CHAPTER 152. PREFERRED PROVIDER ORGANIZATIONS

GENERAL

Sec.

PRIMARY CARE GATEKEEPER PPO PRODUCTS—STATEMENT OF POLICY

Sec.

Authority

The provisions of this Chapter 152 issued under section 630 of The Insurance Company Law of 1921 (40 P. S. § 764a), unless otherwise noted.

Source

The provisions of this Chapter 152 adopted March 6, 1987, effective March 7, 1987, 17 Pa.B. 974, unless otherwise noted.

GENERAL

§ 152.1. Purpose.

This chapter implements section 630 of the act (40 P. S. § 764a).

§ 152.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The act of June 11, 1986 (P. L. 226, No. 64), which amends The Insurance Company Law of 1921 (40 P. S. §§ 341—991).

Admitted assets—Assets set forth in the definition of insolvency in section 503 of The Insurance Department Act of one thousand nine hundred and twenty-one (40 P. S. § 221.3), as admitted assets.

Commissioner—The Insurance Commissioner of the Commonwealth.

Department—The Insurance Department of the Commonwealth.

Enrollee—An individual entitled to receive the benefits of a preferred provider organization with respect to health care services.

Enrollee literature—aterials and communications which a preferred provider organization distributes or makes available for advertising or other purposes, which discuss the provisions, limitations or conditions of benefits available to an enrollee of a preferred provider organization.

Health care insurer—A company which is a risk-assuming preferred provider organization, or licensed to do the business of accident and health insurance in this Commonwealth, or both.

Health care purchaser—A person, partnership, association, governmental unit or corporation which provides health care coverage to its employes or members and their dependents by reimbursing the covered persons directly for covered health services or by contracting with a health care insurer, nonprofit professional health service corporation, nonprofit hospital plan corporation or health maintenance organization to provide, arrange for the provision of, reimburse or pay for covered health services. The term does not include a health care insurer.

Licensed insurer—A company licensed to do the business of accident and health insurance in this Commonwealth.

Physician—An individual licensed under the statutes of this Commonwealth to practice medicine and surgery within the scope of the Osteopathic Medical Practices Act (63 P. S. §§ 271.1—271.18) or the Medical Practice Act of 1985 (63 P. S. §§ 422.1—422.45).

Preferred provider arrangement—

(i) An arrangement established, operated, maintained or underwritten in whole or in part, by or on behalf of or in association with a health care insurer or purchaser in which the insurer or purchaser directly or indirectly does one or more of the following:

(A) Enters into agreements with providers or physicians relating to health care services which may be rendered to enrollees, including agreements relating to the amounts to be charged by the provider or physician for services rendered.

(B) Issues or administers policies or subscriber contracts in this Commonwealth which include incentives for the enrollee to use the services of a provider that has entered into an agreement with the insurer or purchaser.

(C) Issues or administers policies or subscriber contracts in this Commonwealth that provide for reimbursement of services only if the services have been rendered by a provider or physician that has entered into an agreement with the insurer or purchaser.

(ii) A preferred provider arrangement may be established, operated, maintained or underwritten by one or more preferred provider organizations.

Preferred provider organization—

(i) *General.* A person, partnership, association or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred provider arrangement. The term does not include a provider or physician whose only involvement in the preferred provider arrangement is the performance of health care services, a nonprofit professional health service plan corporation, a nonprofit hospital plan corporation or a health maintenance organization.

(ii) *Risk assuming preferred provider organization.* A preferred provider organization which meets the definition in subparagraph (i) and has one or more of the following characteristics:

(A) Assumption by the preferred provider organization of financial risk arising out of contractual liability to pay for or reimburse enrollees for covered health care services.

(B) Participation in financial gains or losses of a health benefits plan based on aggregate measures of expenditures or utilization.

(C) Participation in the overall financial risk of a health benefits plan by placing upper limits on future premium increases.

(D) Other characteristics which create a financial risk to the preferred provider organization and arise out of the preferred provider arrangement.

(iii) *Exclusion.* The term ''risk assuming preferred provider organization'' does not include a third-party administrator, or a licensed insurer, when functioning solely as a third party administrator.

Provider—A provider of a health care service licensed and authorized to perform a health care service which is a covered benefit under a health care plan offered by a purchaser or issued or administered by a health care insurer.

Secretary—The Secretary of Health of the Commonwealth.

Section 630—Section 630 of the act (40 P. S. § 764a).

