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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 845 Session of 2001

INTRODUCED BY SCHWARTZ, KITCHEN, RHOADES, KUKOVICH, BODACK, TARTAGLIONE, LOGAN, MUSTO AND STACK, MAY 7, 2001

REFERRED TO BANKING AND INSURANCE, MAY 7, 2001

AN ACT

Requiring all health insurers, health service corporations and health maintenance organizations to provide individual health benefits coverage on an open enrollment basis; and establishing the Individual Health Coverage Program.

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

CHAPTER 1

GENERAL PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Individual Health Insurance Act.

Section 102. Definitions.

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

"Board." The board of directors of the Individual Health Coverage Program.

"Carrier." An insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in this Commonwealth. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Community rating." A rating system in which the premium for all persons covered by a contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Department." The Insurance Department of the Commonwealth.

"Dependent." The spouse or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person." A person who is a resident of this Commonwealth who is not eligible to be insured under a group health insurance policy, Medicare or Medicaid.

"Financially impaired." A carrier which, after the effective date of this act, is not insolvent but is deemed by the Insurance Commissioner to be potentially unable to fulfill its contractual obligations or a carrier which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Group health benefits plan." A health benefits plan for groups of two or more persons.

"Health benefits plan." A hospital and medical expense insurance policy, health service corporation contract or health maintenance organization subscriber contract delivered or issued for delivery in this Commonwealth. The term does not include the following plans, policies or contracts: accident only, credit, disability, long-term care, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the Federal Government, coverage for

Medicaid services pursuant to a contract with the Commonwealth, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance or hospital confinement indemnity coverage.

"Hospital expenses." Any charges billed by and payable directly by a carrier to a hospital.

"Individual health benefits plans." Includes:

(1) A health benefits plan for eligible persons and their dependents.

(2) A certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy or contract pursuant to continuation of benefits provisions applicable under Federal or State law.

The term does not include a certificate issued under a policy or contract issued to a trust or to the trustees of a fund, which trust or fund is established or adopted by two or more employers, by one or more labor unions or similar employee organizations or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or organizations.

"Licensed producer." As defined in section 701 of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

"Member." A carrier that is a member of the Individual Health Coverage Program under this act.

"Modified community rating." A rating system in which the premium for all persons covered by a contract is formulated

based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but which may differ by health status. The term applies to contracts and policies issued prior to the effective date of this act which are subject to section 315.

"Net earned premium." The premiums earned in this Commonwealth on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. The term includes the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare or Medicaid contracts with the Federal or State government, but shall not include any excess or stop-loss coverage issued by a carrier in connection with any self-insured health benefits plan, or Medicare supplement policies or contracts.

"Open enrollment." The offering of an individual health benefits plan to any eligible person on a guaranteed issue basis, pursuant to procedures established by the board of directors of the Individual Health Coverage Program.

"Plan of operation." The plan of operation of the Individual Health Coverage Program adopted by the board under this act.

"Preexisting condition." A condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

"Program." The Individual Health Coverage Program established under this act.

CHAPTER 3

INDIVIDUAL HEALTH INSURANCE

Section 301. Individual health benefits plans required.

(a) Plans required to be offered.--No later than 180 days after the effective date of this act, a carrier shall, as a condition of issuing health benefits plans in this Commonwealth, offer individual health benefits plans. The plans shall be offered on an open enrollment, community-rated basis, pursuant to the provisions of this act, except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 308.

(b) Choice of plans.--A carrier shall offer to an eligible person a choice of five individual health benefits plans, any of which may contain provisions for managed care. One plan shall be a basic health benefits plan, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value. A carrier may elect to convert any individual contract or policy forms in force on the effective date of this act to any of the five benefit plans, except that the carrier may not convert more than 25% of existing contracts or policies each year, and the replacement plan shall be of no less actuarial value than the policy or contract being replaced. Notwithstanding the provisions of this subsection to the contrary, at any time after three years after the effective date of this act, the board, by regulation, may reduce the number of plans required to be offered by a carrier. Notwithstanding the provisions of this subsection to the

contrary, a health maintenance organization which is a qualified health maintenance organization pursuant to the Health Maintenance Organization Act of 1973 (Public Law 93-222, 87 Stat. 914) shall be permitted to offer a basic health benefits plan in accordance with the provisions of that law in lieu of the five plans required under this subsection.

(c) Benefits of plan.--

(1) A basic health benefits plan shall provide, at a minimum, the following:

(i) Inpatient hospital services.

