INSURANCE COMPANY LAW OF 1921, THE - OMNIBUS AMENDMENTS
Act of Dec. 21, 1998, P.L. 1108, No. 150 Cl. 40
Session of 1998
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HB 366

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 government-owned companies; providing for property and casualty insurance rate and form filings, for the making of rates, for powers and duties of the Insurance Commissioner and for rating organizations; imposing penalties; providing for health insurance coverage for mental illnesses; defining "person" for purposes of the Insurance Company Mutual-to-Stock Conversion Act; further providing for adoption of plan of conversion; prohibiting certain acquisitions of control; further providing for violations; and making repeals.

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

Section 1. Section 300 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, added July 17, 1959 (P.L.545, No.163), is amended to read:

Section 300. Government Owned Companies.--[(a) No domestic, foreign or alien insurance company, association or exchange, in which the major financial interest is held, directly or indirectly, by another state of the United States or by a foreign government or by any political subdivision, instrumentality or agency of either, shall be admitted and authorized to do business.

(b) No certificate of authority to transact any kind of insurance business in this Commonwealth shall be issued, renewed or continued in effect for any such insurance company, association or exchange.

(c) The provisions of this section shall not apply to any insurance company, association or exchange which was so owned, controlled or constituted prior to January 1, 1958, and was authorized to do business in this Commonwealth and was issued a certificate of authority to do so prior to January 1, 1958.] **(a) For purposes of this section, except when the context clearly indicates otherwise:**

(1) "Insurance company" means an insurance company, association or exchange or any other entity subject to the jurisdiction of the Insurance Department.

(2) "Control" has the meaning prescribed in section 1401.

(3) "Government owned" means owned or controlled, directly or indirectly, by another state, territory or jurisdiction of the United States or by a foreign government or by any political subdivision, instrumentality or agency of either.

(b) A government owned insurance company shall not be admitted or authorized to do business in this Commonwealth until it has demonstrated and continues to demonstrate to the Insurance Commissioner's satisfaction that it:

(1) does not receive a subsidy or other competitive advantage as a result of such control or status that would enable it to compete unfairly with similarly situated authorized insurers which are not so controlled or constituted;

(2) is not entitled to claim sovereign or similar governmental immunity or has filed a waiver of sovereign or similar governmental immunity with the Insurance Commissioner;

(3) cedes no more than fifty per centum (50%) of its annual gross written premiums to assuming insurers that neither hold a certificate of authority nor are qualified reinsurers in this Commonwealth;

(4) maintains a policyholders' surplus of at least thirty-five million dollars ($35,000,000) or such other amount determined by the Insurance Commissioner calculated and reported in the manner prescribed by the department pursuant to section 320;

(5) is domiciled in a jurisdiction which has insolvency laws applicable to the insurance company that in law and application are fair, reasonable and not prejudicial to policyholders, creditors or the public generally;

(6) has filed with the Insurance Commissioner an irrevocable consent not to seek the protection of 11 U.S.C. § 304 (relating to cases and ancillary to foreign proceedings);

(7) its operation as an insurer would not be detrimental to the public interests of this Commonwealth;

(8) otherwise satisfies all applicable requirements for the issuance of a certificate of authority, including, but not limited to, reasonable standards of solvency, the deposit of security, the establishment of a special trust fund for the benefit of policyholders or other requirements as may be established from time to time by the Insurance Commissioner; and

(9) is in compliance with the requirements set forth in section 301.

Any entity granted a certificate of authority under the provisions of this section shall notify the Insurance Commissioner within five (5) business days of any material change with respect to clause (1), (2), (3), (4) or (5) of this subdivision or of any material order or other action affecting its certificate of authority.

(c) Upon satisfactory evidence of the violation of this section by an insurance company, the Insurance Commissioner may in the Insurance Commissioner's discretion pursue any one or more of the following courses of action:

(1) suspend or revoke the certificate of authority of such offending company;

(2) refuse for a period not to exceed one year thereafter to issue a new certificate of authority to such offending company;

(3) impose a penalty of not less than five thousand dollars ($5,000) nor more than twenty-five thousand dollars ($25,000) for each action in violation of this section.

