ENGROSSED ORIGINAL

A BILL

20-797

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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To authorize the Commissioner of the Department of Insurance, Securities and Banking to implement and enforce the health insurance market provisions of the Patient Protection and Affordable Care Act, to establish a benchmark plan that includes the essential health benefits and requiring that certain rating standards be used by health insurance issuers when setting rates, to provide uniform definitions for the terms "large employer" and "small employer" and to define "excepted benefits," and to regulate stop-loss insurance.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Federal Health Reform Implementation and Omnibus Amendment Act of 2014".

TITLE I. HEALTH INSURANCE AMENDMENTS

Sec. 101. The Department of Insurance and Securities Regulation Establishment Act of 1996, effective May 21, 1997 (D.C. Law 11-268; D.C. Official Code § 31-101 *et seq.)*("DISB act"), is amended by adding a new section 4a to read as follows:

"Sec. 4a. Compliance with federal health reform.

"(a) Sections 1251, 1252 and 1304 of the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. §§ 18011, 18021, and 18024), and sections 2701 through 2709, 2711 through 2719A, and 2794 of the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; 42 U.S.C. §§ 300gg, 300gg-1, 300gg-2, 300gg-3, 300gg-4, 300gg-5, 300gg-6, 300gg-7, 300gg-8, 300gg-9, 300gg-11, 300gg-12,

300gg-13, 300gg-14, 300gg-15, 300gg-15A, 300gg-16, 300gg-17, 300gg-18, 300gg-19, 300gg-19A, and 300gg-94) , and any rules promulgated thereunder, respectively, are incorporated by reference herein and shall apply to all insurers, hospital and medical services corporations, and health maintenance organizations that deliver or issue for delivery individual or group health insurance policies or contracts in the District.

"(b) The Commissioner has the authority to take action to enforce violations of subsection (a) of this section pursuant to any authority under the DISB act.

"(c) The Commissioner is authorized to promulgate rules to implement the provisions of this section.".

Sec. 102. Section 2 of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Act of 1986, effective February 28, 1987 (D.C. Law 6-195; D.C. Official Code § 31-3101), is amended as follows:

(a) Paragraph (10A) is amended to read as follows:

"(10A)(A)(i) Except as provided in sub-subparagraph (ii) of this subparagraph, "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, a single employer that employed an average of at least 51 employees on business days during the preceding calendar year and at least 2 employees on the first day of the plan year.

"(ii) Beginning in calendar year 2016 and for each succeeding year, "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, a single employer that employed an average of

at least 101 employees on business days during the preceding calendar year and at least 2 employees on the first day of the plan year.

"(B) For the purposes of this paragraph:

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

"(ii) An employer and any 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 health benefit 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 large employer shall be based on the average number of employees that employer is reasonably expected to employ in the current calendar year.".

(b) Paragraph (19A) is amended to read as follows:

"(19A)(A)(i) Except as provided in sub-subparagraph (ii) of this subparagraph, "small employer" means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

"(ii) Beginning in calendar year 2016 and for each succeeding year, "small employer" means a single employer that employed an average of not more than 100 employees during the preceding calendar year.

"(B) For the purposes of this paragraph:

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

"(ii) An employer and any 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 health benefit 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 employer is reasonably expected to employ in the current calendar year.".

Sec. 103. Section 101 of the Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998, effective April 13, 1999 (D.C. Law 12-209; D.C. Official Code § 31-3301.01), is amended as follows:

(a) Paragraph (15) is amended to read as follows:

"(15) "Excepted benefits" means benefits under one or more of the following:

"(A) Benefits not subject to the requirements of this act include:

"(i) Coverage only for accident, or disability income insurance, or any 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) Medical expense and loss of income benefits;

"(vi) Credit-only insurance;

"(vii) Coverage for on-site medical clinics; and

"(viii) Other similar insurance coverage, as specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

"(B) Benefits not subject to the requirements of this chapter if offered separately including:

"(i) Limited scope dental or vision benefits so long as the benefits are offered in a manner not inconsistent with applicable federal law;

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

"(iii) Other similar, limited benefit plans as specified in regulations;

"(C) Benefits not subject to the requirements of this act if offered as independent, non-coordinated benefits, supplemental to minimum essential coverage include:

"(i) Coverage only for a specified disease or illness; and

"(ii) Hospital indemnity or other fixed indemnity insurance; and

"(D) Benefits not subject to the requirements of this act if offered as a separate insurance policy include:

"(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act, approved June 9, 1980 (72 Stat. 1445; 42 U.S.C. § 1395ss(g)(1));

"(ii) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 *et seq*.); and

"(iii) Similar supplemental coverage provided under a group health plan.

