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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# SENATE BILL

## No. 1335 Session of 2006

INTRODUCED BY ARMSTRONG AND STACK, SEPTEMBER 20, 2006

AS AMENDED ON THIRD CONSIDERATION, HOUSE OF REPRESENTATIVES, OCTOBER 24, 2006

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, IN CASUALTY INSURANCE, FOR POLICY CONDITIONS AND FOR GROUP ACCIDENT AND SICKNESS INSURANCE; PROVIDING, IN CASUALTY INSURANCE, FOR AUTISM SPECTRUM DISORDERS COVERAGE AND FOR TICK-BORNE ILLNESSES; PROVIDING FOR RETROACTIVE DENIAL OF REIMBURSEMENTS; AND further providing, in health care insurance, for individual accessibility, for conversion policies and for sunset. <—

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

~~Section 1. Section 1009-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding a subsection to read:~~ <—

SECTION 1. SECTION 617 OF THE ACT OF MAY 17, 1921 (P.L.682, <—

NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921, REPEALED AND ADDED MAY 25, 1951 (P.L.417, NO.99), AMENDED JANUARY 18, 1968 (1967 P.L.969, NO.433) AND JULY 31, 1968 (P.L.1031, NO.311), IS AMENDED TO READ:

SECTION 617. CONDITIONS SUBJECT TO WHICH POLICIES ARE TO BE ISSUED.--(A) NO SUCH POLICY SHALL BE DELIVERED OR ISSUED FOR DELIVERY TO ANY PERSON IN THIS COMMONWEALTH UNLESS:

(1) THE ENTIRE MONEY AND OTHER CONSIDERATIONS THEREFOR ARE EXPRESSED THEREIN; AND

(2) THE TIME AT WHICH THE INSURANCE TAKES EFFECT AND TERMINATES IS EXPRESSED THEREIN; AND

(3) IT PURPORTS TO INSURE ONLY ONE PERSON, EXCEPT THAT A POLICY MAY INSURE, ORIGINALLY OR BY SUBSEQUENT AMENDMENT, UPON THE APPLICATION OF AN ADULT HEAD OF A FAMILY WHO SHALL BE DEEMED THE POLICYHOLDER, ANY TWO OR MORE ELIGIBLE MEMBERS OF THAT FAMILY, INCLUDING HUSBAND, WIFE, DEPENDENT CHILDREN OR ANY CHILDREN UNDER A SPECIFIED AGE WHICH SHALL NOT EXCEED [NINETEEN] <u>TWENTY-THREE</u> YEARS AND ANY OTHER PERSON DEPENDENT UPON THE POLICYHOLDER; AND

(4) THE STYLE, ARRANGEMENT AND OVER-ALL APPEARANCE OF THE POLICY GIVE NO UNDUE PROMINENCE TO ANY PORTION OF THE TEXT, AND UNLESS EVERY PRINTED PORTION OF THE TEXT OF THE POLICY AND OF ANY ENDORSEMENTS OR ATTACHED PAPERS IS PLAINLY PRINTED IN LIGHT-FACED TYPE OF A STYLE IN GENERAL USE, THE SIZE OF WHICH SHALL BE UNIFORM AND NOT LESS THAN TEN-POINT WITH A LOWER-CASE UNSPACED ALPHABET LENGTH NOT LESS THAN ONE HUNDRED AND TWENTY-POINT (THE "TEXT" SHALL INCLUDE ALL PRINTED MATTER EXCEPT THE NAME AND ADDRESS OF THE INSURER, NAME OR TITLE OF THE POLICY, THE BRIEF DESCRIPTION, IF ANY, AND CAPTIONS AND SUBCAPTIONS); AND

(5) THE EXCEPTIONS AND REDUCTIONS OF INDEMNITY ARE SET FORTH

IN THE POLICY AND, EXCEPT THOSE WHICH ARE SET FORTH IN SECTION SIX HUNDRED EIGHTEEN OF THIS ACT, ARE PRINTED, AT THE INSURER'S OPTION, EITHER INCLUDED WITH THE BENEFIT PROVISION TO WHICH THEY APPLY, OR UNDER AN APPROPRIATE CAPTION SUCH AS "EXCEPTIONS," OR "EXCEPTIONS AND REDUCTIONS": PROVIDED, THAT IF AN EXCEPTION OR REDUCTION SPECIFICALLY APPLIES ONLY TO A PARTICULAR BENEFIT OF THE POLICY, A STATEMENT OF SUCH EXCEPTION OR REDUCTION SHALL BE INCLUDED WITH THE BENEFIT PROVISION TO WHICH IT APPLIES; AND

