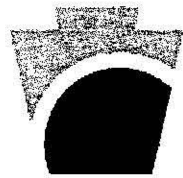


# Testimony before the Pennsylvania House Insurance Committee and House Democratic Policy Committee:

*"Health Insurance Rate Increases"*

Presented by:
Joel Ario
Insurance Commissioner

Tuesday, July 20, 2010

William E. Anderson Library of Penn Hills
The DeLuca Room

**Health Insurance Rate Increases**
**Joel Ario, Pennsylvania Insurance Commissioner**
**Tuesday July 20, 2010**
**Hearing before the PA House Insurance Committee and House Democratic Policy Committee**
**William E. Anderson Library of Penn Hills, The DeLuca Room**

Good morning. My name is Joel Ario and I am the Pennsylvania Insurance Commissioner. I appreciate the opportunity to testify today to provide an overview of trends in the area of health insurance rate increases. As you know, the PA Insurance Department (PID) recently commenced an investigation which was formally acknowledged through a press release issued by Governor Rendell. The results of our investigation are contained in the Department's official report, attached. My comments this morning will summarize the backdrop to this investigation, our findings, and our recommendations for legislative action.

Before I continue with the background of this investigation, I want to formally thank the House for passing HB 746 last year. It is a giant step toward much needed reform and I think the rest of my testimony will reinforce why the Senate should act on it as well.

## Background

In keeping with its mission to protect the consumers of Pennsylvania and to provide a level playing field for all insurance carriers operating in the Commonwealth, the Pennsylvania Insurance Department (the Department) constantly monitors the insurance industry to identify potential problematic trends and issues. Recently, while monitoring and analyzing insurance marketplace activities, the Department noted several indicators that health insurers may be using underwriting and rating practices in the small group accident and health market in ways that raise substantial consumer protection issues, especially for those most in need of health coverage. Specifically, the troubling indicators were discussed in or at a Congressional hearing featuring a Pennsylvania small business that received a 100% rate increase, letters to the Department from consumers and state legislators complaining about rating practices, sample medical questionnaires and other documentation from brokers concerning individual underwriting in the small group market and competitor complaints concerning the scope and pace at which the Blue-branded insurers are expanding their use of medical underwriting and rating.

In response and at the direction of Governor Rendell, the Department opened an investigation into the rating and underwriting practices of the nine largest insurance groups writing small group accident and health coverage in Pennsylvania. Companies from these nine largest groups accounted for 89% of all group accident and health direct written premiums in Pennsylvania for calendar year 2008.

## Findings

### Transparency

Pennsylvania lacks adequate statutory authority to review rates for small group products. We do have authority to review rates for such products offered by the parent Blue entities (hospital plan corporations and professional health service plan corporations) and Health Maintenance Organizations, but we lack statutory authority to require the filing of rates for small group policies issued by commercial insurers, including commercial insurers that are subsidiaries of the Blues. HB 746 provides a remedy for this loophole. Although you have passed the bill in the House, it awaits action by the Senate.

This lack of statutory authority by the Department hampers the ability and effectiveness of the Department to identify trends before they become problematic, causing harm to consumers and disruption of small group rating practices and procedures in the Commonwealth. The Department strongly supports HB 746 and asks the General Assembly to enact this legislative proposal immediately to help develop a smooth "glide path" to the full Federal health reforms triggered in 2014.

### Health Profiling

Our investigation revealed that seven of the nine insurance groups use health profiling tools such as health questionnaires or prescription drug profiling at the time of application to obtain medical information from enrollees of small groups. One group, although not using health questionnaires, uses prescription drug information obtained from HIPAA authorization forms to help "profile" a risk. The other two groups, representing 55% of the total Pennsylvania market included in the investigation, do not use health questionnaires or prescription drug information in the underwriting or rating process. If they decide to become more aggressive in using health profiling tools to determine premiums charged to small groups, there could be a significant shift in the current market creating more uncertainty to consumers and more pricing segmentation; both counter to the Federal reform efforts. However, there is nothing in Pennsylvania's statutes or regulations that would restrict them from using medical or prescription information to develop rates on small group business.

### Claims Data

During the investigative time period, none of the nine insurance groups were found to be providing claims data to small employers for renewals. According to the industry, this is because rates in the small group market are not based on claims experience since that information is not actuarially credible on small risks. Instead, rates and rate changes are based on proprietary "black box" predicative computer modeling as well as demographic changes in the small group market.

### Renewal quotes from incumbent carriers

Our investigation also revealed that renewal quotes from incumbent carriers are being used in the large group market to assist carriers in providing final quotes on new group business. It also was found that one carrier had been requiring a renewal quote from incumbent carriers prior to providing final quotes on new small employer groups, but has stopped this practice since the initiation of the Department's investigation. Further, health insurance brokers have voluntarily

provided renewal quotes to assist in sharpening proposals by potential carriers. There are still complexities in this area that the Department plans to explore in more depth.

**Changes to business model since passage of federal health care reform**

One of the concerns the Department had was that insurance carriers would drastically change their business models in the immediate future, in an attempt to prepare for the changes coming in 2014. However, during the investigation, none of the groups were found to have changed their business models in order to "cleanse" or re-price their existing books of business as the industry moves toward complete implementation of Federal health care reform in 2014. Two groups, representing 55% of the total Pennsylvania market included in the investigation, do not use health profiling tools in the underwriting or rating process. That means if they change their approach there could be an expansion into the use of medical underwriting in the small group market between now and 2014.

**Refusals to write small group policies**

Federal HIPAA requires that each health insurance carrier that offers health insurance coverage in the small group market in any state must accept every small employer that applies for coverage. During the course of the investigation, the Department learned that one insurance group had been refusing to write new small group business if the employer had not been in business for at least one year. This group recently ceased that practice and now writes all small employer groups that apply for coverage. The Department also discovered that another insurance group currently is refusing to write new small groups if employers are not in business for at least six months. The Department is currently working with that insurer to rectify the situation.

**Highmark**

Many of you, especially those of you in the western part of the state, are aware of consumer complaints we have received about Highmark and I've been asked to address those specific complaints today.

