

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1251 Session of 2009

INTRODUCED BY D. COSTA, BARRAR, BRADFORD, BRENNAN, CALTAGIRONE, CASORIO, COHEN, CONKLIN, DEASY, DeLUCA, FREEMAN, GEORGE, GOODMAN, GRUCELA, HALUSKA, HARKINS, HENNESSEY, JOSEPHS, MAHONEY, MANN, MELIO, M. O'BRIEN, PASHINSKI, READSHAW, SIPTROTH, K. SMITH, SOLOBAY, J. TAYLOR, VULAKOVICH, WALKO, BELFANTI, FRANKEL, SEIP, KORTZ AND MATZIE, APRIL 13, 2009

SENATOR D. WHITE, BANKING AND INSURANCE, IN SENATE, AS AMENDED, JUNE 8, 2010

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," PROVIDING FOR MINIMUM NUMBER OF
12 COVERED EMPLOYEES; FURTHER PROVIDING FOR DUTIES OF INSURERS
13 AND INSURANCE PRODUCERS, FOR INVESTMENT, FOR GROUP ACCIDENT
14 AND SICKNESS INSURANCE AND FOR MINI-COBRA SMALL EMPLOYER
15 GROUP HEALTH POLICIES; PROVIDING FOR CONTINUATION OF COVERAGE
16 REINSTATEMENT; in long-term care, further providing for
17 definitions; and providing for appealing an insurer's
18 determination the benefit trigger is not met, for prompt
19 payment of clean claims and for applicability.

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

22 ~~Section 1. The definition of "long term care insurance" in~~
23 ~~section 1103 of the act of May 17, 1921 (P.L.682, No.284), known~~

~~as The Insurance Company Law of 1921, amended July 17, 2007~~
~~(P.L.134, No.40) is amended and the section is amended by adding~~
~~definitions to read:~~

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 354.6. MINIMUM NUMBER OF COVERED EMPLOYES.--ANY
POLICY OF GROUP LIFE INSURANCE ISSUED PURSUANT TO SECTION 2 OF
THE ACT OF MAY 11, 1949 (P.L.1210, NO.367), REFERRED TO AS THE
GROUP LIFE INSURANCE POLICY LAW, AND ANY POLICY OF GROUP
ACCIDENT AND HEALTH INSURANCE ISSUED PURSUANT TO SECTION 621.2
SHALL COVER AT LEAST TWO OR MORE EMPLOYEES AT THE DATE OF ISSUE.

SECTION 2. SECTION 404.2(12) AND (13) OF THE ACT, ADDED JUNE
11, 1986 (P.L.226, NO.64), ARE AMENDED TO READ:

SECTION 404.2. INVESTMENT.--SUBJECT TO THE PROVISIONS OF
SECTIONS 405.2 AND 406.1, THE ASSETS OF ANY LIFE INSURANCE
COMPANY ORGANIZED UNDER THE LAWS OF THIS COMMONWEALTH SHALL BE
INVESTED IN THE FOLLOWING CLASSES OF INVESTMENT, PROVIDED THE
VALUE OF WHICH, AS DETERMINED FOR ANNUAL STATEMENT PURPOSES, BUT
IN NO EVENT IN EXCESS OF COST, SHALL NOT EXCEED THE SPECIFIED
PERCENTAGE OF SUCH COMPANY'S ASSETS AS OF THE THIRTY-FIRST DAY
OF DECEMBER NEXT PRECEDING THE DATE OF INVESTMENT:

* * *

[(12) PUT OPTIONS AND CALL OPTIONS. THE INVESTMENT PRACTICE
OF PUT OPTIONS AND CALL OPTIONS ISSUED UNDER TERMS AND
CONDITIONS REGULATED BY, OR SUBSTANTIALLY SIMILAR TO THOSE TERMS
AND CONDITIONS REQUIRED BY, A NATIONAL SECURITIES EXCHANGE
REGISTERED UNDER THE SECURITIES EXCHANGE ACT OF 1934 (48 STAT.
881, 15 U.S.C. § 78A ET SEQ.), AS AMENDED, OR ANY BOARD OF TRADE
DESIGNATED AS A CONTRACT MARKET BY THE COMMODITY FUTURES TRADING

