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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 5 Session of 1995

INTRODUCED BY GANNON, MICOZZIE, RYAN, PERZEL, BARLEY, FARGO, PHILLIPS, E. Z. TAYLOR, PITTS, D. W. SNYDER, DEMPSEY, CLARK, TRELLO, KING, CORNELL, PESCI, HERMAN, FAJT, CHADWICK, HESS, BROWN, MILLER, ZUG, WAUGH, REBER, GODSHALL, SCHULER, LYNCH, FLICK, LEH, ADOLPH, PETTIT, NYCE, RAYMOND, SHEEHAN, HUTCHINSON, ROHRER, SCHRODER, RUBLEY, PLATTS, STEIL, SATHER, SAYLOR, BROWNE, BIRMELIN, FAIRCHILD, CIVERA, FLEAGLE, STERN, FEESE, HENNESSEY, SEMMEL, GEIST, HERSHEY, FICHTER, ALLEN, ARMSTRONG, MERRY, MARSICO, BUNT, NICKOL, GRUPPO, BOYES, LAWLESS AND STAIRS, FEBRUARY 2, 1995

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 2, 1995

AN ACT

Providing for a health insurance program for families; and imposing additional powers and duties on the Insurance Department.

TABLE OF CONTENTS

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

Section 1. Short title.

This act shall be known and may be cited as the Affordable Insurance Measure for Family Health Care.

Section 2. Statement of purpose.

The General Assembly finds and declares as follows:

(1) The cost of health insurance coverage is not affordable for many small businesses, their employees, self-employed persons, their family members and other individuals.

(2) As a result, almost 1,000,000 Commonwealth citizens do not have any health insurance coverage.

(3) The cost of health insurance should be reduced for these citizens by:

(i) authorizing the development of new classes of hospital and medical insurance coverage for qualified groups, families and individuals; and

(ii) authorizing the department to develop means to assist in limiting the marketing and administrative costs of certain new classes of insurance coverage.

Section 3. Definitions.

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

"Ambulatory surgical facility." A facility not located on the premises of a hospital which provides outpatient surgical treatment. The term does not include individual or group practice offices or private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

"Case characteristics." Demographic and other relevant characteristics that are considered by the insurer in the determination of premium rates for a small business employer. The term excludes claims experienced, health status and duration of coverage since date of issue.

"Children's Health Care Act." The act of December 2, 1992 (P.L.741, No.113).

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Employee." An individual who works a minimum of 30 hours a week for an employer in return for compensation.

"Employer." A business as defined as a small business by the Federal small business administration. Employees of such employer are eligible for coverage under a low-cost comprehensive health insurance policy or a small business health care benefit plan.

"Health care supplier." An entity which is organized for the purpose of arranging for the provision of health care services, including, but not limited to, inpatient, outpatient, primary and specialty physician services, diagnostic and emergency care

and home health care.

"Hospital." An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of persons who are injured, disabled, pregnant, diseased, sick or mentally ill. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, including facilities which provide care and treatment exclusively for persons who are mentally ill and drug or alcohol inpatient detoxification or rehabilitative care.

"Inequitable or inappropriate treatment." Treatment that does not meet the generally accepted medical standard of care within the community where the health care services are provided.

"Insured." An individual or group insured under a low-cost comprehensive health insurance policy or a small business health care benefit plan.

"Insurer." An insurer, health maintenance organization, fraternal benefit society, hospital plan, health services plan corporation or health care supplier offering a low-cost comprehensive health insurance policy or a small business health care benefit plan.

"Intermediate care." Intensive day-care treatment for the mentally ill provided in a State-licensed or State-approved facility or intensive, skilled and intermediate nursing home care provided in a State-licensed or State-approved facility.

"Low-cost comprehensive health insurance policy." A policy or subscription contract which an insurer may choose to offer to a qualified individual, qualified family or qualified group.

