

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1983 Session of 2011

INTRODUCED BY MICOZZIE, DeLUCA, GODSHALL, GROVE, KILLION,  
 CLYMER, HALUSKA, HESS, MILLARD, MURPHY, READSHAW, REICHLEY,  
 STURLA, VULAKOVICH AND BARBIN, NOVEMBER 15, 2011

REFERRED TO COMMITTEE ON INSURANCE, NOVEMBER 15, 2011

AN ACT

1 Amending the act of December 18, 1996 (P.L.1066, No.159),  
 2 entitled "An act providing for review procedures pertaining  
 3 to accident and health insurance form and rate filings;  
 4 providing penalties; and making repeals," dividing the act  
 5 into Federal compliance and Commonwealth exclusivity; in  
 6 Federal compliance, further providing for definitions, for  
 7 required filings, for review procedure, for notice of  
 8 disapproval, for use of disapproved forms or rates, for  
 9 review of form or rate disapproval, for disapproval after  
 10 use, for filing of provider contracts, for record  
 11 maintenance, for public comment and for penalties and  
 12 providing for regulations and for expiration; in Commonwealth  
 13 exclusivity, providing for regulations and for action by the  
 14 Insurance Commissioner; and making editorial changes.

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

17 Section 1. The act of December 18, 1996 (P.L.1066, No.159),  
 18 known as the Accident and Health Filing Reform Act, is amended  
 19 by adding a chapter heading to read:

20 CHAPTER 1

21 PRELIMINARY PROVISIONS

22 Section 2. Section 1 of the act is renumbered to read:  
 23 Section [1] 101. Short title.

1 This act shall be known and may be cited as the Accident and  
2 Health Filing Reform Act.

3 Section 3. The act is amended by adding a chapter heading to  
4 read:

5 CHAPTER 3

6 FEDERAL COMPLIANCE

7 Section 4. The introductory paragraph and the definitions of  
8 "group accident and health insurance" and "insurer" in section 2  
9 of the act are amended, the section is amended by adding a  
10 definition and the section is renumbered to read:

11 Section [2] 301. Definitions.

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

15 \* \* \*

16 "Group accident and health insurance." A form affording  
17 insurance coverage against death, injury, disablement, disease  
18 or sickness resulting from an accident and covering [more than  
19 one person] a large or small group. The term shall not include  
20 blanket accident insurance policies or franchise accident and  
21 sickness insurance policies as defined in [section] sections  
22 621.3 and 621.4 of the act of May 17, 1921 (P.L.682, No.284),  
23 known as The Insurance Company Law of 1921.

24 \* \* \*

25 "Insurer." A foreign or domestic company, association or  
26 exchange, hospital plan corporation, professional health  
27 services plan corporation, fraternal benefits society, health  
28 maintenance organization and risk-assuming preferred provider  
29 organization.

30 \* \* \*

1 "Small group." A group that purchases accident and health  
2 insurance in the small group market, as defined in section  
3 2791(e) (5) of the Public Health Service Act (110 Stat. 1972, 42  
4 U.S.C. § 300gg-91(e) (5)), provided, however, that for plan years  
5 beginning prior to January 1, 2016, or other date as established  
6 in Federal law, "50 employees" is substituted for "100  
7 employees" in the definition of "small employer" in section  
8 2791(e) (4) of the Public Health Service Act.

9 \* \* \*

10 Section 4.1. The act is amended by adding a section to read:  
11 Section 302. (Reserved).

12 Section 5. Sections 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13  
13 of the act are amended to read:

14 Section [3] 303. Required filings.

15 (a) Form filings.--Each insurer [and HMO] shall file with  
16 the department any form which it proposes to issue in this  
17 Commonwealth except a type or kind of form which, in the opinion  
18 of the commissioner, does not require filing. The form filings  
19 required by this section shall be made no less than 45 days, or  
20 a shorter period of time as the department may establish, prior  
21 to their effective dates. The filings shall be subject to filing  
22 and review in accordance with the provisions of section 304.

23 (b) Notice of exemption from form filing.--The commissioner  
24 shall issue notice in the Pennsylvania Bulletin identifying any  
25 type or kind of form which has been exempted from filing. The  
26 commissioner may subsequently require the forms to be filed  
27 under this section upon notice published in the Pennsylvania  
28 Bulletin. Any such subsequent notice shall not be effective  
29 until 90 days after publication.

30 (c) Individual rates.--Each insurer [and HMO] shall file

1 with the department rates for individual accident and health  
2 insurance policies which it proposes to use in this Commonwealth  
3 except those rates which, in the opinion of the commissioner,  
4 cannot practicably be filed before they are used. The  
5 commissioner shall publish notice in the Pennsylvania Bulletin  
6 identifying rates which the commissioner determines cannot  
7 practicably be filed. The filings required by this subsection  
8 shall be made no less than 45 days, or a shorter period of time  
9 as the department may establish, prior to their effective dates.  
10 The filings shall be subject to filing and review in accordance  
11 with the provisions of section 304.

12 (d) Certain group rates exempt.--Except as provided in  
13 subsection (e), an insurer shall not be required to file with  
14 the department rates for accident and health insurance policies  
15 which it proposes to issue on a group[, blanket or franchise]  
16 basis in this Commonwealth.

