pennsylvania
INSURANCE DEPARTMENT
1311 Strawberry Square
Harrisburg, PA 17120

Bureau of Health Coverage, Access, Administration, and Appeals

ANNUAL REPORT INSTRUCTIONS

For Year Ending December 31, 2026

GENERAL INFORMATION

Pennsylvania law (40 P.S. §§ 991.2111(13), 991.2164.14, 991.2181) and regulations (28 Pa. Code § 9.604) require that an insurer and an MA or CHIP managed care plan submit a detailed report of its activities during the preceding calendar year on or before April 30 to the Insurance Department's Bureau of Health Coverage, Access, Administration, and Appeals (HCA3).

Please refer to 40 P.S. § 991.2102 and 28 Pa. Code § 9.602 for definitions of terms.

The information submitted to the Department subject to 40 P.S. § 991.2181.1 will be held confidentially. If data to be submitted is not subject to 40 P.S. § 9.602 but is nonetheless proprietary and confidential, it should be marked and designated as such when submitted to the Department. This will allow the Department (for records not subject to 40 P.S. § 991.2181.1) to exclude the data from any request made pursuant to the Commonwealth's Right-to-Know Law (RTKL) as it would be exempt from disclosure pursuant to 65 P.S. § 67.708(b)(11). The Department would not provide this information in response to a RTKL request, and if the denial were appealed to the Office of Open Records (OOR), the Department would expect that the insurer or MA or CHIP managed care plan would be joined as a necessary third party to the appeal, and the insurer or MA or CHIP managed care plan would have the burden to demonstrate to the OOR in any appeal that the data and information is truly trade secret or confidential proprietary information.

An Annual Report Form should be filled out by each Company (according to NAIC CoCode, not Group number) reporting all lines of business offered by that Company. For data elements that are not applicable because they are not offered by the Company, enter 0 for numerical inputs and N/A for non-numerical input.

Note that the Department is seeking enrollment data for all lines of business under the NAIC CoCode including fully-insured commercial business, self-funded business, Medicare Supplement, and Medicare Advantage products, to understand insurance market distribution. Data elements to be reported by line of business/products are identified in the following chart:

Reporting Requirements	Individual	Small Group fully-insured	Large Group fully-insured	Small Group self-funded	Large Group self-funded	Medicare Advantage	Medicare Supplemental	CHIP	HealthChoices	Community HealthChoices
General Information	X	X	X	X	X	X	X	X	X	X
Section I	X	X	X	X	X	X	X	X	X	X
Section II	X	X	X	X	X	X	X	X	X	X
Section III	X	X	X	X	X	X	X	X	X	X
Section IV	X	X	X					X	X	X
Section V	X	X	X					X	X	X
Section VI	X	X	X					X	X	X
Section VII	X	X	X	X	X	X	X	X	X	X
Section VIII	X	X	X	X	X	X	X	X	X	X
Section IX	X	X	X					X	X	X
Section X	X	X	X	X	X	X	X	X	X	X

REPORT SUBMISSION

When preparing the Annual Report, make sure documents are properly labeled. In addition to the Annual Report form, provide a cover page listing each section and corresponding attachment(s). Please do not alter the contents or tables in the Annual Report Form template.

The Annual Report with attachments must be received by HCA3 on or before April 30.

Submit the Annual Report using the SharePoint link provided by HCA3. If you do not have the SharePoint link for your company, please submit an email request with the subject: "SharePoint - Report Submission Request" to: ra-inhca3@pa.gov.

If you are unable to submit via SharePoint, please make arrangements to provide the filing through other means by contacting: ra-inhca3@pa.gov. The Insurance Department or HCA3 staff will work with you and your IT team to address any access issues.

I. GOVERNANCE

Using the tables in the Annual Report Form, provide the following:

A. Current board of directors by name and affiliation. Indicate those Board members who are subscriber representatives.
B. Current board officers by name.
C. Key plan staff by name and email. If a position is vacant, so indicate and describe current efforts to fill the vacancy.

D. All products (including PPO, EPO, and HMO): Provide a plan organizational chart including the Board of Directors and Executive Staff. Provide the name of the staff member filling each position. Provide the charts as an **Attachment**.
GPPO: Provide a corporate organizational chart(s) explaining the relationship between the HMO and the GPPO affiliate. Include the name of the staff member filling each position on the organization chart(s). Provide the chart(s) as an **Attachment**.

E. **If** there have been revisions, **attach** a copy of the current Corporate By-laws. Plans reporting for the first time must attach their by-laws.

