PRINTER'S NO. 456

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 440 Session of 2017

INTRODUCED BY MURT, V. BROWN, D. COSTA, DRISCOLL, HARPER, KINSEY, McNEILL, MILLARD, D. MILLER, READSHAW, SCHLOSSBERG, SCHWEYER AND WATSON, FEBRUARY 10, 2017

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 10, 2017

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, providing for special provisions relating to particular classes of risk that involve mental health and addiction; and making related repeals regarding Act 284 of 1921.

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

Section 1. Title 40 of the Pennsylvania Consolidated Statutes is amended by adding a part to read:

PART V

SPECIAL PROVISIONS RELATING TO

PARTICULAR CLASSES OF RISK

Chapter

81. Mental Health and Addiction

CHAPTER 81

MENTAL HEALTH AND ADDICTION

Subchapter

A. General Provisions

B. Mental Illness and Drug Abuse and Dependency

C. Benefits for Alcohol Abuse and Dependency

D. Health Insurance Coverage Parity and Nondiscrimination

SUBCHAPTER A

GENERAL PROVISIONS

Sec.

8101. Scope of chapter.

8102. Definitions.

§ 8101. Scope of chapter.

This chapter relates to insurance coverage for mental health and addiction services.

§ 8102. Definitions.

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

"Department." The Insurance Department of the Commonwealth.

"Nonquantitative treatment limitation" or "NQTL." A process, strategy, evidentiary standard or other factor that is not expressed numerically, but otherwise limits the scope or duration of benefits for treatment. An NQTL includes, but is not limited to:

(1) A medical management standard limiting or excluding benefits based on:

(i) medical necessity or medical appropriateness; or

(ii) whether the treatment is experimental or investigative.

(2) A formulary design for prescription drugs.

(3) For a plan with multiple network tiers, such as preferred providers and participating providers, a network tier design.

(4) A standard for provider admission to participate in

a network, including reimbursement rates.

(5) A plan method for determining usual, customary and reasonable charges.

(6) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective.

(7) An exclusion based on failure to complete a course of treatment.

(8) A restriction based on geographic location, facility type, provider specialty or other criteria that limits the scope or duration of benefits for services provided under the plan or coverage.

(9) An in-network or out-of-network geographic limitation.

(10) A limitation on inpatient services for situations in which the participant is a threat to self or others.

(11) An exclusion for court-ordered and involuntary holds.

(12) An experimental treatment limitation.

(13) Service coding.

(14) An exclusion for services provided by a clinical social worker.

(15) Network adequacy.

(16) Provider reimbursement rates, including rates of reimbursement for mental health and substance use services in primary care.

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

SUBCHAPTER B

MENTAL ILLNESS AND DRUG ABUSE AND DEPENDENCY

Sec.

8111. Scope of subchapter.
8112. Applicability.
8113. Definitions.
8114. Minimum standards.
8115. Committee study and reports.

§ 8111. Scope of subchapter.

This subchapter relates to insurance coverage regarding mental illness and alcohol or other drug abuse and dependency.

§ 8112. Applicability.

(a) General rule.--Subject to subsection (b), this subchapter shall apply to any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of 50 or more employees.

(b) Exception.--This subchapter shall not apply to any of the following policies:

(1) Accident only.

(2) Fixed indemnity.

(3) Limited benefit.

(4) Credit.

(5) Dental.

(6) Vision.

(7) Specified disease.

(8) Medicare supplement.

(9) CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) supplement.

(10) Long-term care.

(11) Disability income.

(12) Workers' compensation.

(13) Automobile medical payment.

§ 8113. Definitions.

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

"Committee." The Legislative Budget and Finance Committee.

"Health insurance policy." Any group health, sickness or accident policy or subscriber contract or certificate issued by an entity subject to one of the following:

(1) The Insurance Company Law of 1921.

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

(3) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Mental illness and alcohol or other drug abuse and dependency." Any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in:

(1) the current edition of the mental disorders section of the current International Statistical Classification of Diseases and Related Health Problems; or

(2) the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

§ 8114. Minimum standards.

