reciprocal insurer seeking to convert to a stock company has adopted:

(i) by the affirmative vote of not less than two-thirds of the subscribers' advisory committee or an equivalent governing body of the reciprocal insurer; or

(ii) in the absence of a governing body, by the board of directors or governing body of the attorney for the reciprocal insurer,

a plan of conversion consistent with the requirements of sections 3503 (relating to contents of plan of conversion) and 3504 (relating to optional provisions of plan of conversion).

(2) Before approval of a plan by the commissioner, the reciprocal insurer may amend or withdraw the plan under paragraph (1) by the affirmative vote of not less than two-thirds of:

(i) its subscribers' advisory committee or an equivalent governing body of the reciprocal insurer; or

(ii) in the absence of a governing body, by the board of directors or governing body of the attorney for the reciprocal insurer.

(b) Eligible subscriber.--A person insured under a group policy that is otherwise an eligible subscriber also shall be an eligible subscriber. A person whose policy becomes effective after the adoption of the plan or the voting record date, if a later date, but before the plan's effective date is not an eligible subscriber but shall have the rights established under section 3507 (relating to rights of subscribers whose policies are issued after adoption of plan and before effective date).

(c) Documents.--The following shall apply:

(1) Before a reciprocal insurer's eligible subscribers may vote on approval of a plan, the reciprocal insurer or the attorney shall file the following documents with the commissioner within 90 days after adoption of the plan:

(i) the plan of conversion, including the independent evaluation of pro forma market value required under section 3503(d).

(ii) the form of notice required under subsection (g);

(iii) the form of proxy to be solicited from eligible subscribers under subsection (h);

(iv) the form of notice required under section 3508 (relating to corporate existence) to persons whose policies are issued after adoption of the plan but before its effective date;

(v) the proposed articles of incorporation and bylaws of the stock company;

(vi) the acquisition of control statement, as required under section 1402 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921; and

(vii) other information as the commissioner may request.

(2) Upon filing of the documents required under this subsection with the commissioner, the reciprocal insurer shall send to eligible subscribers a notice advising eligible subscribers of:

(i) the adoption and filing of the plan;

(ii) the ability of subscribers to provide the commissioner and the reciprocal insurer with comments on the plan within 30 days of the date of the notice; and

(iii) the procedure for making comments.

(d) Notice and approval of plan.--The commissioner shall immediately give written notice to the reciprocal insurer of a decision and, in the event of disapproval, a statement in detail of the reasons for the decision. The commissioner shall approve the plan if the commissioner finds the following:

(1) the plan complies with this chapter;

(2) the plan will not prejudice the interests of the subscribers; and

(3) the plan's method of allocating subscription rights is fair and equitable.

(e) Experts.--At the reciprocal insurer's expense, the commissioner may retain a qualified expert not otherwise a part of the commissioner's staff to assist in reviewing the plan and the independent evaluation of the pro forma market value required under section 3503(d).

(f) Hearing.--The commissioner may order a hearing on whether the terms of the plan comply with this chapter after giving written notice to the reciprocal insurer and other interested persons, all of whom have the right to appear at the hearing.

(g) Notice of subscribers' meeting.--The following shall apply:

(1) Eligible subscribers shall be sent notice of the subscribers' meeting to vote upon the plan. The notice must:

(i) briefly but fairly describe the proposed conversion plan;

(ii) inform the subscriber of the subscriber's right to vote upon the plan; and

(iii) be sent to each subscriber's last known address, as shown on the reciprocal insurer's records, at least 30 days before the time fixed for the meeting.

(2) If the reciprocal insurer holds an annual meeting of subscribers and the meeting to vote upon the plan is held at the annual meeting, only a combined notice of meeting is required.

(h) Voting.--The plan shall be voted upon by eligible subscribers and shall be deemed approved upon receiving the affirmative vote of at least two-thirds of the votes cast by eligible subscribers. Unless the governing documents of the reciprocal insurer establish a different date, the record date for determining subscribers eligible to vote on the plan shall be the date of adoption of the plan or other date set forth in the plan that shall be no less than 30 nor more than 90 days before the date of the meeting. Eligible subscribers entitled to vote upon the proposed plan may vote in person or by proxy. Unless the governing documents of the reciprocal insurer provide otherwise, an eligible subscriber may cast one vote.

(i) Approval of plan.--A merger of the reciprocal insurer with and into the stock company must be approved at the meeting of the subscribers called for the purpose of approving the plan of conversion and shall require for approval or ratification the affirmative vote of at least two-thirds of the votes cast by eligible subscribers.

(j) Documents to be filed following approval.--Within 30 days after the eligible subscribers approved the plan, the stock company shall file the following documents with the commissioner:

(1) the minutes of the meeting of the eligible subscribers at which the plan was approved;

(2) the articles of incorporation and bylaws of the stock company; and

(3) articles of merger for the merger of the reciprocal insurer with and into the stock company. The plan shall be consummated upon the filing of the articles of merger.

§ 3503. Contents of plan of conversion.

(a) Contents.--The following provisions shall be included in a plan of conversion:

(1) The reasons for proposed conversion.

(2) The effect of conversion on existing policies, including a provision that the policies in force on the effective date of conversion continue to remain in force under the terms of the policies, except that the following rights, to the extent they existed in the reciprocal insurer, shall be extinguished on the effective date of the conversion:

(i) The voting rights of the subscribers provided under the policies.

(ii) The right to share in the surplus of the reciprocal insurer provided for under the policies.

(iii) The assessment provisions provided for under the policies.

(3) The grant of subscription rights to eligible subscribers, including all of the following:

(i) A provision that each eligible subscriber is to receive, without payment, nontransferable subscription rights to purchase a portion of the capital stock of the stock company and that, in the aggregate, the eligible subscribers may, prior to the right of any other party, purchase 100% of the capital stock of the stock company, exclusive of the shares of capital stock required to be sold or distributed to the holders of surplus notes or the shares of capital stock required to be sold or distributed to subscribers under the reciprocal insurer's constituent documents.

(ii) As an alternative to subscription rights in the stock company, the plan may provide that each eligible subscriber is to receive, without payment, nontransferable subscription rights to purchase a portion of the capital stock of one of the following:

(A) the attorney or a holding company that will act as the holding company for the stock company and, in either case, will hold the stock of the stock company; or

(B) an insurance company or other corporation that will purchase all the stock of or otherwise acquire the stock company.

(iii) A provision that the subscription rights shall be allocated in whole shares among the eligible subscribers using a fair and equitable formula. This formula may, but need not, take into account how the different classes of policies of the eligible subscribers contributed to the surplus of the reciprocal insurer or any other factors that may be fair or equitable.

(b) Oversubscription.--The plan shall provide a fair and equitable means for allocating shares of capital stock in the event of an oversubscription to shares by eligible subscribers exercising subscription rights received under subsection (a)(3).

(c) Shares not subscribed.--The plan shall provide that a share of capital stock not subscribed to by an eligible subscriber exercising subscription rights received under subsection (a)(3) shall be sold in a public offering through an underwriter or in another transaction approved by the commissioner. If the number of shares of capital stock not subscribed by eligible subscribers is so small in number or other factors exist that do not warrant the time or expense of a public offering, the plan of conversion may provide for sale of the unsubscribed shares through a private placement or other alternative method approved by the commissioner that is fair and equitable to eligible subscribers.

(d) Market value of capital stock.--The following shall apply:

(1) The plan shall set the price of the capital stock equal to the estimated pro forma market value of the stock company as successor to the reciprocal insurer based upon an independent evaluation by a qualified expert.

(2) The pro forma market value may be the value that is estimated to be necessary to attract full subscription for the shares, as indicated by the independent evaluation and may be stated as a range of pro forma market value.

(3) If the attorney is a party to the conversion either as the entity that grants subscription rights to subscribers or the attorney is simultaneously acquired by the stock company in connection with the conversion, the incremental value of the attorney shall be included in the estimate of pro forma market value of the stock company as successor to the reciprocal insurer.

(4) The qualified expert shall consider the effect on the pro forma market value of a right of subscribers to a return of capital contained in the subscriber agreement or other operative document of the reciprocal insurer.

(e) Purchase price of capital stock and minimum subscription amount.--The plan shall set the purchase price per share of capital stock equal to a reasonable amount. The minimum subscription amount required of an eligible subscriber, however, cannot exceed $500, but the plan may provide that the minimum number of shares a person may purchase under the plan is 25 shares.

(f) Limitation on amount of capital stock purchase.--The plan shall provide that a person or group of persons acting in concert may not acquire, in the public offering or under the exercise of subscription rights, more than 5% of the capital stock of the stock company or the stock of another corporation that is participating in the conversion plan, as provided in subsection (a)(3)(i), except with the approval of the commissioner. The limitation does not apply to an entity that is to purchase 100% of the capital stock of the converted company as part of the plan of conversion approved by the commissioner.

(g) Limitation on directors and officers.--The plan shall provide that a director or officer or person acting in concert with a director or officer of the reciprocal insurer or the attorney may not acquire capital stock of the stock company or the stock of another corporation that is participating in the conversion plan, as provided in subsection (a)(3)(i), for three years after the effective date of the plan, except through a broker-dealer, without the permission of the commissioner. This subsection does not prohibit the directors and officers from making a block purchase of 1% or more of the outstanding common stock:

(1) other than through a broker-dealer if approved in writing by the department;

(2) through the exercise of subscription rights received under the plan; or

(3) from participation in a stock benefit plan approved by shareholders under section 3509(b) (relating to conflict of interest).

(h) Sale of stock by directors and officers.--The plan shall provide that a director or officer may not sell stock purchased under this section or section 3504(a) (relating to optional provisions of plan of conversion) within one year after the effective date of the conversion.

(i) Holders of surplus notes.--The plan shall provide that the rights of a holder of a surplus note to participate in the conversion shall be governed by the terms of the surplus note and the rights of subscribers to a return of capital shall be governed by the subscriber agreement or other operative document of the reciprocal insurer.

(j) Repurchase of capital stock.--The plan shall provide that, without the prior approval of the commissioner, a stock company, or a corporation participating in the conversion plan under subsection (a)(3)(i), may not for a period of three years from the date of the completion of the conversion repurchase any of its capital stock from a person. The restriction under this subsection shall not apply to either:

(1) a repurchase on a pro rata basis under an offer made to the shareholders of the stock company or a corporation participating in the conversion plan under subsection (a)(3)(i); or

(2) a purchase in the open market by a tax-qualified or nontax-qualified employee stock benefit plan in an amount reasonable and appropriate to fund the plan.

Cross References. Section 3503 is referred to in sections 3502, 3504, 3505, 3509, 3517 of this title.

§ 3504. Optional provisions of plan of conversion.

(a) Subscription rights.--The plan may provide that the directors and officers of the attorney and the reciprocal insurer shall receive, without payment, nontransferable subscription rights to purchase capital stock of the stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 3503(a)(3)(ii) (relating to contents of plan of conversion). The subscription rights shall be allocated among the directors and officers by a fair and equitable formula and shall be subordinate to the subscription rights of eligible subscribers. This chapter may not require the subordination of subscription rights received by directors and officers in their capacity as eligible subscribers.

(b) Maximum share purchase by directors and officers.--The aggregate total number of shares that may be purchased by directors and officers of the attorney and the reciprocal insurer in their capacity under subsection (a) and in their capacity as eligible subscribers under section 3503(a)(3) may not exceed 35% of the total number of shares to be issued if total assets of the reciprocal insurer are less than $50,000,000 or 25% of the total number of shares to be issued if total assets of the reciprocal insurer are more than $500,000,000. For reciprocal companies with total assets of or between $50,000,000 and $500,000,000, the percentage of the total number of shares that may be purchased shall be interpolated.

(c) Liquidation account.--The plan may provide for the creation of a liquidation account for the benefit of subscribers in the event of voluntary liquidation subsequent to conversion in an amount equal to the surplus of the reciprocal insurer, exclusive of the principal amount of a surplus note, on the last day of the quarter immediately preceding the date of adoption of the plan.

Cross References. Section 3504 is referred to in sections 3502, 3503 of this title.

§ 3505. Alternative plan of conversion.

A plan of conversion may be adopted that does not rely in whole or in part upon issuing nontransferable subscription

rights to subscribers to purchase stock of the stock company if the commissioner finds that the plan does not prejudice the interests of the subscribers, is fair and equitable and is not inconsistent with the purpose and intent of this chapter. An alternative plan may:

(1) Include the acquisition or merger of the stock company or a corporation participating in the conversion plan under section 3503(a)(3)(ii) (relating to contents of plan of conversion) by or into a domestic or foreign stock company.

(2) Provide for issuing stock, cash or other consideration to subscribers instead of subscription rights.

(3) Set forth another plan containing any other provisions approved by the commissioner.

§ 3506. Effective date of plan.

A plan is effective when the following have been completed:

(1) The commissioner has approved the plan.

(2) The eligible subscribers have approved the plan.

(3) If the stock company becomes successor to the reciprocal insurer by merger, the eligible subscribers have approved the merger of the reciprocal insurer with and into the stock company and the articles of merger have been filed with the Secretary of the Commonwealth.

§ 3507. Rights of subscribers whose policies are issued after adoption of plan and before effective date.

(a) Notice.--A subscriber shall be sent a written notice regarding the plan upon issuance of a policy if the subscriber's policy is issued after the later of:

(1) the date the proposed plan has been adopted; or

(2) if different, the record date for establishing subscribers eligible to vote on the plan.

The notice shall be sent before the effective date of the plan.

(b) Cancellation and refund.--A subscriber entitled to receive the notice provided for in subsection (a) shall be advised of the subscriber's right of cancellation and to a pro rata refund of unearned premiums.

(c) Limitation on subscribers.--A subscriber who has made or filed a claim under the subscriber's insurance policy may not receive a refund under subsection (b). A person who has exercised the rights provided under subsection (b) may not make or file a claim under the subscriber's insurance policy.

Cross References. Section 3507 is referred to in section 3502 of this title.

§ 3508. Corporate existence.

On the effective date of the conversion, the corporate existence of the reciprocal insurer continues in the stock company. On the effective date of the conversion, the assets, rights, franchises and interests of the reciprocal insurer in and to every species of real, personal and mixed property and the accompanying things in action are vested in the stock company without a deed or other instrument of transfer and the stock company assumes the obligations and liabilities of the reciprocal insurer.

Cross References. Section 3508 is referred to in section 3502 of this title.

§ 3509. Conflict of interest.

(a) Compensation.--A director, officer, agent or employee of the attorney or reciprocal insurer may not receive a fee, commission or other valuable consideration, other than his usual regular salary or compensation, for aiding, promoting or

assisting in a conversion under this chapter except as provided for in the plan approved by the commissioner. This subsection does not prohibit the payment of reasonable fees and compensation to counsel, accountants and actuaries for services performed in the independent practice of their professions, even if the counsel, accountant or actuary is also a director or officer of the attorney or the reciprocal insurer.

(b) Stock benefit plan.--For a period of two years after the effective date of the conversion, a stock company may not implement a non-tax-qualified stock benefit plan unless the plan is approved by a majority of votes eligible to be cast at a meeting of shareholders held not less than six months after the effective date of the conversion.

(c) Costs and expenses.--The costs and expenses connected with a plan of conversion shall be paid for or reimbursed by the reciprocal insurer or the stock company. If the plan provides for participation by another corporation or stock company in the plan under section 3503(a)(3)(ii) (relating to contents of plan of conversion), the corporation or stock company may pay for or reimburse all or a portion of the costs and expenses connected with the plan.

Cross References. Section 3509 is referred to in section 3503 of this title.

§ 3510. Failure to give notice.

If the reciprocal insurer complies substantially and in good faith with the notice requirements of this chapter, the reciprocal insurer's failure to send a subscriber the required notice does not impair the validity of an action taken under this chapter.

§ 3511. Limitation on actions.

An action challenging the validity of or arising out of acts taken or proposed to be taken under this chapter shall be commenced no later than 30 days after the later of the approval of the plan by the commissioner or the deemed approval of the plan by a vote of the eligible subscribers.

§ 3512. Reciprocal insurer insolvent or in hazardous financial condition.

(a) Waiver of requirements.--If a reciprocal insurer seeking to convert is insolvent or is in hazardous financial condition according to information supplied in its most recent annual or quarterly statement filed with the department or as determined by a financial examination performed by the department under Article IX of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, the requirements of this chapter, including notice to and policyholder approval of the plan of conversion, may be waived at the discretion of the commissioner if requested by the attorney or the reciprocal insurer. If a waiver under this section is ordered by the commissioner, the reciprocal insurer shall specify the following in its plan of conversion:

(1) The method and basis for the issuance of the stock company's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the stock company, as successor to the reciprocal insurer, to a sound financial condition.

(2) That the conversion shall be accomplished without granting subscription rights or other consideration to the past, present or future subscribers.

(b) Authority of commissioner.--This section shall not alter or limit the authority of the commissioner under the provisions

of law, including, but not limited to, Article V of The Insurance Department Act of 1921.

§ 3513. Rules and regulations.

The commissioner may promulgate rules and regulations to administer and enforce this chapter.

§ 3514. Laws applicable to stock company.

(a) Control of stock company.--A reciprocal insurer may not convert under this chapter if, as a direct result of the conversion, a person or the person's affiliates acquire control of the stock company, unless that person and the person's affiliates comply with the provisions of section 1402 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921. For purposes of this subsection, the term "control" shall have the meaning provided in section 1401 of The Insurance Company Law of 1921.

(b) Stock insurance company rules.--Except as otherwise specified in this chapter, a stock company resulting from the conversion of a reciprocal insurer under this chapter shall have and may exercise the rights and privileges and shall be subject to the requirements and regulations imposed upon stock insurance companies formed under this act and other laws of this Commonwealth relating to the regulation and supervision of insurance companies, but it may not exercise rights or privileges that other stock insurance companies may not exercise.

§ 3515. Licensing of stock company and commencement of business as an insurance company.

The commissioner may waive the minimum surplus requirement of a stock company in connection with the initial licensing of a stock company that will be the successor to a reciprocal insurer. The stock company may not engage in the business of insurance as a stock company until the completion of the merger with the reciprocal insurer and compliance with the provisions of this chapter.

§ 3516. Amendment of policies.

By endorsement or rider approved by the commissioner and sent to the policyholder, a reciprocal insurer may simultaneously with or after the adoption of a plan of conversion amend an outstanding insurance policy for the purpose of extinguishing a right of the holder of the policy to share in the surplus of the reciprocal insurer. This amendment shall be void if the plan of conversion is not submitted to the commissioner or, if submitted, is disapproved by the commissioner or, if approved by the commissioner, is not approved by the eligible subscribers on or before the first anniversary of its approval by the commissioner.

§ 3517. Prohibition on acquisitions of control.

Except as otherwise specifically provided in section 3503 (relating to contents of plan of conversion), from the date a plan of conversion is adopted until the effective date of the plan of conversion, a person may not directly or indirectly offer to acquire, make an announcement to acquire or acquire in any manner, including making a filing with the department for acquisition under a statute or regulation of this Commonwealth, the beneficial ownership of 10% or more of a class of a voting security of the attorney or the stock company that will be the successor of the reciprocal insurer or of a person that controls the voting securities of the attorney or the stock company that will be the successor of the reciprocal insurer.

Sec.
3701. Purpose of chapter.
3702. Definitions.
3703. Death master file comparison.
3704. Applicability.
3705. Enforcement.
3706. Regulations.

Enactment. Chapter 37 was added November 3, 2016, P.L.1043, No.132, effective in 360 days.

§ 3701. Purpose of chapter.

The purpose of this chapter is to require the complete and proper disclosure, transparency and accountability relating to a method of payment for life insurance death benefits regulated by the Insurance Department.

§ 3702. Definitions.

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

"Beneficiary." A person designated to receive the proceeds from a life insurance policy or retained asset account.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Contract." An annuity contract. The term shall not include an annuity used to fund an employment-based retirement plan or program where:

(1) the insurer does not perform the recordkeeping services; or

(2) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

"Death master file." The Social Security Administration's death master file or any other database or service that is at least as comprehensive for determining that an individual has reportedly died.

"Death master file match." A search of the death master file that results in a match of the Social Security number or the name and date of birth of an insured, annuity owner or retained asset account holder.

"Department." The Insurance Department of the Commonwealth.

"Insured." An individual covered by a life insurance policy.

"Insurer." A person licensed in this Commonwealth to sell life insurance policies or annuity contracts as any of the following:

(1) A single insurance entity.

(2) An insurer under a parent organization that sells annuities using a different charter.

The term as used in this chapter shall not include a fraternal benefit society.

"Knowledge of death." Either of the following:

(1) receipt of an original or valid copy of a certified death certificate; or

(2) a death master file match validated by the insurer in accordance with section 3703(a) (relating to death master file comparison).

"Policy." A policy or certificate of life insurance that provides a death benefit. The term shall not include:

(1) a policy or certificate of life insurance that provides a death benefit under an employee benefit plan subject to the Employee Retirement Income Security Act of

1974 (Public Law 93-406, 88 Stat. 829), as periodically amended, or under any Federal employee benefits program;

(2) a policy or certificate of life insurance that is purchased in conjunction with a preneed funeral contract or prearrangement;

(3) a policy or certificate of credit life or accidental death insurance; or

(4) a policy issued to a group master policyholder for which the insurer does not provide recordkeeping services.

"Recordkeeping services." Those circumstances under which an insurer has agreed with a group policy or contract customer to be responsible for obtaining, maintaining and administering in its own or its agents' systems at least the following information about each individual insured under an insured's group insurance contract, or a line of coverage under the contract:

(1) Social Security number or name and date of birth;

(2) beneficiary designation information;

(3) coverage eligibility;

(4) benefit amount; and

(5) premium payment status.

"Retained asset account." A mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

§ 3703. Death master file comparison.

(a) Comparison.--An insurer shall implement procedures for performing a comparison of its insureds' in-force life insurance policies, contracts and retained asset accounts against the same death master file, on at least a semiannual basis, by using the full death master file once and thereafter using the death master file update files for future comparison to identify potential matches of its insureds. For a potential match identified as a result of a death master file match, all of the following shall apply:

(1) Within 90 days of a death master file match the insurer shall:

(i) complete a good faith effort to confirm the death of the insured or retained asset account holder against other available records and information. The effort shall be documented by the insurer; and

(ii) determine whether benefits are due in accordance with the applicable policy or contract, and if benefits are due:

(A) use good faith efforts to locate the beneficiary or beneficiaries, which shall be documented by the insurer; and

(B) provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim, including instructions on the need to provide an official death certificate, if applicable under the policy or contract.

(2) The insurer shall implement procedures to account for:

(i) common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names and interchanged first and middle names;

(ii) compound last names, maiden or married names and hyphens, blank spaces or apostrophes in last names;

(iii) transposition of the month and date portions of the date of birth; and

(iv) incomplete Social Security numbers.

(3) To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer with locating the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(b) Costs.--An insurer or its service provider may not charge an insured, a retained asset account holder, a beneficiary or other authorized representative for costs associated with a search or verification conducted in accordance with subsection (a).

(c) Payment.--

(1) The benefits from a policy, contract or retained asset account, plus applicable accrued contractual interest, shall first be paid to the designated beneficiaries or owners.

(2) If the beneficiary cannot be found, the benefits shall escheat to the Commonwealth as unclaimed property pursuant to Article XIII.1 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, and, notwithstanding the provisions of section 1301.4(a)1 of The Fiscal Code, shall be due and reportable to the Commonwealth three years after knowledge of death of the insured.

(d) Group life insurance.--An insurer shall confirm the possible death of an insured if the insurer maintains at least the following information regarding those covered under a policy or certificate:

(1) Social Security number or name and date of birth;

(2) beneficiary designation information;

(3) coverage eligibility;

(4) benefit amount; and

(5) premium payment status.

(e) Exceptions and exemptions.--At the written request of an insurer, the commissioner may make an order to:

(1) limit the insurer's death master file comparisons required under this section to the insurer's electronic searchable files or approve a plan and timeline for conversion of the insurer's files to searchable electronic files, upon a demonstration of hardship by the insurer;

(2) exempt the insurer from the death master file comparisons required under this section or permit the insurer to perform the comparisons less frequently than annually, upon a demonstration of hardship by the insurer; or

(3) phase in compliance with this section according to a plan and timeline submitted by the insured and approved by the commissioner.

Cross References. Section 3703 is referred to in section 3702 of this title.

§ 3704. Applicability.

This chapter shall not apply to all of the following:

(1) An annuity contract that does not require the insurer to pay benefits to the beneficiary of the policy.

(2) A policy that provides a death benefit under the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

(3) A Federal employee benefit program.

(4) A policy to fund funeral or burial services.

(5) A policy of credit life insurance or health and accident insurance.

§ 3705. Enforcement.

(a) Actions.--Upon a determination by hearing that an insurer has violated this chapter, the commissioner may pursue one or more of the following courses of action:

(1) issue an order requiring the insurer to cease and desist from engaging in the violation or suspend, revoke or refuse to issue the certificate of qualification or license of the offending insurer.

(2) impose a civil penalty of not more than $5,000 for each violation.

(b) Additional remedies or penalties.--The enforcement remedies imposed under this section shall be in addition to any other remedies or penalties imposed by statute.

(c) Administrative procedure.--An action or adjudication of the commissioner under this section shall be preceded by a hearing in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and shall be subject to review and appeal in accordance with 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

§ 3706. Regulations.

The commissioner may promulgate rules and regulations to administer the provisions of this chapter.

CHAPTER 38
RETROACTIVE DENIAL OF REIMBURSEMENTS

Sec.

3801. Scope of chapter.
3802. Definitions.
3803. Retroactive denial of reimbursement.
3804. Exceptions to retroactive denial of reimbursement.
3805. Coordination of benefits.
3806. Tolling.

Enactment. Chapter 38 was added November 4, 2016, P.L.1144, No.146, effective in 60 days.

§ 3801. Scope of chapter.

This chapter shall not apply to reimbursements made as part of an annual contracted reconciliation of a risk-sharing arrangement under an administrative service provider contract.