II. PRODUCT IDENTIFICATION (All Lines of Business)

If the plan utilizes product name descriptions for various products or lines of business, please identify trade name product type and key features. Using the example below, please complete the chart with the managed care plan product names and provide a brief description.

Product Identification Example:

Product Names	Description
Good Choice	Traditional HMO product with mid-range copays
Best Choice	Traditional HMO product with low copays
Inexpensive Choice	Traditional HMO with high copays
Open Choice	Point of service (POS) product
Gold Choice	Medicare risk contract program
Freedom Choice	Self-funded POS plan offered by the GPPO

III. ENROLLMENT DATA

Enrollment data required in this section is supplemental to information being reported on the HCA3's Quarterly Report for the quarter ending December 31. Be sure that the data being reported is consistent on both forms.

A. Membership by County of Residence - List total membership by county of residence as of December 31 of the reporting calendar year for all lines of business under this NAIC CoCode. The enrollment numbers should be presented according to the following categories: individual, fully-insured small group, fully-insured large group, self-funded small group, self-funded large group, Medicare Advantage, Medicare Supplement, Children's Health Insurance Program (CHIP), HealthChoices, Community HealthChoices. NOTE: Behavioral HealthChoices is excluded from this reporting list.

Plans with membership outside Pennsylvania should indicate that these persons are out-of-state enrollees.

The totals should be the sum of the membership from all counties, other, and out-of-state.

B. Service Area - Describe the plan's service area by each county for which the plan has been given approval to operate. Indicate if only a portion of a county is applicable. Also include portions of your service area that are outside, yet adjacent to, the Commonwealth. Service area expansions that the Department has not yet approved should not be included.

C. Disenrollment - Enter the number of plan members who disenrolled during the calendar year. Terminations have been divided into voluntary, involuntary, and unknown/other categories. The total number should be the sum of these numbers.

IV. DELIVERY SYSTEM INFORMATION

A. ANNUAL QUALITY ASSURANCE REPORT

In accordance with 28 Pa. Code § 9.604(a)(9), provide as an **Attachment** a copy of the most recent quality assurance report that has been submitted to the board of directors. A description of the quality assurance study results and subsequent actions should be included for each and listed in an **Attachment**.

B. PLAN STANDARDS

Plans must have standards and methodologies to verify that the plan's panel of primary care physicians can accept and serve plan patients in accordance with a minimum level of quality. For purposes of the Annual Report Form, if the number of patients per hour varies according to Pediatric or Adult patient load, please give both standards. (See **Annual Report Form**).

C. PROVIDER DIRECTORY

Provide URLs for public facing provider directories as an **Attachment**.

D. CONTRACTS

Section 9.604(a)(8) indicates that the Annual Report shall include "copies of the currently utilized generic or standard form health care provider contracts including copies of any deviations from the standard contracts and reimbursement methodologies." To meet this requirement, please include a list of approved contract names and approval dates for: primary care physicians, specialists, and hospitals. Also include a list of all IDS contracts and their approval dates currently in effect. The contracts should include reimbursement methodology.

E. CONSUMER SATISFACTION

Describe any consumer satisfaction surveys that were undertaken during the past calendar year. Include the methodology used and the survey results. Provide a copy of the consumer satisfaction survey as an **Attachment**.

F. MARKETING

Provide a copy of the most recent marketing materials available to plan members and prospective members (e.g., Quarterly Newsletter) as an **Attachment**.

G. REFERRALS

Provide a copy of the current standard referral form used by PCPs in making in-plan or out-of-plan referrals as an **Attachment**.

H. PRIOR AUTHORIZATION URLs (**NEW**)

For Medicaid and CHIP Plans ONLY, please provide the publicly accessible internet websites for prior authorization on the Annual Report Form. Please include:

- URL for the publicly accessible provider portal to submit electronic prior authorization requests
- URL for the publicly accessible list of services that require prior authorization
- URL for publicly accessible Clinical and Medical Policies
- URL for the publicly accessible information necessary to request peer-to-peer review
- URL for the contact information for the plan's relevant clinical or administrative staff
- URL for copies of applicable submission forms for any health care service that requires prior authorization that is not subject to electronic submission
- URL for the list of any health care services that require prior authorization that are not subject to electronic submissions
- URL for the instructions to submit prior authorization requests if the plan's provider portal is unavailable for any reason

V. COMPLAINT, GRIEVANCE, AND ADVERSE BENEFIT DETERMINATION RESOLUTION SYSTEM

Provide a copy of the current enrollee literature, including subscription agreements, enrollee handbooks and any mass communications to enrollees concerning complaint, grievance, and adverse benefit determination appeal rights and procedures in an **Attachment**.

