PRIOR PRINTER'S NO. 3458 PRINTER'S NO. 4076

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2663 Session of 1994

INTRODUCED BY MICOZZIE, GANNON, COLAFELLA, SAYLOR, FAIRCHILD, CESSAR, CAWLEY, M. COHEN, COWELL, HERMAN, FLEAGLE, BUNT, MELIO, M. N. WRIGHT, STABACK, HUTCHINSON, FARMER, MILLER, DEMPSEY, CARONE, ARMSTRONG, FREEMAN, HENNESSEY, SAURMAN, TIGUE, BAKER, MERRY, COLAIZZO, TRELLO, STERN, ADOLPH, PLATTS, E. Z. TAYLOR, RAYMOND, ULIANA, HARLEY, GERLACH, PHILLIPS, O'BRIEN, PERZEL, DeLUCA, YANDRISEVITS, J. TAYLOR, TOMLINSON, REINARD, CONTI, CLARK, STAIRS, DENT, LEH, RUBLEY, THOMAS, CIVERA, LAWLESS, DURHAM, FLICK AND PITTS, APRIL 6, 1994

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, SEPTEMBER 26, 1994

AN ACT

~~Providing for health care insurance continuity and for additional duties of the Insurance Department.~~ <—

PROVIDING FOR CONTINUITY OF HEALTH INSURANCE BENEFITS IN CERTAIN SITUATIONS. <—

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

Section 1. Short title.

This act shall be known and may be cited as the Health Care Insurance Continuity Act.

Section 2. Statement of purpose.

The General Assembly finds and declares as follows:

(1) This Commonwealth is a leader in the country in regard to health care insurance coverage for its residents.

(2) This Commonwealth's free market approach has been successful in providing health insurance to 90% of its

population.

(3) Uninsured statistics are sporadic as people are moving in and out of coverage.

(4) Eliminating preexisting condition exclusions when a person changes insurance coverage and prohibiting cancellation of a policy for any health reason will provide security and peace of mind to Commonwealth citizens and reduce the number of uninsured.

Section 3. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

~~"Coverage."~~ <—

~~(1) Except as provided in paragraph (2), any of the following:~~

~~(i) A health, sickness or accident insurance policy covering hospital, medical or surgical services for individuals, sole proprietorships or employers.~~

~~(ii) A policy which is a subscriber contract or certificate issued by an insurer to cover hospital, medical or surgical services for individuals, sole proprietorships or employers.~~

~~(iii) A subscriber contract or certificate which is issued by an entity to cover hospital, medical or surgical services for employers and which is subject to:~~

~~(A) section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921;~~

~~(B) the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization~~

~~Act;~~

~~(C) the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code;~~

~~(D) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or~~

~~(E) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).~~

~~(iv) An employee welfare benefit plan as defined in section 3 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).~~

~~(v) Plans under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, 100 Stat. 82).~~

~~(vi) Medicare.~~

~~(vii) Medicare supplements.~~

~~(viii) Medicaid.~~

~~(2) The term excludes all of the following:~~

~~(i) Accident-only insurance.~~

~~(ii) Fixed indemnity insurance.~~

~~(iii) Credit insurance.~~

~~(iv) Disability income insurance.~~

~~(v) Supplements to liability insurance.~~

~~(vi) Workers' compensation or similar insurance.~~

~~(vii) Automobile medical payment insurance.~~

~~(viii) Dental insurance.~~

~~(ix) Vision insurance.~~

~~(x) Specified disease insurance.~~

~~(xi) Long-term care insurance.~~

~~"Department." The Insurance Department of the Commonwealth.~~

~~"Eligible individual." A person who:~~

~~(1) had continuous coverage for a period of at least 12 months to a date not more than 60 days prior to the effective date of new, similar coverage for that person; and~~

~~(2) tendered payment of the required premium for continued coverage with the preceding insurer or employer, but the payment was refused by the person's prior insurer or employer. Proof of tendered payment of the required premium to the prior insurer or employer may be required by the succeeding insurer or employer on a form acceptable to them. The employer shall notify an eligible employee of the provisions of this paragraph.~~