17 (e) Required group rate filings.--Each [hospital plan  
18 corporation, professional health services plan corporation and  
19 HMO] insurer shall file with the department rates for small  
20 group accident and health insurance policies which it proposes  
21 to issue on a group[, blanket or franchise] basis in this  
22 Commonwealth in accordance with the following:

23 (1) Each [hospital plan corporation, professional health  
24 services plan corporation and HMO] insurer shall establish  
25 and file with the department prior to use a base rate which  
26 is not excessive, inadequate or unfairly discriminatory. The  
27 initial base rate for existing hospital plan corporations,  
28 professional health services plan corporations and HMOs shall  
29 be the rate or the rating formula currently on file and  
30 approved by the department as of the effective date of [this

1 act] section 314. The initial base rate or base rating  
2 formula for any [hospital plan corporation, professional  
3 health services plan corporation or HMO] insurer with no base  
4 rate or base rating formula on file and approved as of the  
5 effective date of [this act] section 314 shall be [subject to  
6 filing, review and prior approval by the department] the base  
7 rate or base rating formula in effect on the effective date  
8 of section 314, and shall be filed with the department no  
9 more than 45 days thereafter.

10 (2) Proposed changes to [an approved] a base rate or  
11 [any approved component of an approved] base rating formula  
12 which effect an increase or decrease in the [approved] base  
13 rate or [in an approved component of an approved] base rating  
14 formula of [more than] 10% or more annually in the aggregate  
15 shall be subject to filing[, ] and review [and prior approval]  
16 by the department in accordance with the provisions of  
17 section 304. The filings required by this paragraph shall be  
18 made no less than 45 days, or a shorter period of time as the  
19 department may establish, prior to their effective dates.

20 (3) Proposed changes to [an approved] a base rate or  
21 [any approved component of an approved] base rating formula  
22 which effect an increase or decrease in the [approved] base  
23 rate or [in an approved component of an approved] base rating  
24 formula of [not more] less than 10% annually in the aggregate  
25 shall be [subject to filing and review in accordance with the  
26 provisions of section 4] filed with the department and may be  
27 used 45 days thereafter.

28 (4) Rates developed for a specific group which do not  
29 deviate from the base rate or base rate formula by more than  
30 15% may be used without filing with the department.

1 (5) Rates developed for a specific group which deviate  
2 from the base rate or base rate formula by more than 15%  
3 shall be subject to filing and review in accordance with the  
4 provisions of section [4] 304. The filings required by this  
5 paragraph shall be made no less than 45 days, or a shorter  
6 period of time as the department may establish, prior to  
7 their effective dates.

8 (6) The commissioner shall have discretion to exempt any  
9 type or kind of rate filing under this subsection by  
10 regulation except for filings required under subsection (c)  
11 and paragraph (2).

12 [(f) Applicability of filings.--All filings required by this  
13 section shall be made no less than 45 days prior to their  
14 effective dates. Filings under subsection (e)(1) and (2) shall  
15 be deemed approved at the expiration of 45 days after filing  
16 unless earlier approved or disapproved by the commissioner. The  
17 commissioner, by written notice to the insurer, may within such  
18 45-day period extend the period for approval or disapproval for  
19 an additional 45 days. All other filings under this section  
20 shall become effective as provided in section 4.]

21 (f) Power of the department.--The department may, at the  
22 discretion of the commissioner through notice in the  
23 Pennsylvania Bulletin, adjust the 10% threshold set forth in  
24 subsection (e)(2) and (3) only for purposes of coordinating the  
25 filing requirements of this section to a state-specific  
26 percentage determined by the Secretary of the United States  
27 Department of Health and Human Services.

28 Section [4] 304. Review procedure.

29 (a) General rule.--Filings under section 303(c) and (e)(1),  
30 (2) and (5) shall be reviewed as appropriate and necessary to

1 carry out the provisions of this [act] chapter. [Unless a filing  
2 is disapproved by the department within the 45-day period  
3 provided in section 3(f), filings made under section 3 shall  
4 become effective for use 45 days following:

5 (1) the expiration of any public comment period  
6 established by the commissioner under section 11; or

7 (2) receipt of the filing by the department if no public  
8 comment period is established.] The following apply:

9 (1) Unless a filing that is subject to review under  
10 section 303(c) or (e) (1), (2) or (5) is earlier disapproved  
11 by the department, or the department, by written notice to  
12 the insurer, extends the period for approval or disapproval  
13 for an additional 45 days, the filings shall be deemed  
14 approved 45 days following receipt of the filing by the  
15 department.

16 (2) Unless a resubmitted filing made under subsection  
17 (c) is earlier disapproved by the department, the resubmitted  
18 filing shall be deemed approved 30 days following receipt of  
19 the resubmitted filing by the department.

20 (3) The department may hire the services of a competent  
21 actuarial firm as reasonably necessary under any section of  
22 this chapter to assist the department in the review of an  
23 insurer's rate filing or resubmitted rate filing under  
24 section 303(c) or (e) (1), (2) or (5). The reasonable and  
25 necessary costs for the services shall be paid by the insurer  
26 within 30 days of the insurer's receipt of a bill for the  
27 services.

28 (4) An insurer intending to use any rate deemed approved  
29 under this subsection shall provide written notice to the  
30 department prior to use.

1 (b) Disapproval.--Disapproval of a filing shall be based  
2 only on specific provisions of applicable law, regulation or  
3 statement of policy or if insufficient information is submitted  
4 to support the filing. Rates [filed under section 3(e)] shall  
5 not be disapproved unless the rates are determined to be  
6 excessive, inadequate or unfairly discriminatory.