§ 3802. Definitions.

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

"Abuse." Incidents or practices of providers, physicians or suppliers of services and equipment which are inconsistent with accepted sound medical, business or fiscal practices.

"Fraud." Any activity defined as an offense under 18 Pa.C.S. § 4117 (relating to insurance fraud).

"Health care provider." A person, corporation, facility, institution or other entity licensed, certified or approved by the Commonwealth to provide health care or professional medical services. The term includes, but is not limited to, a physician, chiropractor, optometrist, professional nurse, certified nurse-midwife, podiatrist, hospital, nursing home, ambulatory surgical center or birth center.

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

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including section 630 and Article XXIV thereof.

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

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

(4) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Reimbursement." Payments made to a health care provider by an insurer.

"Waste." The overutilization of professional medical services or the misuse of resources by a health care provider.

§ 3803. Retroactive denial of reimbursement.

(a) General rule.--Except as provided in section 3804 (relating to exceptions to retroactive denial of reimbursement), an insurer may not retroactively deny reimbursement as a result of an overpayment determination more than 24 months after the date the insurer initially paid the health care provider. An insurer that retroactively denies reimbursement to a health care provider under this chapter shall do so based upon coding guidelines and policies in effect at the time the service subject to the retroactive denial was rendered.

(b) Written notice.--An insurer that retroactively denies reimbursement to a health care provider under subsection (a) shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

Cross References. Section 3803 is referred to in sections 3804, 3806 of this title.

§ 3804. Exceptions to retroactive denial of reimbursement.

The provisions of section 3803 (relating to retroactive denial of reimbursement) do not apply if an insurer retroactively denies reimbursement to a health care provider because any of the following apply:

(1) The information submitted to the insurer constitutes fraud, waste or abuse as defined in this chapter.

(2) The claim submitted to the insurer was a duplicate claim.

(3) Denial was required by a Federal or State government plan.

(4) Services were subject to coordination of benefits with another insurer, the medical assistance program or the Medicare program.

Cross References. Section 3804 is referred to in sections 3803, 3805 of this title.

§ 3805. Coordination of benefits.

If an insurer retroactively denies reimbursement for services as a result of coordination of benefits under the provisions of section 3804(4) (relating to exceptions to retroactive denial of reimbursement), the health care provider shall have 12 months from the date of the denial, unless the entity responsible for

payment permits a longer time period, to submit a claim for reimbursement for the service to such entities.

§ 3806. Tolling.

An insurer may request medical or billing records in writing from a health care provider under section 3803 (relating to retroactive denial of reimbursement). The health care provider shall provide the necessary records to the insurer within 60 days of the request. The period of time in which the health care provider is gathering the requested documentation shall be added to the 24-month period.

CHAPTER 39
CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sec.

3901. Purposes and scope of chapter.
3902. Definitions.
3903. Submittal of CGAD.
3904. Contents of CGAD.
3905. Review of CGAD.
3906. Third-party consultants.
3907. Confidentiality.
3908. Penalties.
3909. Rules and regulations.
3910. Construction.
3911. Severability.

Enactment. Chapter 39 was added October 24, 2018, P.L.1182, No.163, effective immediately.

§ 3901. Purposes and scope of chapter.

(a) Purposes.--The purposes of this chapter are to:

(1) Provide the commissioner a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the commissioner to gain and maintain an understanding of the insurer or insurance group's corporate governance framework.

(2) Outline the requirements for completing and filing a CGAD with the commissioner.

(3) Provide for the confidential treatment of the CGAD and related information containing confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(b) Scope.--The requirements of this chapter shall apply to:

(1) an insurer that is domiciled in this Commonwealth; or

(2) an insurance group of which this Commonwealth is the lead state.

§ 3902. Definitions.

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

"Board." The board of directors of the filing entity.

"CGAD-related information." The CGAD or any documents, materials or other information, including proprietary and trade secret information or documents, related to an insurer or insurance group's CGAD.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Corporate governance annual disclosure" or **"CGAD."** The confidential report filed by the insurer or insurance group in accordance with the requirements of this chapter.

"Department." The Insurance Department of the Commonwealth.

"Insurance Company Law." The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Insurance group." The insurers and affiliates included within an insurance holding company system as defined in section 1401 of the Insurance Company Law.

"Insurer." A fraternal benefit society, a health maintenance organization, a preferred provider organization, a company, an association, an exchange, a hospital plan corporation as defined in and subject to Chapter 61 (relating to hospital plan corporations) or a professional health services plan corporation subject to Chapter 63 (relating to professional health services plan corporations) authorized by the commissioner to transact the business of insurance in this Commonwealth.

"Lead state." The state responsible for coordination and communication among state regulators regarding oversight of an insurance group, as determined by the department in consultation with other regulators with domestic insurers in the insurance group.

"NAIC." The National Association of Insurance Commissioners or successor organization and its affiliates and subsidiaries.

"Senior management." A corporate officer or other high-level management official responsible for reporting information to the board of directors at regular intervals, providing information to shareholders or providing information to regulators.

§ 3903. Submittal of CGAD.

(a) General rule.--

(1) Beginning January 1, 2020, a domestic insurer or an insurance group of which this Commonwealth is the lead state shall submit to the department a CGAD no later than June 1 of each calendar year.

(2) If a domestic insurer is a member of an insurance group of which this Commonwealth is not the lead state, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group in accordance with the laws of the lead state.

(b) Exception.--An insurer or insurance group not required to submit a CGAD to the department under subsection (a) shall submit a copy of the most current version of its CGAD to the department upon the commissioner's request.

(c) Amendments.--Each year following the initial filing of the CGAD, the filing entity shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the filing entity, the filing should so state.

(d) Format.--The filing entity may exercise discretion regarding the appropriate format for providing the information required in this chapter and may customize the CGAD to provide the most relevant information necessary to permit the department to understand the corporate governance structure, policies and practices utilized by the filing entity. The department shall include a sample template on its publicly accessible Internet website.

§ 3904. Contents of CGAD.

(a) Contents.--The CGAD must contain the material information necessary to permit the department to gain an understanding of the insurer's or insurance group's corporate governance structure, policies and practices. The commissioner shall consider premium volume, licensing status in other states and corporate complexity and scale when evaluating the comprehensiveness of a company's CGAD.

(b) Discretion.--The insurer or insurance group shall have discretion over the contents of the CGAD if the CGAD includes all of the following information:

(1) A description of the insurer's or insurance group's corporate governance framework, including all of the following:

(i) The board and committees of the board that are ultimately responsible for oversight of the filing entity.

(ii) The level or levels at which board or committee oversight occurs, such as the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level or some combination of these levels.

(iii) The rationale for the current board size and structure.

(iv) The duties of the board and each of its significant committees.

(v) The method of board and committee governance, such as bylaws, charters or informal mandates.

(vi) The structure of the board's leadership.

(vii) A discussion of the roles of the chief executive officer and chairman of the board or their functional counterparts within the organization.

(2) Policies and practices of the board of directors or the most senior governing entity and significant committees of the board or entity, including a discussion of the following factors:

(i) The way in which the qualifications, expertise and experience of each board member meet the needs of the filing entity.

(ii) The method for maintaining an appropriate amount of independence on the board and its significant committees.

(iii) The number of meetings held by the board and its significant committees over the past year as well as information on board member attendance.

(iv) The way in which the filing entity identifies, nominates and elects members to the board and its committees. Factors discussed may include whether a nominating committee exists, whether term limits are placed on directors, how the election and reelection processes function and whether a board diversity policy is in place and, if so, how it functions.

(v) The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance, including any board or committee training programs.

(3) Policies and practices for directing senior management, including a description of any processes, practices or suitability standards used to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles. The description shall identify:

(i) The following:

(A) The specific positions for which suitability standards have been developed and a description of the standards employed.

(B) Procedures in place to monitor any changes in an officer's or key person's suitability, as outlined by the filing entity's standards and procedures to monitor and evaluate such changes.

(ii) The filing entity's code of business conduct and ethics, including a discussion of compliance with laws, rules and regulations, and proactive reporting of any illegal or unethical behavior.

(iii) The filing entity's plans for senior management succession.

(iv) The filing entity's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the department to understand how the organization ensures that compensation programs neither encourage nor reward excessive risk-taking. Elements to be discussed may include any of the following:

(A) The board's role in overseeing management compensation programs and practices.

(B) The various elements of compensation awarded in the filing entity's compensation programs.

(C) The method by which the filing entity determines and calculates the amount of each element of compensation paid.

(D) The way in which compensation programs are related to both company and individual performance over time.

(E) Whether compensation programs include risk adjustments and, if so, how those adjustments are incorporated into the programs for employees at different levels.

(F) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted.

(G) Any other factors relevant in understanding how the filing entity monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(4) A description of the processes by which the board, its committees and senior management ensure an appropriate amount of oversight over critical risk areas impacting the insurer or insurance group's business activities, including a discussion of the following:

(i) The way in which oversight and management responsibilities are delegated among the board, its committees and senior management.

(ii) The way in which the board remains informed of the filing entity's strategic plans, the associated risks and steps that senior management is taking to monitor and manage those risks.

(iii) The way in which reporting responsibilities are organized for each critical risk area. The description should allow the department to understand

the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include the following critical risk areas of the insurer:

(A) Risk management processes.
(B) Actuarial function.
(C) Investment decision-making processes.
(D) Reinsurance decision-making processes.
(E) Business strategy.
(F) Finance decision-making processes.
(G) Compliance function.
(H) Financial reporting.
(I) Internal auditing.
(J) Market conduct decision-making processes.

(5) Any other information as specified by regulation.

(c) Additional information.--The department may request additional information regarding the items provided under subsection (b) that are material and necessary to provide a clear understanding of the corporate governance policies, the reporting or information system or the controls implementing those policies. An insurer or insurance group shall maintain and make available supporting information upon examination or upon the request of the department.

(d) Permissible levels of reporting.--

(1) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level, or some combination thereof, depending upon how the insurer or insurance group has structured its system of corporate governance. When determining which level to choose, the insurer or insurance group shall consider the level at which any of the following occurs:

(i) The insurer's or insurance group's risk appetite is determined.

(ii) Earnings, capital, liquidity, operations and reputation of the insurer or insurance group are overseen collectively and at which the supervision of those factors are coordinated and exercised.

(iii) Legal liability for failure of general corporate governance duties would be placed.

(2) An insurer or insurance group that determines the level of reporting based on any of the criteria under paragraph (1) shall indicate which of the criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) Attestation.--The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer or insurance group's board of directors or the appropriate committee of the board.

§ 3905. Review of CGAD.

(a) Procedures for review.--The review of the CGAD and any additional requests for information shall be made by or through the lead state or, in the case of an insurer that is not part of an insurance group, the department.

(b) Duplicative filings.--An insurer or insurance group providing information substantially similar to the information

required by this chapter in other documents provided to the department, including proxy statements filed in conjunction with registration requirements or other Federal or State filings provided to the department, is not required to duplicate that information in the CGAD but shall only be required to cross-reference the document in which the information is included.

§ 3906. Third-party consultants.

(a) Assistance with review.--The department may retain, at the insurer or insurance group's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the CGAD, CGAD-related information or the insurer's or insurance group's compliance with this chapter. Before retaining a third-party consultant, the department shall consider all of the following:

(1) The complexity of the corporate governance structure of the insurer or insurance group.

(2) Whether subject matter expertise to effectively review the report is available within the department.

(b) Advisory capacity.--A person retained under subsection (a) shall be under the direction and control of the department and shall act in a purely advisory capacity.

(c) Confidentiality.--Each third-party consultant shall be subject to the same confidentiality standards and requirements as the department.

(d) Verification.--As part of the retention process, a third-party consultant shall verify to the department, with notice to the insurer or insurance group, that it:

(1) is free of a conflict of interest;

(2) will comply with the confidentiality standards and requirements of this chapter; and

(3) has internal procedures in place to monitor compliance with this section.

(e) Written consent.--A retention agreement with a third-party consultant shall expressly require the written consent of the insurer or insurance group prior to making information provided under this chapter public.

Cross References. Section 3906 is referred to in section 3907 of this title.

§ 3907. Confidentiality.

(a) General rule.--The CGAD-related information in the possession or control of the department that is produced by, obtained by or disclosed to the department or any other person under this chapter shall be privileged and given confidential treatment and shall not be:

(1) subject to discovery or admissible as evidence in a private civil action;

(2) subject to subpoena;

(3) subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law; or

(4) made public by the department or any other person without the prior written consent of the insurer or insurance group to which it pertains, except as provided in subsection (c).

(b) Private civil actions.--The commissioner, the department, a person who receives CGAD-related information while acting under the authority of the commissioner or department or a person with whom the CGAD-related information is shared under this chapter shall not be permitted or required to testify

in a private civil action concerning confidential CGAD-related information.

(c) Use of CGAD-related information by department.--To assist in the performance of regulatory duties, the department may:

(1) Use CGAD-related information in furtherance of a regulatory or legal action brought pursuant to the department's official duties.

(2) Share CGAD-related information with the NAIC, regulatory or law enforcement officials of this Commonwealth or other jurisdictions, group supervisors, members of a supervisory college under section 1406.1 of the Insurance Company Law and third-party consultants under section 3906 (relating to third-party consultants) if, prior to receiving the CGAD-related information, the recipient demonstrates by written statement the necessary authority and intent to give confidential treatment to the CGAD-related information as required by this chapter.

(3) Receive and maintain as confidential CGAD-related information from the NAIC, regulatory or law enforcement officials of this Commonwealth or other jurisdictions, group supervisors and members of a supervisory college under section 1406.1 of The Insurance Company Law if the CGAD-related information is confidential by law in the jurisdiction from which it was received. CGAD-related information obtained under this paragraph shall be given confidential treatment, shall not be subject to subpoena and shall not be made public by the department, the commissioner or any other person.

(d) Written agreements.--The department shall enter into a written agreement with the NAIC or a third-party consultant governing the sharing and use of information provided under this chapter that includes all of the following:

(1) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information.

(2) Procedures and protocols for sharing CGAD-related information only with regulators from other states in which the insurance group has domiciled insurers, including a written acknowledgment of the recipient's intent and legal authority to maintain the confidential and privileged status of the CGAD-related information.

(3) A provision specifying that ownership of the CGAD-related information shared remains with the department and that the use of the CGAD-related information is subject to the direction and approval of the department.

(4) A provision that prohibits storing CGAD-related information shared under this chapter in a permanent database after the underlying analysis is completed.

(5) A provision requiring prompt notice to the department and to the insurer or insurance group regarding a subpoena, request for disclosure or request for production of the insurer or insurance group's CGAD-related information in the possession of the NAIC or third-party consultant.

(6) A requirement to consent to intervention by an insurer or insurance group in a judicial or an administrative action in which the NAIC or third-party consultant may be required to disclose CGAD-related information or other confidential information about the insurer or insurance group that was shared under this chapter.

(e) No delegation.--The sharing of information by the department under this chapter does not constitute a delegation of regulatory authority or rulemaking. The department shall be

solely responsible for the administration, execution and enforcement of this chapter.

(f) No waiver of privilege or confidentiality.--The sharing of CGAD-related information with, to or by the department as authorized by this chapter does not constitute a waiver of any applicable privilege or claim of confidentiality.

(g) Information with third parties.--CGAD-related information in the possession or control of the NAIC or a third-party consultant as provided under this chapter shall:

(1) be confidential and privileged;

(2) not be subject to the Right-to-Know Law;

(3) not be subject to subpoena; and

(4) not be subject to discovery or admissible as evidence in a private civil action.

Cross References. Section 3907 is referred to in section 3911 of this title.

§ 3908. Penalties.

An insurer or insurance group that fails to timely file a CGAD as required under this chapter or by regulation shall be required, after notice and hearing, to pay a penalty of $200 for each day's delay. The maximum penalty under this section shall be $25,000 per year.

§ 3909. Rules and regulations.

The department may promulgate rules and regulations and issue orders necessary to administer and enforce this chapter.

§ 3910. Construction.

Nothing in this chapter shall be construed to prescribe or impose corporate governance standards and internal procedures in addition to those required under applicable State corporate law. Notwithstanding the foregoing, nothing in this chapter shall be construed to limit the commissioner's authority or the rights or obligations of third parties under Article IX of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

§ 3911. Severability.

(a) General rule.--Except as provided in subsection (b):

(1) The provisions of this chapter are severable.

(2) If a provision of this chapter or its application to a person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this chapter that can be given effect without the invalid provision or application.

(b) Exception.--If the addition of section 3907 (relating to confidentiality) is held invalid, independent of its application to a person or circumstance, the remaining provisions or applications of this chapter are void.

CHAPTER 40
MEDICATION SYNCHRONIZATION

Sec.

4001. Definitions.
4002. Prorated daily cost-sharing rate.
4003. Denial of coverage.
4004. Certain payment structures prohibited.
4005. Application of chapter.

Enactment. Chapter 40 was added July 2, 2019, P.L.333, No.46, effective in 365 days.

§ 4001. Definitions.

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

"Health insurance policy." An individual or group policy, subscriber contract, certificate or plan issued by an insurer that provides medical or health care coverage. The term does not include any of the following:

(1) An accident only policy.
(2) A credit only policy.
(3) A long-term care or disability income policy.
(4) A specified disease policy.
(5) A Medicare supplement policy.
(6) A TRICARE policy, including a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.
(7) A fixed indemnity policy.
(8) A dental only policy.
(9) A vision only policy.
(10) A workers' compensation policy.
(11) An automobile medical payment policy.
(12) Another similar policy providing for limited benefits.

"Insurer." An entity licensed by the department with accident and health authority to issue a health insurance policy that is offered or governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including section 630 and Article XXIV of that act.
(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.
(3) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Maintenance medication." A medication prescribed for a chronic, long-term condition and taken on a regular, recurring basis.

"Medication synchronization." The coordination of prescription drug filling or refilling by a pharmacy or dispensing physician for a health insurance enrollee taking two or more maintenance medications for the purpose of improving medication adherence.

"Pharmacy." As defined in section 2 of the act of September 27, 1961 (P.L.1700, No.699), known as the Pharmacy Act.

§ 4002. Prorated daily cost-sharing rate.

A health insurance policy shall permit and apply a prorated daily cost-sharing rate to maintenance medications that are dispensed by a pharmacy as a partial supply if the pharmacist or prescriber determines the fill or refill to be in the best interest of the patient and the patient requests or agrees to a partial supply for the purpose of medication synchronization. The fill or refill under this section shall be limited to three times per year for each maintenance medication for a covered individual. For each clinically necessary synchronization thereafter, approval may be required at the discretion of the health insurance policy.

§ 4003. Denial of coverage.

(a) Partial supply.--A health insurance policy providing prescription drug coverage may not deny coverage for the dispensing of a maintenance medication that is dispensed by a network pharmacy on the basis that the dispensing is for a partial supply if the prescriber or pharmacist determines the fill or refill to be in the best interest of the patient and

the patient requests or agrees to a partial supply for the purpose of medication synchronization.

(b) Denial codes.--The health insurance policy shall accept early refill and partial supply requests for maintenance medications dispensed for the purpose of medication synchronization using the submission clarification and message codes as adopted by the National Council for Prescription Drug Programs or alternative codes provided by the health insurance policy.

(c) Compliance.--Nothing in this chapter may prohibit a health insurance policy from using other methods to comply with this chapter.

§ 4004. Certain payment structures prohibited.

(a) Prorated dispensing fees.--A health insurance plan providing prescription drug coverage may not use payment structures incorporating prorated dispensing fees.

(b) Full payment.--Dispensing fees for a partial supply or refilled prescriptions shall be paid in full for each maintenance medication dispensed, regardless of any prorated copay for the beneficiary or fee paid for alignment services.

§ 4005. Application of chapter.

(a) Prescription drugs.--This chapter does not apply to prescription drugs that are:

(1) unit-of-use packaging for which medication synchronization is not possible; or

(2) controlled substances classified in Schedule II under section 4(2) of the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act.

(b) Health insurance policies.--This chapter shall apply to health insurance policies as follows:

(1) For a health insurance policy for which either rates or forms are required to be filed with the Federal Government or the Insurance Department, this chapter shall apply to a health insurance policy for which a form or rate is first permitted to be used on or after the effective date of this section.

(2) For a health insurance policy for which neither rates nor forms are required to be filed with the Federal Government or the Insurance Department, this chapter shall apply to a health insurance policy issued or renewed on or after the effective date of this section.

CHAPTER 43
MENTAL HEALTH PARITY AND
ACCESS TO ADDICTION TREATMENT

Sec.

4301. Scope of chapter.
4302. Definitions.
4303. Annual attestation.
4304. Regulations.

Enactment. Chapter 43 was added October 29, 2020, P.L.736, No.89, effective immediately.

Applicability. Section 2 of Act 89 of 2020 provided that Act 89 shall apply to the forms for each insurance policy to be offered, issued or renewed by an insurer in this Commonwealth after December 31, 2021.

§ 4301. Scope of chapter.

This chapter relates to an attestation of compliance with Federal and State insurance laws regarding mental health and substance use disorder benefits.

§ 4302. Definitions.

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

"Health insurance policy." As follows:

(1) An insurance policy, subscriber contract, certificate or plan that provides medical or health care coverage, including emergency services.

(2) The term does not include any of the following types of policies:

(i) Accident only.
(ii) Fixed indemnity.
(iii) Credit.
(iv) Dental only.
(v) Vision only.
(vi) Specified disease.
(vii) Medicare supplement.
(viii) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.
(ix) Long-term care.
(x) Disability income.
(xi) Workers' compensation.
(xii) Automobile medical payment insurance.

"Insurer." An entity licensed by the department with accident and health authority to issue a health insurance policy that is offered or governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including section 630 and Article XXIV of that act.

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

(3) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"MHPAEA." The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, 122 Stat. 3881).

§ 4303. Annual attestation.

(a) Statement regarding MHPAEA compliance.--For the form for each health insurance policy offered, issued or renewed by an insurer, the insurer shall annually file with the department a statement attesting to the insurer's documented analyses of efforts to comply with MHPAEA and the Federal regulations relating to mental health and substance use disorder parity as of the date of the attestation.

(b) Statement regarding MHPAEA nonapplicability.--For the form for each insurance policy offered, issued or renewed by an insurer in this Commonwealth that is required to be filed but to which MHPAEA does not apply, the insurer shall annually file with the department a statement attesting to the nonapplicability of MHPAEA to the policy form.

(c) Filing.--Each attestation required under this section must be filed by April 30 of each year or with the form filing, whichever is earlier.

§ 4304. Regulations.

The department may promulgate regulations necessary to implement this chapter.

CHAPTER 45
INSURANCE DATA SECURITY

Subchapter
A. Preliminary Provisions
B. Procedures
C. Enforcement
D. Miscellaneous Provisions

Enactment. Chapter 45 was added June 14, 2023, P.L.4, No.2, effective in 180 days.

SUBCHAPTER A
PRELIMINARY PROVISIONS

Sec.
4501. Scope of chapter.
4502. Definitions.

§ 4501. Scope of chapter.
This chapter relates to insurance data security.

§ 4502. Definitions.
The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Authorized individual." An individual known to and screened by a licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and its information systems.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Consumer." An individual, including an applicant, policyholder, insured, beneficiary, claimant or certificate holder, who is a resident of this Commonwealth and whose nonpublic information is in a licensee's possession, custody or control.

"Cybersecurity event." As follows:

(1) An event resulting in unauthorized access to, disruption of or misuse of an information system or nonpublic information stored on the information system.

(2) The term does not include:

(i) The unauthorized acquisition of encrypted nonpublic information if the encryption, process or key is not also acquired, released or used without authorization.

(ii) An event in which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

"Department." The Insurance Department of the Commonwealth.

"Encrypted." The transformation of data into a form that has a low probability of assignment of meaning without the use of a protective process or key.

"Information security program." The administrative, technical and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of or otherwise handle nonpublic information.

"Information system." Any of the following:

(1) A discrete set of information resources that is stored in an electronic system and is organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic nonpublic information.

(2) Any specialized system such as an industrial or process control system, telephone switching and private branch exchange system or an environmental control system.

"Insurer." An insurance company, association, exchange, interinsurance exchange, health maintenance organization, preferred provider organization, professional health services plan corporation subject to Chapter 63 (relating to professional health services plan corporations), a hospital plan corporation subject to Chapter 61 (relating to hospital plan corporations), fraternal benefit society, beneficial association, Lloyd's insurer or health plan corporation.

"Licensee." As follows:

(1) A person that is or is required to be licensed, authorized to operate or registered under the insurance laws of this Commonwealth.

(2) The term does not include:

(i) A purchasing group or risk retention group as defined in section 1502 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, that is chartered and licensed in a state other than this Commonwealth.

(ii) A person that is acting as an assuming insurer that is domiciled in another state or jurisdiction.

"Multifactor authentication." Authentication through verification of at least two of the following types of authentication factors:

(1) Knowledge factors, such as a password.

(2) Possession factors, such as a token or text message on a mobile telephone.

(3) Inherence factors, such as a biometric characteristic.

"Nonpublic information." Information that is stored or maintained in an electronic system, is not publicly available information and is any of the following:

(1) Business-related information of a licensee that would cause a materially adverse impact to the business, operations or security of the licensee if the information is tampered with, accessed, used or subject to unauthorized disclosure.

(2) Information concerning a consumer that because of a name, number, personal mark or other identifier, can be used to identify the consumer, in combination with any one or more of the following data elements:

(i) Social Security number.

(ii) Driver's license number or nondriver identification card number.

(iii) Financial account number, credit card number or debit card number.

(iv) A security code, access code or password that would permit access to a consumer's financial account.

(v) Biometric records.

(3) Information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer that can be used to identify a particular consumer and that relates to any of the following:

(i) The past, present or future physical, mental or behavioral health or condition of a consumer or a member of the consumer's family.

(ii) The provision of health care to any consumer.

(iii) Payment for the provision of health care to any consumer.

"Person." An individual or nongovernmental entity, including a nongovernmental partnership, corporation, branch, agency or association.