Section 2. Sections 501 and 502 of the act are repealed.

Section 3. The act is amended by adding an article to read:

ARTICLE V-A.

PROPERTY AND CASUALTY FILING REFORM.

Section 501-A. Short Title of Article.--This article shall be known and may be cited as the Property and Casualty Filing Reform Act.

Section 502-A. Purpose.--The purposes of this article are to:

(1) Protect policyholders and the public from excessive, inadequate or discriminatory rates.

(2) Promote price competition and improve the availability and reliability of insurance.

(3) Encourage efficient and economical marketing practices.

(4) Ensure availability of price and related information to consumers.

(5) This article shall supercede section 354 to the extent that section 354 is to the contrary.

Section 503-A. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Association." Individuals, partnerships or associations of individuals authorized to engage in the business of insurance on the Lloyds plan.

"Classification." The process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Company." The term includes insurance companies as defined in section 101 and title insurance companies, whether incorporated under the laws of this Commonwealth or any other state, territory or district or under the laws of any foreign country.

"Department." The Insurance Department of the Commonwealth.

"Exchange." The term includes individuals, partnerships and corporations authorized to exchange with each other interinsurance or reciprocal insurance contracts.

"Expenses." The portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees.

"Filing." A form or rate filing required by section 505-A.

"Form." A policy, contract, certificate, evidence of coverage, application, rider or endorsement affording insurance coverage or benefit against loss.

"Insurer." A licensed company, exchange or association as defined in section 101 or a rating organization licensed under section 512-A.

"Joint underwriting." A voluntary agreement established to provide insurance coverage for a risk in which two (2) or more insurers jointly contract with the insured at a price and under policy terms agreed upon by the insurers.

"Large commercial risk." A risk of a commercial entity, that is not a personal risk, whose aggregate annual property and casualty premiums on all policies, excluding workers' compensation, total at least twenty-five thousand dollars ($25,000) or which has at least twenty-five (25) full-time employes at the time the policy is written or renewed, and for which the entity uses an employe acting as an insurance manager or buyer or a retained qualified insurance consultant or risk manager provided the insurance is procured in accordance with the laws of this Commonwealth.

"Loss adjustment expense." The expenses incurred by the insurer in the course of settling claims.

"Marine and inland marine insurance." Insurance defined by general custom of the business as inland marine insurance or as otherwise defined by law or ruling of the Insurance Commissioner.

"Personal risks." Personal automobile risks as defined in the act of June 5, 1968 (P.L.140, No.78), entitled "An act regulating the writing, cancellation of or refusal to renew policies of automobile insurance; and imposing powers and duties on the Insurance Commissioner therefor," and personal property risks described in the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

"Rate." The cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, with an adjustment to account for the treatment of expenses, profit and individual insurer variation in loss experience prior to any

application of individual risk variations based on loss or expense considerations. The term does not include minimum premium. The term also includes supplementary rating information.

"Small commercial risks." A risk of a commercial entity which does not qualify as a large commercial risk.

"Statistical plan." The plan, system or arrangement used in collecting data.

"Supplementary rating information." A manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule and other similar information necessary to determine an applicable rate.

Section 504-A. Scope.--(a) This article shall apply to property and casualty insurance, including fidelity, surety and guaranty bond and fire insurance, inland marine insurance and any combination thereof, on risks or operations located in this Commonwealth.

(b) This article shall not apply to any of the following:

(1) Reinsurance other than statutorily authorized joint reinsurance mechanisms.

(2) Insurance on vessels or crafts, their cargoes, marine builders' risk, marine protection and indemnity or other risks commonly insured under marine insurance policies.

(3) Insurance on hulls of aircraft, including their accessories and equipment, or against liability arising out of the ownership, maintenance or use of aircraft.

(4) Personal risks.

(5) Accident and health insurance.

