No. 2008-62

AN ACT

HB 1150

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in preliminary provisions, further providing for effect of act on existing laws; in life insurance, further providing for additional investment authority for subsidiaries; in casualty insurance, providing for autism spectrum disorders coverage and for colorectal cancer screenings coverage; in insurance holding companies, further providing for definitions, for acquisition of control of or merger with domestic insurer, for acquisitions involving insurers not otherwise covered and for standards and management of an insurer within a holding company system; providing for committee review; establishing the Insurance Restructuring Restricted Receipt Account; providing for community health reinvestment; and making a related repeal.

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

Section 1. Section 108 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

Section 108. Effect of Act on Existing Laws.—The provisions of this act, so far as they are the same as those of existing laws, shall be construed as a continuation of such laws and not as new enactments. The repeal by this act of any provision of law shall not revive any law heretofore repealed or superseded, nor shall such repeal affect any act done, liability incurred, or any right accrued or vested, or any suit or prosecution pending or to be instituted to enforce any right or penalty or punish any offense under the authority of the repealed laws. ***The provisions of this act shall not limit the jurisdiction and authority of the Office of Attorney General, including, but not limited to, the jurisdiction and authority granted pursuant to the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."***

Section 2. Section 405.2(c) of the act, amended December 21, 1995 (P.L.714, No.79), is amended to read:

Section 405.2. Additional Investment Authority for Subsidiaries.—* * *

(c) (1) **[At]** ***Except as set forth in paragraph (1.1), at*** no time shall a domestic life insurance company make an investment in any subsidiary which will bring the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) of its total

admitted assets as of the immediately preceding thirty-first day of December. In determining the amount of investments of any domestic life insurance company in subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose.

(1.1) A domestic life insurance company may increase the aggregate value of its investments, as determined for annual statement purposes, but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) but at no time in excess of fifteen per centum (15%) of its total admitted assets as of the immediately preceding thirty-first day of December if the increase has been approved in writing by the Insurance Department prior to making the investment. If the Insurance Department does not approve or disapprove the increased investment within thirty (30) days of receipt of a request for approval, the increased investment shall be deemed approved. In determining the amount of investments of any domestic life insurance company in subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose.

(2) The limitations set forth in **[clause (1)]** ***clauses (1) and (1.1)*** of this subsection shall not apply to investments in any subsidiary which is:

(i) An insurance company or a health maintenance organization holding a certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(ii) A holding company to the extent its business consists of the holding of the stock of, or otherwise controlling, its own subsidiaries.

(iii) A corporation whose business primarily consists of direct or indirect ownership, operation or management of assets authorized as investments pursuant to sections 404.1 and 406.

(iv) A company engaged in any combination of the activities described in subclauses (i), (ii) and (iii) of this clause. Investments made pursuant to subclause (i) shall not be restricted in amount provided that after such investment, as calculated for NAIC annual statement purposes, the insurer's surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. Investments made pursuant to subclause (ii), or to the extent applicable in this subclause, shall in addition not be subject to any limitations on the amount of a domestic life insurance company's assets provided for under any other provision of this act and which might otherwise be applicable: Provided, however, That such life insurance company's investments, to the extent that such life insurance company provided the funds therefor, in each of the subsidiaries of such holding company shall be subject to the limitations, if any, applicable to such investment as if the holding company's interest in each such subsidiary were

instead owned directly by the life insurance company. Investments made pursuant to subclause (iii), or, to the extent applicable, this clause, shall be counted in determining the limitations contained in applicable subsections of sections 404.2 and 406: Provided, however, That the value as calculated for annual statement purposes, but not in excess of the cost thereof, of such investment shall include only funds provided by the insurance company therefor. Investments made in other subsidiaries of such life insurance company by any subsidiary described in subclauses (i), (ii), (iii) and this subclause or by a person whose business primarily consists of direct or indirect ownership, operation or management of real property and interest therein under section 406 shall be deemed investments made by the insurance company only to the extent the funds for such investment were provided by such insurance company.

