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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2758 Session of 2010

INTRODUCED BY DeLUCA, BELFANTI, CALTAGIRONE, CASORIO, D. COSTA, DALEY, DONATUCCI, GRUCELA, HARKINS, JOSEPHS, McILVAINE SMITH, MUNDY, OLIVER, PASHINSKI, PAYTON, READSHAW AND K. SMITH, SEPTEMBER 24, 2010

REFERRED TO COMMITTEE ON INSURANCE, SEPTEMBER 24, 2010

AN ACT

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," providing for affordable small group health care coverage; and making inconsistent repeals.

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

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

ARTICLE XLII

AFFORDABLE SMALL GROUP HEALTH CARE COVERAGE

Section 4201. Scope of article.

This article relates to health care reform.

Section 4202. 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:

"Accident and Health Filing Reform Act." The act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Commonwealth Attorneys Act." The act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

"Commonwealth Documents Law." The act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law.

"Creditable coverage." As defined in section 2701 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 U.S.C. § 300gg).

"Department." The Insurance Department of the Commonwealth.

"Eligible employee." A person employed by a large employer or a small employer on a regularly scheduled basis, with a normal work week of 17.5 hours or more, but does not include persons who work on a temporary, seasonal or substitute basis.

"Health benefit plan." Any individual or group health insurance policy, subscriber contract, certificate or plan which provides health or sickness and accident coverage which is offered by an insurer. The term shall not include any of the following:

(1) An accident only policy.

(2) A credit only policy.

(3) A long-term or disability income policy.

(4) A long-term care policy.

(5) A specified disease policy.

(6) A Medicare supplement policy.

(7) A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(8) A fixed indemnity policy.

(9) A dental only policy.

(10) A vision only policy.

(11) A workers' compensation policy.

(12) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

(13) Any other similar policy providing for limited benefits.

"Individual market." The health insurance market for individuals as defined in section 2791 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 U.S.C. § 300gg-91).

"Insurer." A company or health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under this act or any of the following:

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

(2) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services

plan corporations).

(4) Article XXIV.

"Large employer." In connection with a group health plan with respect to a calendar year and a plan year, an employer who employs an average of 51 or more eligible employees on business days during the preceding calendar year and who employs at least 51 eligible employees on the first day of the plan year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination whether an employer is a large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year.

"Large group market." The health insurance market for large employers.

"Medical loss ratio." As defined in the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119).

"NAIC." The National Association of Insurance Commissioners.

"Plan year." The 12-consecutive-month period beginning on the first day of coverage under a health benefit plan.

"Preexisting condition exclusion." As defined in section 2701 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 U.S.C. § 300gg). Pregnancy and conditions for which medical advice, diagnosis, care or treatment was recommended or received before birth or within the first 60 days after birth or within the first 60 days after adoption of a minor child shall not be treated as conditions described in the definition in section 2701.

"Small employer." In connection with a group health plan with respect to a calendar year and a plan year, an employer who

employs an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination whether an employer is a small employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year.

"Small group health benefit plan." A health benefit plan offered to a small employer.

"Small group market." The health insurance market for small employers.

"Standard plan." One of the health benefit packages established by the Insurance Department in accordance with section 4204.

Section 4203. Health insurance premium rates.

(a) Applicability.--This section shall apply to all small group health benefit plans that are issued, made effective, delivered or renewed in this Commonwealth after the effective date of this section.

(b) Premium rates.--

(1) The premium for a small group health benefit plan shall not be adjusted by an insurer more than once each year, except that rates may be changed more frequently to reflect:

(i) Changes to the enrollment of the small employer group.

(ii) Changes to a small group health benefit plan that have been requested by the small employer.

(iii) Changes pursuant to a government order or

judicial proceeding.

(2) An insurer shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles. Rates shall not be excessive, inadequate or unfairly discriminatory.

(c) Additional rate review and prior approval.--

(1) In conjunction with and in addition to the standards set forth in the Accident and Health Filing Reform Act, and all other applicable statutory and regulatory requirements, all rate filings shall be subject to prior approval by the department within the 45-day period provided under section 3(f) of the Accident and Health Filing Reform Act.

(2) In conjunction with and in addition to the standards set forth under the Accident and Health Filing Reform Act, and all other applicable statutory and regulatory requirements, the department may disapprove a rate filing based upon any of the following:

(i) The rate is not actuarially sound.

(ii) The increase is requested because the insurer has factored in experience that conflicts with recognized best practices in the health care industry, including the allocation of administrative expenses to the plan on a less favorable basis than expenses are allocated to other health benefit plans.

(iii) The increase is requested because the insurer has incurred costs due to failure to follow best practices for cost control, including efforts to promote a reduction in hospital-acquired infections and serious preventable adverse events.

(iv) The medical loss ratio for a plan violates the

Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119).

(3) In the event a plan has a medical loss ratio that violates the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), the department may, in addition to any other remedies available under law, require the insurer to refund the difference to policyholders on a pro rata basis as soon as practicable following receipt of notice from the department of the requirement but in no event later than 120 days following receipt of the notice. The department shall establish procedures under which such refunds will be made.

(d) Procedures.--The filing and review procedures set forth under the Accident and Health Filing Reform Act shall apply to any filing conducted under this section, except that no filing deemed to meet the requirements of this act shall take effect unless the department receives written notice of the insurer's intent to exercise the right granted under this section at least ten calendar days prior to implementation of rates authorized by this act.

Section 4204. Fair marketing standards.