(6) Title insurance.

(7) Workers' compensation insurance.

(8) Insurance covering loss in excess of at least ten thousand dollars ($10,000) from any one event issued to self-insurers. The amount may be changed by department regulation.

Section 505-A. Required Rate and Form Filings.--(a) All forms and rates used by an insurer shall be filed with the department unless otherwise provided in subsections (b), (c) and (d).

(b) The commissioner may publish notice in the Pennsylvania Bulletin of any type of form which is exempted from filing. The commissioner may revoke an exemption by publishing notice in the Pennsylvania Bulletin. Revocation shall take effect ninety (90) days following publication.

(c) (1) Forms for small commercial risks shall be filed with the department no later than forty-five (45) days prior to their effective date. Filings under this section shall be available for use forty-five (45) days after filing, or after a comment period established by the commissioner, unless earlier approved or disapproved by the commissioner.

(2) An insurer shall file rates under this subsection for small commercial risks with the department as follows:

(i) Insurers shall establish an initial base rate for existing lines of business which is not excessive, inadequate or unfairly discriminatory. The initial base rate shall be the rate currently on file and approved by the department on the effective date of this article. The initial base rate for any line of business which is not on file and which has not been approved on the effective date of this article shall be subject to filing, review and prior approval by the department.

(ii) If proposed changes to an approved base rate will increase or decrease the approved base rate by more than ten per centum (10%) annually in the aggregate, the changes shall be subject to filing, review and prior approval by the department.

(iii) If proposed changes to an approved base rate will increase or decrease the approved base rate by ten per centum (10%) or less annually in the aggregate, the changes shall be filed with the department no later than forty-five (45) days prior to their

effective date. Filings under this section shall be available for use forty-five (45) days after filing, or after a comment period established by the commissioner, unless earlier approved or disapproved by the commissioner.

(iv) Rate filings reviewed under subparagraphs (i) and (ii) shall be available for use forty-five (45) days after filing, or at the end of any public comment period established by the commissioner under section 507-A(a), unless earlier approved or disapproved by the commissioner. The commissioner may extend the forty-five-day approval period for an additional forty-five (45) days by written notice to the insurer.

(v) Individual filings shall not be required for a specific individual policy if the rate does not deviate from the base rate by more than twenty-five per centum (25%).

(vi) Rates developed for individual insureds which deviate from the base rate by more than twenty-five per centum (25%) may be used immediately and shall be filed with the department no later than thirty (30) days after the effective date of the rate.

(vii) The commissioner may exempt a rate filing required under this section by publishing a notice in the Pennsylvania Bulletin identifying the type or kind of rate being exempted, to include rates which in the opinion of the commissioner would be impractical to file prior to use. The commissioner may subsequently require exempted rates to be filed by publishing notice of the requirement in the Pennsylvania Bulletin. The subsequent notice shall be effective in ninety (90) days.

(d) The commissioner may evaluate and adjust the restrictions on premium limits and the number of employes of a large commercial risk by regulation. Insurers shall not be required to file forms or rates for large commercial risks with the department in the case of a large commercial risk located in this Commonwealth. If after holding a hearing the commissioner determines that the market is noncompetitive, an order shall be issued to require rate filings for large commercial risks. The commissioner shall consider all relevant factors to determine competitiveness of the market, to include the number of insurers actively engaged in providing coverage, market shares, change in market shares and ease of entry. The insurer shall disclose to the insured that forms and rates under this subsection are exempt from filing requirements. Disclosures made by the insurer shall be maintained by the insurer.

Section 506-A. Rate Filings.--(a) Every insurer making a filing with the commissioner under section 505-A shall file every manual of classifications, rules and rates, every rating plan and every modification of a manual of classifications, rules and rates and a rating plan which it proposes to use in this Commonwealth.

(b) If the commissioner determines that a filing is not accompanied by supporting information and that sufficient information is not available to determine whether the filing meets the requirements of this article, the commissioner may require the insurer to furnish the additional supporting information. Filings may be supported by any or all of the following:

(1) The experience or judgment of the insurer.