~~"Health care supplier." An entity which is organized for the purpose of arranging for the provision of health care services, including, but not limited to, inpatient, outpatient, primary and specialty physician services, diagnostic and emergency care and home health care.~~

~~"Insurer." A health insurance carrier, health maintenance organization, fraternal benefit society, hospital plan, health services plan corporation or health care supplier offering any individual or group health insurance policy, contract, certificate or plan which provides medical coverage on an expense-incurred, service or prepaid basis exclusive of specified disease policies.~~

~~"Similar coverage." Coverage that does not materially differ from another in any of the following respects:~~

~~(1) Type of medical benefits provided.~~

~~(2) Level of medical benefits available based on deductibles, coinsurance and/or copayments.~~

~~(3) Maximum benefits available for specific services.~~

~~(4) Cost containment provisions.~~

~~Section 4. Portability of coverage.~~

~~(a) General rule.--An insurer may not refuse to provide similar coverage to an eligible individual who had previous coverage on the date of application which did not lapse for more than 60 consecutive days during the prior 12-month period. Nothing in this subsection shall require an insurer to provide benefits greater than those provided to a person insured under the prior coverage had it remained in force or to offer coverage not currently offered by the insurer.~~

~~(b) Benefit levels.--Benefits provided under succeeding coverage shall not be less than the benefits provided under the preceding coverage unless the succeeding insurer's coverage does not provide, by rider or otherwise, benefits provided by the preceding coverage. The succeeding insurer shall apply any benefits paid under the preceding similar coverage against the benefit limits of the succeeding coverage and shall credit the eligible individual with any deductibles and copayments to the extent credited under the preceding similar health benefit plan, provided that if the succeeding insurer's similar coverage provides benefits that were not provided by the preceding similar coverage, the additional benefits may be subject to medical underwriting and preexisting condition exclusions to the extent allowed under the insurance laws of this Commonwealth.~~

~~(c) Condition of transacting business.--Beginning on the effective date of this act, every insurer issuing new coverage in this Commonwealth shall, as a condition of transacting business in this Commonwealth, accept tendered payment of the required premium for continued coverage from an eligible individual.~~

~~(d) Application of section.--The requirements of this section shall not apply to an insurer no longer issuing coverage in this Commonwealth.~~

~~Section 5. Guaranteed renewability of coverage.~~

~~An insurer may not cancel or fail to renew coverage, except for any of the following reasons:~~

~~(1) Nonpayment of required premium.~~

~~(2) Fraud or misrepresentation related to an attempt to collect benefits by a person. In case of a group, the failure to renew coverage shall apply only to the individual and any person covered as a spouse or dependent of the individual.~~

~~(3) Noncompliance with the provisions of the policy or plan, including provisions regarding minimum numbers of or percentages of insureds.~~

~~(4) Failure to renew coverage with respect to all individuals and groups within this Commonwealth for whom coverage is provided under similar policies.~~

~~(5) The insurer is determined by the department to be in jeopardy of insolvency.~~

~~Section 6. Exemption.~~

~~Notwithstanding sections 4 and 5, this act shall not be construed to require an insurer to provide coverage for an individual who is a resident of this Commonwealth if all of the following apply:~~

~~(1) The individual is employed outside of this Commonwealth.~~

~~(2) The individual's employer maintains a health insurance policy for the person as an employment benefit.~~

~~Section 7. Regulations.~~

~~The department shall promulgate regulations to administer~~

~~this act. These regulations shall be consistent with the "Group Coverage Discontinuance and Replacement Model Regulation" of the Model Regulation Service (October 1992) of the National Association of Insurance Commissioners.~~

~~Section 8. Severability.~~

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

~~Section 9. Effective date.~~

~~This act shall take effect in 90 days.~~

"GENETIC STATUS." THE PRESENCE OF A PHYSICAL CONDITION IN AN <—
INDIVIDUAL WHICH IS A RESULT OF AN INHERITED TRAIT.

