

Commonwealth of Puerto Rico
OFFICE OF THE INSURANCE COMMISSIONER

RULE NO. 91

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[Stamped: DEPARTMENT OF STATE Number:
7646
Date: December 23, 2008
Approved: Hon. Fernando J. Bonilla
Secretary of State
By: (Signed)
Francisco José Martin Caso
Assistant Secretary for Services]

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Commonwealth of Puerto Rico
OFFICE OF THE INSURANCE COMMISSIONER OF PUERTO RICO
Guaynabo, Puerto Rico

RULE NO. 91

STANDARDS FOR THE REGULATION OF THE COLLECTIVE BARGAINING PROCESS
BETWEEN HEALTH SERVICES ORGANIZATIONS OR THIRD-PARTY ADMINISTRATORS AND
PROVIDERS, AND REPRESENTATIVES OF PROVIDERS, AND TO CREATE THE REVIEW
PANEL AND THE MEDICAL PLAN AND INSURANCE RATE REVIEW BOARD

CHAPTER I. GENERAL PROVISIONS

ARTICLE 1.01 Statement of Public Policy

The Government of Puerto Rico hereby states that it is public policy to authorize collective bargaining of contracts between health services organizations or third-party administrators, and providers and representatives of providers, for the purpose of achieving a balance in the health services contractual process. It is thereby sought to protect access to quality health care and promote the necessary infrastructure for said care, while counteracting any anti-competitive effect that could arise in Puerto Rico.

ARTICLE 1.02 Legal Basis

This Rule is promulgated under Public Law No. 203, enacted on August 8, 2008 and Public Law No. 170, enacted on August 12, 1988, as amended, known as "The Uniform Administrative Procedures Act," 3 L.P.R.A. §§ 2102 *et seq.*

ARTICLE 1.03 Purpose, Scope, and Interpretation of this Rule

A. The purpose of this Rule is to establish and define the certification procedure for groups that are authorized to engage in collective bargaining. The Rule institutes the process of collective bargaining, to ensure that the outcome of such collective bargaining is aligned with applicable state and federal legislation. Furthermore, the Rule sets forth guidelines for the operation of the Arbitration Committee ("Committee") in solving controversies that may be generated by and arise from the collective bargaining process. Likewise, the Rule establishes a Medical Plan and Insurance Rate Board ("the Board") for the supervision and approval of rates used to determine premiums. Finally, the Rule provides for procedures for authorization by the Panel of increases in deductible or co-pay amounts, premiums or rates, and the approval of unilateral acts that may involve increases in premiums or reduction in coverage and/or services.

- B. This Rule is applicable to collective bargaining between providers or their representatives and third-party administrators and/or health services organizations. Likewise, it is applicable to proceedings before the Committee, the Board, and the Panel.

- C. Any issue regarding the scope and the interpretation of this Rule shall be decided in manner that will not affect the delivery of health services. In applicable cases, the terms or concepts of this Rule as drafted in the masculine gender shall be understood as terms or concepts that include the female gender; words used in the singular include the plural.

ARTICLE 1.04 Definitions of Terms

For the purposes of this Rule, the following terms shall have these meanings:

- A. Retaliatory Action - Any agreement, understanding, contract, arrangement or concerted action directed at not providing a service (boycott), in which the providers or health services organizations (or a combination thereof) participate with a view to forcing, persuading or coerce the other party to establish pre-arranged rates or prices for health care services, or to act in any manner to restrict the delivery of such services;

- B. Unilateral Act - Any act performed by a health services organization that affects coverage, rates, premiums, co-pays, deductibles and/or co-insurance, and that is not a result or consequence of collective bargaining or negotiation of rates between a health services organization and a group whose rates are established based on its own experience and demographic composition, among other variables; likewise, a unilateral act is any act that the Commissioner may deem to be such in the exercise of the powers of the office;

- C. Third-Party Administrator - A public or private organization that, without assuming risk, administers claims processing, collection of premiums, contracting, and paying providers or provides administrative services for third parties;

- D. Arbitration - An informal adjudicatory process in which the arbitrators receive evidence from the parties in conflict, and, based on the evidence submitted, issue a decision or award;

- E. Arbitrator - Member of the Arbitration Committee;

- F. Service Area of a health plan - the service area designed by a health services organization to provide services to a specific customer base or in a particular health care facility or geographic area;
- G. Geographic Areas - Areas defined by the Puerto Rico Health Department, with the advice of the Monopoly Affairs Office of the Department of Justice, as provided in Article 2.01 of this Rule;
- H. Insured or subscriber - A person who has entered into an insurance contract or health care plan;
- I. Beneficiary - A person benefited by an insurance contract;
- J. Boycott - Concerted action to refuse to provide or contract for a service, for the purpose of attempting to harming or actually harming the other party and forcing said party to accept demands;
- K. Co-pay - The fixed and pre-determined amount that is the part of the cost of health care service disbursed by the insured or subscriber or beneficiary of said service. When the amount is expressed as a percentage, it shall be called co-insurance;
- L. Committee - Arbitration Committee;
- M. Coverage Criteria- The terms or conditions under which a health services organization agrees to provide health care benefits to the insured or subscribers or beneficiaries;
- N. Coverage - All of the services included in a health care plan;
- O. Deductible - The portion of the cost of a benefit or service covered by a health services organization to be paid for by the insured or subscriber or beneficiary before said insured, subscriber or beneficiary shall have a right to said benefit or service;
- P. Specialty - As defined in Public Law No. 139, enacted on August 1, 2008, known as the "Medical Licensing and Disciplinary Board Act;"

- Q. Impasse - When one or both parties do not renounce from or modify their positions on one or more issues of the negotiation;
- R. Fees - An amount earned by a provider for delivering health care services;
- S. Hospitals - An institution that provides services to the community, providing treatment and medical and/or surgical diagnosis [sic] for disease or injury and/or obstetrical care for hospitalized patients, including general and specialized hospitals such as for tuberculosis, mental illness, and other kinds of hospitals and associated facilities such as intensive care, intermediate care, and self-care units for patients. Radiotherapy and x-ray services, clinical, anatomical pathology and other laboratories, out-patient clinics, external consultation departments, nursing residencies and training facilities, central services facilities, and jointly-operated hospital services, but not including institutions that principally provide home care or custody. This includes, in addition places that principally provide medical diagnosis. treatment or care for no less than twelve (12) consecutive hours, to two (2) or more individuals who are not related, and who have a condition, illness, injury or deformity. Any office, clinic or home of a physician where pregnant women are seen or treated during an abortion, delivery or post-partum, shall be deemed to be a hospital within the meaning of this chapter, regardless of the number of patients and the duration of the stay; it is further provided that the part or section of a dwelling where a physician has an office or sees patients shall not be deemed to be a family home, even though such space is considered to be part of the physical structure of the residence. Notwithstanding the provision of the previous statement, in terms of the meaning of this chapter, it shall not be considered that the office, residence or clinic of a physician is a hospital in the event of a sudden and unexpected delivery or a miscarriage and under circumstances that would make the immediate transfer of the patient to a hospital impossible, so that in said event the patient may be assisted by the physician in the physician's office, residence, or clinic, pending the transfer of the patient to the appropriate hospital and that transfer shall be effected within a period of no more than twelve (12) hours;
- T. Strike - A concerted action for the purpose of interrupting, paralyzing, stopping or obstructing the delivery of health care services, for a given period of time, whether extended or brief, or an indefinite period of time, for the purpose of imposing certain conditions;
- U. Board - Medical Plan and Insurance Review Board;