7 (c) Resubmission.--A filing disapproved by the department  
8 may be resubmitted within 120 days after the date of the  
9 disapproval. [Filings resubmitted within this time shall become  
10 effective for use 30 days after the receipt of the resubmission  
11 by the department unless the filing is disapproved by the  
12 department before the expiration of the 30-day period. This  
13 subsection shall not apply to filings made prior to the  
14 effective date of this act.]

15 (d) Disapproval of resubmissions.--Disapproval of a filing  
16 resubmitted under subsection (c) shall be based only on specific  
17 provisions of applicable law, regulation or statement of policy  
18 or if insufficient information is submitted to support the  
19 filing. Rates shall not be disapproved unless the rates are  
20 determined to be excessive, inadequate or unfairly  
21 discriminatory. Disapproval may not be based on any grounds not  
22 specified in the initial disapproval issued by the department  
23 except to the extent that new information is presented in the  
24 resubmission.

25 (e) Subsequent resubmissions.--Any further resubmission  
26 following a second disapproval shall be considered a new filing  
27 [and reviewed in accordance with subsection (a)] under section  
28 303.

29 (f) [Commissioner's] Department's discretion.--Nothing in  
30 this section shall be construed to prevent the [commissioner]



1 department from affirmatively approving a filing at the  
2 [commissioner's] department's discretion.

3 Section [5] 305. Notice of approval or disapproval.

4 (a) Requirement.--Upon the disapproval of any filing under  
5 this [act] chapter, the department shall notify the insurer [or  
6 HMO] of the disapproval in writing, specifying the reason or  
7 reasons for such disapproval.

8 (b) Report.--A report of the approval or disapproval of a  
9 rate filing subject to review under Federal law shall be  
10 provided by the department to the United States Department of  
11 Health and Human Services in a form and manner prescribed by the  
12 Secretary of the United States Department of Health and Human  
13 Services.

14 Section [6] 306. Use of disapproved forms or rates.

15 It shall be unlawful for any insurer [or HMO] to use in this  
16 Commonwealth a form or rate disapproved under this [act]  
17 chapter.

18 Section [7] 307. Review of form or rate disapproval.

19 (a) Request for hearing.--Within 30 days from the date of  
20 mailing of a notice of disapproval of a filing under this [act]  
21 chapter, the insurer [or HMO] may make a written application to  
22 the commissioner for a hearing.

23 (b) Hearing.--Upon receipt of a timely written application  
24 for hearing, the commissioner shall schedule and conduct a  
25 hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to  
26 practice and procedure of Commonwealth agencies) and Ch. 7  
27 Subch. A (relating to judicial review of Commonwealth agency  
28 action). All of the actions which may be performed by the  
29 commissioner in this section may be performed by the  
30 commissioner's designated representative.

1 Section [8] 308. Disapproval after use.

2 (a) General rule.--Any form or rate filed and used [after  
3 the expiration of the appropriate review period] under this  
4 [act] chapter, whether or not subject to review under this  
5 chapter, may be subsequently disapproved. The [commissioner]  
6 department shall notify the insurer [or HMO] in writing and  
7 provide the opportunity for a hearing as provided in 2 Pa.C.S.  
8 Ch. 5 Subch. A (relating to practice and procedure of  
9 Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial  
10 review of Commonwealth agency action).

11 (b) Discontinuance of form.--If following a hearing the  
12 commissioner finds that a form in use should be disapproved, the  
13 commissioner shall order its use to be discontinued for any  
14 policy issued after a date specified in the order.

15 (c) Discontinuance of rate.--If following a hearing the  
16 commissioner finds that a rate in use should be disapproved, the  
17 commissioner shall order its use to be discontinued  
18 prospectively for any policy issued or renewed after a date  
19 specified in the order.

20 (d) Suspension of forms.--Pending a hearing, the  
21 commissioner may order the suspension of use of a form filed if  
22 the commissioner has reasonable cause to believe that:

23 (1) The form is contrary to applicable law, regulation  
24 or statement of policy.

25 (2) Unless a suspension order is issued, insureds will  
26 suffer substantial harm.

27 (3) The harm insureds will suffer outweighs any hardship  
28 the insurer will suffer by the suspension of the use of the  
29 form.

30 (4) The suspension order will result in no harm to the

1 public.

2 (e) Suspension of rates.--Pending a hearing, the  
3 commissioner may order the suspension of use of a rate filed and  
4 reinstate the last previous rate in effect if the commissioner  
5 has reasonable cause to believe that:

6 (1) The rate is excessive, inadequate or unfairly  
7 discriminatory under section [4(b)] 304(b).

8 (2) Unless a suspension order is issued, insureds will  
9 suffer substantial harm.

10 (3) The harm insureds will suffer outweighs any hardship  
11 the insurer will suffer by the suspension of the use of the  
12 [form] rate.

13 (4) The suspension order will result in no harm to the  
14 public.

15 Section [9] 309. Filing of provider contracts.

16 (a) Filing and review process.--Provider contracts shall be  
17 filed by insurers and reviewed by the department as follows:

18 (1) Provider contracts shall be filed with the  
19 department no later than 30 days prior to the effective date  
20 specified in the contract.

