

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 746 Session of 2009

INTRODUCED BY DeLUCA, BELFANTI, CONKLIN, D. COSTA, DONATUCCI, GOODMAN, KIRKLAND, KORTZ, KULA, MUNDY, M. O'BRIEN, PICKETT, SEIP, STABACK, J. TAYLOR, WHITE, HENNESSEY, JOSEPHS, CALTAGIRONE, K. SMITH, WAGNER AND MURT, MARCH 5, 2009

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, JUNE 4, 2009

AN ACT

1 ~~Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An~~ ←
2 ~~act relating to insurance; amending, revising, and~~
3 ~~consolidating the law providing for the incorporation of~~
4 ~~insurance companies, and the regulation, supervision, and~~
5 ~~protection of home and foreign insurance companies, Lloyds~~
6 ~~associations, reciprocal and inter insurance exchanges, and~~
7 ~~fire insurance rating bureaus, and the regulation and~~
8 ~~supervision of insurance carried by such companies,~~
9 ~~associations, and exchanges, including insurance carried by~~
10 ~~the State Workmen's Insurance Fund; providing penalties; and~~
11 ~~repealing existing laws," further providing for conditions~~
12 ~~subject to which policies are to be issued; providing for~~
13 ~~health insurance coverage for certain children of insured~~
14 ~~parents and for affordable small group health care coverage;~~ ←
15 ~~and making inconsistent repeals. AMENDING THE ACT OF MAY 17,~~ ←
16 ~~1921 (P.L.682, NO.284), ENTITLED "AN ACT RELATING TO~~
17 ~~INSURANCE; AMENDING, REVISING, AND CONSOLIDATING THE LAW~~
18 ~~PROVIDING FOR THE INCORPORATION OF INSURANCE COMPANIES, AND~~
19 ~~THE REGULATION, SUPERVISION, AND PROTECTION OF HOME AND~~
20 ~~FOREIGN INSURANCE COMPANIES, LLOYDS ASSOCIATIONS, RECIPROCAL~~
21 ~~AND INTER-INSURANCE EXCHANGES, AND FIRE INSURANCE RATING~~
22 ~~BUREAUS, AND THE REGULATION AND SUPERVISION OF INSURANCE~~
23 ~~CARRIED BY SUCH COMPANIES, ASSOCIATIONS, AND EXCHANGES,~~
24 ~~INCLUDING INSURANCE CARRIED BY THE STATE WORKMEN'S INSURANCE~~
25 ~~FUND; PROVIDING PENALTIES; AND REPEALING EXISTING LAWS,"~~
26 ~~FURTHER PROVIDING FOR CONDITIONS SUBJECT TO WHICH POLICIES~~
27 ~~ARE TO BE ISSUED; PROVIDING FOR EXEMPTION FROM GENERAL~~
28 ~~APPLICABILITY, FOR HEALTH INSURANCE COVERAGE FOR CERTAIN~~
29 ~~CHILDREN OF INSURED PARENTS FOR GUARANTEED AVAILABILITY AND~~
30 ~~RENEWABILITY OF SMALL GROUP HEALTH BENEFIT PLANS AND FOR~~
31 ~~AFFORDABLE SMALL GROUP HEALTH CARE COVERAGE; AND MAKING~~

1 INCONSISTENT REPEALS.

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

4 ~~Section 1. Section 617(A) (3) and (9) of the act of May 17,~~ ←
5 ~~1921 (P.L.682, No.284), known as The Insurance Company Law of~~
6 ~~1921, added May 25, 1951 (P.L.417, No.99) and January 18, 1968~~
7 ~~(1967 P.L.969, No.433), are amended to read:~~

8 ~~Section 617. Conditions Subject to Which Policies Are to Be~~
9 ~~Issued. (A) No such policy shall be delivered or issued for~~
10 ~~delivery to any person in this Commonwealth unless:~~

11 * * *

12 ~~(3) it purports to insure only one person, except that a~~
13 ~~policy may insure, originally or by subsequent amendment, upon~~
14 ~~the application of an adult head of a family who shall be deemed~~
15 ~~the policyholder, any two or more eligible members of that~~
16 ~~family, including husband, wife, dependent children or any~~
17 ~~children under a specified age which, except as provided under~~
18 ~~section 617.1, shall not exceed nineteen years and any other~~
19 ~~person dependent upon the policyholder; and~~

20 * * *

21 ~~(9) A policy delivered or issued for delivery after January~~
22 ~~1, 1968, under which coverage of a dependent of a policyholder~~
23 ~~terminates at a specified age shall, with respect to an~~
24 ~~unmarried child covered by the policy prior to the attainment of~~
25 ~~the age of nineteen or except as provided under section 617.1,~~
26 ~~the age of thirty, who is incapable of self sustaining~~
27 ~~employment by reason of mental retardation or physical handicap~~
28 ~~and who became so incapable prior to attainment of age nineteen~~
29 ~~and who is chiefly dependent upon such policyholder for support~~
30 ~~and maintenance, not so terminate while the policy remains in~~

1 ~~force and the dependent remains in such condition, if the~~
2 ~~policyholder has within thirty one days of such dependent's~~
3 ~~attainment of the limiting age submitted proof of such~~
4 ~~dependent's incapacity as described herein. The foregoing~~
5 ~~provisions of this paragraph shall not require an insurer to~~
6 ~~insure a dependent who is a mentally retarded or physically~~
7 ~~handicapped child where the policy is underwritten on evidence~~
8 ~~of insurability based on health factors set forth in the~~
9 ~~application or where such dependent does not satisfy the~~
10 ~~conditions of the policy as to any requirement for evidence of~~
11 ~~insurability or other provisions of the policy, satisfaction of~~
12 ~~which is required for coverage thereunder to take effect. In any~~
13 ~~such case the terms of the policy shall apply with regard to the~~
14 ~~coverage or exclusion from coverage of such dependent.~~

15 * * *

16 Section 2. The act is amended by adding a section to read:

17 Section 617.1. Health Insurance Coverage for Certain
18 Children of Insured Parents. (A) An insurer that issues,
19 delivers, executes or renews health care insurance in this
20 Commonwealth, under which coverage of a child would otherwise
21 terminate at a specified age, shall, at the option of the
22 child's parent or guardian, provide coverage to a child of the
23 insured beyond that specified age, up through the age of twenty
24 nine, provided that the child meet all of the following
25 requirements:

26 (1) Is not married.

27 (2) Has no dependents.

28 (3) Is a resident of this Commonwealth or is enrolled as a
29 full time student at an institution of higher education in this
30 Commonwealth.

1 ~~(4) Is not covered by another health insurance policy.~~

2 ~~(B) An insured may exercise the option provided under~~
3 ~~subsection (A) at any time during the term of the policy by~~
4 ~~notice to the insurer.~~

5 ~~(C) Employers shall not be required to contribute to any~~
6 ~~increased premium charged by the insurer for the exercise of the~~
7 ~~option provided under subsection (A), but the contributions may~~
8 ~~be agreed to by the employer.~~

9 ~~(D) This section shall not include the following types of~~
10 ~~insurance or any combination thereof:~~

11 ~~(1) Hospital indemnity.~~

12 ~~(2) Accident.~~

13 ~~(3) Specified disease.~~

14 ~~(4) Disability income.~~

15 ~~(5) Dental.~~

16 ~~(6) Vision.~~

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

19 ~~(8) Medicare supplement.~~

20 ~~(9) Long term care.~~

21 ~~(10) Other limited benefit plans.~~

22 Section 3. The act is amended by adding an article to read:

23 ~~ARTICLE XLII~~

24 ~~AFFORDABLE SMALL GROUP HEALTH CARE COVERAGE~~

25 ~~Section 4201. Scope of article.~~

26 ~~This article relates to health care reform.~~

27 ~~Section 4202. Definitions.~~

28 ~~The following words and phrases when used in this article~~
29 ~~shall have the meanings given to them in this section unless the~~
30 ~~context clearly indicates otherwise:~~

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

4 ~~"Commissioner." The Insurance Commissioner of the~~
5 ~~Commonwealth.~~

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

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

11 ~~"Department." The Insurance Department of the Commonwealth.~~

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

17 ~~(1) An accident only policy.~~

18 ~~(2) A credit only policy.~~

19 ~~(3) A long term or disability income policy.~~

20 ~~(4) A specified disease policy.~~

21 ~~(5) A Medicare supplement policy.~~

22 ~~(6) A Civilian Health and Medical Program of the~~
23 ~~Uniformed Services (CHAMPUS) supplement policy.~~

24 ~~(7) A fixed indemnity policy.~~

25 ~~(8) A dental only policy.~~

26 ~~(9) A vision only policy.~~

27 ~~(10) A workers' compensation policy.~~

28 ~~(11) An automobile medical payment policy under 75-~~
29 ~~Pa.C.S. (relating to vehicles).~~

30 ~~(12) Any other similar policies providing for limited~~

1 benefits.

2 "Health care associated infection." A localized or systemic
3 condition that results from an adverse reaction to the presence
4 of an infectious agent or its toxins and meets all of the
5 following:

6 (1) Occurs in a patient in a health care setting.

7 (2) Was not present or incubating at the time of
8 admission, unless the infection was related to a previous
9 admission to the same setting.

10 (3) If occurring in a hospital setting, meets the
11 criteria for a specific infection site as defined by the
12 Centers for Disease Control and Prevention and its National
13 Health Care Safety Network.

14 "Health insurance region." Any of the following:

15 (1) "Region I." The geographic area covered by the
16 counties of Bucks, Chester, Delaware, Montgomery and
17 Philadelphia.

18 (2) "Region II." The geographic area covered by the
19 counties of Adams, Berks, Cumberland, Dauphin, Franklin,
20 Fulton, Lancaster, Lebanon, Lehigh, Northampton, Perry,
21 Schuylkill and York.

22 (3) "Region III." The geographic area covered by the
23 counties of Bradford, Carbon, Clinton, Lackawanna, Luzerne,
24 Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne
25 and Wyoming.

26 (4) "Region IV." The geographic area covered by the
27 counties of Centre, Columbia, Juniata, Mifflin, Montour,
28 Northumberland, Snyder and Union.