- V. Decision - Decision or award of the Arbitration Committee regarding a controversy submitted for consideration;
- W. Law - Law No. 203, enacted on August 8, 2008;
- X. Methods of payment - Procedure for paying fees earned by providers for the delivery of health care services;
- Y. Collective bargaining - A process of discussing, conversing, and achieving a compromise among positions, engaged in by a health services organization or third party administrator and a hospital or group of providers, to reach an agreement on health care services;
- Z. Office of Monopoly Affairs - An Office under the Department of Justice of the Commonwealth of Puerto Rico, created through Public Law No. 77, enacted on June 25, 1964, as amended, known as "Monopoly and Restriction of Commerce Act," 10 L.P.R.A. §§ 257 *et seq.* ("Monopoly Act");
- AA. Health services organization - Any person who provides or undertakes to provide services to one or more health care plans. This includes disabled insureds or subscribers under Chapter 3 of Public Law No. 77, enacted on June 19, 1957, as amended, known as "Puerto Rico Insurance Code", 26 L.P.R.A. §§ 301 *et seq.*;
- BB. Panel - A group of entities of the Commonwealth of Puerto Rico including: (i) the Health Department; (ii) the Insurance Commissioner; (iii) the Ombudsman, and (iv) the Patient's Ombudsman;
- CC. Person - Natural person, association, insured or subscriber, group, syndicate, trust, company, partnership, organization, corporation or any other legal entity;
- DD. Health Care Plan - Any agreement under which a person undertakes to provide an insured or subscriber, or a group of insureds or subscribers, certain health care services, whether directly or through a provider, or to pay all or part of the cost of such services, in consideration for payment of an amount set forth in the agreement, which shall be considered to have been earned whether or not the insured or subscriber uses the health care services provided by plan. Notwithstanding the above, the health services organization must be principally engaged in providing health care services and

not merely in providing compensation for the cost of such services;

- EE. Premium - An amount that the insured or subscriber pays to a health services organization, under contract, for assuming a risk or in exchange for providing health care services;
- FF. Provider - Any physician, hospital, primary service center, diagnosis and treatment center, dentist, laboratory, pharmacy, emergency medical services, pre-hospitalization services, medical equipment provider, or any other person authorized in Puerto Rico to provide health care services, whether on a group or individual basis, and who, under contract with a health services organization and third party administrators, provide health care services to the subscribers or beneficiaries of a health insurance or health care plan;
- GG. Deadlock - When the parties to the collective bargaining fail to act, or the negotiations to reach an agreement are paralyzed;
- HH. Referral - When a health care services provider sends an insured or subscriber or beneficiary to receive health care service from another provider;
- II. Provider Register - The official register of providers in the Commonwealth of Puerto Rico; the Health Department may take into account the "National Provider Identifier";
- JJ. Provider representative - A third party duly authorized by the provider to negotiate contractual terms on behalf of the provider with health care services organizations or third party administrators;
- KK. Health care services - Medical or dental care, hospitalization or services related to such care or hospitalization;
- LL. Rate - Element or factor that is the basis for determining a premium;
- MM. Multiplier rate - Variations of the same rate.

ARTICLE 1.05 Prohibitions

The following acts are prohibited:

- A. Limiting the delivery of health care services, whether by threatening a boycott, strike or other

concerted action by the providers. These actions shall be subject to the oversight of the Office of Monopoly Affairs to determine whether they are in violation of the provisions of the Law or the Monopoly Act.

- B. Retaliatory action or coercion of any sort by the health services organizations vis a vis the providers during the negotiation process, such as retaining payment, carrying out unreasonable audits or other similar actions.
- C. Compulsory membership groups of health professionals being a provider representative in a collective bargaining process.
- D. Offering or writing health care insurance policies or plans in the Puerto Rico market without the prior approval of rates by the Board, as defined in Chapter V of this Rule, and the approval of forms and evidence of coverage by the Insurance Commissioner, as provided in the Puerto Rico Insurance Code.

CHAPTER II. CERTIFICATION OF GROUPS

ARTICLE 2.01 Groups Authorized to Negotiate

In order to negotiate, as authorized under this Rule, the providers shall meet by specialty group or by geographical area, as established below.

- A. It shall be deemed that there is a group when two or more authorized individuals agree to promote a common negotiation agenda.
- B. It shall be deemed that there is a specialty group when the providers within the same specialty, within the same geographical area, join together for the purposes of collective bargaining, provided that each group does not exceed twenty per cent (20%) of the respective specialty in said geographical area;
- C. It shall be deemed that there is a group by geographical area when providers from different specialties or services, within the same geographical area, associate for the purposes of collective bargaining, provide that each group does not exceed twenty per cent (20%) of each specialty or service, in that geographical area.

D. The geographical areas, as defined by the Health Department, with the advice of the Office of Monopoly Affairs of the Department of Justice, shall be the following:

GEOGRAPHICAL AREA	MUNICIPALITIES
San Juan Area	San Juan
Arecibo Area	Arecibo Manatí. Barceloneta Ciales Florida Morovis Vega Baja Camuy Hatillo Lares Quebradillas Utuado
Humacao Area	Humacao Yabucoa Maunabo Naguabo Las Piedras Fajardo Río Grande Luquillo Ceiba Culebra Vieques
Mayagüez Area	Mayagüez Cabo Rojo Añasco Hormigueros Las Marias Maricao Rincón San Germán Lajas Sabana Grande

Guayama Area	Guayama Arroyo Patillas Salinas Coamo Adjuntas Jayuya Juana Diaz Santa Isabel Villalba Cayey Aibonito Cidra
Carolina Area	Carolina Canóvanas Loíza Trujillo Alto
Caguas Area	Caguas San Lorenzo Juncos Gurabo Aguas Buenas
Bayamón Area	Bayamón
Guaynabo Area	Guaynabo Vega Alta Toa Alta Cataño Dorado Toa Baja Barranquitas Comerio Corozal Naranjito Orocovis
Ponce Area	Ponce Yauco Guánica Guayanilla Peñuelas
Aguadilla Area	Aguadilla San Sebastián Aguada Isabela Moca

- E. The Health Department shall provide the Office of Monopoly Affairs with information regarding registered providers, on a quarterly basis, or as requested.
- F. If a provider practices the same specialty in more than one geographical area, the provider must state to which geographical area the provider belongs for the purposes of negotiations under the Law and this Rule.
- G. Hospitals may only benefit from the mechanism of collective bargaining as established herein, in negotiations with an individual corporation. If a hospital has facilities or operates in more than one location, the hospital shall negotiate individually for each location.

ARTICLE 2.02 Authorized Collective Bargaining

Collective bargaining between certified groups and authorized providers and a health services organization or third party administrator is hereby authorized, as provided in this Rule, when the parties show that there is an imbalance in the contractual process.