21 (2) Provider contracts shall become effective unless  
22 disapproved within 30 days following:

23 (i) the expiration of [the] any public comment  
24 period established by the [commissioner] department under  
25 section [11] 311; or

26 (ii) receipt of the filing by the department if no  
27 public comment is established.

28 (3) The department may disapprove a provider contract  
29 whenever it is determined that the contract:

30 (i) provides for excessive payments;

1           (ii) fails to include reasonable incentives for cost  
2 control;  
3           (iii) contributes to the escalation of the cost of  
4 providing health care services; or  
5           (iv) does not provide for the realization of  
6 potential and achieved savings under the contract by  
7 insureds/subscribers.

8       (b) Review of the disapproval.--Upon disapproval of a  
9 provider contract under this section, the insurer may seek  
10 review of the disapproval as provided in section [7] 307.

11       (c) Payment rates and fee information.--Provider contracts  
12 filed under this section need not contain payment rates and fees  
13 unless requested by the department. Payment rates and fees  
14 requested by the department shall be given confidential  
15 treatment, are not subject to subpoena and may not be made  
16 public by the department, except that the payment rates and fee  
17 information may be disclosed to the insurance department of  
18 another state or to a law enforcement official of this State or  
19 any other state or agency of the Federal Government at any time  
20 so long as the agency or office receiving the information agrees  
21 in writing to hold it confidential and in a manner consistent  
22 with this [act] chapter.

23       (d) Disapproval of existing contract.--If at any time the  
24 commissioner determines that a provider contract which has  
25 become effective under this section violates the standards as  
26 provided in subsection (a) (3), the commissioner may disapprove  
27 the provider contract after notice and hearing as provided in 2  
28 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of  
29 Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial  
30 review of Commonwealth agency action).

1 (e) Department of Health authority.--Nothing in this section  
2 shall be construed to expand or limit the authority of the  
3 Department of Health to review provider contracts under its  
4 authority under the act of December 29, 1972 (P.L.1701, No.364),  
5 known as the Health Maintenance Organization Act, and section  
6 630 of the act of May 17, 1921 (P.L.682, No.284), known as The  
7 Insurance Company Law of 1921, and regulations promulgated  
8 thereunder, including review of size of network and quality of  
9 care provided.

10 Section [10] 310. Record maintenance.

11 Upon request, the [commissioner] department shall be provided  
12 a copy of any form being issued in this Commonwealth. Insurers  
13 [and HMOs] shall maintain complete and accurate specimen or  
14 actual copies of all forms which are issued to Pennsylvania  
15 residents, including copies of all applications, certificates  
16 and endorsements used with policies. Retention of the forms may  
17 be kept on diskette, microfiche or any other electronic method.  
18 Specimen copies shall also indicate the date the form was first  
19 issued in this Commonwealth. The records shall be maintained  
20 until at least two years after a claim can no longer be reported  
21 under the form.

22 Section [11] 311. Public comment.

23 [Public] (a) Certain rate filings.--A form of notice for  
24 each rate filing subject to review under Federal law shall be  
25 required to be provided by the filing insurer for posting on the  
26 department's website. The form of notice shall satisfy the  
27 requirements set forth in section 2794 of the Public Health  
28 Service Act (110 Stat. 1972, 42 U.S.C. § 300gg-94) and any  
29 regulations promulgated thereunder.

30 (b) Other filings.--Except as provided for under subsection

1 (a), public notice of filings made under this [act] chapter  
2 shall not be required. At the [commissioner's] department's  
3 discretion, however, notice of a filing may be published in the  
4 Pennsylvania Bulletin [and a time period established for the  
5 receipt of public comment by the department] or on the  
6 department's website or on any other publicly accessible  
7 electronic medium.

8 (c) Period for public comment.--At the department's  
9 discretion, the department may establish a time period for the  
10 receipt of public comment on any filing.

11 Section [12] 312. Required policy provisions.

12 (a) General rule.--An individual or group, blanket or  
13 franchise form issued by a hospital plan corporation or  
14 professional health services plan corporation shall also be  
15 subject to the following provisions of the act of May 17, 1921  
16 (P.L.682, No.284), known as The Insurance Company Law of 1921:

- 17 (1) Section 617.
- 18 (2) Section 618.
- 19 (3) Section 619.
- 20 (4) Section 619.1.
- 21 (5) Section 621.2(a) (6).
- 22 (6) Section 621.2(b) through (d).
- 23 (7) Section 621.3.
- 24 (8) Section 621.4.
- 25 (9) Section 621.5.
- 26 (10) Section 622.
- 27 (11) Section 625.
- 28 (12) Section 626.
- 29 (13) Section 628.

30 (b) Network-based programs.--Nothing in this [act] chapter

1 shall prohibit a hospital plan corporation or professional  
2 health services plan corporation from establishing or offering  
3 provider network-based programs under 40 Pa.C.S. Ch. 61  
4 (relating to hospital plan corporations) or 63 (relating to  
5 professional health services plan corporations).

6 Section [13] 313. Penalties.

7 (a) General rule.--Upon satisfactory evidence of the  
8 violation of any section of this [act] chapter by an insurer[,  
9 HMO] or any other person, one or more of the following penalties  
10 may be imposed at the commissioner's discretion:

11 (1) Suspension or revocation of the license of the  
12 offending insurer[, HMO] or other person.

13 (2) Refusal, for a period not to exceed one year, to  
14 issue a new license to the offending insurer[, HMO] or other  
15 person.