"Outpatient hospital care." Surgery, anesthesia, pre-admission testing, diagnostic X-rays and preventative and diagnostic medical and laboratory services provided in a hospital or in an ambulatory surgical facility. Also, preventative and diagnostic medical and laboratory services provided by an independent, nonhospital affiliated facility; however, it is unlawful for a provider to refer a person for preventative and diagnostic medical services if the provider has a financial interest with the person or in the entity that receives the referral. It is unlawful for the provider to enter into an arrangement or scheme such as a cross-referral arrangement which the provider knows or should know has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to such entity would be considered unlawful. However, a provider, where circumstances are warranted, may obtain from the Department of Health a waiver to the prohibition on self-referrals and cross-referrals. This exemption does not apply to counties of the first, second and second class A classes.

"Permitted coverage." Health or hospitalization insurance coverage under this act, Medicaid, Medicare or the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, 100 Stat. 82).

"Qualified family." Individuals who are qualified individuals and who are related to each other by blood, marriage or adoption.

"Qualified group." A group in which each covered individual or covered dependent within the group is a qualified individual. The term includes less than all employees of an employer. The term excludes a qualified purchasing group.

"Qualified individual." An individual who is employed in or is a resident of this Commonwealth and who has been without health insurance coverage, other than permitted coverage. The term includes a child newborn to or adopted by an insured after the effective date of a low-cost comprehensive health insurance policy issued to the insured which covers the insured and members of the insured's family.

"Qualified purchasing group." A group organized under section 5.

"Similar plans." Plans which do not materially differ from one another in any of the following respects:

(1) The set of services covered.

(2) Utilization management provisions.

(3) Managed care network provisions.

(4) The criteria used by the insurer in underwriting coverage under a plan where variations in the criteria may reasonably be expected to produce substantial variation in the claims costs incurred under the plan.

"Small business health care benefit plan."

(1) Except as provided in paragraph (2), any of the following:

(i) A health, sickness or accident insurance policy providing hospital, medical or surgical coverage for sole proprietorships or employers.

(ii) A policy which is a subscriber contract or certificate issued by an insurer to provide hospital, medical or surgical coverage for sole proprietorships or employers.

(iii) A subscriber contract or certificate which is issued by an entity to provide hospital, medical or

surgical coverage for employers and which is subject to:

(A) section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921;

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

(C) the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code;

(D) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or

(E) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(2) The term excludes all of the following:

(i) Accident-only coverage.

(ii) Fixed indemnity coverage.

(iii) Low-cost comprehensive health insurance policies.

(iv) Credit insurance.

(v) Medicare supplements.

(vi) Disability income insurance.

(vii) Coverage issued as a supplement to liability insurance.

(viii) Worker's compensation or similar insurance.

(ix) Automobile medical payment insurance.

Section 4. Issuance of low-cost comprehensive health insurance policies permitted.

(a) General rule.--Insurers are authorized to issue low-cost comprehensive health insurance policies to qualified

individuals, qualified families, qualified groups and qualified purchasing groups.

(b) Cancellation prohibited.--An employer is prohibited from canceling a health care policy or subscriber contract for a low-cost comprehensive health insurance policy.

Section 5. Qualified purchasing groups.

Solely for purposes of obtaining a low-cost comprehensive health insurance policy or a small business health care benefit plan, qualified purchasing groups may be formed, composed of qualified individuals, qualified families or qualified groups. Each qualified purchasing group may serve as a master policyholder. Members of qualified groups and members of qualified purchasing groups may join together solely for the purpose of obtaining health insurance coverage under this act. Qualified purchasing groups shall not require a health screening for membership nor require any other unreasonable barriers to membership.

Section 6. Coverage.

(a) Requirements.--Low-cost comprehensive health insurance policies offered must provide the following:

(1) Thirty days of inpatient hospital surgical and medical coverage and outpatient hospital care coverage per policy year. Intermediate care coverage may be substituted for inpatient hospital care on a four-days-for-each-inpatient-day basis, and home health care may be substituted on seven-visits-for-each-inpatient-day basis.