Source

The provisions of this § 152.2 adopted March 6, 1987, effective March 7, 1987, 17 Pa.B. 974; corrected September 18, 1987, effective March 7, 1987, 17 Pa.B. 3741. Immediately preceding text appears at serial pages (118100) to (118102).

Cross References

This section cited in 31 Pa. Code § 154.2 (relating to definitions).

§ 152.3. Content of an application for approval.

(a) The application for approval of a risk-assuming preferred provider organization, which is not a licensed insurer, includes:

(1) A copy of the basic organizational document of the applicant preferred provider organization, such as the articles of incorporation, and amendments thereto.

(2) A copy of the bylaws, rules or similar documents regulating the conduct of the internal affairs of the applicant preferred provider organization.

(3) A list of the names, addresses and official positions of members of the board of directors of the applicant preferred provider organization and of persons who are responsible for the conduct of the affairs of the applicant, including, but not limited to, the chief executive officer, chief operating officer, director of marketing, medical director and director of finance.

(4) A copy of the preferred provider organization's most recent financial statement.

(5) An organization chart describing the relationship between the preferred provider organization and its affiliates, including the state of domicile and the primary business of each entity.

(6) A description of the proposed service area of the provider organization, including geographic boundaries.

(7) A financial analysis prepared for the purpose of determining that the proposed preferred provider organization will have adequate working capital and reserves. The analysis shall include a feasibility study, a business plan with projected financial statements for the next 3 years, a review of proposed provider and physician contracts and charges, a review of proposed rates and a market opportunity analysis. The financial analysis shall be made under the direction of a qualified actuary or certified public accountant.

(8) A copy of every standard form contract with physicians and providers establishing preferred provider arrangements.

(9) A detailed description of the types of financial incentives for preferred physicians and providers within the preferred provider arrangements.

(10) A list of the preferred providers.

(11) A copy of procedures, if any, for referral of covered persons to nonpreferred providers by the preferred provider organization or a preferred provider.

(12) A detailed description of the preferred provider organization's provisions to prevent undertreatment or poor quality care of persons covered by the preferred provider arrangements. Standards regarding the adequacy of a quality assurance system are provided in § 152.4 (relating to scope of Department of Health review of a preferred provider organization).

(13) A copy of every standard form contract with health care insurers and purchasers through which preferred provider arrangements are made available to covered persons.

(14) A copy of every standard form contract with enrollees or groups of enrollees setting forth the preferred provider organization's contractual obligations to provide, arrange for the provision of or pay for covered health care services.

(15) A description of the incentives for enrollees to use the services of a preferred provider contained within the preferred provider organization's enrollee contracts.

(16) A copy of the preferred provider organization's enrollee literature.

(17) A description of provisions within the preferred provider arrangements holding covered person financially harmless for payment denials by the preferred provider organizations for improper utilization of covered health services caused by preferred providers.

(18) A copy of charges made to health care insurers, purchasers or covered persons by the preferred provider organization in consideration for establishment of the preferred provider arrangements.

(19) Other information that the applicant preferred provider organization may wish to submit which reasonably relates to its ability to establish, operate, maintain or underwrite a preferred provider organization.

(b) The application for approval of a risk-assuming preferred provider organization which is a licensed insurer includes the items listed in subsection (a)(6) and (8)—(19).

(c) The application for approval of a preferred provider organization which does not assume financial risk includes the items listed in subsection (a)(6), (8)—(11), (13)—(16) and (19).

(d) The application for approval of a preferred provider organization which is governed and regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C.A. §§ 301—309 and 1001—1461) will consist of the certificate required by § 152.12 (relating to provider organizations governed and regulated under ERISA).

(e) Changes or additions, or both, to the information in subsection (a)(1)—(3) and (5) shall be filed within 30 days of their occurrence after commencement of operations.

(f) Changes or additions, or both, to the information in subsection (a)(6), (8), (9), (11)—(15), (17) and (18) shall be filed at least 60 days prior to use or effective date after commencement of operations.

(g) Changes or additions, or both, to the list of preferred providers shall be filed semiannually on or before March 31 and September 30 of each year.

(h) In addition to the information required by subsections (a)—(d), preferred provider organizations may be requested to provide the Commissioner and the Secretary with other material that is deemed necessary to complete the review of the application.

(i) An applicant which is simultaneously filing an application for a certificate of authority to operate as a health maintenance organization may incorporate by reference portions of that application in its application to operate as a preferred provider organization.

(j) An application for approval of a preferred provider organization shall be made by submitting two copies each to the Commissioner and the Secretary.

Cross References

This section cited in 31 Pa. Code § 152.102 (relating to definitions).