(6) EACH SUCH FORM, INCLUDING RIDERS AND ENDORSEMENTS, SHALL BE IDENTIFIED BY A FORM NUMBER IN THE LOWER LEFT-HAND CORNER OF THE FIRST PAGE THEREOF; AND

(7) IT CONTAINS NO PROVISION PURPORTING TO MAKE ANY PORTION OF THE CHARTER, RULES, CONSTITUTION, OR BY-LAWS OF THE INSURER A PART OF THE POLICY UNLESS SUCH PORTION IS SET FORTH IN FULL IN THE POLICY, EXCEPT IN THE CASE OF THE INCORPORATION OF, OR REFERENCE TO, A STATEMENT OF RATES OR CLASSIFICATION OF RISKS, OR SHORT-RATE TABLE FILED WITH THE COMMISSIONER; AND

(8) IF SUCH POLICY IS ENTITLED OR REFERRED TO AS "NON-CANCELLABLE," SUCH "NON-CANCELLABLE" POLICY IS AUTOMATICALLY RENEWABLE UNTIL AGE SIXTY UPON PAYMENT OF THE REQUIRED PREMIUMS BY THE INSURED; AND

(9) A POLICY DELIVERED OR ISSUED FOR DELIVERY AFTER JANUARY 1, 1968, UNDER WHICH COVERAGE OF A DEPENDENT OF A POLICYHOLDER TERMINATES AT A SPECIFIED AGE SHALL, WITH RESPECT TO AN UNMARRIED CHILD COVERED BY THE POLICY PRIOR TO THE ATTAINMENT OF THE AGE OF [NINETEEN] TWENTY-THREE WHO IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF MENTAL RETARDATION [OR], PHYSICAL HANDICAP OR RECEIVING TREATMENT FOR DRUG OR ALCOHOL ADDICTION, AND WHO BECAME SO INCAPABLE PRIOR TO ATTAINMENT OF AGE [NINETEEN] TWENTY-THREE AND WHO IS CHIEFLY DEPENDENT UPON

SUCH POLICYHOLDER FOR SUPPORT AND MAINTENANCE, NOT SO TERMINATE WHILE THE POLICY REMAINS IN FORCE AND THE DEPENDENT REMAINS IN SUCH CONDITION, IF THE POLICYHOLDER HAS WITHIN THIRTY-ONE DAYS OF SUCH DEPENDENT'S ATTAINMENT OF THE LIMITING AGE SUBMITTED PROOF OF SUCH DEPENDENT'S INCAPACITY AS DESCRIBED HEREIN. THE FOREGOING PROVISIONS OF THIS PARAGRAPH SHALL NOT REQUIRE AN INSURER TO INSURE A DEPENDENT WHO IS A MENTALLY RETARDED [OR], PHYSICALLY HANDICAPPED CHILD OR RECEIVING TREATMENT FOR DRUG OR ALCOHOL ADDICTION WHERE THE POLICY IS UNDERWRITTEN ON EVIDENCE OF INSURABILITY BASED ON HEALTH FACTORS SET FORTH IN THE APPLICATION OR WHERE SUCH DEPENDENT DOES NOT SATISFY THE CONDITIONS OF THE POLICY AS TO ANY REQUIREMENT FOR EVIDENCE OF INSURABILITY OR OTHER PROVISIONS OF THE POLICY, SATISFACTION OF WHICH IS REQUIRED FOR COVERAGE THEREUNDER TO TAKE EFFECT. IN ANY SUCH CASE THE TERMS OF THE POLICY SHALL APPLY WITH REGARD TO THE COVERAGE OR EXCLUSION FROM COVERAGE OF SUCH DEPENDENT.

