INSURANCE COMPANY LAW OF 1921, THE - OMNIBUS AMENDMENTS
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SB 176

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 contents or parts of policies and for applications for policies; providing mastectomy and breast cancer reconstructive surgery coverage standards for health insurance policies; regulating individual access to health care insurance; and providing for penalties.

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

Section 1. Section 318 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

Section 318. [When Application, Constitution, By-Laws, and Rules Are Considered Part of Policy.--All insurance policies, issued by stock or mutual insurance companies or associations doing business in this State, in which the application of the insured, the constitution, by-laws, or other rules of the company form part of the policy or contract between the parties thereto, or have any bearing on said contract, shall contain, or have attached to said policies, correct copies of the application as signed by the applicant, or the constitution, by-laws, or other rules referred to; and, unless so attached and accompanying the policy, no such application, constitution, or by-laws, or other rules shall be received in evidence in any controversy between the parties to, or interested in, the policy, nor shall such application, constitution, by-laws, or other rules be considered a part of the policy or contract between such parties.] **Statement by Insured as Evidence.--No statement made by an insured shall be received in evidence in any controversy between the parties to, or a claimant or claimants interested in, a life insurance or health and accident insurance policy unless a copy of the document containing the statement is or has been furnished to such person or those legally acting on his behalf in the controversy.**

Section 2. Section 623 of the act, added May 25, 1951 (P.L.417, No.99), is amended to read:

Section 623. Application.--[(A) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this Commonwealth shall be reinstated or renewed, and the insured or the beneficiary or assignee of such

policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(B)] No alteration of any written application for [any] such **a** policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Section 3. The act is amended by adding a section to read:

Section 633. Mastectomy and Breast Cancer Reconstruction.--(a) (1) No health insurance policy delivered, issued, executed or renewed in this Commonwealth on or after the effective date of this section shall require outpatient care following a mastectomy performed in a health care facility.

(2) Policies described in clause (1) of this subsection shall provide coverage for inpatient care following a mastectomy for the length of stay that the treating physician determines is necessary to meet generally accepted criteria for safe discharge.

(3) Such policies shall also provide coverage for a home health care visit that the treating physician determines is necessary within forty-eight hours after discharge when the discharge occurs within forty-eight hours following admission for the mastectomy.

(4) Coverage under this section shall, however, remain subject to any copayment, coinsurance or deductible amounts set forth in the policy.

(b) (1) Every health care policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by a health care insurer which provides coverage for the surgical procedure known as mastectomy shall also include coverage for prosthetic devices and reconstructive surgery incident to any mastectomy.

(2) Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

(3) The coverage for prosthetic devices inserted during reconstructive surgery and reconstructive surgery pursuant to this section may be limited to such surgical procedures performed within six years of the date of the mastectomy.

(c) This section shall not apply to the following types of policies:

(1) Accident only.

(2) Limited benefit.

(3) Credit.

(4) Dental.

(5) Vision.

(6) Specified disease.

(7) Medicare supplement.

(8) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

(9) Long-term care or disability income.

(10) Workers' compensation.

(11) Automobile medical payment.

(d) (1) The term "health insurance policy" when used in this section means any individual or group health insurance policy, subscriber contract, certificate or plan which provides medical or

health care coverage by any health care facility or licensed health care provider which is offered by or is governed under this act or any of the following:

(i) Subarticle (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

(ii) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(iii) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."

(iv) The act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."

(v) A nonprofit corporation subject to 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

(2) The term "insurer" when used in this section means any entity that issues an individual or group health insurance policy, contract or plan described under clause (1) of this subsection.

(3) The term "mastectomy" when used in this section means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(4) The term "prosthetic devices" when used in this section means the use of initial and subsequent artificial devices to replace the removed breast or portions thereof pursuant to an order of the patient's physician.

(5) The term "reconstructive surgery" when used in this section means a surgical procedure performed on one breast or both breasts following a mastectomy, as determined by the treating physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the mastectomy. The term "reconstructive surgery" shall include, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

(6) The term "symmetry between breasts" when used in this section means approximate equality in size and shape of the nondiseased breast with the diseased breast after definitive reconstructive surgery on the diseased or nondiseased breast has been performed.