(2) The experience of other insurers or rating organizations.

(3) Any other factors which the insurer deems relevant.

(c) An insurer may satisfy its rate filing requirements by becoming a member of or subscriber to a licensed rating organization which makes rate filings and by authorizing the commissioner to accept filings from the rating organization on the insurer's behalf. Nothing contained in this article shall be construed to require any insurer to become a member of or a subscriber to a licensed rating organization.

Section 507-A. Review Procedures.--(a) Filings shall be reviewed as appropriate and necessary to carry out the provisions

of this article. The commissioner may publish notice of a filing in the Pennsylvania Bulletin, including the time period established by the department for receipt of public comment on the filing.

(b) Disapproval of a filing shall be based only on specific provisions of applicable law, regulations or statements of policy or on insufficiency of supporting information. Rates filed under section 505-A shall not be disapproved unless the rates are determined to be excessive, inadequate or unfairly discriminatory.

(c) A filing disapproved by the department may be resubmitted within one hundred twenty (120) days after the date of the disapproval. Resubmitted filings shall become effective and may be used thirty (30) days after the receipt of the resubmission by the department unless previously approved or disapproved by the department. The provision of this subsection shall apply to filings made after the effective date of this article.

(d) Disapproval of a resubmitted filing shall be based only on specific provisions of applicable law, regulations or statements of policy or on insufficiency of supporting information. Disapproval may not be based on any grounds not specified in the initial disapproval issued by the department except to the extent that new information is presented in the resubmission.

(e) Any resubmission following a second disapproval shall be considered a new filing and shall be reviewed in accordance with subsection (a).

(f) Nothing in this section shall prevent the commissioner from approving a filing.

Section 508-A. Notice of Disapproval.--Upon the disapproval of any filing under this article, the department shall notify the insurer in writing specifying the reason or reasons for the disapproval.

Section 509-A. Use of Disapproved Forms or Rates.--It shall be unlawful for any insurer to use a form or rate disapproved under this article within this Commonwealth.

Section 510-A. Review of Form or Rate Disapproval.--(a) Within thirty (30) days of the date of mailing a notice of disapproval of a filing under this article, the insurer may make a written application to the commissioner for a hearing.

(b) Upon receipt of an application for a hearing under subsection (a), the commissioner may hold a hearing in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action). All actions which may be performed by the commissioner under this section may be performed by the commissioner's designated representative.

Section 511-A. Disapproval After Use.--(a) Any form or rate filed and used after the expiration of the appropriate review period under this article may be subsequently disapproved. The commissioner shall notify the insurer of the disapproval in writing and shall provide the opportunity for a hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(b) If following a hearing the commissioner finds that a form in use should be disapproved, the commissioner may order its use to be discontinued for any policy issued or reviewed after a date specified in the order.

(c) If following a hearing the commissioner finds that a rate in use should be disapproved, the commissioner may order its use to be discontinued for any policy issued or renewed after a date specified in the order. The commissioner may reinstate the last approved rate on file with the department or specify interim rates.

(d) Pending a hearing, the commissioner may order the suspension of use of any form filed if the commissioner has reasonable cause to believe all of the following:

(1) The form is contrary to applicable law or regulations.

(2) The insured will suffer substantial harm if the form is not suspended.

(3) The harm the insured will suffer outweighs any hardship the insurer will suffer by the suspension for the use of the form.

(4) The suspension order will result in no harm to the public.

(e) Pending a hearing, the commissioner may order suspension of use of a rate filed and reinstate the last previous rate in effect or specify interim rates if none has been previously approved if the commissioner has reasonable cause to believe that:

(1) the rate is excessive, inadequate or unfairly discriminatory;

(2) unless a suspension order is issued, insureds will suffer substantial harm;

(3) the harm insureds will suffer outweighs any hardship the insurer will suffer by the suspension of the use of the form; and

(4) the suspension order will result in no harm to the public.

