

A BILL

To preserve consumer and employer access to professional health insurance advisors by amending section 1001 of the Patient Protection and Affordable Care Act as amended by section 10101 of such Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Access to Professional Health Insurance Advisors Act of 2011”.

SEC. 2. PROTECTING THE ABILITY OF LICENSED INSURANCE PROFESSIONALS TO CONTINUE TO SERVE THE PUBLIC.

Effective as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), section 2718 of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended to read as follows:

“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

“(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

“(1) on reimbursement for clinical services provided to enrollees under such coverage;

“(2) for activities that improve health care quality; and

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes, licensed independent insurance producer remuneration, and licensing or regulatory fees.

“The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

“(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

“(A) REQUIREMENT.— Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes, licensed independent insurance producer remuneration, and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

“(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

“(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market or small group market in such State.

“In the case of a State request for an adjustment pursuant to subparagraph (A)(ii), the Secretary shall defer to the State’s findings and determinations regarding destabilization.

“(B) REBATE AMOUNT.—

“(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

“(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

“(II) the total amount of premium revenue (excluding Federal and State taxes, licensed independent insurance producer remuneration, and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342,

and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

“(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

“(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

“(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

“(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

“(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market or small group market due to the establishment of State Exchanges.

“(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

SEC. 3. EFFECTIVE DATE.—

Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in coordination with the National Association of Insurance Commissioners, shall amend any applicable regulations so as to take the amendments made by this Act into account.

SEC. 43. DEFINITIONS.—

For purposes of section 2718 of the Public Health Service Act, as amended in section 3 of this Act, the following terms have the following meanings:

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- (1) The term ‘independent insurance producer’ means an insurance agent or broker, insurance consultant, benefit specialist, limited insurance representative, and any other person required to be licensed under the laws of the particular State to sell, solicit, negotiate, service, effect, procure, renew or bind policies of insurance coverage or offer advice, counsel, opinions or services related to insurance, and who is not employed by or required by contract to represent one insurance issuer or health plan.
- (2) The term ‘remuneration’ means compensation paid by or accrued from an insurance issuer or health plan for services rendered under contractual agreement which may include fees, commissions or rebates.