16 (3) A fine of not more than \$5,000 for each violation of  
17 this [act] chapter.

18 (4) A fine of not more than \$10,000 for each willful  
19 violation of this [act] chapter.

20 (5) A fine of not more than \$10,000 for each violation  
21 of section [6] 306.

22 (6) A fine of not more than \$25,000 for each willful  
23 violation of section [6] 306.

24 (b) Limitation.--Fines imposed against an individual insurer  
25 under this [act] chapter shall not exceed \$500,000 in the  
26 aggregate during a single calendar year.

27 Section 6. The act is amended by adding sections to read:

28 Section 314. Regulations.

29 The department may promulgate regulations as may be necessary  
30 or appropriate to carry out this chapter.

1 Section 315. Expiration.

2 This chapter shall expire upon publication of the notice  
3 under section 5103.

4 Section 7. The act is amended by adding a chapter to read:

5 CHAPTER 5

6 COMMONWEALTH EXCLUSIVITY

7 Section 501. (Reserved).

8 Section 502. Definitions.

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

12 "Commissioner." The Insurance Commissioner of the  
13 Commonwealth.

14 "Company," "association" or "exchange." An entity defined in  
15 section 101 of the act of May 17, 1921 (P.L.682, No.284), known  
16 as The Insurance Company Law of 1921.

17 "Department." The Insurance Department of the Commonwealth.

18 "Filing." A form or rate required by section 503.

19 "Form." A policy, contract, certificate, evidence of  
20 coverage, application, rider or endorsement affording insurance  
21 coverage or benefit against loss from sickness or loss or damage  
22 from bodily injury or death of the insured by accident and each  
23 modification of any of the above.

24 "Fraternal benefits society." An entity organized and  
25 operating under Article XXIV of the act of May 17, 1921  
26 (P.L.682, No.284), known as The Insurance Company Law of 1921.

27 "Group accident and health insurance." A form affording  
28 insurance coverage against death, injury, disablement, disease  
29 or sickness resulting from an accident and covering more than  
30 one person. The term shall not include blanket accident



1 insurance policies as defined in section 621.3 of the act of May  
2 17, 1921 (P.L.682, No.284), known as The Insurance Company Law  
3 of 1921.

4 "Health care provider." A person, corporation, facility,  
5 institution or other entity licensed, certified or approved by  
6 the Commonwealth to provide health care or professional medical  
7 services. The term includes, but is not limited to, physicians,  
8 professional nurses, certified nurse-midwives, podiatrists,  
9 hospitals, nursing homes, ambulatory surgical centers or birth  
10 centers.

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

15 "Hospital plan corporation." An entity organized and  
16 operating under 40 Pa.C.S. Ch. 61 (relating to hospital plan  
17 corporations).

18 "Insurer." A foreign or domestic company, association or  
19 exchange, hospital plan corporation, professional health  
20 services plan corporation, fraternal benefits society and risk-  
21 assuming preferred provider organization.

22 "Preferred provider organization." An entity organized and  
23 operating under section 630 of the act of May 17, 1921 (P.L.682,  
24 No.284), known as The Insurance Company Law of 1921.

25 "Professional health services plan corporation." An entity  
26 organized and operating under 40 Pa.C.S. Ch. 63 (relating to  
27 professional health services plan corporations).

28 "Provider contracts." An agreement made between an insurer  
29 and a health care provider regarding the provision of any  
30 payment for health care services. The term shall not include

1 contracts or related documents which are subject to the  
2 exclusive approval of the Department of Health under 40 Pa.C.S.  
3 § 6324 (relating to rights of health service doctors) and  
4 section 630 of the act of May 17, 1921 (P.L.682, No.284), known  
5 as The Insurance Company Law of 1921.

6 "Rate." A manual of classification, rules and rates, each  
7 rating plan and each modification of any of the above.

8 "Statement of policy." A document as defined in 45 Pa.C.S. §  
9 501 (relating to definitions), provided that the document has  
10 been published in the Pennsylvania Bulletin.

11 Section 503. Required filings.

12 (a) Form filings.--Each insurer and HMO shall file with the  
13 department any form which it proposes to issue in this  
14 Commonwealth except a type or kind of form which, in the opinion  
15 of the commissioner, does not require filing.

16 (b) Notice of exemption from filing.--The commissioner shall  
17 issue notice in the Pennsylvania Bulletin identifying any type  
18 or kind of form which has been exempted from filing. The  
19 commissioner may subsequently require the forms to be filed  
20 under this section upon notice published in the Pennsylvania  
21 Bulletin. Any such subsequent notice shall not be effective  
22 until 90 days after publication.

23 (c) Individual rates.--Each insurer and HMO shall file with  
24 the department rates for individual accident and health  
25 insurance policies which it proposes to use in this Commonwealth  
26 except those rates which, in the opinion of the commissioner,  
27 cannot practicably be filed before they are used. The  
28 commissioner shall publish notice in the Pennsylvania Bulletin  
29 identifying rates which the commissioner determines cannot  
30 practicably be filed.

1 (d) Certain group rates exempt.--Except as provided in  
2 subsection (e), an insurer shall not be required to file with  
3 the department rates for accident and health insurance policies  
4 which it proposes to issue on a group, blanket or franchise  
5 basis in this Commonwealth.