Section 512-A. Rating Organizations.--(a) A corporation, unincorporated association, partnership or individual located within or outside this Commonwealth may make application to the commissioner for a license as a rating organization for the kinds of insurance or subdivisions specified in its application. The applicant shall file the following with the commissioner:

(1) A copy of its constitution, articles of agreement or association, certificate of incorporation and a copy of all bylaws, rules and regulations governing the conduct of its business.

(2) A list of its members and subscribers.

(3) The name and address of a resident of this Commonwealth upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

(4) A statement of its qualifications as a rating organization.

(b) Review.--If the commissioner determines that the information submitted under subsection (a) is acceptable, the commissioner may issue a license specifying the kinds of insurance or subdivisions for which the applicant is authorized to act as a rating organization. A license may be granted or denied in whole or in part by the commissioner within sixty (60) days of the date of its filing.

(c) Licenses issued under this section shall remain in effect for three (3) years unless sooner suspended or revoked by the commissioner. The department shall charge a fee of five thousand dollars ($5,000) for each license. Licenses may be suspended or revoked by the commissioner following notice and hearing if the rating organization ceases to meet the requirements of subsections (a) and (b).

(d) An organization shall notify the commissioner of a change to any of the following:

(1) Its constitution, articles of agreement or association, certificate of incorporation or its bylaws, rules and regulations governing the conduct of its business.

(2) Its list of members and subscribers, which list shall be updated on a quarterly basis.

(3) The name and address of the resident of this Commonwealth designated by it upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

(e) Each rating organization shall permit any nonmember insurer to be a subscriber to its rating services for any kind of insurance or subdivision for which it is authorized to act as a rating organization. Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

(f) Prohibition.--No rating organization shall adopt any rule which would prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(g) (1) Cooperation in ratemaking among rating organizations, or among rating organizations and insurers and concert of action among insurers under the same general management and control, or in other matters within the scope of this article is authorized, provided the resulting filings are subject to all applicable provisions of this article.

(2) If the commissioner finds that an activity or practice described in paragraph (1) is unfair or unreasonable or otherwise inconsistent with the provisions of this article, the commissioner may after notice and hearing issue a written order discontinuing the activity or practice. The order shall specify the reason for a determination that the activity or practice is unfair or unreasonable or otherwise inconsistent with this article.

Section 513-A. Deviation Filings.--(a) (1) Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the rating organization.

(2) A member or subscriber may, notwithstanding paragraph (1), file with the commissioner a uniform percentage decrease or increase to be applied to the premiums produced by the filed rating system for a kind of insurance or class of insurance found by the commissioner to be a proper rating unit for the application of the uniform percentage decrease or increase or for a subdivision of a kind of insurance:

(i) that is comprised of a group of manual classifications which is treated as a separate unit for ratemaking purposes; or

(ii) for which separate expense provisions are included in the filings of the rating organization.

(b) A deviation filing shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the filing and data shall be sent simultaneously to the rating organization. A deviation filing shall be subject to the provisions of sections 505-A and 507-A.

Section 514-A. Information to Insured.--(a) Every rating organization and every insurer which makes its own rates shall, upon request and payment of reasonable costs, furnish all pertinent information to the affected insured or the insured's authorized representative. The information shall be provided within a reasonable time.

(b) Every rating organization and every insurer which makes its own rates shall provide reasonable procedures for any person aggrieved by the application of its rating system within this Commonwealth to be heard upon written request, in person or by the insured's authorized representative, to review the manner in which the rating system has been applied in connection with the insurance afforded the aggrieved person.

Section 515-A. Examinations.--(a) The commissioner may at least once every five (5) years make or cause to be made an examination of each rating organization licensed in this Commonwealth.

(b) The reasonable costs of an examination under subsection (a) shall be paid by the rating organization upon presentation of a detailed account of the costs. The officers, managers, agents and employes of the rating organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner may furnish two (2) copies of the examination report to the rating organization and shall notify the organization that it may within twenty (20) days request a hearing on the report. Before filing

the report for public inspection, the commissioner may grant a hearing to the rating organization.