(ii) Emergency outpatient hospital services.

(iii) Routine and emergency physician services, including those provided in health clinics but excluding those provided in nursing care or intermediate care facilities.

(iv) Prenatal, delivery and postpartum care.

(v) Laboratory and diagnostic X-ray services.

(vi) X-ray, radium and radioactive isotope therapy.

(vii) Services of a nurse midwife.

(viii) Home health services in cases where it is determined that the coverage of such services is cost effective.

(ix) Ambulatory and institutional services.

(x) Drugs or biologicals that are provided as part of any inpatient hospital services.

(2) Notwithstanding the provisions of this subsection or any other law to the contrary, a carrier may, with the approval of the board, modify the coverage provided for under paragraph (1) or provide alternative benefits or services from those required by this subsection if they are within the

intent of this act or if the board changes the benefits included in the basic health benefits plan.

(3) A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year, and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year. Any person previously covered under a group or individual health benefits plan may apply deductibles paid under the previous plan to annual limits under the basic health benefits plan.

(4) Notwithstanding the provisions of paragraph (3) or any other law to the contrary, a carrier may provide for increased deductibles or coinsurance for a basic health benefits plan if approved by the board or if the board increases deductibles or coinsurance included in the basic health benefits plan.

(d) Application.--Every group conversion contract or policy issued after the effective date of this act shall be issued pursuant to this section, except that this requirement shall not apply to any group conversion contract or policy in which a portion of the premium is chargeable to or subsidized by the group policy from which the conversion is made.

(e) Contingency.--If all five of the individual health benefits plans are not established by the board by January 1, 2002, a carrier may phase in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board. However, once the board establishes

all five plans, the carrier shall be required to offer the five plans in accordance with this act.

Section 302. Guarantee of coverage and renewal of policy.

An individual health benefits plan issued pursuant to section 301 is subject to the following provisions:

(1) The health benefits plan shall guarantee coverage for an eligible person and his dependents on a community-rated basis.

(2) A health benefits plan shall be renewable with respect to an eligible person and his dependents at the option of the policy or contract holder except under the following circumstances:

(i) nonpayment of the required premiums by the policy or contract holder;

(ii) fraud or misrepresentation by the policy or contract holder, including equitable fraud, with respect to coverage of eligible individuals or their dependents;

(iii) termination of eligibility of the policy or contract holder; or

(iv) cancellation or amendment by the board of the specific individual health benefits plan.

Section 303. Duties of board.

(a) Board to establish policy and contract forms and benefit levels.--The board shall establish the policy and contract forms and benefit levels to be made available by all carriers for the policies required to be issued pursuant to section 301. The board shall provide the commissioner with an informational filing of the policy and contract forms and benefit levels it establishes.

(b) Cost containment measures.--The individual health

benefits plans established by the board may include cost containment measures such as, but not limited to:

(1) utilization review of health care services, including review of medical necessity of hospital and physician services;

(2) case management benefit alternatives;

(3) selective contracting with hospitals, physicians and other health care providers;

(4) reasonable benefit differentials applicable to participating and nonparticipating providers; and

(5) other managed-care provisions.

(c) Limitation on coverage for preexisting conditions.--An individual health benefits plan offered pursuant to section 301 shall contain a limitation of no more than six months on coverage for preexisting conditions, except that the limitation shall not apply to an individual who has, under a prior group or individual health benefits plan, with no intervening lapse in coverage, been treated or diagnosed by a physician for a condition under that plan or satisfied the preexisting condition limitation, if any, under the prior plan.

(d) Rider packages.--In addition to the five standard individual health benefits plans provided for in section 301, the board may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 305.

(e) Certification of plans.--After the board's establishment of the individual health benefits plans required pursuant to section 301, and notwithstanding any law to the contrary, a carrier shall file the policy or contract forms with the board and certify to the board that the health benefits plans to be

used by the carrier are in substantial compliance with the provisions in the corresponding board-approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the board of the certification, the certified plans may be used until the board, after notice and hearing, disapproves their continued use.

Section 304. Exceptions to required coverage.

(a) Health maintenance organizations.--A health maintenance organization shall not be required to offer coverage to or accept an applicant pursuant to this act if the applicant is not geographically located in the health maintenance organization's approved service area or if the health maintenance organization does not have the capacity in its facilities to enroll additional members. If the health maintenance organization does not have the capacity in its facilities for additional individual enrollees, it also shall not offer coverage to or accept any new group enrollees.