Section 4. The act is amended by adding an article to read:

ARTICLE X-A.

HEALTH CARE INSURANCE INDIVIDUAL ACCESSIBILITY.

Section 1001-A. Purpose.--It is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth by complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936). This article is intended to meet those requirements while retaining the Commonwealth's authority to regulate health insurance in this Commonwealth.

Section 1002-A. Definitions.--(a) As used in this article, the following words and phrases 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.

"Designated insurers." An insurer required to offer health coverage to eligible individuals under section 1003-A.

"Eligible individual." A resident of this Commonwealth who meets the definition in section 2741(b) of the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

"Federal act." The Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

"Fraternal benefit society." An entity holding a current certificate of authority in this Commonwealth under the act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."

"Health maintenance organization" or "HMO." An entity holding a current certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

"Hospital plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

"Insurer." A foreign or domestic insurance company, association or exchange, health maintenance organization, hospital plan corporation, professional health services plan corporation, fraternal benefit society or risk-assuming preferred provider organization. The term does not include a group health plan as defined in section 2791 of the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

"Medical loss ratio." The ratio of incurred medical claim costs to earned premiums.

"Preferred provider organization" or "PPO." An entity holding a current certificate of authority organized and operated under section 630 of this act.

"Professional health services plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations). The term does not include dental service corporations or optometric service corporations as defined under 40 Pa.C.S. § 6302(a) (relating to definitions).

(b) The words, terms and definitions found in the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), including, but not limited to, those definitions in section 2791 of that act, are hereby adopted for purposes of implementing this article unless otherwise provided by this article. The term "health insurance issuer" found in section 2791(b)(2) of the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) shall have the same meaning as "insurer" in subsection (a).

Section 1003-A. Designated Insurers.--(a) The following insurers shall comply with sections 1004-A and 1005-A in order to implement the alternative mechanism requirements of the Federal act:

(1) Hospital plan corporations.

(2) Professional health services plan corporations.

(b) If a designated insurer owns a hospital plan corporation or a professional health services plan corporation which provides services within substantially the same service area as the parent organization, the subsidiary hospital plan corporation and professional health services plan corporation are not required to offer coverage to eligible individuals if the parent organization offers coverage to eligible individuals under sections 1004-A and 1005-A.

Section 1004-A. Alternative Mechanism in Individual Market.--(a) A designated insurer shall:

(1) Offer continuous year-round open enrollment to eligible individuals.

(2) Offer to eligible individuals, upon request, a choice of at least two individual health insurance policies as specified in section 1005-A.

(3) Issue to eligible individuals, upon request, an individual policy that meets the requirements of section 1005-A.

(b) Unless an eligible individual chooses to purchase a policy pursuant to section 1005-A(c), a policy offered or issued to an eligible individual under section 1005-A shall not contain preexisting condition limitations or restrictions.

(c) Designated insurers shall provide financial subsidization of policies issued to eligible individuals. Designated insurers

shall file for review by the commissioner a method for financial subsidization in all rate filings on policy choices for eligible individuals. The total subsidy provided by the designated insurer to all of its products shall not be affected by the requirement to subsidize products issued to eligible individuals.

Section 1005-A. Policy Choice for Eligible Individuals.--(a) Designated insurers shall offer eligible individuals a choice of policies. The choices shall include:

(1) At least one policy that is comparable to a standard health insurance policy or a comprehensive health insurance policy being actively marketed by the insurer to persons other than eligible individuals in the voluntary individual market.

(2) At least one other policy that is being actively marketed by the insurer to persons other than eligible individuals in the voluntary individual market.

(b) Each designated insurer shall file with and identify to the commissioner the comprehensive policy form or the standard policy form the insurer intends to offer to eligible individuals under subsection (a)(1). A designated insurer may elect to identify more than one comprehensive or standard policy form which will be offered to eligible individuals. Each policy form shall contain benefits and limits comparable to policies being actively marketed to persons other than eligible individuals in the voluntary individual market. The policy forms shall be considered comparable even if the policies marketed in the voluntary individual market include a preexisting condition exclusion.