"(E) The term "excepted benefits" does not include any combination of benefits described in paragraph 15(A)(i), B(i), (C)(i) or (C)(ii) of this section.".

(b) A new paragraph (19a) is added to read as follows:

"(19a) "Health Benefit Exchange Authority Establishment Act" means the Health Benefit Exchange Authority Establishment Act of 2011, effective March 2, 2011 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.).".

(c) Paragraph (26) is amended to read as follows:

"(26) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as excepted benefits. It does not include short-term limited duration coverage.".

(d) Paragraph (29) is amended to read as follows:

"(29)(A)(i) Except as provided in sub-subparagraph (ii) of this subparagraph, "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, a single employer that employed an average of at least 51 employees on business days during the preceding calendar year and at least 2 employees on the first day of the plan year.

"(ii) Beginning in calendar year 2016 and for each succeeding year, "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, a single employer that employed an average of at least 101 employees on business days during the preceding calendar year and at least 2 employees on the first day of the plan year.

"(B) For the purposes of this paragraph:

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

"(ii) An employer and any 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 health benefit 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 large employer shall be based on the average number of employees that employer is reasonably expected to employ in the current calendar year.".

(e) Paragraph (42) is amended to read as follows:

"(42)(A)(i) Except as provided in sub-subparagraph (ii) of this subparagraph, "small employer" means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

"(ii) Beginning in calendar year 2016 and for each succeeding year, "small employer" means a single employer that employed an average of not more than 100 employees during the preceding calendar year.

"(B) For the purposes of this paragraph:

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

"(ii) An employer and any 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 health benefit 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 employer is reasonably expected to employ in the current calendar year.".

Sec. 104. The Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010, effective April 8, 2011 (D.C. Law 18-360; D.C. Official Code § 31-3311.01 *et seq*.), is amended as follows:

(a) Section 102(f) is amended by striking the phrase "The Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), in his or her discretion," and inserting the phrase "The Commissioner, in the Commissioner's discretion," in its place.

(b) New section 104a and 104b are added to read as follows:

"Sec. 104a. Essential health benefits.

"(a) Consistent with federal law, the Commissioner, with the approval of the Executive Board of the Health Benefit Exchange Authority, shall, by rule, select the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in the District pursuant to section 1302 of the Affordable Care Act.

"(b) If the essential health benefits benchmark plan for the individual and small group market does not include all of the benefit categories specified by section 1302 of the Affordable Care Act, or a need exists to add additional benefits, the Commissioner, with the approval of the Executive Board of the Health Benefit Exchange Authority, may, by rule, supplement the benchmark plan benefits as needed so long as the benchmark plan meets the minimum requirements of section 1302 of the Affordable Care Act.

"(c)(1) A health plan offering the required essential health benefits for the individual and small group markets, other than a health plan offered through the federal basic health program or Medicaid, may not be offered in the District unless the Commissioner finds that it is substantially equal to the benchmark plan.

"(2) When making this determination, the Commissioner must:

"(A) Ensure that the plan covers the essential health benefits categories specified in section 1302 of the Affordable Care Act; and

"(B) Consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the 10 essential health benefit categories specified by section 1302 of Affordable Care Act.

"(d) Notwithstanding any other provision of benefits mandated by District law, the benchmark plan adopted by the Commissioner shall be the benefits required in all health benefit plans offered in the individual and small group markets. Grandfathered health plans, as defined in section 1251 of the Affordable Care Act, shall be exempt from complying with the requirements of the benchmark plan.

"Sec. 104b. Underwriting ratemaking criteria.

"(a) To implement section 1201 of the Affordable Care Act, the Commissioner, with the approval of the Executive Board of the Health Benefit Exchange Authority, shall have the authority to establish by rule:

"(1)The geographic rating area for the District;

"(2)The age rating or curve; and

"(3)The rating for tobacco uses.

"(b)The Commissioner's authority to implement subsection (a) of this section shall be accomplished in a manner that is not inconsistent with, or would prevent the application of, the Affordable Care Act and its implementing regulations. In exercising the authority under subsection (a) of this section, the Commissioner may provide consumer protections and benefits that exceed those provided in the Affordable Care Act.

"(c) Health insurers are required to merge their experience in the individual and group markets for purposes of setting health insurance rates.".

(c) A new section 112 is added to read as follows:

"Sec. 112. Definitions.

"For the purposes of this title, the term:

'(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act approved March 23, 2010 (124 Stat. 111; 42 U.S.C. 18001, note).