(2) Coverage for office visits for primary care, including prenatal and postnatal maternal care and well-baby care for covered services rendered by a licensed provider. Total covered office visits shall be calculated on the number

of eligible family members multiplied by four and allocated in the aggregate to the family unit on an annual basis.

(3) Coverage for one mammogram screening per year for females 40 years of age or older and coverage for all medically necessary mammograms.

(4) Medically necessary child immunizations.

(5) Annual, lifetime or other benefit limits in amounts established by the department but which initially shall be not less than $100,000 as an annual benefit and $250,000 as a lifetime benefit.

(6) A waiting period as established by the department for transferring from a low-cost comprehensive health insurance policy issued to a qualified individual or qualified family by one insurer to a low-cost comprehensive health insurance policy issued to a qualified individual or qualified family by another insurer.

(7) If the policy covers the insured and members of the insured's family, coverage for newborn children of the insured from the moment of birth and coverage for adopted newborn children and for other adopted children, with prior coverage from the date of the interlocutory decree of adoption. The insurer may require that the insured give notice to its insurer of any newborn child within 90 days following the birth of the newborn child and of any adopted child within 60 days of the date the insured has filed a petition to adopt. The coverage of newborn children or adopted children must not be less than coverage provided for other members of the insured's family.

(8) Such provisions as the department may require for an annual or other deductible or equivalent; patient copayments,

including a differential, for nonpreferred providers; annual stop-loss amounts; conversion; replacement of prior carrier's coverage; and exclusionary period for preexisting conditions.

(b) Options.--In a low-cost comprehensive health insurance policy, the insurer may offer for purchase, individually or in combination, all of the following:

(1) Coverage for additional prenatal care, including one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month until term. Coverage for each visit may include necessary and appropriate screening, including history, physical examination and laboratory and diagnostic procedures deemed appropriate by the physician and based upon recognized medical criteria for the risk group of which the patient is a member. Coverage for each office visit may also include prenatal counseling as the physician deems appropriate.

(2) Coverage for additional obstetrical care, including physicians' services, delivery room and other medically necessary hospital services and services performed by licensed, certified midwives.

(3) Coverage for additional inpatient and outpatient psychiatric treatment and rehabilitative services.

(4) Coverage for cancer chemotherapy and cancer hormone treatments and services.

(5) Benefits for drug and alcohol abuse and dependency.

(6) Coverage for osteopathic services.

(7) Dental coverage.

(8) Pharmaceutical coverage.

(9) Coverage for podiatric services.

(10) Coverage for psychologist services.

(11) Coverage for optometric services.

(12) Coverage for chiropractic services.

(13) Coverage for physical therapist services.

(14) Coverage for services of clinical laboratory professionals.

(15) Coverage for services of certified registered nurses, certified registered nurse practitioners, certified enterostomal therapy nurses, certified community health nurses, certified psychiatric mental health nurses and certified clinical nurse specialists acting within the scope of their license.

(16) Coverage for medical rehabilitation services.

(17) Coverage for additional home health care.

(c) Waiver.--The department shall consider the cost impact and essential nature of each of the provisions in subsections (a) and (b), and the competitive impact of the requirements and may, by regulation, waive required coverage and establish alternative benefit methods to encourage participation of insurers, employers and employees in a manner consistent with meeting the goal of providing basic health services at an affordable price accessible to those eligible for coverage under this act.

(d) Refusal of certain coverage prohibited.--

(1) An insurer may not refuse to provide coverage to a new employee who was previously insured, who on the date of employment would be eligible for coverage and who on the date of employment had prior coverage which did not lapse for more than 60 consecutive days during the prior 12-month period.

Nothing in this paragraph shall require an insurer to provide benefits greater than those provided to a person insured as a standard risk under a small business health care benefit plan, or a low-cost comprehensive health insurance policy greater than those provided under the employee's prior coverage.