On October 13, 2009, HM Health Insurance Company (HHIC), a wholly owned for profit subsidiary of Highmark Inc., submitted an application to license a blue-branded licensee of the Blue Cross Blue Shield Association, a risk assuming PPO company. This request was initially disapproved on November 25, 2009, for failure to file a Conversion policy. Highmark subsequently refilled both the PPO license application for HHIC and a filing requesting approval of a Conversion policy. The license application was reviewed by both the PID and DOH. There was nothing in the PPO license filing for HHIC to prohibit the Pennsylvania Insurance Department or Department of Health from approval, effective July 1, 2010.

Highmark's wholly owned subsidiary company would not be subject to the Department's rate review or front-end regulation. As such, the Department cannot determine, before rates are used, if the proposed rate increases are excessive, inadequate, or unfairly discriminatory. Additionally, Highmark submitted a market withdrawal plan, notifying the Department of its plan to non-renew all small group contracts in its current non-profit company and offer new PPO policies in HHIC, its for-profit subsidiary.

In July, Highmark Blue Shield commenced the withdrawal of products from its small group market and offered replacement coverage through its for-profit subsidiary Highmark Health Insurance Company. Recognizing the financial impact of such a transition on small employers in the Commonwealth, the Department worked diligently to secure an agreement with Highmark to limit the rating factor associated with health status to 25% on the renewal book of business and to hold off on the implementation of new business medical underwriting. While these arrangements offered some relief, for many small employers it is not enough. The Department received 32 complaints from small employers receiving increases up to 79% upon their renewal quotes. This is the single largest number of complaints received by the Department against a carrier dealing with renewal quotes. Highmark's rating complaints for 2010 represent 45% of all employer group complaints investigated by the Department and leads by a ratio of 2.5:1 compared to the next nearest carrier. The renewal quote complaints are expected to increase, especially if Highmark moves more aggressively in utilizing health profiling tools.

Even though the Department does not have rate approval authority over the HHIC rates and subsequent premiums, we still investigate each complaint requesting the factors that had the most significant affect on the renewal premium quote. In the greatest majority of cases, the policy holders receiving the 79% increase were either sole proprietors within an association plan or in a micro-group (less then 9 people). In either case, typical demographic rating factor changes such as age and gender can have substantial impact on the premium charged. Also, in the sole proprietor complaints many self selected very "rich" benefit plans that tend to compound the rating effect.

Highmark did not use "health profiling" tools such as health questionnaires or drug profiling in its kickoff of HHIC for new business effective July 1, 2010 but did indicate that the option is open in future years.

## Recommendations for legislative action

1) The Legislature should pass House Bill 746, which would provide for rating limitations including a 2:1 band on rates with restrictions on the use of rating factors other than age, caps on premium increases, initiation of wellness accounts, development of standard health benefit plans and rate reviews by the Department.

**If there is no legislative action on HB 746, then we would suggest the implementation of the following measures:**

2) The Department's authority should be strengthened in the process of requesting and obtaining documents and information during the course of continuum type projects to include consumer complaint investigations, industry studies and surveys, and investigations of licensees.

3) The use of health profiling tools, such as medical questionnaires and drug profiling, should be limited so that adjustments to base rates have certain specified caps.

4) There should be more transparency in rate filings so that regulators and consumers are more knowledgeable about the factors that affect premiums.

5) There should be clearer guidance in the rate spread/ratio in the small group market leading to less pricing segmentation.

The Insurance Department looks forward to continuing our working relationship with respect to these timely issues that affect the very well being of our PA families. Thank you again for the opportunity to address you this morning and I will be happy to take any questions.

# Small Group Rating and Underwriting Investigation

## Commonwealth of Pennsylvania Insurance Department

## July 2010

Report 7/14/10

## Executive Summary

In keeping with its mission to protect the consumers of Pennsylvania and to provide a level playing field for all insurance carriers operating in the Commonwealth, the Pennsylvania Insurance Department (Department), using various tools and methods, constantly monitors the insurance industry to identify potential problematic trends and issues. Recently while monitoring and analyzing insurance marketplace activities, the Department noted several indicators that health insurers may be using underwriting and rating practices in the small group accident and health market in ways that raise substantial consumer protection issues, especially for those most in need of health coverage. Specifically, the troubling indicators were discussed at a Congressional hearing featuring a Pennsylvania small business that received a 100% rate increase, letters to the Department from consumers and state legislators complaining about rating practices, sample questionnaires and other documentation from brokers concerning individual underwriting in the small group market and competitor complaints concerning the scope and pace at which the Blue-branded (Blues) insurers are expanding their use of medical underwriting and rating.

In response to the troubling indicators and potential issues, and at the direction of Governor Rendell, the Department opened an investigation into the rating and underwriting practices of the nine largest insurance groups (see Attachment A for Market Share Table) writing small group accident and health coverage in Pennsylvania. Companies from these nine largest groups accounted for 89% of all group accident and health direct written premium in Pennsylvania for calendar year 2008 building upon a body of work that commenced in February 2010.

Initially, the Department, to fulfill its consumer protection obligations and to gain more information relative to the industry's rating and underwriting practices in the small group market, utilized a rating and underwriting questionnaire to the nine largest groups operating in the state. The questionnaires were sent to Presidents of the insurance groups on February 16, 2010. (See Attachment B for questionnaire) Over the weeks that followed, responses to the questionnaires were received and analyzed by the Department and findings were recorded. Based on this body of knowledge the Department commenced an investigation and formally acknowledged it through a press release issued by Governor Rendell (See Attachment C). Furthermore, representatives of the Department have contacted and questioned health insurance brokers and the insurance groups with follow-up questions and requests for clarifications on previously provided information with continuous follow-up when needed. Responses to the follow-up questions were received and that information was also analyzed. At this time, the Department is prepared to present its findings of investigations through this report.