* * *

Section 3. The act is amended by adding sections to read:

Section 635.2. Autism Spectrum Disorders Coverage.—(a) A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders.

(b) Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars ($36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. After December 30, 2011, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Pennsylvania Bulletin an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U) in the preceding year, and the published adjusted maximum benefit shall be applicable to the following calendar years to health insurance policies issued or renewed in those calendar years. Payments made by an insurer on behalf of a covered individual for treatment of a health condition unrelated to or distinguishable from the individual's autism spectrum disorder shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this section shall be subject to copayment, deductible and coinsurance provisions and any other general exclusions or limitations of a health insurance policy or government program to the same extent as other medical services covered by the policy or program are subject to these provisions.

(d) This section shall not be construed as limiting benefits which are otherwise available to an individual under a health insurance policy or government program.

(d.1) This section shall not be construed as requiring coverage by insurers of any service based solely on its inclusion in an individualized

education program. Consistent with Federal or State law and upon consent of the parent or guardian of the covered individual, the treatment of autism spectrum disorders may be coordinated with any service included in an individualized education program. Coverage for the treatment of autism spectrum disorders shall not be contingent upon a coordination of services with an individualized education program.

(e) (1) This section shall apply to any health insurance policy offered, issued or renewed on or after July 1, 2009, in this Commonwealth to groups of fifty-one (51) or more employees: Provided, That this section shall not include the following policies:

(i) Accident only.

(ii) Fixed indemnity.

(iii) Limited benefit.

(iv) Credit.

(v) Dental.

(vi) Vision.

(vii) Specified disease.

(viii) Medicare supplement.

(ix) CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) supplement.

(x) Long-term care or disability income.

(xi) Workers' compensation.

(xii) Automobile medical payment.

(2) This section shall apply to any contract executed on or after July 1, 2009, by the adult basic coverage insurance program established under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the "Tobacco Settlement Act," or by the Children's Health Care Program established under this act, or by any successor program of either of them.

(3) On January 1, 2011, insurers shall make a report to the Insurance Department, in a form and manner as determined by the department, to evaluate the implementation of this section.

(f) As used in this section:

(1) "Applied behavioral analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(2) "Autism service provider" means any of the following:

(i) A person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in this Commonwealth.

(ii) Any person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the

Commonwealth's medical assistance program on or before the effective date of this section.

(3) "Autism spectrum disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

(4) "Behavior specialist" means an individual who designs, implements or evaluates a behavior modification intervention component of a treatment plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

(5) "Diagnostic assessment of autism spectrum disorders" means medically necessary assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

(6) "Government program" means any of the following:

(i) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

(ii) The adult basic coverage insurance program established under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the "Tobacco Settlement Act."

(iii) The Children's Health Care Program established under this act.

(7) "Health insurance policy" means any group health, sickness or accident policy, or subscriber contract or certificate offered, issued or renewed by an entity subject to one of the following:

(i) This act.

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

(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(8) "Insurer" means any entity offering a health insurance policy as defined in this section.

(9) "Pharmacy care" means medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications.

(10) "Psychiatric care" means direct or consultative services provided by a physician who specializes in psychiatry.

(11) "Psychological care" means direct or consultative services provided by a psychologist.

(12) "Rehabilitative care" means professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

(13) "Therapeutic care" means services provided by speech language pathologists, occupational therapists or physical therapists.

(14) "Treatment of autism spectrum disorders" shall be identified in a treatment plan and shall include any of the following medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care and therapeutic care that is:

(i) Prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner.

(ii) Provided by an autism service provider.

(iii) Provided by a person, entity or group that works under the direction of an autism service provider.