(c) Nothing in this article shall prohibit an eligible individual from purchasing a policy which includes a preexisting condition provision or is not otherwise offered under this section from a designated insurer or any other insurer.

Section 1006-A. Coordination of Benefits.--Benefits provided under individual policies by an insurer may be subject to coordination of benefits with any other group policy, individual policy, Federal or State government program, labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan except as otherwise provided by law.

Section 1007-A. Excessive Loss Provision.--(a) At any time, the designated insurer may file for a rate adjustment for products offered under section 1005-A with the commissioner in accordance with the act of December 18, 1996 (P.L.1066, No.159) , known as the "Accident and Health Filing Reform Act."

(b) The designated insurer may request that the commissioner conduct a hearing if:

(1) the losses experienced by the designated insurer on products offered under section 1005-A(a)(1) or by eligible individuals under section 1005-A(a)(2) require a rate increase of greater than twenty per centum (20%) and the losses are in excess of a one hundred ten per centum (110%) medical loss ratio for any calendar year; or

(2) the designated insurer requested a rate increase for products under section 1005-A(a) and has reason to believe that continuation as a designated insurer will have a detrimental impact on its financial condition or solvency.

(c) Upon the request of a designated insurer under subsection (b), the commissioner shall conduct a public hearing regarding the rate filing, medical loss ratio or the impact that being a designated insurer is having on the designated insurer's solvency. The hearing shall be held as provided for in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). Following the hearing, the commissioner shall determine the extent of the impact, if any, of being a designated insurer under this article on the designated insurer's rate filing, medical loss ratio,

overall operations and solvency and shall do one or more of the following:

(1) grant, modify or deny the requested rate filing; or

(2) request to withdraw from the approved alternative mechanism and to authorize implementation of the Federal default standards set forth in section 2741 of the Federal act.

Section 1008-A. Review of Filings.--The department shall review filings submitted under sections 1004-A(c), 1005-A(b) and 1007-A(a) in accordance with the act of December 18, 1996 (P.L.1066, No.159), known as the "Accident and Health Filing Reform Act."

Section 1009-A. Conversion Policies.--(a) Notification of the conversion privilege shall be included with each certificate of coverage issued under section 621.2(d). Each certificate holder in an insured group shall be given written notification of the conversion privilege and its duration within a period beginning fifteen (15) days before and ending thirty (30) days after the date of termination of the group coverage. The certificate holder or the holder's dependent shall have no less than thirty-one (31) days following notification to exercise the conversion privilege. Written notification provided by the contract holder and supplied to the certificate holder or mailed to the certificate holder's last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section.

(b) The premium rates for individuals who purchase a comparable group conversion policy offered pursuant to applicable law shall be limited to one hundred twenty per centum (120%) of the approved premium rates for comparable group coverage.

Section 1010-A. Penalties.--Upon satisfactory evidence of a violation of this article by an insurer or other person, the commissioner may pursue any one or more of the following penalties:

(1) Suspend, revoke or refuse to renew the license of the insurer or other person.

(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than five thousand dollars ($5,000).

(4) Impose a civil penalty of not more than ten thousand dollars ($10,000) for a wilful violation of this article.

(b) Penalties imposed on an insurer or other person under this article shall not exceed five hundred thousand dollars ($500,000) in the aggregate during a single calendar year.

Section 1011-A. Regulations.--The department may promulgate regulations as may be necessary or appropriate to carry out this article.

Section 1012-A. Expiration.--This article shall expire on December 31, 2000.

Section 5. The addition of section 633 of the act shall apply to all insurance policies, subscriber contracts and group insurance certificates issued under any group master policy delivered or issued for delivery on or after the effective date of section 633 of the act. Section 633 of the act shall also apply to all renewals of contracts on any renewal date which is on or after the effective date of section 633 of the act.

Section 6. This act shall take effect as follows:

(1) The amendment of sections 318 and 623 of the act shall take effect immediately.

(2) The addition of Article X-A of the act shall take effect on January 1, 1998, or immediately, whichever is later.

(3) This section shall take effect immediately.

(4) The remainder of this act shall take effect in 90 days.

APPROVED--The 4th day of November, A. D. 1997.

THOMAS J. RIDGE