

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,
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NOVEMBER 15, 2011

AS AMENDED ON SECOND CONSIDERATION, HOUSE OF REPRESENTATIVES,
DECEMBER 7, 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:

1 Section [1] 101. Short title.

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

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

6 CHAPTER 3

7 FEDERAL COMPLIANCE

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

12 Section [2] 301. Definitions.

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

16 * * *

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

25 * * *

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

1 * * *

2 "Small group." A group that purchases accident and health
3 insurance in the small group market, as defined in section
4 2791(e) (5) of the Public Health Service Act (110 Stat. 1972, 42
5 U.S.C. § 300gg-91(e) (5)), provided, however, that for plan years
6 beginning prior to January 1, 2016, or other date as established
7 in Federal law, "50 employees" is substituted for "100
8 employees" in the definition of "small employer" in section
9 2791(e) (4) of the Public Health Service Act.

10 * * *

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

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

15 Section [3] 303. Required filings.

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

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

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

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

18 (e) Required group rate filings.--Each [hospital plan
19 corporation, professional health services plan corporation and
20 HMO] insurer shall file with the department rates for small
21 group accident and health insurance policies which it proposes
22 to issue on a group[, blanket or franchise] basis in this
23 Commonwealth FOR OTHER THAN EXCEPTED BENEFITS AS DESCRIBED IN ←
24 SECTION 2791(C) OF THE PUBLIC HEALTH SERVICE ACT (110 STAT.
25 1972, 42 U.S.C. § 300-GG-91(C)) in accordance with the
26 following:

27 (1) Each [hospital plan corporation, professional health
28 services plan corporation and HMO] insurer shall establish
29 and file with the department prior to use a base rate which
30 is not excessive, inadequate or unfairly discriminatory. The

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

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

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

1 used 45 days thereafter.

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

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

12 (6) The commissioner shall have discretion to exempt any
13 type or kind of rate filing under this subsection by
14 regulation except for filings required under subsection (c)
15 and paragraph (2).

16 [(f) Applicability of filings.--All filings required by this
17 section shall be made no less than 45 days prior to their
18 effective dates. Filings under subsection (e) (1) and (2) shall
19 be deemed approved at the expiration of 45 days after filing
20 unless earlier approved or disapproved by the commissioner. The
21 commissioner, by written notice to the insurer, may within such
22 45-day period extend the period for approval or disapproval for
23 an additional 45 days. All other filings under this section
24 shall become effective as provided in section 4.]

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

1 Department of Health and Human Services.

2 Section [4] 304. Review procedure.

3 (a) General rule.--Filings under section 303(c) and (e) (1),
4 (2) and (5) shall be reviewed as appropriate and necessary to
5 carry out the provisions of this [act] chapter. [Unless a filing
6 is disapproved by the department within the 45-day period
7 provided in section 3(f), filings made under section 3 shall
8 become effective for use 45 days following:

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

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

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

20 (2) Unless a resubmitted filing made under subsection
21 (c) is earlier disapproved by the department, the resubmitted
22 filing shall be deemed approved 30 days following receipt of
23 the resubmitted filing by the department.

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

1 services.

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

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

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

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

29 (e) Subsequent resubmissions.--Any further resubmission
30 following a second disapproval shall be considered a new filing

1 [and reviewed in accordance with subsection (a)] under section
2 303.

3 (f) [Commissioner's] Department's discretion.--Nothing in
4 this section shall be construed to prevent the [commissioner]
5 department from affirmatively approving a filing at the
6 [commissioner's] department's discretion.

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

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

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

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

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

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

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

27 (b) Hearing.--Upon receipt of a timely written application
28 for hearing, the commissioner shall schedule and conduct a
29 hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to
30 practice and procedure of Commonwealth agencies) and Ch. 7

1 Subch. A (relating to judicial review of Commonwealth agency
2 action). All of the actions which may be performed by the
3 commissioner in this section may be performed by the
4 commissioner's designated representative.

5 Section [8] 308. Disapproval after use.

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

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

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

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

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

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

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

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

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

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

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

14 (3) The harm insureds will suffer outweighs any hardship
15 the insurer will suffer by the suspension of the use of the
16 [form] rate.