COMMISSION (CFTC) UNDER THE COMMODITY EXCHANGE ACT (49 STAT. 1491, 7 U.S.C. § 1 ET SEQ.), AS AMENDED, IS AUTHORIZED ON THE FOLLOWING CONDITIONS:

(I) A COMPANY SHALL NOT SELL A CALL OPTION ON EITHER:

(A) SECURITIES IT DOES NOT OWN; OR

(B) IN AN AMOUNT GREATER THAN SECURITIES WHICH IT PRESENTLY OWNS: PROVIDED, HOWEVER, THAT IN THE CASE OF FINANCIAL FUTURES CONTRACTS AND STOCK OR BOND INDEX CONTRACTS WHERE IT IS NOT FEASIBLE TO OWN THE UNDERLYING SECURITY, A COMPANY MAY SELL A CALL OPTION ONLY IN CONNECTION WITH A HEDGING TRANSACTION;

(II) A COMPANY SHALL NOT SELL A PUT OPTION UNLESS ITS OBLIGATIONS UNDER SUCH PUT OPTION ARE FULLY SECURED BY A DEPOSIT BY THE COMPANY WITH A BANK OR OTHER CUSTODIAN OF CASH OR CASH EQUIVALENTS;

(III) A COMPANY SHALL NOT PURCHASE AS OPENING TRANSACTIONS UNDER THIS CLAUSE (12) MORE THAN TEN PER CENTUM (10%) OF THE EXCESS OF ITS CAPITAL AND SURPLUS OVER THE MINIMUM REQUIREMENTS OF A NEW STOCK OR MUTUAL COMPANY TO QUALIFY FOR A CERTIFICATE OF AUTHORITY TO WRITE THE KIND OF INSURANCE WHICH THE COMPANY IS AUTHORIZED TO WRITE; AND

(IV) THE INSURANCE COMMISSIONER MAY PROMULGATE REASONABLE RULES AND REGULATIONS FOR TRANSACTIONS UNDER THIS CLAUSE (12), TO INCLUDE, BUT NOT BE LIMITED TO, RULES AND REGULATIONS WHICH IMPOSE FINANCIAL SOLVENCY STANDARDS, VALUATION STANDARDS AND REPORTING REQUIREMENTS.

(13) THE INVESTMENT PRACTICE OF FINANCIAL FUTURES CONTRACTS ISSUED UNDER TERMS AND CONDITIONS REGULATED BY A FEDERAL REGULATORY AGENCY IS AUTHORIZED ON THE FOLLOWING CONDITIONS:

(I) A COMPANY SHALL NOT ENTER INTO FINANCIAL FUTURES CONTRACTS EXCEPT AS A HEDGING TRANSACTION AS THAT TERM IS

1 DEFINED IN A RULE OR REGULATION PROMULGATED PURSUANT TO THIS
2 ACT;

3 (II) A COMPANY SHALL NOT HAVE INITIAL OR MAINTENANCE MARGIN
4 OUTSTANDING UNDER THIS SECTION OF MORE THAN TEN PER CENTUM (10%)
5 OF THE EXCESS OF ITS CAPITAL AND SURPLUS OVER THE MINIMUM
6 REQUIREMENTS OF A NEW STOCK OR MUTUAL COMPANY TO QUALIFY FOR A
7 CERTIFICATE OF AUTHORITY TO WRITE THE KIND OF INSURANCE WHICH
8 THE COMPANY IS AUTHORIZED TO WRITE; AND

9 (III) THE INSURANCE COMMISSIONER MAY PROMULGATE REASONABLE
10 RULES AND REGULATIONS FOR TRANSACTIONS UNDER THIS CLAUSE (13),
11 TO INCLUDE, BUT NOT BE LIMITED TO, RULES AND REGULATIONS WHICH
12 IMPOSE FINANCIAL SOLVENCY STANDARDS, VALUATION STANDARDS AND
13 REPORTING REQUIREMENTS.]