- A. An imbalance exists in the contractual process between a health services organization or a third party administrator and a provider group under the following two circumstances:
 - a. The health services organization or the third party administrator has substantial power in the medical insurance or health care plan business. Substantial power in the medical insurance or health care plan business exists when the share of the health services organization, in and of itself or with its affiliates, exceeds a coverage of twenty-five thousand (25,000) individuals in any one of its plans or exceeds five per cent (5%) of the total of covered individuals in a given geographical area. In the case of third party administrators, the number of covered individuals for which services are provided shall be taken into account;
 - b. The aforementioned substantial power interferes with the ability of providers to offer or deliver quality medical care. To this effect, the group may prove that:
 - i. the members of the group have been forced to reduce staff that provides health care services in regular practice;
 - ii. patient contact hours have been substantially reduced, in order to serve a higher volume;
 - iii. members have been forced to close part or all of their practice;
 - iv. the process to reach a valid or adequate diagnosis becomes unduly burdensome;
 - v. delivery of quality health care has been affected;
 - vi. any other situation that could affect the ability of the providers to offer or deliver quality

health care.

Information provided by the parties for the purpose of complying with the requirements of this sub-paragraph shall be kept confidential as provided in the Monopoly Act.

- B. Certification of groups for collective bargaining under the provisions of this Rule exclude health care plans under the Medicare Advantage program, created by the Medicare Prescription Drug Improvement and Modernization Act, 117 Stat. 2066. Because these are exempted from the Puerto Rico Insurance Code, exclusion is also provided for the Puerto Rico Government Health Plan, pursuant to Public Law No. 72, enacted on September 7, 1993, as amended, known as "Puerto Rico Health Insurance Administration Act, " ("ASES"), 24 L.P.R.A. §§ 7001 *et seq.*, and the provisions of the Medicaid Program, created by the Medicare Prescription Drug Improvement and Modernization Act, *supra*. Likewise, health plans of self-insured employers are excluded, since these are covered by the Employee Retirement Income Security Act (ERISA), 88 Stat. 829.

- C. The Insurance Commissioner shall calculate on an annual basis the number of individuals covered by each health services organization and third party administrators in each geographical area. In order to make this calculation, the Insurance Commissioner may calculate the number of patients covered each quarter, based on information from the previous year.

ARTICLE 2.03 Required Representative

- A. A group of providers may only negotiate with a health services organization through a duly-authorized provider representative. Nevertheless, a provider may negotiate on behalf of the provider's business, when such business provides services to at least one other provider or more that one health care service is provided, while also complying with the requirement of Article 2.01 of this Rule. The agreements reached by said representative, within the limits of the powers granted by the represented parties, shall be binding for the latter.

- B. Representatives of providers are required to:
 - a) Be of legal age;
 - b) Know how to read and write;
 - c) Have obtained a high school diploma;
 - d) Not have committed a crime implying dishonesty or moral turpitude.

- C. No compulsory organization of health professionals may become a representative of the providers in the negotiation process.

ARTICLE 2.04 Licensing Procedures for Provider Representatives

The Insurance Commissioner shall prepare and administer a training program on the Law and this Rule for the purpose of licensing provider representatives. The program shall be offered twice a year and participation in the program shall be a requirement for obtaining the license. The training program is structured as follows:

- A. Any natural person who aspires to become a certified provider representative shall file an application with the Insurance Commissioner, accompanied by the amount of five hundred dollars (\$500) in fees, by certified check or postal money order made out to the Secretary of the Treasury (Secretario de Hacienda). The application form shall be fully filled out and accompanied by the full amount of fees;
- B. The Insurance Commissioner shall notify applicants in writing of the date, time, and place where the Training Program examination will be offered;
- C. The license issued by the Office of the Insurance Commissioner shall be effective for a period of one (1) year and an application for renewal shall be submitted at least thirty (30) days before the date of expiration, pursuant to Rule No. 481 of the Insurance Commissioner, as amended. After this date, a new application must be submitted.
- D. The license issued by the Office of the Insurance Commissioner may be subject to the same kind of continuing education requirements as for other licenses.
- E. Any person who acts as a provider representative or attempts to do so without being duly licensed, may be subject to an administrative fine of not less than one thousand dollars (\$1,000) and not more than five thousand dollars (\$5,000), without prejudice regarding any further legal liability as a consequence of such action.
- F. All provider representatives shall advise the parties they represent regarding the provisions of the Law and this Rule and the possible consequences of engaging in unauthorized or prohibited conduct under the Law or any other legal provision.

- G. No agreement may promote or limit health care services offered by a provider.

- H. The provider representative may represent more than one group in the same geographical area or in different geographical areas, provided that the total amount of parties represented does not exceed the limit established in Article 2.01 of this Rule and Article 31.030 of the Law. Regardless of the above requirements, the Office of Monopoly Affairs may deny certification of a group on the grounds that the group represents an undue concentration of specialties or services.

ARTICLE 2.05 Application for Authorization to Negotiate

- A. In order to initiate collective bargaining, providers must be certified as a group and obtain authorization from the Office of Monopoly Affairs for the negotiations.

- B. The request for authorization shall be submitted by a provider representative, who shall submit evidence of being duly designated by the group and holding a license from the Office of the Insurance Commissioner, pursuant to Article 2.04 of this Rule.

- C. The application shall be accompanied by:
 - a. The provider representative license, issued by the Office of the Insurance Commissioner;
 - b. Evidence of appointment as representative by the group of providers for whom the application is being made.
 - i. Each provider being represented must appoint a representative by means of a sworn statement.
 - ii. The representative shall submit a sworn statement accepting representation of the providers.
 - iii. Each and every sworn statement from the providers shall clearly state:
 - 1. The full name of the designee, including both surnames, telephone and fax numbers, mailing and street business address for the designee, and an email address;
 - 2. The geographical area in which the negotiation will take place if the provider practices the same specialty in more than one geographical area;
 - 3. The provider's health services provider number;
 - 4. The specialty or health services provided and the corresponding license number;
 - 5. The authority and powers conferred on the representative;
 - 6. The scope of the powers conferred;
 - 7. A valid method for verifying the designation of such power;
 - 8. The term granted to the representative for the exercise of such power;

9. The liability of the representative.
- iv. The sworn statement of the representative shall show:
 1. The representative's business telephone and fax numbers, mailing and street address, and business email address;
 2. The full name of the providers who comprise the group being represented;
 3. The health care services provider license numbers of all of the members of the group being represented;
 4. The authority and powers granted by the providers;
 5. A statement expressing whether the person represents, or is negotiating the representation of other group(s), indicating the composition of such group(s).
- D. The application shall comply with the following requirements, which shall be separately and clearly identified:
- a. The percentage of providers requesting certification as a group for collective bargaining purposes with regard to the total number of providers by specialty or service in that geographical area;
 - b. The name of the health services organization or third party administrator with whom negotiations are proposed;
 - c. A detailed statement regarding the imbalance requirement set forth in Article 2.02 of this Rule;
 - d. A money order in the amount of five hundred dollars (\$500.00) made out to the Secretary of the Treasury (Secretario del Departamento de Hacienda de Puerto Rico).
- E. Any incomplete application that does not include any of the above requirements shall be notified to the parties to be corrected within a term of ten (10) days. If the application is not corrected within this term, it shall be deemed to have been denied.