§ 152.4. Scope of Department of Health review of a preferred provider organization.

(a) The Department of Health will review the applications of preferred provider organizations which assume financial risk and which utilize arrangements or provisions which may lead to undertreatment or poor quality care.

(1) Arrangements or provisions which may lead to undertreatment or poor quality care include, but are not limited to, the following:

(i) Contractual arrangements with physicians or providers in which the physicians or providers agree to arrange, pay for or provide health care services for a fixed payment set and received in advance of health care services, sometimes referred to as capitation reimbursement arrangements.

(ii) Contractual arrangements with physicians or providers in which a type of financial incentive structure is employed which conditions the provider's payment for service, or a portion thereof, upon gains or losses experienced by an insurer or purchaser resulting from preferred provider arrangements or which allows a provider to share in the gains or losses, sometimes referred to as fee withholding risk pool arrangements.

(iii) Health benefit plans under which the reimbursement received by an enrollee for a health care service rendered by a nonpreferred provider is less than 80% of the payment which a preferred provider would receive from the preferred provider organization for the same health care service.

(iv) Health benefit plans under which an enrollee who receives a health care service from a nonpreferred provider is liable for payment of more than 20% of the payment which a preferred provider would receive from the preferred provider organization for the same health care service. For the purpose of calculating this percentage, cost-sharing amounts shall be excluded if

cost-sharing is applied by the preferred provider arrangement regardless of whether a health care service is rendered by a preferred or a nonpreferred provider.

(v) Health benefit plans under which coverage for health care services is provided only when the services are rendered by a preferred physician or provider participating in the preferred provider arrangement.

(2) In order to assure that the preferred provider organization is not utilizing arrangements or provisions which may lead to undertreatment or poor quality care, the Department of Health will determine the following:

(i) The preferred provider organization makes available to enrollees a sufficient number and range of providers by class, specialty and geographic service area to adequately serve enrollees and to provide them with adequate access to and availability of health care services covered under the preferred provider organization's benefit plan.

(ii) Adequate disclosure is made to enrollees regarding rights and responsibilities under the preferred provider organization's utilization review programs.

(iii) An adequate grievance system exists which permits enrollees to appeal utilization review decisions which result in denial of payment or denial of access to health care services or which concern alleged poor quality care or undertreatment by a preferred provider.

(iv) If the preferred provider organization chooses to establish selection criteria for provider participation in preferred provider arrangements, the criteria are appropriate and the preferred provider organization has systems to adequately verify that providers accepted for participation meet the selection criteria.

(v) An adequate peer review process exists to monitor factors affecting quality of care.

(vi) For capitated programs, the following quality assurance system standards shall be met:

(A) The system is under the active direction of a provider knowledgeable and experienced in assessing quality of care.

(B) The staffing of the quality assurance function is appropriate to the size and scope of operations of the preferred provider organization and the extent to which its economic incentives may lead to poor quality care.

(C) The quality assurance system actually assesses quality of care through usual and customary quality assurance techniques, such as performance of medical care evaluations and audits and medical record review.

(vii) The preferred provider organization has adequate capacity to remove from preferred provider status a provider found to be providing poor quality care.

(viii) The preferred provider organization has adequately identified and addressed the economic incentives of arrangements or provisions which may lead to undertreatment or poor quality care.

(b) Maintenance of a quality assurance system in accord with Department of Health standards does not require assumption of responsibility for or involvement in the medical treatment of an enrollee beyond that set forth in the contract between the preferred provider organization and the enrollee.

Cross References

This section cited in 31 Pa. Code § 152.3 (relating to content of an application for approval); and 31 Pa. Code § 152.5 (relating to review of application by the Secretary).

§ 152.5. Review of application by the Secretary.

(a) Upon receipt of a complete application for approval for operation as a risk-assuming preferred provider organization, the Secretary will review the submitted materials in accordance with § 152.4 (relating to scope of Department of Health review of a preferred provider organization).

(b) If the Secretary determines that the applicant meets the standards in § 152.4, the Secretary will notify the applicant and the Commissioner of the findings.

(c) If the Secretary determines that an applicant does not meet the standards in § 152.4, the Secretary will notify the applicant and the Commissioner of the disapproval and the reasons, in writing.

(d) Within 30 days from the date of mailing of a notice of disapproval to the preferred provider organization, the preferred provider organization may take written application to the Secretary for a hearing. The hearing shall be held within 30 days after receipt of the application. The procedure before the Secretary will be under the adjudication procedure in 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law). The preferred provider organization is entitled to judicial review as provided by statute.