(2) For occupations, no insurer may refuse to offer coverage solely because of the nature of the employer's business. An insurer may charge an additional premium based on the nature of the employer's business, but the total premium may not exceed 150% of the lowest premium which would be charged to that employer under section 11(b) without regard to the nature of the employer's business.

(e) Nonrenewal.--An insurer may not nonrenew a low-cost comprehensive health insurance policy or a small business health care benefit plan, except for any of the following reasons:

(1) Nonpayment of required premium.

(2) Fraud or misrepresentation related to an attempt to collect benefits by an individual covered by a qualified individual, qualified family, qualified group or qualified purchasing group low-cost comprehensive health insurance policy. In case of a qualified group or qualified purchasing group, the nonrenewal shall apply only to the individual and any person covered as a spouse or dependent of the individual.

(3) Noncompliance with the provisions of the policy or plan, including provisions regarding minimum numbers of or percentages of insureds.

(4) Nonrenewal with respect to all individuals, groups and purchasing groups within this Commonwealth for whom

coverage is provided under similar policies.

(f) Provisions not applicable.--A low-cost comprehensive health insurance policy may be issued without the provision of the benefits or requirements mandated by Article VI-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or by regulations promulgated thereunder.

(g) Continuation of coverage.--A small business health care benefit plan and a low-cost comprehensive health insurance policy must provide for continuation of coverage for any person who has been continuously covered for at least 90 days under a small business health care benefit plan and who thereafter loses coverage by reason of termination of employment, reduction of hours, divorce, attainment of an age specified in the plan, cancellation of the policy by the employer or nonrenewal due to failure to pay required premiums, unless, within 31 days of cancellation or nonrenewal, the employer provides to the person medical, surgical or hospital care or benefit coverage or unless nonrenewal is for the reason set forth in subsection (e)(4). The provisions must require the insured to make a written request to the insurer within 31 days of loss of coverage. The premium for any given period must not exceed 135% of the rate that would have been charged with respect to that person had the person been covered as the employee under the policy during the same period. When the policy under which the person was covered has been canceled or nonrenewed, the rates must be based on the rate which would have been charged to the person had the policy continued in force, as determined by the insurer in accordance with standard actuarial principles.

(h) Quotation of rates.--All insurers are required to quote rates in writing within 30 days of receiving a small business

employer application for coverage by a low-cost comprehensive health insurance policy or a small business health care benefit plan.

(i) Financial impact of mandated benefits.--The Health Care Cost Containment Council is required to submit to the appropriate committee chairmen in the Senate and in the House of Representatives evidence of the financial impact of any proposed mandated benefit to this act. No mandated benefit may be added to this act unless there is proof from the report submitted by the Health Care Cost Containment Council that the mandated benefit will produce a cost savings.

(j) Legislative procedure.--The General Assembly may not add by statute any new mandated health benefit to the low-cost comprehensive health insurance policy unless a vote of two-thirds by the members of the Senate and the House of Representatives respectively is secured.

Section 7. Notice and payroll deduction.

(a) Notice to employees.--

(1) An employer that does not provide a portion of the cost of health insurance for employees shall provide notice to employees of the existence of the low-cost comprehensive health insurance policy and the Children's Health Insurance Program as set forth under the Children's Health Care Act. Notice shall be in a form prepared by the department and may be provided to employees by posting at the place of employment or in any other reasonable manner. If an employee has dependents who may be eligible for the Children's Health Insurance Program, the employer shall provide the necessary enrollment forms to the employee.

(2) An employer that does provide a portion of the cost

of health insurance for employees but not their dependents shall provide notice to employees of the existence of the Children's Health Insurance Program as set forth under the Children's Health Care Act. Notice shall be in a form prepared by the department and may be provided to employees by posting at the place of employment or in any other reasonable manner. If an employee has dependents who may be eligible for the Children's Health Insurance Program, the employer shall provide the necessary enrollment forms to the employee.