(10) EXCEPT FOR A SINGLE PREMIUM NONRENEWABLE POLICY, IT SHALL HAVE PROMINENTLY PRINTED THEREON A NOTICE STATING IN SUBSTANCE THAT THE POLICYHOLDER SHALL BE PERMITTED TO RETURN THE POLICY WITHIN TEN DAYS OF ITS DELIVERY AND TO HAVE THE PREMIUM PAID REFUNDED IF AFTER EXAMINATION OF THE POLICY, THE POLICYHOLDER IS NOT SATISFIED WITH IT FOR ANY REASON. IF A POLICYHOLDER PURSUANT TO SUCH NOTICE, RETURNS THE POLICY TO THE INSURER AT ITS HOME OR BRANCH OFFICE OR TO THE AGENT THROUGH WHOM IT WAS PURCHASED, IT SHALL BE VOID FROM THE BEGINNING AND THE PARTIES SHALL BE IN THE SAME POSITION AS IF NO POLICY HAD BEEN ISSUED.

(B) IF ANY POLICY IS ISSUED BY AN INSURER DOMICILED IN THIS COMMONWEALTH FOR DELIVERY TO A PERSON RESIDING IN ANOTHER STATE, AND IF THE OFFICIAL HAVING RESPONSIBILITY FOR THE ADMINISTRATION

OF THE INSURANCE LAWS OF SUCH OTHER STATE SHALL HAVE ADVISED THE COMMISSIONER THAT ANY SUCH POLICY IS NOT SUBJECT TO APPROVAL OR DISAPPROVAL BY SUCH OFFICIAL, THE COMMISSIONER MAY BY RULING REQUIRE THAT SUCH POLICY MEET THE STANDARDS SET FORTH IN SUBSECTION (A) OF THIS SECTION AND IN SECTION SIX HUNDRED EIGHTEEN.

SECTION 2. SECTION 621.2(A) OF THE ACT, AMENDED FEBRUARY 17, 1994 (P.L.92, NO.9), IS AMENDED TO READ:

SECTION 621.2. GROUP ACCIDENT AND SICKNESS INSURANCE.--(A) GROUP ACCIDENT AND SICKNESS INSURANCE IS HEREBY DECLARED TO BE THAT FORM OF ACCIDENT AND SICKNESS INSURANCE COVERING GROUPS OF PERSONS DEFINED IN THIS SECTION WITH OR WITHOUT ONE OR MORE MEMBERS OF THEIR FAMILIES OR ONE OR MORE OF THEIR DEPENDENTS, OR COVERING ONE OR MORE MEMBERS OF THE FAMILIES OR ONE OR MORE DEPENDENTS OF SUCH GROUPS OR PERSONS AND ISSUED UPON THE FOLLOWING BASIS:

(1) UNDER A POLICY ISSUED TO AN EMPLOYER OR TRUSTEES OF A FUND ESTABLISHED BY AN EMPLOYER, WHO SHALL BE DEEMED THE POLICYHOLDER INSURING AT LEAST TEN EMPLOYES OF SUCH EMPLOYER FOR THE BENEFIT OF PERSONS OTHER THAN THE EMPLOYER. THE TERM "EMPLOYES," AS USED HEREIN, SHALL BE DEEMED TO INCLUDE THE OFFICERS, MANAGERS AND EMPLOYES OF THE EMPLOYER, THE INDIVIDUAL PROPRIETOR OR PARTNER, IF THE EMPLOYER IS AN INDIVIDUAL PROPRIETOR OR PARTNERSHIP, THE OFFICERS, MANAGERS AND EMPLOYES OF SUBSIDIARY OR AFFILIATED CORPORATIONS, THE INDIVIDUAL PROPRIETORS, PARTNERS AND EMPLOYES OF INDIVIDUALS AND FIRMS, IF THE BUSINESS OF THE EMPLOYER AND SUCH INDIVIDUAL OR FIRM IS UNDER COMMON CONTROL THROUGH STOCK OWNERSHIP, CONTRACT OR OTHERWISE. THE TERM "EMPLOYES," AS USED HEREIN, MAY INCLUDE RETIRED EMPLOYES. A POLICY ISSUED TO INSURE EMPLOYES OF A PUBLIC

BODY MAY PROVIDE THAT THE TERM "EMPLOYES" SHALL INCLUDE ELECTED OR APPOINTED OFFICIALS.

