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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

No. 225 Session of 2013

INTRODUCED BY DELUCA, SCHLOSSBERG, BISHOP, YOUNGBLOOD, DAVIDSON, D. COSTA, GODSHALL, DERMODY, STURLA, FRANKEL, FABRIZIO, KULA, MCCARTER, THOMAS AND FREEMAN, JANUARY 22, 2013

REFERRED TO COMMITEE ON INSURANCE, JANUARY 22, 2013

AN ACT

Providing for the American Health Benefit Exchange Act; establishing the Pennsylvania Health Insurance Exchange; imposing duties on the Insurance Department; and providing for powers and duties of the exchange, for health benefit plan certification, for funding and publication of costs and for regulations.

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 American Health Benefit Exchange Act.

Section 2. Purpose and intent.

The purpose of this act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this Commonwealth and to provide for the establishment of a Small Business Health Options Program to assist qualified small employers in this Commonwealth in facilitating the enrollment of their employees in qualified health plans offered

in the small group market.

Section 3. 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:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Educated health care consumer." An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical and scientific matters.

"Exchange." The Pennsylvania Health Insurance Exchange established under section 4.

"Federal act." The Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119) and regulations or guidance issued thereunder.

"Health benefit plan."

(1) A policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse the costs of health care services.

(2) The term does not include:

(i) coverage only for accident or disability income insurance or a combination thereof;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics; or

(viii) other similar insurance coverage specified in Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) The term does not include the following benefits if provided under a separate policy, certificate or contract of insurance or otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) other similar, limited benefits specified in Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996.

(4) The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and an exclusion of benefits under a group health plan maintained by the same plan sponsor, and the benefits are paid for an event without regard to whether benefits are provided for the event under a group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity

insurance.

(5) The term does not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395ss);

(ii) coverage supplemental to the coverage provided under 10 U.S.C. Ch. 55 (relating to medical and dental care); or

(iii) similar supplemental coverage provided to coverage under a group health plan.

"Health carrier" or "carrier." An entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations) or other insurance laws and regulations of this Commonwealth, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, hospital plan corporation, professional health services plan corporation or any other entity providing a plan of health insurance, health benefits or health services.

"Qualified dental plan." A limited scope dental plan that has been certified in accordance with section 7(d).

"Qualified employer." A small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange and, at the option of the employer, some or all of its part-time employees provided the employer:

(1) has its principal place of business in this Commonwealth and elects to provide coverage through the exchange to its eligible employees, wherever employed; or

(2) elects to provide coverage through the SHOP exchange to its eligible employees who are principally employed in this Commonwealth.

"Qualified health plan." A health benefit plan that has certification the plan meets the criteria for certification described in section 1311(c) of the Federal act and section 7 in effect.

"Qualified individual." An individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the exchange.

(2) Resides in this Commonwealth.

(3) At the time of enrollment, the individual is not incarcerated, other than incarceration pending the disposition of charges.

(4) Is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

"Secretary." The Secretary of the United States Department of Health and Human Services.

"SHOP exchange." The Small Business Health Options Program that the exchange is required to establish under section 6(a)(12).

"Small employer."

(1) An employer that employed an average of not more than 50 employees during the preceding calendar year.

(2) The following shall apply:

(i) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 414) shall be treated as a single employer.

(ii) An employer and a predecessor employer shall be treated as a single employer.

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year.

(v) An employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this act as long as it continuously makes enrollment through the SHOP program available to its employees.

Section 4. Pennsylvania Health Insurance Exchange.

(a) Establishment.--The Pennsylvania Health Insurance Exchange is hereby established.

(b) Membership.--The exchange shall consist of the following members:

(1) Three members of the general public appointed by the Governor.

(2) Two members of the Senate appointed by the Majority Leader of the Senate.

(3) Two members of the Senate appointed by the Minority Leader of the Senate.

(4) Two members of the House of Representatives appointed by the Majority Leader of the House of Representatives.

(5) Two members of the House of Representatives appointed by the Minority Leader of the House of Representatives.

(6) The Secretary of the Budget.

(7) The Secretary of Health.

(8) The Secretary of Public Welfare.

(9) The Insurance Commissioner.

(c) Chairperson.--The Governor shall appoint a chairperson of the exchange from one of the three gubernatorial appointees. A member appointed under subsection (b)(2), (3), (4) or (5) may appoint a designee to attend meetings on the member's behalf.

(d) Qualifications.--The members of the exchange shall be 21 years of age or older, citizens of the United States and residents of this Commonwealth.

(e) Initial appointments.--Initial appointments to the exchange shall be made within 30 days of the effective date of this section and shall be made as follows:

(1) Gubernatorial appointees initially appointed under subsection (b)(1) shall serve initial terms of two, three and four years, respectively, as designated by the Governor at the time of appointment and until their successors are appointed and qualified.