Cross References

This section cited in 31 Pa. Code § 152.23 (relating to commencing operations).

§ 152.6. Provider contracts.

(a) Changes in standard form contracts with physicians or providers enabling a risk-assuming preferred provider organization to offer preferred provider arrangements shall be submitted to the Secretary within 10 days of implementation. The Secretary may review the provider contract changes to ascertain whether the changes may lead to undertreatment or poor quality health services.

(b) If the Secretary determines that the changes to the provider contract may lead to undertreatment or poor quality health services, the Secretary will notify

the risk-assuming preferred provider organization and the Commissioner of the disapproval and the reasons in writing.

(c) Within 30 days from the date of mailing of a notice of disapproval to the preferred provider organization, the preferred provider organization may make written application to the Secretary for a hearing. The hearing will be held within 30 days after receipt of the application. The procedure before the Secretary will be under adjudication procedure in 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law). The preferred provider organization is entitled to judicial review as provided by statute.

§ 152.7. Restricted benefit—limited purpose preferred provider organizations.

A risk-assuming preferred provider organization which limits its arrangements to only one class of preferred providers for the purpose of providing a limited scope or range of covered services to covered persons (for example, a dental benefits preferred provider organization or vision service benefits preferred provider organization) shall reflect the fact in the structure and function of its quality assurance system.

§ 152.8. Compliance with Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

If, in the review of the application of a risk-assuming preferred provider organization, the Secretary determines that the preferred provider organization is in fact engaging or proposing to engage in the business of a health maintenance organization as defined in the Health Maintenance Organization Act, the Secretary will so inform the applicant and the Commissioner and require the preferred provider organization to seek licensure as a health maintenance organization. In determining whether or not a risk-assuming preferred provider organization is doing the business of a health maintenance organization, the Department of Health will evaluate and consider the following:

(1) The type and amount of economic risk being assumed by preferred providers.

(2) The degree to which the delivery of health care is organized and managed by the preferred provider organization.

(3) The degree of freedom of provider choice offered to enrollees.

(4) The degree of contractual responsibility assumed by participating primary care physicians for the management of health care of enrollees.

(5) The degree to which preferred providers may share in the financial gains or losses arising from preferred provider arrangements.

(6) The extent to which the preferred provider organization provides basic health services as defined in the Health Maintenance Organization Act and 28 Pa. Code Chapter 9 (relating to health maintenance organizations).

(7) The extent to which the preferred provider organization combines the delivery and financing of health care.

(8) The extent to which the preferred provider organization agrees to provide, arrange for the provision of or pay for health services for a fixed pre-paid fee.

Cross References

This section cited in 31 Pa. Code § 152.103 (relating to HMO and PPO differentiation).

§ 152.9. Minimum capital and reserves.

(a) *General.* Unless the Commissioner determines that additional capital or reserves are required for the protection of policyholders, enrollees, creditors or the public, a risk-assuming preferred provider organization which is not a licensed insurer shall be deemed to have adequate working capital and reserves if its admitted assets exceed its liabilities by $50,000 in excess of the minimum capital and surplus required of a stock casualty insurer with accident and health powers at the time it commences operations, and if it thereafter maintains its admitted assets in excess of liabilities by at least the minimum capital and surplus required of a stock casualty insurer with accident and health powers.

(b) *Exemption.* If the risk-assuming preferred provider organization which is not a licensed insurer only provides or covers limited health care services (for example, dental or vision care services), or is only liable for incentive payments to providers or physicians, the Commissioner may exempt it from the requirements of subsection (a) and establish a lower capital and reserve requirement.

Cross References

This section cited in 31 Pa. Code § 152.11 (relating to review of application by the Commissioner).

§ 152.10. Qualification of officers and directors.

This section applies to risk-assuming preferred provider organizations which are not licensed insurers.

(1) The responsibility, character and general fitness for the preferred provider organization's operations of a person who is chosen, elected or appointed as an officer or director shall be such as to command the confidence of the public and warrant the belief that the preferred provider organization's operations will be honestly and efficiently conducted in accordance with the intent of section 630.

(2) If the Commissioner determines, after a proper investigation, that an officer or director of a preferred provider organization does not meet the qualifications stated in paragraph (1), the person shall cease serving as an officer or director, or both.

(3) The procedure before the Commissioner for the determination stated in paragraph (2) shall be under the adjudication procedure set forth in 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law). The officer or director is entitled to judicial review as provided by statute.

Cross References

This section cited in 31 Pa. Code § 152.11 (relating to review of application by the Commissioner).