14 (12) DERIVATIVE TRANSACTIONS. AN INSURER MAY, DIRECTLY OR
15 INDIRECTLY THROUGH AN INVESTMENT SUBSIDIARY, ENGAGE IN
16 DERIVATIVE TRANSACTIONS UNDER THIS SECTION UNDER THE CONDITIONS
17 SET FORTH IN THIS SECTION.

18 (I) GENERAL CONDITIONS:

19 (A) AN INSURER MAY USE DERIVATIVE INSTRUMENTS UNDER THIS
20 SECTION TO ENGAGE IN HEDGING TRANSACTIONS AND CERTAIN INCOME
21 GENERATION TRANSACTIONS, AS THESE TERMS MAY BE FURTHER DEFINED
22 IN REGULATIONS PROMULGATED BY THE INSURANCE COMMISSIONER.

23 (B) AN INSURER SHALL BE ABLE TO DEMONSTRATE TO THE INSURANCE
24 COMMISSIONER THE INTENDED HEDGING CHARACTERISTICS AND THE
25 ONGOING EFFECTIVENESS OF THE DERIVATIVE TRANSACTION OR
26 COMBINATION OF THE TRANSACTIONS THROUGH CASH FLOW TESTING OR
27 OTHER APPROPRIATE ANALYSES.

28 (II) LIMITATIONS ON HEDGING TRANSACTIONS. AN INSURER MAY
29 ENTER INTO HEDGING TRANSACTIONS UNDER THIS SECTION IF, AS A
30 RESULT OF AND AFTER GIVING EFFECT TO THE TRANSACTION:

1 (A) THE AGGREGATE STATEMENT VALUE OF OPTIONS, CAPS, FLOORS
2 AND WARRANTS NOT ATTACHED TO ANOTHER FINANCIAL INSTRUMENT
3 PURCHASED AND USED IN HEDGING TRANSACTIONS DOES NOT EXCEED SEVEN
4 AND ONE-HALF PER CENTUM (7.5%) OF ITS ADMITTED ASSETS;

5 (B) THE AGGREGATE STATEMENT VALUE OF OPTIONS, CAPS AND
6 FLOORS WRITTEN IN HEDGING TRANSACTIONS DOES NOT EXCEED THREE PER
7 CENTUM (3%) OF ITS ADMITTED ASSETS; AND

8 (C) THE AGGREGATE POTENTIAL EXPOSURE OF COLLARS, SWAPS,
9 FORWARDS AND FUTURES USED IN HEDGING TRANSACTIONS DOES NOT
10 EXCEED SIX AND ONE-HALF PER CENTUM (6.5%) OF ITS ADMITTED
11 ASSETS.

12 (III) LIMITATIONS ON INCOME GENERATION TRANSACTIONS. AN
13 INSURER MAY ENTER INTO THE FOLLOWING TYPES OF INCOME GENERATION
14 TRANSACTIONS ONLY IF, AS A RESULT OF, AND AFTER GIVING EFFECT TO
15 THE TRANSACTIONS, THE AGGREGATE STATEMENT VALUE OF THE FIXED
16 INCOME ASSETS THAT ARE SUBJECT TO CALL OR THAT GENERATE THE CASH
17 FLows FOR PAYMENTS UNDER THE CAPS OR FLOORS, PLUS THE FACE VALUE
18 OF FIXED INCOME SECURITIES UNDERLYING A DERIVATIVE INSTRUMENT
19 SUBJECT TO CALL, PLUS THE AMOUNT OF THE PURCHASE OBLIGATIONS
20 UNDER THE PUTS, DOES NOT EXCEED TEN PER CENTUM (10%) OF ITS
21 ADMITTED ASSETS:

22 (A) SALES OF COVERED CALL OPTIONS ON NONCALLABLE FIXED
23 INCOME SECURITIES, CALLABLE FIXED INCOME SECURITIES IF THE
24 OPTION EXPIRES BY ITS TERMS PRIOR TO THE END OF THE NONCALLABLE
25 PERIOD OR DERIVATIVE INSTRUMENTS BASED ON FIXED INCOME
26 SECURITIES;

27 (B) SALES OF COVERED CALL OPTIONS ON EQUITY SECURITIES, IF
28 THE INSURER HOLDS IN ITS PORTFOLIO, OR CAN IMMEDIATELY ACQUIRE
29 THROUGH THE EXERCISE OF OPTIONS, WARRANTS OR CONVERSION RIGHTS
30 ALREADY OWNED, THE EQUITY SECURITIES SUBJECT TO CALL DURING THE

1 COMPLETE TERM OF THE CALL OPTION SOLD;

2 (C) SALES OF COVERED PUTS ON INVESTMENTS THAT THE INSURER IS
3 PERMITTED TO ACQUIRE UNDER THIS SECTION, IF THE INSURER HAS
4 ESCROWED OR ENTERED INTO A CUSTODIAN AGREEMENT SEGREGATING CASH
5 OR CASH EQUIVALENTS WITH A MARKET VALUE EQUAL TO THE AMOUNT OF
6 ITS PURCHASE OBLIGATIONS UNDER THE PUT DURING THE COMPLETE TERM
7 OF THE PUT OPTIONS SOLD; OR

8 (D) SALES OF COVERED CAPS OR FLOORS, IF THE INSURER HOLDS IN
9 ITS PORTFOLIO THE INVESTMENTS GENERATING THE CASH FLOW TO MAKE
10 THE REQUIRED PAYMENTS UNDER THE CAPS OR FLOORS DURING THE
11 COMPLETE TERM THAT THE CAP OR FLOOR IS OUTSTANDING.

12 (IV) COUNTERPARTY EXPOSURE. AN INSURER SHALL INCLUDE ALL
13 COUNTERPARTY EXPOSURE AMOUNTS IN DETERMINING COMPLIANCE WITH THE
14 LIMITATIONS OF CLAUSE (13).

15 (V) ADDITIONAL TRANSACTIONS. ADDITIONAL TRANSACTIONS MAY BE
16 APPROVED INVOLVING THE USE OF DERIVATIVE INSTRUMENTS IN EXCESS
17 OF THE LIMITS OF SUBCLAUSE (II) OR FOR OTHER RISK MANAGEMENT
18 PURPOSES UNDER REGULATIONS PROMULGATED BY THE INSURANCE
19 COMMISSIONER, BUT REPLICATION TRANSACTIONS SHALL NOT BE
20 PERMITTED FOR OTHER THAN RISK MANAGEMENT PURPOSES.

21 (VI) DEFINITIONS:

22 (A) "CALL OPTION" MEANS AN AGREEMENT GIVING A RIGHT TO BUY
23 OR RECEIVE AN INTEREST BASED ON THE ACTUAL OR EXPECTED PRICE,
24 LEVEL, PERFORMANCE OR VALUE OF ONE OR MORE UNDERLYING INTERESTS.

25 (B) "CAP" MEANS AN AGREEMENT OBLIGATING A SELLER TO MAKE
26 PAYMENTS TO A BUYER, WITH EACH PAYMENT BASED ON THE AMOUNT BY
27 WHICH A REFERENCE PRICE OR LEVEL OR THE PERFORMANCE OR VALUE OF
28 ONE OR MORE UNDERLYING INTERESTS EXCEEDS A PREDETERMINED NUMBER,
29 SOMETIMES CALLED THE "STRIKE RATE" OR "STRIKE PRICE."

30 (C) "COLLAR" MEANS AN AGREEMENT TO RECEIVE PAYMENTS AS THE

BUYER OF AN OPTION, CAP OR FLOOR AND TO MAKE PAYMENTS AS THE
SELLER OF A DIFFERENT OPTION, CAP OR FLOOR.

