PRINTER'S NO. 1403

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1165 Session of 1997

INTRODUCED BY HOLL, OCTOBER 20, 1997

REFERRED TO BANKING AND INSURANCE, OCTOBER 20, 1997

AN ACT

Providing for the regulation of individual access to health care insurance and for penalties.

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 Health Care Insurance Individual Accessibility Act.

Section 2. Purpose.

It is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth by complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936). This act is intended to meet those requirements while retaining the Commonwealth's authority to regulate health insurance in this Commonwealth.

Section 3. Definitions.

(a) General rule.--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:

"Commissioner." The Insurance Commissioner of the Commonwealth.

Company," "association" or "exchange." An entity holding a current certificate of authority which are defined in section 101 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Department." The Insurance Department of the Commonwealth.

Designated insurers." An insurer required to offer health coverage to eligible individuals under section 4.

"Eligible individual." A resident of this Commonwealth who meets the definition in section 2741(b) of the Federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191, 110 Stat. 1936).

"Federal act." The Federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191, 110 Stat. 1936).

"Fraternal benefit society." An entity holding a current certificate of authority in this Commonwealth under the act of December 14, 1992 (P.L.835, No.124), known as the Fraternal Benefit Societies Code.

"Health maintenance organization" or "HMO." An entity holding a current certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Hospital plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

"Insurer." A foreign or domestic insurance company, association or exchange, health maintenance organization,

hospital plan corporation, professional health services plan corporation, fraternal benefit society or risk-assuming preferred provider organization. The term does not include a group health plan as defined in section 2791 of the Federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191, 110 Stat. 1936).

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

"Preferred provider organization" or "PPO." An entity holding a current certificate of authority organized and operated under section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Professional health services plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations). The term does not include dental service corporations or optometric service corporations, as defined under 40 Pa.C.S. § 6302(a) (relating to definitions).

(b) Adoption of Federal act.--The words, terms and definitions found in the Federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191, 119 Stat. 1936), including those in section 2791, are hereby adopted for purposes of implementing this act unless otherwise provided by this act. The term "health insurance issuer" found in section 2791(b)(2) of the Federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191, 110 Stat. 1936) shall have the same meaning as "insurer" in subsection (a).

Section 4. Designated insurers.

(a) Alternative mechanism requirements.--The following insurers shall comply with sections 5 and 6 in order to

implement the alternative mechanism requirements of the Federal act:

(1) Hospital plan corporations.

(2) Professional health services plan corporations.

(b) Certain parent designated insurers.--If a designated insurer owns a hospital plan corporation or a professional health services plan corporation which provides services within substantially the same service area as the parent organization, the subsidiary hospital plan corporation and professional health services plan corporation are not required to offer coverage to eligible individuals if the parent organization offers coverage to eligible individuals under sections 5 and 6.

Section 5. Alternative mechanism in individual market.

(a) Rights of eligible individuals.--A designated insurer shall:

(1) Offer continuous year-round open enrollment to eligible individuals.

(2) Offer to eligible individuals, upon request, a choice of at least two individual health insurance policies, as specified in section 6.

(3) Issue to eligible individuals, upon request, an individual policy that meets the requirements of section 6.

(b) Policy limitations.--Unless an eligible individual chooses to purchase a policy pursuant to section 6(c), a policy offered or issued to an eligible individual under section 6 shall not contain preexisting condition limitations or restrictions.

(c) Financial subsidization for eligible individuals.--Designated insurers shall provide financial subsidization of policies issued to eligible individuals. Designated insurers

shall file for review by the commissioner a method for financial subsidization in all rate filings on policy choices for eligible individuals. The total subsidy provided by the designated insurer to all of its products shall not be affected by the requirement to subsidize products issued to eligible individuals.

Section 6. Policy choice for eligible individuals.

(a) Comprehensive and standard policies.--Designated insurers shall offer eligible individuals a choice of policies. The choices shall include:

(1) At least one other policy that is comparable to a standard health insurance policy or a comprehensive health insurance policy being actively marketed by the insurer to persons other than eligible individuals in the voluntary individual market.