"(2) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking established by the Department of Insurance and Securities

Regulations Establishment Act of 1996, effective May 21, 1997 (D.C. Law 11-268; D.C. Official Code § 31-101 *et seq.).*".

Section 105. The Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31-3501 *et seq*.), is amended as follows:

(a) Section 2 (D.C. Official Code § 3-3501) is amended as follows:

(1) A new paragraph (4A) is added to read as follows:

"(4A)(A)(i) Except as provided in sub-subparagraph (ii) of this subparagraph, "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, a single employer that employed an average of at least 51 employees on business days during the preceding calendar year and at least 2 employees on the first day of the plan year.

"(ii) Beginning in calendar year 2016 and for each succeeding year, "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, a single employer that employed an average of at least 101 employees on business days during the preceding calendar year and at least 2 employees on the first day of the plan year.

"(B) For the purposes of this paragraph:

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

"(ii) An employer and any 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 health benefit 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 large employer shall be based on the average number of employees that employer is reasonably expected to employ in the current calendar year.".

(2) A new paragraph (7C) (to read as follows:

"(7C)(A)(i) Except as provided in sub-subparagraph (ii) of this subparagraph, "small employer" means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

"(ii) Beginning in calendar years 2016 and for each succeeding year, "small employer" means a single employer that employed an average of not more than 100 employees during the preceding calendar year.

"(B) For the purposes of this paragraph:

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

"(ii) An employer and any 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 health benefit 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 employer is reasonably expected to employ in the current calendar year.".

(b) Section 4 (D.C. Official Code § 31-3503) is amended as follows:

(1) Paragraph (27) is amended by striking the phrase "reports; and" and inserting the phrase "reports;" in its place.

(2) Paragraph (28) is amended by striking the period at the sentence and inserting the phrase "; and" in its place.

(3) A new paragraph (29) is added to read as follows:

"(29) Section 4a of Department of Insurance and Securities Regulation Establishment Act of 1996, as added by the Federal Health Reform Implementation and Omnibus Amendment Act of 2014, as approved by the Committee on Business Consumer & Regulatory Affairs on October 10, 2014 (Committee print to Bill 20-797), making applicable sections 1251, 1252, and 1304 of the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S. C. §§ 18011, 18021 and 18024), and sections 2701 through 2709, 2711 through 2719A, and 2794 of the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; approved July 1, 1944 (58 Stat. 682; 42 U.S.C. §§ 300gg, 300gg-1, 300gg-2, 300gg-3, 300gg-4, 300gg-5,

300gg-6, 300gg-7, 300gg-8, 300gg-9, 300gg-11, 300gg-12, 300gg-13, 300gg-14, 300gg-15, 300gg-15A, 300gg-16, 300gg-17, 300gg-18, 300gg-19, 300gg-19A, and 300gg-94), and the respective implementing rules promulgated thereunder.".

(c) Section 13(1) (D.C. Official Code § 31-3512(1)) is amended to read as follows:

"(1) A provision that the group contract holder is entitled to a grace period of the last day of the month for which the premium is due for the payment of any premium due except the first, during which grace period the contract shall continue in force, unless the group contract holder has given the corporation written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the contract; except, that the contract may provide that the contract holder shall be liable to the corporation for the payment of a pro rata premium for the time the contract was in force during such grace period;".

(d) Section 15 (D.C. Official Code § 31-3514) is repealed.

Sec. 106. Section 12(c)(1)(C)(i) of the Life Insurance Act of 1934, effective June 1934 (48 Stat. 1166; D.C. Official Code § 31-4712(c)(1)(C)(i)), is amended to read as follows:

"(C)(i) A provision as follows:

"*GRACE PERIOD*: A grace period of . . . . . (insert 'the last day of the month for which the premium is due' for policies issued on a calendar month basis and a period not less than '31 days' for all other policies) will be granted for the payment of each premium

falling due after the 1st premium, during which grace period the policy shall continue in force.”.

TITLE II. STOP-LOSS INSURANCE

Sec. 201. This title may be cited as the Stop-loss insurance Act of 2014.

Sec. 202. Definitions.

For purposes of this title, the term:

(1) “Aggregate attachment point” means the total amount of health claims incurred by a small employer in a policy year for all covered employees and their dependents, and covered by a stop-loss insurance policy, above which the stop-loss insurer incurs a liability for payment under aggregate stop-loss coverage.

(2) “Attachment point” means the claims amount incurred by an insured group beyond which the insurer incurs a liability for payment.

(3) “Commissioner” means the Commissioner of the Department of Insurance, Securities and Banking.