Complaints, grievances, and adverse benefit determinations are to be reported according to their type, as follows.

Please note that these numbers should not include behavioral health complaints. These will be accounted for in section IX.C. below.

A. MEDICAID & CHIP COMPLAINTS SUMMARY – SINGLE-LEVEL INTERNAL APPEAL

Please identify these complaints in Table A broken out by reason for complaint:

- Not a covered service,
- Out-of-Network service not covered (for any reason), and
- Other

B. MEDICAID & CHIP COMPLAINTS – TWO-LEVEL INTERNAL APPEAL

Please identify these complaints for both internal and external levels in Table B broken out by reason for complaint:

- Quality,
- Network adequacy, and
- Other

Only complaints for which the formal complaint process is initiated should be included in the Annual Report. If the plan is able to resolve the issue prior to issuing a formal decision, the issue should not be counted as a complaint for reporting purposes. In circumstances where a formal complaint is filed and a decision is issued, the complaint should be included in the Annual Report. If the complaint is partially resolved by upholding a denial, the Annual Report should indicate that the case was an uphold for the plan.

Using the definitions below, complete Tables A and B:

- Filed this year: List the number of first-level (Tables A and B), second-level (Table B only), and external complaints (Tables A and B) filed by members during the reporting year.

- Withdrawn this year: List the number of first-level (Tables A and B), second-level (Table B only), and external complaints (Tables A and B) that were withdrawn by members during the reporting year.

- Decisions this year: List the number of decisions for first-level (Tables A and B), second-level (Table B only), and external complaints (Tables A and B) for the year, distinguishing between "overturned", "upheld", or "partially upheld". Partially upheld decisions are decisions that resolve part of the issue (e.g., an increase in service hours is granted) but not all (e.g., all requested services hours are not granted).

C. MEDICAID & CHIP INTERNAL GRIEVANCE

Please identify these grievances in Table C.

D. MEDICAID & CHIP EXTERNAL GRIEVANCE

Please identify these grievances in Table D.

A Grievance for purposes of Act 146 of 2022 is a request by an enrollee, or a health care provider with the written consent of the enrollee, to have a managed care plan or certified

utilization review entity (CRE) reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that does any of the following:

- Disapproves full or partial payment for a requested health service;
- Approves the provision of a requested health care service for a lesser scope or duration than requested;
- Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service.

Using the definitions below, complete Tables C and D for the listed service categories.

- Filed this year: List the number of internal and external grievances, by service category, filed by members during the reporting year.

- Withdrawn this year: List the number of internal and external grievances, by service category, that were withdrawn by the member during the reporting year.

- Decisions this year: List the number of decisions for internal and external grievances, by service category for the year, distinguishing between "overturned", "upheld" or "partially upheld". Partially upheld decisions are decisions that resolve part of the issue (e.g., an increase in service hours is granted) but not all (e.g., all requested services hours are not granted).

Service Categories

- Personal Assistance Services: Services as set forth in the "Section 1915(c) Home and Community-Based Services Waiver" for Community HealthChoices, services aimed at assisting the participant to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that would be performed independently if the participant had no disability.

- Home Modification Services: Physical adaptations to the primary private residence of the participant, as specified in the participant's person-centered service plan (PCSP) and determined necessary in accordance with the participant's assessment, to ensure the health, welfare, and safety of the participant, and enable the participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home.

- Other Home and Community-Based Services (HCBS): Waiver services (long-term services and supports) provided in the home or community, rather than an institution or isolated setting not already addressed in another service category.

- Skilled/Private Duty Nursing Services: Nursing and therapy that can only be

performed by licensed nurses/professional or technical personnel.

- Dental Services: Diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of the teeth and associated structures of the oral cavity; and disease, injury, or impairment that may affect the oral or general health of the member.

- Level of Care: The intensity of effort required to diagnose, treat, preserve, or maintain an individual's physical or emotional status. Grievances for Level of Care are generally related to a reduction in amount, duration, or scope of services not already addressed in another service category. Examples of this would include denials for residential treatment facility or inpatient care.

- Out-of-Network: Services rendered by a provider who has not been credentialed by and does not have a signed Provider Agreement with a Physical Health Managed Care Organization.

- Experimental/Investigational: A procedure that deviates from customary standards of medical practice, is not routinely used in the medical or surgical treatment of a specific illness or condition or is not of proven medical value.

