
THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1336 Session of
2011

INTRODUCED BY D. WHITE, STACK, ERICKSON, WAUGH, BAKER, SCHWANK
AND PILEGGI, NOVEMBER 10, 2011

REFERRED TO BANKING AND INSURANCE, NOVEMBER 10, 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.

24 This act shall be known and may be cited as the Accident and

1 Health Filing Reform Act.

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

4 CHAPTER 3

5 FEDERAL COMPLIANCE

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

10 Section [2] 301. Definitions.

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

14 * * *

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

23 * * *

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

29 * * *

30 "Small group." A group that purchases accident and health

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

8 * * *

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

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

13 Section [3] 303. Required filings.

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

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

29 (c) Individual rates.--Each insurer [and HMO] shall file
30 with the department rates for individual accident and health

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

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

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

22 (1) Each [hospital plan corporation, professional health
23 services plan corporation and HMO] insurer shall establish
24 and file with the department prior to use a base rate which
25 is not excessive, inadequate or unfairly discriminatory. The
26 initial base rate for existing hospital plan corporations,
27 professional health services plan corporations and HMOs shall
28 be the rate or the rating formula currently on file and
29 approved by the department as of the effective date of [this
30 act] section 314. The initial base rate or base rating

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

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

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

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

30 (5) Rates developed for a specific group which deviate

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

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

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

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

27 Section [4] 304. Review procedure.

28 (a) General rule.--Filings under section 303(c) and (e) (1),
29 (2) and (5) shall be reviewed as appropriate and necessary to
30 carry out the provisions of this [act] chapter. [Unless a filing

1 is disapproved by the department within the 45-day period
2 provided in section 3(f), filings made under section 3 shall
3 become effective for use 45 days following:

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

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

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

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

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

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

30 (b) Disapproval.--Disapproval of a filing shall be based

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

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

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

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

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

1 [commissioner's] department's discretion.

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

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

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

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

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

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

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

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

30 Section [8] 308. Disapproval after use.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 (i) provides for excessive payments;

30 (ii) fails to include reasonable incentives for cost

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

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

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

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

30 (e) Department of Health authority.--Nothing in this section

1 shall be construed to expand or limit the authority of the
2 Department of Health to review provider contracts under its
3 authority under the act of December 29, 1972 (P.L.1701, No.364),
4 known as the Health Maintenance Organization Act, and section
5 630 of the act of May 17, 1921 (P.L.682, No.284), known as The
6 Insurance Company Law of 1921, and regulations promulgated
7 thereunder, including review of size of network and quality of
8 care provided.

9 Section [10] 310. Record maintenance.

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

21 Section [11] 311. Public comment.

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

29 (b) Other filings.--Except as provided for under subsection
30 (a), public notice of filings made under this [act] chapter

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

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

10 Section [12] 312. Required policy provisions.

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

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

29 (b) Network-based programs.--Nothing in this [act] chapter
30 shall prohibit a hospital plan corporation or professional

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

5 Section [13] 313. Penalties.

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

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

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

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

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

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

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

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

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

27 Section 314. Regulations.

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

30 Section 315. Expiration.

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

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

4 CHAPTER 5

5 COMMONWEALTH EXCLUSIVITY

6 Section 501. (Reserved).

7 Section 502. Definitions.

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

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

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

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

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

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

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

26 "Group accident and health insurance." A form affording
27 insurance coverage against death, injury, disablement, disease
28 or sickness resulting from an accident and covering more than
29 one person. The term shall not include blanket accident
30 insurance policies as defined in section 621.3 of the act of May

1 17, 1921 (P.L.682, No.284), known as The Insurance Company Law
2 of 1921.

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

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

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

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

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

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

27 "Provider contracts." An agreement made between an insurer
28 and a health care provider regarding the provision of any
29 payment for health care services. The term shall not include
30 contracts or related documents which are subject to the

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

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

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

10 Section 503. Required filings.

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

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

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

30 (d) Certain group rates exempt.--Except as provided in

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

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

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

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

30 (3) Proposed changes to an approved base rate or any

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

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

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

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

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 504.

25 Section 504. Review procedure.

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

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

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

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 503(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 February 17,
18 1997.

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. Disapproval may not be based on any grounds not
24 specified in the initial disapproval issued by the department
25 except to the extent that new information is presented in the
26 resubmission.

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

30 (f) Commissioner's discretion.--Nothing in this section

1 shall be construed to prevent the commissioner from
2 affirmatively approving a filing at the commissioner's
3 discretion.

4 Section 505. Notice of disapproval.

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

8 Section 506. Use of disapproved forms or rates.

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

11 Section 507. Review of form or rate disapproval.

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

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

24 Section 508. Disapproval after use.

25 (a) General rule.--Any form or rate filed and used after the
26 expiration of the appropriate review period under this chapter
27 may be subsequently disapproved. The department shall notify the
28 insurer or HMO in writing and provide the opportunity for 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).

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

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

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

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

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

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

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

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

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

30 (2) Unless a suspension order is issued, insureds will

1 suffer substantial harm.

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

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

7 Section 509. Filing of provider contracts.

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

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

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

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

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

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

21 (i) provides for excessive payments;

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

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

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

29 (b) Review of the disapproval.--Upon disapproval of a
30 provider contract under this section, the insurer may seek

1 review of the disapproval as provided in section 507.

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

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

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

1 Section 510. Record maintenance.

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

13 Section 511. Public comment.

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

19 Section 512. Required policy provisions.

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

25 (1) Section 617.

26 (2) Section 618.

27 (3) Section 619.

28 (4) Section 619.1.

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

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

1 (7) Section 621.3.

2 (8) Section 621.4.

3 (9) Section 621.5.

4 (10) Section 622.

5 (11) Section 625.

6 (12) Section 626.

7 (13) Section 628.

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

14 Section 513. Penalties.

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

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

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

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

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

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

30 (6) A fine of not more than \$25,000 for each willful

1 violation of section 506.

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

5 Section 514. Regulations.

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

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

10 Section [14] 5101. Repeals.

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

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

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

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

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

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

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

29 Section 10(c) of the act of December 29, 1972 (P.L.1701,
30 No.364), known as the Health Maintenance Organization Act,

1 insofar as it provides for the approval of rates and forms.

2 40 Pa.C.S. §§ 6124(a) and 6329(a), insofar as they provide
3 for the approval of rates and contracts.

4 Section [15] 5102. Applicability.

5 This act shall apply as follows:

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

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

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

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

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

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

25 Section [16] 5104. Effective date.

26 This act shall take effect in 60 days.

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

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

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

1 (ii) This section.

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

5 (3) The remainder of this act shall take effect in 90
6 days.