(c) When filed for public inspection, the examination report shall be admissible in evidence in any action or proceeding brought by the commissioner against the rating organization examined or its officers and shall be prima facie evidence of the facts stated in it.

(d) The commissioner may withhold the report of any examination from public inspection for such time as the commissioner may deem proper.

(e) In lieu of an examination, the commissioner may accept the report of an examination conducted by the insurance supervisory official of another state under the laws of that state.

Section 516-A. Record Maintenance.--Upon request, the commissioner shall be provided with a copy of any rate or form issued in this Commonwealth. Insurers shall maintain complete and accurate specimens or actual copies of all rates and forms which are issued to Commonwealth residents, including copies of all applications, binders, endorsements and other applicable and supporting documents used with rates and policies. Rate filings and forms may be retained on diskette, microfiche or by any other electronic method. Specimen copies shall also indicate the date the rate filing or form was first issued in this Commonwealth.

Section 517-A. Assigned Risks and Residual Markets.--(a) Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure insurance through ordinary methods, and the insurers may agree among themselves on the use of reasonable rate modifications for the insurance.

(b) Agreements and rate modifications made under subsection (a) shall be subject to the filing, review and prior approval of the commissioner. Filings shall be available for use at the expiration of a sixty-day (60) period if not earlier approved or disapproved by the commissioner. The commissioner may by written order to the insurer within the sixty-day (60) period extend the period for approval or disapproval for an additional thirty (30) days. This section shall apply to filings for the Fair Plan and the Joint Underwriting Association.

Section 518-A. Violations.--(a) A person or organization shall not wilfully withhold information affecting the rates or premiums chargeable under this article from or knowingly give false or misleading information to the commissioner, a statistical agency designated by the commissioner or an advisory organization. A violation of this section shall be punishable under subsection (b).

(b) Upon satisfactory evidence of a violation of any section of this article by any person or insurer, one (1) or more of the following penalties may be imposed at the commissioner's discretion:

(1) Suspension or revocation of a license.

(2) Refusal for a period not to exceed one (1) year to issue a new license to the offending insurer or other persons.

(3) A fine of not more than five thousand dollars ($5,000) for a violation of this article.

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

(5) A fine of not more than ten thousand dollars ($10,000) for a violation of subsection (a).

(6) A fine of not more than twenty-five thousand dollars ($25,000) for a wilful violation of section 516-A.

(c) Fines imposed against an individual insurer under this article shall not exceed five hundred thousand dollars ($500,000) in the aggregate during a single calendar year.

Section 519-A. Severability.--The provisions of this article are severable. If any provision of this article or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this article which can be given effect without the invalid provision or application.

Section 4. Section 610 of the act is repealed.

Section 5. The act is amended by adding a section to read:

Section 635.1. Mental Illness Coverage.--(a) As used in this section:

(1) "Serious mental illness" means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder and delusional disorder.

(2) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate issued by an entity subject to one (1) of the following:

(i) This act.

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

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

(b) This section shall apply to any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of fifty (50) or more employes: Provided, that this section shall not include the following policies: accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) supplement, long-term care, disability income, workers' compensation or automobile medical payment.

(c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet at a minimum the following standards:

(1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;

(2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;

(3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;

(4) cost-sharing arrangements, including, but not limited to, deductibles and copayments for coverage of serious mental illnesses shall not prohibit access to care. The department shall set up a method to determine whether any cost-sharing arrangements violate this subsection.