(2) UNDER A POLICY ISSUED TO AN ASSOCIATION, INCLUDING A LABOR UNION, WHICH SHALL HAVE A CONSTITUTION AND BY-LAWS AND WHICH HAS BEEN ORGANIZED BY OTHER THAN AN INSURER AND IS MAINTAINED IN GOOD FAITH FOR PURPOSES OTHER THAN THAT OF OBTAINING INSURANCE INSURING AT LEAST TWENTY-FIVE MEMBERS, EMPLOYES OR EMPLOYES OF MEMBERS OF THE ASSOCIATION FOR THE BENEFIT OF PERSONS OTHER THAN THE ASSOCIATION OR ITS OFFICERS OR TRUSTEES, WHICH HAS BEEN IN ACTIVE EXISTENCE FOR AT LEAST TWO YEARS, OPERATES FROM OFFICES OTHER THAN THE INSURER'S AND IS CONTROLLED BY PRINCIPALS OTHER THAN THE INSURER'S. THE TERM "EMPLOYES," AS USED HEREIN, MAY INCLUDE RETIRED EMPLOYES.

(3) UNDER A POLICY ISSUED TO THE TRUSTEES OF A FUND ESTABLISHED BY AN INSURER FOR TWO OR MORE EMPLOYERS OR BY TWO OR MORE EMPLOYERS OR BY AN INSURER FOR ONE OR MORE LABOR UNIONS OR BY ONE OR MORE LABOR UNIONS OR BY AN INSURER FOR ONE OR MORE EMPLOYERS AND ONE OR MORE LABOR UNIONS OR BY ONE OR MORE EMPLOYERS AND ONE OR MORE LABOR UNIONS OR BY AN INSURER FOR ONE OR MORE ASSOCIATIONS MEETING THE QUALIFICATIONS AS DEFINED IN CLAUSE (2) OR BY ONE OR MORE ASSOCIATIONS MEETING THE QUALIFICATIONS AS DEFINED IN CLAUSE (2), WHICH TRUSTEES SHALL BE DEEMED THE POLICYHOLDER TO INSURE EMPLOYES OF THE EMPLOYERS OR MEMBERS OF THE UNIONS OR MEMBERS, EMPLOYES THEREOF AND EMPLOYES OF THE ASSOCIATIONS FOR THE BENEFIT OF PERSONS OTHER THAN THE EMPLOYERS OR THE UNIONS OR THE ASSOCIATIONS. THE TERM "EMPLOYES," AS USED HEREIN, MAY INCLUDE THE OFFICERS, MANAGERS AND EMPLOYES OF THE EMPLOYER AND THE INDIVIDUAL PROPRIETOR OR PARTNERS, IF THE EMPLOYER IS AN INDIVIDUAL PROPRIETOR OR PARTNERSHIP. THE TERM "EMPLOYES," AS USED HEREIN, MAY INCLUDE

RETIRED EMPLOYES. THE POLICY MAY PROVIDE THAT THE TERM "EMPLOYES" SHALL INCLUDE THE TRUSTEES OR THEIR EMPLOYES, OR BOTH, IF THEIR DUTIES ARE PRINCIPALLY CONNECTED WITH SUCH TRUSTEESHIP.

(4) UNDER A POLICY ISSUED TO ANY PERSON OR ORGANIZATION TO WHICH A POLICY OF GROUP LIFE INSURANCE MAY BE ISSUED OR DELIVERED IN THIS COMMONWEALTH TO INSURE ANY CLASS OR CLASSES OF INDIVIDUALS THAT COULD BE INSURED UNDER SUCH GROUP LIFE POLICY.

(5) UNDER A POLICY ISSUED TO COVER ANY OTHER SUBSTANTIALLY SIMILAR GROUP, WHICH IN THE DISCRETION OF THE INSURANCE COMMISSIONER MAY BE SUBJECT TO THE ISSUANCE OF A GROUP ACCIDENT AND SICKNESS POLICY OR CONTRACT.

(5.1) UNDER A POLICY ISSUED TO A GROUP, OTHER THAN ONE DESCRIBED IN CLAUSES (1) THROUGH (5) AND UNDER WHICH THE INSURANCE COMMISSIONER FINDS THAT THE ISSUANCE IS NOT CONTRARY TO THE BEST INTEREST OF THE PUBLIC, THE ISSUANCE WOULD RESULT IN ECONOMIES OF ACQUISITION OR ADMINISTRATION, AND THE BENEFITS ARE REASONABLE IN RELATION TO THE PREMIUMS CHARGED.