**Background**

- *Complaint Analysis for the Past Five Years:* The Department analyzed its complaint data and determined that for the time period 2006 through present, it investigated 313 employer group health complaints involving the nine insurance groups included in this investigation. Based on the way the Department tracks its complaints, it is not possible to determine how many of the 313 complaints dealt with small group plans as compared to large groups. However, the Department determined, based on a sample file review, that the majority of complaints came from the smaller businesses and sole proprietors who are very much engaged in the managing of their insurance purchase decisions. Additionally, based on the significant volume of group accident and health plans in force in Pennsylvania from 2006 through present, the complaint activity would considered to be low. The complaint volume in this market tends to be low because the brokers/producers play a big role in responding to questions and concerns about pricing and rating issues. The affected parties tend not to contact the Department to complain.
- *Pennsylvania's Current Regulatory Powers:* Pennsylvania has statutory authority to review rates for small group products offered by the parent Blue entities (hospital plan corporations and professional health service plan corporations) and Health Maintenance Organizations but does not have statutory authority to require the filing of rates for small group policies issued by commercial insurers, including commercial insurers that are subsidiaries of the Blues.
- *Steps to Strengthen Pennsylvania's Powers:* Over the past eight years, the Department has put forth various legislative proposals and has testified before the General Assembly numerous times in attempts to strengthen its ability to regulate the small group accident and health insurance market. None of those legislative proposals have been enacted. Currently House Bill 746, (see Attachment D for HB 746) which the Administration and the Department strongly supports, proposes to strengthen Pennsylvania's powers in several ways. House Bill 746 strengthens consumer protections by banning the use of health profiling tools such a medical questionnaires and prescription drug profiling, establishes a maximum rate band of 2:1, and allows for geographic area rating similar to that of the federal healthcare reform legislation. Additionally, House Bill 746 provides authorities for the Department to conduct rate reviews. As part of the rate reviews, insurers would be required by March 1st of each year to file reports with the Department on the small group business they write. This information would then be analyzed by the Department to allow it to more closely monitor the marketplace. House Bill 746 has passed in the House of Representatives and is presently pending in the Senate.
- *Potential Impact of Healthcare Reform on Small Group Rating Practices come 2014:* There is the potential for significant impact. After September 23, 2010, policies will be required to include additional benefits, so there may be a push for increased rates to compensate. Beginning January 1, 2011, there will be incentives to keep loss ratios in the small group market at or above 80% which may provide a competing downward push on rates. In 2014, additional reforms will constrict the variations in rates, and, at the same time, impose additional coverage requirements. This may provide upward pressure on rates, though this may be offset by the requirement that

everyone have health insurance coverage that takes effect at the same time. Finally, health insurance exchanges will also become operational in 2014, increasing competition to the benefit of consumers.

- *Statutory Authority of the Department:* One of the concerns the Department struggled with during this process dealt with what to do if unable to obtain requested information from insurance carriers. This is due to the explicit lack of statutory authority requiring insurance licensees to provide requested information to the Department during the course of certain projects to include inquiries, studies, or investigations. This is especially more of a concern in the unregulated segment of the small group market. Also, 48 states have enacted small group rating protections, but Pennsylvania has not. As a result, the Department's rate review authority in the small group market is limited to the Blues companies and HMO's. However, most of the Department's authority to regulate the Blues companies has eroded with the migration over the past twenty years of the Blues' small group business to their downstream for-profit commercial carriers that concluded with the creation of Highmark Health Insurance Company in July 2010. As a result, there is currently no rate regulation in the commercial small group insurance marketplace, the largest segment, which translates into a lack of regulatory and consumer transparency at all levels.
- *Direct Written Premium for Groups Included in Investigation:* During calendar year 2008, the insurance industry, in aggregate, reported $15.8 billion in direct written group accident and health insurance premiums in Pennsylvania. Factored out of this figure is all direct written premium reported for individual accident and health, long-term care, medicare supplement and disability lines of insurance. The nine groups included in this investigation accounted for $14.0 billion of the $15.8 billion in direct written premium, or just under 89% of the premium reported for the industry in 2008. A total of 162 companies, that were not included in the investigation, combined to account for the remaining 11% of direct written group accident and health premium written in the Commonwealth during 2008.

## Findings

- *Transparency:* As referenced in other areas of this executive summary, the lack of statutory authority by the Department hampers the ability and effectiveness of the Department to identify trends before they become problematic causing harm to consumers and disruption of small group rating practices and procedures in the Commonwealth. The Department strongly supports HB 746 and asks the General Assembly to enact this legislative proposal immediately to help develop a smooth "glide path" to the full federal health reforms triggered in 2014.
- *Health Profiling:* Investigation revealed that seven of the nine insurance groups use health profiling tools such as health questionnaires or prescription drug profiling at the time of application to obtain medical information from enrollees of small groups. The other two groups, representing 55% of the total Pennsylvania market included in the investigation do not use health questionnaires or prescription drug information in the underwriting or rating process. If they decide to become more aggressive in using health profiling tools to determine premiums charged to small groups, there could be

a significant shift in the current market creating more uncertainty to consumers and more pricing segmentation; both counter to the federal reform efforts. However, there is nothing in Pennsylvania's statutes or regulations that would restrict them from using medical or prescription information to develop rates on small group business.

  - Investigation also showed that medical information obtained from health questionnaires, or in the one group's case prescription information, is ultimately used to establish the final rate for a group. To be specific, the Department learned that when health profiling tools are used for small group business, base rates are set based on demographic information and then those rates are adjusted using the medical information obtained from the health profiling tools. It was also learned that the base rate can be increased or decreased using information obtained from health profiling tools. Increases to base rates based on information from health profiling tools are capped at 41% for one insurance group, 60% for another group, 200% for another group, 250% for another, and at 300% for two groups. One group failed to provide the information at the time of drafting. However, investigation also revealed that only a very small percentage of new small group business written is adjusted by such a large percentage. In fact, investigation revealed that approximately 88% of all new small groups end up priced at the base rate or below after medical information from health questionnaires is factored in. Furthermore, investigation revealed that less than 1% of all new small groups written in Pennsylvania end up with adjustments of 100% or more to the base rate based on medical or prescription information.
  - Even though the percentage of people adversely affected by the use of health profiling tools (12%) and even less (1%) receiving rate adjustments exceeding 100%, these people tend to be the most vulnerable and in the greatest need for health coverage. House Bill 746 and the recent federal health reforms are directed at leveling this disparity so that health care becomes more affordable to more people.