ARTICLE 2.06 Procedure for Certification by the Office of Monopoly Affairs of the Department of Justice

- A. When a completed application is submitted, the Office of Monopoly Affairs shall evaluate:
 - (i) whether the proposed group fulfills all of the requirements under the Law and this Rule, so that it may be certified as a group for the purposes of negotiation; and
 - (ii) whether the representative fulfills the above requirements.
- B. After certifying the group and the representative, the Office of Monopoly Affairs shall evaluate whether there is an imbalance in the contractual process, as provided in Article 2.02.

- C. The Office of Monopoly Affairs shall have a term of thirty (30) days, to be counted from the submission of the application, to deny or approve the application.
- D. Grounds for denying the application shall be provided, noting deficiencies that may be corrected. In such a case, the applicant shall have a term of ten (10) days from the date of notification in which to correct such curable deficiencies. If such corrections are not made during this period, or a hearing is not requested, the application shall be deemed to be denied *ab initio*.

ARTICLE 2.07 Issue of Certification

When the Office of Monopoly Affairs has determined that the proposed group and the representative thereof have fulfilled the legal requirements to engage in collective bargaining, and there is also an imbalance in the contractual process between the health services organization or the third party administrator and the providers, the Office will issue the corresponding authorization to the authorized group and the representative thereof. Furthermore, the Office of Monopoly Affairs shall deliver said certification to the Office of the Insurance Commissioner within five (5) days of the date of issue.

ARTICLE 2.08 Effective Term of Certification

- A. Certification issued by the Office of Monopoly Affairs shall be effective for a term of one (1) year from the date of issued.
- B. Once the certification is issued, there may be no modification of the composition of the group or the representative thereof, unless a new application for certification is filed with the Office of Monopoly Affairs. Nevertheless, in the event of disaffiliation of a member it shall not be necessary to file a new application for certification, and it shall be sufficient to notify the Office of Monopoly Affairs of said event.
- C. Within thirty (30) days before the expiration of said term, the representative may request an extension of the term of certification for an additional one (1) year, by submitting a sworn statement to the effect that there have been no changes in the composition of the group, or the conditions under which the original certification was granted.
- D. When the term of the certification has expired, the Office of Monopoly Affairs shall return the information submitted for the purpose of obtaining the certification to the applicant.

CHAPTER III. SUPERVISION OF THE COLLECTIVE BARGAINING PROCESS

ARTICLE 3.01 Powers of the Insurance Commissioner

- A. For the purposes of this rule, all parties involved in the negotiation shall be subject to the powers vested in the Commissioner by the Puerto Rico Insurance Code.

- B. The Commissioner may assign any professional that the Commissioner may deem necessary to be present during all or part of the negotiations.

ARTICLE 3.02 Procedure for Receiving Applications

The application for initiating the collective bargaining process shall be submitted to the Insurance Commissioner.

- A. The application shall fulfill the following requirements:
 - a. Certification of the group, and the corresponding designation of a representative, issued by the Office of Monopoly Affairs;
 - b. A provider representative license, issued by the Office of the Insurance Commissioner;
 - c. Information on the group, including
 - i. the following information on the providers:
 - 1. Full name of the representative of the group, including the two surnames* of the representative, and the representative's telephone and fax numbers, mailing and street address of the representative's place(s) of business, and the representative's email address;
 - 2. Full name of each provider in the group, as well as their telephone and fax numbers mailing and street address of the provider's place of business, and the email address of each provider;
 - 3. License Number of each provider in the group; and
 - 4. The health services organization with which the group intends to negotiate.
 - ii. Items that are to be negotiated;
 - iii. A statement of the benefits that are expected to be obtained from the negotiation.
 - d. Evidence of the notification to the other party of the intention to negotiate.
 - e. The amount of five hundred dollars (\$500) in fees, paid by certified check or postal money order, made out to the Secretary of the Treasury (Secretario de Hacienda). If it is determined that there

* Trans. Note: In Puerto Rico the legal name of a person includes both the paternal surname and the maternal surname.

is a need to assign additional resources from the Office of the Insurance Commissioner, the parties shall assume the costs as set forth in Rule No. 3629 of the Insurance Commissioner.

ARTICLE 3.03 Authorization to Negotiate or Close the Case

- A. The Insurance Commissioner shall have thirty (30) days from the date of submission of the application in which to authorize the initiation of collective bargaining.
- B. Once the application is complete and has fulfilled all of the aforementioned requirements, the Insurance Commissioner shall authorize the initiation of negotiations. The authorization shall state the date for initiating the collective bargaining process, rules to be followed, limitations, and any other pertinent information.
- C. When within (15) days from the notice of intention to negotiate, as provided in Article 3.02 (A)(d), the notified party refuses to negotiate or does not respond to said notice, the movant shall notify the Insurance Commissioner to that effect, within seven (7) days of such refusal.
One of the parties may subsequently argue that the other party ultimately agreed to negotiate, and, therefore, may request reopening the case, provided that authorization is obtained from the Office of Monopoly Affairs is in effect.

ARTICLE 3.04 Negotiations Permitted by Law

As provided in Article 31.030 of the Law, the parties may negotiate the following terms and conditions:

- A. Fees and rates for health care services;
- B. Guidelines for clinical practice and coverage criteria;
- C. Administrative procedures, including payment methods and time of service, for the payment of fees to providers;
- D. Conflict-resolution procedures related to disputes between health care services organization or third party administrators and providers, regarding health care plans;
- E. Procedures for subscribers;
- F. Establishing and applying methods for reimbursing providers;

- G. Quality assurance programs;
- H. Review procedures for the use of health care services;
- I. Selection of providers with regard to health care plans and criteria for termination of contract;
- J. The inclusion or alteration of term and conditions, insofar as these are subject to the regulations of the Government of Puerto Rico, prohibiting or requiring the particular term or condition in question, provided, however, that such condition does not limit the rights of providers to jointly request a modification of the regulations by the Government of Puerto Rico.

ARTICLE 3.05 Excluded Negotiations

Matters that may not be subject to negotiation between parties are those that:

- A. Are regulated by state or federal laws or regulations; or
- B. Jeopardize any appropriation of funds by the Government of Puerto Rico or the Government of the United States of America; or
- C. Interfere with the powers to make public policy, conferred by law on the agencies, instrumentalities or public corporations of the Commonwealth of Puerto Rico.

ARTICLE 3.06 Prohibitions within the Collective Bargaining Process

- A. Any action of any of the parties that unreasonably limits the delivery of health care services is prohibited.
- B. Health care services organizations or third party administrators may not take retaliatory or coercive action against providers during the negotiation process, such as retaining payments, authorizing unjustified audits or other similar actions.

ARTICLE 3.07 Disclosure and Use of Information Related to the Negotiations

The information on the negotiations shall be confidential until such time as the Insurance Commissioner authorizes the agreement between the parties.

