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," in health and accident insurance, prohibiting exclusions for preexisting conditions.

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 a section to read:

Section 635.8. Exclusions For Preexisting Conditions.--(a) A health insurer shall be prohibited from discriminating against a qualified individual or a qualified group based on a preexisting medical condition.
(b) Methods of discriminating based on preexisting medical conditions shall include:

(1) refusing to sell, offer or issue a health insurance policy to a qualified individual or a qualified group due to a preexisting medical condition;

(2) selling, offering or issuing a health insurance policy to a qualified individual or a qualified group that excludes coverage for a preexisting medical condition;

(3) considering a qualified individual's or qualified group's prior medical history in the medical underwriting process;

(4) requiring or requesting a qualified individual or a qualified group to provide information regarding prior medical history as part of the health insurer's application or enrollment process; or

(5) any other method or action of a health insurer that the Insurance Commissioner deems a limitation or exclusion of benefits based on the fact that a preexisting medical condition was present before the effective date of coverage, or, if coverage is denied, the date of the denial, under a qualified individual's or a qualified group's health insurance policy.

(c) This section shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Insurance Department or the Federal Government, this section shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Insurance Department or the Federal Government, this section shall apply to any
policy issued or renewed on or after 180 days after the effective date of this section.

(d) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Government program." Any of the following:

(1) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Human Services Code."

(2) A program under Article XXIII-A.

"Health insurance policy." Any individual or group health, sickness or accident policy, or subscriber contract or certificate offered, issued or renewed by a health insurer. The term does not include any of the following types of insurance:

(1) Accident only.

(2) Fixed indemnity.

(3) Limited benefit.

(4) Credit.

(5) Dental.

(6) Vision.

(7) Specified disease.

(8) Medicare supplement.

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

(10) Long-term care or disability income.

(11) Workers' compensation.

(12) Automobile medical payment.

"Health insurer." An entity that issues a health insurance policy and is subject to the following:

(1) this act, including, but not limited to, section 630 and
Article XXIV;

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Preexisting medical condition." A physical or mental condition, including, but not limited to, a disease, an illness, an injury, pregnancy or a genetic defect for which medical advice, diagnosis, care or treatment has been recommended or received prior to the effective date of coverage.

"Qualified group." Any of the following:

(1) A group of qualified individuals covered or applying for coverage under the same health insurance policy.

(2) A group of individuals covered under an employer sponsored group health insurance policy.

"Qualified individual." Any of the following:

(1) An individual who is less than nineteen (19) years of age.

(2) An individual who:
   (i) is covered or applying for coverage under a health insurance policy; and
   (ii) has had health coverage under a health insurance policy or government program for at least nine months of the twelve consecutive month period immediately preceding the date of application or enrollment.

Section 2. This act shall take effect in 30 days.