(b) Potential of creating financially impaired condition.--A carrier shall not be required to offer coverage or accept applications pursuant to this act if the commissioner finds that the acceptance of applications would place the carrier in a financially impaired condition.

Section 305. Rates and filings.

(a) Application for approval of discounted or reduced rates of payment to hospitals.--The board shall make application on behalf of all carriers for approval of discounted or reduced rates of payment to hospitals for health care services provided under an individual health benefits plan under this act.

(b) Government funding or discounts.--In addition to discounted or reduced rates of hospital payment, the board shall

make application on behalf of all carriers for any other subsidies, discounts or funds that may be provided for under Federal or State law or regulation. A carrier may include discounted or reduced rates of hospital payment and other subsidies or funds granted to the board to reduce its premium rates for individual health benefits plans subject to this act.

(c) Filing of full schedule of rates.--A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the board. The board shall forward the informational filing to the commissioner and the Attorney General.

(d) Filing of rate changes.--A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 301 prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Attorney General. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.

(e) Anticipated loss ratio.--

(1) Rates shall be formulated on contracts or policies required pursuant to section 301 so that the anticipated minimum loss ratio for a contract or policy form shall not be less than 85% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the board, and a certification by a member of the American Academy of Actuaries, or other individuals acceptable to the board and to the commissioner, that the carrier is in compliance with

the provisions of this subsection.

(2) Following the close of each calendar year, if the board determines that a carrier's loss ratio was less than 85% for that calendar year, the carrier shall be required to refund to policy or contract holders the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the 85% loss ratio.

Section 306. Individual Health Coverage Program and board.

(a) Program established.--There is hereby established the Individual Health Coverage Program. All carriers subject to the provisions of this act shall be members of the program.

(b) Board.--Within 30 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting which shall take place within 60 days of the effective date of this act. The governing body of the program shall be a board which shall consist of nine representatives. The commissioner or his designee shall serve as an ex officio member on the board. Four members of the board shall be appointed by the Governor, with the advice and consent of the Senate, one of whom shall be a representative of an employer, appointed upon the recommendation of a business trade association, who is a person with experience in the management or administration of an employee health benefit plan; one of whom shall be a representative of organized labor, appointed upon the recommendation of the AFL-CIO, who is a person with experience in the management or administration of an employee health benefit plan; and two of whom shall be consumers of a health benefits plan who are reflective of the population of this Commonwealth. Four board members who

represent carriers shall be elected by the members, subject to the approval of the commissioner. To the extent there is an entity licensed in this Commonwealth that is willing to have a representative serve on the board, a representative from each of the following entities shall be elected:

(1) A health service corporation.

(2) A health maintenance organization.

(3) A mutual health insurer of this Commonwealth.

(4) A foreign health insurance company authorized to do business in this Commonwealth.

In approving the selection of the carrier representatives of the board, the commissioner shall assure that all members of the program are fairly represented.

(c) Term of office.--Initially, two of the Governor's appointees and two of the carrier representatives shall serve for a term of three years, one of the Governor's appointees and one of the carrier representatives shall serve for a term of two years, and one of the Governor's appointees and one of the carrier representatives shall serve for a term of one year. Thereafter, all board members shall serve for a term of three years. Vacancies shall be filled in the same manner as the original appointments.

(d) Initial carrier members.--If the initial carrier representatives to the board are not elected at the organizational meeting, the commissioner shall appoint those members to the initial board within 15 days of the organizational meeting.

(e) Plan of operation.--Within 90 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter, any amendments to the plan

necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may disapprove the plan of operation if the commissioner determines that it is not suitable to assure the fair, reasonable and equitable administration of the program and that it does not provide for the sharing of program losses on an equitable and proportionate basis in accordance with section 308. The plan of operation or amendments thereto shall become effective unless disapproved in writing by the commissioner within 45 days of receipt by the commissioner.

(f) Failure to submit plan of operation.--If the board fails to submit a suitable plan of operation within 90 days after its appointment, the commissioner shall adopt a temporary plan of operation. The commissioner shall amend or rescind a temporary plan adopted under this subsection at the time a plan of operation is submitted by the board.

(g) Plan components.--The plan of operation shall establish procedures for:

(1) The handling and accounting of assets and moneys of the program and an annual fiscal reporting to the commissioner.

