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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

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

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

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

CHAPTER 1

PRELIMINARY PROVISIONS

Section 2. Section 1 of the act is renumbered to read:

Section [1] 101. Short title.

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

Health Filing Reform Act.

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

CHAPTER 3

FEDERAL COMPLIANCE

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

Section [2] 301. Definitions.

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

* * *

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

* * *

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

* * *

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

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

* * *

Section 4.1. The act is amended by adding a section to read:

Section 302. (Reserved).

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

Section [3] 303. Required filings.

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

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

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

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

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

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

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

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

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

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

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

(5) Rates developed for a specific group which deviate

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

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

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

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

Section [4] 304. Review procedure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[commissioner's] department's discretion.

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

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

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

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

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

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

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

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

Section [8] 308. Disapproval after use.

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

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

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

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

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

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

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

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

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

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

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

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

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

Section [9] 309. Filing of provider contracts.

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

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

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

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

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

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

(i) provides for excessive payments;

(ii) fails to include reasonable incentives for cost

control;

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

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

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

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

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

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

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

Section [10] 310. Record maintenance.

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

Section [11] 311. Public comment.

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

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

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

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

Section [12] 312. Required policy provisions.

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

(1) Section 617.

(2) Section 618.

(3) Section 619.

(4) Section 619.1.

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

(6) Section 621.2(b) through (d).

(7) Section 621.3.

(8) Section 621.4.

(9) Section 621.5.

(10) Section 622.

(11) Section 625.

(12) Section 626.

(13) Section 628.

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

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

Section [13] 313. Penalties.

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

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

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

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

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

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

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

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

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

Section 314. Regulations.

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

Section 315. Expiration.

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

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

CHAPTER 5

COMMONWEALTH EXCLUSIVITY

Section 501. (Reserved).

Section 502. Definitions.

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

"Commissioner." The Insurance Commissioner of the Commonwealth.

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

"Department." The Insurance Department of the Commonwealth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 503. Required filings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 504. Review procedure.

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

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

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

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

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

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

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

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

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

Section 505. Notice of disapproval.

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

Section 506. Use of disapproved forms or rates.

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

Section 507. Review of form or rate disapproval.

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

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

Section 508. Disapproval after use.

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

Subch. A (relating to judicial review of Commonwealth agency action).

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

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

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

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

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

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

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

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

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

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

suffer substantial harm.

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

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

Section 509. Filing of provider contracts.

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

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

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

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

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

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

(i) provides for excessive payments;

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

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

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

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

review of the disapproval as provided in section 507.

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

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

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

Section 510. Record maintenance.

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

Section 511. Public comment.

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

Section 512. Required policy provisions.

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

(1) Section 617.

(2) Section 618.

(3) Section 619.

(4) Section 619.1.

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

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

(7) Section 621.3.

(8) Section 621.4.

(9) Section 621.5.

(10) Section 622.

(11) Section 625.

(12) Section 626.

(13) Section 628.

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

Section 513. Penalties.

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

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

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

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

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

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

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

violation of section 506.

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

Section 514. Regulations.

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

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

Section [14] 5101. Repeals.

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

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

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

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

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

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

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

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

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

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

Section [15] 5102. Applicability.

This act shall apply as follows:

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

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

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

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

Section 5103. Action by commissioner.

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

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

Section [16] 5104. Effective date.

This act shall take effect in 60 days.

Section 11. This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

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

(ii) This section.

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

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