(d) The Legislative Budget and Finance Committee shall undertake a study of the cost and benefits of this section eighteen (18) months after the effective date of this section. The committee shall prepare a report of its study for the General Assembly on or before June 30, 2001, and every two years thereafter. Such study and report shall include, but not be limited to, an analysis of the following: the effect on policy premiums; the cost benefit of extending this act to all group health insurance policies offered in this Commonwealth; the cost benefit of this enhanced level of coverage for mental illness and the cost benefit to those employers who offer policies with more liberal benefits; the identity of employers who, after the effective date of this section, provide reduced mental health insurance benefits to employes and who provided more liberal mental health insurance benefits than provided in this act; an analysis of any mental illnesses enumerated under

axis 1 of the Current Diagnostic and Statistical Manual of Mental Disorders not covered under this section, with specific consideration of whether any of them should be included in the definition of serious mental illness; actions taken by the department to assure health insurance policies are in compliance with this section and that quality and access to treatment for mental health conditions are not compromised by providing coverage under this section; identify any segments of this Commonwealth's population that may be excluded from access to treatment for mental health conditions; and an analysis of the use of medical services resulting from the provision of access to mental health treatment as provided by this section.

(1) The department shall fully cooperate and provide all nonconfidential data, records, reports and information that the committee may request in connection with this study.

(2) The study and report authorized in paragraph (1) must be actuarially sound and subject to peer review by the American Academy of Actuaries. Any assumptions upon which the study and the report are based must be common to the current health insurance market in Pennsylvania.

Section 6. Section 805 of the act is repealed.

Section 7. Section 802-A of the act is amended by adding a definition to read:

Section 802-A. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

* * *

"Person." An individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a similar entity or a combination of the foregoing acting in concert.

* * *

Section 8. Section 803-A of the act, added December 21, 1995 (P.L.714, No.79), is amended to read:

Section 803-A. Adoption of Plan of Conversion.--(a) No plan of conversion shall become effective unless the mutual company seeking to convert to a stock company shall have adopted, by the affirmative vote of not less than two-thirds of its board of directors, a plan of conversion consistent with the requirements of sections 804-A, 805-A and 806-A. At any time before approval of a plan by the commissioner, the mutual company, by the affirmative vote of not less than two-thirds of its board of directors, may amend or withdraw the plan.

(b) Before a mutual company's eligible members may vote on approval of a plan, a mutual company whose board of directors has adopted a plan shall file all of the following documents with the commissioner within ninety (90) days after adoption of the plan:

(1) The plan of conversion, including the independent evaluation of pro forma market value required by section 804-A(d).

(2) The form of notice required by subsection (f).

(3) The form of proxy to be solicited from eligible members pursuant to subsection (g).

(4) The form of notice required by section 809-A to persons whose policies are issued after adoption of the plan but before its effective date.

(5) The proposed amended articles of incorporation and bylaws of the converted stock company.

(6) The acquisition of control statement, as required by section 1402.

(7) Such other information as the commissioner may request. Upon filing of the foregoing documents with the commissioner, the mutual company shall send to eligible members a notice advising eligible members of the adoption and filing of the plan, their

ability to provide the commissioner and the mutual company with comments on the plan within thirty (30) days of the date of such notice and procedure therefor.

(c) [The commissioner shall approve or disapprove the plan by not later than sixty (60) days after the filing of the documents under subsection (b). The commissioner may extend the time for approval or disapproval by an additional sixty (60) days upon written notice to the mutual company.] The commissioner shall immediately give written notice to the mutual company of any decision and, in the event of disapproval, a statement in detail of the reasons for the decision. The commissioner shall approve the plan if the commissioner finds each of the following:

(1) The plan complies with this article.

(2) The plan will not prejudice the interests of the members.

(3) The plan's method of allocating subscription rights is fair and equitable.

(d) The commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing the plan and the independent evaluation of the pro forma market value required under section 804-A(d).

(e) The commissioner may order a hearing on whether the terms of the plan comply with this article after giving written notice to the mutual company and other interested persons, all of whom have the right to appear at the hearing.

(f) All eligible members shall be sent notice of the members' meeting to vote upon the plan. The notice shall briefly but fairly describe the proposed conversion plan, shall inform the member of his right to vote upon the plan and shall be sent to each member's last known address, as shown on the mutual company's records, at least thirty (30) days before the time fixed for the meeting. If the meeting to vote upon the plan is held during the mutual company's annual meeting of policyholders, only a combined notice of meeting is required.

