

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL**No. 1336** Session of
2011

INTRODUCED BY D. WHITE, STACK, ERICKSON, WAUGH, BAKER, SCHWANK,
PILEGGI, EARLL, RAFFERTY, ORIE, SOLOBAY, BROWNE AND PIPPY,
NOVEMBER 10, 2011

AS AMENDED ON SECOND CONSIDERATION, DECEMBER 6, 2011

AN ACT

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

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

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

20 CHAPTER 1

21 PRELIMINARY PROVISIONS

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

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

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

5 CHAPTER 3

6 FEDERAL COMPLIANCE

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

11 Section [2] 301. Definitions.

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

15 * * *

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

24 * * *

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

30 * * *

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

9 * * *

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

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

14 Section [3] 303. Required filings.

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

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

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

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

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

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

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

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

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

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

30 (4) Rates developed for a specific group which do not

1 deviate from the base rate or base rate formula by more than
2 15% may be used without filing with the department.

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

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

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

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

30 Section [4] 304. Review procedure.

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

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

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

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

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

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

30 (4) An insurer intending to use any rate deemed approved

1 under this subsection shall provide written notice to the
2 department prior to use.

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

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

17 (d) Disapproval of resubmissions.--Disapproval of a filing
18 resubmitted under subsection (c) shall be based only on specific
19 provisions of applicable law, regulation or statement of policy
20 or if insufficient information is submitted to support the
21 filing. Rates shall not be disapproved unless the rates are
22 determined to be excessive, inadequate or unfairly
23 discriminatory. 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)] under section
30 303.

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

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

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

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

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

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

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

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

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

1 commissioner in this section may be performed by the
2 commissioner's designated representative.

3 Section [8] 308. Disapproval after use.

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

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

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

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

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

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

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

1 form.

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

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

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

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

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

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

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

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

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

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

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

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

30 (3) The department may disapprove a provider contract

1 whenever it is determined that the contract:

2 (i) provides for excessive payments;

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

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

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

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

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

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

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

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

12 Section [10] 310. Record maintenance.

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

24 Section [11] 311. Public comment.

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

1 regulations promulgated thereunder.

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

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

13 Section [12] 312. Required policy provisions.

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

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

1 (13) Section 628.

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

8 Section [13] 313. Penalties.

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

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

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

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

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

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

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

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

29 Section 6. The act is amended by adding sections to read:
30 Section 314. Regulations.

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

3 Section 315. Expiration.

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

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

7 CHAPTER 5

8 COMMONWEALTH EXCLUSIVITY

9 Section 501. (Reserved).

10 Section 502. Definitions.

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

14 "Commissioner." The Insurance Commissioner of the
15 Commonwealth.

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

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

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

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

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

29 "Group accident and health insurance." A form affording
30 insurance coverage against death, injury, disablement, disease

1 or sickness resulting from an accident and covering more than
2 one person. The term shall not include blanket accident
3 insurance policies as defined in section 621.3 of the act of May
4 17, 1921 (P.L.682, No.284), known as The Insurance Company Law
5 of 1921.

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

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

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

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

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

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

30 "Provider contracts." An agreement made between an insurer

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

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

10 "Statement of policy." A document as defined in 45 Pa.C.S. §
11 501 (relating to definitions), provided that the document has
12 been published in the Pennsylvania Bulletin.

13 Section 503. Required filings.

14 (a) Form filings.--Each insurer and HMO shall file with the
15 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.

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

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

1 identifying rates which the commissioner determines cannot
2 practicably be filed.

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

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

14 (1) Each hospital plan corporation, professional health
15 services plan corporation and HMO shall establish a base rate
16 which is not excessive, inadequate or unfairly
17 discriminatory. The initial base rate for existing hospital
18 plan corporations, professional health services plan
19 corporations and HMOs shall be the rate or the rating formula
20 currently on file and approved by the department as of
21 February 17, 1997. The initial base rate or base rating
22 formula for any hospital plan corporation, professional
23 health services plan corporation or HMO with no base rate or
24 base rating formula on file and approved as of February 17,
25 1997, shall be subject to filing, review and prior approval
26 by the department.

27 (2) Proposed changes to an approved base rate or any
28 approved component of an approved rating formula which effect
29 an increase or decrease in the approved base rate or in an
30 approved component of an approved rating formula of more than

1 10% annually in the aggregate shall be subject to filing,
2 review and prior approval by the department.

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

9 (4) Rates developed for a specific group which do not
10 deviate from the base rate or base rate formula by more than
11 15% may be used without filing with the department.