29 (5) "Region V." The geographic area covered by the
30 counties of Bedford, Blair, Cambria, Clearfield, Huntingdon,

1 ~~Jefferson and Somerset.~~

2 ~~(6) "Region VI." The geographic area covered by the~~
3 ~~counties of Allegheny, Armstrong, Beaver, Butler, Fayette,~~
4 ~~Greene, Indiana, Lawrence, Washington and Westmoreland.~~

5 ~~(7) "Region VII." The geographic area covered by the~~
6 ~~counties of Cameron, Clarion, Crawford, Elk, Erie, Forest,~~
7 ~~McKean, Mercer, Potter, Venango and Warren.~~

8 ~~"Individual market." The health insurance market for~~
9 ~~individuals as defined under section 2791 of the Health~~
10 ~~Insurance Portability and Accountability Act of 1996 (Public Law~~
11 ~~104 191, 110 Stat. 1936).~~

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

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

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

24 ~~(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan~~
25 ~~corporations) or Ch. 63 (relating to professional health~~
26 ~~services plan corporations).~~

27 ~~"Insurer group." A group of insurers writing coverage in~~
28 ~~this Commonwealth, including a parent insurer, its subsidiaries~~
29 ~~and affiliates.~~

30 ~~"Large group market." The health insurance market for the~~

1 ~~large group market as defined under section 2791 of the Health-~~
2 ~~Insurance Portability and Accountability Act of 1996 (Public Law-~~
3 ~~104 191, 110 Stat. 1936).~~

4 ~~"Medical loss ratio." The ratio of incurred medical claim-~~
5 ~~costs to earned premiums.~~

6 ~~"Regulatory Review Act." The act of June 25, 1982 (P.L.633,-~~
7 ~~No.181), known as the Regulatory Review Act.~~

8 ~~"Small employer." In connection with a group health plan-~~
9 ~~with respect to a calendar year and a plan year, an employer who-~~
10 ~~employs an average of at least two but not more than 50-~~
11 ~~employees on business days during the preceding calendar year-~~
12 ~~and who employs at least two such employees on the first day of-~~
13 ~~the plan year. In the case of an employer which was not in-~~
14 ~~existence throughout the preceding calendar year, the-~~
15 ~~determination whether an employer is a small employer shall be-~~
16 ~~based on the average number of employees that it is reasonably-~~
17 ~~expected that the employer will employ on business days in the-~~
18 ~~current calendar year.~~

19 ~~"Small group health benefit plan." A health benefit plan-~~
20 ~~offered to a small employer.~~

21 ~~"Small group market." The health insurance market for the-~~
22 ~~small group market as defined in section 2791 of the Health-~~
23 ~~Insurance Portability and Accountability Act of 1996 (Public Law-~~
24 ~~104 191, 110 Stat. 1936).~~

25 ~~"Standard plan." One of the health benefit packages-~~
26 ~~established by the Insurance Department in accordance with-~~
27 ~~section 4203.~~

28 ~~Section 4203. Standard plans.~~

29 ~~(a) Applicability. This section shall apply to all small-~~
30 ~~group health benefit plans issued, made effective, delivered or-~~

1 ~~renewed in this Commonwealth after the effective date of this~~
2 ~~section.~~

3 ~~(b) Standard plans required.~~

4 ~~(1) An insurer shall not offer a plan that does not meet~~
5 ~~the minimum benefits specified in one of the standard plans~~
6 ~~developed by the department in accordance with the following~~
7 ~~criteria:~~

8 ~~(i) The standard plans shall not include coverage~~
9 ~~for behavioral health services except as required by~~
10 ~~Federal law.~~

11 ~~(ii) The standard plans may not contain any~~
12 ~~preexisting condition exclusions.~~

13 ~~(2) Standard plans may include options for deductibles~~
14 ~~and cost sharing if the department determines that the~~
15 ~~options:~~

16 ~~(i) Do not dissuade consumers from seeking necessary~~
17 ~~services.~~

18 ~~(ii) Promote a balance of the impact of cost sharing~~
19 ~~in reducing premiums and in effecting utilization of~~
20 ~~appropriate services.~~

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

23 ~~(3) The following apply:~~

24 ~~(i) The department shall forward notice of the~~
25 ~~elements of the standard plans to the Legislative~~
26 ~~Reference Bureau for publication as a notice in the~~
27 ~~Pennsylvania Bulletin.~~

28 ~~(ii) An insurer subject to the provisions of this~~
29 ~~section shall be required to begin offering its standard~~
30 ~~plans as soon as practicable following the publication~~

1 ~~but in no event later than 180 days following the~~
2 ~~publication under subparagraph (i).~~

3 ~~(c) Additional benefits.~~

4 ~~(1) An insurer shall offer as an additional benefit to~~
5 ~~every standard plan a behavioral health services benefit that~~
6 ~~complies with the provisions of sections 601 A, 602 A, 603 A,~~
7 ~~604 A, 605 A, 606 A, 607 A and 608 A.~~

8 ~~(2) An insurer may offer benefits in addition to those~~
9 ~~in any of its standard plans.~~

10 ~~(3) Each additional benefit shall:~~

11 ~~(i) Be offered and priced separately from benefits~~
12 ~~specified in the standard plan with which the benefits~~
13 ~~are being offered.~~

14 ~~(ii) Not have the effect of duplicating any of the~~
15 ~~benefits in the standard plan with which the benefits are~~
16 ~~being offered.~~

17 ~~(iii) Be clearly specified as additions to the~~
18 ~~standard plan with which the benefits are being offered.~~

19 ~~(4) The department may prohibit an insurer from offering~~
20 ~~an additional benefit under this section if the department~~
21 ~~finds that the additional benefit will be sold in conjunction~~
22 ~~with one of the insurer's standard plans in a manner designed~~
23 ~~to promote risk selection or underwriting practices otherwise~~
24 ~~prohibited under this section or other State law.~~

25 ~~Section 4204. Health insurance premium rates for dominant~~
26 ~~insurers.~~

27 ~~(a) Applicability. This section shall apply to all small~~
28 ~~group health benefit plans that are issued, made effective,~~
29 ~~delivered or renewed in this Commonwealth after the effective~~
30 ~~date of this section, by an insurer that is part of an insurer~~

~~group, if that insurer group insures 10% or more of the covered lives in the health insurance region in which the plan is being issued, made effective, delivered or renewed.~~

~~(b) Premium rates.~~

~~(1) An insurer shall establish a base rate for plans and shall file the base rates with the department as required by law. An insurer may adjust its base rates for the following:~~

~~(i) Age.~~

~~(ii) Health insurance region.~~

~~(iii) Wellness incentives as determined by the department.~~

~~(2) An insurer shall apply all risk adjustment factors under paragraph (1) consistently with respect to all plans subject to this section and consistently with department regulatory authority.~~

~~(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). Additional adjustments may be made to reflect the inclusion of additional benefits as specified under section 4203(c) and differences in family composition.~~

~~(4) 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 to the family composition of employees.~~

1 ~~(iv) Changes pursuant to a government order or~~
2 ~~judicial proceeding.~~

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

7 ~~(6) For purposes of this subsection, an insurer's "base~~
8 ~~rate" for a plan shall refer to a rating methodology that is~~
9 ~~based on the experience of all risks covered by the plan~~
10 ~~without regard to health status, occupation or any other~~
11 ~~factor.~~

12 ~~(c) Additional rate review and prior approval.~~

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

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

24 ~~(i) The rate is not actuarially sound.~~

25 ~~(ii) The increase is requested because the insurer~~
26 ~~has not operated efficiently or has factored in~~
27 ~~experience that conflicts with recognized best practices~~
28 ~~in the health care industry, including the allocation of~~
29 ~~administrative expenses to the plan on a less favorable~~
30 ~~basis than expenses are allocated to other health benefit~~

1 plans.

2 ~~(iii) The increase is requested because the insurer~~
3 ~~has incurred costs due to failure to follow best~~
4 ~~practices for cost control, including costs due to~~
5 ~~avoidable health care associated infections and avoidable~~
6 ~~hospitalizations due to ineffective chronic care~~
7 ~~management.~~

8 ~~(iv) The medical loss ratio for a plan is less than~~
9 ~~85%.~~

10 ~~(3) In the event a plan has a medical loss ratio of less~~
11 ~~than 85%, the department may, in addition to any other~~
12 ~~remedies available under law, require the insurer to refund~~
13 ~~the difference to policyholders on a pro rata basis as soon~~
14 ~~as practicable following receipt of notice from the~~
15 ~~department of the requirement but in no event later than 120~~
16 ~~days following receipt of the notice. The department shall~~
17 ~~establish procedures under which such refunds will be made.~~

18 ~~(d) Procedures. The filing and review procedures set forth~~
19 ~~under the Accident and Health Filing Reform Act shall apply to~~
20 ~~any filing conducted under this section, except that no filing~~
21 ~~deemed to meet the requirements of this act shall take effect~~
22 ~~unless the department receives written notice of the insurer's~~
23 ~~intent to exercise the right granted under this section at least~~
24 ~~ten calendar days prior to the effective date of this section.~~

25 ~~Section 4205. Health insurance premium rates for nondominant~~
26 ~~insurers.~~

27 ~~(a) Applicability. This section applies to all small group~~
28 ~~health benefit plans that are issued, made effective, delivered~~
29 ~~or renewed in this Commonwealth after the effective date of this~~
30 ~~section, by an insurer that is part of an insurer group, if that~~

1 ~~insurer group insures less than 10% of the covered lives in the~~
2 ~~region in which the plan is being issued, made effective,~~
3 ~~delivered or renewed.~~

4 ~~(b) Premium rates.~~

5 ~~(1) An insurer shall establish a base rate for plans and~~
6 ~~shall file the base rates with the department as required by~~
7 ~~law. An insurer may modify its base rates only by the~~
8 ~~following demographic factors:~~

9 ~~(i) Age.~~

10 ~~(ii) Health insurance region.~~

11 ~~(iii) Industry or class of business.~~

12 ~~(iv) Wellness incentives as determined by the~~
13 ~~department.~~

14 ~~(2) An insurer shall apply all risk adjustment factors~~
15 ~~under paragraph (1) consistently with respect to all plans~~
16 ~~subject to this section and consistently with department~~
17 ~~regulatory authority.~~