(4) “Expected claims” means the total amount of claims that, in the absence of medical stop-loss insurance, are projected to be incurred by the insured using reasonable and accepted actuarial principles in a policy year.

(5) “Individual attachment point” means the amount of health claims incurred by a small employer in a policy year for an individual employee or dependent of an employee, and covered by a stop-loss insurance policy, above which the stop-loss insurer incurs a liability for payment, under individual stop-loss coverage. For purposes

of this section, "specific attachment point" has the same meaning as "individual attachment point.

(6) "Stop-loss insurance" means coverage that insures an employer or an employer-sponsored health plan against the risk that:

(A) 1 claim will exceed a specific dollar amount; or

(B) The entire loss of a self-insurance plan will exceed a specific dollar amount.

Sec. 203. Stop-loss policy.

(a) An insurer shall not issue or deliver to a small employer, as defined in section 101(42) of the Health Insurance Portability and Accountability Federal Law Conformity Act of 1998, effective April 13, 1999 (D.C. Law 12-209; D.C. Official Code § 31-3301.01(42), a stop-loss insurance policy unless the employer has a fully-insured employee health benefit plan.

(b) Stop-loss insurance is subject to the following:

(1) The policy must be issued to and insure the employer, the trustee or other sponsor of the plan, or the plan itself, but not the employees, members or participants;

(2) Payment by the insurer must be made to the employer, to the trustee or other sponsor of the plan, or to the plan itself, but not to the employees, members, participants or health care providers; and

(3) Stop-loss insurance policies issued or renewed after the effective date of this act shall not contain any of the following provisions:

(A) An individual attachment point for a policy year that is less than $40,000.

(B) An aggregate attachment point for a policy year that is less than the greater of one of the following:

(i) Five thousand dollars times the total number of group members;

(ii) One hundred twenty percent of expected claims; and

(iii) Forty thousand dollars.

(c)(1) A stop-loss insurer shall not exclude any employee or dependent on the basis of an actual or expected health status-related factor.

(2) Health status-related factors include any of the following: health status; medical condition, including both physical and mental illnesses; claims experience; medical history; receipt of health care; genetic information; disability; evidence of insurability, including conditions arising out of acts of domestic violence of the employee or dependent; or any other health status-related factor as determined by the Commissioner.

(d) A stop-loss insurer shall not cancel or non-renew a stop-loss insurance policy except as follows:

(1) The employer has failed to make the required premium payments;

(2) The employer demonstrates fraud or an intentional misrepresentation of material fact under the terms of the stop-loss insurance policy;

(3) The stop-loss insurer has been determined by the Commissioner to be financially impaired; or

(4) The stop-loss insurer ceases to write, issue, or administer new stop-loss insurance policies in the District; provided, that the following conditions are satisfied:

(A) The insurer provides notice to the Commissioner and employer of its intent to cease writing, issuing, or administering new or existing stop-loss insurance policies in the District at least 180 days before the date the insurer seeks to discontinue the coverage; and

(B) The insurer provides the employer at least 180 days advance written notice of its intent to cancel stop-loss insurance coverage beginning from the date of discontinuation provided to the Commissioner pursuant to subparagraph (A) of this paragraph.

(e) If an insurer elects to cancel or non-renew an employer's stop-loss insurance pursuant to subsection (e)(1), the insurer shall:

(1) Provide the employer notice no less than 30 days before the date of cancellation or expiration of the policy period;

(2) Accept any premium payment by the employer that would satisfy any outstanding amounts owed to the insurer and cure the deficiency giving rise to the cancellation or non-renewal; and

(3) Continue the policy in full force until the date of cancellation or expiration provided in the notice.

(f) Nothing in this section shall be construed to extinguish, limit, or otherwise impair any existing right in law or equity arising under a stop-loss insurance policy.

(g) On April 1, 2015, and on April 1 annually thereafter, a stop-loss insurer shall report to the Commissioner the number of small employer stop-loss policies it had issued and in effect as of December 31 of the previous year. The information shall include new policies issued and policies reissued or renewed in the previous year for groups that have 1 to 50 employees and 51 to 100 employees.

(h) The provisions of this section shall apply to stop-loss insurance policies issued or renewed after the effective date of this act.

(i) The Commissioner is authorized to adopt rules to implement the requirements of this section, including rules providing for:

(1) Additional standards for employee benefit stop-loss insurance policies; and

(2) Required disclosures to policyholders by an insurance carrier providing employee benefit stop-loss insurance.

TITLE III. GENERAL PROVISIONS

Sec. 301. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 302. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), and a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Code § 1-206(c)(1)), and publication in the District of Columbia Register.