Title 40 Pennsylvania Consolidated Statutes (Insurance)

Part V. Health Insurance Markets Oversight

Effective: July 2, 2019

Chapter 91. Preliminary Provisions

§ 9101. Scope of part

This part relates to health insurance markets oversight.

§ 9102. Purpose and intent

The General Assembly finds and declares as follows:

(1) The Commonwealth intends to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth.

(2) The health insurance marketplace in this Commonwealth is unique and unlike the marketplace in any other state.

(3) It is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth as permitted by Federal law, including the Federal acts. The provisions of this part are intended to meet these requirements while retaining the Commonwealth's authority to regulate health insurance in this Commonwealth.

§ 9103. Definitions

Subject to additional definitions contained in subsequent provisions of this part which are applicable to specific provisions of this part, the following words and phrases when used in this part shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Affordable Care Act." The Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152, 124 Stat. 1029).

“Attachment point.” The threshold amount for claims costs incurred by an eligible insurer for an enrolled individual's covered benefits in a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under this part.

“Benefit year.” The calendar year during which an eligible insurer provides coverage through a health care plan.

“Board.” The governing body of the exchange authority.

“Children's Health Insurance Program.” The children's health insurance program under Article XXIII-A of the act of May 17, 1921 (P.L. 682, No. 284) [40 P.S. § 991.2301-A et seq.], known as The Insurance Company Law of 1921.

“Coinsurance rate.” The percentage rate at which the reinsurance program will reimburse an eligible insurer for claims incurred for an enrollee's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

“Commissioner.” The Insurance Commissioner of the Commonwealth.

“Department.” The Insurance Department of the Commonwealth.

“Eligible insurer.” An insurer offering reinsurance-eligible health care plans to consumers in this Commonwealth.

“Enrollee.” A policyholder, certificate holder, subscriber, covered person or other individual who is enrolled to receive health care services pursuant to a health insurance policy.

“Exchange.” A health insurance exchange as contemplated by the Affordable Care Act, established or operating in this Commonwealth, that facilitates or assists in facilitating enrollment in qualified plans.

“Exchange assister.” The term has the meaning given to it in section 2 of the act of June 19, 2015 (P.L. 25, No. 7) [40 P.S. § 4402 et seq.], known as the Navigator and Exchange Assister Accessibility and Regulation Act.

“Exchange authority.” The Pennsylvania Health Insurance Exchange Authority established under section 9302(a) (relating to Pennsylvania Health Insurance Exchange Authority).

“Exchange fund.” The Pennsylvania Health Insurance Exchange Fund established under section 9312 (relating to exchange fund).

"Federal acts." The Affordable Care Act and any amendments thereto, and related provisions of the Public Health Service Act (58 Stat. 682, 42 U.S.C. §201 et seq.).

"Government program." A program of government sponsored or subsidized health care coverage, including:

(1) A premium tax credit or cost-sharing subsidy under the Federal acts.

(2) Coverage under Medicare Parts A and B or Medicare Advantage Part C under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. §1395 et seq.).

(3) A TRICARE or other health care plan provided through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined under 10 U.S.C. §1072 (relating to definitions).

(4) A health care plan provided through the Federal Employees Health Benefits Program established under 5 U.S.C. Ch. 89 (relating to health insurance).

(5) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L. 31, No. 21) [62 P.S. § 101 et seq.], known as the Human Services Code.

(6) The Children's Health Insurance Program.

(7) Health care coverage provided by the Commonwealth, a county, a city, or other State or local governmental entity or an agency, subdivision or department of a governmental entity, including:

(i) a corporation or other arrangement organized by the entity for the provision of health care coverage and subject to control by the entity or an instrumentality of one or more of them;

(ii) the Pennsylvania Employee Benefit Trust Fund for active and retired employees; and

(iii) benefit programs administered by the Department of Corrections.

"Grandfathered health care plan." Individual or group health insurance coverage in which an individual was enrolled prior to the date of enactment of the Affordable Care Act, or as otherwise specified in section 1251 of the Affordable Care Act (42 U.S.C. §18011).

“Health care plan.” A package of coverage benefits with a particular cost-sharing structure, network and service area that is purchased through a health insurance policy.

“Health insurance policy.” A policy, subscriber contract, certificate or plan issued by an insurer that provides hospital or medical/surgical health care coverage. The term does not include any of the following:

(1) An accident only policy.
(2) A credit only policy.
(3) A long-term care or disability income policy.
(4) A specified disease policy.
(5) A Medicare supplement policy.
(6) A fixed indemnity policy.
(7) An adult-only dental only policy.
(8) A vision only policy.
(9) A workers' compensation policy.
(10) An automobile medical payment policy.
(11) A policy under which benefits are provided by the Federal Government to active or former military personnel and their dependents.
(12) Any other similar policies providing for limited benefits.

“Hospital plan corporation.” An entity organized and operating under Chapter 61 (relating to hospital plan corporations).

“Individual market.” The market for health insurance coverage offered to individuals other than in connection with a group.

“Innovation waiver.” A waiver applied for pursuant to section 1332 of the Affordable Care Act (42 U.S.C. §18052).

“Insurance producer.” The term has the meaning given to it in section 601-A of the act of May 17, 1921 (P.L.789, No. 285) [40 P.S. § 310.1], known as The Insurance Department Act of 1921.

“Insurer.” An entity that offers, issues or renews an individual or group health, accident or sickness insurance policy, contract or plan, and that is governed under any of the following:

(1) Chapter 61.
(2) Chapter 63 (relating to professional health services plan corporations).
(3) The Insurance Company Law of 1921, including section 630 and Article XXIV.