(15) "Treatment plan" means a plan for the treatment of autism spectrum disorders developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

(g) (1) The State Board of Medicine, in consultation with the Department of Public Welfare, shall promulgate regulations providing for the licensure or certification of behavior specialists. Behavior specialists licensed or certified by the State Board of Medicine shall be subject to all disciplinary provisions applicable to medical doctors as set forth in the act of December 20, 1985 (P.L.457, No.112), known as the "Medical Practice Act of 1985." The State Board of Medicine may charge reasonable fees as set by board regulation for licensure or certificates or applications permitted by the "Medical Practice Act of 1985."

(2) An applicant applying for a license or certificate as a behavior specialist shall submit a written application on forms provided by the State Board of Medicine evidencing and insuring to the satisfaction of the board that the applicant:

(i) Is of good moral character.

(ii) Has received a master's or higher degree from a board-approved, accredited college or university, including a major course of study in school, clinical or counseling psychology, special education, social work, speech therapy, occupational therapy or another related field.

(iii) Has at least one year of experience involving functional behavior assessments, including the development and implementation of behavioral supports or treatment plans.

(iv) Has completed at least one thousand (1,000) hours in direct clinical experience with individuals with behavioral challenges or at least one thousand (1,000) hours' experience in a related field with individuals with autism spectrum disorders.

(v) Has completed relevant training programs, including professional ethics, autism-specific training, assessments training, instructional strategies and best practices, crisis intervention, comorbidity and medications, family collaboration and addressing specific skill deficits training.

(3) The board shall not issue a license or certificate to an applicant who has been convicted of a felony under the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act," or if an offense under the laws of another jurisdiction which, if committed in this Commonwealth, would be a felony under "The Controlled Substance, Drug, Device and Cosmetic Act," unless:

(i) At least ten (10) years have elapsed from the date of conviction.

(ii) The applicant satisfactorily demonstrates to the board that he has made significant progress in personal rehabilitation since the conviction such that licensure of the applicant should not be expected to create a substantial risk of harm to the health and safety of his patients or the public or a substantial risk of further criminal violations.

(iii) The applicant otherwise satisfies the qualifications contained in or authorized by this section.

As used in this paragraph, the term "convicted" shall include a judgment, an admission of guilt or a plea of nolo contendere.

(h) An insurer shall be required to contract with and to accept as a participating provider any autism service provider within its service area and enrolled in the Commonwealth's medical assistance program who agrees to accept the payment levels, terms and conditions applicable to the insurer's other participating providers for such service.

(i) An insurer may review a treatment plan for treatment of autism spectrum disorders once every six (6) months, subject to its utilization review requirements, including case management, concurrent review and other managed care provisions. A more or less frequent review can be agreed upon by the insurer and the licensed physician or licensed psychologist developing the treatment plan.

(j) For purposes of this section, the results of a diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than twelve (12) months unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.

(k) (1) Upon denial or partial denial by an insurer of a claim for diagnostic assessment of autism spectrum disorders or a claim for treatment of autism spectrum disorders, a covered individual or an authorized representative shall be entitled to an expedited internal review process pursuant to the procedures set forth in Article XXI, followed by an

expedited independent external review process established and administered by the Insurance Department.

(2) An insurer or covered individual or an authorized representative may appeal to a court of competent jurisdiction an order of an expedited independent external review disapproving a denial or partial denial. Pending a ruling of such court, the insurer shall pay for those services, if any, that have been authorized or ordered until such ruling.

(3) The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this subsection.

(l) For purposes of this section, the term "autism service provider" shall include any behavior specialist in this Commonwealth providing treatment of autism spectrum disorders pursuant to a treatment plan until one (1) year from the time that regulations under subsection (g) are promulgated or until three (3) years from the effective date of this section, whichever is later.

Section 635.3. Coverage for Colorectal Cancer Screening.—(a) Except to the extent already covered under another policy, all health insurance policies as defined in this section shall also provide coverage for colorectal cancer screening for covered individuals in accordance with American Cancer Society guidelines for colorectal cancer screening published as of January 1, 2008, and consistent with approved medical standards and practices.

(1) Coverage for nonsymptomatic covered individuals who are fifty (50) years of age or older shall include, but not be limited to:

(i) An annual fecal occult blood test.