17 (4) The suspension order will result in no harm to the
18 public.

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

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

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

25 (2) Provider contracts shall become effective unless
26 disapproved within 30 days following:

27 (i) the expiration of [the] any public comment
28 period established by the [commissioner] department under
29 section [11] 311; or

30 (ii) receipt of the filing by the department if no

1 public comment is established.

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

4 (i) provides for excessive payments;

5 (ii) fails to include reasonable incentives for cost
6 control;

7 (iii) contributes to the escalation of the cost of
8 providing health care services; or

9 (iv) does not provide for the realization of
10 potential and achieved savings under the contract by
11 insureds/subscribers.

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

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

27 (d) Disapproval of existing contract.--If at any time the
28 commissioner determines that a provider contract which has
29 become effective under this section violates the standards as
30 provided in subsection (a) (3), the commissioner may disapprove

1 the provider contract after notice and hearing as provided in 2
2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of
3 Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial
4 review of Commonwealth agency action).

5 (e) Department of Health authority.--Nothing in this section
6 shall be construed to expand or limit the authority of the
7 Department of Health to review provider contracts under its
8 authority under the act of December 29, 1972 (P.L.1701, No.364),
9 known as the Health Maintenance Organization Act, and section
10 630 of the act of May 17, 1921 (P.L.682, No.284), known as The
11 Insurance Company Law of 1921, and regulations promulgated
12 thereunder, including review of size of network and quality of
13 care provided.

14 Section [10] 310. Record maintenance.

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

26 Section [11] 311. Public comment.

27 [Public] (a) Certain rate filings.--A form of notice for
28 each rate filing subject to review under Federal law shall be
29 required to be provided by the filing insurer for posting on the
30 department's website. The form of notice shall satisfy the

1 requirements set forth in section 2794 of the Public Health
2 Service Act (110 Stat. 1972, 42 U.S.C. § 300gg-94) and any
3 regulations promulgated thereunder.

4 (b) Other filings.--Except as provided for under subsection
5 (a), public notice of filings made under this [act] chapter
6 shall not be required. At the [commissioner's] department's
7 discretion, however, notice of a filing may be published in the
8 Pennsylvania Bulletin [and a time period established for the
9 receipt of public comment by the department] or on the
10 department's website or on any other publicly accessible
11 electronic medium.

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

15 Section [12] 312. Required policy provisions.

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

- 21 (1) Section 617.
- 22 (2) Section 618.
- 23 (3) Section 619.
- 24 (4) Section 619.1.
- 25 (5) Section 621.2(a)(6).
- 26 (6) Section 621.2(b) through (d).
- 27 (7) Section 621.3.
- 28 (8) Section 621.4.
- 29 (9) Section 621.5.
- 30 (10) Section 622.

1 (11) Section 625.

2 (12) Section 626.

3 (13) Section 628.

4 (b) Network-based programs.--Nothing in this [act] chapter
5 shall prohibit a hospital plan corporation or professional
6 health services plan corporation from establishing or offering
7 provider network-based programs under 40 Pa.C.S. Ch. 61
8 (relating to hospital plan corporations) or 63 (relating to
9 professional health services plan corporations).
10 Section [13] 313. Penalties.

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

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

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

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

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

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

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

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

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

2 Section 314. Regulations.

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

5 Section 315. Expiration.

6 This chapter shall expire upon publication of the notice
7 under section 5103.

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

9 CHAPTER 5

10 COMMONWEALTH EXCLUSIVITY

11 Section 501. (Reserved).

12 Section 502. Definitions.

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

16 "Commissioner." The Insurance Commissioner of the
17 Commonwealth.

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

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

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

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

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

1 "Group accident and health insurance." A form affording
2 insurance coverage against death, injury, disablement, disease
3 or sickness resulting from an accident and covering more than ←
4 one person A LARGE OR SMALL GROUP. The term shall not include ←
5 blanket accident insurance policies OR FRANCHISE ACCIDENT AND ←
6 SICKNESS INSURANCE POLICIES as defined in section 621.3 SECTIONS ←
7 621.3 AND 621.4 of the act of May 17, 1921 (P.L.682, No.284),
8 known as The Insurance Company Law of 1921.