(b) Withholding and remittance of premium.--An insured may provide a written request to the insured's employer to withhold the amount of premium on a low-cost comprehensive health insurance policy or any premium due under Chapter 7 of the Children's Health Care Act from the insured's pay, along with written instructions for remittance of the premium. Upon request under this subsection, the employer shall withhold the premiums and remit the premium payments to the insurer. This subsection shall not apply if the employer would be required to make remittances to more than two different insurers. An employer required to make a remittance of a premium under this subsection is not required to make remittances more often than once per month. The Department of Labor and Industry, in cooperation with the department, shall provide a copy of the form of notice under this subsection.

Section 8. Discretionary managed care provisions.

The insurer may include any of the following managed care provisions to control the cost of a low-cost comprehensive health insurance policy in a manner which does not result in inequitable or inappropriate treatment of an insured under this

act:

(1) An exclusion for services that are not medically necessary.

(2) A procedure for preauthorization by telephone, to be confirmed in writing, by the insurer of any medical service the cost of which is anticipated to exceed a minimum threshold, except for services necessary to treat a medical emergency.

(3) A preferred panel of providers who have entered into written agreements either directly with the insurer or through an intermediary-prepared provider organization to provide services at specified levels of reimbursement. A written agreement under this paragraph must contain a provision under which the parties agree that the insured will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary.

(4) A provision under which an insured who obtains medical services from a nonpreferred provider shall receive reimbursement only in the amount that would have been received had services been rendered by a preferred provider, less a differential, in an amount to be approved by the department.

(5) Other managed care and cost-control provisions which, subject to the approval of the Department of Health, have the potential to control costs.

Section 9. Responsibility of insured.

Except as provided in section 8(3), nothing in this act shall affect the obligation of an insured to pay for medical services rendered to the insured which are not covered by a low-cost

comprehensive health insurance policy or a small business health care benefit plan.

Section 10. Disclosure.

(a) Statement.--

(1) Before an insurer issues a low-cost comprehensive health insurance policy, it must obtain from the prospective insured a signed written statement, in a form approved by the department, in which the prospective insured does all of the following:

(i) Certifies as to eligibility for coverage under the low-cost comprehensive health insurance policy.

(ii) Acknowledges the nature of the coverage provided and an understanding of the managed care and cost-control features of the low-cost comprehensive health insurance policy.

(iii) Acknowledges that, if misrepresentations are made regarding the insured's eligibility for coverage under a low-cost comprehensive health insurance policy, the person making the misrepresentation and any person covered as a spouse or dependent shall forfeit coverage provided by the low-cost comprehensive health insurance policy.

(iv) Acknowledges that the prospective insured, at the time of application for the low-cost comprehensive health insurance policy, was offered the opportunity to purchase health insurance coverage which would have included all mandated benefits or mandated optional benefits required by the laws of this Commonwealth and that the prospective insured rejected such coverage.

(2) A copy of the statement under paragraph (1) shall be

provided to the prospective insured at the time of low-cost comprehensive health insurance policy delivery and the original of such written statement shall be retained by the insurer for the longer of the period of time in which the low-cost comprehensive health insurance policy remains in effect or five years.

(b) Additional information.--Before an insurer issues a low-cost comprehensive health insurance policy, the insurer shall provide the insured with a written disclosure statement containing information the department requires, in a form approved by the department. The disclosure statement shall be separate from the insurance policy or evidence of coverage provided to the insured. The disclosure statement shall contain at least the following information:

(1) An explanation of those mandated benefits or mandated optional benefits not covered by the low-cost comprehensive health insurance policy but which would otherwise be required to be provided under the laws of this Commonwealth.

(2) An explanation of the managed care and cost-control features of the low-cost comprehensive health insurance policy, appropriate mailing addresses and telephone numbers to be utilized by the insured in seeking information or authorization, a list of any preferred providers then contracting with the insurer and an explanation of the obligations of the providers and the insured with regard to services determined not to be medically necessary.