(6) A POLICY DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JANUARY 1, 1968 UNDER WHICH COVERAGE OF A DEPENDENT OF AN EMPLOYE OR OTHER MEMBER OF THE INSURED GROUP TERMINATES AT A SPECIFIED AGE SHALL, WITH RESPECT TO AN UNMARRIED CHILD COVERED BY THE POLICY PRIOR TO THE ATTAINMENT OF THE AGE OF [NINETEEN] TWENTY-THREE WHO IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF MENTAL RETARDATION [OR], PHYSICAL HANDICAP OR RECEIVING TREATMENT FOR DRUG OR ALCOHOL ADDICTION AND WHO BECAME SO INCAPABLE PRIOR TO ATTAINMENT OF AGE NINETEEN AND WHO IS CHIEFLY DEPENDENT UPON SUCH EMPLOYE OR MEMBER FOR SUPPORT AND MAINTENANCE, NOT SO TERMINATE WHILE THE INSURANCE OF THE EMPLOYE OR MEMBER REMAINS IN FORCE AND THE DEPENDENT REMAINS IN SUCH

CONDITION, IF THE INSURED EMPLOYE OR MEMBER HAS WITHIN THIRTY-ONE DAYS OF SUCH DEPENDENT'S ATTAINMENT OF THE TERMINATION AGE SUBMITTED PROOF OF SUCH DEPENDENT'S INCAPACITY AS DESCRIBED HEREIN. THE FOREGOING PROVISIONS OF THIS PARAGRAPH SHALL NOT REQUIRE AN INSURER TO INSURE A DEPENDENT WHO IS A MENTALLY RETARDED OR PHYSICALLY HANDICAPPED CHILD OF AN EMPLOYE OR OTHER MEMBER OF THE INSURED GROUP WHERE SUCH DEPENDENT DOES NOT SATISFY THE CONDITIONS OF THE GROUP POLICY AS TO ANY REQUIREMENTS FOR EVIDENCE OF INSURABILITY OR OTHER PROVISIONS AS MAY BE STATED IN THE GROUP POLICY REQUIRED FOR COVERAGE THEREUNDER TO TAKE EFFECT. IN ANY SUCH CASE THE TERMS OF THE POLICY SHALL APPLY WITH REGARD TO THE COVERAGE OR EXCLUSION FROM COVERAGE OF SUCH DEPENDENT.

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SECTION 3. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

SECTION 635.2. AUTISM SPECTRUM DISORDERS COVERAGE.--(A) A HEALTH INSURANCE POLICY DELIVERED, ISSUED, EXECUTED OR RENEWED BY AN INSURER IN THIS COMMONWEALTH ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION SHALL PROVIDE COVERAGE FOR AUTISM SPECTRUM DISORDERS FOR AN INDIVIDUAL LESS THAN 24 YEARS OF AGE AND INCLUDE COVERAGE FOR THE FOLLOWING CARE AND SERVICES:

(1) HABILITATION CARE.

(2) PSYCHIATRIC CARE.

(3) PSYCHOLOGICAL CARE.

(4) REHABILITATION CARE.

(5) RESPITE CARE.

(6) THERAPEUTIC CARE.

(B) COVERAGE PROVIDED UNDER THIS SECTION SHALL BE SUBJECT TO A MAXIMUM OF TWO THOUSAND DOLLARS ($2,000) BENEFIT PER MONTH FOR THE COVERED INDIVIDUAL, ADJUSTED ANNUALLY BY THE AVERAGE

PERCENTAGE INCREASE OR DECREASE OF PRIVATE MEDICAL INSURANCE PREMIUMS EACH YEAR. THIS LIMIT SHALL NOT APPLY TO THE COVERAGE OF OTHER HEALTH CONDITIONS OF THE INDIVIDUAL NOT RELATED TO THE TREATMENT OF AUTISM SPECTRUM DISORDERS.

(C) COVERAGE UNDER THIS SECTION SHALL BE SUBJECT TO COPAYMENT, DEDUCTIBLE AND COINSURANCE PROVISIONS OF A HEALTH INSURANCE POLICY TO THE EXTENT THAT OTHER MEDICAL SERVICES COVERED BY THE POLICY ARE SUBJECT TO THOSE PROVISIONS.

(D) 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.