18 ~~(3) An insurer shall not charge a rate that is more than~~
19 ~~50% above or below the base rate, as adjusted as permitted~~
20 ~~under paragraph (1). Additional adjustments may be made to~~
21 ~~reflect the inclusion of additional benefits as specified in~~
22 ~~section 4203(c) and differences in family composition.~~

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

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

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

30 ~~(iii) Changes to the family composition of~~

1 ~~employees.~~

2 ~~(iv) Changes pursuant to a government order or~~
3 ~~judicial proceeding.~~

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

8 ~~(6) For purposes of this subsection, an insurer's "base~~
9 ~~rate" for a plan shall refer to a rating methodology that is~~
10 ~~based on the experience of all risks covered by the plan~~
11 ~~without regard to health status, occupation or any other~~
12 ~~factor.~~

13 ~~(c) Additional rate review and prior approval.~~

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

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

25 ~~(i) The rate is not actuarially sound.~~

26 ~~(ii) The increase is requested because the insurer~~
27 ~~has not operated efficiently or has factored in~~
28 ~~experience that conflicts with recognized best practices~~
29 ~~in the health care industry, including the allocation of~~
30 ~~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 costs due to avoidable health care associated infections and avoidable hospitalizations due to ineffective chronic care management.~~

~~(d) Procedures. The filing and review procedures set forth in 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 the effective date of this section. Section 4206. College student insurance requirements.~~

~~(a) Minimum health benefit package. Within 90 days following the effective date of this section, the commissioner shall establish a minimum health benefit package for full-time students enrolled in public or private baccalaureate and postbaccalaureate programs in this Commonwealth and transmit a description of the package to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. As soon as practicable after the date of publication of the package, but in no event later than 120 days following the publication, all insurers shall offer the package as individual coverage available to students and as group coverage through the institution. The commissioner may make revisions to the minimum health benefit package periodically, but no more than one time per 12 month period. Each revision shall be implemented by~~

1 ~~insurers as soon as practicable following publication of the~~
2 ~~revision in the Pennsylvania Bulletin, but in no event later~~
3 ~~than 120 days following such publication.~~

4 ~~(b) Required health insurance coverage.~~

5 ~~(1) Every full time student enrolled in a public or~~
6 ~~private baccalaureate or postbaccalaureate program in this~~
7 ~~Commonwealth shall maintain health insurance coverage which~~
8 ~~provides the minimum benefit package established under this~~
9 ~~section. The coverage shall be maintained throughout the~~
10 ~~period of the student's enrollment.~~

11 ~~(2) Every student required to meet the mandatory~~
12 ~~coverage under this section shall present evidence of such~~
13 ~~coverage to the institution in which the student is enrolled~~
14 ~~at least annually, in a manner prescribed by the institution.~~

15 ~~(3) Every public or private college or university or~~
16 ~~postbaccalaureate program in this Commonwealth shall make~~
17 ~~available health insurance coverage on a group or individual~~
18 ~~basis for purchase by students who are required to maintain~~
19 ~~the coverage under this section.~~

20 ~~(4) Notwithstanding paragraphs (1), (2) and (3), the~~
21 ~~requirements of this section may be satisfied if the~~
22 ~~baccalaureate or postbaccalaureate program provides on campus~~
23 ~~student health care coverage equivalent to the minimum~~
24 ~~benefit package through its own clinics and health care~~
25 ~~facilities and receives approval from the Department of~~
26 ~~Education, in consultation with the department, that such~~
27 ~~coverage is equivalent. The coverage shall provide that the~~
28 ~~student is covered for hospital admissions and emergency~~
29 ~~services at facilities throughout this Commonwealth.~~

30 ~~(b) Effective date. This section shall apply to every~~

~~1 public or private baccalaureate or postbaccalaureate program in
2 this Commonwealth beginning the first August 1 following 180-
3 days after the publication of the notice of the elements of the
4 standard plans.~~

~~5 (c) Annual certification. Every public or private
6 baccalaureate or postbaccalaureate program in this Commonwealth
7 shall certify to the Department of Education at least annually
8 that the requirements of this section have been met for all
9 periods of the preceding year.~~

~~10 (d) Penalty for failure to comply. The Secretary of
11 Education may impose a fine of up to \$500 per day for each day
12 that a public or private baccalaureate or postbaccalaureate
13 program fails to meet any of its obligations in this section.
14 The fine shall be due within 30 days following receipt by the
15 institution of notice of the violation. Funds collected under
16 this subsection and any returns on the funds shall be deposited
17 into the Tobacco Settlement Fund established under the act of
18 June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement
19 Act.~~

~~20 Section 4207. Fair marketing standards.~~

~~21 Every insurer and producer must meet the following standards,
22 as appropriate:~~

~~23 (1) An insurer that offers small group health benefit
24 plans shall offer to small employers all of the small group
25 health benefit plans that the insurer actively markets in
26 this Commonwealth. An insurer shall be considered to be
27 actively marketing a small group health benefit plan if it
28 offers that plan to any small group not currently covered by
29 that insurer.~~

~~30 (2) The following shall apply:~~

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

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

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

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

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

29 ~~Section 4208. Reporting requirements.~~

30 ~~(a) Health insurance region market share. Not less~~

1 ~~frequently than March 1 of every calendar year, each insurer~~
2 ~~group shall file a report with the department of the insurer~~
3 ~~group's small group market share by health insurance region and~~
4 ~~the small group market share of each insurer within the insurer~~
5 ~~group by health insurance region, for the immediately preceding~~
6 ~~calendar year.~~

7 ~~(b) Segregated report. Not less frequently than March 1 of~~
8 ~~every calendar year, each insurer and each insurer group shall~~
9 ~~file a report with the department for the immediately preceding~~
10 ~~calendar year. The report shall contain the following~~
11 ~~information, both Statewide and by health insurance region,~~
12 ~~segregated for the individual market, the small group market and~~
13 ~~the large group market:~~

14 ~~(1) The aggregate number of covered lives and the time~~
15 ~~periods over which coverage was provided.~~

16 ~~(2) The number of individuals and groups covered by~~
17 ~~health benefit plans issued, made effective, delivered or~~
18 ~~renewed.~~

19 ~~(3) The aggregate loss ratio for all policies issued,~~
20 ~~made effective, delivered or renewed.~~

21 ~~(4) The average annual premium per insured life.~~

22 ~~(5) The average claims cost per insured life.~~

23 ~~(6) The range of administrative expenses, commissions~~
24 ~~paid, profit load, and any other retention items.~~

25 ~~(7) The average administrative expenses, commissions~~
26 ~~paid and profit load and any other retention items.~~

27 ~~(8) A description of each rating method used to~~
28 ~~determine rates indicating the specific group size for which~~
29 ~~each method was used.~~

30 ~~(9) A listing of all factors used in the rating for each~~

1 ~~market and the range of these factors.~~

2 ~~(10) The number of groups, including the number of~~
3 ~~employees and members in those groups, covered by entities~~
4 ~~with administrative services contract or administrative~~
5 ~~services only arrangements.~~

6 ~~(c) Review of reports. By July 1 of each year, the~~
7 ~~department shall review the reports provided for under~~
8 ~~subsection (a) and shall transmit to the Legislative Reference~~
9 ~~Bureau for publication in the Pennsylvania Bulletin a statement~~
10 ~~of the status of each insurer within each region in which the~~
11 ~~insurer provides coverage.~~

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

16 ~~(e) Limitation. The commissioner shall have discretion to~~
17 ~~modify the reporting requirements of this section by~~
18 ~~transmitting notice to the Legislative Reference Bureau for~~
19 ~~publication in the Pennsylvania Bulletin.~~

20 ~~(f) Compliance. For failure to comply with any reports or~~
21 ~~data calls required under this section, the commissioner shall~~
22 ~~impose an administrative penalty of \$1,000 against each insurer~~
23 ~~or \$5,000 against each insurer group for every day that the~~
24 ~~report or data is not provided in accordance with this section.~~
25 ~~Section 4209. Regulations.~~

26 ~~(a) Implementation and administration. The department and~~
27 ~~the Department of Education may promulgate regulations as~~
28 ~~necessary for the implementation and administration of this~~
29 ~~article.~~

30 ~~(b) Exemption. Except as may be otherwise provided in this~~

1 ~~article, the promulgation of regulations under this article by~~
2 ~~the department or the Department of Education shall, until three~~
3 ~~years from the effective date of this section, be exempt from~~
4 ~~the following:~~

5 ~~(1) Sections 201 through 205 of the Commonwealth~~
6 ~~Documents Law.~~

7 ~~(2) The Commonwealth Attorneys Act.~~

8 ~~(3) The Regulatory Review Act.~~

9 ~~Section 4210. Enforcement.~~

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

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

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

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

22 ~~(4) Seek restitution.~~

23 ~~(5) Impose any other penalty or pursue any other remedy~~
24 ~~deemed appropriate by the commissioner.~~

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

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

~~an unfair or deceptive act or practice pursuant to the Unfair Insurance Practices Act.~~

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

~~(c) Private cause of action. Nothing in this article shall be construed as to create or imply a private cause of action for violation of this article.~~

Section 4. ~~Repeals are as follows:~~

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

~~(2) Section 3(e) (2), (3), (4) and (5) of the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act, are repealed insofar as they apply 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 XLIII of the act.~~

Section 5. ~~This act shall take effect as follows:~~

~~(1) The amendment or addition of sections 617(A) (3) and (9) and 617.1 of the act shall take effect in 60 days.~~

~~(2) The remainder of this act shall take effect immediately.~~

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.

1 SECTION 4202. DEFINITIONS.

2 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ARTICLE
3 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
4 CONTEXT CLEARLY INDICATES OTHERWISE:

5 "ACCIDENT AND HEALTH FILING REFORM ACT." THE ACT OF DECEMBER
6 18, 1996 (P.L.1066, NO.159), KNOWN AS THE ACCIDENT AND HEALTH
7 FILING REFORM ACT.