(4) The act of December 29, 1972 (P.L. 1701, No. 364) [40 P.S. § 1551 et seq.], known as the Health Maintenance Organization Act.

"Medical assistance program." The Commonwealth's medical assistance program established under the Human Services Code.

"Professional health services plan corporation." An entity organized and operating under Chapter 63.

"Qualified enrollee." A qualified employee or qualified individual, as defined in section 1312(f) of the Affordable Care Act and regulations promulgated under that act.

"Qualified plan." A plan as defined in section 1301(a) of the Affordable Care Act that provides health care or dental care coverage that has been certified by the department as meeting the criteria set forth in this part and any regulations issued pursuant to this part.

"Reinsurance cap." The upper limit amount for claims costs incurred by an eligible insurer for an enrolled individual's covered benefits in a benefit year, over which the claims costs for benefits are no longer eligible for reinsurance payments under the reinsurance program.

"Reinsurance-eligible enrollee." An enrollee who is insured in a reinsurance-eligible health care plan under this part.

"Reinsurance-eligible health care plan." A health care plan that is not a grandfathered health care plan.

"Reinsurance payment." An amount paid by the reinsurance program to an eligible insurer under the program.

"**Reinsurance program."** The Commonwealth Health Insurance Reinsurance Program established under section 9502(b) (relating to implementation of waiver and establishment of reinsurance program).

"Small group market." The market for health insurance for coverage offered through a group health insurance policy for a group of at least one employee and up to 50 employees, exclusive of dependents.

Chapter 93. State-Based Exchange

§ 9301. Scope of chapter

This chapter relates to the Pennsylvania Health Insurance Exchange Authority.

§ 9302. Pennsylvania Health Insurance Exchange Authority

(a) Establishment.--The Pennsylvania Health Insurance Exchange Authority is established as a State-affiliated entity. The powers and duties of the exchange authority shall be vested in and exercised by a board, which shall have the sole power under section 9305 (relating to powers and duties of exchange authority) to employ staff, including an executive director. Individuals employed by the exchange authority shall be employees of the Commonwealth. The exchange authority may contract with persons or entities, including legal counsel, consultants or service providers, as deemed necessary in the exchange authority's discretion.

(b) Purpose.--The purpose of the exchange authority shall be to create, manage and maintain in this Commonwealth the Pennsylvania Health Insurance Exchange to do all of the following:

(1) Benefit the Pennsylvania health insurance market and persons enrolling in health insurance policies.

(2) Facilitate or assist in facilitating the purchase of on-exchange qualified plans by qualified enrollees in the individual market or the individual and small group markets.

(c) Composition.--The board shall consist of the following members:

(1) Three voting members who shall be the following heads of agencies or a designee who shall be an employee of the agency designated in writing by the head of the agency prior to service:

(i) The commissioner, ex-officio.

(ii) The Secretary of Human Services, ex-officio.

(iii) The Secretary of Health, ex-officio.

(2) Four voting members appointed by the Governor:

(i) One member from among the insurers that offer health insurance policies through the exchange that are a hospital plan corporation, a professional health services plan corporation or a parent, affiliate, subsidiary or other associated entity or successor of a hospital plan corporation or a professional health services plan.

(ii) One member from among the insurers that offer health insurance policies through the exchange that are not a hospital plan corporation, a professional health services plan corporation

or a parent, affiliate, subsidiary or other associated entity or successor of a hospital plan corporation or a professional health services plan.

(iii) One member with experience in health care public education and consumer assistance activities who does not have a conflict of interest as described in subsection (k).

(iv) One member who is a consumer representative.

(3) Four voting members appointed by the General Assembly as follows:

(i) One individual appointed by the President pro tempore of the Senate.

(ii) One individual appointed by the Minority Leader of the Senate.

(iii) One individual appointed by the Speaker of the House of Representatives.

(iv) One individual appointed by the Minority Leader of the House of Representatives.

(4) The executive director shall attend meetings of the board but shall not be a member, may not vote and may not be counted for purposes of establishing a quorum.

(d) Chairperson.--The commissioner or a designee shall serve as chairperson.

(e) Compensation.--Board members shall not be entitled to any compensation for their services as members, except that, subject to the availability of funds, board members shall be entitled to reimbursement for actual and necessary travel expenses. The expenses shall be paid for by the exchange fund.

(f) Terms.--The terms of the board members shall be as follows:

(1) A board member appointed under subsection (c)(3) who:

(i) Is a member of the General Assembly shall serve a term concurrent with their holding of public office.

(ii) Is not a member of the General Assembly shall serve a term concurrent with their appointing official's holding of public office.

(2) A board member appointed under subsection (c)(2) shall serve a term of four years, not to exceed more than two full consecutive four-year terms, except that the following shall apply:

(i) Initial appointments shall be so staggered that less than 50% of the membership shall expire each year.

(ii) A member's term shall continue until the member's replacement is appointed.

(g) Vacancies.--Vacancies in appointed positions shall be filled in the same manner as the original appointment. Members shall serve until their successors are appointed and qualified.

(h) Formation.--The exchange authority shall be formed within 60 days of the effective date of this section. Prior to formation of the exchange authority, the commissioner may take action necessary to effect a timely transition from a federally administered exchange to the Pennsylvania Health Insurance Exchange.

(i) Quorum.--A majority of the appointed members of the board shall constitute a quorum. Action may be taken by the board at a meeting upon a vote of a quorum of its members present in person or through electronic means. If a tie vote occurs at any meeting, it shall be the duty of the chairperson of the board to cast a second and deciding vote.

(j) Meetings.--The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly, which shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(k) Experience and interests.--For purposes of this chapter, the board shall assure that it complies with section 1321 of the Affordable Care Act (42 U.S.C. §18041) and regulations promulgated under the Affordable Care Act regarding conflicts of interest and relevant experience.