6 (e) Required group rate filings.--Each hospital plan  
7 corporation, professional health services plan corporation and  
8 HMO shall file with the department rates for accident and health  
9 insurance policies which it proposes to issue on a group,  
10 blanket or franchise basis in this Commonwealth in accordance  
11 with the following:

12 (1) Each hospital plan corporation, professional health  
13 services plan corporation and HMO shall establish a base rate  
14 which is not excessive, inadequate or unfairly  
15 discriminatory. The initial base rate for existing hospital  
16 plan corporations, professional health services plan  
17 corporations and HMOs shall be the rate or the rating formula  
18 currently on file and approved by the department as of  
19 February 17, 1997. The initial base rate or base rating  
20 formula for any hospital plan corporation, professional  
21 health services plan corporation or HMO with no base rate or  
22 base rating formula on file and approved as of February 17,  
23 1997, shall be subject to filing, review and prior approval  
24 by the department.

25 (2) Proposed changes to an approved base rate or any  
26 approved component of an approved rating formula which effect  
27 an increase or decrease in the approved base rate or in an  
28 approved component of an approved rating formula of more than  
29 10% annually in the aggregate shall be subject to filing,  
30 review and prior approval by the department.

1           (3) Proposed changes to an approved base rate or any  
2 approved component of an approved rating formula that effect  
3 an increase or decrease in the approved base rate or in an  
4 approved component of an approved rating formula of not more  
5 than 10% annually in the aggregate shall be subject to filing  
6 and review in accordance with the provisions of section 504.

7           (4) Rates developed for a specific group which do not  
8 deviate from the base rate or base rate formula by more than  
9 15% may be used without filing with the department.

10           (5) Rates developed for a specific group which deviate  
11 from the base rate or base rate formula by more than 15%  
12 shall be subject to filing and review in accordance with the  
13 provisions of section 504.

14           (6) The commissioner shall have discretion to exempt any  
15 type or kind of rate filing under this subsection by  
16 regulation.

17           (f) Applicability of filings.--All filings required by this  
18 section shall be made no less than 45 days prior to their  
19 effective dates. Filings under subsection (e)(1) and (2) shall  
20 be deemed approved at the expiration of 45 days after filing  
21 unless earlier approved or disapproved by the commissioner. The  
22 commissioner, by written notice to the insurer, may within such  
23 45-day period extend the period for approval or disapproval for  
24 an additional 45 days. All other filings under this section  
25 shall become effective as provided in section 504.

26 Section 504. Review procedure.

27           (a) General rule.--Filings shall be reviewed as appropriate  
28 and necessary to carry out the provisions of this chapter.  
29 Unless a filing is disapproved by the department within the 45-  
30 day period provided in section 503(f), filings made under

1 section 503 shall become effective for use 45 days following:

2 (1) the expiration of any public comment period  
3 established by the commissioner under section 511; or

4 (2) receipt of the filing by the department if no public  
5 comment period is established.

6 (b) Disapproval.--Disapproval of a filing shall be based  
7 only on specific provisions of applicable law, regulation or  
8 statement of policy or if insufficient information is submitted  
9 to support the filing. Rates filed under section 503(e) shall  
10 not be disapproved unless the rates are determined to be  
11 excessive, inadequate or unfairly discriminatory.

12 (c) Resubmission.--A filing disapproved by the department  
13 may be resubmitted within 120 days after the date of the  
14 disapproval. Filings resubmitted within this time shall become  
15 effective for use 30 days after the receipt of the resubmission  
16 by the department unless the filing is disapproved by the  
17 department before the expiration of the 30-day period. This  
18 subsection shall not apply to filings made prior to February 17,  
19 1997.

20 (d) Disapproval of resubmissions.--Disapproval of a filing  
21 resubmitted under subsection (c) shall be based only on specific  
22 provisions of applicable law, regulation or statement of policy  
23 or if insufficient information is submitted to support the  
24 filing. Disapproval may not be based on any grounds not  
25 specified in the initial disapproval issued by the department  
26 except to the extent that new information is presented in the  
27 resubmission.

28 (e) Subsequent resubmissions.--Any further resubmission  
29 following a second disapproval shall be considered a new filing  
30 and reviewed in accordance with subsection (a).

1 (f) Commissioner's discretion.--Nothing in this section  
2 shall be construed to prevent the commissioner from  
3 affirmatively approving a filing at the commissioner's  
4 discretion.

5 Section 505. Notice of disapproval.

6 Upon the disapproval of any filing under this chapter, the  
7 department shall notify the insurer or HMO of the disapproval in  
8 writing, specifying the reason or reasons for such disapproval.

9 Section 506. Use of disapproved forms or rates.

10 It shall be unlawful for any insurer or HMO to use in this  
11 Commonwealth a form or rate disapproved under this chapter.

12 Section 507. Review of form or rate disapproval.

13 (a) Request for hearing.--Within 30 days from the date of  
14 mailing of a notice of disapproval of a filing under this  
15 chapter, the insurer or HMO may make a written application to  
16 the commissioner for a hearing.

17 (b) Hearing.--Upon receipt of a timely written application  
18 for hearing, the commissioner shall schedule and conduct a  
19 hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to  
20 practice and procedure of Commonwealth agencies) and Ch. 7  
21 Subch. A (relating to judicial review of Commonwealth agency  
22 action). All of the actions which may be performed by the  
23 commissioner in this section may be performed by the  
24 commissioner's designated representative.