- *Claims Data to Small Groups:* During the investigative time period, none of the nine insurance groups were found to be providing claims data to small employers for renewals. According to the industry, this is because rates in the small group market are not based on claims experience since that information is not actuarially credible on small risks. Instead, rates and rate changes are based on proprietary "black box" predicative computer modeling as well as demographic changes in the small group market.
- *Renewal Quotes from Incumbent Carriers:* Also, investigation revealed that renewal quotes from incumbent carriers are being used in the large group market to assist carriers in providing final quotes on new group business. It also was found that one carrier had been requiring a renewal quote from incumbent carriers prior to providing

final quotes on new small employer groups, but has stopped this practice since the initiation of the Department's investigation. Further, health insurance brokers have voluntarily provided renewal quotes to assist in sharpening proposals by potential carriers. There are still complexities in this area that the Department plans to explore in more depth.

- *Changes to Business Model Since Passage of Federal Health Care Reform:* One of the concerns the Department had was that insurance carriers would drastically change their business models in the immediate future, in an attempt to prepare for the changes coming in 2014. However, during the investigation none of the groups were found to have changed their business models in order to "cleanse" or re-price their existing books of business as the industry moves toward complete implementation of federal health care reform in 2014. Two groups, representing 55% of the total Pennsylvania market included in the investigation do not use health profiling tools in the underwriting or rating process. That means if they change their policy there will be a large expansion in the use of medical underwriting in the small group market between now and 2014.
- *Refusal to Write Small Group Business:* Federal HIPAA requires that each health insurance carrier that offers health insurance coverage in the small group market in any state, must accept every small employer that applies for coverage. During the course of the investigation, the Department learned that one insurance group had been refusing to write new small group business if the employer had not been in business for at least one year. This group recently ceased that practice and now writes all small employer groups that apply for coverage. The Department also discovered that another insurance group currently is refusing to write new small groups if employers are not in business for at least six months. The Department is currently working with that insurer to rectify the situation.

**Recommendations/Actions**

- The following changes or actions are proposed based on findings from this project:
    - The Legislature should pass House Bill 746 which, as already referenced on page three of this report, would strengthen Pennsylvania's authorities in the regulation of the small group market.
    - If House Bill 746 is not passed, the following recommendations are proposed:

      1) The Department's authority should be strengthened in the process of requesting and obtaining documents and information during the course of non-examination type projects to include consumer complaint investigations, industry studies and surveys, educational reviews and investigations of licensees.

      2) The use of health profiling tools, such as medical questionnaires and drug profiling, should be limited so that adjustments to base rates have certain specified caps.

3) There should be more transparency in rate filings so that regulators and consumers are more knowledgeable about the factors that affect premiums.

4) There should be clearer guidance in the rate spread/ratio in the small group market leading to less pricing segmentation.

All of these things will provide a smoother glide path to 2014. They will ensure greater transparency with respect to rating practices. As such, PA will experience a smoother transition to those changes that are part of federal healthcare reform.

# Attachment A - Market Share Table

| Insurance Group | 2008 Group A&H Direct Premium Written in PA | Direct Premium Written Market Share |
|---|---|---|
| Independence Blue Cross | $4,837,302,984 | 30.6% |
| Highmark | $3,882,453,824 | 24.5% |
| Aetna | $1,454,717,813 | 9.2% |
| Capital Blue Cross | $1,167,970,446 | 7.4% |
| Health America | $868,952,554 | 5.5% |
| BC Northeast PA | $668,763,542 | 4.4% |
| United Healthcare | $558,448,156 | 3.5% |
| Geisinger | $498,838,101 | 3.2% |
| UPMC | $60,568,895 | .4% |
| Remaining 162 Companies Reporting Premium | $1,803,521,843 | 11.4% |
| Totals | $15,821,538,158 | 100% |

# Attachment B - Sample Questionnaire

## Questionnaire Relative to Industry Rating and Underwriting Practices

Specific Market Practices. For each of the companies in the XYZ Group of insurers, please provide answers and appropriate attachments to the following questions for the time period from January 1, 2008 to the present, noting any changes during that period.

1. Does the company provide claims data to small employers for renewals?
2. Does the company request a renewal quote from the incumbent carrier prior to providing a final quote for a new small employer group?
3. Describe the rating methodology used by the company to establish the premium for an adult child seeking coverage under her parent's policy pursuant to Act 4 of 2009, 40 P.S.§752.1.

Underwriting and Rating Practices (Small Group). For each of the companies in the group, please provide an overview of your underwriting and rating practices, including answers to the following questions, in the Small Group Line of Business (2-50 employees) for the time period from January 1, 2008 to the present, noting any changes during that period. Be specific as to underwriting and rating practices for your Dominant Product (Dominant Product means the one with the highest premium for 2008 and 2009), and also describe any variations for other products.

1. Does the company use health questionnaires for small employer groups? If yes, please provide a copy of any such questionnaires.
2. List all the rating factors the company uses in setting the rates (e.g., age, gender, industry, etc.) and provide the range of each factor.
3. Explain the company's rating methodology, including how each factor is applied and what weight (if any) is given to each rating factor in the development of the rate and the use of any caps or limits on health status or claims experience. Also indicate what, if any, cap or limit your company uses on aggregate or composite rating factors produced by combining all factors in the rating formula.
4. List and quantify any discounts and surcharges that may be included in the rates.
5. Describe any use of flexible rate bands or other practices that can be used to vary rates beyond what has been reported in earlier answers.
6. Indicate the total number of lives covered in the small group market for the group and by company, using estimates if necessary.

Underwriting and Rating Practices (Individual Market). For each of the companies in the group, please provide an overview of your underwriting and rating practices, including answers to the following questions, in the Individual Line of Business for the time period from January 1, 2008 to the present, noting any changes during that period. Be specific as to underwriting and rating practices for your Dominant Product (Dominant Product means the one with the highest premium for 2008 and 2009).