(l) Conflict of interest.--The following apply:

(1) Except as provided under paragraph (2), a non-State employee board member shall not be subject to 65 Pa.C.S. Ch. 11 (relating to ethics standards and financial disclosure), including the requirements for filing statements of financial interests.

(2) A non-State employee board member may not engage in conduct that, if that member were a State employee, would constitute a conflict of interest under 65 Pa.C.S. Ch. 11.

(3) A majority of the voting members of the board may not have a conflict of interest as set forth in section 1321 of the Affordable Care Act and regulations promulgated under the Affordable Care Act.

§ 9303. Advisory council

(a) Establishment.--An advisory council is created to advise the exchange authority under section 9304(g) (relating to meetings and operation).

(b) Composition.--The advisory council shall consist of the following members, who may not be in the employ of the Commonwealth:

(1) Four consumer representatives which include two representatives appointed by the Governor at least one of whom shall be a registered insurance exchange navigator or assister, one appointed by the President pro tempore of the Senate and one appointed by the Speaker of the House of Representatives.

(2) One representative selected by the Hospital and Healthsystem Association of Pennsylvania.

(3) One representative selected by the Pennsylvania Medical Society.

(4) One representative selected by the Pennsylvania Chamber of Business and Industry from a small group employer.

(5) One representative selected by the Pennsylvania Association of Health Underwriters.

§ 9304. Meetings and operation

(a) Chairperson.--The members of the advisory council shall annually elect a chairperson from among its membership.

(b) Terms of members.--Each member's term shall be four years, not to exceed more than two full consecutive four-year terms, except that:

(1) Initial appointments shall be staggered to ensure less than 50% of the membership expire each year.

(2) A member's term shall continue until the member's successor is appointed.

(c) Meetings.--All meetings of the advisory council shall be conducted in accordance with 65 Pa.C.S. Ch. 7 (relating to open meetings), except as provided in this section. Meetings must be held in accordance with the following:

(1) The advisory council shall meet at least twice per year, with each meeting held prior to a meeting of the board. Additional meetings may be held upon reasonable notice at times and locations selected by the board. The council shall meet at the call of the chairperson or upon written request of three members of the council.

(2) The executive director of the exchange authority, or a designee, shall attend each meeting of the advisory council.

(3) Meeting dates shall be set by a majority vote of members of the advisory council or by call of the chairperson upon seven days' notice to all members.

(4) The advisory council shall post notice of the council's meetings on the exchange authority's publicly accessible Internet website at least five days prior to each meeting. The notice must specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public.

(5) All action taken by the advisory council shall be taken in open public session and may not be taken except upon a majority vote of the members present at a meeting at which a quorum is present.

(d) Compensation.--The members of the advisory council shall not be entitled to any compensation for their services as members, except that, subject to the availability of money, the members of the advisory council shall be entitled to reimbursement for actual and necessary travel expenses. The expenses shall be paid for by the exchange fund.

(e) Vacancies.--Vacancies in appointed positions shall be filled in the same manner as the original appointment. Members shall serve until their successors are appointed and qualified.

(f) Quorum.--A majority of the advisory council members shall constitute a quorum and a quorum may act for the advisory council in all matters.

(g) Duties.--Upon request by the exchange authority, the advisory council shall advise the exchange authority on the following administrative and operational decisions:

(1) Initial operational decisions.

(2) Ongoing financing decisions.

(3) Other decisions as the exchange authority may deem appropriate.

§ 9305. Powers and duties of exchange authority

(a) Corporate operations.--The exchange authority shall exercise all powers and duties necessary and appropriate to carry out its purpose, including the following:

(1) Adopt bylaws.

(2) Employ staff.

(3) Make, execute and deliver contracts.

(4) Apply for, solicit and receive money from any source consistent with the purpose of this chapter.

(5) Establish priorities for, allocate and disburse money received.

(6) Submit annually to the Appropriations Committee of the Senate and the Appropriations Committee of the House of Representatives, at the same time the exchange authority submits its budget to the Governor, a copy of its budget request and all subsequently revised budget requests for the ensuing fiscal year. The budget shall include the amounts to be appropriated out of the fund established under section 9312 (relating to exchange fund) necessary to administer the provisions of this chapter and the conveyance of money to the Reinsurance Fund established under section 9510 (relating to Reinsurance Fund).

(7) Establish travel reimbursement policies for the exchange authority, its board, and its advisory council.

(8) Coordinate with the appropriate Federal and State agencies to seek waivers from statutory or regulatory requirements as necessary to carry out the purposes of this chapter.

(9) Enter into other arrangements, including without limitation, interagency agreements with Federal agencies and Commonwealth agencies or other states' agencies, as may be necessary or appropriate to carry out the duties of the exchange authority.

(10) Give reasonable public notice of any policies and procedures the exchange authority may implement to accomplish the operation of the exchange authority.

(11) Perform other operational activities necessary or appropriate to further the purposes of this chapter.

(12) The board shall consider the advice of the advisory council provided under section 9304(g) (relating to meetings and operation).

(b) Programmatic duties.--The exchange authority shall perform all duties necessary or appropriate to advance its purpose, including the following:

(1) Educate consumers, including through outreach, a navigator program and postenrollment support.

(2) Assist individuals to access income-based assistance for which they may be eligible, including premium tax credits, cost-sharing reductions and government programs.

(3) Take into consideration the need for consumer choice in rural, urban and suburban areas across the Commonwealth.