"Publicly available information." Information that a licensee has a reasonable basis to believe is lawfully made available to the general public from any of the following:

(1) Federal, State or local government records.

(2) Widely distributed media.

(3) Disclosures to the general public that are required to be made in accordance with Federal, State or local law.

"Risk assessment." The assessment that each licensee is required to conduct under section 4512 (relating to risk assessment).

"Third-party service provider." As follows:

(1) A person that contracts with a licensee to maintain, process or store, or is otherwise permitted to access, nonpublic information through its provision of services to the licensee.

(2) The term does not include a licensee.

SUBCHAPTER B
PROCEDURES

Sec.

4511. Differentiation between types of information.
4512. Risk assessment.
4513. Information security program.
4514. Corporate oversight.
4515. Oversight of third-party service provider arrangements.
4516. Certification.
4517. Investigation of cybersecurity event.
4518. Notification of cybersecurity event.

§ 4511. Differentiation between types of information.

For purposes of determining what constitutes publicly available information, a licensee is deemed to have a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(1) that the information is of the type that is available to the general public; and

(2) whether a consumer is able to direct that the information not be made available to the general public and, if so, that the consumer has not done so.

§ 4512. Risk assessment.

A licensee shall conduct a risk assessment, which must:

(1) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of nonpublic information, including the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers.

(2) Assess the likelihood and potential damage of threats, taking into consideration the sensitivity of the nonpublic information.

(3) Assess the sufficiency of policies, procedures, information systems and other safeguards in place to manage threats in each relevant area of the licensee's operations, including:

(i) Employee training and management.

(ii) Information systems, including network and software design and information classification,

governance, processing, storage, transmission and disposal.

(iii) Detection, prevention and response to attacks, intrusions or other system failures.

(4) Implement information safeguards to manage the threats identified in its ongoing assessment.

(5) At least annually, assess the effectiveness of the safeguards' key controls, systems and procedures.

Cross References. Section 4512 is referred to in sections 4502, 4514, 4516, 4521, 4532, 4536 of this title.

§ 4513. Information security program.

(a) Requirement for implementation and objectives.--Each licensee shall develop, implement and maintain a comprehensive written information security program based on the licensee's risk assessment that:

(1) Contains administrative, technical and physical safeguards for the protection of nonpublic information and the licensee's information systems.

(2) Is commensurate with the following:

(i) The size and complexity of the licensee.

(ii) The nature and scope of the licensee's activities, including the licensee's use of third-party service providers.

(iii) The sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody or control.

(3) Is designed to protect:

(i) The security and confidentiality of nonpublic information and the security of the information systems.

(ii) Against any threats or hazards to the security or integrity of nonpublic information and the information systems.

(iii) Against unauthorized access to or use of nonpublic information and that minimizes the likelihood of harm to a consumer.

(4) Defines and periodically reevaluates a schedule for retention of nonpublic information and a mechanism for its destruction when no longer needed.

(b) Designation of responsibility.--A licensee shall designate one or more employees, an affiliate or an outside vendor to act on behalf of the licensee who shall be responsible for the information security program of the licensee.

(c) Standards.--A licensee shall develop an information security program based on its risk assessment and shall:

(1) Design its information security program to mitigate the identified risks, in a manner that is commensurate with the following:

(i) The size and complexity of the licensee.

(ii) The nature and scope of the licensee's activities, including the licensee's use of third-party service providers.

(iii) The sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody or control.

(2) Determine which security measures are appropriate and implement the security measures by:

(i) Placing access controls on information systems, including controls to authenticate and permit access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information.

(ii) Identifying and managing the data, personnel, devices, systems and facilities that enable the licensee to achieve business purposes in accordance with their relative importance to business objectives and the licensee's risk strategy.

(iii) Restricting physical access to nonpublic information only to authorized individuals.

(iv) Protecting, by encryption or other appropriate means, all nonpublic information transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media.

(v) Adopting secure development practices for in-house developed applications utilized by the licensee.

(vi) Modifying the information systems in accordance with the licensee's information security program.

(vii) Utilizing effective controls, which may include multifactor authentication procedures, for any employees accessing nonpublic information.

(viii) Regularly testing and monitoring systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems.

(ix) Including audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee.

(x) Implementing measures to protect against destruction, loss or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures.

(xi) Developing, implementing and maintaining procedures for the secure disposal of nonpublic information in any format.

(3) Include cybersecurity risks in the licensee's enterprise risk management process.

(4) Stay informed regarding emerging threats or vulnerabilities and utilize security measures when sharing information relative to the character of the sharing and the type of information shared.

(5) Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

(d) Monitoring, evaluation and adjustment.--A licensee shall monitor, evaluate and adjust, as appropriate, the information security program consistent with:

(1) Any relevant changes in technology.

(2) The sensitivity of the licensee's nonpublic information.

(3) Internal or external threats to information.

(4) The licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to information systems.

(e) Incident response plan.--As part of its information security program, each licensee shall establish and maintain a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity or availability of nonpublic information in its possession, the licensee's information systems or the continuing functionality of any aspect of the

licensee's business or operations. The incident response plan shall address the following areas:

(1) The internal process for responding to a cybersecurity event.

(2) The goals of the incident response plan.

(3) The definition of clear roles, responsibilities and levels of decision-making authority.

(4) External and internal communications and information sharing.

(5) Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls.

(6) Documentation and reporting regarding cybersecurity events and related incident response activities.

(7) The evaluation and revision of the incident response plan following a cybersecurity event, as necessary.

Cross References. Section 4513 is referred to in sections 4514, 4516, 4521, 4532, 4536 of this title.

§ 4514. Corporate oversight.

(a) Duties.--If a licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(1) Require the licensee's executive management or delegates to develop, implement and maintain the licensee's information security program.

(2) Require the licensee's executive management or delegates to report in writing at least annually, the following information:

(i) The overall status of the information security program and the licensee's compliance with this chapter.

(ii) Material matters related to the information security program, addressing issues such as:

(A) Risk assessment, risk management and control decisions.

(B) Third-party service provider arrangements.

(C) The results of testing.

(D) Cybersecurity events.

(E) Any violation of this chapter and management's responses to the violation.

(F) Recommendations for changes in the information security program.

(b) Delegation.--If the executive management of a licensee delegates any of its responsibilities under this section or section 4512 (relating to risk assessment), 4513 (relating to information security program) or 4515 (relating to oversight of third-party service provider arrangements), the executive management shall oversee the development, implementation and maintenance of the licensee's information security program prepared by the delegated entity, which shall provide a written report to the executive management in accordance with the reporting requirements of this chapter.

Cross References. Section 4514 is referred to in sections 4516, 4521, 4532, 4536 of this title.

§ 4515. Oversight of third-party service provider arrangements.

A licensee shall:

(1) Exercise due diligence in selecting its third-party service provider.

(2) Require a third-party service provider to implement appropriate administrative, technical and physical measures to protect and secure the information systems and nonpublic

information that are accessible to, or held by, the third-party service provider.

Cross References. Section 4515 is referred to in sections 4514, 4516, 4521, 4532, 4536 of this title.

§ 4516. Certification.

(a) Requirement.--No later than the April 15 that is at least one year after the effective date of this section, and each April 15 thereafter, each insurer domiciled in this Commonwealth shall submit to the commissioner, in the form and manner prescribed by the department, a written statement certifying that the insurer is in compliance with the requirements of sections 4512 (relating to risk assessment), 4513 (relating to information security program), 4514 (relating to corporate oversight) and 4515 (relating to oversight of third-party service provider arrangements).

(b) Documentation.--

(1) Each insurer shall maintain all records, schedules and data supporting the certification under this section for a period of five years and shall make that information available for examination by the department.

(2) To the extent that an insurer has identified areas, systems or processes that require material improvement, updating or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address the areas, systems or processes. The documentation shall be available for inspection by the department.

Cross References. Section 4516 is referred to in sections 4521, 4532, 4536 of this title.

§ 4517. Investigation of cybersecurity event.

(a) Requirement.--If a licensee discovers that a cybersecurity event has or may have occurred regarding the licensee, the licensee or an outside vendor or service provider designated to act on behalf of the licensee shall conduct a prompt investigation.

(b) Determination.--During an investigation under this section, the licensee or an outside vendor or service provider designated to act on behalf of the licensee shall, at a minimum, do as much of the following as possible:

(1) Determine whether a cybersecurity event has occurred.

(2) Assess the nature and scope of the cybersecurity event.

(3) Identify any nonpublic information that may have been involved in the cybersecurity event.

(4) Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release or use of nonpublic information in the licensee's possession, custody or control.

(c) Third-party service provider.--If the licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, the licensee shall complete the steps specified in subsection (b) or confirm and document that the third-party service provider has completed those steps.

(d) Records.--A licensee shall maintain records concerning all cybersecurity events for a period of at least five years from the date of the cybersecurity event and shall produce those records upon demand of the commissioner.

Cross References. Section 4517 is referred to in section 4535 of this title.

§ 4518. Notification of cybersecurity event.

(a) Notification to commissioner.--A licensee shall notify the commissioner as promptly as possible, but in no event later than five business days from a determination, that a cybersecurity event involving nonpublic information that is in the possession of the licensee has occurred when either of the following criteria have been met:

(1) The cybersecurity event has a reasonable likelihood of materially harming a consumer residing in this Commonwealth or any material part of the normal operations of the licensee and either:

(i) in the case of an insurer, this Commonwealth is the insurer's state of domicile; or

(ii) in the case of an insurance producer, as defined in section 601-A of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, this Commonwealth is the insurance producer's home state.

(2) The licensee reasonably believes that the nonpublic information involves 250 or more consumers residing in this Commonwealth and the cybersecurity event:

(i) impacts the licensee of which notice is required to be provided to a governmental body, self-regulatory agency or another supervisory body under any Federal or State law; or

(ii) has a reasonable likelihood of materially harming a consumer residing in this Commonwealth or any material part of the normal operations of the licensee.

(b) Content of notification.--As part of the notification under this section, a licensee shall provide as much of the following information as possible in electronic form:

(1) The date of the cybersecurity event.

(2) A description of how the information was exposed, lost, stolen or breached, including the specific roles and responsibilities of third-party service providers, if any.

(3) How the cybersecurity event was discovered.

(4) Whether any lost, stolen or breached information has been recovered and, if so, how this was done.

(5) The identity of the source of the cybersecurity event.

(6) Whether the licensee has filed a police report or has notified any regulatory, governmental or law enforcement agency and, if so, when the notification was provided.

(7) A description of the specific types of information acquired without authorization, including particular data elements such as the types of medical information, financial information or other types of information allowing identification of the consumer.

(8) The period during which the information systems were compromised by the cybersecurity event.

(9) The number of total consumers in this Commonwealth affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the commissioner and update this estimate with each subsequent report to the commissioner under this section.

(10) The results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed.

(11) A description of efforts being undertaken to remediate the situation that permitted the cybersecurity event to occur.

(12) A copy of the licensee's privacy policy and a statement outlining the steps that the licensee will take to investigate and notify consumers affected by the cybersecurity event.

(13) The name of a contact person familiar with the cybersecurity event and authorized to act for the licensee.

(c) Continuing obligation.--A licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the commissioner regarding material changes to previously provided information relating to a cybersecurity event.

(d) Other notices required.--A licensee shall comply with section 3 of the act of December 22, 2005 (P.L.474, No.94), known as the Breach of Personal Information Notification Act, as applicable, and provide a copy of the notice sent to consumers under the Breach of Personal Information Notification Act to the commissioner, whenever the licensee is required to notify the commissioner under subsection (a).

(e) Notice regarding cybersecurity events of third-party service providers.--

(1) In the case of a cybersecurity event in a system maintained by a third-party service provider of which the licensee has become aware, the licensee shall treat the event as it would under subsection (a) unless the third-party service provider provides the notice required under subsection (a) directly to the commissioner.

(2) The computation of a licensee's deadlines under this section shall begin on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

(f) Notice regarding cybersecurity events of reinsurers to insurers.--

(1) In the case of a cybersecurity event involving nonpublic information that is used by a licensee, which is acting as an assuming insurer, or that is in the possession, custody or control of a licensee, which is acting as an assuming insurer and which does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within three business days of making the determination that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with the affected consumers shall fulfill the consumer notification requirements imposed under section 3 of the Breach of Personal Information Notification Act and any other notification requirements relating to a cybersecurity event imposed under this section.

(2) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody or control of a third-party service provider of a licensee that is an assuming insurer, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within three business days of receiving notice from its third-party service provider that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with the affected consumers shall fulfill the consumer notification requirements imposed under section 3 of the Breach of

Personal Information Notification Act and any other notification requirements relating to a cybersecurity event imposed under this section.

(3) A licensee acting as an assuming insurer shall have no other notice obligations relating to a cybersecurity event or other data breach under this section or any other law of this Commonwealth.

(g) Notice regarding cybersecurity events of insurers to producers of record.--In the case of a cybersecurity event involving nonpublic information in the possession, custody or control of a licensee that is an insurer or its third-party service provider for which a consumer accessed the insurer's services through an insurance producer, and for which consumer notice is required under section 3 of the Breach of Personal Information Notification Act, the insurer shall notify the producers of record of all affected consumers of the cybersecurity event no later than the time at which notice is provided to the affected consumers. The insurer shall be excused from this obligation in those instances in which the insurer does not have the current producer of record information for an individual consumer.

Cross References. Section 4518 is referred to in sections 4532, 4535 of this title.

SUBCHAPTER C
ENFORCEMENT

Sec.
4521. Power to examine licensees.
4522. Penalties.

§ 4521. Power to examine licensees.

(a) Insurers.--The commissioner shall have the powers provided under Article IX of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, to examine and investigate an insurer to determine whether the insurer has been or is engaged in conduct in violation of section 4512 (relating to risk assessment), 4513 (relating to information security program), 4514 (relating to corporate oversight), 4515 (relating to oversight of third-party service provider arrangements) or 4516 (relating to certification).

(b) Licensees other than insurers.--

(1) The commissioner shall have the power to examine and investigate a licensee not subject to Article IX of The Insurance Department Act of 1921 to determine whether the licensee has engaged in conduct in violation of this chapter.

(2) Each licensee subject to examination in accordance with paragraph (1) shall keep all books, records, accounts, papers, documents and any computer or other recordings relating to compliance with this chapter in the manner and time periods as the department, in its discretion, may require in order that the department's authorized representatives may verify and ascertain whether the company or person has complied with the requirements of this chapter.

(3) Each licensee subject to examination in accordance with paragraph (1) from whom information is sought and the officers, directors, employees and agents of the licensee shall provide to the examiners timely, convenient and free access at all reasonable hours at the licensee's offices to all books, records, accounts, papers, documents and any computer or other recordings relating to the property,

assets, business and affairs of the licensee being examined. The following apply:

(i) The officers, directors, employees and agents of the licensee shall facilitate the examination and aid in the examination insofar as it is in their power to do so.

(ii) The refusal of a licensee by its officers, directors, employees or agents to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension, revocation, refusal or nonrenewal of any license or authority held by the licensee to engage in an insurance or other business subject to the department's jurisdiction.

(iii) A proceeding for suspension, revocation, refusal or nonrenewal of any license or authority shall be conducted in accordance with 2 Pa.C.S. (relating to administrative law and procedure).

(c) Authorized actions by commissioner.--Notwithstanding and in addition to the powers specified under this section, whenever the commissioner has reason to believe that a licensee has been or is engaged in conduct in this Commonwealth that violates this chapter, the commissioner may take an action that is necessary or appropriate to enforce the provisions of this chapter.

§ 4522. Penalties.

Upon the determination, after notice and hearing, that this chapter has been violated, the commissioner may impose the following penalties:

(1) Suspension or revocation of the licensee's license, authorization to operate or registration.

(2) Refusal to issue or renew a license, authorization to operate or registration.

(3) A cease and desist order.

(4) For each violation of this chapter that a licensee knew or reasonably should have known was a violation, a penalty of not more than $5,000, not to exceed an aggregate penalty of $100,000 in a single calendar year.

(5) For each violation of this chapter that a licensee did not know nor reasonably should have known was a violation, a penalty of not more than $1,000, not to exceed an aggregate penalty of $20,000 in a single calendar year.

SUBCHAPTER D
MISCELLANEOUS PROVISIONS

Sec.

4531. Confidentiality.
4532. Exemptions.
4533. Rules and regulations.
4534. Construction with other laws.
4535. Prevention or abrogation of agreements.
4536. Initial compliance.

§ 4531. Confidentiality.

(a) Requirement.--All information, documents, materials and copies thereof in the possession or control of the department that are produced by, obtained by or disclosed to the department or any other person in the course of an examination or investigation under this chapter shall be privileged and given confidential treatment and:

(1) Shall not be subject to discovery or admissible in evidence in a private civil action.

(2) Shall not be subject to subpoena.

(3) Shall be exempt from access under the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

(4) Shall not be made public by the department or any other person, except to regulatory or law enforcement officials of other jurisdictions, without the prior written consent of the licensee to which it pertains, except as provided in subsection (c).

(b) Civil actions.--The commissioner, department or any person that receives documents, materials or other information while acting under the authority of the commissioner or department or with whom the documents, materials or other information are shared under this chapter may not be permitted or required to testify in a private civil action concerning confidential documents, materials or information covered under subsection (a).

(c) Department actions.--To assist in the performance of the regulatory duties under this chapter, the department:

(1) May share documents, materials or other information, including confidential and privileged documents, materials or other information subject to subsection (a), with the following:

(i) Federal, state and international regulatory agencies.

(ii) The National Association of Insurance Commissioners and its affiliates or subsidiaries.

(iii) Federal, state and international law enforcement authorities.

(iv) Third-party consultants, if the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information.

(2) May receive documents, materials or other information, including otherwise confidential and privileged documents, materials or other information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(d) No delegation.--The sharing of information by the department under this chapter shall not constitute a delegation of regulatory authority or rulemaking. The department shall be solely responsible for the administration, execution and enforcement of this chapter.

(e) No waiver of privilege or confidentiality.--The sharing of confidential information with, to or by the department as authorized by this chapter shall not constitute a waiver of any applicable privilege or claim of confidentiality.

(f) Information with third parties.--Confidential information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant as provided under this chapter shall:

(1) Be confidential and privileged.

(2) Be exempt from access under the Right-to-Know Law.

(3) Not be subject to subpoena.

(4) Not be subject to discovery or admissible as evidence in a private civil action.

§ 4532. Exemptions.

(a) Licensee criteria.--A licensee meeting any of the following criteria shall be exempt from sections 4512 (relating to risk assessment), 4513 (relating to information security program), 4514 (relating to corporate oversight), 4515 (relating to oversight of third-party service provider arrangements) and 4516 (relating to certification):

(1) The licensee has fewer than 10 employees.

(2) The licensee has less than $5,000,000 in gross revenue.

(3) The licensee has less than $10,000,000 in year-end total assets.

(b) Federal law.--A licensee that is subject to and governed by the privacy, security and breach notification rules issued by the United States Department of Health and Human Services under 45 CFR Pts. 160 (relating to general administrative requirements) and 164 (relating to security and privacy), established in accordance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) and the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5, 123 Stat. 226-279 and 467-496), and which maintains nonpublic information in the same manner as protected health information shall be deemed to comply with the requirements of this chapter except for the notification requirements of section 4518(a), (b) and (c) (relating to notification of cybersecurity event).

(c) Employees, agents, representatives and designees.--An employee, agent, representative or designee of a licensee, who is also a licensee, shall be exempt from sections 4512, 4513, 4514, 4515 and 4516 and need not develop its own information security program to the extent that the employee, agent, representative or designee is covered by the information security program of the other licensee.

(d) Compliance.--If a licensee ceases to qualify for an exemption under this section, the licensee shall have 180 days to comply with this chapter.

§ 4533. Rules and regulations.

The commissioner may issue rules and regulations necessary to carry out the provisions of this chapter.

§ 4534. Construction with other laws.

(a) Private cause of action.--Nothing in this chapter shall be construed to:

(1) Create or imply a private cause of action for a violation of this chapter.

(2) Curtail a private cause of action that otherwise exists in the absence of this chapter.

(b) Exclusive standards.--Notwithstanding any other provision of law, this chapter shall establish the exclusive State standards applicable to licensees for data security, the licensees' investigation of a cybersecurity event and notification to the commissioner.

§ 4535. Prevention or abrogation of agreements.

Nothing in this chapter shall prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider or any other party to fulfill any of the investigation requirements imposed under section 4517 (relating to investigation of cybersecurity event) or notice requirements imposed under section 4518 (relating to notification of cybersecurity event).

§ 4536. Initial compliance.

Licensees shall have one year from the effective date of this section to implement sections 4512 (relating to risk

assessment), 4513 (relating to information security program), 4514 (relating to corporate oversight) and 4516 (relating to certification) and two years from the effective date of this section to implement section 4515 (relating to oversight of third-party service provider arrangements).

PART III
SPECIAL PROVISIONS RELATING TO PARTICULAR CLASSES OF INSURERS

Article
A. Health Plan Corporations
B. Fraternal and Beneficial Societies

Enactment. Part III was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

ARTICLE A
HEALTH PLAN CORPORATIONS

Chapter
61. Hospital Plan Corporations
63. Professional Health Services Plan Corporations

CHAPTER 61
HOSPITAL PLAN CORPORATIONS

Subchapter
A. Preliminary Provisions and Certification
B. Regulation Generally

Enactment. Chapter 61 was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

2022 Partial Repeal. Section 11(2)(iii) of Act 146 of 2022 provided that Chapter 61 is repealed insofar as it is inconsistent with Act 146.

Cross References. Chapter 61 is referred to in sections 3802, 3902, 4001, 4302, 4502, 9103 of this title; section 4117 of Title 18 (Crimes and Offenses); sections 4304.1, 4326 of Title 23 (Domestic Relations); sections 3302, 3303 of Title 35 (Health and Safety); section 6160 of Title 42 (Judiciary and Judicial Procedure); section 7309 of Title 51 (Military Affairs); section 1719 of Title 75 (Vehicles).

SUBCHAPTER A
PRELIMINARY PROVISIONS AND CERTIFICATION

Sec.
6101. Definitions.
6102. Certification of hospital plan corporations.
6103. Exemptions applicable to certified hospital plan corporations.
6104. Uncertified plans prohibited.
6105. Penalties.

§ 6101. Definitions.

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

"Hospital plan corporation." A corporation not-for-profit engaged in the business of maintaining and operating a nonprofit hospital plan.

"Nonprofit hospital plan." A plan whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits may be provided to subscribers to such plan.

Cross References. Section 6101 is referred to in section 6301 of this title; section 102 of Title 15 (Corporations and Unincorporated Associations).

§ 6102. Certification of hospital plan corporations.

(a) General rule.--A corporation not-for-profit incorporated for the purpose of establishing, maintaining and operating a nonprofit hospital plan shall not commence business until it shall have received from the department a certificate of authority authorizing the corporation to establish, maintain and operate such a nonprofit hospital plan.

(b) Exemption.--The provisions of subsection (a) of this section shall not apply to any nonprofit corporation incorporated with the approval of the department under the former provisions of section 218 of the Nonprofit Corporation Law of 1933. For the purposes of this chapter such a corporation shall be deemed to be a holder of a certificate of authority issued under this section.

(c) Form of application.--Every application for a certificate of authority under this section shall be made to the department in writing and shall be in such form and contain such information as the regulations of the department may require.

(d) Standards for issuance of certificate.--A certificate of authority shall be issued by order of the department only if and when the department shall find and determine that the application complies with the provisions of this chapter and the regulations of the department thereunder.

(e) Procedure before department.--For the purpose of enabling the department to make the finding or determination required by subsection (d) of this section, the department, by publication of notice in the Pennsylvania Bulletin, shall afford reasonable opportunity for hearing, which shall be public, and, before or after any such hearing, it may make such inquiries, audits and investigations, and may require the submission of such supplemental studies and information, as it may deem necessary or proper to enable it to reach a finding or determination. The department, in granting a certificate of authority, may impose such conditions as it may deem to be just and reasonable. In every case the department shall make a finding or determination in writing, stating whether or not the application has been approved, and, if it has been approved in part only, specifying the part which has been approved and the part which has been denied. Any holder of a certificate of authority, exercising the authority conferred thereby, shall be deemed to have waived any and all objections to the terms and conditions of such certificate.

(f) Judicial review.--Orders of the department upon an application for a certificate of authority under this section shall be subject to judicial review in the manner and within the time provided by law.

Cross References. Section 6102 is referred to in sections 6124, 6304, 6329 of this title.

§ 6103. Exemptions applicable to certified hospital plan corporations.

(a) General insurance laws.--A hospital plan corporation holding a certificate of authority under this chapter shall not be subject to the laws of this Commonwealth now in force relating to the business of insurance, and no statute hereafter enacted relating to the business of insurance shall apply to such a corporation unless such statute shall specifically refer and apply to a corporation subject to this chapter.

(b) Tax laws.--Every hospital plan corporation holding a certificate of authority under this chapter is hereby declared to be a charitable and benevolent institution, and all its funds and investments shall be exempt from taxation by the Commonwealth and its political subdivisions.

§ 6104. Uncertified plans prohibited.

It shall be unlawful for any person, other than a hospital plan corporation holding a certificate of authority under this chapter, to establish, maintain or operate a nonprofit hospital plan in this Commonwealth.

§ 6105. Penalties.

Any person who violates any of the provisions of this chapter, or any regulation or order of the department made pursuant thereto, any person who hinders or prevents the department in the discharge of any duty imposed on it by this chapter, any person who fraudulently procures or attempts to procure any benefit from any hospital plan corporation holding a certificate of authority under this chapter, and any person who willfully makes any false statement in any proceeding or report under this chapter, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than $3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. Any act or default by any corporation, association, or common law trust, in violation of any provision of this chapter or of any regulation or order of the department made pursuant thereto, shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

SUBCHAPTER B
REGULATION GENERALLY

Sec.