(3) An explanation of the primary and preventive care features of the low-cost comprehensive health insurance policy.

(c) Effect of false statement.--A material statement made by an applicant for coverage under a low-cost comprehensive health insurance policy, the Children's Health Insurance Program set forth under the Children's Health Care Act or a small business health care benefit plan which falsely certifies as to the applicant's eligibility for coverage under a low-cost comprehensive health insurance policy shall serve as the basis for termination of coverage under the policy.

Section 11. Filing and approval.

(a) Approval of department.--All forms, including applications, enrollment forms, policies, certificates, evidences of coverage, riders, amendments, endorsements, disclosure forms and marketing communications, used in connection with the sale or advertisement of a low-cost comprehensive health insurance policy or a small business health care benefit plan must be submitted to the department for approval in accordance with applicable statutes and regulations.

(b) Premiums.--

(1) Except as provided in paragraph (2), the premiums charged for small business health care benefit plans or for low-cost comprehensive health insurance policies shall be the same for all insureds with similar case characteristics.

(2) An insurer may charge an additional premium for a small business health care benefit plan or for a low-cost comprehensive health insurance policy based upon the claim experience of the insured, the health of individuals covered under the plan or policy and the duration of coverage. If an additional premium is charged under this paragraph, the total premium for the plan or policy may not exceed 150% of the lowest premium charged by the insurer to insureds with

similar case characteristics but without the same claim experience, health of covered individuals and duration of coverage.

(3) Subject to the limitations set forth in paragraphs (1) and (2), the percentage increase in the premium rate charged to a small employer may not exceed the sum of:

(i) the percentage change in the new business premium rate for employers with similar case characteristics as measured between the first day of the calendar year in which the new rates take effect and the first day of the prior calendar year; plus

(ii) an adjustment not to exceed 15% annually based on claims experience, health status or duration of coverage; plus

(iii) any adjustment due to changes in the coverage provided or changes in the case characteristics of the employer.

(4) A small business health care benefit plan or low-cost comprehensive health insurance policy may establish a community-rated premium for all employers qualified under this act which differs from the community rate offered to employers which are not qualified under this act.

(c) Department may require insurers to provide certain information.--The department may require that, as to each low-cost comprehensive health insurance policy approved, the insurer provide a statement of the portion of the rate or premium applicable to the low-cost comprehensive health insurance policy coverage required by this act and such other information as the department may require so that prospective purchasers of policies may have an ability to make a direct comparison of the

cost of the benefits within policies of the same class issued by different insurers. The department may include rate comparison or other cost information in the form of a notice which may be provided by the department to employers.

(d) Certain rate increases void.--An insurer who raises rates after the effective date of this subsection shall be presumed to be evading the rate limitation provisions of this act. Such a rate increase shall be invalid. This subsection shall expire in 180 days.

Section 12. Revisions of premium rates.

(a) General rule.--Revisions of premium rates on individual accident and health insurance policy forms which provide for reimbursement on an expense-incurred basis shall not be disapproved by the commissioner if the rates are filed pursuant to a loss ratio guarantee that meets the requirements of this section. Rates shall continue to be approved if the insurer complies with the terms of the loss ratio guarantee. Premium rates shall be deemed approved upon filing with the commissioner if the filing is accompanied by a loss ratio guarantee. This loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain at least the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved.

(2) A guarantee that the actual loss ratios of this Commonwealth for the experience period in which the new rates take effect, and for each experience period thereafter until new rates are filed, shall meet or exceed the loss ratios under paragraph (1). If the annual earned premium volume in

this Commonwealth under the particular policy form is less than $1,000,000 and therefore not actuarially credible, the loss ratio guarantee shall be based on the loss ratio for the policy form in all states, but excluding any state with respect to which all of the following conditions are met:

(i) the state has in effect a statute or regulation which would permit the insurer to use rates on the policy form upon the filing of a loss ratio guarantee and which provides minimum standards for actuarial credibility;

(ii) the insurer has filed a loss ratio guarantee on the policy form in the state which meets the requirements of the state and which covers the experience period in question; and

(iii) the minimum standards for actuarial credibility in the state for the policy form have been met for the experience period in question.