"GROUP HEALTH CONTRACT." A HEALTH INSURANCE AGREEMENT ISSUED BY AN INSURER TO COVER EMPLOYEES OF AN EMPLOYER OR A TRUST FUND ESTABLISHED TO COVER EMPLOYEES OF ONE OR MORE EMPLOYERS AND AN ASSOCIATION OF EMPLOYEES. THE TERM DOES NOT INCLUDE ACCIDENT-ONLY, FIXED INDEMNITY, LIMITED BENEFIT, CREDIT, DENTAL, VISION, GROUP LONG-TERM CARE, GROUP LONG-TERM DISABILITY, MEDICARE SUPPLEMENT, CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES SUPPLEMENT INSURANCE, WORKERS' COMPENSATION OR SIMILAR INSURANCE, OR AUTOMOBILE MEDICAL-PAYMENT INSURANCE.

"HEALTH INSURANCE AGREEMENT." AN ACCIDENT AND HEALTH INSURANCE POLICY, CONTRACT OR GROUP INSURANCE CERTIFICATE ISSUED BY AN INSURER ON AN INDIVIDUAL OR GROUP BASIS.

"INSURER." ANY INSURANCE COMPANY, ASSOCIATION OR RECIPROCAL, NONPROFIT HOSPITAL PLAN CORPORATION; NONPROFIT PROFESSIONAL HEALTH SERVICE PLAN; HEALTH MAINTENANCE ORGANIZATION ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972 (P.L.1701,

NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT; RISK-ASSUMING PREFERRED PROVIDER ORGANIZATION ORGANIZED AND REGULATED UNDER THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921; PREFERRED PROVIDER WITH A "HEALTH MANAGEMENT GATEKEEPER" ROLE FOR PRIMARY CARE PHYSICIANS ORGANIZED AND REGULATED AS A HEALTH SERVICES CORPORATION OR A PREFERRED PROVIDER ORGANIZATION SUBJECT TO THE PROVISIONS OF SECTION 630 OF THE INSURANCE COMPANY LAW OF 1921; FRATERNAL BENEFIT SOCIETY SUBJECT TO THE PROVISIONS OF THE ACT OF DECEMBER 14, 1992 (P.L.835, NO.134), KNOWN AS THE FRATERNAL BENEFIT SOCIETIES CODE.

SECTION 4. CONTINUITY OF COVERAGE.

(A) APPLICABILITY.--THIS SECTION SHALL APPLY TO GROUP HEALTH CONTRACTS ISSUED OR RENEWED BY INSURERS ON OR AFTER THE EFFECTIVE DATE OF THIS ACT.

(B) PERSONS PROTECTED BY THIS SECTION.--THE PROTECTIONS OF THIS SECTION SHALL APPLY TO ANY PERSON WHO SEEKS COVERAGE UNDER OR ENROLLMENT IN A GROUP HEALTH CONTRACT IF ALL OF THE FOLLOWING APPLY:

(1) THE PERSON WAS COVERED UNDER A PRIOR HEALTH INSURANCE AGREEMENT OR WAS COVERED UNDER A GOVERNMENTAL HEALTH FINANCING PROGRAM SUCH AS MEDICAL ASSISTANCE OR MEDICARE FOR AT LEAST 90 DAYS BEFORE DISCONTINUANCE OR TERMINATION OF THE PRIOR HEALTH INSURANCE AGREEMENT. UNDER THIS PARAGRAPH, A DEPENDENT OF AN EMPLOYEE IS COVERED IF THE EMPLOYEE AND THE DEPENDENT WERE COVERED UNDER THE PRIOR HEALTH INSURANCE AGREEMENT.

