AN ACT

Preventing illegal multiple employer welfare arrangements; prohibiting other illegal health insurers; establishing duties of the Insurance Department; and imposing penalties.

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

Section 1. Short title.

This act shall be known as and may be cited as the Prevention of Illegal Multiple Employer Welfare Arrangements and Other Illegal Health Insurers Act.

Section 2. Definitions.

"Admitted insurer." An insurer licensed to do insurance business in this Commonwealth.

"Arrangement." A fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits.

"Department." The Insurance Department of the Commonwealth.

"Employee leasing arrangement." A labor leasing, staff leasing, employee leasing, professional employer organization,

contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides workers to another business or entity.

"Employee welfare benefit plan" or "health benefit plan." A plan, fund or program which was or is established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

"Fully insured." For the health care benefits or coverage provided or offered by or through a health benefit plan or arrangement:

(1) an admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and

(2) the liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is directly to the individual employee, member or dependent.

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

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

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

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

(4) Article XXIV of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Licensee." A person that is, or that is required to be, licensed or registered under the laws of this Commonwealth as a producer, third party administrator, insurer, employee leasing arrangement or preferred provider organization.

"MEWA." Multiple Employer Welfare Arrangements.

"MEWA contact." The individual or position designated by the Insurance Department to be the MEWA contact as identified on the Insurance Department's publicly accessible Internet website.

"Nonadmitted insurer." An insurer not licensed to do insurance business in this Commonwealth.

"Preferred provider organization." An entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers or any other person who provides a health benefit plan.

"Producer." A person required to be licensed under the laws of this Commonwealth to sell, solicit or negotiate insurance.

"Professional employer organization." An arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an ongoing and extended, rather than a temporary or

project-specific, relationship.

"Third party administrator" or "administrator." The term shall have the meaning provided under the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

"Transacting of insurance." The term includes:

(1) issuing a stop loss policy covering an employer located in this Commonwealth. Stop loss policy coverage of an employer for claims incurred under the employer's self-funded health benefit plan is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance;

(2) issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this Commonwealth or otherwise, with an employer located in this Commonwealth directly or indirectly the beneficiary of the trust;

(3) agreeing to loan or advance funds to pay claims incurred under an employer's self-funded health benefit plan if the availability of funds to advance is significantly dependent on payment of contributions and the claims experience of two or more employers who have entered into similar loan or advance agreements; or

(4) engaging in a risk distribution arrangement providing for compensation of loss through the provision of services, including an arrangement established through marketing or representations to consumers, without specification in a contract.

"Unauthorized health insurance."

(a) The term includes:

(1) health insurance offered by a nonadmitted insurer

except to the extent the laws of this Commonwealth allow the coverage to be offered by an nonadmitted insurer licensed in another state through an employer or group located out of State; and

(2) health care benefits or coverage offered by a professional employer organization or an employee leasing arrangement that is not fully insured by an admitted insurer.

(b) The term does not include:

(1) Health care benefits or coverage under an employee welfare benefit plan of the employees of two or more employers, including one or more self-employed individuals, that is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40 (relating to plans established or maintained under or pursuant to collective bargaining agreements under section 3(40)(A) of ERISA).

(2) Health care benefits or coverage under an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative as defined under the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1002(40)(B)).

(3) Health care benefits or coverage under an employee welfare benefit plan of the employees of two or more employers but only if the employers are within the same control group so the plan is deemed to be a single employer plan under the Employee Retirement Income Security Act of 1974.

(4) Health care benefits or coverage under a church plan as defined under the Employee Retirement Income Security Act of 1974.

Section 3. Licensee reporting requirement.

(a) General rule.--A licensee shall file a written report with the department MEWA contact when a licensee knows a product is, or is about to be, offered to the public in this Commonwealth, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. Knowledge of a producer regarding an unrelated unauthorized health insurance arrangement is not imputed to licensed insurers represented by that producer.