If the aggregate earned premium for all included states is less than $1,000,000, the experience period shall be extended until the end of the calendar year in which $1,000,000 of earned premium is attained.

(3) A guarantee that the actual loss ratio results of this Commonwealth, or multistate results, if applicable, for the experience period at issue shall be independently audited at the insurer's expense. This audit shall be completed in the second quarter of the year following the end of the experience period and the audited results shall be reported to the commissioner no later than June 30 following the end of the experience period.

(4) A guarantee that affected policyholders in this Commonwealth shall be issued a proportional refund, based on

premium earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio under paragraph (1). If multistate loss ratios are used, then the total amount refunded in this Commonwealth shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned on the policy form in this Commonwealth and divided by the total premium earned in all included states on the policy form. The refund shall be made to all policyholders in this Commonwealth who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal ten dollars or more. The refund shall include interest, at the then-current accident and health reserve interest rate established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due.

(5) A guarantee that refunds of less than ten dollars shall be aggregated by the insurer and paid to the department.

(b) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Experience period." The period for which a loss ratio guarantee is calculated, ordinarily a calendar year.

"Loss ratio." The ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.

(c) Application.--This section shall apply only to revisions

of premium rates which have been approved by the commissioner on or after the effective date of this section.

Section 13. Records and reports.

(a) Enrollment, costs, etc.--An insurer issuing or renewing a low-cost comprehensive health insurance policy, coverage under the Children's Health Insurance Program as set forth in the Children's Health Care Act or a small business health care benefit plan in this Commonwealth shall maintain separate records of enrollment, claim costs, premium income, utilization and other information as required by the department.

(b) Annual report.--An insurer providing a low-cost comprehensive health insurance policy or coverage under the Children's Health Insurance Program as set forth in the Children's Health Care Act shall furnish an annual report to the department in a form prescribed by the department. The report shall contain information the department requires to analyze the effect of insurance coverage issued under this act. The annual report shall be in a form consistent with the forms adopted by the National Association of Insurance Commissioners.

Section 14. Regulations.

The department may promulgate regulations to administer this act. Regulations shall be consistent with the "Group Coverage Discontinuance and Replacement Model Regulation" of the Model Regulation Service (most current edition).

Section 15. Penalties.

(a) Revocation of certificate of authority.--Whenever the commissioner believes, from evidence satisfactory to him, that any insurance company, association, or exchange is doing an insurance business within this Commonwealth in violation of any provision of this act or any order or requirement of the

commissioner issued or promulgated pursuant to authority expressly granted the commissioner by any provision of this or any other act, or is about to violate any such provision, order, or requirement, the commissioner may, in his discretion, take against the offending party or parties any one or more of the following courses of action:

(1) Revoke the certificate of authority of the offending company, association or exchange.

(2) Refuse to renew the certificate of authority of the offending company, association or exchange. This remedy is in addition to any other remedy provided by this act or any other act.

(b) Notice and hearing.--Before the commissioner shall take any action under this section, he shall give written notice to the person, company, association or exchange accused of a violation, stating specifically the nature of the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing before the commissioner regarding the matter shall be held.

Section 16. Premiums tax of domestic companies.

Domestic carriers' premiums received from coverage provided under the Children's Health Insurance Program as set forth in the Children's Health Care Act are exempt from the provisions of Article IX of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

Section 17. Repeals.

All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 18. Effective date.

This act shall take effect as follows:

(1) Sections 11(d) and 14 and this section shall take effect immediately.

(2) The remainder of this act shall take effect in 180 days.