(2) Collecting assessments from members to provide for sharing program losses in accordance with the provisions of section 308 and administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(3) Approving the coverage, benefit levels and contract forms for individual health benefits plans in accordance with the provisions of section 301.

(4) The imposition of an interest penalty for late

payment of an assessment pursuant to section 308.

(5) Any additional matters at the discretion of the board.

(h) Appointment of insurance producer.--The board shall appoint a licensed producer to advise the board on issues related to sales of individual health benefits plans issued pursuant to this act.

Section 307. Powers and authority of program and board.

The program shall have the general powers and authority granted under the laws of this Commonwealth to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this Commonwealth, except that the program shall not have the power to issue health benefits plans directly to either groups or individuals. The board shall have the specific authority to:

(1) Assess members their proportionate share of program losses and administrative expenses in accordance with the provisions of section 308 and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year.

(2) Establish rules, conditions and procedures pertaining to the sharing of program losses and administrative expenses among the members of the program.

(3) Review rate applications and form filings submitted by carriers in accordance with this act.

(4) Define the provisions of individual health benefits plans in accordance with the requirements of this act.

(5) Enter into contracts which are necessary or proper to carry out the provisions and purposes of this act.

(6) Establish a procedure for the joint distribution of information on individual health benefits plans issued pursuant to section 301.

(7) Establish, at the board's discretion, standards for the application of a means test for individual health benefits plans issued pursuant to section 301.

(8) Establish, at the board's discretion, reasonable guidelines for the purchase of new individual health benefits plans by persons who already are enrolled in or insured by another individual health benefits plan.

(9) Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the program and provide for performance audits from time to time.

(10) Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of or against the program or a member.

(11) Appoint from among its members appropriate legal, actuarial and other committees as necessary to provide technical and other assistance in the operation of the program, in policy and other contract design and any other function within the authority of the program.

(12) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(13) Contract for an independent actuary and any other professional services the board deems necessary to carry out

its duties under this act.

Section 308. Program losses; immunity; payments; and nongroup persons.

(a) Equitable sharing of program losses.--The board shall establish procedures for the equitable sharing of program losses among all members in accordance with their total market share as follows:

(1) (i) By March 1, 2003, and following the close of each calendar year thereafter, on a date established by the board:

(A) every carrier issuing health benefits plans in this Commonwealth shall file with the board its net earned premium for the preceding calendar year ending December 31; and

(B) every carrier issuing individual health benefits plans in this Commonwealth shall file with the board the net earned premium on policies or contracts issued under section 301 and the claims paid and the administrative expenses attributable to those policies or contracts. If the claims paid and reasonable administrative expenses for that calendar year exceed the net earned premium and any investment income thereon, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act. For the purposes of this subparagraph, "reasonable administrative expenses" shall be actual expenses or a maximum of 25% of premium, whichever amount is less.

(ii) Every member shall be liable for an assessment to reimburse carriers issuing individual health benefits

plans in this Commonwealth which sustain net paid losses for the previous year, unless the member has received an exemption from the board under subsection (d) and has written a minimum number of nongroup persons as provided for in that subsection. The assessment of each member shall be in the proportion that the net earned premium of the member for the calendar year preceding the assessment bears to the net earned premium of all members for the calendar year preceding the assessment.

(2) A member that is financially impaired may seek from the commissioner a deferment in whole or in part from any assessment issued by the board. The commissioner may defer, in whole or in part, the assessment of the member if, in the opinion of the commissioner, the payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in this section. The member receiving the deferment shall remain liable to the program for the amount deferred.

(b) Immunity from liability.--The participation in the program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by this act shall not be the basis of any legal action, criminal or civil liability, or penalty against the program, a member of the board or a member of the program either jointly or separately except as otherwise provided in this act.

(c) Payment of assessment.--Payment of an assessment made under this section shall be a condition of issuing health

benefits plans in this Commonwealth for a carrier. Failure to pay the assessment shall be grounds for forfeiture of a carrier's authorization to issue health benefits plans of any kind in this Commonwealth, as well as any other penalties permitted by law.

(d) Exemption and enrollment of nongroup persons under managed care or indemnity plan.--

(1) Notwithstanding the provisions of this act to the contrary, a carrier may apply to the board, by a date established by the board, for an exemption from the assessment and reimbursement for losses provided for in this section. A carrier which applies for an exemption shall agree to enroll or insure a minimum number of nongroup persons on an open enrollment community-rated basis, under a managed care or indemnity plan, as specified in this subsection, provided that any indemnity plan so issued conforms with sections 301 through 304 and 315. For the purposes of this subsection, nongroup persons include individually enrolled persons, conversion policies issued pursuant to this act, Medicare cost and risk lives and Medicaid recipients. In determining whether the carrier meets the minimum number of nongroup persons required pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed 50% of the total.