6121. Eligible hospitals.
6122. Action as agent under Federal and other programs.
6123. Investment of funds.
6124. Rates and contracts.
6125. Reports and examinations.
6126. Solicitors and agents.
6127. Dissolution or liquidation.

§ 6121. Eligible hospitals.

Any hospital plan corporation may enter into contracts for the rendering of hospitalization to any of its subscribers only with hospitals operated by the Commonwealth, or its agencies, or by political subdivisions, or by corporations organized under the laws of this Commonwealth for hospital purposes, or with such other hospitals as are approved by the Department of Public Welfare.

References in Text. The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Cross References. Section 6121 is referred to in section 6124 of this title.

§ 6122. Action as agent under Federal and other programs.

(a) General rule.--Any hospital plan corporation may, with the approval of the department, act as a contracting agency or organization under section 1841 of Title XVIII of the Federal Social Security Act, as amended or supplemented, with power to perform all the services which may be required of a contracting agency or organization thereunder and may perform administrative services similar or related to those which may be required of an agency or organization thereunder in connection with a Federal, State or local governmental health care program and may perform administrative services similar or related to those which may be required of such an agency or organization in connection with or associated with nongovernmental organizations, individuals, groups and agencies in the health care field.

(b) Legislative amendment of stated purposes of existing corporations.--The stated purposes of all existing hospital plan corporations are hereby amended so as to include the performance of the activities authorized by subsection (a) of this section.

§ 6123. Investment of funds.

Any statute to the contrary notwithstanding, funds of any hospital plan corporation, equal to its reserves, shall be invested in compliance with the requirements of law for the investment of the capital and reserves of life insurance companies. The funds of any such corporation, equal to its surplus, shall be invested in compliance with the requirements of law for the investment of the surplus of life insurance companies.

§ 6124. Rates and contracts.

(a) General rule.--The rates charged to subscribers by hospital plan corporations, all rates of payments to hospitals made by such corporations pursuant to the contracts provided for in this chapter, all acquisition costs in connection with the solicitation of subscribers to such hospital plans, the reserves to be maintained by such corporations, the certificates issued by such corporations representing their agreements with subscribers, and any and all contracts entered into by any such corporation with any hospital, shall, at all times, be subject to the prior approval of the department.

(b) Procedure.--Every application for such approval shall be made to the department in writing and shall be subject to the provisions of subsections (c) through (f) of section 6102 of this title (relating to certification of hospital plan corporations) except that the department may substitute publication in the Pennsylvania Bulletin of notice of reasonable opportunity to submit written comments for publication of opportunity for hearing in any case where the right to an oral hearing is not conferred by the Constitution of the United States or the Constitution of Pennsylvania. Within 60 days after the filing of the application the department shall approve or refuse such application.

(c) Maintenance of contractual relationships.--

(1) Declaration of necessity.--It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance

of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.

(2) Notification period.--No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.

(3) Hearing period.--Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) Negotiation period.--If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of the hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) Retroactivity.--Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

(Aug. 2, 1975, P.L.293, No.94, eff. imd.)

1996 Partial Repeal. Section 14 of Act 159 of 1996, known as the Accident and Health Filing Reform Act, provided that subsec. (a) is repealed insofar as it provides for the approval of rates and contracts.

1975 Amendment. Act 94 added subsec. (c). See sections 2 and 3 of Act 94 of 1975 in the appendix to this title for special provisions relating to applicability and effective date and retroactivity.

References in Text. Section 14 of Act 159 of 1996, known as the Accident and Health Filing Reform Act, was renumbered 5101 by the act of December 22, 2011, P.L.614, No.134.

§ 6125. Reports and examinations.

(a) Annual report.--Every hospital plan corporation shall on or before March 1 of each year, file with the department a statement, verified by at least two of the principal officers of the corporation showing its condition at the end of the preceding calendar year. Such statement shall be in such form, and shall contain such matters, as the department shall prescribe.

(b) Examination.--Every hospital plan corporation shall be subject to examination not less frequently than every three years by the department and its agents, who shall have free access to all the books, records, papers and documents that relate to the business of the corporation, and the power to examine the officers, agents, employees and subscribers to the nonprofit hospital plan of the corporation, under oath, in relation to the affairs, transactions and financial condition of the corporation. Such examinations shall be made at such times as the department shall deem necessary.

§ 6126. Solicitors and agents.

Solicitors and agents for every hospital plan corporation shall meet the prerequisites provided by law for agents of insurance companies.

§ 6127. Dissolution or liquidation.

No hospital plan corporation shall be dissolved under the provisions of Title 15 (relating to corporations and unincorporated associations) or under any other provision of law except with the prior approval of the department. Articles of dissolution for a hospital plan corporation filed in the Department of State, whether pursuant to a decree of court liquidating the corporation or otherwise, shall not be effective unless and until approved by the Insurance Department. Any dissolution or liquidation of a hospital plan corporation shall be under the supervision of the department, which shall have all powers with respect thereto granted to it under laws of this Commonwealth governing the dissolution or liquidation of insurance companies.

CHAPTER 63
PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS

Subchapter

A. Preliminary Provisions and Certification
B. Regulation Generally

Enactment. Chapter 63 was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

2022 Partial Repeal. Section 11(2)(iv) of Act 146 of 2022 provided that Chapter 63 is repealed insofar as it is inconsistent with Act 146.

Cross References. Chapter 63 is referred to in sections 3802, 3902, 4001, 4302, 4502, 9103 of this title; section 4117 of Title 18 (Crimes and Offenses); sections 4304.1, 4326 of Title 23 (Domestic Relations); sections 3302, 3303 of Title 35 (Health and Safety); section 6160 of Title 42 (Judiciary and Judicial Procedure); section 7309 of Title 51 (Military Affairs); section 1719 of Title 75 (Vehicles).

SUBCHAPTER A
PRELIMINARY PROVISIONS AND CERTIFICATION

Sec.
6301. Application of chapter.
6302. Definitions.
6303. Statement of legislative findings and policy.
6304. Certification of professional health service corporations.
6305. Initial reserves.
6306. Standards concerning incorporators.
6307. Exemptions applicable to certificated professional health service corporations.
6308. Uncertificated plans prohibited.
6309. Penalties.
6310. Enforcement.

§ 6301. Application of chapter.

(a) General rule.--This chapter shall apply to every person engaged in the business of maintaining and operating a nonprofit health service plan and to every person who shall violate any provision of this chapter.

(b) Exceptions.--Notwithstanding subsection (a) of this section, this chapter shall not apply to:

(1) Any hospital plan corporations as defined in section 6101 of this title (relating to hospital plan corporation definitions).

(2) Any fraternal benefit society subject to regulation under Chapter 65 of this title (relating to fraternal benefit societies).

References in Text. Chapter 65, referred to in this section, is repealed. The subject matter is now contained in Article XXIV of the act of May 17, 1921, P.L.682, No.284, known as The Insurance Company Law of 1921.

§ 6302. Definitions.

(a) General rule.--The following words and phrases when used in this chapter shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Ancillary health services." The general and usual services rendered and care administered by ancillary health service providers as defined herein.

"Ancillary health service providers." The following persons duly licensed or certified under the laws of this Commonwealth to provide ancillary health services: Clinical laboratory permittees as defined in the act of September 26, 1951 (P.L.1539, No.389), known as The Clinical Laboratory Act.

"Chiropractic services." The general and usual services rendered and care administered by doctors of chiropractic, as defined in the act of August 10, 1951 (P.L.1182, No.264), known as the Chiropractic Registration Act of 1951.

"Clinical social work services." The general and usual services rendered and care administered by licensed clinical social workers, as defined by the "practice of clinical social

work" in the act of July 9, 1987 (P.L.220, No.39), known as the Social Workers, Marriage and Family Therapists and Professional Counselors Act.

"Dental service corporation." A corporation not-for-profit engaged in the business of maintaining and operating a nonprofit dental service plan.

"Dental services." The general and usual services rendered and care administered by doctors of dental surgery, as defined in the act of May 1, 1933 (P.L.216, No.76), known as The Dental Law.

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

"General medical service corporation." A corporation not-for-profit engaged in the business of maintaining and operating a nonprofit professional health service plan.

"Health care facility." As defined in the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Health service doctor." Any health care professional duly licensed or certified under Commonwealth statute regulating a particular branch of health care practice, including, but not limited to, doctor of dental surgery, doctor of medicine, doctor of optometry, doctor of osteopathy, doctor of podiatry, doctor of chiropractic, licensed physical therapist, licensed clinical social worker, licensed occupational therapist, licensed marriage and family therapist, licensed professional counselor, certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, certified clinical nurse specialist, licensed psychologist, licensed speech-language pathologist, licensed audiologist or licensed teacher of persons who are hearing impaired.

"Income." Net income from gains, profits and net income derived from professions, vocations, trades, businesses, commerce or sales, or dealings in property, whether real or personal, growing out of the ownership or use of or interest in such property, also from interest, rent, dividends, securities, or the transaction of any business carried on for gain or profit, or gains or profits and income derived from any source whatever and income derived from salaries, wages or compensation for personal service of whatever kind and in whatever form paid.

"Licensed marriage and family therapy services." The general and usual services rendered and care administered by persons licensed pursuant to 49 Pa. Code Ch. 48 (relating to State Board of Social Workers, Marriage and Family Therapists and Professional Counselors-Licensure of Marriage and Family Therapists).

"Licensed professional counseling services." The general and usual services rendered and care administered by persons licensed pursuant to 49 Pa. Code Ch. 49 (relating to State Board of Social Workers, Marriage and Family Therapists and Professional Counselors-Licensure of Professional Counselors).

"Low income." Low income as set forth in section 6325 (relating to income status and effect).

"Medical services." The general and usual services rendered and care administered by doctors of medicine, as defined in the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

"Nonprofit dental service plan." A plan whereby for prepayment, periodical or lump sum payment dental services only

may be provided to persons of low income or over-income and their dependents.

"Nonprofit optometric service plan." A plan whereby for prepayment, periodical or lump sum payment optometric services only may be provided to persons of low income and over-income and their dependents.

"Nonprofit professional health service plan." A plan whereby for prepayment, periodical or lump sum payment professional health services may be provided to persons of low income or over-income and their dependents. The term does not include a plan which is primarily a nonprofit dental service plan or a nonprofit optometric service plan.

"Occupational therapy services." The general and usual services rendered and care administered by licensed occupational therapists, as defined by "occupational therapy" in the act of June 15, 1982 (P.L.502, No.140), known as the Occupational Therapy Practice Act.

"Optometric service corporation." A corporation not-for-profit engaged in the business of maintaining and operating a nonprofit optometric service plan.

"Optometric services." The general and usual services rendered and care administered by doctors of optometry, as defined in the act of June 6, 1980 (P.L.197, No.57), known as the Optometric Practice and Licensure Act.

"Osteopathic services." The general and usual services rendered and care administered by doctors of osteopathy, as defined in the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

"Over-income." Over-income as set forth in section 6325 (relating to income status and effect).

"Person with dependents." Any person who furnishes other persons with their chief support, whether or not such dependent person is related to or living with him.

"Physical therapy services." The general and usual services rendered and care administered by licensed physical therapists, as defined as "physical therapy" in the act of October 10, 1975 (P.L.383, No.110), known as the Physical Therapy Practice Act.

"Podiatry services." The general and usual services rendered and care administered by doctors of podiatry, as defined in the act of March 2, 1956 (1955 P.L.1206, No.375), known as the Podiatry Practice Act.

"Professional health service corporation." A dental service corporation, a general medical service corporation, or an optometric service corporation.

"Professional health services." Professional services provided by a duly licensed health service doctor, provided that the services are medically necessary.

"Psychological services." The general and usual services rendered and care administered by licensed psychologists as defined as the "practice of psychology" in the act of March 23, 1972 (P.L.136, No.52), known as the Professional Psychologists Practice Act.

"Speech-language pathology services," "audiology services" and "services of teachers of persons who are hearing impaired." The general and usual services rendered and care administered by licensed speech-language pathologists, licensed teachers of persons who are hearing impaired or licensed audiologists, as defined in the act of December 21, 1984 (P.L.1253, No.238), known as the Speech-Language and Hearing Licensure Act.

"Subscribers of low income." Persons of low income who subscribe to a nonprofit professional health service plan, a

nonprofit dental service plan or a nonprofit optometric service plan.

"Subscribers of over-income." Persons of over-income who subscribe to a nonprofit professional health service plan, a nonprofit dental service plan or a nonprofit optometric service plan.

(b) Rule of construction.--The definitions specified in subsection (a) are for the purposes of this chapter only and not for the purpose of defining dental practice, medical practice, optometric practice, osteopathic practice, podiatry practice, chiropractic practice, physical therapy practice, psychological practice, speech-language pathology practice, audiology practice or the practice of teaching persons who are hearing impaired as such.

(Oct. 10, 1980, P.L.801, No.151, eff. 90 days; Mar. 30, 1982, P.L.220, No.70, eff. imd.; Nov. 17, 1982, P.L.681, No.193, eff. 60 days; Apr. 20, 1988, P.L.363, No.57, eff. 60 days; Apr. 21, 1994, P.L.124, No.14, eff. 60 days; Oct. 9, 2008, P.L.1393, No.108, eff. 120 days)

2008 Amendment. Act 108 amended the defs. of "health service doctor" and "professional health services" and added the defs. of "clinical social work services," "licensed marriage and family therapy services," "licensed professional counseling services" and "occupational therapy services."

References in Text. The act of August 10, 1951, P.L.1182, No.264, known as the Chiropractic Registration Act of 1951, referred to in the def. of "chiropractic services," was repealed by the act of December 16, 1986, P.L.1646, No.188, known as the Chiropractic Practice Act.

Cross References. Section 6302 is referred to in section 102 of Title 15 (Corporations and Unincorporated Associations).

§ 6303. Statement of legislative findings and policy.

(a) Declaration of necessity.--It is hereby declared that adequate professional health services are essential for the maintenance of the physical and mental health of the residents of this Commonwealth, and that it is necessary that provision be made for adequate professional health services to persons of low income who are unable to provide such services for themselves or their dependents without depriving themselves or their dependents of such necessaries of life as food, clothing and shelter.

(b) Construction of chapter.--It is hereby declared to be the purpose and intent of this chapter and the policy of the General Assembly to authorize qualified persons to provide adequate professional health services for residents of this Commonwealth who are unable to provide such services for themselves or their dependents at their own cost without depriving themselves or their dependents of such necessaries of life as food, clothing and shelter, and provide persons of over-income with the limited professional health services benefits set forth in this chapter.

Cross References. Section 6303 is referred to in section 6325 of this title.

§ 6304. Certification of professional health service corporations.

(a) General rule.--A corporation not-for-profit incorporated for the purpose of establishing, maintaining and operating a nonprofit professional health service plan, nonprofit dental service plan or nonprofit optometric service plan shall not commence business until it shall have received from the

department a certificate of authority authorizing the corporation to establish, maintain and operate a nonprofit professional health service plan, a nonprofit dental service plan or a nonprofit optometric service plan, as the case may be.

(b) Exemptions.--The provisions of subsection (a) of this section shall not apply to any nonprofit corporation incorporated with the approval of the department under the former provisions of section 219 or 220 of the Nonprofit Corporation Law of 1933. For the purposes of this chapter such a corporation shall be deemed to be a holder of a certificate of authority issued under this section as:

(1) an optometric service corporation, if incorporated under the former provisions of section 219 of the Nonprofit Corporation Law of 1933 for the primary purpose of providing a nonprofit optometric service plan;

(2) a general medical service corporation, if incorporated under the former provisions of section 219 of the Nonprofit Corporation Law of 1933 for any other purpose; or

(3) a dental service corporation, if incorporated under the former provisions of section 220 of the Nonprofit Corporation Law of 1933.

(c) Form of application.--Every application for a certificate of authority under this section shall be made to the Insurance Department in writing and shall be in such form and contain such information as the regulations of the Department of Health and the Insurance Department may require. The Insurance Department shall forward the application to the Department of Health for action thereon and report to the Insurance Department.

(d) Standards for issuance of certificate.--A certificate of authority shall be issued by order of the Insurance Department only if and when the Department of Health and the Insurance Department shall severally find and determine that the application complies with the provisions of this chapter and the regulations of the Department of Health and the Insurance Department thereunder.

(e) Procedure.--The proceedings before the Department of Health and the Insurance Department shall be subject to the provisions of section 6102(e) of this title (relating to procedure before department) and the term department in such section shall be deemed to be a reference also to the Department of Health. Each department shall make a thorough investigation of the applicant and the area in and the plan under which it proposes to operate.

(f) Judicial review.--The final orders of the Department of Health and the Insurance Department upon an application for a certificate of authority under this section shall be deemed to be a single order for the purposes of judicial review and to have been issued on the date the Insurance Department issues its final order after having considered the final action of the Department of Health upon the application. Such order, and all other orders of each department, shall be subject to judicial review in the manner and within the time provided by law.

Cross References. Section 6304 is referred to in section 6322 of this title.

§ 6305. Initial reserves.

No professional health service corporation shall receive a certificate of authority under this chapter unless it has set up a minimum reserve of $25,000 for the exclusive purpose of

meeting the contractual obligations of its subscribers. All or any part of such $25,000 may be in the form of borrowed money to be repaid in whole or in part from surplus. Money borrowed to satisfy the requirements of this section may be repaid only when authorized by two-thirds of the board of directors of such corporation in office and the Insurance Department.

§ 6306. Standards concerning incorporators.

No certificate of authority shall be issued to a professional health service corporation unless all of its incorporators were residents of this Commonwealth and citizens of the United States.

(Apr. 28, 1978, P.L.202, No.53)

1978 Repeal. Act 53 repealed section 6306 in part, effective February 13, 1973. The repealed provisions have been deleted from the text.

§ 6307. Exemptions applicable to certificated professional health service corporations.

(a) General insurance laws.--A professional health service corporation shall be subject to regulation and supervision by the Department of Health and the Insurance Department under this chapter. A professional health service corporation holding a certificate of authority under this chapter shall not be subject to the laws of this Commonwealth now in force relating to the business of insurance, and no statute hereafter enacted relating to the business of insurance shall apply to such a corporation unless such statute shall specifically refer and apply to a corporation subject to this chapter.

(b) Tax laws.--Every professional health service corporation holding a certificate of authority under this chapter is hereby declared to be a charitable and benevolent institution, and all its income, funds, investments and property shall be exempt from all taxation by the Commonwealth or its political subdivisions.

§ 6308. Uncertificated plans prohibited.

(a) General rule.--It shall be unlawful for any person, other than a professional health service corporation holding a certificate of authority under this chapter relating to the plan being maintained or operated by such corporation, to establish, maintain or operate in this Commonwealth a nonprofit dental service plan, a nonprofit optometric service plan, or a nonprofit professional health service plan.

(b) Exemptions.--Nothing in subsection (a) of this section shall be construed as preventing any person from furnishing professional health services for the prevention of disease among his employees or from furnishing any of such services as required under The Pennsylvania Workmen's Compensation Act and related statutes, when the employee is not charged for such service.

References in Text. The short title of the act of June 2, 1915, P.L.736, No.338, known as The Pennsylvania Workmen's Compensation Act, referred to in subsec. (b), was amended by the act of July 2, 1993, P.L.190, No.44. The amended short title is now the Workers' Compensation Act.

§ 6309. Penalties.

Any person who violates any provision of this chapter or of any regulation or order of the Department of Health or of the Insurance Department made pursuant thereto, any person who hinders or prevents the Department of Health or the Insurance Department in the discharge of any duty imposed on it by this chapter, any person who fraudulently procures or attempts to

procure any benefit from any professional health service corporation holding a certificate of authority under this chapter, and any person who willfully makes any false statement in any proceeding or report under this chapter, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than $3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. Any act or default by any corporation, association, or common law trust, in violation of any provision of this chapter or of any regulation or order of either department made pursuant thereto, shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

§ 6310. Enforcement.

When necessary to effect the purposes of this chapter, in addition to all other remedies in law or equity, the Insurance Department or the Department of Health, or both, may commence an action in mandamus or for an injunction to prevent any violation of the provisions of this chapter or the continuance of any such violation, or to enforce compliance herewith. Any court having jurisdiction is hereby vested with authority to determine the cause and to issue such process as may be necessary to accomplish the purposes of this chapter.

SUBCHAPTER B
REGULATION GENERALLY

Sec.

6321. Required reserves.
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§ 6321. Required reserves.

A professional health service corporation shall at all times while engaged in business maintain reserves, in such form and amount as the department may determine, to insure its subscribers against loss through the failure of the corporation to provide the services agreed to in its contracts.

§ 6322. Scope of service.

(a) Territory of service.--The certificate of authority of a professional health service corporation shall define the limits of the area in which it may operate. If the corporation is deemed to be a holder of a certificate of authority under section 6304(b) of this title (relating to exemptions), the articles of incorporation of the corporation on the effective date of this chapter, regardless of any subsequent amendment to such articles, shall be deemed to be its initial certificate of authority for the purposes of this section.

(b) Classes and kinds of services.--The certificate of authority, bylaws, or resolutions of the board of directors of a professional health service corporation may limit the professional health services that will be provided for its subscribers, and may divide such professional health services as it elects to provide into classes or kinds, and it may enter into contracts with its subscribers or groups of subscribers to secure professional health services of any kind or class so delimited. A general medical services corporation shall make available to its subscribers or groups of subscribers, upon request of any individual for his individual subscriptions or any group for its group subscriptions, contracts which provide coverage for professional health services with appropriate premiums.

(c) Services provided only by licensed persons.--A professional health service corporation shall not provide professional health services for its subscribers otherwise than through health service doctors, duly licensed to practice in their respective fields under the laws of this Commonwealth.

(d) Services provided only to domiciliaries.--A professional health service corporation shall provide professional health services only to persons domiciled within this Commonwealth. If a subscriber, regularly domiciled within this Commonwealth and entitled to professional health services, or any of his dependents so entitled, necessarily employs professional health services within the meaning of this chapter, while absent from this Commonwealth, a professional health service corporation to which he is a subscriber may, in its discretion, and if satisfied as to the necessity for such services and satisfied that it was such as the subscriber would have been entitled to under similar circumstances in this Commonwealth, pay to the persons who rendered the services such fees and charges as would have been payable if the services had been rendered in this Commonwealth. A professional health service corporation organized under the laws of, and operating near the boundaries of, this Commonwealth may, with the consent of the proper officers of and as authorized by the laws of the adjacent state, provide professional health services therein; but all operations of any such corporation, whether within or without this Commonwealth, shall remain at all times subject to the provisions of this chapter.

(e) Liability of corporation limited.--All professional health services provided by or on behalf of a professional health service corporation shall be in accordance with the best professional health service practice in the community at the time, but the corporation providing such services shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice, on the part of any officer or employee or on the part of any health service doctor in the course of rendering professional health services to subscribers, and the corporation may so provide in its contracts with subscribers.

(f) Legislative amendment of stated purposes of existing corporations.--The stated purposes of all existing general medical service corporations are hereby amended so as to include the furnishing of osteopathic, dental, optometric, podiatry, chiropractic, physical therapy, clinical social work, occupational therapy, psychological, speech-language pathology and audiology services and the services of teachers of persons who are hearing impaired through doctors of osteopathy, dentistry, optometry, podiatry and chiropractic and through licensed physical therapists, licensed clinical social workers,

licensed marriage and family therapists, licensed occupational therapists, licensed professional counselors, psychologists, speech-language pathologists, audiologists and teachers of persons who are hearing impaired, respectively.
(Oct. 10, 1980, P.L.801, No.151, eff. 90 days; Mar. 30, 1982, P.L.220, No.70, eff. imd.; Apr. 20, 1988, P.L.363, No.57, eff. 60 days; Apr. 21, 1994, P.L.124, No.14, eff. 60 days; Oct. 9, 2008, P.L.1393, No.108, eff. 120 days)

2008 Amendment. Act 108 amended subsec. (f).
1980 Amendment. Act 151 amended subsecs. (b) and (f).
Cross References. Section 6322 is referred to in section 6324 of this title.

§ 6323. Action as agent under Federal and other programs.

(a) General rule.--Any professional health service corporation may, with the approval of the department, act as a contracting agency or organization under section 1842 of Title XVIII of the Federal Social Security Act, as amended or supplemented, with power to perform all the services which may be required of a contracting agency or organization thereunder and may perform administrative services similar or related to those which may be required of an agency or organization thereunder in connection with a Federal, State or local governmental health care program and may perform administrative services similar or related to those which may be required of such an agency or organization in connection with or associated with nongovernmental organizations, individuals, groups and agencies in the health care field.

(b) Legislative amendment of stated purposes of existing corporations.--The stated purposes of all existing professional health service corporations are hereby amended so as to include the performance of the activities authorized by subsection (a) of this section.

§ 6324. Rights of health service doctors.

(a) Admission to plan.--Every health service doctor practicing within the area covered by any professional health service corporation shall have the right, on complying with such regulations as the corporation may make with the approval of the Department of Health, to register with such corporation for such general or special professional health services as he may be licensed to practice, within that area, but the corporation may, with the approval of the Department of Health, refuse to place the name of any health service doctor on its register. Any professional health service corporation may, with the approval of the Department of Health, remove from its register the name of any health service doctor after due notice and opportunity for hearing for cause satisfactory to the corporation. Nothing in this section shall be construed to limit the discretion of a professional health service corporation to determine the classes or kinds of services that will be covered under its contracts.

(b) Freedom from control.--Subject to the provisions of section 6322(e) of this title (relating to liability of corporation limited), a professional health service corporation shall impose no restrictions on the health service doctors who administer to its subscribers, as to methods of diagnosis or treatment. The relation between a subscriber, or any of his dependents, and the health service doctor shall be identical with the relation that ordinarily exists in the community between a health service doctor and his patient. Subject to the provisions of subsection (a) of this section, no person shall be permitted to interfere with the choice or selection by a

patient of his health service doctor after that choice or selection has been made by an adult of sound mind.