(E) 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:

(1) "AUTISM SPECTRUM DISORDERS" MEANS ANY OF THE PERVASIVE DEVELOPMENTAL DISORDERS AS DEFINED BY THE MOST RECENT EDITION OF THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM), INCLUDING AUTISTIC DISORDER, RETT'S DISORDER, CHILDHOOD DISINTEGRATIVE DISORDER, ASPERGER'S DISORDER AND PERVASIVE

DEVELOPMENT DISORDER NOT OTHERWISE SPECIFIED.

(2) "HABILITATION CARE" MEANS CARE DESIGNED TO ASSIST INDIVIDUALS IN ACQUIRING, RETAINING AND IMPROVING THE SELF-HELP, SOCIALIZATION AND ADAPTIVE SKILLS NECESSARY TO RESIDE SUCCESSFULLY IN HOME OR COMMUNITY-BASED SETTINGS. HABILITATION CARE MAY BE PROVIDED FOR UP TO 24 HOURS A DAY BASED ON THE NEEDS OF THE INDIVIDUAL RECEIVING THE CARE AND INCLUDES, BUT IS NOT LIMITED TO, HEALTH, SOCIAL OR HOME OR COMMUNITY-BASED SERVICES OR OTHER SERVICES NEEDED TO INSURE THE OPTIMAL FUNCTIONING OF AN INDIVIDUAL IN THE INDIVIDUAL'S HOME OR COMMUNITY-BASED SETTING.

(3) "HEALTH INSURANCE POLICY" MEANS ANY GROUP HEALTH, SICKNESS OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR CERTIFICATE ISSUED BY AN INSURANCE ENTITY SUBJECT TO ONE 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) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS THE "INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT."

(IV) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

(4) "PSYCHIATRIC CARE" MEANS DIRECT OR CONSULTATIVE SERVICES PROVIDED BY A PSYCHIATRIST LICENSED IN THE STATE IN WHICH HE OR SHE PRACTICES.

(5) "PSYCHOLOGICAL CARE" MEANS DIRECT OR CONSULTATIVE SERVICES PROVIDED BY A LICENSED PSYCHOLOGIST IN THE STATE IN WHICH HE OR SHE PRACTICES.

(6) "REHABILITATION CARE" MEANS PROFESSIONAL, COUNSELING AND

GUIDANCE SERVICES AND TREATMENT PROGRAMS THAT ARE NECESSARY TO DEVELOP, MAINTAIN AND RESTORE, TO THE MAXIMUM EXTENT PRACTICABLE, THE FUNCTIONING OF AN INDIVIDUAL.

(7) "RESPITE CARE" MEANS CARE FURNISHED IN RELIEF OF THE PRIMARY CARE-GIVER ON AN INTERMITTENT BASIS FOR A LIMITED PERIOD TO AN INDIVIDUAL WHO RESIDES PRIMARILY IN A PRIVATE RESIDENCE WHEN SUCH CARE WILL HELP THE INDIVIDUAL TO CONTINUE RESIDING IN THE PRIVATE RESIDENCE. THIS TERM SHALL INCLUDE NURSING CARE OR PRIVATE NURSING CARE PROVIDED ON A RESPITE BASIS.

(8) "THERAPEUTIC CARE" MEANS SERVICES PROVIDED BY LICENSED OR CERTIFIED SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS, PHYSICAL THERAPISTS OR BEHAVIORAL HEALTH SPECIALISTS.

SECTION 635.3. TICK-BORNE ILLNESSES.--(A) EXCEPT AS PROVIDED IN SUBSECTION (B), EVERY HEALTH CARE POLICY WHICH, ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION, IS DELIVERED, ISSUED FOR DELIVERY, RENEWED, EXTENDED OR MODIFIED IN THIS COMMONWEALTH BY A HEALTH INSURER MUST COVER PRESCRIBED TREATMENT FOR LYME DISEASE OR RELATED TICK-BORNE ILLNESS IF THE DIAGNOSIS AND TREATMENT PLAN ARE DOCUMENTED IN THE PATIENT'S MEDICAL RECORD, INCLUDING LONG-TERM THERAPIES AND TREATMENT AS PRESCRIBED BY THE PATIENT'S ATTENDING PHYSICIAN.

(B) SUBSECTION (A) SHALL NOT APPLY TO ANY OF THE FOLLOWING TYPES OF INSURANCE:

(1) HOSPITAL INDEMNITY.

(2) ACCIDENT.

(3) SPECIFIED DISEASE.