- Medical Procedures: A course of action intended to achieve a result in the care of persons with health problems. Grievances for Medical Procedures are generally related to services denied due to lack of medical necessity or approval of a different, but similar service.

- Durable Medical Equipment: Items or devices that can withstand repeated use; which are used primarily and customarily to serve a medical purpose; which are customarily not useful to a person in the absence of illness or injury, and which are appropriate for home use.
  and
  Medical Supplies: Health care related items that are consumable, disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.

- Pharmacy: Pharmaceutical services furnished directly to members by pharmacies, including authorizations for prescription drugs.

- Other: Denials for services not included in any other service category.

E. COMMERCIAL INSURER INTERNAL COMPLAINT

Please identify these complaints for both internal and external levels in Table E broken out by reason for complaint:

- Quality,

- Network adequacy, and
- Other

F. COMMERCIAL INSURER INTERNAL APPEALS OF AN ADVERSE BENEFIT DETERMINATION

Please identify these appeals of adverse benefit determinations in Table F.

G. COMMERCIAL INSURER EXTERNAL APPEALS OF AN ADVERSE BENEFIT DETERMINATION

Please identify these appeals of adverse benefit determinations in Table G.

Using the definitions below, complete Tables F and G for the listed basis of adverse benefit determination.

Act 146 of 2022 defines an adverse benefit determination as the following:

(1) A determination by an insurer or a utilization review entity on behalf of an insurer that, based upon the information provided and upon application of utilization review, a request for a benefit under a health insurance policy does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.

(2) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer of a person's eligibility for coverage under a health insurance policy or noncompliance with an administrative policy.

(3) A rescission of coverage determination by an insurer. *Recissions of coverage are reviewed as an administrative denial by the Department and are not included here.*

Additionally, disputes regarding an insurer's compliance with the surprise billing and cost-sharing protections under sections 2799a-1 and 2799a-2 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-19) and regulations promulgated there under, are eligible for an appeal of an adverse benefit determination.

VI. UTILIZATION DATA

Provide the following information regarding utilization.

A. INPATIENT UTILIZATION BY TYPE OF SERVICE

Complete the chart for each inpatient data element identified in the columns and for each type of inpatient service listed. These data should include the count of inpatient services

received by the total membership during the time period (January 1 through December 31) per 1,000 members (covered members).

Please note that the Utilization Data (Admissions per 1,000 members and Inpatient Days per 1,000 members) is based on covered members (not member months).

The only calculation by member months is in the last column (Average Cost Per Member Per Month) of Table D in Section IX Behavioral Health.

Admissions per 1,000 Members - Number of Admissions / 1,000 Covered Members

Total Patient Days Incurred - Count of Patient Days for admissions that were discharged within the calendar year. Example: If admitted 12/30/26 and discharged 1/3/27, do not include these patient days in the 2026 Annual Report.

Average Length of Stay (LOS): For discharges only. Calculate the LOS by dividing the total days by the number of admissions.

Inpatient Days per 1,000 Members/Year - Number of Inpatient Days / 1,000 Covered Members

Hospital admissions are divided into five basic types of services, based on the treatment modality:

- Medical - admissions which treat physical illnesses where no major surgical procedure is performed.
- Surgical - admissions which treat surgical procedures as the primary method for treatment.
- Obstetric - admissions pertaining to pregnancy and childbirth, as well as to maternal and perinatal complications.
- Mental Health - admissions requiring treatment for psychiatric illnesses, such as depression, psychosis, and anxiety. Do not include inpatient substance abuse treatments.
- Substance Use Disorder - admissions requiring treatment for substance use disorder. Additional substance abuse data is reported in Section IX.D.

Please note that for purposes of this section, “observation status” is not included in the definition of admission.

B. OUTPATIENT UTILIZATION

Complete the chart for each type of outpatient encounter identified and for each source of enrollment. These data should include the count of outpatient encounters experienced by the total membership during the time period (January 1 through December 31) per 1,000 members. Outpatient encounters are defined as follows:

- Outpatient Services: health services provided to members who are not confined to a

health care institution. Outpatient services are distinct from "inpatient" services.

- Encounter: a face-to-face contact, including telehealth encounters, between a member and a provider of health care services who exercises independent judgment in the care and provision of health service(s) to the member. Please note that for purposes of this section, "encounter" excludes immunizations.