25 Section 508. Disapproval after use.

26 (a) General rule.--Any form or rate filed and used after the  
27 expiration of the appropriate review period under this chapter  
28 may be subsequently disapproved. The department shall notify the  
29 insurer or HMO in writing and provide the opportunity for a  
30 hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to

1 practice and procedure of Commonwealth agencies) and Ch. 7  
2 Subch. A (relating to judicial review of Commonwealth agency  
3 action).

4 (b) Discontinuance of form.--If following a hearing the  
5 commissioner finds that a form in use should be disapproved, the  
6 commissioner shall order its use to be discontinued for any  
7 policy issued after a date specified in the order.

8 (c) Discontinuance of rate.--If following a hearing the  
9 commissioner finds that a rate in use should be disapproved, the  
10 commissioner shall order its use to be discontinued  
11 prospectively for any policy issued or renewed after a date  
12 specified in the order.

13 (d) Suspension of forms.--Pending a hearing, the  
14 commissioner may order the suspension of use of a form filed if  
15 the commissioner has reasonable cause to believe that:

16 (1) The form is contrary to applicable law, regulation  
17 or statement of policy.

18 (2) Unless a suspension order is issued, insureds will  
19 suffer substantial harm.

20 (3) The harm insureds will suffer outweighs any hardship  
21 the insurer will suffer by the suspension of the use of the  
22 form.

23 (4) The suspension order will result in no harm to the  
24 public.

25 (e) Suspension of rates.--Pending a hearing, the  
26 commissioner may order the suspension of use of a rate filed and  
27 reinstate the last previous rate in effect if the commissioner  
28 has reasonable cause to believe that:

29 (1) The rate is excessive, inadequate or unfairly  
30 discriminatory under section 504(b).

1           (2) Unless a suspension order is issued, insureds will  
2 suffer substantial harm.

3           (3) The harm insureds will suffer outweighs any hardship  
4 the insurer will suffer by the suspension of the use of the  
5 form.

6           (4) The suspension order will result in no harm to the  
7 public.

8 Section 509. Filing of provider contracts.

9           (a) Filing and review process.--Provider contracts shall be  
10 filed by insurers and reviewed by the department as follows:

11           (1) Provider contracts shall be filed with the  
12 department no later than 30 days prior to the effective date  
13 specified in the contract.

14           (2) Provider contracts shall become effective unless  
15 disapproved within 30 days following:

16           (i) the expiration of the public comment period  
17 established by the commissioner under section 511; or

18           (ii) receipt of the filing by the department if no  
19 public comment is established.

20           (3) The department may disapprove a provider contract  
21 whenever it is determined that the contract:

22           (i) provides for excessive payments;

23           (ii) fails to include reasonable incentives for cost  
24 control;

25           (iii) contributes to the escalation of the cost of  
26 providing health care services; or

27           (iv) does not provide for the realization of  
28 potential and achieved savings under the contract by  
29 insureds/subscribers.

30           (b) Review of the disapproval.--Upon disapproval of a



1 provider contract under this section, the insurer may seek  
2 review of the disapproval as provided in section 507.

3 (c) Payment rates and fee information.--Provider contracts  
4 filed under this section need not contain payment rates and fees  
5 unless requested by the department. Payment rates and fees  
6 requested by the department shall be given confidential  
7 treatment, are not subject to subpoena and may not be made  
8 public by the department, except that the payment rates and fee  
9 information may be disclosed to the insurance department of  
10 another state or to a law enforcement official of this State or  
11 any other state or agency of the Federal Government at any time  
12 so long as the agency or office receiving the information agrees  
13 in writing to hold it confidential and in a manner consistent  
14 with this chapter.

15 (d) Disapproval of existing contract.--If at any time the  
16 commissioner determines that a provider contract which has  
17 become effective under this section violates the standards as  
18 provided in subsection (a) (3), the commissioner may disapprove  
19 the provider contract after notice and hearing as provided in 2  
20 Pa.C.S. Chs. 5 Subch. A (relating to practice and procedure of  
21 Commonwealth agencies) and 7 Subch. A (relating to judicial  
22 review of Commonwealth agency action).

23 (e) Department of Health authority.--Nothing in this section  
24 shall be construed to expand or limit the authority of the  
25 Department of Health to review provider contracts under its  
26 authority under the act of December 29, 1972 (P.L.1701, No.364),  
27 known as the Health Maintenance Organization Act, and section  
28 630 of the act of May 17, 1921 (P.L.682, No.284), known as The  
29 Insurance Company Law of 1921, and regulations promulgated  
30 thereunder, including review of size of network and quality of

1 care provided.

2 Section 510. Record maintenance.

3 Upon request, the department shall be provided a copy of any  
4 form being issued in this Commonwealth. Insurers and HMOs shall  
5 maintain complete and accurate specimen or actual copies of all  
6 forms which are issued to residents of this Commonwealth,  
7 including copies of all applications, certificates and  
8 endorsements used with policies. Retention of the forms may be  
9 kept on diskette, microfiche or any other electronic method.  
10 Specimen copies shall also indicate the date the form was first  
11 issued in this Commonwealth. The records shall be maintained  
12 until at least two years after a claim can no longer be reported  
13 under the form.

14 Section 511. Public comment.

15 Public notice of filings made under this chapter shall not be  
16 required. At the commissioner's discretion, however, notice of a  
17 filing may be published in the Pennsylvania Bulletin and a time  
18 period established for the receipt of public comment by the  
19 department.