(ii) A sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years.

(iii) A colonoscopy at least once every ten (10) years.

(2) Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating physician.

(3) Coverage for nonsymptomatic covered individuals who are at high or increased risk for colorectal cancer who are under fifty (50) years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008.

(b) The coverage required under this section shall be subject to annual deductibles, coinsurance and copayment requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(c) For the purpose of this section:

(1) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate offered to groups of

fifty-one (51) or more employes issued by an entity subject to any one of the following:

(i) This act.

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

(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

(2) "Colonoscopy" means an examination of the rectum and the entire colon using a lighted instrument called a colonoscope.

(3) "Colorectal cancer screening" means any of the following procedures that are furnished to an individual for the purpose of early detection of colorectal cancer:

(i) Screening fecal-occult blood or fecal immunochemical test.

(ii) Screening flexible sigmoidoscopy.

(iii) Screening colonoscopy.

(iv) Screening barium enema.

(v) Screening test consistent with approved medical standards and practices to detect colon cancer.

(4) "Nonsymptomatic person at high or increased risk" means an individual who poses a higher than average risk for colorectal cancer according to the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

(5) "Symptomatic person" means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

Section 4. The introductory paragraph and the definitions of "insurer" and "person" in section 1401 of the act, amended December 20, 2000 (P.L.967, No.132), are amended and the section is amended by adding a definition to read:

Section 1401. Definitions.—As used in this article, *and for the purposes of this article only,* the following words and phrases shall have the meanings given to them in this section:

* * *

"Insurer." Any health maintenance organization, preferred provider organization, company, association [or], exchange, *hospital plan corporation as defined in and subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations),* authorized by the Insurance Commissioner to

transact the business of insurance in this Commonwealth except that the term shall not include:

(1) the Commonwealth or any agency or instrumentality thereof;

(2) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision; ***or***

(3) fraternal benefit societies**[; or**

(4) nonprofit medical and hospital service associations].

* * *

"Person." An individual, ***an insurer,*** a corporation, a partnership, a limited liability company, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert. The term shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

* * *

"Shareholder." A record holder or record owner of shares of an insurer.

(1) The term shall include all of the following:

(i) A member of an insurer that is a domestic nonstock corporation under 15 Pa.C.S. Ch. 21 (relating to nonstock corporations) or a prior statute.

(ii) A member, as defined in 15 Pa.C.S. § 5103 (relating to definitions), of an insurer that is a domestic nonprofit corporation under 15 Pa.C.S. Ch. 51 (relating to general provisions) or a prior statute.

(iii) A subscriber of an insurer that is a domestic reciprocal exchange under Article X or a prior statute.

(2) The term shall not include any subscriber, insured or customer of:

(i) a hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or

(ii) a professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

* * *

Section 5. Section 1402 of the act, amended or added December 18, 1992 (P.L.1519, No.178) and December 21, 1998 (P.L.1108, No.150), is amended to read:

Section 1402. Acquisition of Control of or Merger ***or Consolidation*** with Domestic Insurer.—(a) (1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would directly or indirectly or by conversion or by exercise of any right to acquire, be in control of such insurer, and no person shall enter into an agreement to merge ***or consolidate*** with or otherwise to acquire control of a domestic insurer or any person

controlling a domestic insurer unless, at the time any such offer, request or invitation is made or any such agreement is entered into or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the department and has sent to such insurer a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the department in the manner hereinafter prescribed.

(2) For purposes of this section, a "domestic insurer" shall include any person controlling a domestic insurer unless such person as determined by the department is either directly or through its affiliates primarily engaged in business other than the business of insurance. Such person shall, however, file a preacquisition notification with the department containing the information set forth in section 1403(c)(2) thirty (30) days prior to the proposed effective date of the acquisition. Failure to file is subject to section 1403(e)(3). For purposes of this section, "person" shall not include any securities broker holding, in the usual and customary manner, less than twenty per centum (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

(b) The statement to be filed with the department under this section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger, ***consolidation*** or other acquisition of control referred to in subsection (a) is to be effected, hereinafter called "acquiring party," and

(i) if such person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years; or

(ii) if such person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to those positions. This list shall include for each individual the information required by subparagraph (i).