1. Does the company use health questionnaires for individual applicants? If yes, please provide a copy of any such questionnaires.
2. List all the rating factors the company uses in setting the rates (e.g., age, gender, industry, etc.) and provide the range of each factor.
3. Explain the company's rating methodology, including how each factor is applied and what weight (if any) is given to each rating factor in the development of the rate and the use of any caps or limits on health status or claims experience. Also indicate what, if any, cap or limit your company uses on aggregate or composite rating factors produced by combining all factors in the rating formula.
4. List and quantify any discounts and surcharges that may be included in the rates.
5. Describe any use of flexible rate bands or other practices that can be used to vary rates beyond what has been reported in earlier answers.
6. Indicate if the company has any guaranteed issue products in its Individual business? If so, describe any differences in the rating practices applicable to the guaranteed issue business.
7. Indicate the total number of lives covered in the individual market for the group and by company, using estimates if necessary.

Changes in Underwriting and Rating Practices. Please answer the following questions from the perspective of your group as a whole.

1. Explain any changes in rating methodologies used by companies within your group since January 1, 2008. Do you expect to implement any changes in 2010 or 2011? Examples of changes include addition and deletion of rating factors, changes of range or weights of factors, etc.
2. Describe any movement of business from one company to another within the group since January 1, 2008. Do you expect any such movements in 2010 or 2011.
3. Explain any significant differences in the rating processes of the different companies in your group of companies.

# Attachment C – Governor Rendell Press Release

## Governor Rendell Announces New Investigation of Health Insurance Companies

*State to Prepare for New Marketplace in 2014 with National Health Care Reform*

HARRISBURG, Pa., June 9 /PRNewswire-USNewswire/ -- Governor Edward G. Rendell today announced that the Insurance Department is investigating Pennsylvania's nine largest health insurance companies to determine the reasons behind a pattern of controversial rate increases, and especially the extent to which those increases are driven by the use of questionable health profiling tools.

"Federal health reform brings many opportunities for health insurance companies, starting with 32 million new customers," Governor Rendell said. "So I am disappointed to see these companies hiking premiums for those most in need of health care, especially when they know that all discrimination against sick people will be prohibited in 2014 under the federal reform law."

Earlier this week, HHS Secretary Kathleen Sebelius announced a new grant program to help states strengthen oversight of insurance premiums and rate hikes. The grants, worth $1 million, will be awarded to states that demonstrate how the grant funds will be used to develop or enhance their processes of reviewing and approving, disapproving or modifying health insurance premium requests. Pennsylvania will apply for a grant by the July 7 deadline.

"We need a smooth transition into 2014, but instead, we are seeing some truly exorbitant rate increases -- with some small businesses seeing annual increases in excess of 50 percent," the Governor added. "This level of increase is not about passing on increases in health spending, which average in the 5 percent to 10 percent range; this is about companies trying to get the highest possible rates before the federal reforms take effect."

"Recent market surveillance work, including a department survey and reports from brokers, suggest that some companies are expanding the use of individualized medical questionnaires and drug profiling in the small group market," Insurance Commissioner Joel Ario added. "The two largest health insurance companies, Highmark and Independence Blue Cross (IBC) do not use these tools, but the next seven largest insurance companies all do."

"We expected to see some improvement last month when we secured Highmark's agreement to hold off on its previously announced intent to introduce medical questionnaires in the small group market," said Ario. "Instead, we've seen increased competition to identify and drive premiums up for the most vulnerable groups."

Pennsylvania has some of the weakest protections in the nation against rate increases for small businesses, with no cap on rate increases simply because someone in the group has a serious health condition. However, the law will change in 2014 when individuals and small businesses can buy health insurance through exchanges that will prohibit any premium differences based on health status.

"The stories coming in from disadvantaged groups are heartbreaking," the Governor said. "I urge the General Assembly to give the commissioner the authority needed to stop these rate increases, or we'll likely see a lot more disruption between now and 2014."

**Media contacts:**

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Gary Tuma, Governor's Office; 717-783-1116

Attachment D HB 746

PRIOR PRINTER'S NOS. 832, 2004 PRINTER'S NO. 2210

THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

# No. 746 Session of 2009

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

AS AMENDED ON SECOND CONSIDERATION, HOUSE OF REPRESENTATIVES, JUNE 17, 2009

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," further providing for conditions subject to which policies are to be issued; providing for

exemption from general applicability, for health insurance coverage for certain children of insured parents for guaranteed availability and renewability of small group health benefit plans and for affordable small group health care coverage; and making inconsistent repeals.

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

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding an article to read:

ARTICLE XLII

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AFFORDABLE SMALL GROUP HEALTH CARE COVERAGE

Section 4201. Scope of article.

This article relates to health care reform.

Section 4202. Definitions.

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

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

"Commissioner." The Insurance Commissioner of the Commonwealth.

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

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

"Creditable coverage." As defined in section 2701 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 U.S.C. § ~~300gg-91)~~ 300GG). <--

"Department." The Insurance Department of the Commonwealth.

"Eligible employee." A person employed by a large employer or a small employer on a regularly scheduled basis, with a normal work week of 17.5 hours or more, but does not include persons who work on a temporary, seasonal or substitute basis.

"Geographic average rate." The arithmetical average of the lowest premium and the corresponding highest premium to be charged by an insurer in a health insurance region for the insurer's small employer health ~~benefits plan~~ BENEFIT PLANS. The <-- term does not include premium differences that are due to



differences in benefit design or family composition.

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

(1) An accident only policy.

(2) A credit only policy.

(3) A long-term ~~care~~ or disability income policy. <--

(4) A long-term care policy.

(5) A specified disease policy.

(6) A Medicare supplement policy.

(7) A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(8) A fixed indemnity policy.

(9) A dental only policy.

(10) A vision only policy.

(11) A workers' compensation policy.

(12) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

(13) Any other similar policies providing for limited benefits.

"Health insurance region." Any of the following:

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

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

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

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

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

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

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

"Individual market." The health insurance market for individuals as defined in section 2791 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 U.S.C. § 300gg-91).

"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 this act 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 Ch. 63 (relating to professional health services plan corporations).

(4) Article XXIV.