(c) Disputes.--All matters, disputes, or controversies relating to the professional health services rendered by the health service doctors, or any questions involving professional ethics, shall be considered and determined only by health service doctors as selected in a manner prescribed in the bylaws of the professional health service corporation.

(Oct. 9, 2008, P.L.1393, No.108, eff. 120 days)

2008 Amendment. Act 108 amended subsec. (a).

§ 6325. Income status; effect.

(a) Income standards.--

(1) Every professional health service corporation shall from time to time, by action of its members, fix the requisites for persons of low income eligible for the benefits of and under this chapter, such requisites to afford due consideration to the marital status and to the number of dependents of the persons involved and such requisites to be consistent with the declaration contained in section 6303(a) of this title (relating to declaration of necessity). Any requisites thus fixed shall be subject to the approval of the department.

(2) All persons not meeting the requisites for persons of low income as thus fixed shall be persons of over-income.

(b) Determination of status.--

(1) The professional health service corporation shall determine whether an applicant for subscription is in receipt of a low income or over-income within the meaning of this chapter and after the application has been approved, the subscriber shall be deemed to be of low income or over-income until his status has been redetermined by the corporation, which redetermination may be made at any time.

(2) The professional health service corporation, in determining the income status of any applicant or subscriber, may, through its officers and agents, examine under oath any applicant or subscriber claiming a low income status and any other person consenting thereto who is believed to have material knowledge concerning the income status of the applicant or subscriber. The determination of the corporation shall be final.

(c) Effect of status.--Every person of low income and every person of over-income, residing in the area served by a professional health service corporation, shall be entitled, upon complying with regulations adopted by that corporation and the payment of such initiation and other fees as are authorized by the department, to the services of any health service doctor registered with the corporation, under such terms and conditions as are customary in professional health services in the community, but only within the limits of services for which such health service doctors are registered. A professional health service corporation may for cause refuse to enter into contractual relations with an applicant and may, for cause, after due notice and opportunity for hearing, rescind any contract that it has entered into with any subscriber and refund any unearned portion of any fees paid and may, on default in payment of the agreed dues, fees, payments or any charges by subscriber or someone on his behalf, discontinue coverage without notice and opportunity for hearing, after having notified a subscriber of his default, and having allowed him two days to procure such coverages. Any payment made by the corporation to health service doctors for services rendered to

subscribers of over-income shall be a payment only to the extent agreed upon between the corporation and the health service doctors on account of any greater sum which may be due the health service doctors for rendering such services.

(d) Prohibited contracts.--No contract by or on behalf of any professional health service corporation shall provide for any periodic payment or any other payment by that corporation to a subscriber which is not related to the value of the service provided to such subscriber on account of illness or injury, nor be in any way related to the payment of any such benefit by any other entity.

Cross References. Section 6325 is referred to in section 6302 of this title.

§ 6326. Specifically authorized contract provisions.

A professional health service corporation may, as a condition precedent to entering into a contract with an applicant or group of applicants for professional health service, require any of the following:

(1) A physical examination of the applicant and of each of his dependents, if any, and proof of his or their substantial freedom from any disease or condition requiring immediate professional health service or likely to require it within the next 12 months, before a contract becomes effective.

(2) A waiting period after a contract is entered into and before the subscriber is entitled to professional health service.

(3) An agreement that the subscriber or someone on his behalf shall pay the stated fee or fees for professional health services in the case of any given illness or injury or other condition requiring professional health service, before becoming entitled to treatment under the terms of the contract.

(4) An agreement that, as a condition precedent to payment by the corporation for professional health services performed for the subscriber, the subscriber or someone on his behalf will submit to the corporation such information as is reasonably necessary to enable it to determine the amount of such payment, which information shall be submitted in the form and verified in the manner prescribed by the corporation.

(5) An agreement that any rights of the subscriber to receive services or payments under his contract with the corporation are personal to the subscriber and may not be assigned.

§ 6327. Subscriptions provided for persons on relief.

Every government agency which is charged by law with the duty of providing professional health services for persons unable to provide it at their own expense or to procure it through persons to whose support and assistance they are by law entitled, is hereby empowered, in the exercise of its authority, to provide any such service if, in the judgment of the agency, it is in the public interest so to do, through a subscription or subscriptions, paid for from any lawfully available public funds, with any professional health service corporation on behalf of any person or persons entitled to such relief.

§ 6328. Board of directors.

(a) Professional health service corporations generally.--The business of every professional health service corporation, except a general medical service corporation, shall be managed

by a board of directors of at least nine persons, all of whom shall be residents of this Commonwealth.

(b) General medical service corporation.--

(1) A general medical service corporation shall be managed by a board of not less than 21, nor more than 36 members, all of whom shall be residents of this Commonwealth, and at no time shall the board be less than 50% subscribers who have coverage under a contract issued by the corporation, and who are generally representative of broad segments of subscribers covered under contracts issued by such corporation, whose background and experience indicate that they are qualified to act in the interests of such subscribers and who or whose spouse does not derive substantial income from the delivery or administration of health care.

(2) The bylaws of every general medical service corporation shall provide appropriate procedures for the nomination and election or appointment of the directors of the corporation and the nomination and election or appointment of committees of the board in such a manner that the interests of the subscribers of the corporation will be justly and reasonably represented.

(3) All directors of the corporation shall be members of the corporation.

(4) A health service doctor, who provides professional health services for the corporation's subscribers, may be a director but in no event shall be counted among the directors who represent subscribers.

(5) Every general medical service corporation shall within six months of the effective date of this act submit for review by the Insurance Commissioner and the Secretary of Health bylaws meeting the standards of this section. Whenever a general medical service corporation changes its bylaws, said change shall be submitted within 30 days to the commissioner and secretary for their review to determine whether such changes meet statutory standards of this section.

(6) In the event that the Insurance Commissioner or the Secretary of Health find, after notice to the corporation and hearing, that a general medical service corporation has not met the requirements of this section, the commissioner or secretary shall notify the corporation of the findings and order the corporation, in specific terms, to meet the requirements of this section. Such findings and order shall be subject to judicial review in the manner and within the time provided by law.

(Apr. 28, 1978, P.L.202, No.53, eff. 60 days; Oct. 4, 1978, P.L.1001, No.211, eff. imd.)

§ 6329. Rates and contracts.

(a) General rule.--All rates charged subscribers or groups of subscribers by any professional health service corporation, and the form and content of all contracts between any such corporation and its subscribers or groups of subscribers, all methods and rates of payment by such corporation to health service doctors serving its subscribers, all acquisition costs in procuring subscribers, the reserves to be maintained by such corporation, and all contracts entered into by any such corporation and extending over a period of more than one year or calling for the expenditure by the corporation of any amount in excess of 20% of its reserves, shall be approved by the department before they become effective.

(b) Procedure.--Every application for such approval shall be made to the department in writing and shall be subject to the provisions of subsections (c) through (f) of section 6102 of this title (relating to certification of hospital plan corporations), except that the department may substitute publication in the Pennsylvania Bulletin of notice of reasonable opportunity to submit written comments for publication of opportunity for hearing in any case where the right to an oral hearing is not conferred by the Constitution of the United States or the Constitution of Pennsylvania. Within 60 days after the filing of the application the department shall approve or refuse such application.

1996 Partial Repeal. Section 14 of Act 159 of 1996, known as the Accident and Health Filing Reform Act, provided that subsec. (a) is repealed insofar as it provides for the approval of rates and contracts.

References in Text. Section 14 of Act 159 of 1996, known as the Accident and Health Filing Reform Act, was renumbered 5101 by the act of December 22, 2011, P.L.614, No.134.

§ 6330. Investment of funds.

Any statute to the contrary notwithstanding, funds of any professional health service corporation, equal to its reserves, shall be invested in compliance with the requirements of law for the investment of the capital and reserves of life insurance companies. The funds of any such corporation, equal to its surplus, shall be invested in compliance with the requirements of law for the investment of the surplus of life insurance companies.

§ 6331. Reports and examinations.

(a) Annual report.--Every professional health service corporation shall, on or before March 1 of each year, file with the department a statement, verified by at least two of the principal officers of the corporation, summarizing its financial activities during the preceding calendar year, and showing its financial condition at the end of that year. Such statement shall be in such form, and shall contain such matters, as the department shall prescribe.

(b) Examination and special reports.--Every professional health service corporation shall be subject to examination not less frequently than once in every three years by the department and its agents, who shall have free access to all the books, records, papers and documents that relate to the business of the corporation, and the power to examine the officers, agents, employees, and subscribers for the professional health services of the corporation, and all health service doctors registered with the corporation, and all other persons having or having had substantial part in the work of the corporation, in relation to its affairs, transactions, and financial condition. Such examination shall be made at such times as the department shall deem necessary. The department may, at any time, without making such examination, call on any such corporation for a written report, authenticated by at least two of its principal officers, concerning the financial affairs and status of the corporation.

§ 6332. Regulation by Department of Health.

(a) Annual reports.--Every professional health service corporation shall, on or before March 1 of each year, file with the Department of Health a report of its activities, other than its financial activities, during the preceding calendar year. Every such report shall be verified by at least two of the principal officers of the corporation and shall be in such form, and shall contain such matter, as the Department of Health shall

prescribe. The Department of Health is hereby authorized to inquire into the activities of every professional health service corporation and to determine whether the corporation is providing adequate professional health services to its subscribers in accordance with the best professional health service practice in the community.

(b) Examination and special reports.--The Department of Health and its agents shall have free access to all the books, records, papers and documents that relate to the business of the corporation, other than financial, and the power to examine the officers, agents, employees, and subscribers for the professional health services of the corporation, and all health service doctors registered with the corporation, and all other persons having or having had substantial part in the work of the corporation, in relation to its affairs, transactions, and condition of the corporation, other than financial. Such examinations shall be made at such times as the Department of Health shall deem necessary. The Department of Health may, at any time, without making such examination, call on any such corporation for a written report, authenticated by at least two of its principal officers, concerning the affairs of the corporation other than its financial affairs.

(c) Extension or improvement of service pursuant to order.--In the event the Department of Health finds that a professional health service corporation does not provide adequate professional health services to its subscribers in accordance with the best professional health service practice in the community, the Department of Health may notify the corporation of its findings and order the corporation, in specific terms, to extend or improve the professional health services furnished by the corporation. Such order shall be entered after notice and opportunity for hearing and shall be subject to judicial review in the manner and within the time provided by law.

§ 6333. Dental service agents.

Any dental service corporation may select any person to act as its agent in the performance of any of its functions.

§ 6334. Dissolution or liquidation.

No professional health service corporation shall be dissolved under the provisions of Title 15 (relating to corporations and unincorporated associations) or under any other provision of law, except with the prior approval of the department. Articles of dissolution for a professional health service corporation filed in the Department of State, whether pursuant to a decree of court liquidating the corporation or otherwise, shall not be effective unless and until approved by the Insurance Department. Any dissolution or liquidation of a professional health service corporation shall be under the supervision of the Insurance Department which shall have all powers with respect thereto granted to it under the laws of this Commonwealth governing the dissolution or liquidation of insurance companies.

§ 6335. Ancillary health services.

Anything in this chapter to the contrary notwithstanding, a professional health service corporation may provide ancillary health services through ancillary health service providers. An ancillary health service provider may register with a professional health service corporation as a participating provider and continue as such upon complying with such regulations as the corporation may make with the approval of the Department of Health.

(Nov. 17, 1982, P.L.681, No.193, eff. 60 days)

1982 Amendment. Act 193 added section 6335.

ARTICLE B
FRATERNAL AND BENEFICIAL SOCIETIES

Chapter
65. Fraternal Benefit Societies (Repealed)
67. Beneficial Societies

CHAPTER 65
FRATERNAL BENEFIT SOCIETIES
(Repealed)

1992 Repeal. Chapter 65 (Subchapters A - G) was added November 15, 1972, P.L.1063, No.271, and repealed December 14, 1992, P.L.835, No.134, effective in 60 days. The subject matter is now contained in Article XXIV of the act of May 17, 1921, P.L.682, No.284, known as The Insurance Company Law of 1921.

CHAPTER 67
BENEFICIAL SOCIETIES

Sec.
6701. Regulation.

Enactment. Chapter 67 was added November 15, 1972, P.L.1063, No.271, effective in 90 days.

Cross References. Chapter 67 is referred to in section 4117 of Title 18 (Crimes and Offenses).

§ 6701. Regulation.

All beneficial societies or associations not subject to regulation under Chapter 65 of this title (relating to fraternal benefit societies), transacting any class of insurance, shall file with the department copies of their charter, constitution, and laws and annually make a report in such form as the department may require, showing their condition and standing at the end of the preceding calendar year, and of their transactions for such year, and the department may at any time make an examination of the books and accounts of any such society.

References in Text. Chapter 65, referred to in this section, is repealed. The subject matter is now contained in Article XXIV of the act of May 17, 1921, P.L.682, No.284, known as The Insurance Company Law of 1921.

PART IV
STANDARD VALUATION

Chapter
71. Reserve Liabilities

Enactment. Part IV was added June 30, 2016, P.L.399, No.59, effective immediately.

CHAPTER 71
RESERVE LIABILITIES

Subchapter
A. General Provisions
B. Valuation of Reserves for Contracts and Policies
C. Confidentiality
D. Exemptions
E. Miscellaneous Provisions

Enactment. Chapter 71 was added June 30, 2016, P.L.399, No.59, effective immediately.

SUBCHAPTER A
GENERAL PROVISIONS

Sec.
7101. Scope of chapter.
7102. Definitions.
7103. Special applicability provisions.
7104. Notice regarding operative date of valuation manual.
7105. Regulations.

§ 7101. Scope of chapter.
This chapter relates to standards for the valuation of reserve liabilities for life insurance, accident and health insurance and deposit-type contracts depending on their date of issuance.

§ 7102. Definitions.
The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Accident and health insurance." A contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness or medical conditions and as may be specified in the valuation manual.

"Appointed actuary." A qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required by section 7114 (relating to actuarial opinion of reserves on or after operative date of valuation manual).

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Company." An entity, including a fraternal benefit society, that:

(1) has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in this Commonwealth and has at least one policy in force or on claim; or

(2) is required to hold a certificate of authority to write life insurance contracts, accident and health insurance contracts or deposit-type contracts in this Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Deposit-type contract." A contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

"Experience data." Documents, materials, data and other information submitted by a company under section 7127 (relating to experience reporting for policies in force on or after operative date of valuation manual).

"Experience materials." Documents, materials, data and other information, including all working papers and copies of all these items created or produced in connection with experience

data, which include any potentially company-identifying or personally identifiable information provided to or obtained by the commissioner.

"Fraternal benefit society." As provided for under Article XXIV of The Insurance Company Law of 1921.

"Group-wide supervisor." The chief insurance regulatory official who is:

(1) Authorized to engage in conducting and coordinating group-wide supervision activities.

(2) From the jurisdiction determined or acknowledged by the department under section 1406.2(c) of The Insurance Company Law of 1921 to have sufficient, significant contacts with the international insurance group.

"IAIS." The International Association of Insurance Supervisors or its successor organization.

"Life insurance." A contract that incorporates mortality risk, including an annuity or pure endowment contract, and as may be specified in the valuation manual.

"NAIC." The National Association of Insurance Commissioners, its subsidiaries or affiliates or its successor organization.

"Operative date of the valuation manual." The January 1 of the first calendar year following the first July 1 when all of the following have occurred:

(1) The valuation manual has been adopted by NAIC by an affirmative vote of at least 42 members or 75% of the members voting, whichever is greater.

(2) The Standard Valuation Law, as amended by NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by both of the following:

(i) States representing more than 75% of the direct premiums written as reported for life, accident and health annual statements, health annual statements or fraternal annual statements submitted in 2008.

(ii) At least 42 of the 55 NAIC member jurisdictions, including the 50 states, American Samoa, the United States Virgin Islands, the District of Columbia, Guam and the Commonwealth of Puerto Rico.

"Policyholder behavior." An action taken by a policyholder, certificate holder, contract holder or any other person having the right to elect options as to a policy or contract subject to this chapter. The options shall:

(1) Include lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization or benefit elections prescribed by the policy or contract.

(2) Exclude events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

"Principle-based valuation." A reserve valuation that:

(1) Uses one or more methods or one or more assumptions determined by the insurer.

(2) Is required to comply with section 7126 (relating to requirements of principle-based valuation) as specified in the valuation manual.

"Qualified actuary." An individual who:

(1) Is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing these statements of actuarial opinion.

(2) Meets the requirements specified in the valuation manual.

"Reserve liabilities," "reserves" or "net value." An amount recorded in financial statements to reflect potential obligations.

"Tail risk." A risk that occurs where:

(1) the frequency of low probability events is higher than expected under a normal probability distribution; or

(2) there are observed events of very significant size or magnitude.

"The Insurance Company Law of 1921." The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Valuation manual." The manual of valuation instructions adopted by NAIC or as subsequently amended and adopted by NAIC. Unless a change in the valuation manual specifies a later effective date, a change to the valuation manual is effective on January 1 following the date when the change to the valuation manual has been adopted by NAIC by an affirmative vote representing both of the following:

(1) At least 75% of the members of NAIC voting, but not less than a majority of the total membership.

(2) Members of NAIC representing jurisdictions totaling more than 75% of the direct premiums written as reported in the most recently available life, accident and health annual statements, health annual statements or fraternal annual statements.

Cross References. Section 7102 is referred to in section 7104 of this title.

§ 7103. Special applicability provisions.

The standards for the valuation of reserve liabilities for life insurance, accident and health insurance and deposit-type contracts shall be subject to the following applicability provisions:

(1) The following shall apply to policies or contracts subject to this chapter that were issued on or after May 17, 1921, and prior to the operative date of the valuation manual:

(i) Section 7115 (relating to computation of minimum standard).

(ii) Section 7116 (relating to computation of minimum standard for annuities).

(iii) Section 7117 (relating to computation of minimum standard by calendar year of issue).

(iv) Section 7118 (relating to reserve valuation method for life insurance and endowment benefits).

(v) Section 7119 (relating to reserve valuation method for annuity and pure endowment benefits).

(vi) Section 7120 (relating to minimum reserves).

(vii) Section 7121 (relating to optional reserve calculation).

(viii) Section 7122 (relating to reserve calculation for valuation net premium exceeding gross premium charged).

(ix) Section 7123 (relating to reserve calculation for indeterminate premium plans).

(2) Except as otherwise provided in this chapter, section 7124 (relating to minimum standard for accident and health insurance contracts) shall apply to policies issued before, on or after the operative date of the valuation manual.

(3) The following shall not apply to policies or contracts subject to this chapter that were issued on or

after May 17, 1921, and prior to the operative date of the valuation manual:

(i) Section 7125 (relating to valuation manual for policies issued on or after operative date of valuation manual).

(ii) Section 7126 (relating to requirements of principle-based valuation).

(4) Sections 7125 and 7126 shall apply to policies issued on or after the operative date of the valuation manual.

§ 7104. Notice regarding operative date of valuation manual.

Upon the occurrence of the last occurring event under the definition of "operative date of the valuation manual" in section 7102 (relating to definitions), the commissioner shall issue a notice regarding the operative date of the valuation manual to be published in the Pennsylvania Bulletin and on the department's publicly accessible Internet website.

§ 7105. Regulations.

The department may promulgate regulations, as necessary, to implement, administer and enforce this chapter.

SUBCHAPTER B
VALUATION OF RESERVES FOR CONTRACTS AND POLICIES

Sec.

7111. Reserve valuation for policies and contracts issued prior to operative date of valuation manual.
7112. Reserve valuation for policies and contracts issued on or after operative date of valuation manual.
7113. Actuarial opinion of reserves prior to operative date of valuation manual.
7114. Actuarial opinion of reserves on or after operative date of valuation manual.
7115. Computation of minimum standard.
7116. Computation of minimum standard for annuities.
7117. Computation of minimum standard by calendar year of issue.
7118. Reserve valuation method for life insurance and endowment benefits.
7119. Reserve valuation method for annuity and pure endowment benefits.
7120. Minimum reserves.
7121. Optional reserve calculation.
7122. Reserve calculation for valuation net premium exceeding gross premium charged.
7123. Reserve calculation for indeterminate premium plans.
7124. Minimum standard for accident and health insurance contracts.
7125. Valuation manual for policies issued on or after operative date of valuation manual.
7126. Requirements of principle-based valuation.
7127. Experience reporting for policies in force on or after operative date of valuation manual.

§ 7111. Reserve valuation for policies and contracts issued prior to operative date of valuation manual.

(a) Applicability.--This section shall apply to each policy or contract issued prior to the operative date of the valuation manual.

(b) Annual valuation.--The commissioner shall annually value, or cause to be valued, the reserve liabilities for all outstanding life insurance policies and annuity and pure

endowment contracts of each company doing business in this Commonwealth. The commissioner may certify the amount of reserves.

(c) Calculation.--In calculating reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(d) Other jurisdictions.--In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this chapter.

(e) Minimum standard.--The minimum standard for the valuation of policies and contracts issued prior to the operative date of section 410A of The Insurance Company Law of 1921 shall be as follows:

(1) The net value of all outstanding policies of life insurance, issued by the company prior to January 1, 1890, shall be computed upon the basis of the American experience table of mortality, with interest at not less than 4.5% and not more than 6% per year.

(2) The net value of all outstanding policies, issued between January 1, 1890, and January 1, 1903, shall be computed on the combined experience or actuaries' table of mortality, with interest at 4% per year.

(3) The net value of all outstanding policies of life insurance, issued on and after January 1, 1903, shall be computed on the American experience table of mortality, with interest at 3.5% per year, but a company may value its group term insurance policies, under which premium rates are not guaranteed for a period in excess of five years, according to the American men ultimate table of mortality, with interest at 3.5% per year.

(4) The net value of all policies of life insurance, issued on and after January 1, 1921, where the premiums are payable monthly or more frequently, shall be computed according to the American experience table of mortality, with interest at 3.5% per year, but a company may voluntarily value its industrial policies according to the standard industrial mortality table, with interest at 3.5% per year.

(5) The net value of a policy at any time shall be taken to be the single net premium which will, at that time, affect the insurance, less the value at that time of the future net premiums called for by the table of mortality and rate of interest designated.

(6) Except as otherwise provided in sections 7116(a) (relating to computation of minimum standard for annuities) and 7117(a) (relating to computation of minimum standard by calendar year of issue) for group annuity and pure endowment contracts, the legal minimum standard for valuation of annuities issued after January 1, 1912, shall be computed according to McClintock's table of mortality among annuitants, with interest at 3.5% per year, but the following shall apply:

(i) For annuities and pure endowments purchased under group annuity and pure endowment contracts, the legal minimum standard may, at the option of the company, be computed according to the 1971 Group Annuity Mortality Table or any modification of this table approved by the commissioner, with interest at 5% per year.

(ii) Annuities deferred 10 or more years, and written in connection with life or term insurance, shall

be valued upon the same mortality table from which the consideration or premiums were computed, with interest at not more than 3.5% per year.

(7) At any time and under any of its policies of life insurance, a company may elect to reserve on the following, with its obligations under these policies to be valued accordingly:

(i) the American experience table of mortality with a lower rate of interest, but at a rate not less than 2% per year; or

(ii) the American men ultimate table of mortality, with any modification and extension below 20 years of age as may be approved by the commissioner, with interest at a rate not less than 2% nor more than 3.5% per year.

(8) On or after the operative date of section 410A of The Insurance Company Law of 1921, reserves for any policies or contracts may be calculated, at the option of the company, according to any standard which produces greater aggregate reserves for all these policies or contracts than the standard in use by the company immediately prior to the exercise of the option.

(9) With the approval of the commissioner, a company that adopts a standard under paragraph (8) may adopt a lower standard of valuation for any policies or contracts if that lower standard is not lower than:

(i) the minimum reserves provided under this section;

(ii) the standard specified in the policies or contracts; or

(iii) the standard used by the company for the determination of the nonforfeiture values of the policies or contracts.

§ 7112. Reserve valuation for policies and contracts issued on or after operative date of valuation manual.

(a) Applicability.--This section shall apply to each policy or contract issued on or after the operative date of the valuation manual.

(b) Annual valuation.--The commissioner shall annually value, or cause to be valued, the reserve liabilities for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts and deposit-type contracts of each company doing business in this Commonwealth. The commissioner may certify the amount of reserves.

(c) Other jurisdictions.--In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this chapter.

(d) Applicable standards.--The following provisions shall govern a policy or contract under this section:

(1) Section 7124(a), (b), (d) and (e) (relating to minimum standard for accident and health insurance contracts).

(2) Section 7125 (relating to valuation manual for policies issued on or after operative date of valuation manual).

(3) Section 7126 (relating to requirements of principle-based valuation).

Cross References. Section 7112 is referred to in sections 7124, 7125 of this title.

§ 7113. Actuarial opinion of reserves prior to operative date of valuation manual.

(a) Applicability.--This section shall apply to an actuarial opinion prepared prior to the operative date of the valuation manual.

(b) Regulations regarding actuarial opinion.--Through regulations, the commissioner:

(1) Shall define the specifics of the actuarial opinion under this section and add any other items deemed to be necessary to fulfill the purpose of this section.

(2) May provide for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

(c) Annual submission and purpose.--Each company doing business in this Commonwealth shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the company's policies and contracts specified by the commissioner by regulation:

(1) are computed appropriately;

(2) are based on assumptions that satisfy contractual provisions;

(3) are consistent with prior reported amounts; and

(4) comply with the applicable laws of this Commonwealth.

(d) Opinion regarding company obligations.--The following shall apply regarding the opinion of the qualified actuary and the company's obligations:

(1) Except as exempted by regulation, each company shall include in the actuarial opinion required under this section an opinion by the same qualified actuary as to whether the reserves and related actuarial items held in support of the company's policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(2) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(3) If a company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or if the commissioner determines that the supporting memorandum provided by the company fails to meet the standards prescribed by regulation or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(e) Requirements.--Each actuarial opinion under this section shall be governed by the following:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1993.

(2) The opinion shall apply to all business in force, including individual and group accident and health insurance

plans, in form and substance acceptable to the commissioner as specified by regulation.