(2) Legislative appointees initially appointed under

subsection (b)(2), (3), (4) or (5) shall serve until the third Tuesday in January 2016 and until their successors are appointed and qualified.

(f) Terms of office.--Upon the expiration of a term of a member appointed under subsection (b), the following shall apply:

(1) The term of office of a gubernatorial appointee shall be three years and until a successor is appointed and qualified.

(2) The term of office of a legislative appointee shall be two years and until a successor is appointed and qualified.

(3) A legislative appointee shall serve no more than three full consecutive terms.

(4) A gubernatorial appointee shall serve no more than two full consecutive terms.

(g) Vacancies.--Appointments to fill vacancies shall be made within 60 days of the creation of the vacancy. Members who are appointed to fill vacancies may continue to serve on the exchange as follows:

(1) A member appointed to fill a vacancy under subsection (f)(1) may serve two full terms following the expiration of the term related to the vacancy.

(2) A member appointed to fill a vacancy under subsection (f)(2) may serve three full terms following the expiration of the term related to the vacancy.

(h) Reimbursement for expenses.--Members of the exchange may be reimbursed for reasonable expenses for their attendance at exchange meetings as well as any committee meetings.

(i) Meetings.--The exchange shall hold meetings as often as

necessary but no less than on a quarterly basis. The first meeting of the exchange shall be held within 60 days of the effective date of this section.

(j) Quorum.--For the purpose of conducting exchange business, a quorum shall be at least one more than half the number of exchange members.

(k) Qualified majority vote.--A majority of members of the exchange present at a meeting constitute a qualified majority vote.

Section 5. General requirements.

(a) Deadline.--The exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2015.

(b) Prohibition.--The exchange shall not make available any health benefit plan that is not a qualified health plan.

(c) Limited scope dental benefits.--The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. 9232(c)(2)(A)) through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal act.

(d) Additional prohibition.--Neither the exchange nor a carrier offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of

section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 6. Powers and duties of exchange.

(a) Duties.--The exchange shall:

(1) Facilitate the purchase and sale of qualified health plans.

(2) Provide for the establishment of a SHOP exchange, separate from the activities of the exchange related to the individual market and that is designed to assist qualified small employers in this Commonwealth in facilitating the enrollment of their employees in qualified health plans.

(3) Meet the requirements of this act and any regulations implemented under this act.

(4) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the secretary under section 1311(c) of the Federal act and section 7, of health benefit plans as qualified health plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(6) Provide for enrollment periods, as determined by the secretary under section 1311(c)(6) of the Federal act.

(7) Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on the plans.

(8) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311(c)(3) of the Federal act and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the Federal act.

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-15).

(10) In accordance with section 1413 of the Federal act, inform individuals of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.), the Children's Health Insurance Program under Title XXI of the Social Security Act or an applicable State or local public program and if through screening of the application by the exchange, the exchange determines an individual is eligible for a program, enroll the individual in the program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 36B) and any cost-sharing reduction under section 1402 of the Federal act.

(12) Establish a SHOP exchange through which qualified employers may access coverage for their employees, which shall enable a qualified employer to specify a level of coverage so its employees may enroll in a qualified health plan offered through the SHOP exchange at the specified level of coverage.

(13) Subject to section 1411 of the Federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the

individual responsibility requirement or from the penalty imposed by that section because:

(i) there is no affordable qualified health plan available through the exchange or the individual's employer covering the individual; or

(ii) the individual meets the requirements for another exemption from the individual responsibility requirement or penalty.

(14) Transfer the following to the United States Secretary of the Treasury:

(i) A list of the individuals who are issued a certification under paragraph (13), including the name and taxpayer identification number of each individual.

(ii) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(A) the employer did not provide minimum essential health benefits coverage; or

(B) the employer provided the minimum essential health benefits coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(iii) The name and taxpayer identification number of:

(A) Each individual who notifies the exchange under section 1411(b)(4) of the Federal act that the individual has changed employers.

(B) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(15) Provide to each employer the name of each employee of the employer described in paragraph (14)(ii) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

(16) Perform duties required of the exchange by the secretary or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions.

(17) Select entities qualified to serve as navigators in accordance with section 1311(i) of the Federal act and award grants to enable navigators to:

(i) Conduct public education activities to raise awareness of the availability of qualified health plans.

(ii) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal act.

(iii) Facilitate enrollment in qualified health plans.

(iv) Provide referrals to an applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or other appropriate State agency, for an enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or

a determination under the plan or coverage.

(v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

(18) Review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

(19) Consult with stakeholders relevant to carrying out the activities required under this act, including:

(i) Educated health care consumers who are enrollees in qualified health plans.

(ii) Individuals and entities with experience in facilitating enrollment in qualified health plans.