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

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

20 "Hospital plan corporation." An entity organized and
21 operating under 40 Pa.C.S. Ch. 61 (relating to hospital plan
22 corporations).

23 "Insurer." A foreign or domestic company, association or
24 exchange, hospital plan corporation, professional health
25 services plan corporation, fraternal benefits society, HEALTH ←
26 MAINTENANCE ORGANIZATION and risk-assuming preferred provider
27 organization.

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

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

4 "Provider contracts." An agreement made between an insurer
5 and a health care provider regarding the provision of any
6 payment for health care services. The term shall not include
7 contracts or related documents which are subject to the
8 exclusive approval of the Department of Health under 40 Pa.C.S.
9 § 6324 (relating to rights of health service doctors) and
10 section 630 of the act of May 17, 1921 (P.L.682, No.284), known
11 as The Insurance Company Law of 1921.

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

14 "SMALL GROUP." A GROUP THAT PURCHASES ACCIDENT AND HEALTH ←
15 INSURANCE IN THE SMALL GROUP MARKET, AS DEFINED IN SECTION
16 2791(E) (5) OF THE PUBLIC HEALTH SERVICE ACT (110 STAT. 1972, 42
17 U.S.C. § 300GG-91(E) (5)), PROVIDED, HOWEVER, THAT FOR PLAN YEARS
18 BEGINNING PRIOR TO JANUARY 1, 2016, OR OTHER DATE AS ESTABLISHED
19 IN FEDERAL LAW, "50 EMPLOYEES" IS SUBSTITUTED FOR "100
20 EMPLOYEES" IN THE DEFINITION OF "SMALL EMPLOYER" IN SECTION
21 2791(E) (4) OF THE PUBLIC HEALTH SERVICE ACT.

22 "Statement of policy." A document as defined in 45 Pa.C.S. §
23 501 (relating to definitions), provided that the document has
24 been published in the Pennsylvania Bulletin.
25 Section 503. Required filings.

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

30 (b) Notice of exemption from filing.--The commissioner shall

1 issue notice in the Pennsylvania Bulletin identifying any type
2 or kind of form which has been exempted from filing. The
3 commissioner may subsequently require the forms to be filed
4 under this section upon notice published in the Pennsylvania
5 Bulletin. Any such subsequent notice shall not be effective
6 until 90 days after publication.

7 (c) Individual rates.--Each insurer and HMO shall file with
8 the department rates for individual accident and health
9 insurance policies which it proposes to use in this Commonwealth
10 except those rates which, in the opinion of the commissioner,
11 cannot practicably be filed before they are used. The
12 commissioner shall publish notice in the Pennsylvania Bulletin
13 identifying rates which the commissioner determines cannot
14 practicably be filed.

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

20 (e) Required group rate filings.--Each ~~hospital plan~~ ←
21 ~~corporation, professional health services plan corporation and~~
22 ~~HMO~~ INSURER shall file with the department rates for SMALL GROUP ←
23 accident and health insurance policies which it proposes to
24 issue on a group, blanket or franchise basis in this
25 Commonwealth in accordance with the following:

26 (1) Each ~~hospital plan corporation, professional health~~ ←
27 ~~services plan corporation and HMO shall establish~~ INSURER ←
28 SHALL ESTABLISH AND FILE WITH THE DEPARTMENT PRIOR TO USE a
29 base rate which is not excessive, inadequate or unfairly
30 discriminatory. The initial base rate for ~~existing hospital~~ ←

1 ~~plan corporations, professional health services plan~~
2 ~~corporations and HMOs~~ INSURERS shall be the rate or the ←
3 rating formula currently on file and approved by the
4 department as of February 17, 1997. The initial base rate or
5 base rating formula for any ~~hospital plan corporation,~~ ←
6 ~~professional health services plan corporation or HMO~~ INSURER ←
7 with no base rate or base rating formula on file and approved
8 as of February 17, 1997, shall be subject to filing, review
9 and prior approval by the department.

10 (2) Proposed changes to an approved base rate or any
11 approved component of an approved rating formula which effect
12 an increase or decrease in the approved base rate or in an
13 approved component of an approved rating formula of more than
14 10% annually in the aggregate shall be subject to filing,
15 review and prior approval by the department.