8 "COMMISSIONER." THE INSURANCE COMMISSIONER OF THE
9 COMMONWEALTH.

10 "COMMONWEALTH ATTORNEYS ACT." THE ACT OF OCTOBER 15, 1980
11 (P.L.950, NO.164), KNOWN AS THE COMMONWEALTH ATTORNEYS ACT.

12 "COMMONWEALTH DOCUMENTS LAW." THE ACT OF JULY 31, 1968
13 (P.L.769, NO.240), REFERRED TO AS THE COMMONWEALTH DOCUMENTS
14 LAW.

15 "CREDITABLE COVERAGE." AS DEFINED IN SECTION 2701 OF THE
16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
17 (PUBLIC LAW 104-191, 42 U.S.C. § 300GG-91).

18 "DEPARTMENT." THE INSURANCE DEPARTMENT OF THE COMMONWEALTH.

19 "ELIGIBLE EMPLOYEE." A PERSON EMPLOYED BY A LARGE EMPLOYER
20 OR A SMALL EMPLOYER ON A REGULARLY SCHEDULED BASIS, WITH A
21 NORMAL WORK WEEK OF 17.5 HOURS OR MORE, BUT DOES NOT INCLUDE
22 PERSONS WHO WORK ON A TEMPORARY, SEASONAL OR SUBSTITUTE BASIS.

23 "GEOGRAPHIC AVERAGE RATE." THE ARITHMETICAL AVERAGE OF THE
24 LOWEST PREMIUM AND THE CORRESPONDING HIGHEST PREMIUM TO BE
25 CHARGED BY AN INSURER IN A HEALTH INSURANCE REGION FOR THE
26 INSURER'S SMALL EMPLOYER HEALTH BENEFITS PLAN. THE TERM DOES NOT
27 INCLUDE PREMIUM DIFFERENCES THAT ARE DUE TO DIFFERENCES IN
28 BENEFIT DESIGN OR FAMILY COMPOSITION.

29 "HEALTH BENEFIT PLAN." ANY INDIVIDUAL OR GROUP HEALTH
30 INSURANCE POLICY, SUBSCRIBER CONTRACT, CERTIFICATE OR PLAN WHICH

1 PROVIDES HEALTH OR SICKNESS AND ACCIDENT COVERAGE WHICH IS
2 OFFERED BY AN INSURER. THE TERM SHALL NOT INCLUDE ANY OF THE
3 FOLLOWING:

4 (1) AN ACCIDENT ONLY POLICY.

5 (2) A CREDIT ONLY POLICY.

6 (3) A LONG-TERM CARE OR DISABILITY INCOME POLICY.

7 (4) A LONG-TERM CARE POLICY.

8 (5) A SPECIFIED DISEASE POLICY.

9 (6) A MEDICARE SUPPLEMENT POLICY.

10 (7) A CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE
11 UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT POLICY.

12 (8) A FIXED INDEMNITY POLICY.

13 (9) A DENTAL ONLY POLICY.

14 (10) A VISION ONLY POLICY.

15 (11) A WORKERS' COMPENSATION POLICY.

16 (12) AN AUTOMOBILE MEDICAL PAYMENT POLICY UNDER 75
17 PA.C.S. (RELATING TO VEHICLES).

18 (13) ANY OTHER SIMILAR POLICIES PROVIDING FOR LIMITED
19 BENEFITS.

20 "HEALTH INSURANCE REGION." ANY OF THE FOLLOWING:

21 (1) "REGION I." THE GEOGRAPHIC AREA COVERED BY THE
22 COUNTIES OF BUCKS, CHESTER, DELAWARE, MONTGOMERY AND
23 PHILADELPHIA.

24 (2) "REGION II." THE GEOGRAPHIC AREA COVERED BY THE
25 COUNTIES OF ADAMS, BERKS, CUMBERLAND, DAUPHIN, FRANKLIN,
26 FULTON, LANCASTER, LEBANON, LEHIGH, NORTHAMPTON, PERRY,
27 SCHUYLKILL AND YORK.

28 (3) "REGION III." THE GEOGRAPHIC AREA COVERED BY THE
29 COUNTIES OF BRADFORD, CARBON, CLINTON, LACKAWANNA, LUZERNE,
30 LYCOMING, MONROE, PIKE, SULLIVAN, SUSQUEHANNA, TIOGA, WAYNE

1 AND WYOMING.

2 (4) "REGION IV." THE GEOGRAPHIC AREA COVERED BY THE
3 COUNTIES OF CENTRE, COLUMBIA, JUNIATA, MIFFLIN, MONTOUR,
4 NORTHUMBERLAND, SNYDER AND UNION.

5 (5) "REGION V." THE GEOGRAPHIC AREA COVERED BY THE
6 COUNTIES OF BEDFORD, BLAIR, CAMBRIA, CLEARFIELD, HUNTINGDON,
7 JEFFERSON AND SOMERSET.

8 (6) "REGION VI." THE GEOGRAPHIC AREA COVERED BY THE
9 COUNTIES OF ALLEGHENY, ARMSTRONG, BEAVER, BUTLER, FAYETTE,
10 GREENE, INDIANA, LAWRENCE, WASHINGTON AND WESTMORELAND.

11 (7) "REGION VII." THE GEOGRAPHIC AREA COVERED BY THE
12 COUNTIES OF CAMERON, CLARION, CRAWFORD, ELK, ERIE, FOREST,
13 MCKEAN, MERCER, POTTER, VENANGO AND WARREN.

14 "INDIVIDUAL MARKET." THE HEALTH INSURANCE MARKET FOR
15 INDIVIDUALS AS DEFINED IN SECTION 2791 OF THE HEALTH INSURANCE
16 PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (PUBLIC LAW 104-191,
17 42 U.S.C. § 300GG-91).

18 "INSURER." A COMPANY OR HEALTH INSURANCE ENTITY LICENSED IN
19 THIS COMMONWEALTH TO ISSUE ANY INDIVIDUAL OR GROUP HEALTH,
20 SICKNESS OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR
21 CERTIFICATE OR PLAN THAT PROVIDES MEDICAL OR HEALTH CARE
22 COVERAGE BY A HEALTH CARE FACILITY OR LICENSED HEALTH CARE
23 PROVIDER THAT IS OFFERED OR GOVERNED UNDER THIS ACT OR ANY OF
24 THE FOLLOWING:

25 (1) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364),
26 KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

27 (2) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS
28 THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM
29 STANDARDS ACT.

30 (3) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN

1 CORPORATIONS) OR CH. 63 (RELATING TO PROFESSIONAL HEALTH
2 SERVICES PLAN CORPORATIONS).

3 (4) ARTICLE XXIV.

4 "INSURER GROUP." A GROUP OF INSURERS WRITING COVERAGE IN
5 THIS COMMONWEALTH, INCLUDING A PARENT INSURER, ITS SUBSIDIARIES
6 AND AFFILIATES.

7 "LARGE EMPLOYER." IN CONNECTION WITH A GROUP HEALTH PLAN
8 WITH RESPECT TO A CALENDAR YEAR AND A PLAN YEAR, AN EMPLOYER WHO
9 EMPLOYS AN AVERAGE OF 51 OR MORE ELIGIBLE EMPLOYEES ON BUSINESS
10 DAYS DURING THE PRECEDING CALENDAR YEAR AND WHO EMPLOYS AT LEAST
11 51 ELIGIBLE EMPLOYEES ON THE FIRST DAY OF THE PLAN YEAR. IN THE
12 CASE OF AN EMPLOYER WHICH WAS NOT IN EXISTENCE THROUGHOUT THE
13 PRECEDING CALENDAR YEAR, THE DETERMINATION WHETHER AN EMPLOYER
14 IS A LARGE EMPLOYER SHALL BE BASED ON THE AVERAGE NUMBER OF
15 ELIGIBLE EMPLOYEES THAT IT IS REASONABLY EXPECTED THAT THE
16 EMPLOYER WILL EMPLOY ON BUSINESS DAYS IN THE CURRENT CALENDAR
17 YEAR.

18 "LARGE GROUP MARKET." THE HEALTH INSURANCE MARKET FOR LARGE
19 EMPLOYERS.

20 "MEDICAL LOSS RATIO." THE RATIO OF INCURRED MEDICAL CLAIM
21 COSTS TO HEALTH EARNED PREMIUMS, AS REPORTED ON THE STATEMENT
22 CONVENTION BLANK ADOPTED BY THE NATIONAL ASSOCIATION OF
23 INSURANCE COMMISSIONERS AND FILED WITH THE INSURANCE
24 COMMISSIONER.

25 "NAIC." THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

26 "PLAN YEAR." THE 12-CONSECUTIVE-MONTH PERIOD BEGINNING ON
27 THE FIRST DAY OF COVERAGE UNDER A HEALTH BENEFIT PLAN.

28 "PREEXISTING CONDITION EXCLUSION." AS DEFINED IN SECTION
29 2701 OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
30 OF 1996 (PUBLIC LAW 104-191, 42 U.S.C. § 300GG-91). PREGNANCY

1 AND CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR
2 TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE BIRTH OR WITHIN THE
3 FIRST 60 DAYS AFTER BIRTH OR WITHIN THE FIRST 60 DAYS AFTER
4 ADOPTION AS A MINOR CHILD SHALL NOT BE TREATED AS CONDITIONS
5 DESCRIBED IN THE DEFINITION IN SECTION 2701.

6 "REGULATORY REVIEW ACT." THE ACT OF JUNE 25, 1982 (P.L.633,
7 NO.181), KNOWN AS THE REGULATORY REVIEW ACT.