(2) Notwithstanding the provisions of paragraph (1) to the contrary, a health maintenance organization qualified pursuant to the Health Maintenance Organization Act of 1973, (Public Law 93-222, 87 Stat. 914) and tax exempt under section 501(c)(3) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.) may include up to

one-third Medicaid recipients and up to one-third Medicare recipients in determining whether it meets its minimum number.

(3) The minimum number of nongroup persons, as determined by the board, shall equal the total number of community-rated and modified community-rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives, of all carriers subject to this act as of the end of the calendar year, multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for that calendar year, including those carriers that are exempt from the assessment.

(4) Within 180 days after the effective date of this act and on or before March 1 of each year thereafter, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the preceding calendar year. The board shall determine each carrier's minimum number of nongroup persons in accordance with this subsection.

(5) On or before March 1 of each year, every carrier that was granted an exemption for the preceding calendar year shall file with the board the number of nongroup persons, by category, enrolled or insured as of December 31 of the preceding calendar year. To the extent that the carrier has failed to enroll the minimum number of nongroup persons established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number enrolled or insured by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if:

(i) by the end of calendar year 2002, it has enrolled or insured at least 40% of the minimum number of nongroup persons required;

(ii) by the end of calendar year 2003, it has enrolled or insured at least 75% of the minimum number of nongroup persons required; and

(iii) by the end of calendar year 2004, it has enrolled or insured 100% of the minimum number of nongroup persons required.

(7) Any carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to write a minimum number of nongroup persons by writing either managed care or indemnity business, or both.

(e) Limitation.--Notwithstanding the provisions of this section to the contrary, no carrier shall be liable for an assessment to reimburse any carrier pursuant to this section in an amount which exceeds 35% of the aggregate net paid losses of all carriers filing pursuant to subsection (a)(1)(i). To the extent that this limitation results in any unreimbursed paid losses to any carrier, the unreimbursed net paid losses shall be distributed among carriers:

(1) which owe assessments pursuant to subsection (a)(1)(ii);

(2) whose assessments do not exceed 35% of the aggregate net paid losses of all carriers; and

(3) who have not received an exemption pursuant to

subsection (d).

For the purposes of paragraph (3), a carrier shall be deemed to have received an exemption notwithstanding the fact that the carrier failed to enroll or insure the minimum number of nongroup persons required for that calendar year.

Section 309. Statement of net paid losses and reimbursement.

(a) Statement of net paid losses.--No later than March 1, 2003, any carrier issuing individual health benefits plans in this Commonwealth shall file with the board a statement of any net paid losses for the calendar year ending December 31, 2002, as calculated pursuant to section 308, along with any supporting information required by the board.

(b) Reimbursement.--The losses filed pursuant to subsection (a) shall be reimbursed in an amount up to $10,000,000 or 50% of the paid losses, whichever amount is less, to the carrier filing the losses. The assessment shall be made as a separate assessment from those required pursuant to section 308, but shall be assessed in the same manner and at the same time as the first assessment made after the effective date of this act as provided for in section 308, except that the carrier filing for the reimbursement shall not be subject to an assessment under this section.

Section 310. Determination of carriers with disproportionate share of substandard risks and recommendations for remedial action.

The board shall determine whether any carrier has a disproportionate share of substandard risks insured or enrolled under its individual health benefits plans and shall make recommendations to the Governor and the General Assembly for remedial action to minimize the losses sustained by the carrier

as a result of insuring these risks.

Section 311. Sale of plan.

A health benefits plan issued pursuant to section 301 may be sold through a licensed producer.

Section 312. Rate filings.

Notwithstanding the provisions of any other insurance law of this Commonwealth to the contrary, a health maintenance organization shall not be required to submit any rate filings with the commissioner for an individual health benefits plan that is subject to the provisions of this act, but shall be subject to the minimum loss ratio provisions of section 305.

Section 313. Action by board.

(a) General rule.--All actions adopted by the board shall be subject to the provisions of this section, notwithstanding any provisions of law to the contrary.