(4) Assess and collect fees from on-exchange insurers to support the operation of the exchange under this chapter and the reinsurance program established under section 9502(b) (relating to implementation of waiver and establishment of reinsurance program), except that the exchange authority may not assess or collect any form of obligation other than an exchange user fee on total monthly premiums for on-exchange policies and unless approved by unanimous consent of the board, the fee may not exceed 3% of total monthly premiums for on-exchange policies. In no case may the fee exceed 3.5%.

(5) Disburse receipted fees, including to benefit the reinsurance program established under section 9502(b).

(c) Enforcement and State sovereignty.--The exchange authority shall ensure that the exchange complies with the Federal acts and rules and regulations that may be imposed by the Federal Government pursuant to the Federal acts in a manner that maintains State sovereignty over the health insurance market in this Commonwealth. Enforcement responsibilities shall be delegated to the appropriate State agency and shall be sufficient to prevent a determination by the United States Secretary of Health and Human Services that the Commonwealth has failed to substantially enforce any provision of the Federal acts.

§ 9306. Limitations

Except as expressly provided in this chapter, nothing in this chapter shall be construed to limit or supersede the authority vested in a Commonwealth agency, including:

(1) The Insurance Department, including the department's authority to regulate the business of insurance within this Commonwealth, including health insurance policies whether offered on or off the exchange.

(2) The Department of Human Services, including with respect to the medical assistance program or the Children's Health Insurance Program.

(3) The Department of Health.

(4) The Office of Attorney General.

§ 9307. Confidentiality and disclosure

(a) General rule.--Except as provided in this chapter, all working papers, recorded information, documents and copies of working papers, recorded information and documents produced by, obtained by or disclosed to the exchange authority or any other person in the course of the exercise of the exchange authority's powers and duties under this chapter:

(1) shall be confidential;

(2) shall not be subject to subpoena;

(3) shall not be subject to the act of February 14, 2008 (P.L. 6, No. 3) [65 P.S. § 67.101 et seq.], known as the Right-to-Know Law;

(4) shall not be subject to discovery or admissible in evidence in any private civil action; and

(5) may not be made public by the exchange authority or any other person.

(b) Personal health and financial information.--The exchange authority shall protect personally identifiable health and financial information in accordance with all applicable Federal and State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5, 123 Stat. 226-279 and 467-496) and implementing regulations.

(c) Information disclosure.--Subject to the confidentiality provisions of this section:

(1) Information shall be shared, as appropriate, for the purpose of determining and coordinating the eligibility of individuals for the exchange or any government program, including the Children's Health Insurance Program and medical assistance program, or for compliance with Federal law:

(i) Among the exchange authority and departments, including:

(A) The department.

(B) The Department of Aging.

(C) The Department of Drug and Alcohol Programs.

(D) The Department of Health.

(E) The Department of Human Services.

(F) The Department of Labor and Industry.

(G) The Department of Revenue.

(ii) Between the exchange authority and Federal agencies, including:

(A) The Centers for Medicare and Medicaid Services.

(B) The Treasury Department.

(2) Information may be disclosed:

(i) As necessary to comply with the audit requirements of section 9310 (relating to audits) and the reporting requirements of section 9311 (relating to reports), only in an aggregated and de-identified form.

(ii) In any circumstance, other than those described in paragraph (1) or subparagraph (i), only if the prior written consent of the company or person to which the information pertains has been obtained.

(d) Construction.--Nothing in this section shall be construed to prohibit the exchange authority from accessing the information necessary to carry out its responsibilities in accordance with law.

§ 9308. Not an entitlement

Nothing in this chapter shall constitute an entitlement derived from the Commonwealth or a claim on any money of the Commonwealth.

§ 9309. Nonliability

(a) General rule.--Except as provided under subsection (b), there shall be no liability on the part of and no cause of action of any nature may arise against the exchange authority, board or advisory council or members thereof, the commissioner, the department, an insurer, insurance producer or an exchange assister or an authorized representative, agent or employee thereof, for the use of information furnished pertaining to:

(1) An application for, inquiry concerning, or enrollment or disenrollment in a health insurance policy or government program, including an inquiry regarding eligibility for enrollment or eligibility for a government program, relevant to health insurance available through an exchange or health care coverage or other benefits through a government program.

(2) A charge, assessment or fee imposed on or received from a person or entity relevant to the exchange.

(b) Limitation.--Subsection (a) shall apply only insofar as the person or entity is acting within the scope of the person's or entity's duties and responsibilities under this chapter.

§ 9310. Audits

(a) Annual audit.--The accounts and books of the exchange authority shall be examined and audited annually by an independent certified public accounting firm. The audit shall at a minimum:

(1) Assess compliance with the requirements of this chapter.

(2) Identify any material weaknesses or significant deficiencies and identify ways to correct the material weaknesses or deficiencies.

(b) Sharing of audit.--By December 31 of each year, the exchange authority shall electronically share the audit of the preceding fiscal year required under subsection (a) and related documents by:

(1) Posting the following on the exchange authority's publicly accessible Internet website:

(i) The audit.

(ii) A summary of the audit, including any material weakness or significant deficiency identified and how the exchange authority intends to correct the material weakness or significant deficiency.

(2) Providing an electronic link to the posted audit under paragraph (1)(i) to the Secretary of the Senate and the Chief Clerk of the House of Representatives.

(3) Providing an electronic link to the posted audit under paragraph (1)(i) to the department.

(c) Payment.--The cost of the annual audit required under subsection (a) shall be paid for from money in the exchange fund.

§ 9311. Reports

(a) Report.--The exchange authority shall prepare an annual report on the activities of the exchange authority for the year and:

(1) Electronically transmit the report to:

(i) The Governor.

(ii) The President pro tempore of the Senate.