20 Section 512. Required policy provisions.

21 (a) General rule.--An individual or group, blanket or  
22 franchise form issued by a hospital plan corporation or  
23 professional health services plan corporation shall also be  
24 subject to the following provisions of the act of May 17, 1921  
25 (P.L.682, No.284), known as The Insurance Company Law of 1921:

26 (1) Section 617.

27 (2) Section 618.

28 (3) Section 619.

29 (4) Section 619.1.

30 (5) Section 621.2(a)(6).

1           (6) Section 621.2(b), (c) and (d).

2           (7) Section 621.3.

3           (8) Section 621.4.

4           (9) Section 621.5.

5           (10) Section 622.

6           (11) Section 625.

7           (12) Section 626.

8           (13) Section 628.

9           (b) Network-based programs.--Nothing in this chapter shall  
10 prohibit a hospital plan corporation or professional health  
11 services plan corporation from establishing or offering provider  
12 network-based programs under 40 Pa.C.S. Ch. 61 (relating to  
13 hospital plan corporations) or 63 (relating to professional  
14 health services plan corporations).

15 Section 513. Penalties.

16           (a) General rule.--Upon satisfactory evidence of the  
17 violation of any section of this chapter by an insurer, HMO or  
18 any other person, one or more of the following penalties may be  
19 imposed at the commissioner's discretion:

20           (1) Suspension or revocation of the license of the  
21 offending insurer, HMO or other person.

22           (2) Refusal, for a period not to exceed one year, to  
23 issue a new license to the offending insurer, HMO or other  
24 person.

25           (3) A fine of not more than \$5,000 for each violation of  
26 this chapter.

27           (4) A fine of not more than \$10,000 for each willful  
28 violation of this chapter.

29           (5) A fine of not more than \$10,000 for each violation  
30 of section 506.

1           (6) A fine of not more than \$25,000 for each willful  
2           violation of section 506.

3           (b) Limitation.--Fines imposed against an individual insurer  
4           under this chapter shall not exceed \$500,000 in the aggregate  
5           during a single calendar year.

6           Section 514. Regulations.

7           The department may promulgate regulations as may be necessary  
8           or appropriate to carry out this chapter.

9           Section 8. Sections 14 and 15 of the act are amended to  
10          read:

11          Section [14] 5101. Repeals.

12          (a) Absolute.--The following acts and parts of acts are  
13          repealed:

14                Sections 616 and the last sentence of section 621.5 of the  
15          act of May 17, 1921 (P.L.682, No.284), known as The Insurance  
16          Company Law of 1921.

17                Section 3104 of the act of December 2, 1992 (P.L.741,  
18          No.113), known as the Children's Health Care Act.

19          (b) Partial.--The following acts and parts of acts are  
20          repealed to the extent specified:

21                Section 354 of the act of May 17, 1921 (P.L.682, No.284),  
22          known as The Insurance Company Law of 1921, insofar as it  
23          provides for the approval of accident and health forms.

24                Section 621.2(a)(1) of the act of May 17, 1921 (P.L.682,  
25          No.284), known as The Insurance Company Law of 1921, insofar as  
26          it defines the number of employees in a group insurance policy.

27                Section 630(f) of the act of May 17, 1921 (P.L.682, No. 284),  
28          known as The Insurance Company Law of 1921, insofar as it  
29          provides for the approval of rates and forms.

30                Section 10(c) of the act of December 29, 1972 (P.L.1701,

1 No.364), known as the Health Maintenance Organization Act,  
2 insofar as it provides for the approval of rates and forms.

3 40 Pa.C.S. §§ 6124(a) and 6329(a), insofar as they provide  
4 for the approval of rates and contracts.

5 Section [15] 5102. Applicability.

6 This act shall apply as follows:

7 (1) [Section 4] Sections 304 and 504 shall apply to  
8 benefits forms filings for hospital plan corporations and  
9 professional health services plan corporations made on or  
10 after July 1, 1997.

11 (2) [Section 12] Sections 312 and 512 shall apply to new  
12 forms issued after July 1, 1997.

13 (3) This act shall apply to all forms or rate filings  
14 made and all provider contracts filed after [the effective  
15 date of this act] February 17, 1997.

16 Section 9. The act is amended by adding a section to read:  
17 Section 5103. Action by commissioner.

18 If Congress of the United States repeals section 1003 of the  
19 Patient Protection and Affordable Care Act (Public Law 111-148,  
20 42 U.S.C. § 300gg-94) or if the Supreme Court of the United  
21 States invalidates section 1003 of the Patient Protection and  
22 Affordable Care Act, the commissioner shall transmit notice of  
23 that action to the Legislative Reference Bureau for publication  
24 in the Pennsylvania Bulletin.

25 Section 10. Section 16 of the act is amended to read:

26 Section [16] 5104. Effective date.

27 This act shall take effect in 60 days.

28 Section 11. This act shall take effect as follows:

29 (1) The following provisions shall take effect  
30 immediately:

- 1           (i) The addition of section 5103 of the act.
- 2           (ii) This section.
- 3           (2) The addition of Chapter 5 of the act shall take  
4 effect upon publication of the notice under section 5103 of  
5 the act.
- 6           (3) The remainder of this act shall take effect in 90  
7 days.