§ 152.11. Review of application by the Commissioner.

(a) Upon receipt of a complete application for approval for operation as a risk-assuming preferred provider organization, the Commissioner will review the submitted materials to determine that the following exist:

(1) The applicant is a licensed insurer or has adequate working capital and reserves as defined in § 152.9 (relating to minimum capital and reserves).

(2) The applicant's enrollee literature adequately discloses provisions, limitations and conditions of benefits available.

(3) The applicant's policy forms provide for emergency services as described in § 152.15 (relating to emergency services).

(4) If the applicant is not a licensed insurer, that:

(i) Its preferred provider arrangements contain provisions to assure insolvency protection as described in § 152.14 (relating to insolvency protection).

(ii) Its policy forms provide for a preexisting condition limitation as described in § 152.16 (relating to preexisting condition limitation).

(iii) Its officers and directors meet the qualifications in § 152.10(a) (relating to qualification of officers and directors).

(b) Upon receipt of a complete application for approval by a preferred provider organization which does not assume financial risk, the Commissioner will review the submitted materials to determine that the applicant's enrollee literature adequately discloses provisions, limitations and conditions of benefits available.

(c) If the Commissioner finds that the applicant meets the applicable standards in subsection (a) or (b), the Commissioner will notify the applicant and the Secretary of the determination.

(d) If the Commissioner determines that an applicant does not meet the applicable standards in subsection (a) or (b), the Commissioner will notify the applicant of the disapproval, in writing, specifying the reason for the disapproval. Within 30 days from the date of mailing of the notice to the preferred provider organization, the preferred provider organization may make written application to the Commissioner for a hearing. The hearing will be held within 30 days after receipt of the application. The procedure before the Commissioner will be under the adjudication procedure in 2 Pa.C.S. §§ 501—508 and 701—704 (relating to

the Administrative Agency Law). The preferred provider organization is entitled to judicial review as provided by statute.

Cross References

This section cited in 31 Pa. Code § 152.22 (relating to fees); and 31 Pa. Code § 152.23 (relating to commencing operations).

§ 152.12. Provider organizations governed and regulated under ERISA.

A preferred provider organization which is governed and regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C.A. §§ 301—309 and 1001—1461) (ERISA) shall file a certificate to that effect with the Commissioner and, to the extent that it is regulated under ERISA, is not subject to other provisions of this chapter.

Cross References

This section cited in 31 Pa. Code § 152.3 (relating to content of an application for approval); and 31 Pa. Code § 153.3 (relating to simplified review of company merger, assumption or name change form and rate filings—statement of policy).

§ 152.13. Investments.

Investments by risk-assuming preferred provider organizations which are not licensed insurers shall be made under the statutes governing the investments of domestic life insurance companies. See The Insurance Company Law of 1921 (40 P. S. §§ 341—991).

§ 152.14. Insolvency protection.

Preferred provider arrangements with providers or physicians, or both, shall contain provisions to assure, in the event of an insolvency, that the enrollees of a risk-assuming preferred provider organization which is not a licensed insurer are not held liable for expenses which were to have been assumed by the preferred provider organization.

Cross References

This section cited in 31 Pa. Code § 152.11 (relating to review of application by the Commissioner).

§ 152.15. Emergency services.

If an enrollee requires emergency health care services, and cannot reasonably be attended to by a preferred provider or physician, the preferred provider arrangement shall pay for the emergency health care services so that the enrollee is not liable for a greater out-of-pocket expense than if the enrollee were attended to by a preferred provider or physician.

Cross References

This section cited in 31 Pa. Code § 152.11 (relating to review of application by the Commissioner).

§ 152.16. Preexisting condition limitation.

A risk-assuming preferred provider organization which is not a licensed insurer may not use a policy or contract which contains a preexisting condition limitation which is more restrictive than the following: a preexisting condition is a disease or physical condition for which medical advice or treatment has been received within 90 days immediately prior to becoming covered under the preferred provider arrangement. The condition is covered after the individual has been covered for more than 12 months under the group contract.

Cross References

This section cited in 31 Pa. Code § 152.11 (relating to review of application by the Commissioner).

§ 152.17. Approval of enrollee literature after commencement of operations.

(a) Except for enrollee literature which has been reviewed and approved as part of its application for approval, no enrollee literature may be used by a preferred provider organization until the forms of the literature have been submitted to and formally approved by the Commissioner.

(b) Forms of enrollee literature will be deemed approved at the expiration of 60 days after filing, unless earlier approved or disapproved by the Commissioner. The approval becomes void upon subsequent notice of disapproval from the Commissioner.

