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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2979 Session of 1996

INTRODUCED BY OLASZ, KING, COLAIZZO, STABACK, MERRY, READSHAW, PESCI, DeLUCA, CLARK, RAMOS, MELIO, YOUNGBLOOD, SHANER, BOSCOLA AND STEELMAN, OCTOBER 10, 1996

REFERRED TO COMMITTEE ON INSURANCE, OCTOBER 10, 1996

AN ACT

Amending the act of December 29, 1972 (P.L.1701, No.364), entitled "An act providing for the establishment of nonprofit corporations having the purpose of establishing, maintaining and operating a health service plan; providing for supervision and certain regulations by the Insurance Department and the Department of Health; giving the Insurance Commissioner and the Secretary of Health certain powers and duties; exempting the nonprofit corporations from certain taxes and providing penalties," providing for managed care plans.

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

Section 1. The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, is amended by adding a section to read:

Section 8.1. Cost Containment.--(a) A managed care plan shall work with its participating providers to establish quality-based cost-effective practice guidelines.

(b) A managed care plan shall supply any available data to a participating provider comparing the provider's practice profile with that of other providers practicing in the same area.

(c) (1) Notwithstanding any law to the contrary relating to loss ratios, health care policies or contracts may not be delivered or executed in this Commonwealth, unless these policies or contracts are expected to return to policyholders and contractholders in the form of aggregate health care benefits, not including refunds or credits, the amounts enumerated in subsection (c)(2) as estimated for the entire period for which rates are computed to provide coverage.

(2) For all policies and contracts delivered, issued for delivery or executed on or after January 1, 1997, the commissioner shall disapprove any premium rates filed by any managed care entity, whether initial or revised, unless it is anticipated that the aggregate benefits estimated to be paid under all these policies or contracts maintained in force by the managed care entity for the period for which coverage is provided will return to policyholders or contractholders direct service ratios of at least eighty-five per centum (85%) of the aggregate premiums collected for a group health policy or contract and at least eighty-five per centum (85%) of the aggregate premiums collected for an individual health policy or contract.

(d) The applicable percentages for each policy or contract referred to in subsection (c)(2) must increase by one percentage point on January 1 of each year, beginning January 1, 1998, until a ninety per centum (90%) direct service ratio is reached on January 1, 2002.

(e) A managed care entity that enters the market after January 1, 1997, does not start at the beginning of the phasein schedule provided for in subsection (c) and shall instead comply with the direct service ratio requirements applicable to other

managed care entities in that market for each time period. All filings of rates and rating schedules must demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings for rate revisions must also demonstrate that the anticipated direct service ratio over the entire future period for which revised rates are computed to provide coverage can be expected to meet the appropriate direct service ratio standard, and the aggregate direct service ratio from the inception of a policy or contract must equal or exceed the appropriate direct service ratio standard.

Section 2. This act shall take effect in 60 days.