16 (3) Proposed changes to an approved base rate or any
17 approved component of an approved rating formula that effect
18 an increase or decrease in the approved base rate or in an
19 approved component of an approved rating formula of not more
20 than 10% annually in the aggregate shall be subject to filing
21 and review in accordance with the provisions of section 504.

22 (4) Rates developed for a specific group which do not
23 deviate from the base rate or base rate formula by more than
24 15% may be used without filing with the department.

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

29 (6) The commissioner shall have discretion to exempt any
30 type or kind of rate filing under this subsection by

1 regulation.

2 (f) Applicability of filings.--All filings required by this
3 section shall be made no less than 45 days prior to their
4 effective dates. Filings under subsection (e)(1) and (2) shall
5 be deemed approved at the expiration of 45 days after filing
6 unless earlier approved or disapproved by the commissioner. The
7 commissioner, by written notice to the insurer, may within such
8 45-day period extend the period for approval or disapproval for
9 an additional 45 days. All other filings under this section
10 shall become effective as provided in section 504.

11 Section 504. Review procedure.

12 (a) General rule.--Filings shall be reviewed as appropriate
13 and necessary to carry out the provisions of this chapter.
14 Unless a filing is disapproved by the department within the 45-
15 day period provided in section 503(f), filings made under
16 section 503 shall become effective for use 45 days following:

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

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

21 (b) Disapproval.--Disapproval of a filing shall be based
22 only on specific provisions of applicable law, regulation or
23 statement of policy or if insufficient information is submitted
24 to support the filing. Rates filed under section 503(e) shall
25 not be disapproved unless the rates are determined to be
26 excessive, inadequate or unfairly discriminatory.

27 (c) Resubmission.--A filing disapproved by the department
28 may be resubmitted within 120 days after the date of the
29 disapproval. Filings resubmitted within this time shall become
30 effective for use 30 days after the receipt of the resubmission

1 by the department unless the filing is disapproved by the
2 department before the expiration of the 30-day period. This
3 subsection shall not apply to filings made prior to February 17,
4 1997.

5 (d) Disapproval of resubmissions.--Disapproval of a filing
6 resubmitted under subsection (c) shall be based only on specific
7 provisions of applicable law, regulation or statement of policy
8 or if insufficient information is submitted to support the
9 filing. Disapproval may not be based on any grounds not
10 specified in the initial disapproval issued by the department
11 except to the extent that new information is presented in the
12 resubmission.

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

16 (f) Commissioner's discretion.--Nothing in this section
17 shall be construed to prevent the commissioner from
18 affirmatively approving a filing at the commissioner's
19 discretion.

20 Section 505. Notice of disapproval.

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

24 Section 506. Use of disapproved forms or rates.

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

27 Section 507. Review of form or rate disapproval.

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

1 the commissioner for a hearing.

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

10 Section 508. Disapproval after use.

11 (a) General rule.--Any form or rate filed and used after the
12 expiration of the appropriate review period under this chapter
13 may be subsequently disapproved. The department shall notify the
14 insurer or HMO in writing and provide the opportunity for a
15 hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to
16 practice and procedure of Commonwealth agencies) and Ch. 7
17 Subch. A (relating to judicial review of Commonwealth agency
18 action).

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

23 (c) Discontinuance of rate.--If following a hearing the
24 commissioner finds that a rate in use should be disapproved, the
25 commissioner shall order its use to be discontinued
26 prospectively for any policy issued or renewed after a date
27 specified in the order.

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

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

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

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

8 (4) The suspension order will result in no harm to the
9 public.

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

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

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

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

21 (4) The suspension order will result in no harm to the
22 public.

23 Section 509. Filing of provider contracts.

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

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

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

1 (i) the expiration of the public comment period
2 established by the commissioner under section 511; or
3 (ii) receipt of the filing by the department if no
4 public comment is established.

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

7 (i) provides for excessive payments;

8 (ii) fails to include reasonable incentives for cost
9 control;

10 (iii) contributes to the escalation of the cost of
11 providing health care services; or

12 (iv) does not provide for the realization of
13 potential and achieved savings under the contract by
14 insureds/subscribers.