(iii) The Minority Leader of the Senate.

(iv) The Speaker of the House of Representatives.

(v) The Minority Leader of the House of Representatives.

(vi) The chair and minority chair of:

(A) The Appropriations Committee of the Senate.

(B) The Appropriations Committee of the House of Representatives.

(C) The Banking and Insurance Committee of the Senate.

(D) The Insurance Committee of the House of Representatives.

(E) The Health and Human Services Committee of the Senate.

(F) The Health Committee of the House of Representatives.

(2) Post the report on the exchange authority's publicly accessible Internet website.

(b) Federal compliance.--The exchange authority shall comply with applicable Federal reporting requirements.

(c) Department notification.--The exchange authority shall provide a copy of or electronic link to the report provided under subsection (a) or (b) to the department.

§ 9312. Exchange fund

(a) Establishment.--The Pennsylvania Health Insurance Exchange Fund is established as a special fund within the State Treasury. The exchange fund shall be administered by the exchange authority for the purposes set forth in this chapter, including the deposit of money that may be received pursuant to and disbursements permitted by this chapter.

(b) Deposit and use of money.--The following apply:

(1) Money deposited into the exchange fund shall be held for the purposes set forth in this chapter and may not be considered a part of the General Fund.

(2) Money in the exchange fund may only be used to effectuate the purposes of this chapter as determined by the exchange authority.

(3) All interest earned from the investment or deposit of money in the exchange fund shall be deposited into the exchange fund.

(4) All accrued and future earnings from money invested by the exchange authority and other accrued and future earnings from nonappropriated money, including, but not limited to, money obtained from the Federal Government and fees, shall be available to the exchange authority and shall be deposited into the State Treasury and may be utilized at the discretion of the board for carrying out any of the corporate purposes of the exchange authority.

(5) Placement of money by the State Treasurer in depositories or investments shall be consistent with guidelines approved by the board.

(6) For the purpose of administration, the exchange authority shall be subject to sections 610, 613 and 614 of act of April 9, 1929 (P.L. 177, No. 175) [71 P.S. §§ 230, 233, 234], known as The Administrative Code of 1929.

(c) Nonlapsing and revolving fund.--The exchange fund shall be a nonlapsing fund. All money in the exchange fund and interest accrued are appropriated to the exchange authority for expenditure consistent with this chapter.

§ 9313. Federal guidance

Until the exchange authority promulgates regulations, the exchange authority shall operate the exchange pursuant to:

(1) any applicable Federal rules, regulations or guidance; or

(2) interim State guidelines consistent with this chapter.

§ 9314. Expiration

Upon publication of the notice under section 9703(b) (relating to action by commissioner), the exchange authority shall initiate steps to cease operations of the exchange authority and shall cease operations not later than 15 months after publication of the notice.

Chapter 95. Reinsurance Program

§ 9501. Application

(a) Application.--The department is authorized to apply to the United States Secretary of Health and Human Services under section 1332 of the Affordable Care Act [42 U.S.C. §18052] for a state innovation waiver to:

(1) Waive any applicable provisions of the Affordable Care Act with respect to health insurance coverage in this Commonwealth.

(2) Establish a reinsurance program in accordance with an approved waiver.

(3) Maximize Federal funding for the reinsurance program for plan years beginning on or after implementation of the program.

(b) Public review.--On or before 180 days after the effective date of this section, the department shall make a draft application available for a 30-day public review and comment period. The department shall consider any comments in its final submitted application.

(c) Amendment.--The department may amend the waiver application as necessary to carry out the provisions of this chapter.

(d) Notification.--The department shall notify the chair and minority chair of the Appropriations Committee of the Senate, the chair and minority chair of the Appropriations Committee of the House of Representatives, the chair and minority chair of the Banking and Insurance Committee of the Senate and the chair and minority chair of the Insurance Committee of the House of

Representatives promptly of any amendment to the waiver application and of any Federal actions regarding the waiver application.

§ 9502. Implementation of waiver and establishment of reinsurance program

(a) Implementation.--Upon approval of the department's application for an innovation waiver by the United States Department of Health and Human Services, the department shall implement a reinsurance program.

(b) Establishment.--Contingent upon Federal approval, the Commonwealth Health Insurance Reinsurance Program is established in the department for the purposes of stabilizing the rates and premiums for health insurance policies in the individual market and providing greater financial certainty to consumers of health insurance in this Commonwealth. The reinsurance program shall be considered a reinsurance entity to carry out a reinsurance program under the Federal acts.

(c) Operation.--Operation of a reinsurance program shall be contingent on Federal approval of the waiver application submitted pursuant to section 9501 (relating to application).

§ 9503. Administration and operation of reinsurance program

(a) General rule.--The department shall take all actions necessary to administer the approved reinsurance program in a manner consistent with applicable Federal and State law.

(b) Functions.--The department shall perform all functions necessary and appropriate to carry out the operation of the reinsurance program and to effectuate the purposes for which the reinsurance program is organized, in accordance with the approved waiver. The functions include:

(1) Establishing procedures for and performing administrative and accounting operations of the reinsurance program.

(2) Seeking and receiving funding for the reinsurance program and to maximize Federal funding for the reinsurance program, including from:

(i) The exchange authority.

(ii) Federal funding that is or becomes available to states to support administration and implementation of state-based reinsurance programs.

(iii) Other available sources.

(3) Collecting data submissions and reinsurance payment requests by eligible insurers.

(4) Making reinsurance payments to eligible insurers.

(5) Resolving disputes related to the amount of reinsurance payments.

(6) Suing or being sued, including taking any legal action necessary or proper for the recovery of money for reinsurance payments.