(2) THE COVERAGE UNDER THE PRIOR HEALTH INSURANCE AGREEMENT OR GOVERNMENTAL PROGRAM TERMINATED NOT MORE THAN THREE MONTHS BEFORE THE PERSON ENROLLED OR WAS ELIGIBLE TO

ENROLL IN THE SUCCEEDING GROUP HEALTH CONTRACT. A PERIOD OF INELIGIBILITY FOR ANY HEALTH INSURANCE AGREEMENT IMPOSED BY TERMS OF EMPLOYMENT MAY NOT BE CONSIDERED IN DETERMINING WHETHER THE COVERAGE ENDED WITHIN THREE MONTHS OF THE DATE THE PERSON ENROLLED OR WAS ELIGIBLE TO ENROLL IN THE GROUP HEALTH CONTRACT.

(C) PROTECTIONS.--AN INSURER MAY NOT DO ANY OF THE FOLLOWING:

(1) REQUEST OR REQUIRE A PERSON PROTECTED BY SUBSECTION (B) TO PROVIDE, OR OTHERWISE SEEK TO OBTAIN EVIDENCE OF, HEALTH OR GENETIC STATUS OR HISTORY AS A CONDITION OF ENROLLING THE PERSON IN A GROUP HEALTH CONTRACT.

(2) DECLINE TO ENROLL A PERSON PROTECTED BY SUBSECTION (B) IN A GROUP HEALTH CONTRACT BASED ON HEALTH OR GENETIC STATUS OR HISTORY IF THE PERSON IS OTHERWISE ELIGIBLE TO BE ENROLLED.

(3) IMPOSE A PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD FOR ANY CONDITION EXCEPT TO THE EXTENT THAT THERE IS A PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD FROM THE PRIOR HEALTH INSURANCE AGREEMENT THAT REMAINS UNEXPIRED. IN THIS EVENT, THE INSURER SHALL CREDIT THE TIME THE PERSON WAS COVERED UNDER THE PREVIOUS HEALTH INSURANCE AGREEMENT, EXCLUSIVE OF ANY APPLICABLE WAITING PERIOD UNDER THAT AGREEMENT.

(D) DETERMINATION OF WAITING PERIOD.--IF A DETERMINATION OF THE EXISTENCE OF A PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD UNDER THE PRIOR HEALTH INSURANCE AGREEMENT IS REQUIRED FOR THE INSURER ISSUING OR ENTERING INTO A SUCCEEDING GROUP HEALTH CONTRACT TO COMPLY WITH THIS SECTION, THE ISSUER OF THE PRIOR HEALTH INSURANCE AGREEMENT SHALL, AT THE REQUEST OF

THE ISSUER OF THE SUCCEEDING GROUP HEALTH CONTRACT, FURNISH A STATEMENT AS TO THE EXISTENCE AND TERMS OF ANY PREEXISTING CONDITION EXCLUSION PERIOD OR WAITING PERIOD UNDER THE PRIOR HEALTH INSURANCE AGREEMENT.

(E) LIMITED LIABILITY AFTER DISCONTINUANCE.--THE INSURER THAT ISSUED THE PRIOR HEALTH INSURANCE AGREEMENT IS LIABLE AFTER DISCONTINUANCE OF THAT HEALTH INSURANCE AGREEMENT ONLY TO THE EXTENT OF ITS ACCRUED LIABILITIES AND EXTENSION OF BENEFITS.

(F) DUPLICATION.--NOTHING IN THIS SECTION SHALL BE CONSTRUED AS REQUIRING AN EMPLOYER OR INSURER ISSUING OR ENTERING INTO A SUCCEEDING GROUP HEALTH CONTRACT TO PROVIDE THE SAME OR SIMILAR TYPE OR EXTENT OF COVERAGE AS THE PRIOR HEALTH INSURANCE AGREEMENT. NOTHING IN THIS SECTION SHALL REQUIRE AN EMPLOYER TO PROVIDE ANY HEALTH INSURANCE TO EMPLOYEES.

SECTION 5. EFFECTIVE DATE.

THIS ACT SHALL TAKE EFFECT IN 180 DAYS.