(D) "COUNTERPARTY EXPOSURE AMOUNT" MEANS:

(I) THE NET AMOUNT OF CREDIT RISK ATTRIBUTABLE TO A
DERIVATIVE INSTRUMENT ENTERED INTO WITH A BUSINESS ENTITY OTHER
THAN AN OVER-THE-COUNTER DERIVATIVE INSTRUMENT. THE AMOUNT OF
CREDIT RISK EQUALS:

(A) THE MARKET VALUE OF THE OVER-THE-COUNTER DERIVATIVE
INSTRUMENT IF THE LIQUIDATION OF THE DERIVATIVE INSTRUMENT WOULD
RESULT IN A FINAL CASH PAYMENT TO THE INSURER; OR

(B) ZERO IF THE LIQUIDATION OF THE DERIVATIVE INSTRUMENT
WOULD NOT RESULT IN A FINAL CASH PAYMENT TO THE INSURER.

(II) IF OVER-THE-COUNTER DERIVATIVE INSTRUMENTS ARE ENTERED
INTO UNDER A WRITTEN MASTER AGREEMENT THAT PROVIDES FOR NETTING
OF PAYMENTS OWED BY THE RESPECTIVE PARTIES, AND THE DOMICILIARY
JURISDICTION OF THE COUNTERPARTY IS EITHER WITHIN THE UNITED
STATES OR, IF NOT WITHIN THE UNITED STATES, WITHIN A FOREIGN
JURISDICTION LISTED IN THE PURPOSES AND PROCEDURES OF THE
SECURITIES VALUATION OFFICE OF THE NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS AS ELIGIBLE FOR NETTING, THE AMOUNT OF
CREDIT RISK SHALL BE THE GREATER OF ZERO OR THE NET SUM OF:

(A) THE MARKET VALUE OF THE OVER-THE-COUNTER DERIVATIVE
INSTRUMENTS ENTERED INTO UNDER THE AGREEMENT, THE LIQUIDATION OF
WHICH WOULD RESULT IN A FINAL CASH PAYMENT TO THE INSURER; AND

(B) THE MARKET VALUE OF THE OVER-THE-COUNTER DERIVATIVE
INSTRUMENTS ENTERED INTO UNDER THE AGREEMENT, THE LIQUIDATION OF
WHICH WOULD RESULT IN A FINAL CASH PAYMENT BY THE INSURER TO THE
BUSINESS ENTITY.

(III) FOR OPEN TRANSACTIONS, MARKET VALUE SHALL BE
DETERMINED AT THE END OF THE MOST RECENT QUARTER OF THE

INSURER'S FISCAL YEAR AND SHALL BE REDUCED BY THE MARKET VALUE
OF ACCEPTABLE COLLATERAL HELD BY THE INSURER OR PLACED IN ESCROW
BY ONE OR BOTH PARTIES.

(E) "COVERED" MEANS THAT AN INSURER OWNS OR CAN IMMEDIATELY
ACQUIRE, THROUGH THE EXERCISE OF OPTIONS, WARRANTS OR CONVERSION
RIGHTS ALREADY OWNED, THE UNDERLYING INTEREST IN ORDER TO
FULFILL OR SECURE ITS OBLIGATIONS UNDER A CALL OPTION, CAP OR
FLOOR IT HAS WRITTEN, OR HAS SET ASIDE UNDER A CUSTODIAL OR
ESCROW AGREEMENT CASH OR CASH EQUIVALENTS WITH A MARKET VALUE
EQUAL TO THE AMOUNT REQUIRED TO FULFILL ITS OBLIGATIONS UNDER A
PUT OPTION IT HAS WRITTEN, IN AN INCOME GENERATION TRANSACTION.

(F) "DERIVATIVE INSTRUMENT" MEANS AN AGREEMENT, OPTION,
INSTRUMENT OR A SERIES OR COMBINATION OF AGREEMENTS, OPTIONS OR
INSTRUMENTS:

(I) TO MAKE OR TAKE DELIVERY OF, OR ASSUME OR RELINQUISH, A
SPECIFIED AMOUNT OF ONE OR MORE UNDERLYING INTERESTS, OR TO MAKE
A CASH SETTLEMENT IN LIEU THEREOF; OR

(II) THAT HAS A PRICE, PERFORMANCE, VALUE OR CASH FLOW BASED
PRIMARILY UPON THE ACTUAL OR EXPECTED PRICE, LEVEL, PERFORMANCE,
VALUE OR CASH FLOW OF ONE OR MORE UNDERLYING INTERESTS.