(b) Notice provisions.--Circumstances where a licensee knows that a product is, or is about to be, offered to the public in this Commonwealth, including when the licensee knows that any person is:

(1) recruiting producers to solicit or offer, or is soliciting or offering, a health benefit plan generally to the public in this Commonwealth; or

(2) seeking an administrator for, or is administering a health benefit plan that is intended to be offered generally to the public in this Commonwealth.

(c) Reasonable notice.--Circumstances where a licensee reasonably should know that a product is unauthorized health insurance include, but are not limited to, the following:

(1) The licensee knows that the product is represented to be a self-funded plan and that it is offered widely to the multiple employers or generally to individuals.

(2) The licensee knows that the product is a professional employer organization self-funded plan and that it is offered widely to multiple client employers.

(3) The licensee knows that the plan is represented to be a self-funded plan established or maintained pursuant to a

collective bargaining agreement and that the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

(d) Disclosure.--The following shall apply:

(1) A report filed under this section is confidential and privileged from disclosure in response to a subpoena or otherwise under the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law, and shall not be subject to discovery or admissible in evidence in any private action. Nothing in this act shall limit the commissioner's authority to use a report filed under this act in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purposes of this act.

(2) Nothing in this act shall prevent or be construed as preventing the commissioner from disclosing the contents of a report filed under this section to the insurance department of any other state or agency of the Federal Government at any time, or any other regulatory or law enforcement agency provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this regulation.

(e) Immunity.--There is immunity from civil liability under section 349.1 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(f) Compliance.--A licensee complies with this section if the licensee files the required report within 30 days or a period reasonable under the circumstances, whichever is later.

Section 4. Responsibility to exercise due diligence.

(a) Soliciting producer.--

(1) A producer, prior to engaging in or assisting any person to engage in offering a health benefit plan to an employer or person located in this Commonwealth, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) the insurer issued the policy;

(ii) the coverage is as represented;

(iii) the insurer is an admitted insurer in this Commonwealth; and

(iv) the policy has been filed with, and approved by, the department or is exempt from filing requirements.

(2) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40 (relating to plans established or maintained under or pursuant to collective bargaining agreements under section 3(40)(A) of ERISA).

(3) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

(4) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the

employer controls and directs the work of the employee.

(b) Stop loss policy producer.--

(1) A producer, prior to submitting an application for a stop loss policy to an insurer for a health benefit plan offered to employees, employee dependents or a person located in this Commonwealth, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

(i) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(ii) The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers.

(iii) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

(c) Third party administrator.--A third party administrator, prior to entering into any administrative contract for a health benefit plan, and prior to assisting any person with administration of a health benefit plan, covering employees of an employer or a person located in this Commonwealth, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including

those measures reasonably appropriate to establish:

(1) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) the insurer issued the policy;

(ii) the coverage is as represented;

(iii) the insurer is an admitted insurer in this Commonwealth; and

(iv) the policy has been filed with, and approved by, the department or is exempt from filing requirements.

(2) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(3) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

(4) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

(d) Insurer.--

(1) An insurer, prior to issuing a stop loss policy for a health benefit plan covering employees, employee dependents or individuals located in this Commonwealth, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including

those measures reasonably appropriate to establish:

(i) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(ii) The health benefit plan is not offered by an employee leasing arrangement or professional employer organization to client employers.

(iii) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

(2) An insurer shall not engage in the transacting of insurance by issuing a stop loss policy unless the insurer is an admitted insurer in this Commonwealth and the stop loss policy form has been filed and approved by the department, or the form is exempt from filing. The transacting of insurance includes, but is not limited to:

(i) Issuing a stop loss policy covering an employer located in this Commonwealth. Coverage of an employer for claims incurred under the employer's self-funded health benefit plan with a stop loss policy is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance.

(ii) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this Commonwealth or otherwise, when an employer located in

this Commonwealth is directly or indirectly the beneficiary of the trust.