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

"Large employer." In connection with a group health plan with respect to a calendar year and a plan year, an employer who employs an average of 51 or more eligible employees on business days during the preceding calendar year and who employs at least 51 eligible employes on the first day of the plan year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination whether an employer is a large employer shall be based on the average number of

eligible employes that it is reasonably expected that the employer will employ on business days in the current calendar year.

"Large group market." The health insurance market for large employers.

"Medical loss ratio." The ratio of incurred medical claim costs to health earned premiums, as reported on the statement convention blank adopted by the National Association of Insurance Commissioners and filed with the Insurance Commissioner.

"NAIC." The National Association of Insurance Commissioners.

"Plan year." The 12-consecutive-month period beginning on the first day of coverage under a health benefit plan.



"Preexisting condition exclusion." As defined in section 2701 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 U.S.C. § ~~300gg-91)~~ 300GG). <--
Pregnancy and conditions for which medical advice, diagnosis, care or treatment was recommended or received before birth or within the first 60 days after birth or within the first 60 days after adoption as a minor child shall not be treated as conditions described in the definition in section 2701.

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

"RATING GEOGRAPHIC AVERAGE RATE." THE ARITHMETICAL AVERAGE OF THE LOWEST PREMIUM AND THE CORRESPONDING HIGHEST PREMIUM TO BE CHARGED BY AN INSURER IN THE SERVICE AREA WHERE THE INSURER OFFERS SMALL EMPLOYER HEALTH BENEFIT PLANS OR WHERE THE INSURER HAS A PROVIDER NETWORK. <--

"Small employer." In connection with a group health plan with respect to a calendar year and a plan year, an employer who employs an average of at least two but not more than 50 eligible employes on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination whether an employer is a small employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year.

"Small group health benefit plan." A health benefit plan offered to a small employer.

"Small group market." The health insurance market for small employers.



"Standard plan." One of the health benefit packages established by the Insurance Department in accordance with section 4204.

Section 4203. Exemption from general applicability.

Sections 4204 and 4206 shall not apply to small group health benefit plans issued, made effective, delivered or renewed in this Commonwealth by any insurer that is part of an insurer group where that insurer group insures or administers health care coverage for less than 1% of the health insurance premiums in the Commonwealth, as measured by NAIC annual statement data. If the NAIC annual statement data does not contain the specificity to demonstrate that the insurer group premium for health insurance is less than 1% of the health insurance premium in the Commonwealth, an insurer group seeking to claim exemption from the requirements of this article shall present additional evidence supported by a statement by an independent~~,~~ certified public accountant, utilizing agreed-upon procedures acceptable to the department to demonstrate its market share.

Section 4204. Standard plans.

(a) Applicability.--This section shall apply to all small group health benefit plans issued, made effective, delivered or renewed in this Commonwealth after the effective date of this section.

(b) Standard plans required.--

(1) An insurer shall not offer a plan that does not meet the minimum benefits specified in one of the standard plans developed by the department. ~~The department shall consult~~

~~with insurers in developing the standard plans.~~

(2) The standard plans may not contain any preexisting condition exclusions.



(3) Standard plans may include options for deductibles and cost-sharing if the department determines that the options:

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

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

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

(4) The following apply:

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

(ii) An insurer subject to the provisions of this section shall be required to begin offering its standard plans as soon as practicable following the publication but in no event later than 180 days following the publication under subparagraph (i).

(5) Each standard plan shall qualify as creditable coverage.

(c) Additional benefits.--

(1) An insurer may offer benefits in addition to those in any of its standard plans.

(2) Each additional benefit shall:

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

(ii) Not have the effect of duplicating any of the



benefits in the standard plan with which the benefits are being offered.

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

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

(D) STANDARD PLAN BULLETIN.--THE DEPARTMENT SHALL ISSUE A STANDARD PLAN BULLETIN. <--

(E) CONSULTING WITH INSURERS.--PRIOR TO ISSUANCE OF A

4 BULLETIN, THE DEPARTMENT SHALL CONSULT WITH INSURERS CONCERNING
5 THE DEVELOPMENT OF A STANDARD PLAN BULLETIN.
6 (F) OPEN MEETINGS.--MEETINGS HELD UNDER SUBSECTION (B) SHALL
7 BE OPEN TO THE PUBLIC.
8 (G) PUBLICATION.--THE DEPARTMENT SHALL PUBLISH THE PROPOSED
9 STANDARD PLAN BULLETIN IN THE PENNSYLVANIA BULLETIN AND SOLICIT
10 PUBLIC COMMENTS FOR A MINIMUM OF 30 DAYS. AFTER CONSIDERATION OF
11 THE COMMENTS IT RECEIVES, THE DEPARTMENT MAY PROCEED TO ADOPT
12 THE FINAL STANDARD PLAN BULLETIN BY PUBLICATION IN THE
13 PENNSYLVANIA BULLETIN. THE DEPARTMENT SHALL INCLUDE ITS
14 RESPONSES TO THE PUBLIC COMMENTS THAT IT RECEIVED CONCERNING THE
15 PROPOSED BULLETIN.
16 Section 4205. Guaranteed availability and renewability of small
17 group health benefit plans.
18 (a) Availability.--The availability of each small group
19 health benefit plan offered under this article is subject to the
20 provisions of the act of June 25, 1997 (P.L.295, No.29), known



as the Pennsylvania Health Care Insurance Portability Act.
(b) Preexisting conditions.--Any preexisting condition
exclusions for small group health benefit plans shall comply
with section 2701 of Title XXVII of the Public Health Service
Act (Public Law 104-191, 42 U.S.C. § ~~300gg-91)~~ 300GG). <--
(c) Renewability.--The renewability of each small group

health benefit plan offered under this article is subject to the provisions of the Pennsylvania Health Care Insurance Portability Act.

Section 4206. Health insurance premium rates.

(a) Applicability.--This section shall apply to all small group health benefit plans that are issued, made effective, delivered or renewed in this Commonwealth after the effective date of this section.

(b) Premium rates.--

(1) An insurer shall establish a RATING geographic average rate for plans and shall file the RATING geographic average rates with the department as required by law. The RATING geographic average rate may not be changed more frequently than once every 12 months. An insurer may adjust its RATING geographic average rates for age only.