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

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

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

28 Section 504. Review procedure.

29 (a) General rule.--Filings shall be reviewed as appropriate
30 and necessary to carry out the provisions of this chapter.

1 Unless a filing is disapproved by the department within the 45-
2 day period provided in section 503(f), filings made under
3 section 503 shall become effective for use 45 days following:

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

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

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

14 (c) Resubmission.--A filing disapproved by the department
15 may be resubmitted within 120 days after the date of the
16 disapproval. Filings resubmitted within this time shall become
17 effective for use 30 days after the receipt of the resubmission
18 by the department unless the filing is disapproved by the
19 department before the expiration of the 30-day period. This
20 subsection shall not apply to filings made prior to February 17,
21 1997.

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

30 (e) Subsequent resubmissions.--Any further resubmission

1 following a second disapproval shall be considered a new filing
2 and reviewed in accordance with subsection (a).

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

7 Section 505. Notice of disapproval.

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

11 Section 506. Use of disapproved forms or rates.

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

14 Section 507. Review of form or rate disapproval.

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

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

27 Section 508. Disapproval after use.

28 (a) General rule.--Any form or rate filed and used after the
29 expiration of the appropriate review period under this chapter
30 may be subsequently disapproved. The department shall notify the

1 insurer or HMO in writing and provide the opportunity for a
2 hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to
3 practice and procedure of Commonwealth agencies) and Ch. 7
4 Subch. A (relating to judicial review of Commonwealth agency
5 action).

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

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

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

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

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

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

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

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

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

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 Section 509. Filing of provider contracts.

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

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

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

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

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

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

24 (i) provides for excessive payments;

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

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

29 (iv) does not provide for the realization of
30 potential and achieved savings under the contract by

1 insureds/subscribers.

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

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

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

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

1 Insurance Company Law of 1921, and regulations promulgated
2 thereunder, including review of size of network and quality of
3 care provided.

4 Section 510. Record maintenance.

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

16 Section 511. Public comment.

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

22 Section 512. Required policy provisions.

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

28 (1) Section 617.

29 (2) Section 618.

30 (3) Section 619.

- 1 (4) Section 619.1.
- 2 (5) Section 621.2(a)(6).
- 3 (6) Section 621.2(b), (c) and (d).
- 4 (7) Section 621.3.
- 5 (8) Section 621.4.
- 6 (9) Section 621.5.
- 7 (10) Section 622.
- 8 (11) Section 625.
- 9 (12) Section 626.
- 10 (13) Section 628.

11 (b) Network-based programs.--Nothing in this chapter shall
12 prohibit a hospital plan corporation or professional health
13 services plan corporation from establishing or offering provider
14 network-based programs under 40 Pa.C.S. Ch. 61 (relating to
15 hospital plan corporations) or 63 (relating to professional
16 health services plan corporations).
17 Section 513. Penalties.

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

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

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

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

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

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

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

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

8 Section 514. Regulations.

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

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

13 Section [14] 5101. Repeals.

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

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

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

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

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

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

29 Section 630(f) of the act of May 17, 1921 (P.L.682, No. 284),
30 known as The Insurance Company Law of 1921, insofar as it

1 provides for the approval of rates and forms.

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

5 40 Pa.C.S. §§ 6124(a) and 6329(a), insofar as they provide
6 for the approval of rates and contracts.

7 Section [15] 5102. Applicability.

8 This act shall apply as follows:

9 (1) [Section 4] Section 504 shall apply to benefits
10 forms filings for hospital plan corporations and professional
11 health services plan corporations made on or after July 1,
12 1997.

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

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

18 ~~(4) The provisions of this act shall not apply to~~
19 ~~coverage for excepted benefits as defined in 45 CFR~~
20 ~~146.145(c) (relating to special rules related to health~~
21 ~~plans).~~ ←

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

23 Section 5103. Action by commissioner.

24 If Congress of the United States repeals section 1003 of the
25 Patient Protection and Affordable Care Act (Public Law 111-148,
26 42 U.S.C. § 300gg-94) or if the Supreme Court of the United
27 States invalidates section 1003 of the Patient Protection and
28 Affordable Care Act, the commissioner shall transmit notice of
29 that action to the Legislative Reference Bureau for publication
30 in the Pennsylvania Bulletin.

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

2 Section [16] 5104. Effective date.

3 This act shall take effect in 60 days.

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

5 (1) The following provisions shall take effect
6 immediately:

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

8 (ii) This section.

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

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