8 "SMALL EMPLOYER." IN CONNECTION WITH A GROUP HEALTH PLAN
9 WITH RESPECT TO A CALENDAR YEAR AND A PLAN YEAR, AN EMPLOYER WHO
10 EMPLOYS AN AVERAGE OF AT LEAST TWO BUT NOT MORE THAN 50 ELIGIBLE
11 EMPLOYEES ON BUSINESS DAYS DURING THE PRECEDING CALENDAR YEAR AND
12 WHO EMPLOYS AT LEAST TWO ELIGIBLE EMPLOYEES ON THE FIRST DAY OF
13 THE PLAN YEAR. IN THE CASE OF AN EMPLOYER WHICH WAS NOT IN
14 EXISTENCE THROUGHOUT THE PRECEDING CALENDAR YEAR, THE
15 DETERMINATION WHETHER AN EMPLOYER IS A SMALL EMPLOYER SHALL BE
16 BASED ON THE AVERAGE NUMBER OF ELIGIBLE EMPLOYEES THAT IT IS
17 REASONABLY EXPECTED THAT THE EMPLOYER WILL EMPLOY ON BUSINESS
18 DAYS IN THE CURRENT CALENDAR YEAR.

19 "SMALL GROUP HEALTH BENEFIT PLAN." A HEALTH BENEFIT PLAN
20 OFFERED TO A SMALL EMPLOYER.

21 "SMALL GROUP MARKET." THE HEALTH INSURANCE MARKET FOR SMALL
22 EMPLOYERS.

23 "STANDARD PLAN." ONE OF THE HEALTH BENEFIT PACKAGES
24 ESTABLISHED BY THE INSURANCE DEPARTMENT IN ACCORDANCE WITH
25 SECTION 4204.

26 SECTION 4203. EXEMPTION FROM GENERAL APPLICABILITY.

27 SECTIONS 4204 AND 4206 SHALL NOT APPLY TO SMALL GROUP HEALTH
28 BENEFIT PLANS ISSUED, MADE EFFECTIVE, DELIVERED OR RENEWED IN
29 THIS COMMONWEALTH BY ANY INSURER THAT IS PART OF AN INSURER
30 GROUP WHERE THAT INSURER GROUP INSURES OR ADMINISTERS HEALTH

1 CARE COVERAGE FOR LESS THAN 1% OF THE HEALTH INSURANCE PREMIUMS
2 IN THE COMMONWEALTH, AS MEASURED BY NAIC ANNUAL STATEMENT DATA.
3 IF THE NAIC ANNUAL STATEMENT DATA DOES NOT CONTAIN THE
4 SPECIFICITY TO DEMONSTRATE THAT THE INSURER GROUP PREMIUM FOR
5 HEALTH INSURANCE IS LESS THAN 1% OF THE HEALTH INSURANCE PREMIUM
6 IN THE COMMONWEALTH, AN INSURER GROUP SEEKING TO CLAIM EXEMPTION
7 FROM THE REQUIREMENTS OF THIS ARTICLE SHALL PRESENT ADDITIONAL
8 EVIDENCE SUPPORTED BY A STATEMENT BY AN INDEPENDENT, CERTIFIED
9 PUBLIC ACCOUNTANT, UTILIZING AGREED-UPON PROCEDURES ACCEPTABLE
10 TO THE DEPARTMENT TO DEMONSTRATE ITS MARKET SHARE.

11 SECTION 4204. STANDARD PLANS.

12 (A) APPLICABILITY.--THIS SECTION SHALL APPLY TO ALL SMALL
13 GROUP HEALTH BENEFIT PLANS ISSUED, MADE EFFECTIVE, DELIVERED OR
14 RENEWED IN THIS COMMONWEALTH AFTER THE EFFECTIVE DATE OF THIS
15 SECTION.

16 (B) STANDARD PLANS REQUIRED.--

17 (1) AN INSURER SHALL NOT OFFER A PLAN THAT DOES NOT MEET
18 THE MINIMUM BENEFITS SPECIFIED IN ONE OF THE STANDARD PLANS
19 DEVELOPED BY THE DEPARTMENT. THE DEPARTMENT SHALL CONSULT
20 WITH INSURERS IN DEVELOPING THE STANDARD PLANS.

21 (2) THE STANDARD PLANS MAY NOT CONTAIN ANY PREEXISTING
22 CONDITION EXCLUSIONS.

23 (3) STANDARD PLANS MAY INCLUDE OPTIONS FOR DEDUCTIBLES
24 AND COST-SHARING IF THE DEPARTMENT DETERMINES THAT THE
25 OPTIONS:

26 (I) DO NOT DISSUADE CONSUMERS FROM SEEKING NECESSARY
27 SERVICES.

28 (II) PROMOTE A BALANCE OF THE IMPACT OF COST-SHARING
29 IN REDUCING PREMIUMS AND IN EFFECTING UTILIZATION OF
30 APPROPRIATE SERVICES.

1 (III) LIMIT THE TOTAL COST-SHARING THAT MAY BE
2 INCURRED BY AN INDIVIDUAL IN A YEAR.

3 (4) THE FOLLOWING APPLY:

4 (I) THE DEPARTMENT SHALL FORWARD NOTICE OF THE
5 ELEMENTS OF THE STANDARD PLANS TO THE LEGISLATIVE
6 REFERENCE BUREAU FOR PUBLICATION AS A NOTICE IN THE
7 PENNSYLVANIA BULLETIN.

8 (II) AN INSURER SUBJECT TO THE PROVISIONS OF THIS
9 SECTION SHALL BE REQUIRED TO BEGIN OFFERING ITS STANDARD
10 PLANS AS SOON AS PRACTICABLE FOLLOWING THE PUBLICATION
11 BUT IN NO EVENT LATER THAN 180 DAYS FOLLOWING THE
12 PUBLICATION UNDER SUBPARAGRAPH (I).

13 (5) EACH STANDARD PLAN SHALL QUALIFY AS CREDITABLE
14 COVERAGE.

15 (C) ADDITIONAL BENEFITS.--

16 (1) AN INSURER MAY OFFER BENEFITS IN ADDITION TO THOSE
17 IN ANY OF ITS STANDARD PLANS.

18 (2) EACH ADDITIONAL BENEFIT SHALL:

19 (I) BE OFFERED AND PRICED SEPARATELY FROM BENEFITS
20 SPECIFIED IN THE STANDARD PLAN WITH WHICH THE BENEFITS
21 ARE BEING OFFERED.

22 (II) NOT HAVE THE EFFECT OF DUPLICATING ANY OF THE
23 BENEFITS IN THE STANDARD PLAN WITH WHICH THE BENEFITS ARE
24 BEING OFFERED.

25 (III) BE CLEARLY SPECIFIED AS ADDITIONS TO THE
26 STANDARD PLAN WITH WHICH THE BENEFITS ARE BEING OFFERED.

27 (3) THE DEPARTMENT MAY PROHIBIT AN INSURER FROM OFFERING
28 AN ADDITIONAL BENEFIT UNDER THIS SECTION IF THE DEPARTMENT
29 FINDS THAT THE ADDITIONAL BENEFIT WILL BE SOLD IN CONJUNCTION
30 WITH ONE OF THE INSURER'S STANDARD PLANS IN A MANNER DESIGNED

1 TO PROMOTE RISK SELECTION OR UNDERWRITING PRACTICES OTHERWISE
2 PROHIBITED UNDER THIS SECTION OR OTHER STATE LAW.

3 SECTION 4205. GUARANTEED AVAILABILITY AND RENEWABILITY OF SMALL
4 GROUP HEALTH BENEFIT PLANS.

5 (A) AVAILABILITY.--THE AVAILABILITY OF EACH SMALL GROUP
6 HEALTH BENEFIT PLAN OFFERED UNDER THIS ARTICLE IS SUBJECT TO THE
7 PROVISIONS OF THE ACT OF JUNE 25, 1997 (P.L.295, NO.29), KNOWN
8 AS THE PENNSYLVANIA HEALTH CARE INSURANCE PORTABILITY ACT.

9 (B) PREEXISTING CONDITIONS.--ANY PREEXISTING CONDITION
10 EXCLUSIONS FOR SMALL GROUP HEALTH BENEFIT PLANS SHALL COMPLY
11 WITH SECTION 2701 OF TITLE XXVII OF THE PUBLIC HEALTH SERVICE
12 ACT (PUBLIC LAW 104-191, 42 U.S.C. § 300GG-91).

13 (C) RENEWABILITY.--THE RENEWABILITY OF EACH SMALL GROUP
14 HEALTH BENEFIT PLAN OFFERED UNDER THIS ARTICLE IS SUBJECT TO THE
15 PROVISIONS OF THE PENNSYLVANIA HEALTH CARE INSURANCE PORTABILITY
16 ACT.

17 SECTION 4206. HEALTH INSURANCE PREMIUM RATES.

18 (A) APPLICABILITY.--THIS SECTION SHALL APPLY TO ALL SMALL
19 GROUP HEALTH BENEFIT PLANS THAT ARE ISSUED, MADE EFFECTIVE,
20 DELIVERED OR RENEWED IN THIS COMMONWEALTH AFTER THE EFFECTIVE
21 DATE OF THIS SECTION.

22 (B) PREMIUM RATES.--

23 (1) AN INSURER SHALL ESTABLISH A GEOGRAPHIC AVERAGE RATE
24 FOR PLANS AND SHALL FILE THE GEOGRAPHIC AVERAGE RATES WITH
25 THE DEPARTMENT AS REQUIRED BY LAW. THE GEOGRAPHIC AVERAGE
26 RATE MAY NOT BE CHANGED MORE FREQUENTLY THAN ONCE EVERY 12
27 MONTHS. AN INSURER MAY ADJUST ITS GEOGRAPHIC AVERAGE RATES
28 FOR AGE ONLY.

29 (2) AN INSURER SHALL APPLY THE RISK ADJUSTMENT FACTOR
30 UNDER PARAGRAPH (1) CONSISTENTLY WITH RESPECT TO ALL PLANS

1 SUBJECT TO THIS SECTION.

2 (3) AN INSURER SHALL NOT CHARGE A RATE THAT IS MORE THAN
3 33% ABOVE OR BELOW THE GEOGRAPHIC AVERAGE RATE AS PERMITTED
4 UNDER PARAGRAPH (1). ADDITIONAL ADJUSTMENTS MAY BE MADE TO
5 REFLECT THE INCLUSION OF ADDITIONAL BENEFITS AS SPECIFIED
6 UNDER SECTION 4204(C) AND DIFFERENCES IN FAMILY COMPOSITION.