(2) The source, nature and amount of the consideration used or to be used in effecting the merger, ***consolidation*** or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection (a) which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (a), and a statement as to the method by which the fairness of the proposal was arrived.

(6) The amount of each class of any security referred to in subsection (a) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (a) in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection (a) during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid therefor.

(9) A description of any recommendations to purchase any security referred to in subsection (a) made during the twelve calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in subsection (a) and, if distributed, of additional soliciting material relating thereto.

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(12) Such additional information as the department may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(c) If the person required to file the statement referred to in subsection (a) is a partnership, limited partnership, syndicate or other group, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection (a) is a corporation, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to such corporation, each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten per centum (10%) of the outstanding voting securities of such corporation.

(d) If any material change occurs in the facts set forth in the statement filed with the department and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the department and sent to such insurer within two (2) business days after the person learns of such change.

(e) If any offer, request, invitation, agreement or acquisition referred to in subsection (a) is proposed to be made by means of a registration statement under the Securities Act of 1933 (48 Stat. 74, 15 U.S.C. § 77a et seq.), or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 (48 Stat. 881, 15 U.S.C. § 78a et seq.), or under a State law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) may utilize such documents in furnishing the information called for by that statement.

(f) (1) The department shall approve any merger, ***consolidation*** or other acquisition of control referred to in subsection (a) unless it finds any of the following:

(i) After the **[change]** ***merger, consolidation or other acquisition*** of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.

(ii) The effect of the merger, ***consolidation*** or other acquisition of control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:

(A) the informational requirements of section 1403(c)(2) and the standards of section 1403(d)(2) shall apply;

(B) the merger, ***consolidation*** or other acquisition ***of control*** shall not be disapproved if the department finds that any of the situations meeting the criteria provided by section 1403(d)(3) exist; and

(C) the department may condition the approval of the merger, ***consolidation*** or other acquisition ***of control*** on the removal of the basis of disapproval within a specified period of time.

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable **[to policyholders of the insurer and not in the public interest.]** ***and fail to confer benefit on policyholders of the insurer and are not in the public interest.***

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger, ***consolidation*** or other acquisition of control.

(vi) The **[acquisition]** ***merger, consolidation or other acquisition of control*** is likely to be hazardous or prejudicial to the insurance buying public.

(vii) The merger, ***consolidation*** or other acquisition of control is not in compliance with the laws of this Commonwealth, including Article VIII-A.

(2) If the merger, ***consolidation*** or other acquisition of control is approved, the department shall so notify the person filing the statement and the insurer **[whose stock]** ***that*** is proposed to be acquired, and such a determination is hereafter referred to as an approving determination. Notice shall also be given by the department of any determination which is not an approving determination. If an approving determination is made by the department and not otherwise, the proposed offer and acquisition may thereafter be made and consummated on the terms and conditions and in the manner described in the statement and subject to such conditions as may be prescribed by the department as hereinafter provided. An approving determination by the department shall be deemed to extend to offers or acquisitions made pursuant thereto within one year following the date of determination. The department may, as a condition of its approving determination, require the inclusion in any offer of provisions requiring the offer to remain open a specified minimum length of time, permitting withdrawal of shares deposited prior to the time the offeror becomes bound to consummate the acquisition and requiring pro rata acceptance of any shares deposited pursuant to the offer. The department shall hold a hearing before making the determination required by this subsection if, within ten (10) days following the filing with the department of the statement, written request for the holding of such hearing is made either by the person

proposing to make the acquisition, by the insurer **[whose stock]** ***that*** is proposed to be acquired or, if **[such]** ***the*** issuer ***of stock proposed to be acquired*** is not an insurer, by the **[insurance company]** ***insurer*** controlled by such issuer. Otherwise, the department shall determine in its discretion whether such a hearing shall be held. Thirty (30) days' notice of any such hearing shall be given to the person proposing to make the acquisition, to the issuer whose stock is proposed to be acquired and, if such issuer is not an insurer, to the insurance company controlled by such issuer. Notice of any such hearing shall also be given to such other persons, if any, as the department may determine.