(2) An insurer shall apply the risk adjustment factor under paragraph (1) consistently with respect to all plans subject to this section.

(3) An insurer shall not charge a rate that is more than 33% above or below the RATING geographic average rate as permitted under paragraph (1). Additional adjustments may be made to reflect the inclusion of additional benefits as specified under section 4204(c) and differences in family composition.

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

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

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

(iii) Changes pursuant to a government order or judicial proceeding.

(5) Except for adjustments related to enrollment or benefit changes, any small group receiving a rate increase at renewal shall have that increase limited to a 10% adjustment from the applicable group rate. The applicable group rate is the rate the group was charged in the prior benefit year adjusted for any change in the geographic average rate for the relevant region from the prior year to the current year.

(6) Rate changes required by the rate bands in paragraph (3) shall be phased in so that any small group receiving a rate increase at renewal shall have the portion of that rate increase attributable to the implementation of the rate bands in paragraph (3) limited to 10% of the prior rate.

(7) An insurer shall adjust the RATING geographic <--
average rate in an additional amount of not less than 5% and
not more than 20% for any small employer ~~who participates in~~ <--

GROUP WHO COMPLETES a wellness program~~. The wellness program~~ <--
~~must satisfy~~ THAT SATISFIES minimum standards established by <--
the department in coordination with the department of health
~~and published~~. THE DEPARTMENTS WILL PUBLISH THE MINIMUM <--
STANDARDS by notice in the Pennsylvania Bulletin, and may not
violate the requirements of the Federal wellness program



regulations under 45 CFR § ~~146.121F~~ 146.121 (relating to <--
prohibiting discrimination against participants and
beneficiaries based on a health factor).

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

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

(c) Additional rate review and prior approval.--

(1) In conjunction with and in addition to the standards
set forth in the act of December 18, 1996 (P.L.1066, No.159),
known as the Accident and Health Filing Reform Act, and all
other applicable statutory and regulatory requirements, all

rate filings shall be subject to prior approval by the department within the 45-day period provided by section 3(f) of the Accident and Health Filing Reform Act.

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

(i) The rate is not actuarially sound.

(ii) The increase is requested because the insurer ~~has not operated efficiently or~~ has factored in experience that conflicts with recognized best practices in the health care industry, including the allocation of <--



administrative expenses to the plan on a less favorable basis than expenses are allocated to other health benefit plans.

(iii) The increase is requested because the insurer has incurred costs due to failure to follow best practices for cost control, including efforts to promote a reduction in hospital-acquired infections and serious preventable adverse events.

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

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

(d) Procedures.--The filing and review procedures set forth under the Accident and Health Filing Reform Act shall apply to any filing conducted under this section, except that no filing deemed to meet the requirements of this act shall take effect unless the department receives written notice of the insurer's intent to exercise the right granted under this section at least ten calendar days prior to implementation of rates authorized by this act.

Section 4207. College student insurance requirements.

(a) Minimum health benefit package.--Within 90 days following the effective date of this section, the department shall establish a minimum health benefit package for full-time



students enrolled in public or private baccalaureate and postbaccalaureate programs in this Commonwealth and transmit a description of the package to the Legislative Reference Bureau

for publication in the Pennsylvania Bulletin. As soon as practicable after the date of publication of the package, but in no event later than 120 days following the publication, all insurers shall offer the package as individual coverage available to students and as group coverage through the institution. The department may make revisions to the minimum health benefit package periodically, but no more than one time per 12-month period. Each revision shall be implemented by insurers as soon as practicable following publication of the revision in the Pennsylvania Bulletin, but in no event later than 120 days following such publication.

(b) Required health insurance coverage.--

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

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

(3) Every public or private college or university or postbaccalaureate program in this Commonwealth shall make

available health insurance coverage on a group or individual basis for purchase by students who are required to maintain the coverage under this section.



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

(c) Effective date.--This section shall apply to public or private baccalaureate or postbaccalaureate program in this Commonwealth beginning the first August 1 following 180 days after the publication of the notice of the elements of the standard plans.

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

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



Section 4208. Fair marketing standards.

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

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

(2) The following shall apply:

(i) Except as provided in subparagraph (ii), a producer or an insurer that provides small group health

benefit plans shall not encourage or direct a small employer to refrain from filing an application for coverage with the insurer or seek coverage from another insurer because of a health status-related factor or the nature of the industry, occupation or geographic location of the small employer.

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

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



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

(5) A producer or insurer that provides small group

health benefit plans shall not induce or encourage a small employer to exclude an employee or the employee's dependents from health coverage or benefits available under the plan.

Section 4209. Reporting requirements.

(a) Health insurance region small group market share.--Not less frequently than March 1 of every calendar year, THE DEPARTMENT MAY REQUIRE each insurer group ~~shall~~ TO file a report with the department of the insurer group's small group market share by health insurance region and the small group market share of each insurer within the insurer group by health insurance region, for the immediately preceding calendar year.

(b) Health insurance market reports.--Not less frequently than March 1 of every calendar year, THE DEPARTMENT MAY REQUIRE each insurer and each insurer group ~~shall~~ TO file the following reports with the department:

(1) Aggregate financial information for the preceding year derived from each insurer's NAIC annual statement blank or, if ~~unavailable~~ NOT AVAILABLE FROM THE ANNUAL STATEMENT BLANK, from other certifiable records:

(i) ~~Amount~~ TOTAL AMOUNT of general administrative expenses, including identification of the five largest nonmedical administrative expenses.

(ii) ~~Amount~~ TOTAL AMOUNT of surplus maintained.

(iii) ~~Amount~~ TOTAL AMOUNT of reserves maintained for

unpaid claims.

(iv) ~~Net~~ TOTAL NET underwriting gain or loss.

(v) Insurer's net income after taxes.

(2) Market information for the preceding calendar year, derived from each insurer's NAIC annual statement blank or, if ~~unavailable~~ NOT AVAILABLE FROM THE ANNUAL STATEMENT BLANK, from other certifiable records, segmented both Statewide and by health insurance region, segregated for the individual market, the small group market and the large group market:

(i) ~~Number~~ TOTAL NUMBER of members as of December 31.