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board, or its successor, and on any additional standards as specified by regulation.

(4) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this Commonwealth.

(5) Except in cases of fraud or willful misconduct, a qualified actuary shall not be liable for damages to any person, other than the insurance company or fraternal benefit society and the commissioner, for any act, error, omission, decision or conduct with respect to the actuarial opinion.

(6) Disciplinary action by the commissioner against the company, fraternal benefit society or the qualified actuary shall be prescribed by regulation.

(7) The confidentiality provisions under Subchapter C (relating to confidentiality) shall apply.

(f) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Qualified actuary." A member in good standing of the American Academy of Actuaries who meets the requirements under 31 Pa. Code Ch. 84b (relating to actuarial opinion and memorandum).

Cross References. Section 7113 is referred to in sections 7120, 7121, 7131, 7137 of this title.

§ 7114. Actuarial opinion of reserves on or after operative date of valuation manual.

(a) Applicability.--This section shall apply to an actuarial opinion prepared on or after the operative date of the valuation manual.

(b) Compliance with valuation manual.--The actuarial opinion under this section must comply with the requirements set forth in the valuation manual.

(c) Annual submission and purpose.--Each company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this Commonwealth shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the company's policies and contracts:

(1) are computed appropriately;

(2) are based on assumptions that satisfy contractual provisions;

(3) are consistent with prior reported amounts; and

(4) comply with the applicable laws of this Commonwealth.

(d) Opinion regarding company obligations.--The following shall apply regarding the opinion of the appointed actuary and the company's obligations:

(1) Except as exempted in the valuation manual, each company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this Commonwealth shall include in the actuarial opinion required under this section an opinion by the same appointed actuary as to whether the reserves and related actuarial items held in support of the company's policies and contracts

specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(2) A memorandum, in form and substance as specified in the valuation manual and as acceptable to the commissioner, shall be prepared to support each actuarial opinion.

(3) If a company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or if the commissioner determines that the supporting memorandum provided by the company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(e) Requirements.--Each actuarial opinion under this section shall be governed by the following:

(1) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(2) The opinion shall be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after the operative date of the valuation manual.

(3) The opinion shall apply to all policies and contracts subject to subsection (d), plus other actuarial liabilities as may be specified in the valuation manual.

(4) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board, or its successor, and on any additional standards as prescribed in the valuation manual.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this Commonwealth.

(6) Except in cases of fraud or willful misconduct, an appointed actuary shall not be liable for damages to any person, other than the company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuarial opinion.

(7) Disciplinary action by the commissioner against the company or the appointed actuary shall be prescribed by regulation.

(8) The confidentiality provisions under Subchapter C (relating to confidentiality) shall apply.

Cross References. Section 7114 is referred to in sections 7102, 7120, 7121, 7131, 7137 of this title.

§ 7115. Computation of minimum standard.

(a) Applicability.--This section shall govern the minimum standard for the valuation of a company's policies and contracts except as provided in the following sections:

(1) Section 7116 (relating to computation of minimum standard for annuities).

(2) Section 7117 (relating to computation of minimum standard by calendar year of issue).

(3) Section 7124 (relating to minimum standard for accident and health insurance contracts).

(b) Policies and contracts issued prior to May 17, 1921.--The minimum standard for the valuation of policies and contracts issued prior to May 17, 1921, shall be as provided by the laws in effect immediately prior to May 17, 1921.

(c) Policies and contracts issued on or after May 17, 1921.--The minimum standard for the valuation of policies and contracts issued on or after May 17, 1921, shall be, together with the tables referenced under subsection (d), the commissioners reserve valuation methods established under sections 7118 (relating to reserve valuation method for life insurance and endowment benefits), 7119 (relating to reserve valuation method for annuity and pure endowment benefits), 7122 (relating to reserve calculation for valuation net premium exceeding gross premium charged) and 7124:

(1) Three and one-half percent interest.

(2) Four percent interest for life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 23, 1976, and prior to January 1, 1979.

(3) Four and one-half percent interest for policies issued on or after January 1, 1979.

(d) Applicable tables.--Together with the requirements under subsection (c), the tables and other provisions of this section shall govern:

(1) For ordinary policies of life insurance issued on the standard basis, excluding disability and accidental death benefits in these policies, the following tables shall apply:

(i) The Commissioners 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of section 410A(d)(2) of The Insurance Company Law of 1921.

(ii) The Commissioners 1958 Standard Ordinary Mortality Table for policies issued on or after the operative date of section 410A(d)(2) of The Insurance Company Law of 1921 and prior to the operative date of section 410A(e) of The Insurance Company Law of 1921. For policies issued on female risks, all modified net premiums and present values referred to in this subparagraph may be calculated according to any age not more than six years younger than the actual age of the insured.

(iii) For policies issued on or after the operative date of section 410A(e) of The Insurance Company Law of 1921, the calculation shall be in accordance with the following tables as specified by regulation:

(A) The Commissioners 1980 Standard Ordinary Mortality Table.

(B) At the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.

(C) Any ordinary mortality table that is adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for the policies.

(2) For industrial life insurance policies issued on the standard basis, excluding disability and accidental death benefits in these policies, the following tables shall apply:

(i) The 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of section 410A(d)(3) of The Insurance Company Law of 1921.

(ii) For policies issued on or after the operative date of section 410A(d)(3) of The Insurance Company Law of 1921, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table that is adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for the policies.

(3) For individual annuity and pure endowment contracts, excluding disability and accidental death benefits in these policies, any of the following shall apply:

(i) The 1937 Standard Annuity Mortality Table.

(ii) At the option of the company, the Annuity Mortality Table for 1949, Ultimate.

(iii) Any modification of either of the tables under subparagraphs (i) and (ii) as approved by the commissioner.

(4) For group annuity and pure endowment contracts, excluding disability and accidental death benefits in the contracts, any of the following shall apply:

(i) The Group Annuity Mortality Table for 1951 or any modification of the table approved by the commissioner, with interest at 3.5%.

(ii) At the option of the company, the 1971 Group Annuity Mortality Table or any modification of the table approved by the commissioner, in which event 5% interest shall be used in determining the minimum standard for the valuation of the contracts.

(iii) At the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, the following shall apply:

(i) For policies or contracts issued on or after January 1, 1966:

(A) the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit; or

(B) any tables of disablement rates and termination rates that are adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for the policies or contracts.

(ii) For policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966:

(A) any of the tables under subparagraph (i); or

(B) at the option of the company, the Class (3) Disability Table (1926).

(iii) For policies issued prior to January 1, 1961, the Class (3) Disability Table (1926).

A table under this paragraph shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(6) For accidental death benefits in or supplementary to policies, the following shall apply:

(i) For policies issued on or after January 1, 1966:

(A) the 1959 Accidental Death Benefits Table; or

(B) any accidental death benefits table that is adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for the policies.

(ii) For policies issued on or after January 1, 1961, and prior to January 1, 1966:

(A) any of the tables under subparagraph (i); or

(B) at the option of the company, the Inter-Company Double Indemnity Mortality Table.

(iii) For policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

A table under this paragraph shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(7) For group life insurance, life insurance issued on the substandard basis and other special benefits, those tables approved by the commissioner shall apply.

Cross References. Section 7115 is referred to in sections 7103, 7118, 7122 of this title.

§ 7116. Computation of minimum standard for annuities.

(a) Computation generally.--Except as provided in section 7117 (relating to computation of minimum standard by calendar year of issue), the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of section 301(c)(1)(B) of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, and for annuities and pure endowments purchased on or after that operative date under group annuity and pure endowment contracts shall be the commissioner's reserve valuation methods established under sections 7118 (relating to reserve valuation method for life insurance and endowment benefits) and 7119 (relating to reserve valuation method for annuity and pure endowment benefits) and the following:

(1) For individual annuity and pure endowment contracts issued prior to January 1, 1979, excluding disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any modification of the table approved by the commissioner, and 6% interest for single premium immediate annuity contracts and 4% interest for all other individual annuity and pure endowment contracts.

(2) For individual single premium immediate annuity contracts issued on or after January 1, 1979, excluding disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table that is adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for the contracts, or any modification of the tables approved by the commissioner, and 7.5% interest or a higher rate of interest as may be approved by the commissioner.

(3) For individual annuity and pure endowment contracts issued on or after January 1, 1979, other than single premium immediate annuity contracts and excluding disability and accidental death benefits in the contracts, the 1971

Individual Annuity Mortality Table or any individual annuity mortality table that is adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for the contracts, or any modification of the tables approved by the commissioner, and 5.5% interest for single premium deferred annuity and pure endowment contracts and 4.5% interest for all other individual annuity and pure endowment contracts or a higher rate of interest as may be approved by the commissioner.

(4) For annuities and pure endowments purchased prior to January 1, 1979, under group annuity and pure endowment contracts and excluding disability and accidental death benefits purchased under the contracts, the 1971 Group Annuity Mortality Table or any modification of the table approved by the commissioner, and 6% interest.

(5) For annuities and pure endowments purchased on or after January 1, 1979, under group annuity and pure endowment contracts and excluding disability and accidental death benefits purchased under the contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table that is adopted after 1980 by NAIC and approved by regulation for use in determining the minimum standard of valuation for annuities and pure endowments, or any modification of the tables approved by the commissioner, and 7.5% interest or a higher rate of interest as may be approved by the commissioner.

(b) Operative date.--After June 23, 1976, a company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for that company. A company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no election, the operative date of this section for that company shall be January 1, 1979.

Cross References. Section 7116 is referred to in sections 7103, 7111, 7115 of this title.

§ 7117. Computation of minimum standard by calendar year of issue.

(a) Applicability.--The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this section:

(1) Life insurance policies issued in a particular calendar year on or after the operative date of section 410A(e) of The Insurance Company Law of 1921.

(2) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1981.

(3) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1981, under group annuity and pure endowment contracts.

(4) The net increase, if any, in a particular calendar year after January 1, 1981, in amounts held under guaranteed interest contracts.

(b) Calendar year statutory valuation interest rates.--The following shall apply:

(1) Subject to paragraph (2), the calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearest 0.25%:

(i) For life insurance:

$$I = .03 + W(R1 - .03) + W/2(R2 - .09).$$

Where R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in this section and W is the weighting factor defined in this section.

(ii) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W(R1 - .03).$$

Where R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in this section and W is the weighting factor defined in this section.

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (ii):

(A) The formula for life insurance stated in subparagraph (i) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years.

(B) The formula for single premium immediate annuities stated in subparagraph (ii) shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less.

(iv) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (ii) shall apply.

(v) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (ii) shall apply.

(2) The following shall apply:

(i) If the calendar year statutory valuation interest rate for a life insurance policy issued in any calendar year determined without reference to this subparagraph differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 0.5%, the calendar year statutory valuation interest rate for the life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year.

(ii) For purposes of applying subparagraph (i), the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined in 1979, and shall be determined for each subsequent calendar year regardless of the operative date of section 410A(e) of The Insurance Company Law of 1921.

(c) Weighting factors.--The weighting factors referred to in subsection (b) shall be as follows:

(1) For life insurance, the guarantee duration shall be the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or

nonforfeiture values, or both, which are guaranteed in the original policy. Weighting factors for life insurance shall be as provided in the following table:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

(2) Weighting factors for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options shall be .80.

(3) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in paragraph (2), shall be as specified in subparagraphs (i), (ii) and (iii), according to the rules and definitions in subparagraphs (iv), (v) and (vi):

(i) For annuities and guaranteed interest contracts valued on an issue year basis, the following table shall apply:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less	.80	.60	.50
More than 5, but not more than 10	.75	.60	.50
More than 10, but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in subparagraph (i) shall be increased by .15 for plan type A, .25 for plan type B and .05 for plan type C.

(iii) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in subparagraph (i) or derived in subparagraph (ii) shall be increased by .05 for plan types A, B and C.

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) Each plan type referenced in this paragraph shall be defined as follows:

(A) "Plan type A." A plan in which at any time the policyholder may withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(II) without an adjustment but in installments over five years or more;

(III) as an immediate life annuity; or

(IV) no withdrawal permitted.

(B) "Plan type B." A plan in which, before expiration of the interest rate guarantee, the policyholder may withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(II) without an adjustment but in installments over five years or more; or

(III) no withdrawal permitted.

At the end of interest rate guarantee, funds may be withdrawn without an adjustment in a single sum or installments over less than five years.

(C) "Plan type C." A plan in which the policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either:

(I) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

(II) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) The following shall apply:

(A) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis.

(B) Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options shall be valued on an issue year basis.

(C) As used in this section:

(I) An issue year basis of valuation shall refer to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract.

(II) A change in fund basis of valuation shall refer to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) Reference interest rate.--The reference interest rate referred to in subsection (b) shall be defined as follows:

(1) For life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(2) For single premium immediate annuities and for annuity benefits involving life contingencies arising from

other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(3) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph (2), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph (2), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(5) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(6) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in paragraph (2), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(e) Alternative method to determine reference interest rate.--If the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc. or if NAIC determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by NAIC and approved by regulation may be substituted.

Cross References. Section 7117 is referred to in sections 7103, 7111, 7115, 7116, 7118, 7122, 7151 of this title.

§ 7118. Reserve valuation method for life insurance and endowment benefits.

(a) Uniform insurance amount and premiums.--Except as otherwise provided in sections 7119 (relating to reserve valuation method for annuity and pure endowment benefits), 7122 (relating to reserve calculation for valuation net premium exceeding gross premium charged) and 7124 (relating to minimum standard for accident and health insurance contracts), for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, reserves according to the commissioners reserve valuation method shall be the excess, if any, of the

present value, at the date of valuation, of the future guaranteed benefits provided for by those policies, over the then present value of any future modified net premiums therefor. The modified net premiums for a policy shall be the uniform percentage of the respective gross premiums for the benefits so that the present value, at the date of issue of the policy, of all modified net premiums shall be equal to the sum of the then present value of the benefits provided for by the policy and the excess of paragraph (1) over paragraph (2), as follows:

(1) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age one year greater than the age at issue of the policy.

(2) A net one-year term premium for the benefits provided for in the first policy year.

(b) First-year excess.--For a life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, reserves according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined under this subsection as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium shall, except as otherwise provided in section 7122, be the greater of the reserve as of the policy anniversary calculated as described in subsection (a) and the reserve as of the policy anniversary calculated as described in subsection (a), but with:

(1) The value defined in subsection (a) being reduced by 15% of the amount of this excess first year premium.

(2) All present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date.

(3) The policy being assumed to mature on that date as an endowment.

(4) The cash surrender value provided on that date being considered as an endowment benefit.

In making the comparison under this subsection, the mortality and interest bases stated in sections 7115 (relating to computation of minimum standard) and 7117 (relating to computation of minimum standard by calendar year of issue) shall be used.

(c) Consistent method.--Reserves according to the commissioners reserve valuation method shall be calculated by a method consistent with the principles of this section, except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums, for:

(1) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums.

(2) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation,

established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 408).

(3) Disability and accidental death benefits in all policies and contracts.

(4) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

Cross References. Section 7118 is referred to in sections 7103, 7115, 7116, 7120, 7122, 7123 of this title.

§ 7119. Reserve valuation method for annuity and pure endowment benefits.

(a) Applicability.--This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 408).

(b) Calculation.--The following shall apply:

(1) Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable prior to the end of the respective contract year.

(2) The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in the contracts for determining guaranteed benefits.

(3) The valuation considerations shall be the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

Cross References. Section 7119 is referred to in sections 7103, 7115, 7116, 7118, 7120, 7123 of this title.

§ 7120. Minimum reserves.

(a) Amount calculated.--A company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after May 17, 1921, shall not be less than the aggregate reserves calculated by using the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies and in accordance with the methods set forth in:

(1) Section 7118 (relating to reserve valuation method for life insurance and endowment benefits).

(2) Section 7119 (relating to reserve valuation method for annuity and pure endowment benefits).

(3) Section 7122 (relating to reserve calculation for valuation net premium exceeding gross premium charged).

(4) Section 7123 (relating to reserve calculation for indeterminate premium plans).

(b) Amount necessary to render actuarial opinion.--The aggregate reserves for all policies, contracts and benefits shall not be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by section 7113 (relating to actuarial opinion of reserves prior to operative date of valuation manual) or 7114 (relating to actuarial opinion of reserves on or after operative date of valuation manual).

Cross References. Section 7120 is referred to in section 7103 of this title.

§ 7121. Optional reserve calculation.

(a) Issuance prior to May 17, 1921.--Reserves for policies and contracts issued prior to May 17, 1921, may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for all these policies and contracts than the minimum reserves required by law.

(b) Issuance on or after May 17, 1921.--Reserves for any category of policies, contracts or benefits established by the commissioner, issued on or after May 17, 1921, may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided under this chapter, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies or contracts.

(c) Adoption of alternative standards.--The following shall apply:

(1) Subject to paragraph (2), a company that adopts at any time a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this chapter may adopt a lower standard of valuation with the approval of the commissioner, but not lower than the minimum provided in this chapter.

(2) For the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by section 7113 (relating to actuarial opinion of reserves prior to operative date of valuation manual) or 7114 (relating to actuarial opinion of reserves on or after operative date of valuation manual) shall not be deemed to be the adoption of a higher standard of valuation.

Cross References. Section 7121 is referred to in section 7103 of this title.

§ 7122. Reserve calculation for valuation net premium exceeding gross premium charged.

(a) Calculation of minimum reserve.--The following shall apply:

(1) If in any contract year the gross premium charged by a company on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of:

(i) The reserve calculated according to the mortality table, rate of interest and method actually used for the policy or contract.

(ii) The reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium.

(2) The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in sections 7115 (relating to computation of minimum standard) and 7117 (relating to computation of minimum standard by calendar year of issue).

(b) How to apply this section for certain policies.--The following shall apply:

(1) For a life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the provisions of this section shall be applied as if the method actually used in calculating the reserve for the policy were the method described in section 7118 (relating to reserve valuation method for life insurance and endowment benefits), ignoring section 7118(b).

(2) The minimum reserve at each policy anniversary of the policy under paragraph (1) shall be the greater of the minimum reserve calculated in accordance with section 7118, including section 7118(b), and the minimum reserve calculated in accordance with this section.

Cross References. Section 7122 is referred to in sections 7103, 7115, 7118, 7120, 7123 of this title.

§ 7123. Reserve calculation for indeterminate premium plans.

(a) Applicability.--This section shall apply to either of the following:

(1) A plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience.

(2) A plan of life insurance or annuity that is of a nature that the minimum reserves cannot be determined by the methods described in any of the following:

(i) Section 7118 (relating to reserve valuation method for life insurance and endowment benefits).

(ii) Section 7119 (relating to reserve valuation method for annuity and pure endowment benefits).

(iii) Section 7122 (relating to reserve calculation for valuation net premium exceeding gross premium charged).

(b) Nature and calculation of reserves.--The reserves that are held under a plan under this section shall be:

(1) Appropriate in relation to the benefits and the pattern of premiums for the plan.

(2) Computed by a method that is consistent with the principles of this chapter, as determined by regulation.

Cross References. Section 7123 is referred to in sections 7103, 7120 of this title.

§ 7124. Minimum standard for accident and health insurance contracts.

(a) Annual valuation of reserve liabilities.--On an annual basis as of the December 31 of the preceding year, the commissioner shall value or cause to be valued, or require the insurer to value or cause to be valued the reserve liabilities of each company doing business in this Commonwealth, with respect to all the accident and health insurance contracts of the company.

(b) Issuances after operative date of valuation manual.--For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual shall be the minimum standard of valuation required under section 7112 (relating to reserve valuation for policies and contracts issued on or after operative date of valuation manual).

(c) Issuances prior to operative date of valuation manual.--For accident and health insurance contracts issued on or after May 17, 1921, and prior to the operative date of the valuation manual, the following shall apply:

(1) The minimum standard of valuation shall be the standard adopted by the commissioner by regulation.

(2) The company shall maintain a claim reserve for incurred but unpaid claims and an active life reserve that shall:

(i) place a sound value on its liabilities under these contracts; and

(ii) be not less than the reserve according to appropriate standards as prescribed by regulation.

(3) The active life reserve shall not be less in the aggregate than the pro rata gross unearned premiums for the contracts.

(d) Foreign or alien insurers.--For a foreign or alien insurer, the commissioner may accept a like valuation of the insurance supervising official of the state, province or foreign country in which that insurer is domiciled, if that valuation is made upon a basis and according to standards producing an aggregate reserve not less than contained in this chapter.

(e) Applicability.--This section shall not apply to total and permanent disability benefits supplementary to life insurance or annuity policies or contracts.

Cross References. Section 7124 is referred to in sections 7103, 7112, 7115, 7118 of this title.

§ 7125. Valuation manual for policies issued on or after operative date of valuation manual.

(a) Standard in valuation manual.--Except as provided in subsection (c) or (e), for policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual shall be the minimum standard of valuation required under section 7112 (relating to reserve valuation for policies and contracts issued on or after operative date of valuation manual).

(b) Specific information in valuation manual.--The valuation manual shall specify:

(1) Minimum valuation standards for and definitions of the policies or contracts subject to section 7112, which shall be:

(i) The commissioners reserve valuation method for life insurance contracts other than annuity contracts.

(ii) The commissioners annuity reserve valuation method for annuity contracts.

(iii) Minimum reserves for all other policies or contracts.

(2) Which policies or contracts or types of policies or contracts are subject to the requirements of a principle-based valuation in section 7126(a) (relating to requirements of principle-based valuation) and the minimum valuation standards consistent with those requirements.

(3) For policies and contracts subject to a principle-based valuation under section 7126:

(i) Requirements for the format of reports to the commissioner under section 7126(b)(3), including information necessary to determine if the valuation is appropriate and in compliance with this chapter.

(ii) Assumptions prescribed for risks over which the company does not have significant control or influence.

(iii) Procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of those procedures.

(4) For policies not subject to a principle-based valuation under section 7126, the minimum valuation standard, which shall:

(i) be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) develop reserves that quantify the benefits, guarantees and the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events having a reasonable probability of occurring.

(5) Other requirements, including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls.

(6) The data and form of the data required under section 7127 (relating to experience reporting for policies in force on or after operative date of valuation manual) and with whom the data must be submitted. The valuation manual may specify other requirements, including data analyses and reporting of analyses.

(c) Absent or noncompliant valuation requirement.--In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this chapter, the company shall, with respect to those requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

(d) Actuarial examination and review.--The following shall apply:

(1) The commissioner may engage a qualified actuary, at the expense of a company, to:

(i) perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company; or

(ii) review and opine on the company's compliance with any requirement under this chapter.

(2) The commissioner may rely on the opinion regarding provisions contained in this chapter of a qualified actuary engaged by the commissioner of another state, district or territory of the United States.

(3) As used in this subsection, the term "engage" shall include employment and contracting.

(e) Change, adjustment and disciplinary action.--The commissioner may require a company to change any assumption or method or adjust company reserves if, in the opinion of the commissioner, the change or adjustment is necessary to comply with the requirements of the valuation manual or this chapter. The commissioner may take disciplinary action as permitted by law.

Cross References. Section 7125 is referred to in sections 7103, 7112, 7131, 7141 of this title.

§ 7126. Requirements of principle-based valuation.

(a) Characteristics of valuation.--For policies or contracts specified in the valuation manual, a company shall establish reserves using a principle-based valuation that:

(1) Quantifies benefits and guarantees and the funding associated with contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events having a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, the valuation must reflect conditions appropriately adverse to quantify the tail risk.

(2) Incorporates assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(3) Incorporates assumptions that are:

(i) Prescribed in the valuation manual.

(ii) If not prescribed in the valuation manual, established by utilizing either of the following:

(A) The company's available experience, to the extent it is relevant and statistically credible.

(B) Other relevant and statistically credible experience, to the extent that company data is not available, relevant or statistically credible.

(4) Provides margins for uncertainty, including adverse deviation and estimation error, so that the greater the uncertainty, the larger the margin and resulting reserve.

(b) Company requirements.--A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(2) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. These controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to this valuation are included in the valuation and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(3) Develop and file with the commissioner upon request a principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) Formulaic reserve component.--A principle-based valuation may include a prescribed formulaic reserve component.

Cross References. Section 7126 is referred to in sections 7102, 7103, 7112, 7125, 7131, 7137, 7141 of this title.

§ 7127. Experience reporting for policies in force on or after operative date of valuation manual.

A company shall submit to the commissioner, or the commissioner's designee or agent, mortality, morbidity, policyholder behavior or expense experience and other data as prescribed in the valuation manual.

Cross References. Section 7127 is referred to in sections 7102, 7125 of this title.

SUBCHAPTER C
CONFIDENTIALITY

Cross References. Subchapter C is referred to in sections 7113, 7114 of this title.

Sec.

7131. Confidential information defined.
7132. General rule for confidential information.
7133. Private civil actions.
7134. Use of confidential information by department.
7135. Agreements.
7136. No waiver of privilege or confidentiality.
7137. Limited exceptions.

§ 7131. Confidential information defined.

As used in this subchapter, the following words and phrases shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Confidential information." Any of the following:

(1) A memorandum in support of an opinion submitted under section 7113 (relating to actuarial opinion of reserves prior to operative date of valuation manual) or 7114 (relating to actuarial opinion of reserves on or after operative date of valuation manual) and any other documents, materials and other information, including all working papers and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with the memorandum.

(2) All documents, materials and other information, including all working papers and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under section 7125(d) (relating to valuation manual for policies issued on or after operative date of valuation manual), except that confidential information shall not include an examination report or other material prepared in connection with an examination made under Article IX of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, to the extent not held to be private and confidential information under section 905 of The Insurance Department Act of 1921.

(3) Reports, documents, materials and other information developed by a company in support of or in connection with an annual certification by the company under section 7126(b)(2) (relating to requirements of principle-based valuation), which evaluates the effectiveness of the

company's internal controls regarding a principle-based valuation, and any other documents, materials and other information, including all working papers and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with the reports, documents, materials and other information.