7 (4) THE PREMIUM FOR A SMALL GROUP HEALTH BENEFIT PLAN
8 SHALL NOT BE ADJUSTED BY AN INSURER MORE THAN ONCE EACH YEAR,
9 EXCEPT THAT RATES MAY BE CHANGED MORE FREQUENTLY TO REFLECT:

10 (I) CHANGES TO THE ENROLLMENT OF THE SMALL EMPLOYER
11 GROUP.

12 (II) CHANGES TO A SMALL GROUP HEALTH BENEFIT PLAN
13 THAT HAVE BEEN REQUESTED BY THE SMALL EMPLOYER.

14 (III) CHANGES PURSUANT TO A GOVERNMENT ORDER OR
15 JUDICIAL PROCEEDING.

16 (5) EXCEPT FOR ADJUSTMENTS RELATED TO ENROLLMENT OR
17 BENEFIT CHANGES, ANY SMALL GROUP RECEIVING A RATE INCREASE AT
18 RENEWAL SHALL HAVE THAT INCREASE LIMITED TO A 10% ADJUSTMENT
19 FROM THE APPLICABLE GROUP RATE. THE APPLICABLE GROUP RATE IS
20 THE RATE THE GROUP WAS CHARGED IN THE PRIOR BENEFIT YEAR
21 ADJUSTED FOR ANY CHANGE IN THE GEOGRAPHIC AVERAGE RATE FOR
22 THE RELEVANT REGION FROM THE PRIOR YEAR TO THE CURRENT YEAR.

23 (6) RATE CHANGES REQUIRED BY THE RATE BANDS IN PARAGRAPH
24 (3) SHALL BE PHASED IN SO THAT ANY SMALL GROUP RECEIVING A
25 RATE INCREASE AT RENEWAL SHALL HAVE THE PORTION OF THAT RATE
26 INCREASE ATTRIBUTABLE TO THE IMPLEMENTATION OF THE RATE BANDS
27 IN PARAGRAPH (3) LIMITED TO 10% OF THE PRIOR RATE.

28 (7) AN INSURER SHALL ADJUST THE GEOGRAPHIC AVERAGE RATE
29 IN AN ADDITIONAL AMOUNT OF NOT LESS THAN 5% AND NOT MORE THAN
30 20% FOR ANY SMALL EMPLOYER WHO PARTICIPATES IN A WELLNESS

1 PROGRAM. THE WELLNESS PROGRAM MUST SATISFY MINIMUM STANDARDS
2 ESTABLISHED BY THE DEPARTMENT IN COORDINATION WITH THE
3 DEPARTMENT OF HEALTH AND PUBLISHED BY NOTICE IN THE
4 PENNSYLVANIA BULLETIN, AND MAY NOT VIOLATE THE REQUIREMENTS
5 OF THE FEDERAL WELLNESS PROGRAM REGULATIONS UNDER 45 C.F.R. §
6 146.121F (RELATING TO PROHIBITING DISCRIMINATION AGAINST
7 PARTICIPANTS AND BENEFICIARIES BASED ON A HEALTH FACTOR).

8 (8) AN INSURER SHALL BASE ITS RATING METHODS AND
9 PRACTICES ON COMMONLY ACCEPTED ACTUARIAL ASSUMPTIONS AND
10 SOUND ACTUARIAL PRINCIPLES. RATES SHALL NOT BE EXCESSIVE,
11 INADEQUATE OR UNFAIRLY DISCRIMINATORY.

12 (9) FOR PURPOSES OF THIS SUBSECTION, AN INSURER'S
13 "GEOGRAPHIC AVERAGE RATE" FOR A PLAN SHALL REFER TO A RATING
14 METHODOLOGY THAT IS BASED ON THE EXPERIENCE OF ALL RISKS
15 COVERED BY THE PLAN WITHOUT REGARD TO HEALTH STATUS,
16 OCCUPATION OR ANY OTHER FACTOR.

17 (C) ADDITIONAL RATE REVIEW AND PRIOR APPROVAL.--

18 (1) IN CONJUNCTION WITH AND IN ADDITION TO THE STANDARDS
19 SET FORTH IN THE ACT OF DECEMBER 18, 1996 (P.L.1066, NO.159),
20 KNOWN AS THE ACCIDENT AND HEALTH FILING REFORM ACT, AND ALL
21 OTHER APPLICABLE STATUTORY AND REGULATORY REQUIREMENTS, ALL
22 RATE FILINGS SHALL BE SUBJECT TO PRIOR APPROVAL BY THE
23 DEPARTMENT WITHIN THE 45-DAY PERIOD PROVIDED BY SECTION 3(F)
24 OF THE ACCIDENT AND HEALTH FILING REFORM ACT.

25 (2) IN CONJUNCTION WITH AND IN ADDITION TO THE STANDARDS
26 SET FORTH UNDER THE ACCIDENT AND HEALTH FILING REFORM ACT AND
27 ALL OTHER APPLICABLE STATUTORY AND REGULATORY REQUIREMENTS,
28 THE DEPARTMENT MAY DISAPPROVE A RATE FILING BASED UPON ANY OF
29 THE FOLLOWING:

30 (I) THE RATE IS NOT ACTUARIALLY SOUND.

1 (II) THE INCREASE IS REQUESTED BECAUSE THE INSURER
2 HAS NOT OPERATED EFFICIENTLY OR HAS FACTORED IN
3 EXPERIENCE THAT CONFLICTS WITH RECOGNIZED BEST PRACTICES
4 IN THE HEALTH CARE INDUSTRY, INCLUDING THE ALLOCATION OF
5 ADMINISTRATIVE EXPENSES TO THE PLAN ON A LESS FAVORABLE
6 BASIS THAN EXPENSES ARE ALLOCATED TO OTHER HEALTH BENEFIT
7 PLANS.

8 (III) THE INCREASE IS REQUESTED BECAUSE THE INSURER
9 HAS INCURRED COSTS DUE TO FAILURE TO FOLLOW BEST
10 PRACTICES FOR COST CONTROL, INCLUDING EFFORTS TO PROMOTE
11 A REDUCTION IN HOSPITAL-ACQUIRED INFECTIONS AND SERIOUS
12 PREVENTABLE ADVERSE EVENTS.

13 (IV) THE MEDICAL LOSS RATIO FOR A PLAN IS LESS THAN
14 85%.

15 (3) IN THE EVENT A PLAN HAS A MEDICAL LOSS RATIO OF LESS
16 THAN 85%, THE DEPARTMENT MAY, IN ADDITION TO ANY OTHER
17 REMEDIES AVAILABLE UNDER LAW, REQUIRE THE INSURER TO REFUND
18 THE DIFFERENCE TO POLICYHOLDERS ON A PRO RATA BASIS AS SOON
19 AS PRACTICABLE FOLLOWING RECEIPT OF NOTICE FROM THE
20 DEPARTMENT OF THE REQUIREMENT BUT IN NO EVENT LATER THAN 120
21 DAYS FOLLOWING RECEIPT OF THE NOTICE. THE DEPARTMENT SHALL
22 ESTABLISH PROCEDURES UNDER WHICH SUCH REFUNDS WILL BE MADE.

23 (D) PROCEDURES.--THE FILING AND REVIEW PROCEDURES SET FORTH
24 UNDER THE ACCIDENT AND HEALTH FILING REFORM ACT SHALL APPLY TO
25 ANY FILING CONDUCTED UNDER THIS SECTION, EXCEPT THAT NO FILING
26 DEEMED TO MEET THE REQUIREMENTS OF THIS ACT SHALL TAKE EFFECT
27 UNLESS THE DEPARTMENT RECEIVES WRITTEN NOTICE OF THE INSURER'S
28 INTENT TO EXERCISE THE RIGHT GRANTED UNDER THIS SECTION AT LEAST
29 TEN CALENDAR DAYS PRIOR TO IMPLEMENTATION OF RATES AUTHORIZED BY
30 THIS ACT.

1 SECTION 4207. COLLEGE STUDENT INSURANCE REQUIREMENTS.

2 (A) MINIMUM HEALTH BENEFIT PACKAGE.--WITHIN 90 DAYS
3 FOLLOWING THE EFFECTIVE DATE OF THIS SECTION, THE DEPARTMENT
4 SHALL ESTABLISH A MINIMUM HEALTH BENEFIT PACKAGE FOR FULL-TIME
5 STUDENTS ENROLLED IN PUBLIC OR PRIVATE BACCALAUREATE AND
6 POSTBACCALAUREATE PROGRAMS IN THIS COMMONWEALTH AND TRANSMIT A
7 DESCRIPTION OF THE PACKAGE TO THE LEGISLATIVE REFERENCE BUREAU
8 FOR PUBLICATION IN THE PENNSYLVANIA BULLETIN. AS SOON AS
9 PRACTICABLE AFTER THE DATE OF PUBLICATION OF THE PACKAGE, BUT IN
10 NO EVENT LATER THAN 120 DAYS FOLLOWING THE PUBLICATION, ALL
11 INSURERS SHALL OFFER THE PACKAGE AS INDIVIDUAL COVERAGE
12 AVAILABLE TO STUDENTS AND AS GROUP COVERAGE THROUGH THE
13 INSTITUTION. THE DEPARTMENT MAY MAKE REVISIONS TO THE MINIMUM
14 HEALTH BENEFIT PACKAGE PERIODICALLY, BUT NO MORE THAN ONE TIME
15 PER 12-MONTH PERIOD. EACH REVISION SHALL BE IMPLEMENTED BY
16 INSURERS AS SOON AS PRACTICABLE FOLLOWING PUBLICATION OF THE
17 REVISION IN THE PENNSYLVANIA BULLETIN, BUT IN NO EVENT LATER
18 THAN 120 DAYS FOLLOWING SUCH PUBLICATION.

19 (B) REQUIRED HEALTH INSURANCE COVERAGE.--

20 (1) EVERY FULL-TIME STUDENT ENROLLED IN A PUBLIC OR
21 PRIVATE BACCALAUREATE OR POSTBACCALAUREATE PROGRAM IN THIS
22 COMMONWEALTH SHALL MAINTAIN HEALTH INSURANCE COVERAGE WHICH
23 PROVIDES THE MINIMUM BENEFIT PACKAGE ESTABLISHED UNDER THIS
24 SECTION. THE COVERAGE SHALL BE MAINTAINED THROUGHOUT THE
25 PERIOD OF THE STUDENT'S ENROLLMENT.