ARTICLE 3.08 Supervision and Monitoring

- A. The parties have the continuing obligation to draft a report and file such with the Insurance Commissioner, at least every forty-five (45) days, as follows:
 - a. the dates of meetings held during the period;
 - b. a progress report showing for each of the items authorized for negotiation: (i) the agreements reached; (ii) pending issues, and (iii) unresolved controversies.

- B. The negotiations shall have a term of ninety (90) days from the date of authorization of initiation, provided that before the end of such term, the parties may request an extension which shall not exceed an additional thirty (30) days.

ARTICLE 3.09 Deadlock or impasse in the negotiations

- A. When there is a deadlock or impasse in the negotiations, the pending controversies shall be referred to the Committee, as established in Chapter 4 of this Rule. In addition to the definition in Article 1.04 (q), it shall be deemed that there is an impasse when the term provided in Article 3.08 (B) for the completion of negotiations has concluded and the parties have not been able to reach a final agreement.

- B. When there is a deadlock or impasse, the parties shall submit a report to the Insurance Commissioner and the Committee within the next ten (10), containing:
 - a. A detailed account of the agreements reached up to that point;
 - b. A detailed explanation of the issues on which an agreement has not been reached and the reasons for such failure.

ARTICLE 3.10 Termination of Collective Bargaining

Collective bargaining ends when:

- A. The parties adopt a final agreement.

- B. The term for negotiations as provided in Article 3.08 (B) expires, in which case, the Insurance Commissioner shall refer the parties to the Arbitration Committee.

ARTICLE 3.11 Final Report

When the collective bargaining has reached a final agreement, within fifteen (15) days of the termination

of the negotiation, the parties shall submit to the Office of the Insurance Commissioner:

- A. The proposed formal agreement and a sworn statement to the effect that this is the full and final agreement between the parties;

- B. A final report, accompanied by a sworn statement by the parties, containing:
 - a. An implementation plan for the agreements;
 - b. The possible effects of the implementation of the agreement, including the expected impact in terms of costs or coverage;
 - c. All of the benefits that are expected from the agreements that have been reached;
 - d. Any other information the Commissioner may deem pertinent.

ARTICLE 3.12 Evaluation of the Negotiations

- A. The Commissioner will approve the agreement when the social benefits or the favorable effects on competition outweigh the negative effects related to anti-competitive practices. The Commissioner will also verify that the terms of the agreement are consistent with the Puerto Rico Insurance Code, and all other applicable law or regulations.

- B. It may be determined that there is social benefit under the following conditions, but not limited to such:
 - a. The establishment or improvement of preventive health care programs that produce a reduction in costs and produce benefits for consumers, health care services organizations, and providers;
 - b. The establishment or improvement of fraud detection and management programs;
 - c. The reestablishment of the competitive balance in the health care services market;
 - d. The promotion of investment in infrastructure and medical advances.

- C. In taking into account anti-competitive effects, the Insurance Commissioner may consider whether the agreement:
 - a. provides for the payment of excessively high fees;
 - b. contributes to an increase in the cost of health care services;
 - c. tends to restrict access and/or the delivery of health care services.

- D. The Insurance Commissioner shall make a determination and approve or deny approval of the agreement within thirty (30) days of being notified of the Report.

- E. If the Insurance Commissioner denies approval of the agreement, an explanation of deficiencies and suggestions to correct the deficiencies of the document shall be included in the notice of the Commissioner's decision. The parties may correct the deficiencies and submit the document again for approval, within thirty (30) days of notification by the Commissioner.

ARTICLE 3.13 Remedies

The non-prevailing party in a decision made by the Commissioner may request an administrative hearing within fifteen (15) days of the notice, under Article 2.190 of the Insurance Code. The hearing shall be governed by the procedures set forth in Public Law No. 170, *supra*.

ARTICLE 3.14 Constraint on the Enforcement of the Agreement

The parties shall be barred from using or enforcing the agreement until the Insurance Commissioner has approved such agreement.

Chapter IV. ARBITRATION COMMITTEE

ARTICLE 4.01 Purpose

The purpose of arbitration is to provide the parties with the opportunity to present the facts, the legal theories, and the evidence adjudicatory proceedings that are faster and more informal than judicial proceedings. Proceedings are finalized with a decision in which all of the controversies and issues are decided.

ARTICLE 4.02 Composition and Designation of the Committee

- A. In response to a written application made by any of the parties, the Health Department, further to notice from the second party, will appoint a Committee. The Committee will be governed by this regulation and Public Law No. 376, enacted on May 8, 1951, as amended, known as the " Puerto Rico Arbitration Act," 32 L.P.R.A. §§ 3201 *et seq*.
- C. The Committee shall be constituted within fifteen (15) days of the receipt of notice from the party being submitted to the arbitration process.
- D. The Committee shall be comprised of the following three arbitrators:
 - a. An economist, preferably having experience in the health or insurance fields, appointed by the President of the Economists Association;
 - b. A neutral independent intervenor, certified by the Bureau of Alternative Conflict Resolution

Methods under the Office of the Chief Justice of the Puerto Rico Supreme Court;

- c. An expert in the area of health care service, who does not have any conflict of interest, designated by the Secretary of the Health Department.

ARTICLE 4.03 Appointment of Arbitrators

- A. The Health Department shall maintain an updated list of arbitrators comprised of legally competent persons of legal age, who know how to read and write. In addition, the arbitrators shall have a recognized reputation as professionals capable of independent judgment.

- B. The Health Department shall notify each arbitrator of the appointment, and request written acceptance within three (3) days, to be counted from the date of notice of the appointment. If acceptance is not received within this term, it shall be deemed that the arbitrator does not accept the appointment. In said event, the Health Department shall proceed during the following two (2) days to designate such new arbitrators as may be necessary to complete the Committee, and shall proceed in the same manner with notice and acceptances of appointments and so forth, as may be necessary, until the Committee is complete..

ARTICLE 4.04 Arbitrator Recusal

- A. Before assuming their positions, arbitrators shall be sworn in by an authorized official and shall undertake that they will faithfully and competently discharge the duties of the position, hear all arguments without prejudice, impartially examine the issues in controversy, and enter a decision pursuant to law.

- B. The parties may waive the obligation imposed on the arbitrators to take an oath if the hearing is initiated without objections to the lack of such oath.

- C. The arbitrators may not have a personal, professional or business relationship with the parties.

- D. Prior to accepting the position, the arbitrators must reveal any circumstance that could cast a justifiable doubt on their impartiality and independence, and the designation may be annulled. From the moment of the appointment, the arbitrator shall reveal to the parties in a timely manner any circumstance that may have arisen that could compromise the impartiality and independence of said arbitrator.

- E. Arbitrators may be recused for circumstances that may have arisen after the arbitrator undertook the position or that were unknown at the time of the arbitration. Recusals must be sworn to and must set forth the grounds for the recusal. The recusal shall be submitted as soon as the petitioner becomes knowledgeable of the grounds for the recusal.