(4) DISABILITY INCOME.

(5) DENTAL.

(6) VISION.

(7) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED

SERVICES (CHAMPUS) SUPPLEMENT.

(8) MEDICARE SUPPLEMENT.

(9) LONG-TERM CARE.

(10) OTHER LIMITED INSURANCE BENEFIT PLANS.

SECTION 4. THE ACT IS AMENDED BY ADDING AN ARTICLE TO READ:

ARTICLE VI-B

RETROACTIVE DENIAL OF REIMBURSEMENTS

SECTION 601-B. SCOPE OF ARTICLE.

THIS ARTICLE SHALL NOT APPLY TO REIMBURSEMENTS MADE AS PART OF AN ANNUAL CONTRACTED RECONCILIATION OF A RISK-SHARING ARRANGEMENT UNDER AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT.

SECTION 602-B. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ARTICLE SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"CODE." ANY OF THE FOLLOWING CODES:

(1) THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE, AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION.

(2) IF FOR DENTAL SERVICE, THE APPLICABLE CODE ADOPTED BY THE AMERICAN DENTAL ASSOCIATION.

(3) ANOTHER APPLICABLE CODE UNDER AN APPROPRIATE UNIFORM CODING SCHEME USED BY AN INSURER IN ACCORDANCE WITH THIS ARTICLE.

"CODING GUIDELINES." THOSE STANDARDS OR PROCEDURES USED OR APPLIED BY A PAYOR TO DETERMINE THE MOST ACCURATE AND APPROPRIATE CODE OR CODES FOR PAYMENT BY THE PAYOR FOR A SERVICE OR SERVICES.

"FRAUD." THE INTENTIONAL MISREPRESENTATION OR CONCEALMENT OF INFORMATION IN ORDER TO DECEIVE OR MISLEAD.

"HEALTH CARE PROVIDER." A PERSON, CORPORATION, FACILITY,

INSTITUTION OR OTHER ENTITY LICENSED, CERTIFIED OR APPROVED BY THE COMMONWEALTH TO PROVIDE HEALTH CARE OR PROFESSIONAL MEDICAL SERVICES. THE TERM INCLUDES, BUT IS NOT LIMITED TO, A PHYSICIAN, DENTIST, ORTHODONTIST, CHIROPRACTOR, OPTOMETRIST, PROFESSIONAL NURSE, CERTIFIED NURSE-MIDWIFE, PODIATRIST, HOSPITAL, NURSING HOME, AMBULATORY SURGICAL CENTER OR BIRTH CENTER.

"INSURER." AN ENTITY SUBJECT TO ANY OF THE FOLLOWING:

(1) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

(2) THIS ACT.

(3) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

"MEDICAL ASSISTANCE PROGRAM." THE PROGRAM ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

"MEDICARE." THE FEDERAL PROGRAM ESTABLISHED UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395 ET SEQ.).

"REIMBURSEMENT." PAYMENTS MADE TO A HEALTH CARE PROVIDER BY AN INSURER ON EITHER A FEE-FOR-SERVICE, CAPITATED OR PREMIUM BASIS.

SECTION 603-B. RETROACTIVE DENIAL OF REIMBURSEMENT.

(A) GENERAL RULE.--IF AN INSURER RETROACTIVELY DENIES REIMBURSEMENT TO A HEALTH CARE PROVIDER, THE INSURER MAY ONLY:

(1) RETROACTIVELY DENY REIMBURSEMENT FOR SERVICES SUBJECT TO COORDINATION OF BENEFITS WITH ANOTHER INSURER, THE MEDICAL ASSISTANCE PROGRAM OR THE MEDICARE PROGRAM DURING THE 12-MONTH PERIOD AFTER THE DATE THAT THE INSURER PAID THE HEALTH CARE PROVIDER; AND

(2) EXCEPT AS PROVIDED IN PARAGRAPH (1), RETROACTIVELY DENY REIMBURSEMENT DURING A 18-MONTH PERIOD AFTER THE DATE THAT THE INSURER PAID THE HEALTH CARE PROVIDER.