(4) A principle-based valuation report developed under section 7126(b)(3) and any other documents, materials and other information, including all working papers and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with the report.

(5) Experience data, experience materials and any other documents, materials, data and other information, including all working papers and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with experience data or experience materials.

Cross References. Section 7131 is referred to in section 7137 of this title.

§ 7132. General rule for confidential information.

Except as otherwise provided in this subchapter, confidential information shall be privileged and given confidential treatment and shall not be:

(1) Subject to discovery or admissible as evidence in a private civil action.

(2) Subject to subpoena.

(3) Subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Cross References. Section 7132 is referred to in section 7137 of this title.

§ 7133. Private civil actions.

The commissioner, department or any person who receives documents, materials or other information while acting under the authority of the commissioner or department or with whom the documents, materials or other information are shared under this chapter may not be permitted or required to testify in any private civil action concerning any confidential information covered under this subchapter.

§ 7134. Use of confidential information by department.

To assist in the performance of its duties, the department may:

(1) Use confidential information in the furtherance of any regulatory or legal action brought against a company as a part of the department's official duties.

(2) Share confidential information with regulatory or law enforcement officials of this Commonwealth or other jurisdictions, IAIS, NAIC and its affiliates and subsidiaries, group-wide supervisors and members of a supervisory college under section 1406.1 of The Insurance Company Law of 1921, if prior to receiving the confidential information the recipient agrees, and has the legal authority to agree, to maintain the confidential and privileged status of the confidential information in the same manner and to the same extent as required for the commissioner.

(3) Receive, and shall maintain as confidential, any confidential information from the Actuarial Board for Counseling and Discipline or its successor, from NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of this Commonwealth or other

jurisdictions with the understanding that the documents, materials or other information received are confidential by law in those jurisdictions and shall be given the same confidential treatment provided by this subchapter.

Cross References. Section 7134 is referred to in section 7136 of this title.

§ 7135. Agreements.

The department may enter into agreements governing sharing and use of confidential information consistent with this subchapter.

§ 7136. No waiver of privilege or confidentiality.

(a) Sharing of information by department.--The sharing of confidential information with or by the department as authorized by section 7134 (relating to use of confidential information by department) shall not constitute a waiver of any applicable privilege or claim of confidentiality in the documents, materials or information.

(b) Privilege established in other jurisdictions.--A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subchapter shall be available and enforced in any proceeding in, and in any court of, this Commonwealth.

§ 7137. Limited exceptions.

Notwithstanding section 7132 (relating to general rule for confidential information), confidential information as defined in section 7131(1) and (4) (relating to confidential information defined):

(1) May be shared with the Actuarial Board for Counseling and Discipline if the information is required for the purpose of professional disciplinary proceedings and the Actuarial Board for Counseling and Discipline recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of the documents, materials, data and other information in the same manner and to the same extent as required for the commissioner.

(2) May be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the related memorandum in support of an opinion submitted under section 7113 (relating to actuarial opinion of reserves prior to operative date of valuation manual) or 7114 (relating to actuarial opinion of reserves on or after operative date of valuation manual) or a principle-based valuation report developed under section 7126(b)(3) (relating to requirements of principle-based valuation) by reason of an action required by this chapter or regulations promulgated under this chapter.

(3) May be released by the commissioner with the written consent of the company.

(4) Is no longer confidential once any portion of a memorandum in support of an opinion submitted under section 7113 or 7114 or a principle-based valuation report developed under section 7126(b)(3) is:

(i) cited by the company in its marketing materials;

(ii) publicly released to a governmental agency other than a State insurance department; or

(iii) released by the company to the news media.

SUBCHAPTER D
EXEMPTIONS

Sec.
7141. Single-state company exemption.
7142. Small company exemption (Repealed).
7143. Adoption of exemption standards of NAIC Valuation Manual.

§ 7141. Single-state company exemption.

(a) Requirements.--A company may file a written request with the commissioner to exempt specific product forms or product lines issued by a domestic company from the requirements of sections 7125 (relating to valuation manual for policies issued on or after operative date of valuation manual) and 7126 (relating to requirements of principle-based valuation) if the company:

(1) Is licensed and doing business only in this Commonwealth.

(2) Computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by regulation.

(b) Written exemption.--An exemption under subsection (a) that is granted by the commissioner shall be in writing.

(c) Revocation.--The commissioner may revoke the exemption under subsection (a) if the conditions under subsection (a)(1) and (2) are no longer met after 180 days' written notice to the company regarding the conditions.

(d) Additional effects of exemption.--A company granted an exemption under subsection (a) shall also be exempt from any requirement under this chapter that is created by a reference to section 7125 or 7126 for the product forms or product lines exempted.

§ 7142. Small company exemption (Repealed).

2023 Repeal. Section 7142 was repealed June 14, 2023, P.L.4, No.2, effective immediately.

§ 7143. Adoption of exemption standards of NAIC Valuation Manual.

(a) Findings and declarations.--The General Assembly finds and declares that the work of NAIC and the participation of the commissioner in NAIC are essential to the general implementation of this chapter.

(b) Standards.--To effectuate the decision as to whether to exempt certain policies, certificates or products of a particular company from certain provisions of the NAIC Valuation Manual, the commissioner shall determine, on an annual basis, whether to adopt the standards for exemption specified in the most recent version of the NAIC Valuation Manual by submitting a statement of policy to the Legislative Reference Bureau for publication in the next available issue of the Pennsylvania Bulletin.

(c) Statement of policy.--A statement of policy issued under subsection (b) shall be exempt from the following:

(1) Section 205 of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law.

(2) Section 204(b) and 301(10) of the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

(3) The act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

(d) Construction.--Nothing in this section shall affect any other provision in this chapter or apply to any action taken by the department prior to the effective date of this section.

(June 14, 2023, P.L.4, No.2, eff. imd.)

2023 Amendment. Act 2 added section 7143.

SUBCHAPTER E
MISCELLANEOUS PROVISIONS

Sec.
7151. Effect on The Insurance Company Law of 1921.

§ 7151. Effect on The Insurance Company Law of 1921.

(a) Fraternal benefit organizations.--The following shall apply:

(1) Section 2451(b) of The Insurance Company Law of 1921 shall apply to the minimum reserves for certificates issued after February 11, 1994 and prior to the effective date of this chapter.

(2) The minimum reserves for certificates issued on or after the effective date of this chapter shall be governed by this chapter.

(b) Standard nonforfeiture law for life insurance.--Notwithstanding any provision of The Insurance Company Law of 1921:

(1) For policies issued prior to the operative date of the valuation manual, any commissioners standard ordinary mortality table that was adopted after 1980 by NAIC and is approved by regulation for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table.

(2) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by regulation any commissioners standard ordinary mortality table adopted by NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, that minimum nonforfeiture standard shall supersede the minimum nonforfeiture standard provided by the valuation manual.

(3) For policies issued prior to the operative date of the valuation manual, any commissioners standard industrial mortality table that was adopted after 1980 by NAIC and that is approved by regulation for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

(4) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any commissioners standard industrial mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the

operative date of the valuation manual, that minimum nonforfeiture standard shall supersede the minimum nonforfeiture standard provided by the valuation manual.

(c) Nonforfeiture interest rate.--Notwithstanding any provision of The Insurance Company Law of 1921, the nonforfeiture rate shall be as follows:

(1) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per year for any policy issued in a particular calendar year shall be equal to 125% of the calendar year statutory valuation interest rate for the policy as defined in section 7117 (relating to computation of minimum standard by calendar year of issue) rounded to the nearest 0.25%, but the nonforfeiture interest rate shall not be less than 4%.

(2) For policies issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per year for any policy issued in a particular calendar year shall be provided by the valuation manual.

PART V
HEALTH INSURANCE MARKETS OVERSIGHT

Chapter

91. Preliminary Provisions
93. State-based Exchange
95. Reinsurance Program
97. Miscellaneous Provisions

Enactment. Part V was added July 2, 2019, P.L.294, No.42, effective immediately.

CHAPTER 91
PRELIMINARY PROVISIONS

Sec.

9101. Scope of part.
9102. Purpose and intent.
9103. Definitions.

Enactment. Chapter 91 was added July 2, 2019, P.L.294, No.42, effective immediately.

§ 9101. Scope of part.

This part relates to health insurance markets oversight.

§ 9102. Purpose and intent.

The General Assembly finds and declares as follows:

(1) The Commonwealth intends to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth.

(2) The health insurance marketplace in this Commonwealth is unique and unlike the marketplace in any other state.

(3) It is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth as permitted by Federal law, including the Federal acts. The provisions of this part are intended to meet these requirements while retaining the Commonwealth's authority to regulate health insurance in this Commonwealth.

§ 9103. Definitions.

Subject to additional definitions contained in subsequent provisions of this part which are applicable to specific

provisions of this part, the following words and phrases when used in this part shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Affordable Care Act." The Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152, 124 Stat. 1029).

"Attachment point." The threshold amount for claims costs incurred by an eligible insurer for an enrolled individual's covered benefits in a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under this part.

"Benefit year." The calendar year during which an eligible insurer provides coverage through a health care plan.

"Board." The governing body of the exchange authority.

"Children's Health Insurance Program." The children's health insurance program under Article XXIII-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Coinsurance rate." The percentage rate at which the reinsurance program will reimburse an eligible insurer for claims incurred for an enrollee's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Eligible insurer." An insurer offering reinsurance-eligible health care plans to consumers in this Commonwealth.

"Enrollee." A policyholder, certificate holder, subscriber, covered person or other individual who is enrolled to receive health care services pursuant to a health insurance policy.

"Exchange." A health insurance exchange as contemplated by the Affordable Care Act, established or operating in this Commonwealth, that facilitates or assists in facilitating enrollment in qualified plans.

"Exchange assister." The term has the meaning given to it in section 2 of the act of June 19, 2015 (P.L.25, No.7), known as the Navigator and Exchange Assister Accessibility and Regulation Act.

"Exchange authority." The Pennsylvania Health Insurance Exchange Authority established under section 9302(a) (relating to Pennsylvania Health Insurance Exchange Authority).

"Exchange fund." The Pennsylvania Health Insurance Exchange Fund established under section 9312 (relating to exchange fund).

"Federal acts." The Affordable Care Act and any amendments thereto, and related provisions of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 201 et seq.).

"Government program." A program of government sponsored or subsidized health care coverage, including:

(1) A premium tax credit or cost-sharing subsidy under the Federal acts.

(2) Coverage under Medicare Parts A and B or Medicare Advantage Part C under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

(3) A TRICARE or other health care plan provided through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined under 10 U.S.C. § 1072 (relating to definitions).

(4) A health care plan provided through the Federal Employees Health Benefits Program established under 5 U.S.C. Ch. 89 (relating to health insurance).

(5) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code.

(6) The Children's Health Insurance Program.

(7) Health care coverage provided by the Commonwealth, a county, a city, or other State or local governmental entity or an agency, subdivision or department of a governmental entity, including:

(i) a corporation or other arrangement organized by the entity for the provision of health care coverage and subject to control by the entity or an instrumentality of one or more of them;

(ii) the Pennsylvania Employee Benefit Trust Fund for active and retired employees; and

(iii) benefit programs administered by the Department of Corrections.

"Grandfathered health care plan." Individual or group health insurance coverage in which an individual was enrolled prior to the date of enactment of the Affordable Care Act, or as otherwise specified in section 1251 of the Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18011).

"Health care plan." A package of coverage benefits with a particular cost-sharing structure, network and service area that is purchased through a health insurance policy.

"Health insurance policy." A policy, subscriber contract, certificate or plan issued by an insurer that provides hospital or medical/surgical health care coverage. The term does not include any of the following:

(1) An accident only policy.

(2) A credit only policy.

(3) A long-term care or disability income policy.

(4) A specified disease policy.

(5) A Medicare supplement policy.

(6) A fixed indemnity policy.

(7) An adult-only dental only policy.

(8) A vision only policy.

(9) A workers' compensation policy.

(10) An automobile medical payment policy.

(11) A policy under which benefits are provided by the Federal Government to active or former military personnel and their dependents.

(12) Any other similar policies providing for limited benefits.

"Hospital plan corporation." An entity organized and operating under Chapter 61 (relating to hospital plan corporations).

"Individual market." The market for health insurance coverage offered to individuals other than in connection with a group.

"Innovation waiver." A waiver applied for pursuant to section 1332 of the Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18052).

"Insurance producer." The term has the meaning given to it in section 601-A of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

"Insurer." An entity that offers, issues or renews an individual or group health, accident or sickness insurance policy, contract or plan, and that is governed under any of the following:

(1) Chapter 61.

(2) Chapter 63 (relating to professional health services plan corporations).

(3) The Insurance Company Law of 1921, including section 630 and Article XXIV.

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

"Medical assistance program." The Commonwealth's medical assistance program established under the Human Services Code.

"Professional health services plan corporation." An entity organized and operating under Chapter 63.

"Qualified enrollee." A qualified employee or qualified individual, as defined in section 1312(f) of the Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18032(f)) and regulations promulgated under that act.

"Qualified plan." A plan as defined in section 1301(a) of the Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18021(a)) that provides health care or dental care coverage that has been certified by the department as meeting the criteria set forth in this part and any regulations issued pursuant to this part.

"Reinsurance cap." The upper limit amount for claims costs incurred by an eligible insurer for an enrolled individual's covered benefits in a benefit year, over which the claims costs for benefits are no longer eligible for reinsurance payments under the reinsurance program.

"Reinsurance-eligible enrollee." An enrollee who is insured in a reinsurance-eligible health care plan under this part.

"Reinsurance-eligible health care plan." A health care plan that is not a grandfathered health care plan.

"Reinsurance payment." An amount paid by the reinsurance program to an eligible insurer under the program.

"Reinsurance program." The Commonwealth Health Insurance Reinsurance Program established under section 9502(b) (relating to implementation of waiver and establishment of reinsurance program).

"Small group market." The market for health insurance for coverage offered through a group health insurance policy for a group of at least one employee and up to 50 employees, exclusive of dependents.

CHAPTER 93
STATE-BASED EXCHANGE

Sec.

9301. Scope of chapter.
9302. Pennsylvania Health Insurance Exchange Authority.
9303. Advisory council.
9304. Meetings and operation.
9305. Powers and duties of exchange authority.
9306. Limitations.
9307. Confidentiality and disclosure.
9308. Not an entitlement.
9309. Nonliability.
9310. Audits.
9311. Reports.
9312. Exchange fund.
9313. Federal guidance.
9314. Expiration.

Enactment. Chapter 93 was added July 2, 2019, P.L.294, No.42, effective immediately.

Cross References. Chapter 93 is referred to in section 9703 of this title.

§ 9301. Scope of chapter.

This chapter relates to the Pennsylvania Health Insurance Exchange Authority.

§ 9302. Pennsylvania Health Insurance Exchange Authority.

(a) Establishment.--The Pennsylvania Health Insurance Exchange Authority is established as a State-affiliated entity. The powers and duties of the exchange authority shall be vested in and exercised by a board, which shall have the sole power under section 9305 (relating to powers and duties of exchange authority) to employ staff, including an executive director. Individuals employed by the exchange authority shall be employees of the Commonwealth. The exchange authority may contract with persons or entities, including legal counsel, consultants or service providers, as deemed necessary in the exchange authority's discretion.

(b) Purpose.--The purpose of the exchange authority shall be to create, manage and maintain in this Commonwealth the Pennsylvania Health Insurance Exchange to do all of the following:

(1) Benefit the Pennsylvania health insurance market and persons enrolling in health insurance policies.

(2) Facilitate or assist in facilitating the purchase of on-exchange qualified plans by qualified enrollees in the individual market or the individual and small group markets.

(c) Composition.--The board shall consist of the following members:

(1) Three voting members who shall be the following heads of agencies or a designee who shall be an employee of the agency designated in writing by the head of the agency prior to service:

(i) The commissioner, ex-officio.

(ii) The Secretary of Human Services, ex-officio.

(iii) The Secretary of Health, ex-officio.

(2) Four voting members appointed by the Governor:

(i) One member from among the insurers that offer health insurance policies through the exchange that are a hospital plan corporation, a professional health services plan corporation or a parent, affiliate, subsidiary or other associated entity or successor of a hospital plan corporation or a professional health services plan.

(ii) One member from among the insurers that offer health insurance policies through the exchange that are not a hospital plan corporation, a professional health services plan corporation or a parent, affiliate, subsidiary or other associated entity or successor of a hospital plan corporation or a professional health services plan.

(iii) One member with experience in health care public education and consumer assistance activities who does not have a conflict of interest as described in subsection (k).

(iv) One member who is a consumer representative.

(3) Four voting members appointed by the General Assembly as follows:

(i) One individual appointed by the President pro tempore of the Senate.

(ii) One individual appointed by the Minority Leader of the Senate.

(iii) One individual appointed by the Speaker of the House of Representatives.

(iv) One individual appointed by the Minority Leader of the House of Representatives.

(4) The executive director shall attend meetings of the board but shall not be a member, may not vote and may not be counted for purposes of establishing a quorum.

(d) Chairperson.--The commissioner or a designee shall serve as chairperson.

(e) Compensation.--Board members shall not be entitled to any compensation for their services as members, except that, subject to the availability of funds, board members shall be entitled to reimbursement for actual and necessary travel expenses. The expenses shall be paid for by the exchange fund.

(f) Terms.--The terms of the board members shall be as follows:

(1) A board member appointed under subsection (c)(3) who:

(i) Is a member of the General Assembly shall serve a term concurrent with their holding of public office.

(ii) Is not a member of the General Assembly shall serve a term concurrent with their appointing official's holding of public office.

(2) A board member appointed under subsection (c)(2) shall serve a term of four years, not to exceed more than two full consecutive four-year terms, except that the following shall apply:

(i) Initial appointments shall be so staggered that less than 50% of the membership shall expire each year.

(ii) A member's term shall continue until the member's replacement is appointed.

(g) Vacancies.--Vacancies in appointed positions shall be filled in the same manner as the original appointment. Members shall serve until their successors are appointed and qualified.

(h) Formation.--The exchange authority shall be formed within 60 days of the effective date of this section. Prior to formation of the exchange authority, the commissioner may take action necessary to effect a timely transition from a federally administered exchange to the Pennsylvania Health Insurance Exchange.

(i) Quorum.--A majority of the appointed members of the board shall constitute a quorum. Action may be taken by the board at a meeting upon a vote of a quorum of its members present in person or through electronic means. If a tie vote occurs at any meeting, it shall be the duty of the chairperson of the board to cast a second and deciding vote.

(j) Meetings.--The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly, which shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(k) Experience and interests.--For purposes of this chapter, the board shall assure that it complies with section 1321 of the Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18041) and regulations promulgated under the Affordable Care Act regarding conflicts of interest and relevant experience.

(l) Conflict of interest.--The following apply:

(1) Except as provided under paragraph (2), a non-State employee board member shall not be subject to 65 Pa.C.S. Ch. 11 (relating to ethics standards and financial disclosure), including the requirements for filing statements of financial interests.

(2) A non-State employee board member may not engage in conduct that, if that member were a State employee, would constitute a conflict of interest under 65 Pa.C.S. Ch. 11.

(3) A majority of the voting members of the board may not have a conflict of interest as set forth in section 1321 of the Affordable Care Act and regulations promulgated under the Affordable Care Act.

Cross References. Section 9302 is referred to in section 9103 of this title.

§ 9303. Advisory council.

(a) Establishment.--An advisory council is created to advise the exchange authority under section 9304(g) (relating to meetings and operation).

(b) Composition.--The advisory council shall consist of the following members, who may not be in the employ of the Commonwealth:

(1) Four consumer representatives which include two representatives appointed by the Governor at least one of whom shall be a registered insurance exchange navigator or assister, one appointed by the President pro tempore of the Senate and one appointed by the Speaker of the House of Representatives.

(2) One representative selected by the Hospital and Healthsystem Association of Pennsylvania.

(3) One representative selected by the Pennsylvania Medical Society.

(4) One representative selected by the Pennsylvania Chamber of Business and Industry from a small group employer.

(5) One representative selected by the Pennsylvania Association of Health Underwriters.

§ 9304. Meetings and operation.

(a) Chairperson.--The members of the advisory council shall annually elect a chairperson from among its membership.

(b) Terms of members.--Each member's term shall be four years, not to exceed more than two full consecutive four-year terms, except that:

(1) Initial appointments shall be staggered to ensure less than 50% of the membership expire each year.

(2) A member's term shall continue until the member's successor is appointed.

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

(1) The advisory council shall meet at least twice per year, with each meeting held prior to a meeting of the board. Additional meetings may be held upon reasonable notice at times and locations selected by the board. The council shall meet at the call of the chairperson or upon written request of three members of the council.

(2) The executive director of the exchange authority, or a designee, shall attend each meeting of the advisory council.

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

(4) The advisory council shall post notice of the council's meetings on the exchange authority's publicly accessible Internet website at least five days prior to each meeting. The notice must specify the date, time and place

of the meeting and shall state that the council's meetings are open to the general public.

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

(d) Compensation.--The members of the advisory council shall not be entitled to any compensation for their services as members, except that, subject to the availability of money, the members of the advisory council shall be entitled to reimbursement for actual and necessary travel expenses. The expenses shall be paid for by the exchange fund.

(e) Vacancies.--Vacancies in appointed positions shall be filled in the same manner as the original appointment. Members shall serve until their successors are appointed and qualified.

(f) Quorum.--A majority of the advisory council members shall constitute a quorum and a quorum may act for the advisory council in all matters.

(g) Duties.--Upon request by the exchange authority, the advisory council shall advise the exchange authority on the following administrative and operational decisions:

(1) Initial operational decisions.

(2) Ongoing financing decisions.

(3) Other decisions as the exchange authority may deem appropriate.

Cross References. Section 9304 is referred to in sections 9303, 9305 of this title.

§ 9305. Powers and duties of exchange authority.

(a) Corporate operations.--The exchange authority shall exercise all powers and duties necessary and appropriate to carry out its purpose, including the following:

(1) Adopt bylaws.

(2) Employ staff.

(3) Make, execute and deliver contracts.

(4) Apply for, solicit and receive money from any source consistent with the purpose of this chapter.

(5) Establish priorities for, allocate and disburse money received.

(6) Submit annually to the Appropriations Committee of the Senate and the Appropriations Committee of the House of Representatives, at the same time the exchange authority submits its budget to the Governor, a copy of its budget request and all subsequently revised budget requests for the ensuing fiscal year. The budget shall include the amounts to be appropriated out of the fund established under section 9312 (relating to exchange fund) necessary to administer the provisions of this chapter and the conveyance of money to the Reinsurance Fund established under section 9510 (relating to Reinsurance Fund).

(7) Establish travel reimbursement policies for the exchange authority, its board and its advisory council.

(8) Coordinate with the appropriate Federal and State agencies to seek waivers from statutory or regulatory requirements as necessary to carry out the purposes of this chapter.

(9) Enter into other arrangements, including, without limitation, interagency agreements with Federal agencies and Commonwealth agencies or other states' agencies as may be necessary or appropriate to carry out the duties of the exchange authority.

(10) Give reasonable public notice of any policies and procedures the exchange authority may implement to accomplish the operation of the exchange authority.

(11) Perform other operational activities necessary or appropriate to further the purposes of this chapter.

(12) The board shall consider the advice of the advisory council provided under section 9304(g) (relating to meetings and operation).

(b) Programmatic duties.--The exchange authority shall perform all duties necessary or appropriate to advance its purpose, including the following:

(1) Educate consumers, including through outreach, a navigator program and postenrollment support.

(2) Assist individuals to access income-based assistance for which they may be eligible, including premium tax credits, cost-sharing reductions and government programs.

(3) Take into consideration the need for consumer choice in rural, urban and suburban areas across the Commonwealth.

(4) Assess and collect fees from on-exchange insurers to support the operation of the exchange under this chapter and the reinsurance program established under section 9502(b) (relating to implementation of waiver and establishment of reinsurance program), except that the exchange authority may not assess or collect any form of obligation other than an exchange user fee on total monthly premiums for on-exchange policies and unless approved by unanimous consent of the board, the fee may not exceed 3% of total monthly premiums for on-exchange policies. In no case may the fee exceed 3.5%.

(5) Disburse receipted fees, including to benefit the reinsurance program established under section 9502(b).

(c) Enforcement and State sovereignty.--The exchange authority shall ensure that the exchange complies with the Federal acts and rules and regulations that may be imposed by the Federal Government pursuant to the Federal acts in a manner that maintains State sovereignty over the health insurance market in this Commonwealth. Enforcement responsibilities shall be delegated to the appropriate State agency and shall be sufficient to prevent a determination by the United States Secretary of Health and Human Services that the Commonwealth has failed to substantially enforce any provision of the Federal acts.

Cross References. Section 9305 is referred to in section 9302 of this title.

§ 9306. Limitations.

Except as expressly provided in this chapter, nothing in this chapter shall be construed to limit or supersede the authority vested in a Commonwealth agency, including:

(1) The Insurance Department, including the department's authority to regulate the business of insurance within this Commonwealth, including health insurance policies whether offered on or off the exchange.

(2) The Department of Human Services, including with respect to the medical assistance program or the Children's Health Insurance Program.

(3) The Department of Health.

(4) The Office of Attorney General.

§ 9307. Confidentiality and disclosure.

(a) General rule.--Except as provided in this chapter, all working papers, recorded information, documents and copies of working papers, recorded information and documents produced by, obtained by or disclosed to the exchange authority or any other

person in the course of the exercise of the exchange authority's powers and duties under this chapter:

(1) shall be confidential;

(2) shall not be subject to subpoena;

(3) shall not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law;

(4) shall not be subject to discovery or admissible in evidence in any private civil action; and

(5) may not be made public by the exchange authority or any other person.

(b) Personal health and financial information.--The exchange authority shall protect personally identifiable health and financial information in accordance with all applicable Federal and State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5, 123 Stat. 226-279 and 467-496) and implementing regulations.