26 (2) EVERY STUDENT REQUIRED TO MEET THE MANDATORY
27 COVERAGE UNDER THIS SECTION SHALL PRESENT EVIDENCE OF SUCH
28 COVERAGE TO THE INSTITUTION IN WHICH THE STUDENT IS ENROLLED
29 AT LEAST ANNUALLY, IN A MANNER PRESCRIBED BY THE INSTITUTION.

30 (3) EVERY PUBLIC OR PRIVATE COLLEGE OR UNIVERSITY OR

1 POSTBACCALAUREATE PROGRAM IN THIS COMMONWEALTH SHALL MAKE
2 AVAILABLE HEALTH INSURANCE COVERAGE ON A GROUP OR INDIVIDUAL
3 BASIS FOR PURCHASE BY STUDENTS WHO ARE REQUIRED TO MAINTAIN
4 THE COVERAGE UNDER THIS SECTION.

5 (4) NOTWITHSTANDING PARAGRAPHS (1), (2) AND (3), THE
6 REQUIREMENTS OF THIS SECTION MAY BE SATISFIED IF THE
7 BACCALAUREATE OR POSTBACCALAUREATE PROGRAM PROVIDES ON-CAMPUS
8 STUDENT HEALTH CARE COVERAGE EQUIVALENT TO THE MINIMUM
9 BENEFIT PACKAGE THROUGH ITS OWN CLINICS AND HEALTH CARE
10 FACILITIES AND RECEIVES APPROVAL FROM THE DEPARTMENT OF
11 EDUCATION, IN CONSULTATION WITH THE DEPARTMENT, THAT SUCH
12 COVERAGE IS EQUIVALENT. THE COVERAGE SHALL PROVIDE THAT THE
13 STUDENT IS COVERED FOR HOSPITAL ADMISSIONS AND EMERGENCY
14 SERVICES AT FACILITIES THROUGHOUT THIS COMMONWEALTH.

15 (C) EFFECTIVE DATE.--THIS SECTION SHALL APPLY TO PUBLIC OR
16 PRIVATE BACCALAUREATE OR POSTBACCALAUREATE PROGRAM IN THIS
17 COMMONWEALTH BEGINNING THE FIRST AUGUST 1 FOLLOWING 180 DAYS
18 AFTER THE PUBLICATION OF THE NOTICE OF THE ELEMENTS OF THE
19 STANDARD PLANS.

20 (D) ANNUAL CERTIFICATION.--EVERY PUBLIC OR PRIVATE
21 BACCALAUREATE OR POSTBACCALAUREATE PROGRAM IN THIS COMMONWEALTH
22 SHALL CERTIFY TO THE DEPARTMENT OF EDUCATION AT LEAST ANNUALLY
23 THAT THE REQUIREMENTS OF THIS SECTION HAVE BEEN MET FOR ALL
24 PERIODS OF THE PRECEDING YEAR.

25 (E) PENALTY FOR FAILURE TO COMPLY.--THE SECRETARY OF
26 EDUCATION MAY IMPOSE A FINE OF UP TO \$500 PER DAY FOR EACH DAY
27 THAT A PUBLIC OR PRIVATE BACCALAUREATE OR POSTBACCALAUREATE
28 PROGRAM FAILS TO MEET ANY OF ITS OBLIGATIONS IN THIS SECTION.
29 THE FINE SHALL BE DUE WITHIN 30 DAYS FOLLOWING RECEIPT BY THE
30 INSTITUTION OF NOTICE OF THE VIOLATION. FUNDS COLLECTED UNDER

1 THIS SUBSECTION AND ANY RETURNS ON THE FUNDS SHALL BE DEPOSITED
2 INTO THE TOBACCO SETTLEMENT FUND ESTABLISHED UNDER THE ACT OF
3 JUNE 26, 2001 (P.L.755, NO.77), KNOWN AS THE TOBACCO SETTLEMENT
4 ACT.

5 SECTION 4208. FAIR MARKETING STANDARDS.

6 EVERY INSURER AND PRODUCER MUST MEET THE FOLLOWING STANDARDS,
7 AS APPROPRIATE:

8 (1) AN INSURER THAT OFFERS SMALL GROUP HEALTH BENEFIT
9 PLANS SHALL OFFER TO SMALL EMPLOYERS ALL OF THE SMALL GROUP
10 HEALTH BENEFIT PLANS THAT THE INSURER ACTIVELY MARKETS IN
11 THIS COMMONWEALTH. AN INSURER SHALL BE CONSIDERED TO BE
12 ACTIVELY MARKETING A SMALL GROUP HEALTH BENEFIT PLAN IF IT
13 OFFERS THAT PLAN TO ANY SMALL GROUP NOT CURRENTLY COVERED BY
14 THAT INSURER.

15 (2) THE FOLLOWING SHALL APPLY:

16 (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II), A
17 PRODUCER OR AN INSURER THAT PROVIDES SMALL GROUP HEALTH
18 BENEFIT PLANS SHALL NOT ENCOURAGE OR DIRECT A SMALL
19 EMPLOYER TO REFRAIN FROM FILING AN APPLICATION FOR
20 COVERAGE WITH THE INSURER OR SEEK COVERAGE FROM ANOTHER
21 INSURER BECAUSE OF A HEALTH STATUS-RELATED FACTOR OR THE
22 NATURE OF THE INDUSTRY, OCCUPATION OR GEOGRAPHIC LOCATION
23 OF THE SMALL EMPLOYER.

24 (II) THE PROVISIONS OF SUBPARAGRAPH (I) SHALL NOT
25 APPLY WITH RESPECT TO INFORMATION PROVIDED BY AN INSURER
26 OR PRODUCER TO A SMALL EMPLOYER REGARDING AN ESTABLISHED
27 GEOGRAPHIC SERVICE AREA OR A RESTRICTED NETWORK PROVISION
28 OF AN INSURER.

29 (3) AN INSURER THAT PROVIDES SMALL GROUP HEALTH BENEFIT
30 PLANS SHALL NOT ENTER INTO A CONTRACT, AGREEMENT OR

1 ARRANGEMENT THAT PROVIDES FOR OR RESULTS IN A PRODUCER'S
2 COMPENSATION BEING VARIED BECAUSE OF A HEALTH STATUS-RELATED
3 FACTOR OR THE NATURE OF THE INDUSTRY OR OCCUPATION OF THE
4 SMALL EMPLOYER.

5 (4) AN INSURER THAT PROVIDES SMALL GROUP HEALTH BENEFIT
6 PLANS SHALL NOT TERMINATE, FAIL TO RENEW OR LIMIT ITS
7 CONTRACT OR AGREEMENT WITH A PRODUCER FOR A REASON OR REASONS
8 RELATED TO A HEALTH STATUS-RELATED FACTOR OR OCCUPATION OF
9 THE SMALL EMPLOYER.

10 (5) A PRODUCER OR INSURER THAT PROVIDES SMALL GROUP
11 HEALTH BENEFIT PLANS SHALL NOT INDUCE OR ENCOURAGE A SMALL
12 EMPLOYER TO EXCLUDE AN EMPLOYEE OR THE EMPLOYEE'S DEPENDENTS
13 FROM HEALTH COVERAGE OR BENEFITS AVAILABLE UNDER THE PLAN.

14 SECTION 4209. REPORTING REQUIREMENTS.

15 (A) HEALTH INSURANCE REGION SMALL GROUP MARKET SHARE.--NOT
16 LESS FREQUENTLY THAN MARCH 1 OF EVERY CALENDAR YEAR, EACH
17 INSURER GROUP SHALL FILE A REPORT WITH THE DEPARTMENT OF THE
18 INSURER GROUP'S SMALL GROUP MARKET SHARE BY HEALTH INSURANCE
19 REGION AND THE SMALL GROUP MARKET SHARE OF EACH INSURER WITHIN
20 THE INSURER GROUP BY HEALTH INSURANCE REGION, FOR THE
21 IMMEDIATELY PRECEDING CALENDAR YEAR.

22 (B) HEALTH INSURANCE MARKET REPORTS.--NOT LESS FREQUENTLY
23 THAN MARCH 1 OF EVERY CALENDAR YEAR, EACH INSURER AND EACH
24 INSURER GROUP SHALL FILE THE FOLLOWING REPORTS WITH THE
25 DEPARTMENT:

26 (1) AGGREGATE FINANCIAL INFORMATION FOR THE PRECEDING
27 YEAR DERIVED FROM EACH INSURER'S NAIC ANNUAL STATEMENT BLANK
28 OR, IF UNAVAILABLE, FROM OTHER CERTIFIABLE RECORDS:

29 (I) AMOUNT OF GENERAL ADMINISTRATIVE EXPENSES,
30 INCLUDING IDENTIFICATION OF THE FIVE LARGEST NONMEDICAL

1 ADMINISTRATIVE EXPENSES.

2 (II) AMOUNT OF SURPLUS MAINTAINED.

3 (III) AMOUNT OF RESERVES MAINTAINED FOR UNPAID
4 CLAIMS.

5 (IV) NET UNDERWRITING GAIN OR LOSS.

6 (V) INSURER'S NET INCOME AFTER TAXES.

7 (2) MARKET INFORMATION FOR THE PRECEDING CALENDAR YEAR,
8 DERIVED FROM EACH INSURER'S NAIC ANNUAL STATEMENT BLANK OR,
9 IF UNAVAILABLE, FROM OTHER CERTIFIABLE RECORDS, SEGMENTED
10 BOTH STATEWIDE AND BY HEALTH INSURANCE REGION, SEGREGATED FOR
11 THE INDIVIDUAL MARKET, THE SMALL GROUP MARKET AND THE LARGE
12 GROUP MARKET:

13 (I) NUMBER OF MEMBERS AS OF DECEMBER 31.

14 (II) NUMBER OF MEMBER MONTHS.

15 (III) PREMIUMS EARNED.

16 (IV) INCURRED MEDICAL CLAIMS COSTS.

17 (V) MEDICAL LOSS RATIO.