(G) "DERIVATIVE TRANSACTION" MEANS A TRANSACTION INVOLVING
THE USE OF ONE OR MORE DERIVATIVE INSTRUMENTS.

(H) "FLOOR" MEANS AN AGREEMENT OBLIGATING A SELLER TO MAKE
PAYMENTS TO A BUYER IN WHICH EACH PAYMENT IS BASED ON THE AMOUNT
THAT A PREDETERMINED NUMBER, SOMETIMES CALLED THE "FLOOR RATE"
OR "FLOOR PRICE," EXCEEDS A REFERENCE PRICE, LEVEL, PERFORMANCE
OR VALUE OF ONE OR MORE UNDERLYING INTERESTS.

(I) "FORWARD" MEANS AN AGREEMENT, OTHER THAN A FUTURE, TO
MAKE OR TAKE DELIVERY OF, OR EFFECT A CASH SETTLEMENT BASED ON
THE ACTUAL OR EXPECTED PRICE, LEVEL, PERFORMANCE OR VALUE OF,

1 ONE OR MORE UNDERLYING INTERESTS.

2 (J) "FUTURE" MEANS AN AGREEMENT, TRADED ON A QUALIFIED
3 EXCHANGE OR QUALIFIED FOREIGN EXCHANGE, TO MAKE OR TAKE DELIVERY
4 OF, OR EFFECT A CASH SETTLEMENT BASED ON THE ACTUAL OR EXPECTED
5 PRICE, LEVEL, PERFORMANCE OR VALUE OF, ONE OR MORE UNDERLYING
6 INTERESTS.

7 (K) "HEDGING TRANSACTION" MEANS A DERIVATIVE TRANSACTION
8 THAT IS ENTERED INTO AND MAINTAINED TO REDUCE:

9 (I) THE RISK OF A CHANGE IN THE VALUE, YIELD, PRICE, CASH
10 FLOW OR QUANTITY OF ASSETS OR LIABILITIES THAT THE INSURER HAS
11 ACQUIRED OR INCURRED OR ANTICIPATES ACQUIRING OR INCURRING; OR

12 (II) THE CURRENCY EXCHANGE RATE RISK OR THE DEGREE OF
13 EXPOSURE AS TO ASSETS OR LIABILITIES THAT AN INSURER HAS
14 ACQUIRED OR INCURRED OR ANTICIPATES ACQUIRING OR INCURRING.

15 (L) "INCOME GENERATION TRANSACTION" MEANS A DERIVATIVE
16 TRANSACTION INVOLVING THE WRITING OF COVERED CALL OPTIONS,
17 COVERED PUT OPTIONS, COVERED CAPS OR COVERED FLOORS THAT IS
18 INTENDED TO GENERATE INCOME OR ENHANCE RETURN.

19 (M) "INVESTMENT SUBSIDIARY" MEANS A SUBSIDIARY OF AN INSURER
20 ENGAGED OR ORGANIZED TO ENGAGE EXCLUSIVELY IN THE OWNERSHIP AND
21 MANAGEMENT OF ASSETS AUTHORIZED AS INVESTMENTS FOR THE INSURER
22 IF THE SUBSIDIARY AGREES TO LIMIT ITS INVESTMENT IN ANY ASSET SO
23 THAT ITS INVESTMENT WILL NOT CAUSE THE AMOUNT OF THE TOTAL
24 INVESTMENT OF THE INSURER TO EXCEED ANY OF THE INVESTMENT
25 LIMITATIONS OR VIOLATE ANY OTHER PROVISION APPLICABLE TO THE
26 INSURER. AS USED IN THIS DEFINITION, THE TOTAL INVESTMENT OF THE
27 INSURER SHALL INCLUDE:

28 (I) DIRECT INVESTMENT BY THE INSURER IN AN ASSET; AND

29 (II) THE INSURER'S PROPORTIONATE SHARE OF AN INVESTMENT IN
30 AN ASSET BY AN INVESTMENT SUBSIDIARY OF THE INSURER, WHICH SHALL

1 BE CALCULATED BY MULTIPLYING THE AMOUNT OF THE SUBSIDIARY'S
2 INVESTMENT BY THE PERCENTAGE OF THE INSURER'S OWNERSHIP INTEREST
3 IN THE SUBSIDIARY.

4 (N) "OPTION" MEANS AN AGREEMENT GIVING A RIGHT TO BUY OR
5 RECEIVE, SELL OR DELIVER, ENTER INTO, EXTEND OR TERMINATE OR
6 EFFECT A CASH SETTLEMENT BASED ON THE ACTUAL OR EXPECTED PRICE,
7 LEVEL, PERFORMANCE OR VALUE OF ONE OR MORE UNDERLYING INTERESTS.

8 (O) "OVER-THE-COUNTER DERIVATIVE INSTRUMENT" MEANS A
9 DERIVATIVE INSTRUMENT ENTERED INTO THROUGH A QUALIFIED EXCHANGE,
10 QUALIFIED FOREIGN EXCHANGE OR CLEARED THROUGH A QUALIFIED
11 CLEARINGHOUSE.

12 (P) "PUT OPTION" MEANS AN AGREEMENT GIVING A RIGHT TO SELL
13 OR DELIVER AN INTEREST BASED ON THE ACTUAL OR EXPECTED PRICE,
14 LEVEL, PERFORMANCE OR VALUE OF ONE OR MORE UNDERLYING INTERESTS.

15 (Q) "REPLICATION TRANSACTION" MEANS A DERIVATIVE TRANSACTION
16 THAT IS INTENDED TO REPLICATE THE PERFORMANCE OF ONE OR MORE
17 ASSETS THAT AN INSURER IS AUTHORIZED TO ACQUIRE UNDER THIS
18 ARTICLE. A DERIVATIVE TRANSACTION THAT IS ENTERED INTO AS A
19 HEDGING TRANSACTION SHALL NOT BE CONSIDERED A REPLICATION
20 TRANSACTION.

21 (R) "SWAP" MEANS AN AGREEMENT TO EXCHANGE OR TO NET PAYMENTS
22 AT ONE OR MORE TIMES BASED ON THE ACTUAL OR EXPECTED PRICE,
23 LEVEL, PERFORMANCE OR VALUE OF ONE OR MORE UNDERLYING INTERESTS.

24 (S) "WARRANT" MEANS AN INSTRUMENT THAT GIVES THE HOLDER THE
25 RIGHT TO PURCHASE AN UNDERLYING FINANCIAL INSTRUMENT AT A GIVEN
26 PRICE AND TIME OR AT A SERIES OF PRICES AND TIMES OUTLINED IN
27 THE WARRANT AGREEMENT. WARRANTS MAY BE ISSUED ALONE OR IN
28 CONNECTION WITH THE SALE OF OTHER SECURITIES, FOR EXAMPLE, AS
29 PART OF A MERGER OR RECAPITALIZATION AGREEMENT, OR TO FACILITATE
30 DIVESTITURE OF THE SECURITIES OF ANOTHER BUSINESS ENTITY.

1 (13) GENERAL THREE PER CENTUM (3%) DIVERSIFICATION.