(c) If the Commissioner determines that the literature does not adequately disclose the provisions, limitations and conditions of benefits available to enrollees, the Commissioner will notify the preferred provider organization, in writing, of the objections.

(d) Upon disapproval, the Commissioner will notify the preferred provider organization and the Secretary, in writing, specifying the reason for the disapproval. Within 30 days from the date of mailing of the notice to the preferred provider organization, the preferred provider organization may make written application to the Commissioner for a hearing. The hearing shall be held within 30 days after receipt of the application. The procedure before the Commissioner will be under the adjudication procedure in 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law). The preferred provider organization is entitled to judicial review as provided by statute.

§ 152.18. Policy review after commencement of operations.

(a) Except for policies which have been reviewed and approved as part of its application for approval, no policies, contracts or agreements between a risk-assuming preferred provider organization which is not a licensed insurer and its insureds may be used until the policies, contracts or agreements have been submitted to and formally approved by the Commissioner.

(b) Forms of policies will be deemed approved at the expiration of 60 days after filing, unless approved or disapproved earlier by the Commissioner. The approval becomes void until subsequent notice of disapproval from the Commissioner.

(c) Upon disapproval, the Commissioner will notify the preferred provider organization, in writing, specifying the reason for the disapproval. Within 30 days from the date of mailing of the notice to the preferred provider organization, the preferred provider organization may make written application to the Commissioner for a hearing. The hearing will be held within 30 days after receipt of the application. The procedure before the Commissioner will be under the adjudication procedure in 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law). The preferred provider organization is entitled to judicial review as provided by statute.

Cross References

This section cited in 31 Pa. Code § 153.3 (relating to simplified review of company merger, assumption or name change form and rate filings—statement of policy).

§ 152.19. Annual reporting requirements.

An approved risk-assuming preferred provider organization shall file with the Secretary and the Commissioner on or before March 31 of each year an annual report of its activities during the prior calendar year. Annual reports include:

(1) A copy of the annual financial statement required by § 152.21 (relating to financial statements and examinations).

(2) A description of results in its quality assurance activities undertaken during the year.

(3) A summary of the number of covered persons in the preferred provider organization.

(4) A summary of total number of grievances handled, a compilation of causes underlying the grievances and the resolution of grievances.

(5) A summary of utilization experience of the preferred provider organization.

§ 152.20. Investigations.

(a) The Commissioner and the Secretary may investigate a preferred provider organization in order to determine whether it is complying with this chapter.

(b) The Commissioner, the Secretary and their deputies, agents and examiners will have free access to the books, records, papers and documents of a preferred provider organization.

§ 152.21. Financial statements and examinations.

A risk-assuming preferred provider organization which is not a licensed insurer shall be governed by the statutes and regulations applicable to the filing and preparation of financial statements and the frequency and conduct of examinations by the Commissioner and deputies which apply to licensed domestic insurers, including adherence to statutory accounting practices and establishing reserves on a sound actuarial basis.

Cross References

This section cited in 31 Pa. Code § 152.19 (relating to annual reporting requirements); and 31 Pa. Code § 152.22 (relating to fees).

§ 152.22. Fees.

This section applies to a risk-assuming preferred provider organization which is not a licensed insurer.

(1) If an investigation or examination is undertaken under §§ 152.11 (relating to review of application by the Commissioner) or 152.21 (relating to financial statements and examinations), the preferred provider organization will be assessed the expenses incurred by the Department, including compensation of Department employes or consultants acting on behalf of the Department, and expenses of the persons for travel, lodging and food. The amounts shall be assessed under 4 Pa. Code Chapter 40 (relating to travel and subsistence).

(2) Fees assessed under this section are assessed and billed to preferred provider organizations under established Department procedures and this title.

§ 152.23. Commencing operations.

A preferred provider organization may not commence operations until one of the following occurs:

(1) The Commissioner approves its application under § 152.11 (relating to review of application by the Commissioner) and, if a risk-assuming preferred provider organization, the Secretary approves its application under § 152.5 (relating to review of application by the Secretary).

(2) The Commissioner determines that it is governed by and regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C.A. §§ 301—309 and 1001—1461) and it has filed a certificate to that effect with the Commissioner.

(3) The preferred provider organization has complied with the filing requirements of this chapter and 60 days have elapsed without the issuance of a disapproval or notice of deficiencies from the Commissioner or the Secretary.

§ 152.24. Cease and desist orders and orders to cease operations.

(a) A cease and desist order or an order to cease all or a part of the operations of a preferred provider organization, or both, may be issued if the preferred provider organization violates this chapter.