(7) Submitting invoices or other requests for money as may be necessary and appropriate under the innovation waiver.

(c) Delegation.--Except as prohibited by applicable Federal law and regulation, and as may be necessary or appropriate to carry out department duties, the department may administer the reinsurance program directly or through:

(1) Other Federal agencies, Commonwealth agencies or other states' agencies.

(2) Contracted persons or entities, including with legal, actuarial, economic, third-party administrator or other persons or entities, as the department deems appropriate, to provide consultation services and technical assistance in operating the reinsurance program. Contracted persons or entities shall submit regular reports to the department regarding the person's or entity's performance, the frequency, content and form of which shall be determined by the department.

(d) Coordination with exchange authority.--The department shall coordinate with the exchange authority as may be necessary to fund and operate the reinsurance program.

§ 9504. Reinsurance parameters

(a) Adoption of reinsurance terms.--The department shall, after consultation with all insurers then currently participating in the exchange, and not less than 60 days before final rates for health insurance policies are required to be submitted each year, determine and adopt the attachment point, reinsurance cap and coinsurance rate applicable to the reinsurance program for the following year.

(b) Parameters.--In determining the attachment point, reinsurance cap and coinsurance rate applicable to the reinsurance program for the following year, the department shall seek to:

(1) Manage the program within the amount of total program funding available to the department.

(2) With respect to the individual market:

(i) Mitigate the impact of high-cost claims on premium rates.

(ii) Stabilize or reduce premium rates.

(iii) Increase participation.

(c) Publication and notice.--The department shall transmit notice of the adopted attachment point, reinsurance cap and coinsurance rate to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin and shall:

(1) Post notice on the department's publicly accessible Internet website.

(2) Electronically send notice to the chair and minority chair of the Banking and Insurance Committee of the Senate and the chair and minority chair of the Insurance Committee of the House of Representatives.

(3) Electronically send notice to each participating insurer via a contact person or electronic mailing address, as identified by the insurer.

(d) Limitation.--After the department adopts the attachment point, reinsurance cap and coinsurance rate for the next year, the department may not, before or during that benefit year, change the attachment point, reinsurance cap or coinsurance rate in a manner less favorable to the insurers participating in the exchange at the time of adoption.

§ 9505. Insurer eligibility and duties

(a) Eligibility for payment.--An insurer shall be eligible for a reinsurance payment if:

(1) The claims costs for a reinsurance-eligible enrollee's covered benefits in a benefit year exceed the attachment point.

(2) The eligible insurer has implemented and documented reasonable care management practices for enrollees who are the subject of reinsurance claims through the reinsurance program.

(3) The eligible insurer makes its requests for reinsurance payments in accordance with any requirements established by the department including requirements related to the format, structure and timing for submission of claims for reinsurance payments.

(4) The eligible insurer participated in the exchange, or is affiliated with an entity that participated in the exchange, in the benefit year in which the claims costs for which a reinsurance payment is sought were incurred.

(b) Reporting requirement.--An insurer that seeks reinsurance payments under this chapter must report to the department, in the form and manner prescribed by the department, information about reinsurance-eligible enrollees insured by the insurer as necessary for the department to calculate reinsurance payments.

(c) Confidentiality.--Reinsurance claims submitted under this section are confidential and are not subject to public disclosure, except as provided under section 9514 (relating to immunity).

(d) Consideration for rate filings.--In a rate filing for a health insurance policy to be offered through the exchange, the impact of reinsurance payments under this chapter shall be identified.

(e) Limitation.--The calculation of reinsurance payments due to an eligible insurer shall be net of all other available insurance payments applicable to a claim, including insurance accessible through subrogation or coordination of benefits.

§ 9506. Payment of coverage and administrative costs

(a) General rule.--Consistent with Federal requirements, the department shall pay the following from the Reinsurance Fund:

(1) Administrative expenses of the reinsurance program, including the annual audit required under section 9508 (relating to annual audit).

(2) Reinsurance payments for coverage of reinsurance-eligible enrollees.

(b) Operations.--The department may promulgate regulations necessary and appropriate to establish processes for the settlement of reinsurance coverage claims and disbursement of reinsurance money.

(c) Request for review.--An insurer that is aggrieved by a determination of the department relating to the amount of reinsurance payments due to the insurer may file a request for administrative review of the decision. The procedures and requirements of 2 Pa.C.S. Ch. 5 Subch. A [2 Pa. C.S. §501 et seq.] (relating to practice and procedure of Commonwealth agencies) shall apply to requests for review filed under this section. Notwithstanding otherwise applicable time limitations, in order to permit timely finalization of rates for the open enrollment period for the exchange, a challenge to the department's determination of the attachment point, reinsurance cap and coinsurance rate published in the Pennsylvania Bulletin under section 9504(c) (relating to reinsurance parameters) must be made within 10 business days of the date of publication.

§ 9507. Not an entitlement

(a) No entitlement.--The provision of reinsurance program money or benefits accrued through the Reinsurance Fund may not constitute an entitlement derived from the Commonwealth or a claim on any other money of the Commonwealth.

(b) Contingency with respect to Federal money.--Notwithstanding any provision of this chapter, the department shall have no responsibility to pay reinsurance amounts that would be payable out of Federal money if the Federal Government does not transmit sufficient money for the Reinsurance Fund to fully recompense those actions.

§ 9508. Annual audit

(a) Annual audit.--The reinsurance program shall be examined and audited annually by an independent certified public accounting firm. The audit shall, at a minimum:

(1) Assess compliance with the requirements of this chapter.

(2) Identify any material weaknesses or significant deficiencies and identify and implement solutions to correct the material weaknesses or deficiencies.