(b) Notice requirements.--

(1) Prior to the adoption of an action of the board, the board shall publish notice of its intended action in three newspapers of general circulation in this Commonwealth and may publish the notice of intended action in any trade or professional publication which it deems necessary. The notice of intended action shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views. The board shall provide the notice of intended action and a detailed description of the intended action by mail, or otherwise, to affected trade and professional associations, carriers subject to this act and such other interested persons or organizations which may request notification. The board shall forward the notice of intended

action and the detailed description of the intended action concurrently to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(2) The board shall not charge any fee for placement upon the mailing list of associations, carriers or other persons to be notified, but the board may charge a fee to an association, carrier or other person requesting a copy of the text of the intended action, which fee shall not be in excess of the actual cost of reproducing and mailing the copy.

(3) A copy of the text of the intended action shall be available in the department.

(c) Public hearing.--The board shall hold a public hearing on the establishment and modification of health benefits plans, and the board may hold a public hearing on any other intended action. Notice of a hearing shall be given in the notice of intended action provided for in subsection (b).

(d) Opportunity to comment in writing.--

(1) Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 20 calendar days from the date of notice.

(2) The board shall give due consideration to all comments received. Within a reasonable period of time following submission of the comments pursuant to this subsection, the board shall prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the board's response to the

data, views and arguments contained in the submissions. A copy of the report shall be filed with the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(e) Final action.--The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection (d) or the hearing provided for in subsection (c), whichever date is later. The final action adopted by the board shall be submitted for publication in the Pennsylvania Bulletin and shall be effective on the date of the submission or such later date as the board may establish.

(f) Construction.--Nothing in this section shall be construed to prohibit the commissioner from adopting any rule or regulation pursuant to the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, or from taking any other action required or authorized by this act.

(g) Definition.--As used in this section, the term "action" includes, but is not limited to:

(1) The establishment and modification of health benefits plans.

(2) Procedures and standards for the:

(i) assessment of members and the apportionment thereof;

(ii) filing of policy forms;

(iii) making of rate filings;

(iv) evaluation of material submitted by carriers with respect to loss ratios; and

(v) establishment of refunds to policy or contract holders.

(3) The promulgation or modification of policy forms.

The term shall not include the hearing and resolution of contested cases, personnel matters and applications for withdrawal or exemptions.

Section 314. Prohibition.

A carrier shall not require an eligible person to purchase any other insurance coverage, including, but not limited to, life insurance, accident insurance or disability insurance, as a condition of or in conjunction with the purchase of a health benefits plan under this act.

Section 315. Applicability; duplicative coverage; penalties; rates.

(a) Plan issued on or after effective date of act.--An individual health benefits plan issued on or after the effective date of this act shall be subject to the provisions of this act.

(b) Plans issued prior to effective date of act.--

(1) An individual health benefits plan issued on an open enrollment, modified community-rated basis or community-rated basis prior to the effective date of this act shall not be subject to sections 301 through 305, unless otherwise specified therein.

(2) An individual health benefits plan issued other than on an open enrollment basis prior to the effective date of this act shall not be subject to the provisions of this act, except that the plan shall be liable for assessments made pursuant to section 308.

(3) A group conversion contract or policy issued prior to the effective date of this act that is not issued on a modified community-rated basis or community-rated basis shall not be subject to the provisions of this act, except that the contract or policy shall be liable for assessments made

pursuant to section 308.

(c) Duplicative coverage prohibited.--After the effective date of this act, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan, except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group plan occurring on or after January 1, 2002.

(d) Penalties.--Except as otherwise provided in subsection (c), after the effective date of this act, a person who is covered by an individual health benefits plan who is a participant in or is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in or who is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan shall be subject to a fine by the commissioner in an amount not less than twice the annual premium paid for the individual health benefits plan, together with any other penalties permitted by law.

(e) Rates.--Every individual health benefits plan issued prior to the effective date of this act shall be rated as follows:

(1) No later than 180 days after the effective date of this act, the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 150% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

(2) During the period July 1, 2003, to June 30, 2004, the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 125% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

(3) On and after July 1, 2004, every individual health benefits plan which was issued before the effective date of this act shall be community rated upon the date of its renewal.

(4) A carrier that issues an individual health benefits plan with modified community rating subject to the provisions of this subsection shall make an informational filing with the board whenever it adjusts or modifies its rates.

CHAPTER 7

MISCELLANEOUS PROVISIONS

Section 701. Effective date.

This act shall take effect in 60 days.