(c) Information disclosure.--Subject to the confidentiality provisions of this section:

(1) Information shall be shared, as appropriate, for the purpose of determining and coordinating the eligibility of individuals for the exchange or any government program, including the Children's Health Insurance Program and medical assistance program, or for compliance with Federal law:

(i) Among the exchange authority and departments, including:

(A) The department.

(B) The Department of Aging.

(C) The Department of Drug and Alcohol Programs.

(D) The Department of Health.

(E) The Department of Human Services.

(F) The Department of Labor and Industry.

(G) The Department of Revenue.

(ii) Between the exchange authority and Federal agencies, including:

(A) The Centers for Medicare and Medicaid Services.

(B) The Treasury Department.

(2) Information may be disclosed:

(i) As necessary to comply with the audit requirements of section 9310 (relating to audits) and the reporting requirements of section 9311 (relating to reports), only in an aggregated and de-identified form.

(ii) In any circumstance, other than those described in paragraph (1) or subparagraph (i), only if the prior written consent of the company or person to which the information pertains has been obtained.

(d) Construction.--Nothing in this section shall be construed to prohibit the exchange authority from accessing the information necessary to carry out its responsibilities in accordance with law.

§ 9308. Not an entitlement.

Nothing in this chapter shall constitute an entitlement derived from the Commonwealth or a claim on any money of the Commonwealth.

§ 9309. Nonliability.

(a) General rule.--Except as provided under subsection (b), there shall be no liability on the part of and no cause of action of any nature may arise against the exchange authority, board or advisory council or members thereof, the commissioner, the department, an insurer, insurance producer or an exchange

assister or an authorized representative, agent or employee thereof, for the use of information furnished pertaining to:

(1) An application for, inquiry concerning or enrollment or disenrollment in a health insurance policy or government program, including an inquiry regarding eligibility for enrollment or eligibility for a government program, relevant to health insurance available through an exchange or health care coverage or other benefits through a government program.

(2) A charge, assessment or fee imposed on or received from a person or entity relevant to the exchange.

(b) Limitation.--Subsection (a) shall apply only insofar as the person or entity is acting within the scope of the person's or entity's duties and responsibilities under this chapter.

§ 9310. Audits.

(a) Annual audit.--The accounts and books of the exchange authority shall be examined and audited annually by an independent certified public accounting firm. The audit shall at a minimum:

(1) Assess compliance with the requirements of this chapter.

(2) Identify any material weaknesses or significant deficiencies and identify ways to correct the material weaknesses or deficiencies.

(b) Sharing of audit.--By December 31 of each year, the exchange authority shall electronically share the audit of the preceding fiscal year required under subsection (a) and related documents by:

(1) Posting the following on the exchange authority's publicly accessible Internet website:

(i) The audit.

(ii) A summary of the audit, including any material weakness or significant deficiency identified and how the exchange authority intends to correct the material weakness or significant deficiency.

(2) Providing an electronic link to the posted audit under paragraph (1)(i) to the Secretary of the Senate and the Chief Clerk of the House of Representatives.

(3) Providing an electronic link to the posted audit under paragraph (1)(i) to the department.

(c) Payment.--The cost of the annual audit required under subsection (a) shall be paid for from money in the exchange fund.

Cross References. Section 9310 is referred to in section 9307 of this title.

§ 9311. Reports.

(a) Report.--The exchange authority shall prepare an annual report on the activities of the exchange authority for the year and:

(1) Electronically transmit the report to:

(i) The Governor.

(ii) The President pro tempore of the Senate.

(iii) The Minority Leader of the Senate.

(iv) The Speaker of the House of Representatives.

(v) The Minority Leader of the House of Representatives.

(vi) The chair and minority chair of:

(A) The Appropriations Committee of the Senate.

(B) The Appropriations Committee of the House of Representatives.

(C) The Banking and Insurance Committee of the Senate.

(D) The Insurance Committee of the House of Representatives.

(E) The Health and Human Services Committee of the Senate.

(F) The Health Committee of the House of Representatives.

(2) Post the report on the exchange authority's publicly accessible Internet website.

(b) Federal compliance.--The exchange authority shall comply with applicable Federal reporting requirements.

(c) Department notification.--The exchange authority shall provide a copy of or electronic link to the report provided under subsection (a) or (b) to the department.

Cross References. Section 9311 is referred to in section 9307 of this title.

§ 9312. Exchange fund.

(a) Establishment.--The Pennsylvania Health Insurance Exchange Fund is established as a special fund within the State Treasury. The exchange fund shall be administered by the exchange authority for the purposes set forth in this chapter, including the deposit of money that may be received pursuant to and disbursements permitted by this chapter.

(b) Deposit and use of money.--The following apply:

(1) Money deposited into the exchange fund shall be held for the purposes set forth in this chapter and may not be considered a part of the General Fund.

(2) Money in the exchange fund may only be used to effectuate the purposes of this chapter as determined by the exchange authority.

(3) All interest earned from the investment or deposit of money in the exchange fund shall be deposited into the exchange fund.

(4) All accrued and future earnings from money invested by the exchange authority and other accrued and future earnings from nonappropriated money, including, but not limited to, money obtained from the Federal Government and fees, shall be available to the exchange authority and shall be deposited into the State Treasury and may be utilized at the discretion of the board for carrying out any of the corporate purposes of the exchange authority.

(5) Placement of money by the State Treasurer in depositories or investments shall be consistent with guidelines approved by the board.

(6) For the purpose of administration, the exchange authority shall be subject to sections 610, 613 and 614 of act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

(c) Nonlapsing and revolving fund.--The exchange fund shall be a nonlapsing fund. All money in the exchange fund and interest accrued are appropriated to the exchange authority for expenditure consistent with this chapter.

Cross References. Section 9312 is referred to in sections 9103, 9305 of this title.

§ 9313. Federal guidance.

Until the exchange authority promulgates regulations, the exchange authority shall operate the exchange pursuant to:

(1) any applicable Federal rules, regulations or guidance; or

(2) interim State guidelines consistent with this chapter.

§ 9314. Expiration.

Upon publication of the notice under section 9703(b) (relating to action by commissioner), the exchange authority shall initiate steps to cease operations of the exchange authority and shall cease operations not later than 15 months after publication of the notice.

CHAPTER 95
REINSURANCE PROGRAM

Sec.

9501. Application.
9502. Implementation of waiver and establishment of reinsurance program.
9503. Administration and operation of reinsurance program.
9504. Reinsurance parameters.
9505. Insurer eligibility and duties.
9506. Payment of coverage and administrative costs.
9507. Not an entitlement.
9508. Annual audit.
9509. Annual report of operations.
9510. Reinsurance Fund.
9511. Procurements within one year.
9512. Access to information and records.
9513. Confidentiality and information disclosure.
9514. Immunity.
9515. Regulation of insurers.
9516. Expiration.

Enactment. Chapter 95 was added July 2, 2019, P.L.294, No.42, effective immediately.

Cross References. Chapter 95 is referred to in section 9703 of this title.

§ 9501. Application.

(a) Application.--The department is authorized to apply to the United States Secretary of Health and Human Services under section 1332 of the Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18052) for a state innovation waiver to:

(1) Waive any applicable provisions of the Affordable Care Act with respect to health insurance coverage in this Commonwealth.

(2) Establish a reinsurance program in accordance with an approved waiver.

(3) Maximize Federal funding for the reinsurance program for plan years beginning on or after implementation of the program.

(b) Public review.--On or before 180 days after the effective date of this section, the department shall make a draft application available for a 30-day public review and comment period. The department shall consider any comments in its final submitted application.

(c) Amendment.--The department may amend the waiver application as necessary to carry out the provisions of this chapter.

(d) Notification.--The department shall notify the chair and minority chair of the Appropriations Committee of the Senate, the chair and minority chair of the Appropriations Committee of the House of Representatives, the chair and minority chair of the Banking and Insurance Committee of the

Senate and the chair and minority chair of the Insurance Committee of the House of Representatives promptly of any amendment to the waiver application and of any Federal actions regarding the waiver application.

Cross References. Section 9501 is referred to in sections 9502, 9512 of this title.

§ 9502. Implementation of waiver and establishment of reinsurance program.

(a) Implementation.--Upon approval of the department's application for an innovation waiver by the United States Department of Health and Human Services, the department shall implement a reinsurance program.

(b) Establishment.--Contingent upon Federal approval, the Commonwealth Health Insurance Reinsurance Program is established in the department for the purposes of stabilizing the rates and premiums for health insurance policies in the individual market and providing greater financial certainty to consumers of health insurance in this Commonwealth. The reinsurance program shall be considered a reinsurance entity to carry out a reinsurance program under the Federal acts.

(c) Operation.--Operation of a reinsurance program shall be contingent on Federal approval of the waiver application submitted pursuant to section 9501 (relating to application).

Cross References. Section 9502 is referred to in sections 9103, 9305, 9510 of this title.

§ 9503. Administration and operation of reinsurance program.

(a) General rule.--The department shall take all actions necessary to administer the approved reinsurance program in a manner consistent with applicable Federal and State law.

(b) Functions.--The department shall perform all functions necessary and appropriate to carry out the operation of the reinsurance program and to effectuate the purposes for which the reinsurance program is organized, in accordance with the approved waiver. The functions include:

(1) Establishing procedures for and performing administrative and accounting operations of the reinsurance program.

(2) Seeking and receiving funding for the reinsurance program and to maximize Federal funding for the reinsurance program, including from:

(i) The exchange authority.

(ii) Federal funding that is or becomes available to states to support administration and implementation of state-based reinsurance programs.

(iii) Other available sources.

(3) Collecting data submissions and reinsurance payment requests by eligible insurers.

(4) Making reinsurance payments to eligible insurers.

(5) Resolving disputes related to the amount of reinsurance payments.

(6) Suing or being sued, including taking any legal action necessary or proper for the recovery of money for reinsurance payments.

(7) Submitting invoices or other requests for money as may be necessary and appropriate under the innovation waiver.

(c) Delegation.--Except as prohibited by applicable Federal law and regulation, and as may be necessary or appropriate to carry out department duties, the department may administer the reinsurance program directly or through:

(1) Other Federal agencies, Commonwealth agencies or other states' agencies.

(2) Contracted persons or entities, including with legal, actuarial, economic, third-party administrator or other persons or entities, as the department deems appropriate, to provide consultation services and technical assistance in operating the reinsurance program. Contracted persons or entities shall submit regular reports to the department regarding the person's or entity's performance, the frequency, content and form of which shall be determined by the department.

(d) Coordination with exchange authority.--The department shall coordinate with the exchange authority as may be necessary to fund and operate the reinsurance program.

§ 9504. Reinsurance parameters.

(a) Adoption of reinsurance terms.--The department shall, after consultation with all insurers then currently participating in the exchange, and not less than 60 days before final rates for health insurance policies are required to be submitted each year, determine and adopt the attachment point, reinsurance cap and coinsurance rate applicable to the reinsurance program for the following year.

(b) Parameters.--In determining the attachment point, reinsurance cap and coinsurance rate applicable to the reinsurance program for the following year, the department shall seek to:

(1) Manage the program within the amount of total program funding available to the department.

(2) With respect to the individual market:

(i) Mitigate the impact of high-cost claims on premium rates.

(ii) Stabilize or reduce premium rates.

(iii) Increase participation.

(c) Publication and notice.--The department shall transmit notice of the adopted attachment point, reinsurance cap and coinsurance rate to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin and shall:

(1) Post notice on the department's publicly accessible Internet website.

(2) Electronically send notice to the chair and minority chair of the Banking and Insurance Committee of the Senate and the chair and minority chair of the Insurance Committee of the House of Representatives.

(3) Electronically send notice to each participating insurer via a contact person or electronic mailing address, as identified by the insurer.

(d) Limitation.--After the department adopts the attachment point, reinsurance cap and coinsurance rate for the next year, the department may not, before or during that benefit year, change the attachment point, reinsurance cap or coinsurance rate in a manner less favorable to the insurers participating in the exchange at the time of adoption.

Cross References. Section 9504 is referred to in sections 9506, 9512 of this title.

§ 9505. Insurer eligibility and duties.

(a) Eligibility for payment.--An insurer shall be eligible for a reinsurance payment if:

(1) The claims costs for a reinsurance-eligible enrollee's covered benefits in a benefit year exceed the attachment point.

(2) The eligible insurer has implemented and documented reasonable care management practices for enrollees who are the subject of reinsurance claims through the reinsurance program.

(3) The eligible insurer makes its requests for reinsurance payments in accordance with any requirements established by the department, including requirements related to the format, structure and timing for submission of claims for reinsurance payments.

(4) The eligible insurer participated in the exchange, or is affiliated with an entity that participated in the exchange, in the benefit year in which the claims costs for which a reinsurance payment is sought were incurred.

(b) Reporting requirement.--An insurer that seeks reinsurance payments under this chapter must report to the department, in the form and manner prescribed by the department, information about reinsurance-eligible enrollees insured by the insurer as necessary for the department to calculate reinsurance payments.

(c) Confidentiality.--Reinsurance claims submitted under this section are confidential and are not subject to public disclosure, except as provided under section 9514 (relating to immunity).

(d) Consideration for rate filings.--In a rate filing for a health insurance policy to be offered through the exchange, the impact of reinsurance payments under this chapter shall be identified.

(e) Limitation.--The calculation of reinsurance payments due to an eligible insurer shall be net of all other available insurance payments applicable to a claim, including insurance accessible through subrogation or coordination of benefits.

§ 9506. Payment of coverage and administrative costs.

(a) General rule.--Consistent with Federal requirements, the department shall pay the following from the Reinsurance Fund:

(1) Administrative expenses of the reinsurance program, including the annual audit required under section 9508 (relating to annual audit).

(2) Reinsurance payments for coverage of reinsurance-eligible enrollees.

(b) Operations.--The department may promulgate regulations necessary and appropriate to establish processes for the settlement of reinsurance coverage claims and disbursement of reinsurance money.

(c) Request for review.--An insurer that is aggrieved by a determination of the department relating to the amount of reinsurance payments due to the insurer may file a request for administrative review of the decision. The procedures and requirements of 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) shall apply to requests for review filed under this section. Notwithstanding otherwise applicable time limitations, in order to permit timely finalization of rates for the open enrollment period for the exchange, a challenge to the department's determination of the attachment point, reinsurance cap and coinsurance rate published in the Pennsylvania Bulletin under section 9504(c) (relating to reinsurance parameters) must be made within 10 business days of the date of publication.

§ 9507. Not an entitlement.

(a) No entitlement.--The provision of reinsurance program money or benefits accrued through the Reinsurance Fund may not

constitute an entitlement derived from the Commonwealth or a claim on any other money of the Commonwealth.

(b) Contingency with respect to Federal money.--Notwithstanding any provision of this chapter, the department shall have no responsibility to pay reinsurance amounts that would be payable out of Federal money if the Federal Government does not transmit sufficient money for the Reinsurance Fund to fully recompense those actions.

§ 9508. Annual audit.

(a) Annual audit.--The reinsurance program shall be examined and audited annually by an independent certified public accounting firm. The audit shall, at a minimum:

(1) Assess compliance with the requirements of this chapter.

(2) Identify any material weaknesses or significant deficiencies and identify and implement solutions to correct the material weaknesses or deficiencies.

(b) Sharing of audit.--By December 31 of each year, the department shall electronically share the audit of the preceding fiscal year required under subsection (a) and related documents by:

(1) Posting the following on the department's publicly accessible Internet website:

(i) The audit.

(ii) A summary of the audit, including any material weakness or significant deficiency identified and how the department intends to correct the material weakness or significant deficiency.

(2) Providing an electronic link to the posted audit under paragraph (1)(i) to the Secretary of the Senate and the Chief Clerk of the House of Representatives.

(c) Payment.--The cost of the annual audit required under subsection (a) shall be paid for from money in the Reinsurance Fund.

Cross References. Section 9508 is referred to in sections 9506, 9513 of this title.

§ 9509. Annual report of operations.

(a) Report.--No later than November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the department shall prepare a financial report for the applicable benefit year. The report must include, at a minimum, the following information for the benefit year that is the subject of the report:

(1) Money deposited into the Reinsurance Fund.

(2) Requests for reinsurance payments received from eligible insurers.

(3) Reinsurance payments made to eligible insurers.

(4) Administrative and operational expenses incurred for the reinsurance program.

(b) Comparative report.--No later than 60 days after individual market health insurance rates are final, the department shall prepare a report summarizing the quantifiable impact of the reinsurance program on individual market health insurance rates for the following plan year.

(c) Distribution of reports.--The department shall:

(1) Electronically transmit the reports under this section to:

(i) The President pro tempore of the Senate.

(ii) The Minority Leader of the Senate.

(iii) The Speaker of the House of Representatives.

(iv) The Minority Leader of the House of Representatives.

(v) The chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Appropriations Committee of the House of Representatives.

(vi) The chair and minority chair of the Banking and Insurance Committee of the Senate and the chair and minority chair of the Insurance Committee of the House of Representatives.

(2) Post the reports under this section on the department's publicly accessible Internet website.

Cross References. Section 9509 is referred to in section 9513 of this title.

§ 9510. Reinsurance Fund.

(a) Establishment and administration of Reinsurance Fund.--The Reinsurance Fund is established as a special fund within the State Treasury. The Reinsurance Fund shall be administered by the department for the purposes set forth in this chapter, including the deposit of Federal money and all other money received pursuant to and disbursements permitted by this chapter.

(b) Exclusive purpose.--The Reinsurance Fund shall be dedicated exclusively for the reinsurance program established under section 9502(b) (relating to implementation of waiver and establishment of reinsurance program).

(c) Use.--The following apply:

(1) Expenditures from the Reinsurance Fund shall be used to:

(i) Implement and operate the reinsurance program.

(ii) Make reinsurance payments to eligible insurers under the reinsurance program. Payments to insurers shall be calculated and made on a pro rata basis.

(2) In making expenditures from the Reinsurance Fund, available Federal money must be expended first.

(3) Pending disbursement, money in the Reinsurance Fund shall be invested or reinvested in the same manner as money in the custody of the State Treasurer. All earnings received from the investment or reinvestment of money shall be credited to the Reinsurance Fund.

(d) Expenses.--All costs and expenses of the reinsurance program shall be paid from the Reinsurance Fund, including compensation of employees and any independent contractors or consultants hired by the department.

(e) Nonlapsing and revolving fund.--The following apply:

(1) The Reinsurance Fund shall be a nonlapsing fund. All money placed in the Reinsurance Fund and interest accrued are appropriated to the department for expenditure consistent with the provisions of this chapter.

(2) Nothing in this section shall prevent money in the Reinsurance Fund from being used as a revolving fund to cover necessary expenditures if Federal money is requested and committed but not yet received or if other money is committed but not yet received.

(f) Limitations.--The following limitations apply:

(1) In each fiscal year, the total amount of annual expenditures from the Reinsurance Fund, including administrative and consulting expenses, may not exceed the amount of expected Federal and other money budgeted for deposit in the Reinsurance Fund in that fiscal year.

(2) Notwithstanding any general or specific powers granted to the department under this chapter, whether express or implied, the department may not pledge, in favor of the reinsurance program, the credit or taxing power of the Commonwealth or any political subdivision.

Cross References. Section 9510 is referred to in section 9305 of this title.

§ 9511. Procurements within one year.

Notwithstanding any other provision of law and for the limited purpose of fulfilling the requirements under this chapter, procurement of contracts and agreements for the implementation and operation of the reinsurance program initiated within one year of the effective date of this section shall not be subject to the provisions of 62 Pa.C.S. (relating to procurement). No contract or agreement entered into under this section may exceed a term of five years.

§ 9512. Access to information and records.

(a) Reports and access.--An insurer shall, without charge, report information and provide access to and furnish records as the department requests in order for the department to:

(1) Prepare the State innovation waiver application submitted under section 9501(a) (relating to application).

(2) Determine reinsurance parameters under section 9504 (relating to reinsurance parameters).

(3) Determine the reinsurance payments due to each insurer.

(4) Monitor costs and revenues associated with the reinsurance program.

(5) Administer the reinsurance program.

(6) Assure compliance with applicable Federal and State law.

(b) Time period.--The information and records requested under subsection (a) shall be provided to the department within 30 days of receipt by an insurer of the written request, unless required at an earlier date for department compliance with a request from a Federal or other State agency.

(c) Use.--Information and records provided to the department under subsection (a) may only be used for the purposes specified in subsection (a).

(d) Exemptions.--Any instructions, forms or reports issued by the department and required to be completed by an insurer under this section shall not be subject to:

(1) The act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law.

(2) The act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

(3) The act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

§ 9513. Confidentiality and information disclosure.

(a) General rule.--Except as provided for in this section, all working papers, recorded information, documents and copies of working papers, recorded information and documents produced by, obtained by or disclosed to the department or any other person in the course of exercising the department's powers and duties under this chapter:

(1) shall be confidential;

(2) shall not be subject to subpoena;

(3) shall not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law;

(4) shall not be subject to discovery or admissible in evidence in any private civil action; and

(5) may not be made public by the department or any other person.

(b) Personal health and financial information.--The department shall protect personally identifiable health and financial information in accordance with Federal and State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5, 123 Stat. 226-279 and 467-496) and implementing regulations.

(c) Information disclosure.--Subject to the confidentiality provisions of this section:

(1) Information shall be shared as follows:

(i) Between the department and the Centers for Medicare and Medicaid Services for purposes of compliance with the Federal acts.

(ii) Between the department and each insurer participating in the reinsurance program.

(iii) Between the department and the exchange authority.

(2) Information may be disclosed as follows:

(i) As necessary to comply with the audit requirements of section 9508 (relating to annual audit) and the reporting requirements of section 9509 (relating to annual report of operations), only in an aggregated and de-identified form.

(ii) In any circumstance other than as described in paragraph (1) or subparagraph (i), only if the prior written consent of the company or person to which the information pertains is obtained.

(d) Construction.--Nothing in this section shall be construed to prohibit the department from accessing the information reasonably required to carry out its responsibilities in accordance with law.

§ 9514. Immunity.

(a) General rule.--Except as provided in subsection (b), the department, a Commonwealth agency or person or entity under contract with the department for the reinsurance program, or an authorized representative, agent or employee of any of them, may not be subject to civil or criminal liability and no cause of action of any nature shall arise for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter, or for the reasonable and good faith use of any information pertaining to the reinsurance program.

(b) Exception.--This section shall not prohibit legal actions against the reinsurance program to enforce the reinsurance program's statutory or contractual duties or obligations.

Cross References. Section 9514 is referred to in section 9505 of this title.

§ 9515. Regulation of insurers.

Nothing in this chapter shall be construed to limit or supersede the regulatory authority vested with the department to regulate the business of insurance within this Commonwealth, including health insurance policies offered on or off the exchange.

§ 9516. Expiration.

Upon publication of the notice under section 9703(b) (relating to action by commissioner), the department shall

initiate steps to cease operation of the reinsurance program and shall cease operation of the reinsurance program no later than 15 months after publication of the notice.

CHAPTER 97
MISCELLANEOUS PROVISIONS

Sec.
9701. Regulations.
9702. Enforcement.
9703. Action by commissioner.

Enactment. Chapter 97 was added July 2, 2019, P.L.294, No.42, effective immediately.

§ 9701. Regulations.

(a) Authority to promulgate.--The department and the exchange authority may promulgate regulations as may be necessary and appropriate to carry out the provisions of this part.

(b) Omission of proposed rulemaking.--The General Assembly finds and declares as follows:

(1) This part is essential to:

(i) the provision of health care for the citizens of this Commonwealth; and

(ii) the financial viability of the health care system in this Commonwealth.

(2) The finding and declaration under paragraph (1) constitutes good cause for the omission of notice of proposed rulemaking under section 204(3) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law.

§ 9702. Enforcement.

(a) General rule.--Upon satisfactory evidence of a violation of this part by an insurer or other person, one or more of the following penalties may be imposed at the commissioner's discretion:

(1) Suspension or revocation of the license of the insurer or other person.

(2) Refusal, for a period not to exceed one year, to issue a new license to the insurer or other person.

(3) A fine of not more than $5,000 for each violation.

(4) A fine of not more than $10,000 for each willful violation.

(b) Limitation.--

(1) Fines imposed against an individual insurer under this part may not exceed $500,000 in the aggregate during a single calendar year.

(2) Fines imposed against any other person under this part may not exceed $100,000 in the aggregate during a single calendar year.

(c) Additional remedies.--The enforcement remedies imposed under this subsection are in addition to any other remedies or penalties that may be imposed under any other applicable law of this Commonwealth, including:

(1) The act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. Violations of this part shall be deemed to be an unfair method of competition and an unfair or deceptive act or practice under the Unfair Insurance Practices Act.

(2) The act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act.

(d) Administrative procedure.--The administrative provisions of this section shall be subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). A party against whom penalties are assessed in an administrative action may appeal to Commonwealth Court as provided in 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

§ 9703. Action by commissioner.

(a) Sunset.--This part shall sunset immediately if any of the following occur:

(1) The Congress of the United States repeals or defunds those provisions of the Affordable Care Act integral to the exchange authority established under Chapter 93 (relating to State-based exchange) or the reinsurance program established under Chapter 95 (relating to reinsurance program).

(2) A court of the United States with competent jurisdiction invalidates the provisions of the Affordable Care Act integral to the duties of the exchange authority established under Chapter 93 or the reinsurance program established under Chapter 95.

(3) The Executive Branch of the United States repeals or defunds the provisions of the Affordable Care Act and its subsequent regulations integral to the duties of the exchange authority established under Chapter 93 or the reinsurance program established under Chapter 95.

(b) Notice.--If this part sunsets pursuant to subsection (a), the commissioner shall transmit notice of that action to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

Cross References. Section 9703 is referred to in sections 9314, 9516 of this title.

APPENDIX TO TITLE 40
INSURANCE

Supplementary Provisions of Amendatory Statutes

1975, AUGUST 2, P.L.293, NO.94

§ 2. Applicability.

The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa.C.S. Chap. 61 (relating to hospital plan corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Explanatory Note. Act 94 added section 6124(c) of Title 40.

§ 3. Effective date and retroactivity.

This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.