(b) Before the Commissioner or the Secretary, whichever is appropriate, will take an action under subsection (a), written notice will be given to the preferred provider organization stating specifically the nature of the alleged violation and fixing a time and place, at least 10 days thereafter, when a hearing on the matter will be held. Hearing procedure and appeals from decisions of the Commissioner or Secretary will be provided under 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law).

§ 152.25. Application of insurance laws to preferred provider organizations and their agents.

(a) A preferred provider organization which is a licensed insurer, and its agents, remain subject to statutes, rules and regulations which apply to licensed insurers and their agents in this Commonwealth.

(b) A risk-assuming preferred provider organization which is not a licensed insurer is subject to the following statutes and regulations promulgated thereunder:

(1) Article V of The Insurance Department Act of one thousand nine hundred and twenty-one (40 P. S. §§ 221.1—221.63).

(2) The Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15).

(3) The act of August 1, 1975 (P. L. 157, No. 81) (40 P. S. §§ 771—774).

(4) Article VI-A of the act (40 P. S. §§ 908-1—908-8).

(5) Section 621.2(a)(6) and (d) of the act of May 17, 1921 (P. L. 682, No. 284) (40 P. S. § 756.2(a)(6) and (d)).

(6) The act of December 23, 1981 (P. L. 583, No. 168) (40 P. S. §§ 3001—3003).

(7) The act of December 27, 1965 (P. L. 1247, No. 506) (40 P. S. §§ 1501—1503).

(8) The act of April 18, 1978 (P. L. 33, No. 16) (40 P. S. §§ 767—769).

(c) Agents for risk-assuming preferred provider organizations which are not licensed insurers will be licensed as accident and health insurance agents and subject to statutes, rules and regulations applicable to insurance agents.

PRIMARY CARE GATEKEEPER PPO PRODUCTS—STATEMENT OF POLICY

§ 152.101. Scope.

A PPO product filing by an approved PPO complying with this chapter is acceptable. A preferred provider agreement filing by a nonprofit hospital corpo-

ration or a nonprofit professional health service plan corporation, or both, otherwise complying with 40 Pa.C.S. Chapter 61 or 63, or both (relating to rules of evidence; juvenile matters) and complying with this chapter is acceptable.

Source

The provisions of this § 152.101 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

Cross References

This section cited in 31 Pa. Code § 152.102 (relating to definitions).

§ 152.102. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

ERISA-exempt PPO—A PPO which, in accordance with § 152.3(d) (relating to content of an application for approval), has submitted and received joint Department and Department of Health approval of an ERISA-exemption certificate.

Gatekeeper product—A product offered by a PPO which requires an enrollee to preselect a particular primary care physician from among a list of participating primary care physicians, and to receive from the physician, as a condition for receipt of a higher level of benefits or reimbursement level, or both, referrals for nonemergency specialty, hospital and other services.

HMO—Health maintenance organization.

PPO—Preferred provider organization.

Passive gatekeeper product—A product offered by a PPO which does not require an enrollee to preselect a particular primary care physician, but requires, as a condition for receipt of a higher level of benefits or reimbursement level, or both, that an enrollee receive care from or a referral from a participating preferred primary care physician. The products are permissible if their restrictions are adequately disclosed to enrollees and receive appropriate approval of the Department. However, since they do not lock enrollees into use of a particular primary care physician, they are not subject to §§ 152.101, 152.103—152.105 and this section (relating to primary care gatekeeper PPO products—statement of policy).

Source

The provisions of this § 152.102 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

Cross References

This section cited in 28 Pa. Code § 9.502 (relating to definitions).

§ 152.103. HMO and PPO differentiation.

(a) *General*. Under the time provisions of § 152.8 (relating to compliance with Health Maintenance Organization Act (40 P. S. §§ 1551—1567)), the Secretary of Health will determine when a PPO is engaging in the business of an HMO and required to seek licensure as such. The use of a primary care gatekeeper is a feature associated with HMOs, and is a required feature, under Department of Health HMO regulations at 28 Pa. Code Chapter 9 (relating to health maintenance organizations) of licensed HMOs. A PPO using a primary care gatekeeper feature, otherwise meeting the standards of this chapter, will not be considered an HMO by the Secretary or be required to obtain an HMO certificate of authority prior to commencement of operations if it meets the following standards:

(1) Preferred primary care physicians are reimbursed solely on a fee-for-service basis.

(2) Preferred primary care physicians are not at financial risk for the provision for health service utilization to enrollees through use of risk incentive withhold pools or other means of financial reward for utilization control.