(iii) Representatives of small businesses and self-employed individuals.

(iv) The medical assistance program within the Department of Public Welfare.

(v) Advocates for enrolling hard to reach populations.

(20) Meet the following financial integrity requirements:

(i) Keep an accurate accounting of activities, receipts and expenditures and annually submit to the secretary, the Governor, the commissioner and the General Assembly a report concerning the accountings.

(ii) Fully cooperate with an investigation conducted by the secretary under the secretary's authority under the Federal act and allow the secretary, in coordination

with the Inspector General of the United States Department of Health and Human Services, to:

(A) Investigate the affairs of the exchange.

(B) Examine the properties and records of the exchange.

(C) Require periodic reports in relation to the activities undertaken by the exchange.

(iii) In carrying out its activities under this act, not use funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of Federal or State legislative and regulatory modifications.

(b) Contracting.--The exchange may contract with an eligible entity for any of its functions described in this act. An eligible entity includes, but is not limited to, the Department of Public Welfare or an entity that has experience in individual and small group health insurance, but a health carrier or an affiliate of a health carrier is not an eligible entity.

(c) Information-sharing agreements.--The exchange may enter into information-sharing agreements with Federal and State agencies and other State exchanges to carry out its responsibilities under this act provided the agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with Federal and State laws and regulations.

Section 7. Health benefit plan certification.

(a) Permissible certification.--The department may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits

package described in section 1302(a) of the Federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (d), if:

(i) The exchange has determined that an adequate choice of qualified dental plans is available to supplement the plan's coverage.

(ii) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange.

(2) The premium rates and contract language have been approved by the commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal act for catastrophic plans and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal act and if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal act.

(5) The health carrier offering the plan:

(i) Is licensed and in good standing to offer health insurance coverage in this Commonwealth.

(ii) Offers at least one qualified health plan in the silver level and at least one plan in the gold level

through each component of the exchange in which the carrier participates, where "component" refers to the SHOP exchange and the exchange for individual coverage.

(iii) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer.

(iv) Does not charge cancellation fees or penalties in violation of section 5(d).

(v) Complies with the regulations developed by the secretary under section 1311(d) of the Federal act and other requirements as the exchange may establish.

(6) The plan meets the requirements of certification as promulgated by regulation by the secretary under section 1311(c)(1) of the Federal act and by the exchange under section 9.

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this Commonwealth.

(b) Prohibitions.--The department shall not exclude a health benefit plan:

(1) on the basis that the plan is a fee-for-service plan;

(2) through the imposition of premium price controls by the department; or

(3) on the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or

too costly.

(c) Requirements.--The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Subject to the act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act, submit a justification for a premium increase before implementation of the increase. The carrier shall prominently post the information on its publicly available Internet website. The exchange shall take the information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-94), into consideration when determining whether to allow the carrier to make plans available through the exchange.

(2) (i) Make available to the public, in the format described in subparagraph (ii), and submit to the exchange, the secretary and the commissioner, accurate and timely disclosure of the following:

(A) Claims payment policies and practices.

(B) Periodic financial disclosures.

(C) Data on enrollment.

(D) Data on disenrollment.

(E) Data on the number of claims that are denied.

(F) Data on rating practices.

(G) Information on cost-sharing and payments with respect to any out-of-network coverage.

(H) Information on enrollee and participant rights under Title I of the Federal act.

(I) Other information as determined appropriate by the secretary.

(ii) The information required in subparagraph (i) shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, the information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

(d) Applicability.--

(1) The provisions of this act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the exchange.

(2) The health carrier shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary under section 1302(b)(1)(J) of the Federal act and other minimum dental benefits as the exchange or the secretary may specify

by regulation.

(4) A health carrier and a dental carrier may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by the dental carrier and the other benefits are provided by the health carrier.

Section 8. Funding and publication of costs.

(a) Funding.--The exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this act.

(b) Publication of costs.--The exchange shall publish the average costs of licensing, regulatory fees and other payments required by the exchange and the administrative costs of the exchange on a publicly available Internet website to educate consumers on the costs. The information shall include information on money lost to waste, fraud and abuse.

Section 9. Regulations.

The exchange and the department may individually or jointly promulgate regulations to implement the provisions of this act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the secretary under Subtitle D of Title I of the Federal act.

Section 10. Relation to other laws.

Nothing in this act and no action taken by the exchange under this act shall be construed to preempt or supersede the authority of the department and the commissioner to regulate the business if insured within this Commonwealth. Except as expressly provided to the contrary in this act, health carriers offering qualified health plans in this Commonwealth shall comply with the applicable insurance laws and regulations of this Commonwealth and orders issued by the department or

commissioner.

Section 20. Effective date.

This act shall take effect in 180 days.