(3) The department may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the proposed acquisition of control.

(g) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the department by order shall exempt therefrom as:

(1) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

(2) as otherwise not comprehended within the purposes of this section.

(h) The following shall constitute a violation of this section:

(1) the failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b);

(2) the effectuation or any attempt to effectuate an acquisition of control of or merger ***or consolidation*** with a domestic insurer unless the department has given its approval thereto; or

(3) a violation of section 819-A.

(i) The department shall, within seventy-two (72) hours of receiving a statement filed under this section, provide notification to the Office of Attorney General that the filing was received.

(j) As used in this section, the term "annual statement" shall mean the annual report of the financial condition required to be filed under 40 Pa.C.S. § 6331 (relating to reports and examinations).

Section 6. Section 1403(a), (b) and (d), added December 18, 1992 (P.L.1519, No.178), are amended to read:

Section 1403. Acquisitions Involving Insurers not Otherwise Covered.—(a) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Acquisition." Any agreement, arrangement or activity the consummation of which results in a person acquiring, directly or indirectly, the control of another person and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance **[and]**, mergers ***and consolidations***.

"Involved insurer." Includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger ***or consolidation***.

(b) (1) Except as exempted in paragraph (2), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this Commonwealth.

(2) This section shall not apply to any of the following:

(i) An acquisition subject to approval or disapproval by the department pursuant to section 1402.

(ii) A purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this Commonwealth. If a purchase of securities results in a presumption of control as described in the definition of "control" in section **[1301]** ***1401***, it is not solely for investment purposes unless the insurance department of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary insurance department to the Insurance Department of the Commonwealth.

(iii) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the department in accordance with subsection (c)(2) thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by this paragraph.

(iv) The acquisition of already affiliated persons.

(v) An acquisition if, as an immediate result of the acquisition:

(A) in no market would the combined market share of the involved insurers exceed five per centum (5%) of the total market;

(B) there would be no increase in any market share; or

(C) in no market would:

(I) the combined market share of the involved insurers exceeds twelve per centum (12%) of the total market; and

(II) the market share increases by more than two per centum (2%) of the total market.

For the purpose of this subparagraph, a market means direct written insurance premium in this Commonwealth for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this Commonwealth.

(vi) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business.

(vii) An acquisition of an insurer whose domiciliary insurance department affirmatively finds that such insurer is in failing condition; there is a lack of

feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary insurance department to the Insurance Department of the Commonwealth.

(3) Sections 1409(b) and (c) and 1411 shall not apply to acquisitions provided for in this subsection.

* * *

(d) (1) The department may enter an order under subsection (e)(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this Commonwealth or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c).

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1), the department shall consider the following:

(i) Any acquisition covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards as follows:

(A) if the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more; or

(B) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more.

A highly concentrated market is one in which the share of the four largest insurers is seventy-five per centum (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in paragraph (1). For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven per centum (7%) or more of the market over a period of time extending from any base

year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition **[or merger]**, ***merger or consolidation*** covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (1) if:

(A) there is a significant trend toward increased concentration in the market;

(B) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(C) another involved insurer's market is two per centum (2%) or more.

(iii) For the purposes of this paragraph:

(A) The term "insurer" includes any company or group of companies under common management, ownership or control.

(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the department shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this Commonwealth and the relevant geographical market is assumed to be this Commonwealth.