Report outpatient encounters for the following service types:

- Primary Care – encounters provided by primary care providers only. This section should include encounters by members with their designated PCP or a provider who is eligible to be designated as a PCP.
- Specialty Care – encounters provided by specialist physicians.
- Mental Health Services – services provided for the treatment of conditions or diagnoses relating to the emotional, psychological, and social well-being of an individual.
- Substance Use Disorder (SUD) Services – services provided for the treatment of conditions or diagnoses relating to drug or alcohol dependency or other substance use disorder.

C. EMERGENCY SERVICES

List the number of claims for emergency health delivery services including emergency physician and hospital costs incurred by plan members. Report emergency service claims as in-area or out-of-area. For purposes of this section, "in-area" refers to the plan's defined service delivery area. All other areas are "out-of-area." The Received/Total should be the sum of the claims Paid, Pending, and Rejected. Please note, this section does not refer to the plan's network.

Provide a copy of the plan's definition of what constitutes "emergency" as well as a definition of "out-of-area" services as an **Attachment**.

D. OUT-OF-NETWORK AUTHORIZATIONS/REFERRALS

For both outpatient and inpatient services provided by out-of-network providers (or at out-of-network facilities) provide:

- The number of requests received for authorization (total);
- The number of referrals/authorizations granted/approved; and
- The number of referrals/authorizations denied.
- The number of referrals pending.

VII. INTEGRATED DELIVERY SYSTEMS (IDS)

If the managed care organization contracts with an IDS, complete the table by listing the name, address, type and enrollment of the IDS. For more information on IDSs refer to the 28 Pa. Code Ch. 9, Subch. J (§§ 9.721-9.725) Health Care Provider Contracts.

VIII. CERTIFIED REVIEW ENTITY (CRE)

If the managed care organization contracts with a CRE, complete the table by listing the name, address, phone, and type for all contracted CREs that perform UR on behalf of the plan or a contracted IDS. For more information on CREs, refer to Act 68 as amended by Act 146 (40 P.S. §§ 991.2151-991.2152) and 28 Pa. Code Ch. 9, Subch. K (§§ 9.741-9.753).

IX. BEHAVIORAL HEALTH

If the plan subcontracts with a behavioral health organization or other entity to provide management of mental health benefits, complete A-D.

For purposes of this section, behavioral health refers to both mental health and substance use disorder.

A. Provide the following information for all behavioral health subcontracting entities:
   - Name of Subcontractor
   - Point of contact
   - Telephone number for point of contact
   - Email address for point of contact
   - Services provided by each subcontractor
   - Contract between the plan and the subcontractor as an **Attachment**
   - A copy of the plan's most recent monitoring report of the subcontractor's performance as an **Attachment**
   - Each subcontractor's credentialing criteria as an **Attachment**
   - A copy of any clinical quality assurance audits conducted by the plan for each subcontractor, or conducted by subcontractor as an **Attachment**

B. Answer questions 1-10

C. Provide complaint and grievance information for all behavioral health claims broken out by mental health and substance use disorder claims.

D. Provide substance use disorder treatment data. References to covered individuals are the total number of unique members enrolled during the year.

   Number of Members - Provide number of members treated during the calendar year for substance use disorder in Inpatient Non-Hospital Detox, Nonhospital Residential/Inpatient, Partial Hospitalization/Intensive Outpatient and Outpatient facilities.

   Visits per 1,000 Members - Provide the number of visits by members under substance use disorder treatment for Partial Hospitalization/Intensive Outpatient or Outpatient facilities during the calendar year for each one thousand covered individuals.

   Admissions per 1,000 Members - Provide the total number of Inpatient Non-Hospital Detox and Non-Hospital Residential/Inpatient admissions by plan member during the calendar year for each one thousand covered individuals.

Days per 1,000 Members/Year (Inpatient) - Provide the total number of Inpatient Non-Hospital Detox and Non-Hospital Residential/Inpatient days by plan members during the calendar year for each one thousand covered individuals.

Average Length of Stay (LOS) - Calculate the LOS by dividing the total Inpatient Non-Hospital Detox and Non-Hospital Residential/Inpatient days by the number of members.

Per Member Per Month (PMPM) Costs - Provide the average PMPM costs for each category of service. *This is the only calculation by member months.*

X. CERTIFICATION

This report must be signed by both the **Plan Medical Director and Chief Executive Officer**, certifying the accuracy and completeness of the report. Signature is required for local plan executives, not corporate administrators, where applicable.

If you have any questions regarding the completion of the Insurer or MA or CHIP Managed Care Plan's Annual Report, please contact the Bureau of Health Coverage, Access, Administration, and Appeals (HCA3) at: ra-inhca3@pa.gov or (717) 787-4192.