(b) Sharing of audit.--By December 31 of each year, the department shall electronically share the audit of the preceding fiscal year required under subsection (a) and related documents by:

(1) Posting the following on the department's publicly accessible Internet website:

(i) The audit.

(ii) A summary of the audit, including any material weakness or significant deficiency identified and how the department intends to correct the material weakness or significant deficiency.

(2) Providing an electronic link to the posted audit under paragraph (1)(i) to the Secretary of the Senate and the Chief Clerk of the House of Representatives.

(c) Payment.--The cost of the annual audit required under subsection (a) shall be paid for from money in the Reinsurance Fund.

§ 9509. Annual report of operations

(a) Report.--No later than November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the department shall prepare a financial report for the applicable benefit year. The report must include, at a minimum, the following information for the benefit year that is the subject of the report:

(1) Money deposited into the Reinsurance Fund.

(2) Requests for reinsurance payments received from eligible insurers.

(3) Reinsurance payments made to eligible insurers.

(4) Administrative and operational expenses incurred for the reinsurance program.

(b) Comparative report.--No later than 60 days after individual market health insurance rates are final, the department shall prepare a report summarizing the quantifiable impact of the reinsurance program on individual market health insurance rates for the following plan year.

(c) Distribution of reports.--The department shall:

(1) Electronically transmit the reports under this section to:

(i) The President pro tempore of the Senate.

(ii) The Minority Leader of the Senate.

(iii) The Speaker of the House of Representatives.

(iv) The Minority Leader of the House of Representatives.

(v) The chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Appropriations Committee of the House of Representatives.

(vi) The chair and minority chair of the Banking and Insurance Committee of the Senate and the chair and minority chair of the Insurance Committee of the House of Representatives.

(2) Post the reports under this section on the department's publicly accessible Internet website.

§ 9510. Reinsurance Fund

(a) Establishment and administration of Reinsurance Fund.--The Reinsurance Fund is established as a special fund within the State Treasury. The Reinsurance Fund shall be administered by the department for the purposes set forth in this chapter, including the deposit of Federal money and all other money received pursuant to and disbursements permitted by this chapter.

(b) Exclusive purpose.--The Reinsurance Fund shall be dedicated exclusively for the reinsurance program established under section 9502(b) (relating to implementation of waiver and establishment of reinsurance program).

(c) Use.--The following apply:

(1) Expenditures from the Reinsurance Fund shall be used to:

(i) Implement and operate the reinsurance program.

(ii) Make reinsurance payments to eligible insurers under the reinsurance program. Payments to insurers shall be calculated and made on a pro rata basis.

(2) In making expenditures from the Reinsurance Fund, available Federal money must be expended first.

(3) Pending disbursement, money in the Reinsurance Fund shall be invested or reinvested in the same manner as money in the custody of the State Treasurer. All earnings received from the investment or reinvestment of money shall be credited to the Reinsurance Fund.

(d) Expenses.--All costs and expenses of the reinsurance program shall be paid from the Reinsurance Fund, including compensation of employees and any independent contractors or consultants hired by the department.

(e) Nonlapsing and revolving fund.--The following apply:

(1) The Reinsurance Fund shall be a nonlapsing fund. All money placed in the Reinsurance Fund and interest accrued are appropriated to the department for expenditure consistent with the provisions of this chapter.

(2) Nothing in this section shall prevent money in the Reinsurance Fund from being used as a revolving fund to cover necessary expenditures if Federal money is requested and committed but not yet received or if other money is committed but not yet received.

(f) Limitations.--The following limitations apply:

(1) In each fiscal year, the total amount of annual expenditures from the Reinsurance Fund, including administrative and consulting expenses, may not exceed the amount of expected Federal and other money budgeted for deposit in the Reinsurance Fund in that fiscal year.

(2) Notwithstanding any general or specific powers granted to the department under this chapter, whether express or implied, the department may not pledge, in favor of the reinsurance program, the credit or taxing power of the Commonwealth or any political subdivision.

§ 9511. Procurements within one year

Notwithstanding any other provision of law and for the limited purpose of fulfilling the requirements under this chapter, procurement of contracts and agreements for the implementation and operation of the reinsurance program initiated within one year of the effective date of this section shall not be subject to the provisions of 62 Pa.C.S. (relating to procurement). No contract or agreement entered into under this section may exceed a term of five years.

§ 9512. Access to information and records

(a) Reports and access.--An insurer shall, without charge, report information and provide access to and furnish records as the department requests in order for the department to:

(1) Prepare the State innovation waiver application submitted under section 9501(a) (relating to application).

(2) Determine reinsurance parameters under section 9504 (relating to reinsurance parameters).

(3) Determine the reinsurance payments due to each insurer.

(4) Monitor costs and revenues associated with the reinsurance program.

(5) Administer the reinsurance program.

(6) Assure compliance with applicable Federal and State law.

(b) Time period.--The information and records requested under subsection (a) shall be provided to the department within 30 days of receipt by an insurer of the written request, unless required at an earlier date for department compliance with a request from a Federal or other State agency.

(c) Use.--Information and records provided to the department under subsection (a) may only be used for the purposes specified in subsection (a).

(d) Exemptions.--Any instructions, forms or reports issued by the department and required to be completed by an insurer under this section shall not be subject to:

(1) The act of July 31, 1968 (P.L. 769, No. 240) [45 P.S. § 1102 et seq.], referred to as the Commonwealth Documents Law.

(2) The act of October 15, 1980 (P.L. 950, No. 164) [71 P.S. § 732-101 et seq.], known as the Commonwealth Attorneys Act.

(3) The act of June 25, 1982 (P.L. 633, No. 181) [71 P.S. § 745.1 et seq.], known as the Regulatory Review Act.