(B) WRITTEN NOTICE.--AN INSURER THAT RETROACTIVELY DENIES REIMBURSEMENT TO A HEALTH CARE PROVIDER UNDER SUBSECTION (A) SHALL PROVIDE THE HEALTH CARE PROVIDER WITH A WRITTEN STATEMENT SPECIFYING THE BASIS FOR THE RETROACTIVE DENIAL. IF THE RETROACTIVE DENIAL OF REIMBURSEMENT RESULTS FROM COORDINATION OF BENEFITS, THE WRITTEN STATEMENT SHALL PROVIDE THE NAME AND ADDRESS OF THE ENTITY ACKNOWLEDGING RESPONSIBILITY FOR PAYMENT OF THE DENIED CLAIM.

SECTION 604-B. EFFECT OF NONCOMPLIANCE.

EXCEPT AS PROVIDED IN SECTION 605-B, AN INSURER THAT DOES NOT COMPLY WITH THE PROVISIONS OF SECTION 603-B MAY NOT RETROACTIVELY DENY REIMBURSEMENT OR ATTEMPT IN ANY MANNER TO RETROACTIVELY COLLECT REIMBURSEMENT ALREADY PAID TO A HEALTH CARE PROVIDER.

SECTION 605-B. FRAUDULENT OR IMPROPERLY CODED INFORMATION.

(A) REASONS FOR DENIAL.--THE PROVISIONS OF SECTION 603-B DO NOT APPLY IF AN INSURER RETROACTIVELY DENIES REIMBURSEMENT TO A HEALTH CARE PROVIDER BECAUSE:

(1) THE INFORMATION SUBMITTED TO THE INSURER WAS FRAUDULENT;

(2) THE INFORMATION SUBMITTED TO THE INSURER WAS IMPROPERLY CODED AND THE INSURER HAS PROVIDED TO THE HEALTH CARE PROVIDER SUFFICIENT INFORMATION REGARDING THE CODING GUIDELINES USED BY THE INSURER AT LEAST 30 DAYS PRIOR TO THE DATE THE SERVICES SUBJECT TO THE RETROACTIVE DENIAL WERE RENDERED; OR

(3) THE CLAIM SUBMITTED TO THE INSURER WAS A DUPLICATE

CLAIM.

(B) IMPROPER CODING.--INFORMATION SUBMITTED TO THE INSURER MAY BE CONSIDERED TO BE IMPROPERLY CODED UNDER SUBSECTION (A)(2) IF THE INFORMATION SUBMITTED TO THE INSURER BY THE HEALTH CARE PROVIDER:

(1) USES CODES THAT DO NOT CONFORM WITH THE CODING GUIDELINES USED BY THE CARRIER APPLICABLE AS OF THE DATE THE SERVICE OR SERVICES WERE RENDERED; OR

(2) DOES NOT OTHERWISE CONFORM WITH THE CONTRACTUAL OBLIGATIONS OF THE HEALTH CARE PROVIDER TO THE INSURER APPLICABLE AS OF THE DATE THE SERVICE OR SERVICES WERE RENDERED.

SECTION 606-B. COORDINATION OF BENEFITS.

IF AN INSURER RETROACTIVELY DENIES REIMBURSEMENT FOR SERVICES AS A RESULT OF COORDINATION OF BENEFITS UNDER PROVISIONS OF SECTION 605-B(A), THE HEALTH CARE PROVIDER SHALL HAVE SIX MONTHS FROM THE DATE OF THE DENIAL, UNLESS AN INSURER PERMITS A LONGER TIME PERIOD, TO SUBMIT A CLAIM FOR REIMBURSEMENT FOR THE SERVICE TO THE INSURER, THE MEDICAL ASSISTANCE PROGRAM OR MEDICARE PROGRAM RESPONSIBLE FOR PAYMENT.

SECTION 5. SECTION 1009-A OF THE ACT IS AMENDED BY ADDING A SUBSECTION TO READ:

Section 1009-A. Conversion Policies.--* * *

(c) The premium rate for an individual who purchases a conversion policy that is also offered by an insurer on a guaranteed issue basis in the individual health insurance market in this Commonwealth shall be the same as the premium rate charged for that policy in the individual market. This premium rate shall be subject to review by the department as set forth in applicable statutes and regulations. Any insurer utilizing

this option shall notify the department.

Section ~~2~~ 6. Section 1012-A of the act, amended December 23, 2003 (P.L.358, No.50), is amended to read: <—

[Section 1012-A. Expiration.--This article shall expire on December 31, 2006.]

Section ~~3~~ 7. This act shall take effect immediately. <—