15 (b) Review of the disapproval.--Upon disapproval of a
16 provider contract under this section, the insurer may seek
17 review of the disapproval as provided in section 507.

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

30 (d) Disapproval of existing contract.--If at any time the

1 commissioner determines that a provider contract which has
2 become effective under this section violates the standards as
3 provided in subsection (a)(3), the commissioner may disapprove
4 the provider contract after notice and hearing as provided in 2
5 Pa.C.S. Chs. 5 Subch. A (relating to practice and procedure of
6 Commonwealth agencies) and 7 Subch. A (relating to judicial
7 review of Commonwealth agency action).

8 (e) Department of Health authority.--Nothing in this section
9 shall be construed to expand or limit the authority of the
10 Department of Health to review provider contracts under its
11 authority under the act of December 29, 1972 (P.L.1701, No.364),
12 known as the Health Maintenance Organization Act, and section
13 630 of the act of May 17, 1921 (P.L.682, No.284), known as The
14 Insurance Company Law of 1921, and regulations promulgated
15 thereunder, including review of size of network and quality of
16 care provided.

17 Section 510. Record maintenance.

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

29 Section 511. Public comment.

30 Public notice of filings made under this chapter shall not be

1 required. At the commissioner's discretion, however, notice of a
2 filing may be published in the Pennsylvania Bulletin and a time
3 period established for the receipt of public comment by the
4 department.

5 Section 512. Required policy provisions.

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

11 (1) Section 617.

12 (2) Section 618.

13 (3) Section 619.

14 (4) Section 619.1.

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

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

17 (7) Section 621.3.

18 (8) Section 621.4.

19 (9) Section 621.5.

20 (10) Section 622.

21 (11) Section 625.

22 (12) Section 626.

23 (13) Section 628.

24 (b) Network-based programs.--Nothing in this chapter shall
25 prohibit a hospital plan corporation or professional health
26 services plan corporation from establishing or offering provider
27 network-based programs under 40 Pa.C.S. Ch. 61 (relating to
28 hospital plan corporations) or 63 (relating to professional
29 health services plan corporations).

30 Section 513. Penalties.

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

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

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

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

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

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

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

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

21 Section 514. Regulations.

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

24 Section 8. Sections 14 and 15 of the act are amended to
25 read:

26 Section [14] 5101. Repeals.

27 (a) Absolute.--The following acts and parts of acts are
28 repealed:

29 Sections 616 and the last sentence of section 621.5 of the
30 act of May 17, 1921 (P.L.682, No.284), known as The Insurance

1 Company Law of 1921.

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

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

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

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

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

15 Section 10(c) of the act of December 29, 1972 (P.L.1701,
16 No.364), known as the Health Maintenance Organization Act,
17 insofar as it provides for the approval of rates and forms.

18 40 Pa.C.S. §§ 6124(a) and 6329(a), insofar as they provide
19 for the approval of rates and contracts.

20 Section [15] 5102. Applicability.

21 This act shall apply as follows:

22 (1) [Section 4] Section 504 shall apply to benefits
23 forms filings for hospital plan corporations and professional
24 health services plan corporations made on or after July 1,
25 1997.

26 (2) [Section 12] Section 512 shall apply to new forms
27 issued after July 1, 1997.

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

1 Section 9. The act is amended by adding a section to read:

2 Section 5103. Action by commissioner.

3 If Congress of the United States repeals section 1003 of the
4 Patient Protection and Affordable Care Act (Public Law 111-148,
5 42 U.S.C. § 300gg-94) or if the Supreme Court of the United
6 States invalidates section 1003 of the Patient Protection and
7 Affordable Care Act, the commissioner shall transmit notice of
8 that action to the Legislative Reference Bureau for publication
9 in the Pennsylvania Bulletin.

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

11 Section [16] 5104. Effective date.

12 This act shall take effect in 60 days.

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

14 (1) The following provisions shall take effect
15 immediately:

16 (i) The addition of section 5103 of the act.

17 (ii) This section.

18 (2) The addition of Chapter 5 of the act shall take
19 effect upon publication of the notice under section 5103 of
20 the act.

21 (3) The remainder of this act shall take effect in 90
22 days.