§ 9513. Confidentiality and information disclosure

(a) General rule.--Except as provided for in this section, all working papers, recorded information, documents and copies of working papers, recorded information and documents produced by, obtained by or disclosed to the department or any other person in the course of exercising the department's powers and duties under this chapter:

(1) shall be confidential;

(2) shall not be subject to subpoena;

(3) shall not be subject to the act of February 14, 2008 (P.L. 6, No. 3) [65 P.S. §67.101 et seq.], known as the Right-to-Know Law;

(4) shall not be subject to discovery or admissible in evidence in any private civil action; and

(5) may not be made public by the department or any other person.

(b) Personal health and financial information.--The department shall protect personally identifiable health and financial information in accordance with Federal and State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5, 123 Stat. 226-279 and 467-496) and implementing regulations.

(c) Information disclosure.--Subject to the confidentiality provisions of this section:

(1) Information shall be shared as follows:

(i) Between the department and the Centers for Medicare and Medicaid Services for purposes of compliance with the Federal acts.

(ii) Between the department and each insurer participating in the reinsurance program.

(iii) Between the department and the exchange authority.

(2) Information may be disclosed as follows:

(i) As necessary to comply with the audit requirements of section 9508 (relating to annual audit) and the reporting requirements of section 9509 (relating to annual report of operations), only in an aggregated and de-identified form.

(ii) In any circumstance other than as described in paragraph (1) or subparagraph (i), only if the prior written consent of the company or person to which the information pertains is obtained.

(d) Construction.--Nothing in this section shall be construed to prohibit the department from accessing the information reasonably required to carry out its responsibilities in accordance with law.

§ 9514. Immunity

(a) General rule.--Except as provided in subsection (b), the department, a Commonwealth agency or person or entity under contract with the department for the reinsurance program, or an authorized representative, agent or employee of any of them may not be subject to civil or criminal liability and no cause of action of any nature shall arise for any action taken or not

taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter, or for the reasonable and good faith use of any information pertaining to the reinsurance program.

(b) Exception.--This section shall not prohibit legal actions against the reinsurance program to enforce the reinsurance program's statutory or contractual duties or obligations.

§ 9515. Regulation of insurers

Nothing in this chapter shall be construed to limit or supersede the regulatory authority vested with the department to regulate the business of insurance within this Commonwealth, including health insurance policies offered on or off the exchange.

§ 9516. Expiration

Upon publication of the notice under section 9703(b) (relating to action by commissioner), the department shall initiate steps to cease operation of the reinsurance program and shall cease operation of the reinsurance program no later than 15 months after publication of the notice.

Chapter 97. Miscellaneous Provisions

§ 9701. Regulations

(a) Authority to promulgate.--The department and the exchange authority may promulgate regulations as may be necessary and appropriate to carry out the provisions of this part.

(b) Omission of proposed rulemaking.--The General Assembly finds and declares as follows:

(1) This part is essential to:

(i) the provision of health care for the citizens of this Commonwealth; and

(ii) the financial viability of the health care system in this Commonwealth.

(2) The finding and declaration under paragraph (1) constitutes good cause for the omission of notice of proposed rulemaking under section 204(3) of the act of July 31, 1968 (P.L. 769, No. 240) [45 P.S. § 1204], referred to as the Commonwealth Documents Law.

§ 9702. Enforcement

(a) General rule.--Upon satisfactory evidence of a violation of this part by an insurer or 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 insurer or other person.

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

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

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

(b) Limitation.--

(1) Fines imposed against an individual insurer under this part may not exceed $500,000 in the aggregate during a single calendar year.

(2) Fines imposed against any other person under this part may not exceed $100,000 in the aggregate during a single calendar year.

(c) Additional remedies.--The enforcement remedies imposed under this subsection are in addition to any other remedies or penalties that may be imposed under any other applicable law of this Commonwealth, including:

(1) The act of July 22, 1974 (P.L. 589, No. 205) [40 P.S. § 1171.1 et seq.], known as the Unfair Insurance Practices Act. Violations of this part shall be deemed to be an unfair method of competition and an unfair or deceptive act or practice under the Unfair Insurance Practices Act.

(2) The act of June 25, 1997 (P.L. 295, No. 29) [40 P.S. § 1302.1 et seq.], known as the Pennsylvania Health Care Insurance Portability Act.

(d) Administrative procedure.--The administrative provisions of this section shall be subject to 2 Pa.C.S. Ch. 5 Subch. A [2 Pa. C.S. § 501 et seq.] (relating to practice and procedure of Commonwealth agencies). A party against whom penalties are assessed in an administrative action may appeal to Commonwealth Court as provided in 2 Pa.C.S. Ch. 7 Subch. A [2 Pa. C.S. § 701 et seq.] (relating to judicial review of Commonwealth agency action).

§ 9703. Action by commissioner

(a) Sunset.--This part shall sunset immediately if any of the following occur:

(1) The Congress of the United States repeals or defunds those provisions of the Affordable Care Act integral to the exchange authority established under Chapter 93 (relating to

State-based Exchange) or the reinsurance program established under Chapter 95 (relating to reinsurance program).

(2) A court of the United States with competent jurisdiction invalidates the provisions of the Affordable Care Act integral to the duties of the exchange authority established under Chapter 93 or the reinsurance program established under Chapter 95.

(3) The Executive Branch of the United States repeals or defunds the provisions of the Affordable Care Act and its subsequent regulations integral to the duties of the exchange authority established under Chapter 93 or the reinsurance program established under Chapter 95.

(b) Notice.--If this part sunsets pursuant to subsection (a), the commissioner shall transmit notice of that action to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.