(2) At least one other policy that is being actively marketed by the insurer to persons other than eligible individuals in the voluntary individual market.

(b) Filing requirements.--Each designated insurer shall file with and identify to the commissioner the comprehensive policy form or the standard policy form the insurer intends to offer to eligible individuals under subsection (a)(1). A designated insurer may elect to identify more than one comprehensive or standard policy form which will be offered to eligible individuals. Each policy form shall contain benefits and limits comparable to policies being actively marketed to persons other than eligible individuals in the voluntary individual market. The policy forms shall be considered comparable even if the policies marketed in the voluntary individual market include a preexisting condition exclusion.

(c) Preexisting condition provisions.--Nothing in this act shall prohibit an eligible individual from purchasing a policy which includes a preexisting condition provision or is not otherwise offered under this section from a designated insurer or any other insurer.

Section 7. Coordination of benefits.

Benefits provided under individual policies by an insurer may be subject to coordination of benefits with any other group policy, individual policy, Federal or State government program, labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan, except as otherwise provided by law.

Section 8. Excessive loss provision.

(a) General rule.--At any time, the designated insurer may file for a rate adjustment for products offered under section 6 with the commissioner in accordance with the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act.

(b) Request for hearing.--The designated insurer may request that the commissioner conduct a hearing if:

(1) the losses experienced by the designated insurer on products offered under section 6(a)(1) or by eligible individuals under section 6(a)(2) require a rate increase of greater than 20% and the losses are in excess of a 110% medical loss ratio for any calendar year; or

(2) the designated insurer requested a rate increase for products under section 6(a) and has reason to believe that continuation as a designated insurer will have a detrimental impact on its financial condition or solvency.

(c) Action by commissioner.--Upon the request of a

designated insurer under subsection (b), the commissioner shall conduct a public hearing regarding the rate filing, medical loss ratio and the impact that being a designated insurer is having on the designated insurer's solvency. The hearing shall be held as provided for in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). Following the hearing, the commissioner shall determine the extent of the impact, if any, of being a designated insurer under this act on the designated insurer's rate filing, medical loss ratio, overall operations and solvency, and shall do one or more of the following:

(1) grant, modify or deny the requested rate filing; or

(2) request to withdraw from the approved alternative mechanism and to authorize implementation of the Federal default standards set forth in section 2741 of the Federal act.

Section 9. Review of filings.

The department shall review filings submitted under sections 5(c), 6(b) and 8(a) in accordance with the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act.

Section 10. Conversion policies.

(a) Notification.--Notification of the conversion privilege shall be included with each certificate of coverage issued under section 621.2(d) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921. Each certificate holder in an insured group shall be given written notification of the conversion privilege and its duration within a period beginning 15 days before and ending 30 days after the date of termination of the group coverage. The certificate holder or the

holder's dependent shall have no less than 31 days following notification to exercise the conversion privilege. Written notification provided by the contract holder and supplied to the certificate holder or mailed to the certificate holder's last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section.

(b) Limitation on rates for conversion policies.--The premium rates for individuals who purchase a comparable conversion policy offered pursuant to applicable law shall be limited to 120% of the approved premium rates for comparable group coverage.

Section 11. Penalties.

(a) General rule.--Upon satisfactory evidence of a violation of this act by an insurer or other person, the commissioner may pursue any one or more of the following penalties:

(1) Suspend, revoke or refuse to renew the license of the insurer or other person.

(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than $5,000.

(4) Impose a civil penalty of not more than $10,000 for a willful violation of this act.

(b) Limitation.--Penalties imposed on an insurer or other person under this act shall not exceed $500,000 in the aggregate during a single calendar year.

Section 12. Regulations.

The department may promulgate regulations as may be necessary or appropriate to carry out this act.

Section 13. Expiration.

This act shall expire on December 31, 2000.

Section 14. Effective date.

This act shall take effect January 1, 1998.