(3) An insurer shall not engage in the transacting of insurance in this Commonwealth by issuing a stop loss policy unless, prior to issuing a contract for the stop loss policy, the insurer discloses clearly and conspicuously to the employer, in writing:

(i) the employer is not covered for claims below the stop loss attachment point;

(ii) a description of the attachment point, including the specific and aggregate attachment points; and

(iii) the insurer provides no other coverage of the employer's retention.

(e) Preferred provider organization.--

(1) A preferred provider organization, prior to entering into any contract with a person offering or providing a health benefit plan in this Commonwealth, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish, through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) the insurer issued the policy;

(ii) the coverage is as represented;

(iii) the insurer is an admitted insurer in this Commonwealth; and

(iv) the policy has been filed with and approved by

the department or is exempt from filing requirements.

(2) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(3) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

(4) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and dependents of employees, of the employer and the employer controls and directs the work of the employee.

(f) Defense.--

(1) A licensee or other person who acts according to the written advice of the MEWA contact has a defense to any violation of this section if:

(i) the information provided by the licensee or other person to the MEWA contact, to the extent material to the MEWA contact's advice, is accurate and complete; and

(ii) the information is provided by the licensee or other person to the MEWA contact in writing.

(2) For purposes of this act, the department's published list of admitted insurers on its publicly accessible Internet website is deemed to be accurate. A licensee or other person has a defense to any allegation that a listed insurer is not an admitted insurer. Nothing in this subsection relieves a

licensee or other person from conducting due diligence to determine whether an entity is in fact the same entity as a listed admitted insurer.

(3) A violation of this section is mitigated, and the department shall reduce or eliminate any sanction otherwise applicable, if a licensee or other person demonstrates all of the following:

(i) It maintained supervisory procedures and controls that complied with section 5.

(ii) The violation occurred despite the maintenance of those procedures and controls.

(iii) It promptly reported the health benefit plan to the MEWA contact once the licensee or other person had actual knowledge that it was unauthorized health insurance.

(iv) It took prompt corrective action.

(g) Due diligence.--Nothing in this section requires a producer, third party administrator, insurer or preferred provider organization to conduct due diligence with respect to a health benefit plan that it is not assisting and with respect to which it does not engage in the transacting of insurance.

Section 5. Supervisory procedures and controls.

(a) General rule.--A producer, third party administrator, insurer, preferred provider organization or an agent of the same shall establish and maintain documented supervision procedures and controls that are reasonably designed to achieve compliance with this regulation.

(b) Procedures.--The supervisory procedures shall include:

(1) Training.

(2) Internal controls.

(3) Periodic audits.

(4) Supervisory review.

(5) Monitoring and enforcement of contractual provisions established under section 4(c) and (e).

(c) Requirements.--The extent of the supervisory procedures and controls a producer is required to maintain under this section may appropriately reflect the size and complexity of the producer's operations and the scope and nature of the producer's insurance activities.

Section 6. Licensing education requirements.

(a) General rule.--A producer shall not be licensed in this Commonwealth to sell health insurance unless the producer, prior to licensing, receives not less than one hour of education in:

(1) identification of unauthorized health insurance; and

(2) the producer's responsibilities under this act.

(b) Continuing education.--An insurer providing health insurance in this Commonwealth shall require its listed producers to obtain not less that one hour of continuing education every four years covering:

(1) identification of unauthorized health insurance; and

(2) the producer's responsibilities under this regulation.

(c) Procedures and controls.--A third party administrator, preferred provider organization or insurer shall include in its application for a license a brief summary of its procedures and controls required under section 5. A license may be denied if the applicant fails to demonstrate that the applicant maintains the required procedures and controls.

Section 7. Penalties and liability.

(a) Violation.--A person that violates this act is subject

to the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

(b) Penalty.--A person who violates section 3 is subject to a penalty of up to $1,000 for each violation.

Section 8. Rules and regulations.

The department may promulgate all necessary regulations to implement this act.

Section 9. Effective date.

This act shall take effect in 60 days.