18 (VI) AVERAGE PREMIUM PER MEMBER PER MONTH FOR THE
19 REPORTING YEAR, DERIVED BY DIVIDING EARNED PREMIUMS BY
20 MEMBER MONTHS.

21 (VII) AVERAGE PREMIUM PER MEMBER PER MONTH FOR THE
22 PRECEDING REPORTING YEAR, DERIVED BY DIVIDING EARNED
23 PREMIUMS BY MEMBER MONTHS.

24 (VIII) A DESCRIPTION OF EACH RATING METHOD USED TO
25 DETERMINE RATES INDICATING THE SPECIFIC GROUP SIZE FOR
26 WHICH EACH METHOD WAS USED.

27 (IX) A LISTING OF ALL FACTORS USED IN THE RATING FOR
28 EACH MARKET AND THE RANGE OF THESE FACTORS.

29 (3) AGGREGATE MARKET INFORMATION FOR THE PRECEDING YEAR
30 DERIVED FROM EACH INSURER'S NAIC ANNUAL STATEMENT BLANK OR,

1 IF UNAVAILABLE, FROM OTHER CERTIFIABLE RECORDS, FOR COVERED
2 LIVES IN PENNSYLVANIA BY INDIVIDUAL MARKET, SMALL GROUP
3 MARKET AND LARGE GROUP MARKET:

4 (I) NUMBER OF MEMBERS COVERED BY ENTITIES WITH
5 ADMINISTRATIVE SERVICES CONTRACTS OR ADMINISTRATIVE
6 SERVICES-ONLY ARRANGEMENTS.

7 (II) NUMBER OF MEMBERS COVERED BY ASSOCIATIONS OR
8 OUT-OF-STATE TRUSTS COVERING LIVES IN PENNSYLVANIA.

9 (C) SUBMISSION.--EACH REPORT REQUIRED BY THIS SECTION SHALL
10 BE ELECTRONICALLY SUBMITTED IN A FORMAT AND ACCORDING TO
11 INSTRUCTIONS PRESCRIBED BY THE DEPARTMENT.

12 (D) REVIEW OF REPORTS.--BY JULY 1 OF EACH YEAR, THE
13 DEPARTMENT SHALL REVIEW THE REPORTS PROVIDED FOR UNDER
14 SUBSECTION (A) AND SHALL TRANSMIT TO THE LEGISLATIVE REFERENCE
15 BUREAU FOR PUBLICATION IN THE PENNSYLVANIA BULLETIN A STATEMENT
16 OF THE STATUS OF EACH INSURER WITHIN EACH REGION IN WHICH THE
17 INSURER PROVIDES COVERAGE.

18 (E) PUBLIC ACCESS.--THE DEPARTMENT SHALL MAKE THE
19 INFORMATION REPORTED UNDER THIS SECTION AVAILABLE TO THE PUBLIC
20 THROUGH A SEARCHABLE PUBLIC INTERNET WEBSITE.

21 (F) DATA CALLS.--THE DEPARTMENT MAY ISSUE DATA CALLS AS
22 NECESSARY TO FULFILL THE REQUIREMENTS OF THIS ARTICLE. ANY DATA
23 CALLS ISSUED UNDER THIS SECTION SHALL BE PUBLISHED IN THE
24 PENNSYLVANIA BULLETIN.

25 (G) LIMITATION.--THE DEPARTMENT SHALL HAVE DISCRETION TO
26 MODIFY THE REPORTING REQUIREMENTS OF THIS SECTION BY
27 TRANSMITTING NOTICE TO THE LEGISLATIVE REFERENCE BUREAU FOR
28 PUBLICATION IN THE PENNSYLVANIA BULLETIN.

29 (H) COMPLIANCE.--FOR FAILURE TO COMPLY WITH ANY REPORTS OR
30 DATA CALLS REQUIRED UNDER THIS SECTION, THE COMMISSIONER SHALL

1 IMPOSE AN ADMINISTRATIVE PENALTY OF \$1,000 AGAINST EACH INSURER
2 OR \$5,000 AGAINST EACH INSURER GROUP FOR EVERY DAY THAT THE
3 REPORT OR DATA IS NOT PROVIDED IN ACCORDANCE WITH THIS SECTION.

4 (I) DEFINITION.--AS USED IN THIS SECTION, SPECIFICALLY FOR
5 PURPOSES OF THE REPORTING REQUIRED IN SUBSECTION (B), MEMBER
6 MEANS AN INDIVIDUAL PERSON COVERED BY A HEALTH BENEFIT PLAN, AN
7 ASSOCIATION OR AN OUT-OF-STATE TRUST. THE TERM INCLUDES
8 DEPENDENTS.

9 SECTION 4210. REGULATIONS.

10 (A) IMPLEMENTATION AND ADMINISTRATION.--THE DEPARTMENT AND
11 THE DEPARTMENT OF EDUCATION MAY PROMULGATE REGULATIONS AS
12 NECESSARY FOR THE IMPLEMENTATION AND ADMINISTRATION OF THIS
13 ARTICLE.

14 (B) EXEMPTION.--EXCEPT FOR THE REGULATIONS PROMULGATED UNDER
15 SECTION 4211, THE PROMULGATION OF REGULATIONS UNDER THIS ARTICLE
16 BY THE DEPARTMENT OR THE DEPARTMENT OF EDUCATION SHALL, UNTIL
17 THREE YEARS FROM THE EFFECTIVE DATE OF THIS SECTION, BE EXEMPT
18 FROM THE FOLLOWING:

19 (1) SECTIONS 201, 202, 203, 204 AND 205 OF THE
20 COMMONWEALTH DOCUMENTS LAW.

21 (2) THE COMMONWEALTH ATTORNEYS ACT.

22 (3) THE REGULATORY REVIEW ACT.

23 SECTION 4211. SMALL EMPLOYER GROUPS.

24 A GROUP OF TWO OR MORE SMALL EMPLOYERS MAY JOIN TOGETHER FOR
25 THE PURPOSE OF PURCHASING SMALL GROUP HEALTH BENEFIT PLANS
26 PROVIDED FOR UNDER THIS ARTICLE. THE DEPARTMENT SHALL ESTABLISH
27 CERTIFICATION REQUIREMENTS AND PROMULGATE REGULATIONS FOR
28 IMPLEMENTATION OF THIS SECTION. THE REGULATIONS SHALL, AT A
29 MINIMUM, REQUIRE THAT PURCHASES MADE UNDER THIS SECTION BE FROM
30 AN INSURER LICENSED BY THE DEPARTMENT, AND MAY ESTABLISH THE

1 MINIMUM NUMBER OF SMALL EMPLOYERS THAT MAY PARTICIPATE IN THE
2 GROUP. THE REGULATIONS MAY ALSO PROVIDE THAT INDIVIDUALS MAY
3 PARTICIPATE IN THE SMALL GROUP HEALTH PLANS.

4 SECTION 4212. ENFORCEMENT.

5 (A) DETERMINATION OF VIOLATION.--UPON A DETERMINATION THAT A
6 PERSON LICENSED BY THE DEPARTMENT HAS VIOLATED ANY PROVISION OF
7 THIS ARTICLE, THE COMMISSIONER MAY, SUBJECT TO 2 PA.C.S. CHS. 5
8 SUBCH. A (RELATING TO PRACTICE AND PROCEDURE OF COMMONWEALTH
9 AGENCIES) AND 7 SUBCH. A (RELATING TO JUDICIAL REVIEW OF
10 COMMONWEALTH AGENCY ACTION), DO ANY OF THE FOLLOWING:

11 (1) ISSUE AN ORDER REQUIRING THE PERSON TO CEASE AND
12 DESIST FROM ENGAGING IN THE VIOLATION.

13 (2) SUSPEND OR REVOKE OR REFUSE TO ISSUE OR RENEW THE
14 CERTIFICATE OR LICENSE OF THE OFFENDING PARTY OR PARTIES.

15 (3) IMPOSE AN ADMINISTRATIVE PENALTY OF UP TO \$5,000 FOR
16 EACH VIOLATION.

17 (4) SEEK RESTITUTION.

18 (5) IMPOSE ANY OTHER PENALTY OR PURSUE ANY OTHER REMEDY
19 DEEMED APPROPRIATE BY THE COMMISSIONER.

20 (B) OTHER REMEDIES.--THE ENFORCEMENT REMEDIES IMPOSED UNDER
21 THIS SECTION SHALL BE IN ADDITION TO ANY OTHER REMEDIES OR
22 PENALTIES THAT MAY BE IMPOSED BY ANY OTHER STATUTE, INCLUDING:

23 (1) THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS
24 THE UNFAIR INSURANCE PRACTICES ACT. A VIOLATION BY ANY PERSON
25 OF THIS ARTICLE IS DEEMED AN UNFAIR METHOD OF COMPETITION AND
26 AN UNFAIR OR DECEPTIVE ACT OR PRACTICE PURSUANT TO THE UNFAIR
27 INSURANCE PRACTICES ACT.

28 (2) THE ACT OF DECEMBER 18, 1996 (P.L.1066, NO.159),
29 KNOWN AS THE ACCIDENT AND HEALTH FILING REFORM ACT.

30 SECTION 2. REPEALS ARE AS FOLLOWS:

1 (1) THE GENERAL ASSEMBLY DECLARES THAT THE REPEAL UNDER
2 PARAGRAPH (2) IS NECESSARY TO EFFECTUATE THE ADDITION OF
3 ARTICLE XLII OF THE ACT.

4 (2) SECTION 3 OF THE ACT OF DECEMBER 18, 1996 (P.L.1066,
5 NO.159), KNOWN AS THE ACCIDENT AND HEALTH FILING REFORM ACT,
6 IS REPEALED INSOFAR AS IT APPLIES TO SMALL GROUP HEALTH
7 BENEFIT PLAN RATES.

8 (3) ALL OTHER ACTS AND PARTS OF ACTS ARE REPEALED
9 INSOFAR AS THEY ARE INCONSISTENT WITH THE ADDITION OF ARTICLE
10 XLII OF THE ACT.

11 SECTION 3. THIS ACT SHALL TAKE EFFECT IMMEDIATELY.