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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1601 Session of 2007

INTRODUCED BY EACHUS, JUNE 21, 2007

REFERRED TO COMMITTEE ON INSURANCE, JUNE 21, 2007

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 small group health benefits.

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 XXII

SMALL GROUP HEALTH BENEFITS

Section 2201. Scope of article.

This article relates to health benefit plans offered by an insurer to employees of a small employer.

Section 2202. 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 rate." An insurer's rating methodology that is based on the experience of all risks covered by that plan without regard to health status, occupation or any other factor. An insurer may adjust its community rate for age, geographic region as approved by the Insurance Department and family composition.

"Department." The Insurance Department of the Commonwealth.

"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) Accident only policy.

(2) Limited benefit policy.

(3) Credit only policy.

(4) Long-term or disability income policy.

(5) Specified disease policy.

(6) Medicare supplement policy.

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

(8) Fixed indemnity.

(9) Dental only.

(10) Vision only.

(11) Workers' compensation policy.

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

"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).

"Medical loss ratio." The ratio of incurred medical claim costs to earned premiums.

"Preexisting condition." A disease or physical condition for which medical advice or treatment has been recommended or received prior to the effective date of coverage.

"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 employees on business days during the preceding calendar year and who employs at least two such 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 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.

"Standard plan." The health benefit package established by the Insurance Department in accordance with section 2203(d).

Section 2203. Health insurance rate increases and standard plan.

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

(b) Premium rates.--

(1) All insurers shall establish community rates for plans subject to this section and shall file the rates with the department as required by law.

(2) An insurer shall apply all risk adjustment factors under subsection (c)(1)(i), (ii) and (iii) consistently with respect to all plans subject to this section.

(3) An insurer shall not charge a rate that is more than 33% above or below the community rate, as adjusted as permitted under paragraph (1).

(4) 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.--

(1) In conjunction with and in addition to the standards set forth under the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act, and all other applicable statutory and regulatory

requirements, the department may disapprove a rate filing based upon the following:

(i) The rate is not actuarially sound.

(ii) The increase is requested because the insurer has not operated efficiently or has factored in experience that conflicts with recognized best practices in the health care industry.

(iii) The increase is requested because the insurer has incurred costs of additional care due to avoidable hospital-acquired infections and avoidable hospitalizations due to ineffective chronic care management, after data for the incidents has become available to and can be analyzed by the insurer and the department.

(iv) For small group health plans, the medical loss ratio is less than 85%.

(2) In the event a small group health benefit plan has a medical loss ratio of less than 85%, 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 such requirement but in no event later than 120 days following receipt of the notice. The department shall establish procedures for the circumstances under which the refunds will be required.

(3) The filing and review procedures set forth under the Accident and Health Filing Reform Act shall apply to any filing conducted under this section.

(d) Standard plan required.--

(1) An insurer shall not offer a plan that does not meet

the minimum benefits specified in the standard plan developed by the department in accordance with the following criteria:

(i) Plans offered by an insurer on an expense-incurred basis shall be actuarially equivalent to at least the minimum benefits required to be offered under the standard plan.

(ii) The standard plan shall at least include all of the benefits of the basic benefit package except that it shall not include coverage for drug and alcohol treatment and mental health care services.

(iii) The standard plan shall not contain preexisting condition exclusion.

(2) The standard plan may include options for deductible and cost-sharing provisions if the department determines that the provisions meet all of the following:

(i) Dissuade consumers from seeking unnecessary services.

(ii) Balance the effect of cost-sharing in reducing premiums and in effecting utilization of appropriate services.

(iii) Limit the total cost-sharing that may be incurred by an individual in a year.

(3) Each individual in this Commonwealth who applies to an insurer for enrollment in a plan offered by the insurer shall be accepted as an enrollee.

(4) The department shall forward a notice of the elements of the standard plan to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. Insurers subject to the provisions of this section shall be required to begin offering the standard plan as soon as practicable

following the publication but in no event later than 120 days following the publication.

(e) Optional additional coverage.--

(1) An insurer may offer benefits in addition to those in the standard plan if the additional benefits meet all of the following:

(i) Are offered and priced separately from benefits specified in the standard plan.

(ii) Do not have the effect of duplicating any of the benefits in the standard plan.

(iii) Are clearly specified as enhancements to the standard plan.

(2) Each benefit offered in addition to the standard plan that increases health care choices or lowers the cost-sharing arrangement is subject to all of the provisions of this section applicable to the standard plan.

(3) The department may prohibit an insurer from offering an additional benefit under this section if the department finds that the additional benefit will be sold in conjunction with the standard plan of the insurer in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this section or other statute.

(f) Regulations.--The department may promulgate regulations necessary for the implementation and administration of this article.

Section 2. This act shall take effect in 120 days.