ARTICLE 4.05 Grounds for Recusal; Procedure

- A. Arbitrators may be recused under the grounds set forth in the Puerto Rico Rules of Civil Procedure for the recusal of judges.
- B. Recusals shall be brought before the Committee in writing and be duly supported. If the recusal is not accepted, the petitioning party may bring the recusal before a Court of First Instance in Puerto Rico.
- C. When a petition for recusal has been submitted, the arbitrator may resign from the position, without implying in any manner that the grounds for the recusal are valid.
- D. Arbitration proceedings shall be stayed while the matter of the recusal is pending before the Court of First Instance, and shall be resumed as soon as said Court has ruled on the matter.

ARTICLE 4.06 Substitution of Arbitrators

- A. Regardless of the reason for which a new arbitrator must be appointed, the appointment shall be made following the same procedure as for the arbitrator who is being substituted.
- B. Once the substitute has been appointed, the arbitrators, by agreement of the parties, shall decide whether they should repeat any of the proceedings. If it is decided that any of the proceedings should be repeated, the parties shall agree on the extension of time needed for such proceedings.

ARTICLE 4.07 Jurisdiction

The arbitrators shall have jurisdiction on the issues and controversies related to the collective bargaining brought before their consideration in the case and they shall fully resolve all of such issues and controversies.

ARTICLE 4.08 Powers of the Arbitrators

In all cases under their consideration, the arbitrators may:

- A. Set the date, time and place of the arbitration hearings;
- B. Notify the parties of hearings;
- C. Hold and preside over arbitration hearings;
- D. Issue subpoenas for witnesses;
- E. Take oaths and affirmations;
- F. Issue and write such instructions and orders as may be necessary for the efficient, orderly, and timely processing of the case before their consideration;
- G. Impose sanctions on the parties for failure to appear at the arbitration hearings;
- H. Decide on issues related to discovery of evidence and order additional production or discovery of evidence by the parties;
- I. Issue decisions or awards.

ARTICLE 4.09 Notice of Arbitration

Within ten (10) days of the time at which a deadlock or impasse in the negotiation is declared, the party that requested the arbitration shall serve the other party, whether in person or by certified mail, with written notice of the intention to initiate arbitration. The notice shall state that the party being notified shall be barred from alleging the existence of a controversy in the event of a deadlock or impasse in the collective bargaining process, as provided under Law. The notice shall also state that within fifteen (15) days of service thereof, the party being served may in turn serve notice for a stay of arbitration.

ARTICLE 4.10 Arbitrators' Fees

The parties shall pay the arbitrators' fees. Payment shall be made at the Finance Office of the Health Department, by certified check or postal money order, made out to the Department of Health or the Secretary of the Treasury. The fees, as set forth below, are not reimbursable:

Filing fees for negotiations unrelated to rates	\$3,000.00
Agreement submitted arising from negotiations unrelated to rates	\$1,500.00
Filing fees for negotiations related to rates	\$5,000.00
For agreements submitted for negotiations related to rates	\$2,500.00

ARTICLE 4.11 Procedure for Submitting Controversies to Arbitration

- A. Any party intending to submit a controversy to arbitration under the provisions of this Rule, shall file an original and five (5) copies in writing along with the pertinent documentation, in person, with the Office of the Secretary of Health at the Health Department, specifying all relevant facts, using the form provided for this purpose. The petition shall specify whether information provided by third parties is included. The parties or their representatives shall undertake in writing to provide the arbitrators with all pertinent information regarding the matter under arbitration.
- B. The parties shall accompany the above documents with a payment of one hundred dollars (\$100.00) by certified check or postal money order made out to the Health Department or the Secretary of the Treasury at the Finance Office of the Health Department.

Article 4.12 Hearings

- A. The arbitrators shall set a date and place for the hearing and notify the parties ten (10) days in advance. The arbitrators may only suspend the hearing before the Committee for just cause, further to a request from any of the parties, notified at least three (3) days before the date for which the suspension is being requested.
- B. All of the arbitrators shall meet and act as one during the hearing.
- C. The parties shall submit a brief Report, with an original and five (5) copies, including all documentary, real, and testimonial evidence which they propose to present at the hearing, at least seven (7) days before the date set for the hearing. The document shall be notified to all parties within

the same period of time. The arbitrators may refuse to accept as evidence any evidence that was not included in the Report.

- D. Proceedings before the arbitrators shall be informal. The Rules of Evidence for the General Court of Justice may be used as guidelines at the arbitration hearings, but they will be applied flexibly. However, the rules regarding privilege shall be strictly applied. The facts, the controversies, and the legal theories of the case shall be submitted principally through the arguments and issues brought by the parties and documentary or real evidence.
- E. Testimonial evidence at arbitration hearings shall be used as little as possible. Before testifying, witnesses shall state under oath that they will tell the truth. If a witness should violate the oath, the witness shall be subject to perjury under the applicable provisions of the Puerto Rico Penal Code. The parties shall have the right to cross-examine the witnesses who appear at the proceedings.
- F. The failure to appear by any of the parties shall not be grounds for suspending an arbitration hearing. The arbitrators may issue a decision based on a statement under oath of the grounds on supporting the appearing party's position, sworn statements or any other evidence, which, in the judgment of the arbitrators, are sufficient to show the merits of the position of said party.

ARTICLE 4.13 Term for the Decision

The arbitration decision shall be awarded within thirty (30) days following the last arbitration hearing. The parties may extend said term through a written agreement signed by all parties.

ARTICLE 4.14 Content of the Decision

The decision shall be brief and concise, in writing, and include findings of fact and conclusions of law, clearly stating the remedies granted to the prevailing party and shall be signed by all of the arbitrators. The arbitrators shall deliver a copy of the decision to each of the parties or their counsel.

ARTICLE 4.15 Right to Counsel

Parties may be represented by counsel duly admitted to the practice of law in Puerto Rico in all arbitration proceedings or hearings.

ARTICLE 4.16 Revocation of the Decision

A. In any of the following cases, the Puerto Rico Court of First Instance, at the request of any of the

parties and further to notice and hearing, enter an order revoking the decision:

- a. When the decision was obtained through corruption, fraud or any other undue means;
- b. When there was bias or corruption among the arbitrators;
- c. When the arbitrators act erroneously by refusing to postpone the hearing, having been shown just cause for postponement, or refusing to hear evidence that is relevant to the controversy, or incurring any other error that may be prejudicial to the rights of any of the parties;
- d. When the arbitrators exceed the limits of their functions or when the decision issued does not resolve the matter in a final and definitive manner;
- e. If the submission to arbitration was not valid or the proceedings were initiated without serving notice of the intention to engage in arbitration.

B. In the event that a decision is revoked, the Puerto Rico Court of First Instance may, at its discretion, order a new hearing before the same arbitrators or new arbitrators, to be selected in the manner provided for in this Rule.

ARTICLE 4.17 Modification or Correction of the Decision

- A. In any of the following cases, the Puerto Rico Court of First Instance shall, further to notice and hearing, and at the request of any of the parties, enter an order modifying or correcting the decision:
- a. When there was an obvious error in calculation with regard to numbers or in the description of any person, thing or property;
 - b. When the arbitrators have decided on a matter that was not submitted for arbitration;
 - c. When the decision is imperfect in terms of form, without affecting the merits of the controversy.
- B. The order shall modify and correct the decision to enable the enforcement of the intent of the decision.