(ii) ~~Number~~ TOTAL NUMBER of member months.

(iii) Premiums earned.

(iv) Incurred medical claims costs.

(v) Medical loss ratio.

(vi) Average premium per member per month for the reporting year, derived by dividing TOTAL earned premiums by TOTAL member months.

(vii) Average premium per member per month for the preceding reporting year, derived by dividing TOTAL earned premiums by TOTAL member months.

(viii) A description of each rating method used to determine rates indicating the specific group size for which each method was used.

(ix) A listing of all factors used in the rating for

each market and the range of these factors.

(3) Aggregate market information for the preceding year derived from each insurer's NAIC annual statement blank or, if ~~unavailable~~ NOT THERE AVAILABLE, from other certifiable records, for covered lives in Pennsylvania by individual <--



market, small group market and large group market:

(i) ~~Number~~ TOTAL NUMBER of members covered by entities with administrative services contracts or administrative services-only arrangements. <--

(ii) ~~Number~~ TOTAL NUMBER of members covered by associations or out-of-State trusts covering lives in Pennsylvania. <--

(c) Submission.--Each report required by this section shall be electronically submitted in a format and according to instructions prescribed by the department.

(d) Review of reports.--By July 1 of each year, the department shall review the reports provided for under subsection (a) and shall transmit to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin a statement of the status of each insurer within each region in which the insurer provides coverage.

(e) Public access.--The department shall make the information reported under this section available to the public

through a searchable public Internet website.

(f) Data calls.--The department may issue data calls as necessary to fulfill the requirements of this article. Any data calls issued under this section shall be published in the Pennsylvania Bulletin.

(g) Limitation.--The department shall have discretion to modify the reporting requirements of this section by transmitting notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(h) Compliance.--For failure to comply with any reports or data calls required under this section, the commissioner shall impose an administrative penalty of $1,000 against each insurer



or $5,000 against each insurer group for every day that the report or data is not provided in accordance with this section.

(i) Definition.--As used in this section, specifically for purposes of the reporting required in subsection (b), member means an individual person covered by a health benefit plan, an association or an out-of-State trust. The term includes dependents.

Section 4210. Regulations.

~~(a) Implementation and administration.--~~The department and the Department of Education ~~may~~ SHALL promulgate regulations as necessary for the implementation and administration of this <--

article.

~~(b) Exemption.--Except for the regulations promulgated under section 4211, the promulgation of regulations under this article by the department or the Department of Education shall, until three years from the effective date of this section, be exempt from the following:~~ <--

~~(1) Sections 201, 202, 203, 204 and 205 of the Commonwealth Documents Law.~~

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

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

THE DEPARTMENT MAY PROMULGATE REGULATIONS AS NECESSARY FOR THE IMPLEMENTATION OF THIS ACT. <--

Section 4211. Small employer groups.

~~A group of two or more small employers may join together for the purpose of purchasing small group health benefit plans provided for under this article. The department shall establish certification requirements and promulgate regulations for implementation of this section. The regulations shall, at a minimum, require that purchases made under this section be from~~ <--



~~an insurer licensed by the department, and may establish the minimum number of small employers that may participate in the group. The regulations may also provide that individuals may participate in the small group health plans.~~

(A) FORMATION AUTHORITY.--A GROUP OF TWO OR MORE SMALL EMPLOYERS MAY FORM A PURCHASING GROUP FOR THE PURPOSE OF PURCHASING A SMALL GROUP HEALTH BENEFIT PLAN PROVIDED FOR UNDER THIS ARTICLE FROM AN INSURER.

(B) CERTIFICATION.--NO INSURANCE POLICY MAY BE ISSUED, DELIVERED OR RENEWED TO A PURCHASING GROUP UNLESS THAT PURCHASING GROUP HAS A VALID CERTIFICATION FROM THE DEPARTMENT.

(C) REGULATIONS.--THE DEPARTMENT MAY PROMULGATE REGULATIONS, INCLUDING CERTIFICATION REQUIREMENTS, AS NECESSARY FOR THE IMPLEMENTATION AND ADMINISTRATION OF THIS SECTION.

(D) MINIMUM NUMBER IN GROUP.--THE REGULATIONS MAY ESTABLISH A MINIMUM NUMBER OF SMALL EMPLOYERS THAT MAY FORM AND PARTICIPATE IN A PURCHASING GROUP. THE REGULATIONS MAY ALSO PROVIDE THAT INDIVIDUALS MAY PARTICIPATE IN A PURCHASING GROUP.

(E) CERTIFICATION SUBJECT TO CRITERIA.--UNLESS CERTIFICATION REQUIREMENTS ARE PROMULGATED, CERTIFICATION UNDER THIS SUBSECTION SHALL BE SUBJECT TO THE CRITERIA SET FORTH IN SECTION 621.2(A)(5.1).

(F) APPLICABILITY.--THE PROVISIONS OF THIS SECTION SHALL APPLY NOTWITHSTANDING THE PROVISIONS OF SECTION 621.2(A)(2).

Section 4212. Enforcement.

(a) Determination of violation.--Upon a determination that a person licensed by the department has violated any provision of this article, the commissioner may, subject to 2 Pa.C.S. Chs. 5

Subch. A (relating to practice and procedure of Commonwealth agencies) and 7 Subch. A (relating to judicial review of



Commonwealth agency action), do any of the following:

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

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

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

(4) Seek restitution.

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

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

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

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

Section 2. Repeals are as follows:

2 (1) The General Assembly declares that the repeal under

3 paragraph (2) is necessary to effectuate the addition of

4 Article XLII of the act.

5 (2) Section 3 of the act of December 18, 1996 (P.L.1066,

6 No.159), known as the Accident and Health Filing Reform Act,

7 is repealed insofar as it applies to small group health

8 benefit plan rates.

9 (3) All other acts and parts of acts are repealed

10 insofar as they are inconsistent with the addition of Article



XLII of the act.

Section 3. This act shall take effect immediately.