(C) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(iv) Even though an acquisition is not prima facie violative of the competitive standard under subparagraphs (i) and (ii), the department may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subparagraphs (i) and (ii), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

(3) An order may not be entered under subsection (e)(1) if:

(i) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(ii) the acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

* * *

Section 7. The act is amended by adding sections to read:

Section 1403.1. Committee Review.—(a) The Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives may review an application or statement submitted by a hospital plan corporation or professional health services plan corporation seeking the approval of a merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation under this act.

(b) The Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives shall have the following powers and duties:

(1) To convene the committee for purposes of reviewing an application for approval of a merger, consolidation or other acquisition of control under this section.

(2) To receive and review all filings submitted to the department relating to the merger, consolidation or other acquisition of control and all accompanying data and other information. This paragraph shall not apply to information deemed confidential or proprietary by the department.

(3) To consult experts, hold hearings and obtain additional information relating to the merger, consolidation or other acquisition of control.

(4) To develop written comments and recommendations on the merger, consolidation or acquisition of control and submit them to the department within forty-five (45) days of the close of the public comment period established under this paragraph, developed by the department on the merger, consolidation or other acquisition of control. The department shall publish the date of the close of the public comment period in the Pennsylvania Bulletin prior to final closure of the public comment period. The department may issue a final order and determination on or after one hundred five (105) days following the public comment period.

(c) The commissioner, the department and its attorneys and experts, including experts employed or retained by the department, shall be available to provide testimony to each committee relating to the merger, consolidation or other acquisition of control. Nothing in this act shall affect any privileges or immunities of the department or its attorneys, experts or consultants. The department or its attorneys, experts or consultants shall not be required to appear before either committee within thirty (30) days following the department's issuance of a final order and determination.

(d) The department shall provide a detailed written response to each comment and recommendation submitted by the Banking and Insurance Committee of the Senate or the Insurance Committee of the House of Representatives in its final order. The order and determination shall not be issued before sixty (60) days have elapsed following receipt of the comments and recommendations under subsection (b)(4).

(e) If no comments and recommendations are received under subsection (b)(4), the department may issue a final order and determination on or after one hundred five (105) days following the close of the public comment period.

Section 1403.2. Insurance Restructuring Restricted Receipt Account.—(a) There is established in the State Treasury a restricted receipt account to be known as the Insurance Restructuring Restricted Receipt Account. Interest earned on money in the account shall be deposited into the account.

(b) All net economic benefits, including proceeds, savings, funds or moneys derived from and any agreement related to or from the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation which are to be paid to the Commonwealth or a Commonwealth program shall be deposited into the account for purposes as determined by the General Assembly.

(c) No contract or written agreement between a hospital plan corporation or professional health services plan corporation and the Commonwealth or any other entity relating to the disbursement or spending of money in the account may be entered into until moneys that may exist or are to be derived from any contract or written agreement for deposit into the account are appropriated by the General Assembly.

(d) No moneys or funds may be transferred or paid from the account unless appropriated by the General Assembly.

Section 8. Section 1405(c) of the act, amended February 17, 1994 (P.L.92, No.9), is amended to read:

Section 1405. Standards and Management of an Insurer within a Holding Company System.—* * *

(c) (1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this article.

(2) Nothing herein shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of subsection (a)(1).

(3) *(i)* Not less than one-third of the directors of a domestic insurer **[and not less than one-third of the members of each committee of the board of directors of any domestic insurer]** shall be persons who are not officers or employes of such insurer or of any entity controlling, controlled by or under common control with such insurer and who are not beneficial owners of a controlling interest in the voting stock of such insurer or any such entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors **[or any committee thereof]**.

(ii) Not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employes of such insurer or of any entity controlling, controlled by or under common control with such insurer. At least one such person must be included in any quorum for the transaction of business at any meeting of each committee.