ARTICLE 4.18 Binding Nature of the Decision

The terms of a decision issued by the Committee shall be binding, except in the event that there are legal grounds for review.

ARTICLE 4.19 Motion to Revoke, Modify or Correct; Suspension of Proceedings to Enforce the Decision

The party wishing to revoke, modify or correct a decision shall file a petition before the Court of First Instance or the Committee, notifying the other party or counsel thereof, within ninety (90) days of

receiving the decision under Article 4.14 of the Rule.

ARTICLE 4.20 Judicial Review

- A. Any non-prevailing party in a decision issued by the Committee may request, within thirty (30) days following notification of the decision, review by the Puerto Rico Court of First Instance, within the territorial limits of the parties' residence or that of any of the parties. Said review shall be effected summarily, further to service of notice as provided by law.

- B. The decision of the Committee shall remain in full force and effect until such time as the decision of the Puerto Rico Court of First Instance becomes final and revokes said decision.

ARTICLE 4.21 Submission to the Insurance Commissioner

The final decision or ruling issued on the controversies submitted to arbitration shall be made a part of the contract proposed in the collective bargaining and shall be submitted by the parties to the Insurance Commissioner, under the terms provided in Article 3.11 of this Rule.

CHAPTER V. MEDICAL PLAN AND INSURANCE RATE REVIEW BOARD

ARTICLE 5.01 Purpose

The purpose of this Chapter is to foster public welfare by regulating the rates used to determine premiums for insurance plans that provide health care benefits, in order to ensure that said amounts are fair, appropriate, reasonable, and non-discriminatory.

ARTICLE 5.02 Duties and Powers

The Board shall have the following duties and powers:

- A. To regulate, supervise, and approve the rates used to determine the premium to be paid for health insurance or a health care plan. For this purpose, the Board shall study, analyze, and approve the structure, components, and factors used to determine the rates;

- B. To review decisions made by the Panel regarding increases in premiums or reductions in coverage and/or services resulting from a unilateral act.

ARTICLE 5.03 Board

The Board shall be attached to the Office of the Insurance Commissioner.

ARTICLE 5.04 Composition

- A. The Board shall be comprised of:
 - a. The Insurance Commissioner, who shall be the Chair, but shall not have the right to vote, except as may be necessary to arrive at a decision because the members of the Board are equally divided;
 - b. A citizen who is knowledgeable in the public health area, appointed by the Insurance Commissioner with the recommendation of the Secretary of the Health Department;

- B. In addition, as associate members of the Board there will be:
 - a. One (1) provider representative;
 - b. One (1) representatives of health care services organizations or third party administrators; and

- C. The members of the Board may not have any direct ownership or financial interest in the matters before the consideration of the Board.

ARTICLE 5.05 Associate Members

- A. Associate members, as mentioned in Paragraph (B) of the previous Article shall be appointed by the Insurance Commissioner and shall fulfill the following requirements:
 - a. Having been a resident of Puerto Rico for at least one (1) year and having specific knowledge in the insurance or health care plan fields;
 - b. Not having been convicted of any offense implying dishonesty or moral turpitude.

- B. Of the associate members mentioned in sub-paragraphs (B) (a) and (b) of the previous Article, an appointment will be made of one as indicated in each sub-paragraph, for a term of three (3) years, and the remainder for a term of two (2) years.

- C. The successors of the associate members shall be appointed for a term of five (5) years. Any person chosen to fill a vacancy shall fulfill the same requirements as were fulfilled by the member being substituted and shall be appointed for the remainder of the term of such member.

- D. At the expiration of the term of any of the associate members, the member may continue to exercise the functions of the position until a successor has been appointed and assumed the position.

- E. Such associate members of the Board who are not public servants shall have the right to receive the

amount of seventy-five dollars (\$75.00) for every duly notified meeting, up to a maximum of five thousand dollars (\$5,000.00) a year.

ARTICLE 5.06 Quorum

The Board shall be deemed to have been duly constituted when there are three (3) or more members recorded as present. Decisions are to be made by the majority of the attending members. Each member shall have the right to one (1) vote. The Board shall call a meeting at least once a month, or as many times as may be necessary to comply with the provisions of this Rule.

ARTICLE 5.07 Advisory Committees

- A. The Board shall be advised and assisted in its functions by four (4) Advisory Committees that will issue recommendations on any matter referred to them. These Advisory Committees shall be the:
- a. Legal Committee;
 - b. Committee on Examinations and Audits;
 - c. Actuarial and Policy and Risk Analysts Committee;
 - d. Adjudication and Reconsideration Committee.
- B. The Committees shall be constituted by staff of the Office of the Insurance Commissioner, who have been charged with the function and responsibility of constituting said Committees. The Insurance Commissioner may create any other committee and appoint staff or consultants that the Commissioner may deem necessary to carry out the functions of said Advisory Committees.

ARTICLE 5.08 Submission

Parties interested in the approval of insurance or a plan providing health care benefits shall submit the following to the Commissioner:

- A. The form and/or evidence of coverage, approved by the Commissioner as provided in Chapter 11 of the Puerto Rico Insurance Code, 26 L.P.R.A. §§ 1101 *et seq.*, and Article 19.080 of Chapter 19 of the Puerto Rico Insurance Code, 26 L.P.R.A. § 1908. It is further provided that no reduction of coverage arising from a unilateral act may enter into effect without the unanimous agreement or consent of the Panel.
- a. If the Commissioner determines that compared to the previously filed product, there has been a reduction in coverage, as a result of a unilateral act of the insurer, the Commissioner shall notify the filing party of the form and/or evidence of coverage that such will not enter into effect nor be approved without the prior unanimous consent of the Panel, unless the filing party corrects the

objections of which the party has been notified.

- b. In such an event, within fifteen (15) days of said notice, the filing party shall correct the objection made by the Commissioner or request in writing the consent of the Panel approving the reduction in coverage. Once said consent is submitted to the Insurance Commissioner, the terms for approval of said filing shall resume.
- c. If the interested party does not agree with the decision of the Panel, the party may request review by the Board within thirty (30) days of the notification. In said case, the Board shall hold an administrative hearing to hold a full review of the decision.

B. The rates or multiplier rates to be used to determine the premiums of an insurance policy or plan providing health care benefits, as provided in Chapter 12 of the Puerto Rico Insurance Code, 26 L.P.R.A. §§ 1201 *et seq.*, and Article 19.080 of Chapter 19 of the Puerto Rico Insurance Code, 26 L.P.R.A. § 1908.

ARTICLE 5.09 Approval of Rates

When the rates or multiplier rates have been filed with the Office of the Insurance Commissioner, pursuant to Paragraph (B) of the previous Article, the decision on their reasonability shall be referred to the Board for the approval of their use, as provided in Chapters 12,19, and 31 of the Puerto Rico Insurance Code and this Rule.