(g) The plan shall be voted upon by eligible members and shall be adopted upon receiving the affirmative vote of at least two-thirds of the votes cast by eligible members. Members entitled to vote upon the proposed plan may vote in person or by proxy. The number of votes each eligible member may cast shall be determined by the mutual company's bylaws. If the bylaws are silent, each eligible member may cast one vote.

(h) The amended articles shall be considered at the meeting of the policyholders called for the purpose of adopting the plan of conversion and shall require for adoption the affirmative vote of at least two-thirds of the votes cast by eligible members.

(i) Documents to be filed following approval.--Within thirty (30) days after the eligible members have approved the plan, the converted stock company shall file both of the following documents with the commissioner:

(1) The minutes of the meeting of the eligible members at which the plan was approved.

(2) The amended articles of incorporation and bylaws of the converted stock company.

Section 9. The act is amended by adding a section to read:

Section 819-A. Prohibition on Acquisitions of Control.--Except as otherwise specifically provided in section 804-A, from the date a plan of conversion is adopted by the board of directors of a mutual insurance company until the effective date of the plan of conversion, no person shall directly or indirectly offer to acquire, make any announcement to acquire or acquire in any manner, including making a filing with the department for such acquisition under a statute or regulation of this Commonwealth, the beneficial ownership of ten per centum (10%) or more of a class of a voting security of

the converted stock company or of a person which controls the voting securities of the converted stock company.

Section 10. Section 1402(f)(1) and (h) of the act, added December 18, 1992 (P.L.1519, No.178), are amended to read:

Section 1402. Acquisition of Control of or Merger with Domestic Insurer.--* * *

(f) (1) The department shall approve any merger or other acquisition of control referred to in subsection (a) unless it finds any of the following:

(i) After the change of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.

(ii) The effect of the merger or other acquisition of control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:

(A) the informational requirements of section 1403(c)(2) and the standards of section 1403(d)(2) shall apply;

(B) the merger or other acquisition shall not be disapproved if the department finds that any of the situations meeting the criteria provided by section 1403(d)(3) exist; and

(C) the department may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time.

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control.

(vi) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(vii) The merger or other acquisition of control is not in compliance with the laws of this Commonwealth, including Article VIII-A.

* * *

(h) The following shall constitute a violation of this section:

(1) the failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b); [or]

(2) the effectuation or any attempt to effectuate an acquisition of control of or merger with a domestic insurer unless the department has given its approval thereto[.]; **or**

(3) a violation of section 819-A.

Section 11. Section 1507 of the act is repealed.

Section 12. The following acts and parts of acts are repealed insofar as they are inconsistent with the addition of Article V-A of the act:

Act of June 11, 1947 (P.L.538, No.246), known as The Casualty and Surety Rate Regulatory Act.

Act of June 11, 1947 (P.L.551, No.247), known as The Fire, Marine and Inland Marine Rate Regulatory Act.

Section 13. (a) The addition of Article V-A of the act shall apply to all forms issued or rates used after the effective date of Article V-A.

(b) The amendment or addition of sections 802-A, 803-A, 819-A and 1402(f)(1) and (h) of the act shall not be applicable to any offer to acquire, announcement to acquire or acquisition of voting securities of a converted stock company, or of any person which controls voting securities of a converted stock company, which converted prior to the effective date of this act or which converts after the effective date of this act pursuant to an application filed in the Insurance Department prior to the effective date of this act.

Section 14. This act shall take effect as follows:

(1) The amendment of sections 300, 802-A, 803-A, 819-A and 1402(f)(1) and (h) of the act shall take effect immediately.

(2) Section 13(b) and this section shall take effect immediately.

(3) The addition of section 635.1 of the act shall take effect in 120 days.

(4) The remainder of this act shall take effect in 60 days.

APPROVED--The 21st day of December, A. D. 1998.

THOMAS J. RIDGE