(3) The PPO is not an exclusive provider organization.

(b) *Exception.* A PPO will be permitted to utilize primary care gatekeepers which are capitated or at financial risk, or both, if the primary care gatekeeper services are being offered under a subcontract between the PPO and an affiliated licensed HMO, if:

(1) The provisions of the subcontract are acceptable to the Departments and the Department of Health.

(2) The HMO's quality assurance systems, and similar consumer protection measures are extended to the PPO enrollees in a manner found acceptable by the Department of Health.

Source

The provisions of this § 152.103 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

Cross References

This section cited in 31 Pa. Code § 152.102 (relating to definitions).

§ 152.104. Filing requirements.

(a) A PPO desiring to offer a gatekeeper product shall submit a formal product filing to the Division of HMOs/PPOs of the Department and the Bureau of Health Financing and Program Development of the Department of Health. Two copies shall be filed with each Department and shall include:

(1) The group master policy, certificate and enrollee literature. Adequate primary care benefits shall be provided when an enrollee seeks care from the

enrollee's primary care physician. Copayments may not be so high as to act as a barrier to an enrollee's use of the primary care physician.

(2) Initial rates and rating methodology.

(3) Copies of preferred provider contracts, which should contain features required by the Department of Health in HMO contracts, including:

(i) NAIC/National Association of HMO Regulators enrollee hold harmless language.

(ii) A provision for a preferred provider to participate in activities of and abide by the decisions of the PPO's quality assurance and utilization review committee.

(iii) A provision for a preferred provider to cooperate with and abide by the decisions of the PPO's enrollee grievance system.

(iv) A provision for the preferred provider to abide by PPO rules and regulations for preferred providers, including those regarding hospital privileges, credentialing, in-office reviews and similar rules.

(v) A provision for the provider to provide the PPO and the Department of Health with access to enrollee medical records for the purposes of quality oversight and grievance resolution.

(vi) A provision for immediate termination of participation and preferred status if the provider is found to be harming patients.

(4) Provisions of the proposed quality assurance and utilization review systems, including staffing and professional qualifications of the medical director, quality assurance, utilization review and provider relations staff.

(5) A description of the proposed grievance system.

(6) A description of the PPO's ability to collect data and meet the annual and quarterly reporting requirements of the Department of Health.

(7) A copy of a notice form to be used when an enrollee seeks care without first obtaining a referral from the enrollee's primary care physician, adequately disclosing the benefit or reimbursement advantages, or both, of seeking care by or through the enrollee's primary care physician.

(b) As is the usual and customary practice of the Department and the Department of Health, the filing will be approved by joint approval letter, and no final approval action will be taken by either Department until both Departments complete their review and find the application to be acceptable.

Source

The provisions of this § 152.104 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

Cross References

This section cited in 31 Pa. Code § 152.104 (relating to definitions).

§ 152.105. Delivery system and quality of care oversight.

(a) The use of a gatekeeper product by a PPO restricts enrollee freedom of provider choice and is an arrangement which may lead to undertreatment or poor quality care, since enrollee access to specialty and other needed care is restricted. Gatekeeper PPOs, in order to adequately address the issue of potential undertreatment or poor quality care and to protect their enrollees, and in return for the privilege of being permitted use of gatekeepers, shall:

(1) Establish and maintain compliance with the same Department of Health standards regarding quality of care oversight as required of HMOs in 28 Pa. Code §§ 9.74, 9.75 and 9.93 (Reserved).

(2) Establish and maintain compliance with the same Department of Health standards regarding enrollee grievance systems as required of HMOs in 28 Pa. Code § 9.73 (Reserved).

(3) Establish and maintain data systems capable of making quarterly and annual reports to the Departments substantially equivalent to those required of HMOs as found in 28 Pa. Code §§ 9.91 and 9.92 (Reserved).

(4) Submit and receive prior approval from the Department and the Department of Health of advertising, marketing and enrollee literature which adequately explains the role of the primary care gatekeeper and the limitations of coverage.

(5) Submit evidence of compliance with the Department of Health's accessibility and availability standards equal to these established for HMOs, and evidence of sufficient trained and experienced staff to monitor and control the delivery system on an appropriate local or regional basis.

(b) In applying the HMO standards to gatekeeper PPOs, the Department of Health may take into consideration the fact that HMOs are independent entities while PPOs may be product lines of insurers.

Source

The provisions of this § 152.105 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

Cross References

This section cited in 31 Pa. Code § 152.102 (relating to definitions).

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