- A. If it is found that there is an increase in rates or any other element that is the result of a unilateral act, the effect of which is reflected on the premium, the Board shall notify the interested party that the filing cannot enter into effect without the unanimous consent of the Panel or the correction of the objection expressed by the Board.
 - a. If the filing party fails to correct the objection and proceeds to request the consent of the Panel, any decision made by the Panel on the matter may be subject to full review by the Board, further to the request of any of the parties, under the term provided in Article 5.10 of this Rule;
 - b. If the increase in premiums is based on or arises as a consequence of the implementation of agreements made in collective bargaining, as authorized in Chapter 31 of the Puerto Rico Insurance Code and this Rule, the decision made by the Panel shall be conclusive for the Board and may not be subject to review. In said event, the interested parties may only appeal the decision before the Court of Appeals, pursuant to Public Law No. 170, *supra*.

- B. If the Board determines that there was an increase in the deductible or co-pay and that said increase

arises as a consequence of the implementation of agreements made in collective bargaining, as authorized in Chapter 31 of the Puerto Rico Insurance Code and this Rule, the Board shall notify the interest party that the filing cannot enter into effect without the unanimous consent of the Panel.

ARTICLE 5.10 Review of Ruling by the Board

The non-prevailing petitioner affected by a determination of the Board may request an administrative hearing, within thirty (30) days following the notification of said determination, as provided in Article 2.190 of Public Law No. 263, enacted on August 13, 2008. With regard to the determination made by the Board further to holding a hearing or refusing to hold such hearing, the non-prevailing party may seek judicial review before the Court of Appeals, under the provisions of the Puerto Rico Insurance Code and Public Law No. 170, *supra*.

ARTICLE 5.11 Exclusions

The following bodies are excluded from the provisions of this Chapter: (i) the Association of Employees of the Commonwealth of Puerto Rico, as created under Public Law No. 133, enacted on June 28, 1966, as amended, known as the "Commonwealth of Puerto Rico Employees Act," 3 L.P.R.A. §§ 862 *et seq.*; (ii) the Health Plan of the Government of Puerto Rico, as created under Public Law No. 72, *supra*; (iii) the insurance issued by the State Insurance Fund Corporation, as created by Public Law No. 45, enacted on April 18, 1935, as amended, known as the "Compensation for Occupational Accidents Act," 11 L.P.R.A. §§ 1 *et seq.*; (iv) the Medicare Advantage program created by the Medicare Prescription Drug Improvement and Modernization Act, 117 Stat. 2066; (v) medical plans organized under the Employee Retirement Income Security Act ("ERISA"), 88 Stat. 829 and the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), 100 Stat. 82; (vi) Group Plans contracted by employers for their employees or a group for its members, and those in which the negotiation of rates between a health services organization and a group whose rates are established based on its own experience and demographic composition, among other variables, and whose rates are based on accepted actuarial principles ("Tailor Made"); (vii) medical plans under Public Law No. 95, enacted on June 29, 1963, known as the "Public Employee Health Benefits Act," as amended, 3 L.P.R.A. §§ 729 *et seq.*; (viii) medical plans resulting from collective bargaining with government or private employers, or any other plan whose issuer is not under the jurisdiction of the Office of the Insurance Commissioner.

ARTICLE 5.12 Transitory Provision

Any person, who at the time of the approval of this Rule, is authorized to write, and who in fact writes insurance or plans that provide health care benefits and who is not expressly excluded by this Rule, may

file, within ninety (90) days of the approval of this Rule, the forms, evidence of coverage, and rates currently being used and written. This filing does not require prior approval by the Commissioner or any other entity.

CHAPTER VI. PANEL PROCEEDINGS

ARTICLE 6.01 Purpose

The purpose of this Chapter is to allow officials and agencies of the Commonwealth of Puerto Rico that are charged with defending consumer welfare with regard to health care services, plans, and insurance to intervene in the approval proceedings of the Panel regarding increases in deductibles, co-pays, premiums or rates and reductions in coverage of an insurance product.

ARTICLE 6.02 Composition

Pursuant to the Law, the Panel shall be comprised of: (i) the Health Department (ii) the Insurance Commissioner; (iii) the Ombudsman, and (iv) the Patients' Ombudsman.

ARTICLE 6.03 Authority

The Panel shall have the authority to approve the following, with a view to ensuring that they are fair, appropriate, reasonable, and non-discriminatory:

- A. Increases in deductible, co-pay or premium amounts resulting from negotiations authorized under the Law and this Rule;
- B. Any increase in premiums or reduction in coverage and/or services based on a unilateral act.
For these results to enter into effect in Puerto Rico, there must be unanimous agreement in the Panel.

ARTICLE 6.04 Powers

The Panel shall have such powers and mechanisms provided by the organic laws of the government bodies that comprise the Panel to ensure enforcement of the Law and this Rule.

ARTICLE 6.05 Procedure for Approval by the Panel

- A. When the Commissioner determines that the insurance policy or plan providing health care benefits, submitted for approval under Article 5.08 of this Rule, shows an increase in the deductible, co-pay or

premium amounts or a reduction in coverage, with regard to which the Panel has authority, the Commissioner shall notify the filing party within sixty (60) days of the filing, stating that such application will not be approved for use in Puerto Rico unless the requirement of obtaining prior unanimous consent is complied with, as provided under Law. Said party shall request approval from the Panel, providing notice of the request no later than ten (10) days from the date of receipt of notice from the Commissioner.

- B. Notice to the Panel shall include a certified copy of the Commissioner's case record.
- C. The Panel shall make a final decision based on the matters brought before it, within thirty (30) days of the submission of the application. If the Panel deems it necessary, a written recommendation by a competent official designated by the Panel may be requested.
- D. After the final ruling of the Panel, under Public Law No. 170, *supra*, the non-prevailing party shall have thirty (30) days from the notice of the ruling to apply for review before the Board, in the case of unilateral increases, or before the Court of Appeals, if the increases are the result of collective bargaining.

CHAPTER VII FINAL PROVISIONS

ARTICLE 7.01 Derogation Clause

Unless otherwise provided, this Rule abrogates any rule, guideline, procedure or part thereof that may conflict with the provisions herein.

ARTICLE 7.02 Proviso

Any matter not covered by this Rule shall be resolved by the Insurance Commissioner, the Secretary of Health and the Secretary of Justice, under applicable legislation, regulations, and executive orders. Any matter not provided for herein shall be governed by the standards of sound public administration and current public policy.

ARTICLE 7.03 Severability Clause

In the event that any provision of this Rule or any amendment that may be made hereto in the future, is found to be void or unconstitutional by an authority of competent jurisdiction, such decision shall not

affect the validity of the remaining provisions thereof, and the effect of such a ruling shall be limited to the word, paragraph, sentence, article or specific part found to be void or unconstitutional.

CHAPTER VIII EFFECT

This Rule shall enter into effect with six (6) months of the approval thereof by the Department of State, under the provisions of Public Law No. 170, *supra*.

Chapter IX AMENDMENTS

This Rule may be amended jointly by the Insurance Commissioner, the Secretary of Health and the Secretary of Justice.

(signed)

DORELISSE JUARBE
COMMISSIONER OF INSURANCE

(signed)

ROBERTO SANCHEZ-RAMOS
SECRETARY OF JUSTICE

(signed)

JOHNNY RULLAN
SECRETARY OF HEALTH

Date of approval: December 23, 2008

Date of Filing at
the Department of State:

Date of Filing at
the Library of the Legislature: