PRINTER'S NO. 1604

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1191 Session of 2007

INTRODUCED BY FOLMER, EICHELBERGER, PICCOLA AND BROWNE, DECEMBER 3, 2007

REFERRED TO BANKING AND INSURANCE, DECEMBER 3, 2007

AN ACT

Establishing the Pennsylvania High-Risk Health Insurance Pool and the State Comprehensive Health Insurance Pool Board; providing for the powers and duties of the pool and the board; for selection of administering insurer and for payment of plan costs; and prescribing plan benefits.

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

Section 1. Short title.

This act shall be known and may be cited as the High-Risk Health Insurance Pool Act.

Section 2. 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 State Comprehensive Health Insurance Pool Board.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Health insurance." A hospital or medical expense incurred

policy, nonprofit health care services plan contract, health maintenance organization, subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, when sold to an individual or as a group policy. This term does not include short-term, accident, dental-only, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Insured." A person who is a legal resident of this Commonwealth and a citizen of the United States who is eligible to receive benefits from the pool. The term includes a dependent and family member.

"Insurer." An entity that is authorized in this Commonwealth to write health insurance or that provides health insurance in this Commonwealth. The term includes an insurance company, nonprofit health care services plan, fraternal benefits society, health maintenance organization, third-party administrators, State or local governmental unit, to the extent permitted by Federal law any self-insured arrangement covered by section 3 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1002), that provides health care benefits in this Commonwealth, any other entity providing a plan of health insurance or health benefits subject to State insurance regulation and any reinsurer or stop-loss plan providing reinsurance or stop-loss coverage to a health insurer in this

Commonwealth.

"Medicare." Coverage under both Parts A and B of Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.)

"Physician." An individual licensed to practice medicine under the laws of this Commonwealth.

"Plan." The Comprehensive Health Insurance Plan as adopted by the State Comprehensive Health Insurance Board.

"Pool." The State High-Risk Health Insurance Pool.

"Preexisting condition." A condition for which medical advice, care or treatment was recommended or received during the X months prior to effective date of coverage under the pool. Except as otherwise provided in this act, preexisting conditions shall not be covered during the X months following the person's effective date of coverage under the plan.

"Producer." A person who is licensed to sell health insurance in this Commonwealth.

"Resident." Any of the following:

(1) An individual who has been legally domiciled in this Commonwealth for a minimum of 90 days for persons eligible for enrollment in the pool.

(2) An individual who is legally domiciled in this Commonwealth and is eligible for enrollment in the pool as a result of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

(3) An individual who is legally domiciled in the pool and is eligible for enrollment as a result of the Trade Adjustment Assistance Reform Act of 2002 (Public Law 107-210, 116 Stat. 933).

Section 3. Pennsylvania High-Risk Health Insurance Pool.

(a) Establishment.--A nonprofit legal entity to be known as

the Pennsylvania High-Risk Health Insurance Pool is hereby established.

(b) Availability date for health insurance policies.--Health insurance policies available in accordance with this act shall be available for sale within one year from the effective date of this section.

Section 4. Pool coverage eligibility.

(a) General rule.--Any individual person who is and continues to be a resident of this Commonwealth and a citizen of the United States shall be eligible for coverage from the pool if evidence is provided of one of the following:

(1) (i) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers, provided that at least two insurers offer individual health insurance coverage in this Commonwealth.

(ii) If only one insurer offers individual market health insurance coverage in this Commonwealth then one rejection shall be sufficient.

(iii) A rejection or refusal by an insurer offering only stop-loss, excess loss or reinsurance coverage with respect to the applicant shall not be sufficient except under this subsection.

(2) (i) A refusal by two insurers to issue insurance except at a rate exceeding the pool rate, provided that at least two insurers offer individual health insurance coverage in this Commonwealth.

(ii) If only one insurer offers individual market health insurance coverage in this Commonwealth, then one quote that exceeds the pool rate shall be sufficient.

(3) A diagnosis of the individual with one of the medical or health conditions listed by the board in accordance with section 6. A person diagnosed with one or more of these conditions shall be eligible for a pool coverage without applying for health insurance coverage.

(4) For persons eligible due to eligibility under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the maintenance of health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days of which the most recent coverage was through an employer-sponsored plan.

(5) For persons eligible as a result of certification for Federal trade adjustment assistance or for pension benefit guarantee corporation assistance as provided by the Trade Adjustment Assistance Reform Act of 2002 (Public Law 107-210. 116 Stat. 933), coverage with no preexisting conditions limitation for individuals with three months of prior creditable coverage with a break in coverage of no more than 63 days.

(b) Dependents.--Each dependent of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool. In the instance of a child who is the primary insured, resident family members shall also be eligible for coverage.

(c) Preexisting waiting periods.--A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

(d) Conditions for ineligibility.--A person is ineligible for coverage from the pool if the person:

(1) has in effect on the date pool coverage takes effect health insurance coverage from an insurer or insurance arrangement;

(2) is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation except:

(i) coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person is satisfying any preexisting condition waiting period under a pool policy;

(ii) employer group coverage conditioned by the limitations described by subsection (a)(4) and (5); or

(iii) individual coverage conditioned by the limitation described by subsection (a)(1), (2) or (3).

(3) has terminated coverage in the pool within 12 months of the date that application is made to the pool unless the person demonstrates a good faith reason for the termination;

(4) is confined in a county jail or imprisoned in a State correctional institution;

(5) has premiums that are paid for or reimbursed by any third-party payer or under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee or dependent thereof, of a government agency or health care provider, or if the individual receives premium payment assistance through the Federal health insurance tax credit established by the Trade Adjustment Assistance Reform Act of 2002; or

(6) has not had prior coverage with the pool terminated for nonpayment of premiums or fraud.

(e) Waiver of preexisting condition requirements.--Pool

preexisting condition requirements shall be waived for the following individuals:

(1) an individual for whom, as of the date on which the individual seeks plan coverage, the aggregate of the periods of creditable coverage is 18 months or more and whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan, or health insurance coverage offered in connection with any such plans, or any other type of creditable coverage that may be required by the Health Insurance Portability and Accountability Act of 1996, or the regulations under that act;

(2) an individual who is eligible for Federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the Trade Adjustment Assistance Reform Act of 2002, provided that as of the date on which the individual was certified as eligible for Federal trade adjustment assistance, the individual had at least three months of prior creditable coverage with no longer than a 63-day break in coverage as established by the Trade Adjustment Assistance Reform Act of 2002 or the regulations under that act.

(f) Termination of pool coverage.--Pool coverage shall terminate:

(1) on the date a person is no longer a resident of the person's state, except for a child who is a student under 23 years of age and who is financially dependent on a parent, a child for whom a person may be obligated to pay child support or a child of any age who is disabled and dependent on a

parent;

(2) on the date a person requests coverage to end;

(3) on the death of the covered person;

(4) on the date State law requires cancellation of the policy;

(5) at the option of the pool, 30 days after the pool sends to the person an inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;

(6) on the 31st day after the day on which a premium payment for pool coverage becomes due, if the payment is not made before that date;

(7) on the date a person reaches the maximum lifetime limit, as provided in section 12; or

(8) at such time as the person ceases to meet the eligibility requirements of this section.

(g) Termination due to eligibility.--A person who ceases to meet the eligibility requirements of this section may have the person's coverage terminated at the end of the policy period.

Section 5. State Comprehensive Health Insurance Pool Board.

(a) Establishment.--The State Comprehensive Health Insurance Pool Board is established. The board members, appointed by the Insurance Commissioner, shall consist of:

(1) Two representatives of domestic insurance companies licensed to do business in this Commonwealth.

(2) One representative of a nonprofit health care service plan.

(3) One representative of a health maintenance organization.

(4) One member representing the medical provider

community, such as a physician licensed to practice medicine in this Commonwealth or a hospital administrator.

(5) Five members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital or other health care provider and are not reasonably expected to qualify for coverage in the pool. Representatives of the general public include persons whose only affiliation with an insurance company or plan, group hospital service corporation or health maintenance organization are as an insured or persons who have coverage through a plan provided by the corporation or organization.

(6) One member to represent resident licensed health insurance producers.

No elected official may be a member of the board.

(b) Special qualification.--In making appointments to the board, the commissioner shall strive to ensure that at least one person serving on the board is at least 60 years of age.

(c) Terms of board members.--The original members of the board shall be appointed for the following terms:

(1) Three members for a term of one year.

(2) Two members for a term of two year.

(3) Two members for a term of three years.

(4) All terms after the initial term shall be for three years.

(d) Chairman.--The board shall elect one of its members as chairman, who may serve in that capacity only for two years.

(e) Reimbursement of expenses.--Members of the board may be reimbursed from moneys of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be

compensated for their services.

(f) Limitation of liability.--Members of the board are not liable for an action or omission performed in good faith in the performance of powers and duties under this act, and no cause of action may arise against a member for the action or omission.

(g) Plan to be submitted.--

(1) The board shall adopt a plan pursuant to this act and submit its articles, bylaws and operating rules to the commissioner for approval.

(2) If the board fails to adopt a plan and suitable articles, bylaws and operating rules within 180 days after appointment of the board, the commissioner shall promulgate rules to effectuate the provisions of this act and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating procedures submitted by the board and approved by the commissioner.

Section 6. Board duties.

The board shall:

(1) Operate, supervise and administer the pool.

(2) Establish administrative and accounting procedures for the operation of the pool.

(3) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board.

(4) Select an administering insurer in accordance with section 8.

(5) Require that all policy forms issued by the board conform to standard forms developed by the board. The forms shall be approved by the commissioner.

(6) Develop a program to publicize the existence of the

plan, the eligibility requirements of the plan, the procedures for enrollment in the plan and shall maintain public awareness of the plan.

(7) Promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate.

(8) No later than June 1 of each year, make an annual report to the Governor, the General Assembly and the commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses and paid and incurred losses.

Section 7. Operation of pool.

(a) General rule.--The pool may exercise any of the authority that an insurance company authorized to write health insurance in this Commonwealth may exercise under the laws of this Commonwealth.

(b) Specific powers.--As part of its authority, the pool may:

(1) Provide health benefits coverage to persons who are eligible for that coverage under this act.

(2) Enter into contracts that are necessary to carry out this act, including, with the approval of the commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions.

(3) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool.

(4) Institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amount paid by the pool as a mistake of fact or law and to recover other amounts due the pool.

(5) Establish appropriate rates, rate schedules, rate adjustments, expense allowance, agents' referral fees and claim reserve formulas and perform any actuarial function appropriate to the operation of the pool.

(6) Adopt policy forms, endorsements and riders and applications for coverage.

(7) Issue insurance policies subject to this act and the plan of operation.

(8) Appoint appropriate legal, actuarial and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool.

(9) Employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions.

(10) Contract for stop-loss insurance for risks incurred by the pool.

(11) Borrow money as necessary to implement the purposes of the pool.

(12) Issue additional types of health insurance policies to provide optional coverage which comply with applicable

provisions of Federal and State law, including Medicare supplemental health insurance.

(13) Provide for and employ cost containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion and concurrent utilization case management for the purpose of making the benefit plans more cost effective.

(14) Design, utilize, contract or otherwise arrange for delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations.

(15) Provide for reinsurance on either a facultative or treaty basis, or both.

Section 8. Selection of administering insurer.

(a) General rule.--The board shall select an insurer, through a competitive bidding process, to administer the plan. The board shall evaluate the bids submitted under this subsection based on criteria established by the board, which criteria shall include, but not be limited to, the following:

(1) The insurer's proven ability to handle large group accident and health policies insurance.

(2) The efficiency of the insurer's claims-paying procedures.

(3) An estimate of total charges for administering the plan.

(b) Term of contract.--

(1) The administering insurer must enter into a contract with the board. The term of the contract shall be for a period of three years.

(2) At least one year prior to the expiration of each

three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period.

(3) The selection of the administering insurer for the succeeding three-year period shall be made at least six months prior to the end of the current three-year period.

(c) Duties of administering insurer.--The administering insurer shall:

(1) Perform all eligibility and administrative claims-payment functions relating to the plan.

(2) Pay an agent's referral fee as established by the board to each agent who refers an applicant to the plan, if the applicant is accepted. The selling or marketing of plans shall not be limited to the administering insurer or its agents. The referral fees shall be paid by the administering insurer from moneys received as premiums for the plan.

(3) Establish a premium billing procedure for collection of premiums from persons insured under the plan.

(4) Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:

(i) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions will be made.

(ii) Evaluating the eligibility of each claim for payment under the plan.

(iii) Notifying each claimant within 30 days after receiving a properly completed and executed proof of

loss, whether the claim is accepted, rejected or compromised.

(5) Submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the reports shall be determined by the board.

(6) Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expenses allowance, the expense of administration pertaining to the reinsurance operations of the pool and the incurred losses for the year, and report this information to the board and the commissioner.

(7) Pay claims expenses from the premium payments received from or on behalf of covered persons under the plan.

Section 9. Payment of plan costs.

(a) General rule.--The board shall pay plan costs, excluding any premium, deductible and copayment subsidies, first from Federal funds, if any, that are transferred to the fund under subsection (b) and that exceed premium, deductible and copayment subsidy costs in a policy year. The remainder of the plan costs, excluding premium, deductible and copayment subsidy costs, shall be paid as follows:

(1) 66 2/3% from premiums paid by eligible persons.

(2) 33 1/3% from the funds appropriated to the Community Health Reimbursement Program.

(b) Application for Federal funds.--The board shall make application for any Federal grants or other sources under which the plan may be eligible to receive moneys. To the extent allowable, the board shall use any moneys received from a Federal grant or other source to offset plan deficits before drawing from any alternative funding sources authorized under

this section.

(c) Surplus funds.--

(1) If grants, assessments and other receipts by the pool exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce premiums.

(2) As used in this subsection, the term "future losses" include reserves for claims incurred but not reported.

Section 10. Direct insurance by pool.

The coverage provided by the plan shall be directly insured by the pool and the policies administered through the administering insurer.

Section 11. Plan benefits.

(a) General rule.--The plan shall offer in an annually renewable policy the coverage specified in this section for each eligible person. In approving any of the benefit plans to be offered by the plan, the board shall establish such benefit levels, deductibles, coinsurance factors, exclusions and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with individual market health insurance that is provided in the individual health insurance market in this Commonwealth.

(b) High deductible health plan option.--Notwithstanding any other provisions of this section, the plan shall provide every eligible person the option of selecting a health plan option from at least one high deductible health plan that would qualify to be used in conjunction with a health savings account under section 223 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.). In conjunction with such a high deductible health plan, the plan shall provide for the

establishment and administration of health savings accounts on behalf of eligible persons who chose to be covered by a high deductible health plan under this section.

(c) Major medical expense coverage.--The plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection (f) to a lifetime limit of $1,000,000 per covered individual.

(d) Covered expenses.--

(1) The usual customary charges or negotiable reimbursement for the following services and articles, when prescribed by a physician and medically necessary, shall be covered expenses:

(i) Hospital services.

(ii) Professional services for the diagnosis or treatment of injuries, illness or conditions, other than dental, which are rendered by a physician or by others at his direction.

(iii) Drugs requiring a physician's prescription.

(iv) Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than 100 calendar days during a policy year, if the services and reimbursements are the type which would qualify as reimbursable services under Medicare.

(v) Services of a home health agency, which services are of a type that would qualify reimbursable services under Medicare.

(vi) Use of radium or other radioactive materials.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prosthesis, other than dental prosthesis.

(x) Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids.

(xi) Diagnostic X-rays and laboratory tests.

(xii) Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(xiii) Services of a physical therapist.

(xiv) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat a condition.

(xv) Processing of blood, including, but not limited to, collecting, testing, fractioning and distributing blood.

(xvi) Services for the treatment of alcohol and drug abuse, but the insured shall be required to make a 50% copayment, and the payment of the plan shall not exceed $4,000.

(xvii) As an option, made available at an additional premium, services provided by a duly licensed chiropractor.

(e) Excluded expenses.--Covered expenses shall not include the following:

(1) A charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions.

(2) A charge for care which is primarily for custodial or domiciliary purposes which does not qualify as an eligible service under Medicaid.

(3) A charge for confinement in a private room, to the extent that the charge is in excess of the charge by the institution for its most common semiprivate room unless a private room is prescribed as medically necessary by a physician.

(4) Any part of a charge for services or articles rendered or provided by a physician or other health care personnel that exceeds the prevailing charge in the locality where the service is provided or any charge for services or articles not medically necessary.

(5) A charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the services or articles.

(6) An expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred.

(7) A charge for routine physical examinations.

(8) A charge for the services of blood donors and any fee for the failure to replace the first three pints of blood provided to an eligible person annually.

(9) A charge for personal services or supplies provided by a hospital or nursing home or any other nonmedical or nonprescribed services or supplies.

(f) Annual deductible choices.--The board shall provide for at least two choices of annual deductibles for major medical expenses, plus the benefits payable under any other type of insurance coverage or workers' compensation, provided that if

two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

(g) Schedule of premium rates to be determined.--

(1) The board shall annually determine the schedule of premium rates for each benefit plan option offered by the pool.

(2) Rates and rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(3) (i) The board shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage.

(ii) The initial pool rate may not be less than 135% and may not exceed 150% of rates established as applicable for individual standard rates.

(iii) Subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves and any other cost factors subject to the limitations described in this subsection.

(iv) In no event shall pool rates exceed 150% of rates applicable to individual standard risks.

(4) All rates and rate schedules shall be submitted to

the commissioner for approval, and the pool may not use them unless the commissioner approves the rates and rate schedules. The commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided by this section.

(h) Last payer of benefits.--The board shall provide that the pool shall be the last payer of benefits whenever any other benefit or source of third party payment is available.

Section 12. Effective date.

This act shall take effect in 60 days.