Every insurer and producer must meet the following standards, as appropriate:

(1) An insurer that offers small group health benefit plans shall offer to small employers all of the small group health benefit plans that the insurer actively markets in this Commonwealth. An insurer shall be considered to be actively marketing a small group health benefit plan if it offers that plan to any small group not currently covered by that insurer.

(2) The following shall apply:

(i) Except as provided in subparagraph (ii), a producer or an insurer that provides small group health benefit plans shall not encourage or direct a small employer to refrain from filing an application for coverage with the insurer or seek coverage from another insurer because of a health status-related factor or the nature of the industry, occupation or geographic location of the small employer.

(ii) The provisions of subparagraph (i) shall not apply with respect to information provided by an insurer or producer to a small employer regarding an established geographic service area or a restricted network provision of an insurer.

(3) An insurer that provides small group health benefit plans shall not enter into a contract, agreement or arrangement that provides for or results in a producer's compensation being varied because of a health status-related factor or the nature of the industry or occupation of the small employer.

(4) An insurer that provides small group health benefit plans shall not terminate, fail to renew or limit its contract or agreement with a producer for a reason or reasons related to a health status-related factor or occupation of the small employer.

(5) A producer or insurer that provides small group health benefit plans shall not induce or encourage a small employer to exclude an employee or the employee's dependents from health coverage or benefits available under the plan.

Section 4205. Reporting requirements.

(a) Health insurance market reports.--Not less frequently than March 1 of every calendar year, the department may require each insurer and each insurer group to file the following reports with the department:

(1) Aggregate financial information for the preceding year derived from each insurer's NAIC annual statement blank or, if not available from the annual statement blank, from other certifiable records:

(i) Total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses.

(ii) Total amount of surplus maintained.

(iii) Total amount of reserves maintained for unpaid claims.

(iv) Total net underwriting gain or loss.

(v) Insurer's net income after taxes.

(2) Market information for the preceding calendar year, derived from each insurer's NAIC annual statement blank or, if not available from the annual statement blank, from other certifiable records that are segmented Statewide and segregated for the individual market, the small group market and the large group market:

(i) Total number of members as of December 31.

(ii) Total number of member months.

(iii) Premiums earned.

(iv) Incurred medical claims costs.

(v) Medical loss ratio.

(vi) Average premium per member per month for the reporting year, derived by dividing earned premiums by member months.

(vii) Average premium per member per month for the preceding reporting year, derived by dividing earned premiums by member months.

(viii) A description of each rating method used to determine rates indicating the specific group size for which each method was used.

(ix) A listing of all factors used in the rating for each market and the range of these factors.

(3) Aggregate market information for the preceding year derived from each insurer's NAIC annual statement blank or, if not available there, from other certifiable records, for covered lives in Pennsylvania by individual market, small group market and large group market:

(i) Total number of members covered by entities with administrative services contracts or administrative services-only arrangements.

(ii) Total number of members covered by associations or out-of-State trusts covering lives in Pennsylvania.

(b) Submission.--Each report required by this section shall be electronically submitted in a format and according to instructions prescribed by the department.

(c) Public access.--The department shall make the information reported under this section available to the public through a searchable public Internet website.

(d) Data calls.--The department may issue data calls as necessary to fulfill the requirements of this article. Any data calls issued under this section shall be published in the Pennsylvania Bulletin.

(e) Limitation.--The department shall have discretion to modify the reporting requirements of this section by

transmitting notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(f) Compliance.--For failure to comply with any reports or data calls required under this section, the commissioner shall impose an administrative penalty of $1,000 against each insurer for every day that the report or data is not provided in accordance with this section.

(g) Definition.--As used in this section, specifically for purposes of the reporting required in subsection (a), "member" means an individual person covered by a health benefit plan, an association or an out-of-State trust. The term includes dependents.

Section 4206. Regulations.

The department and the Department of Education shall promulgate regulations as necessary for the implementation and administration of this article. The department may promulgate regulations as necessary for the implementation of this article.

Section 4207. Small employer groups.

(a) Formation authority.--A group of two or more small employers may form a purchasing group for the purpose of purchasing a small group health benefit plan provided for under this article from an insurer.

(b) Certification.--No insurance policy may be issued, delivered or renewed to a purchasing group unless that purchasing group has a valid certification from the department.

(c) Certification subject to criteria.--Unless certification requirements are promulgated, certification under this subsection shall be subject to the criteria set forth in section 621.2(a)(5.1).

(d) Applicability.--The provisions of this section shall

apply notwithstanding the provisions of section 621.2(a)(2).

Section 4208. Enforcement.

(a) Determination of violation.--Upon a determination that a person licensed by the department has violated any provision of this article, the commissioner may, subject to 2 Pa.C.S. Chs. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and 7 Subch. A (relating to judicial review of Commonwealth agency action), do any of the following:

(1) Issue an order requiring the person to cease and desist from engaging in the violation.

(2) Suspend or revoke or refuse to issue or renew the certificate or license of the offending party or parties.

(3) Impose an administrative penalty of up to $5,000 for each violation.

(4) Seek restitution.

(b) Other remedies.--The enforcement remedies imposed under this section shall be in addition to any other remedies or penalties that may be imposed by any other statute, including:

(1) The act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. A violation by any person of this article is deemed an unfair method of competition and an unfair or deceptive act or practice under the Unfair Insurance Practices Act.

(2) The Accident and Health Filing Reform Act.

Section 2. Repeals are as follows:

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

(2) Section 3 of the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act,

is repealed insofar as it applies to small group health benefit plan rates.

(3) All other acts and parts of acts are repealed insofar as they are inconsistent with the addition of Article XLII of the act.

Section 3. This act shall take effect immediately.