A health insurance policy covered under this subchapter shall provide coverage for mental illness and alcohol or other drug abuse and dependency that meets at a minimum all of the following standards:

(1) Coverage for mental illness and alcohol or other drug abuse and dependency shall include at least 30 inpatient and 60 outpatient days annually.

(2) A person covered under the policy shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis.

(3) There shall be no difference in either the annual or lifetime dollar limits in coverage for mental illness and alcohol or other drug abuse and dependency and any other illness.

(4) There shall be no difference in cost-sharing arrangements, including, but not limited to, deductibles and copayments for coverage of mental illness and alcohol or other drug abuse and dependency and for coverage of any other illness.

(5) A health insurance policy may not impose an NQTL with respect to a mental illness and alcohol or other drug abuse and dependency in any classification of benefits unless, under the terms of the policy as written and in operation, any process, strategy, evidentiary standard or other factor used in applying the NQTL to mental illness and alcohol or other drug abuse and dependency benefits in the classification are comparable to, and are applied no more stringently than, the process, strategy, evidentiary standard or other factor used in applying the NQTL with respect to medical or surgical benefits in the same classification.

§ 8115. Committee study and reports.

(a) Study.--The committee shall undertake a study of the cost and benefits of this subchapter, as a continuation of the study under section 635.1(d) of The Insurance Company Law of 1921.

(b) Reports.--The committee shall prepare a report of its study for the General Assembly on or before June 30 of each odd-

numbered year, as a continuation of the series of reports begun under section 635.1 of The Insurance Company Law of 1921.

(c) Topics included in study and report.--The study and each report under this section shall include, but not be limited to, an analysis of the following:

(1) The effect on policy premiums.

(2) The cost benefit of extending this act to all group health insurance policies offered in this Commonwealth.

(3) The cost benefit of this enhanced level of coverage for mental illness and alcohol or other drug abuse and dependency and the cost benefit to those employers who offer policies with more liberal benefits.

(4) The identity of employers who, after the effective date of this section, provide reduced mental health insurance benefits to employees and who provided more liberal mental health insurance benefits than provided in The Insurance Company Law of 1921.

(5) Any mental illnesses enumerated under Axis 1 of the Current Diagnostic and Statistical Manual of Mental Disorders not covered under this subchapter, with specific consideration of whether any of them should be included in the definition of the term "mental illness and alcohol or other drug abuse and dependency."

(6) Actions taken by the department to assure health insurance policies are in compliance with this subchapter and that quality and access to treatment for mental health conditions are not compromised by providing coverage under this subchapter.

(7) Any segments of this Commonwealth's population that may be excluded from access to treatment for mental health

conditions.

(8) The use of medical services resulting from the provision of access to mental health treatment as provided by this subchapter.

(d) Cooperation.--The department shall fully cooperate and provide all nonconfidential data, records, reports and information that the committee may request in connection with the study.

(e) Quality control.--The study and reports under this section must be actuarially sound and subject to peer review by the American Academy of Actuaries. Any assumptions upon which the study and the reports are based must be common to the current health insurance market in this Commonwealth.

SUBCHAPTER C

BENEFITS FOR ALCOHOL ABUSE AND DEPENDENCY

Sec.

§ 8121. Scope of subchapter.

This subchapter relates to benefits for alcohol abuse and dependency.

§ 8122. Definitions.

The following words and phrases when used in this subchapter

shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Alcohol or drug abuse." Any use of alcohol or other drugs which produces:

(1) a pattern of pathological use causing impairment in social or occupational functioning; or

(2) physiological dependency evidenced by physical tolerance or withdrawal.

"Detoxification." The process in which an alcohol-intoxicated, drug-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the Department of Health through the period necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

"Drugs." Addictive drugs and drugs of abuse listed as scheduled drugs in the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act.

"Hospital." A facility licensed as a hospital by the Department of Health or the Department of Human Services or operated by the Commonwealth and conducting an alcoholism or drug addiction treatment program licensed by the Department of Health.

"Inpatient care." The provision of medical, nursing, counseling or therapeutic services 24 hours a day in a hospital or nonhospital facility, according to individualized treatment plans.

"Nonhospital facility." A facility, except for transitional living facilities, licensed by the Department of Health for the care or treatment of alcohol-dependent or other drug-dependent persons.

"Nonhospital residential care." The provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol or other drug abuse or dependency in a residential environment, according to individualized treatment plans.

"Outpatient care." The provision of medical, nursing, counseling or therapeutic services in a hospital or nonhospital facility on a regular and predetermined schedule, according to individualized treatment plans.

"Partial hospitalization." The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or nonhospital facility licensed as an alcoholism or drug addiction treatment program by the Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in outpatient care but who does not require inpatient care.

§ 8123. Mandated policy coverages and options.

(a) Applicability.--

(1) This section shall apply to the following:

(i) All group health or sickness or accident insurance policies that provide hospital or medical/surgical coverage.

(ii) All group subscriber contracts or certificates that provide hospital or medical/surgical coverage and that are issued by any entity subject to any of the following:

(A) The Insurance Company Law of 1921.

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

(C) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(2) This section shall not apply to Medicare or Medicaid supplemental contracts or limited coverage accident and sickness policies, including, but not limited to, cancer insurance, polio insurance, dental care and similar policies as may be identified as exempt from this section by the Insurance Commissioner.

(b) Mandated coverage.--In addition to the other requirements under The Insurance Company Law of 1921, all policies, contracts or certificates under subsection (a) shall include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections 8124 (relating to inpatient detoxification), 8125 (relating to nonhospital residential alcohol or other drug services) and 8126 (relating to outpatient alcohol or other drug services).

(c) Combination permissible.--The benefits specified in subsection (b) may be provided through a combination of policies, contracts or certificates.

(d) Prospective payment plans.--The benefits specified in subsection (b) may be provided through prospective payment plans.

§ 8124. Inpatient detoxification.

(a) Location.--Inpatient detoxification as a covered benefit under this subchapter shall be provided either in a hospital or

in an inpatient nonhospital facility that:

(1) has a written affiliation agreement with a hospital for emergency, medical and psychiatric or psychological support services;

(2) meets minimum standards for client-to-staff ratios and staff qualifications that shall be established by the Department of Health; and

(3) is licensed as an alcoholism or drug addiction treatment program, or both.

(b) Coverage.--The following services shall be covered under inpatient detoxification:

(1) Lodging and dietary services.

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.

(3) Diagnostic X-ray services.

(4) Psychiatric, psychological and medical laboratory testing.

(5) Drugs, medicines, equipment use and supplies.

(c) Limitation.--Treatment under this section may be subject to a lifetime limit for any covered individual of four admissions for detoxification. Reimbursement per admission may be limited to seven days of treatment or an equivalent amount.

§ 8125. Nonhospital residential alcohol or other drug services.

(a) Treatment and benefits.--

(1) Minimal additional treatment as a covered benefit under this subchapter shall be provided in a facility that:

(i) meets minimum standards for client-to-staff ratios and staff qualifications that shall be established by the Department of Drug and Alcohol Programs; and

(ii) is appropriately licensed by the Department of

Health as an alcoholism or drug addiction treatment program, or both.

(2) Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) Covered services.--The following services shall be covered under this section:

(1) Lodging and dietary services.

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.

(3) Rehabilitation therapy and counseling.

(4) Family counseling and intervention.

(5) Psychiatric, psychological and medical laboratory tests.

(6) Drugs, medicines, equipment use and supplies.

(c) Extent of treatment.--

(1) The treatment under this section shall be covered as required by The Insurance Company Law of 1921 for a minimum of 30 days per year for residential care. Additional days shall be available as provided in section 8126(c) (relating to outpatient alcohol or other drug services).

(2) Treatment under this section may be subject to a lifetime limit for any covered individual of 90 days.

§ 8126. Outpatient alcohol or other drug services.

(a) Treatment and benefits.--

(1) Minimal additional treatment as a covered benefit under this subchapter shall be provided in a facility appropriately licensed by the Department of Health as an

alcoholism or drug addiction treatment program.

(2) Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) Covered services.--The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services.

(2) Rehabilitation therapy and counseling.

(3) Family counseling and intervention.

(4) Psychiatric, psychological and medical laboratory tests.

(5) Drugs, medicines, equipment use and supplies, including coverage for at least one opioid antagonist, including the medication product, administration devices and any pharmacy administration fees related to the dispensing of the opioid antagonist. This coverage must include refills for expired or utilized opioid antagonist.

(c) Extent of treatment.--

(1) Treatment under this section shall be covered as required by The Insurance Company Law of 1921 for a minimum of:

(i) 30 outpatient, full-session visits or equivalent partial visits per year; and

(ii) 30 separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to 15 additional nonhospital, residential alcohol treatment days.

(2) Treatment under this section may be subject to a lifetime limit for any covered individual of 120 outpatient, full-session visits or equivalent partial visits.

(d) Clinical review criteria.--For any utilization review or benefit determination for the treatment of alcohol or other drug abuse and dependency, including, but not limited to, prior authorization and medical necessity determinations, the clinical review criteria shall be the most recent Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions established by the American Society of Addiction Medicine. No additional criteria may be used during utilization review or benefit determination for treatment of substance use disorders.

(e) Treatment criteria.--Any Federal Drug Administration-approved forms of medication-assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered, if the treatment is medically necessary, according to most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

§ 8127. Deductibles, copayment plans and prospective pay.

(a) Application to benefits.--Reasonable deductible or copayment plans, or both, after approval by the Insurance Commissioner, may be applied to benefits paid to or on behalf of patients during the course of alcohol or other drug abuse or dependency treatment. In the first instance or course of treatment, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

(b) Prospective payment plan.--In the first instance or course of treatment under a prospective payment plan, no

deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

§ 8128. Rules and regulations.

The Insurance Commissioner and the Secretary of Health shall jointly promulgate those rules and regulations as are deemed necessary for the effective implementation and operation of this subchapter.

§ 8129. Preservation of certain benefits.

Nothing in this subchapter shall serve to diminish the benefits of any insured or subscriber existing on the effective date of this subchapter nor prevent the offering or acceptance of benefits that exceed the minimum benefits required by The Insurance Company Law of 1921.

SUBCHAPTER D

HEALTH INSURANCE COVERAGE PARITY AND NONDISCRIMINATION

Sec.

§ 8131. Scope of subchapter.

This subchapter relates to health insurance coverage parity and nondiscrimination.

§ 8132. Purpose of subchapter.

(a) Findings.--The General Assembly finds that it is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth by

implementing the requirements of the following, which are collectively contained in the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 201 et seq.):

(1) The MHPAEA.

(2) The Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881).

(3) Michelle's Law (Public Law 110-381, 122 Stat. 4081-4086).

(b) Legislative intent.--The provisions of this subchapter are intended to meet the requirements of the acts under subsection (a) while retaining the Commonwealth's authority to regulate health insurance in this Commonwealth.

§ 8133. Definitions.

(a) General rule.--The following words and phrases when used in this subchapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Federal acts." The following Federal laws, which are collectively contained in the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 201 et seq.):

(1) The MHPAEA.

(2) The Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881).

(3) Michelle's Law (Public Law 110-381, 122 Stat. 4081-4086).

"Fraternal benefit society." An entity holding a current certificate of authority under Article XXIV of The Insurance Company Law of 1921.

"Health maintenance organization." An entity holding a

current certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Hospital plan corporation." An entity holding a current certificate of authority organized and operated under Chapter 61 (relating to hospital plan corporations).

"Insurer." A foreign or domestic insurance company, association or exchange, health maintenance organization, hospital plan corporation, professional health services plan corporation, fraternal benefit society or risk-assuming preferred provider organization. The term shall not include a group health plan as defined in section 2791 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-91).

"MHPAEA." Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, 122 Stat. 3881).

"Preferred provider organization." An entity holding a current certificate of authority under section 630 of The Insurance Company Law of 1921.

"Professional health services plan corporation." An entity holding a current certificate of authority under Chapter 63 (relating to professional health services plan corporations). This term shall not include dental service corporations or optometric service corporations, as those terms are defined under section 6302(a) (relating to definitions).

(b) Federal law.--The words, terms and definitions found in the Federal acts, including those in section 2791 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-91), are adopted for purposes of implementing this subchapter, except as noted in this section. The term "health insurance issuer" under

section 2791(b)(2) of the Public Health Service Act shall have the meaning provided under "insurer" in subsection (a).

§ 8134. Adoption of and compliance with Federal acts.

(a) Compliance.--Insurers shall comply with the Federal acts as contained in sections 2701, 2702, 2705, 2707, 2721, 2753 and 2754 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. §§ 300gg, 300gg-1, 300gg-5, 300gg-7, 300gg-21, 300gg-53 and 300gg-54). Medicaid and the children's health insurance program under Article XXIII-A of The Insurance Company Law of 1921 shall comply with final rules promulgated for Medicaid in 42 CFR Pt. 447 (relating to payments for services).

(b) Report.--Each insurer shall submit an annual report to the department on or before March 1 that contains the following information:

(1) The frequency with which the insurer required prior authorization for all prescribed procedures, services or medications for mental health benefits during the previous calendar year, the frequency with which the insurer required prior authorization for all prescribed procedures, services or medications for alcohol or other drug abuse and dependency benefits during the previous calendar year and the frequency with which the insurer required prior authorization for all prescribed procedures, services or medications for medical and surgical benefits during the previous calendar year. Insurers must submit this information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits and prescription drug benefits. Frequency shall be expressed as a percentage, with total prescribed procedures, services or medications

within each classification of benefits as the denominator and the overall number of times prior authorization was required for any prescribed procedures, services or medications within each corresponding classification of benefits as the numerator.

(2) A description of the process used to develop or select the medical necessity criteria for mental health benefits, the process used to develop or select the medical necessity criteria for alcohol or other drug abuse and dependency benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(3) Identification of all NQTLs that are applied to mental health benefits, all NQTLs that are applied to alcohol or other drug abuse and dependency benefits and all NQTLs that are applied to medical and surgical benefits. NQTLs are defined as whichever is more extensive of how they are defined in 45 CFR Pt. 146 (relating to requirements for the group health insurance market) or how they are defined in State law.

(4) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (2) and for each NQTL identified in paragraph (3), as written and in operation, the processes, strategies, evidentiary standards or other factors used to apply the medical necessity criteria and each NQTL to mental health and alcohol or other drug abuse and dependency benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used to apply the medical necessity criteria and each NQTL, as

written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis shall:

(i) Identify the specific factors the insurer used in performing its NQTL analysis.

(ii) Identify and define the specific evidentiary standards relied on to evaluate the factors.

(iii) Describe how the evidentiary standards are applied to each service category for mental health benefits, alcohol or other drug abuse and dependency benefits, medical benefits and surgical benefits.

(iv) Disclose the results of the analyses of the specific evidentiary standards in each service category.

(v) Disclose the specific findings of the insurer in each service category and the conclusions reached with respect to whether the processes, strategies, evidentiary standards or other factors used in applying the NQTL to mental health or alcohol or other drug abuse and dependency benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(5) The rates of and reasons for denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs and emergency care mental health services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year.

(6) The rates of and reasons for denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs and emergency care alcohol or other drug abuse and dependency services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year.

(7) A certification signed by the insurer's chief executive officer and chief medical officer that states that the insurer has completed a comprehensive review of the administrative practices of the insurer for the prior calendar year for compliance with the necessary provisions of the MHPAEA, and any amendments to those provisions, and Federal guidelines or regulations issued under those provisions, including 45 CFR Pts. 146 and 147 (relating to health insurance reform requirements for the group and individual health insurance markets) and 45 CFR 156.115(a)(3) (relating to provision of EHB).

(8) Any other information necessary to clarify data provided in accordance with this section requested by the commissioner, including information that may be proprietary or have commercial value. The commissioner shall not certify any health policy of an insurer that fails to submit all data as required by this section.

§ 8135. Penalties.

Upon satisfactory evidence of a violation of this subchapter by any insurer or other person, the commissioner may, in the commissioner's discretion, pursue any one of the following courses of action:

(1) Suspend, revoke or refuse to renew the license of the offending person.

(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than $5,000 for each action in violation of this subchapter.

(4) Impose a civil penalty of not more than $10,000 for each action in willful violation of this subchapter.

§ 8136. Regulations and regulatory implementation.

(a) Regulations.--The department may promulgate regulations as may be necessary or appropriate to carry out this subchapter.

(b) Implementation of Federal act.--The department shall implement and enforce applicable provisions of the MHPAEA and Federal guidelines or regulations issued under those provisions, including 45 CFR Pts. 146 (relating to regulations for the group health insurance market) and 147 (relating to health insurance reform requirements for the group and individual health insurance markets) and 45 CFR 156.115(a)(3) (relating to provision of EHB), which include:

(1) Ensuring compliance by individual and group health insurance policies.

(2) Detecting violations of the law by individual and group health insurance policies.

(3) Accepting, evaluating and responding to complaints regarding violations.

(4) Maintaining and regularly reviewing, for possible parity violations, a publicly available consumer complaint log regarding mental health and alcohol or other drug abuse and dependency coverage.

(5) Conducting parity compliance market conduct examinations of individual and group health insurance

policies, including, but not limited to, reviews of network adequacy, reimbursement rates, denials and prior authorizations.

(c) Report and presentation.--

(1) Not later than June 30 of each year, the department shall issue a report to the General Assembly and provide an educational presentation to the General Assembly.

(2) The report and presentation shall:

(i) Cover the methodology the department is using to check for compliance with the MHPAEA and any Federal regulations or guidelines relating to the compliance and oversight of the MHPAEA and 42 U.S.C. § 18031(j) (relating to affordable choices of health benefit plans).

(ii) Cover the methodology the department is using to check for compliance with Subchapters B (relating to mental illness and drug abuse and dependency) and C (relating to benefits for alcohol abuse and dependency).

(iii) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and alcohol or other drug abuse and dependency benefits under Federal and State laws and summarize the results of such market conduct examinations. This shall include:

(A) The number of market conduct examinations initiated and completed.

(B) The benefit classifications examined by each market conduct examination.

(C) The subject matter of each market conduct examination, including quantitative and nonquantitative treatment limitations.

(D) A summary of the basis for the final decision rendered in each market conduct examination.

(iv) Detail any educational or corrective actions the regulatory agency has taken to ensure insurer compliance with the MHPAEA, 42 U.S.C. § 18031(j) and Subchapters B and C.

(v) Detail the department's educational approaches relating to informing the public about mental health and alcohol or other drug abuse and dependency parity protections under Federal and State law.

(3) Individually identifiable information shall be excluded from the reports consistent with Federal privacy protections.

(4) The report must be written in nontechnical, readily understandable language and shall be made available to the public by, among other means as the department finds appropriate, posting the report on the department's publicly accessible Internet website.

Section 2. Repeals are as follows:

(1) The General Assembly declares that the repeal under paragraph (2) is necessary to effectuate the addition of 40 Pa.C.S. Ch. 81.

(2) The following provisions of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, are repealed:

(i) Section 635.1.

(ii) Article VI-A.

(iii) Article VI-B.

Section 3. The addition of 40 Pa.C.S. Ch. 81 is a continuation of section 635.1 and Articles VI-A and VI-B of the

act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921. The following apply:

(1) Except as otherwise provided in 40 Pa.C.S. Ch. 81, all activities initiated under section 635.1 and Articles VI-A and VI-B of The Insurance Company Law of 1921 shall continue and remain in full force and effect and may be completed under 40 Pa.C.S. Ch. 81. Orders, regulations, rules and decisions which were made under section 635.1 and Articles VI-A and VI-B of The Insurance Company Law of 1921 and which are in effect on the effective date of 40 Pa.C.S. Ch. 81 shall remain in full force and effect until revoked, vacated or modified under 40 Pa.C.S. Ch. 81. Contracts, obligations and collective bargaining agreements entered into under section 635.1 and Articles VI-A and VI-B of The Insurance Company Law of 1921 are not affected nor impaired by the repeal of section 635.1 and Articles VI-A and VI-B of The Insurance Company Law of 1921.

(2) Except as otherwise provided in 40 Pa.C.S. Ch. 81, any difference in language between 40 Pa.C.S. Ch. 81 and section 635.1 and Articles VI-A and VI-B of The Insurance Company Law of 1921 is intended only to conform to the style of the Pennsylvania Consolidated Statutes and is not intended to change or affect the legislative intent, judicial construction or administration and implementation of section 635.1 and Articles VI-A and VI-B of The Insurance Company Law of 1921.

Section 4. This act shall take effect immediately.