(4) The board of directors of a domestic insurer shall establish **[one or more committees]** *a committee* comprised solely of directors who are not officers or employes of the insurer or of any entity controlling, controlled by or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee **[or committees]** shall have responsibility for recommending the selection of independent certified public accountants**[,]** *and* reviewing the insurer's financial condition, the scope and results of the independent audit and any internal audit**[, nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers]**. *The committee may also have the responsibilities described in paragraph (4.1) if one or more committees described in paragraph (4.1) are not separately established.*

(4.1) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employes of the insurer or of any entity controlling, controlled by or under common control with the insurer. The committee or committees shall have responsibility for recommending candidates to be nominated by the board of directors, in addition to any other nominations by voting shareholders or policyholders, for election as directors by voting shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of paragraphs (3) **[and]**, (4) *and (4.1)* shall not apply to a domestic insurer if the person controlling such insurer is an insurer or **[a publicly held corporation]** *another business entity* having a board of directors and committees thereof which already meet the requirements of paragraphs (3) **[and (4)]**, *(4) and (4.1)*.

* * *

Section 9. The act is amended by adding an article to read:

ARTICLE XXV
COMMUNITY HEALTH REINVESTMENT

Section 2501. Definitions.

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

"Community health reinvestment activity." Community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following:

(1) Health care coverage for persons who are determined by recognized standards as determined by the Insurance Department to be unable to pay for coverage.

(2) Health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services.

(3) Programs for the prevention and treatment of disease or injury, including mental retardation, mental disorders, mental health counseling or the promotion of health or wellness.

The term shall not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with State health care programs, programs provided as an employee benefit, use of facilities for meetings held by community groups or expenses for in-service training, continuing education, orientation or mentoring of employees.

"Department." The Insurance Department of the Commonwealth.

"Plan." A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

Section 2502. Duties of plan and department.

(a) Plan duties.—A plan shall have the following duties:

(1) To submit a proposal to the department on or before March 30 of each year setting forth the manner in which the plan will provide proposed community health reinvestment activities conducted or provided by the plan during the next fiscal year.

(2) To annually provide to the department, the Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives the name and address of each officer, director or employee who serves on the board of directors of a hospital or other health care facility as defined in section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or on the board of an entity that owns, operates or manages a hospital or other health care facility. This paragraph shall apply to a nonprofit or for-profit subsidiary or affiliate of a hospital plan corporation or professional health services plan corporation. The information shall be submitted by January 31 for the immediately preceding year.

(b) Department duties.—The department shall have the following duties:

(1) To develop a form which shall be used by each plan for the submission of the proposal under subsection (a)(1). The form shall require the itemization of individual community health reinvestment activities and the cost of each activity under the Agreement on Community Health Reinvestment entered into February 2, 2005, by the

Insurance Department and Capital Blue Cross, Highmark, Inc., the Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross and published at 35 Pa.B. 4155 or any successor or other agreements. The proposal shall be on a form published by the department in the Pennsylvania Bulletin.

(2) To approve or disapprove the expenditures in the proposal submitted under subsection (a)(1).

Section 2503. Public record.

All proposals submitted under section 2502 shall be public records.

Section 2504. Regulations.

The department may promulgate regulations as necessary for the administration of this article.

Section 10. Repeals are as follows:

(1) The General Assembly declares the repeal under paragraph (2) is necessary to effectuate the addition of section 1403.2 of the act.

(2) Section 1716.1-E of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, is repealed.

(3) The act of December 19, 1990 (P.L.834, No.198), known as the GAA Amendments Act of 1990, is repealed insofar as it is inconsistent with this act.

Section 11. This act shall not apply to any merger, consolidation or other acquisition of control completed or consummated prior to the effective date of this section and, if required, following the issuance of an approving determination.

Section 12. This act shall apply to any application, statement or other plan or proposal relating to a merger, consolidation or other acquisition of control filed with the Insurance Department on or after January 1, 2007.

Section 13. This act shall take effect as follows:

(1) The amendment or addition of sections 405.2(c), 635.3 and 1405(c) of the act shall take effect in 60 days.

(2) The remainder of this act shall take effect immediately.

APPROVED—The 9th day of July, A.D. 2008.

EDWARD G. RENDELL