2 (I) EXCEPT AS OTHERWISE SPECIFIED IN THIS SECTION, AN
3 INSURER SHALL NOT ACQUIRE, DIRECTLY OR INDIRECTLY THROUGH AN
4 INVESTMENT SUBSIDIARY, AN INVESTMENT UNDER THIS SECTION IF, AS A
5 RESULT OF AND AFTER GIVING EFFECT TO THE INVESTMENT, THE INSURER
6 WOULD HOLD MORE THAN THREE PER CENTUM (3%) OF ITS ADMITTED
7 ASSETS IN INVESTMENTS OF ALL KINDS ISSUED, ASSUMED, ACCEPTED,
8 INSURED OR GUARANTEED BY A SINGLE PERSON, OR FIVE PER CENTUM
9 (5%) OF ITS ADMITTED ASSETS IN INVESTMENT IN THE VOTING
10 SECURITIES OF A DEPOSITORY INSTITUTION OR ANY COMPANY THAT
11 CONTROLS THE INSTITUTION.

12 (II) THE THREE PER CENTUM (3%) LIMITATION UNDER SUBCLAUSE
13 (I) SHALL NOT APPLY TO THE AGGREGATE AMOUNTS INSURED BY A SINGLE
14 FINANCIAL GUARANTY INSURER WITH THE HIGHEST GENERIC RATING
15 ISSUED BY A NATIONALLY RECOGNIZED STATISTICAL RATING
16 ORGANIZATION.

17 (III) ASSET-BACKED SECURITIES SHALL NOT BE SUBJECT TO THE
18 LIMITATIONS OF SUBCLAUSE (I), BUT AN INSURER SHALL NOT ACQUIRE
19 AN ASSET-BACKED SECURITY IF, AS A RESULT OF AN AFTER GIVING
20 EFFECT TO THE INVESTMENT, THE AGGREGATE AMOUNT OF ASSET-BACKED
21 SECURITIES SECURED BY OR EVIDENCING AN INTEREST IN A SINGLE
22 ASSET OR SINGLE POOL OF ASSETS HELD BY A TRUST OR OTHER BUSINESS
23 ENTITY THEN HELD BY THE INSURER WOULD EXCEED THREE PER CENTUM
24 (3%) OF ITS ADMITTED ASSETS.

25 * * *

26 SECTION 3. SECTION 403-B(E) OF THE ACT, ADDED MARCH 22, 2010
27 (P.L.147, NO.14), IS AMENDED TO READ:
28 SECTION 403-B. DUTIES OF INSURERS AND INSURANCE PRODUCERS.

29 * * *

30 (E) COMPLIANCE WITH OTHER RULES.--[COMPLIANCE WITH THE

1 FINANCIAL INDUSTRY REGULATORY AUTHORITY CONDUCT RULES PERTAINING
2 TO SUITABILITY SHALL SATISFY THE REQUIREMENTS UNDER THIS SECTION
3 FOR THE RECOMMENDATION OF ANNUITIES REGISTERED UNDER THE
4 SECURITIES ACT OF 1933 (48 STAT. 74, 15 U.S.C. § 77A ET SEQ.) OR
5 RULES AND REGULATIONS ADOPTED UNDER THE SECURITIES ACT OF 1933.]
6 SALES MADE BY AN INSURANCE PRODUCER SUBJECT TO AND IN COMPLIANCE
7 WITH THE FINANCIAL INDUSTRY REGULATORY AUTHORITY CONDUCT RULES
8 PERTAINING TO SUITABILITY SHALL SATISFY THE REQUIREMENTS UNDER
9 THIS SECTION FOR THE RECOMMENDATION OF ANNUITIES. NOTHING IN
10 THIS SUBSECTION SHALL LIMIT THE COMMISSIONER'S ABILITY TO
11 ENFORCE THE PROVISIONS OF THIS ARTICLE.

12 * * *

13 SECTION 4. SECTION 621.2(A)(1) OF THE ACT, AMENDED FEBRUARY
14 17, 1994 (P.L.92, NO.9), IS AMENDED TO READ:

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

23 (1) UNDER A POLICY ISSUED TO AN EMPLOYER OR TRUSTEES OF A
24 FUND ESTABLISHED BY AN EMPLOYER, WHO SHALL BE DEEMED THE
25 POLICYHOLDER INSURING AT LEAST [TEN] TWO EMPLOYEES OF SUCH
26 EMPLOYER FOR THE BENEFIT OF PERSONS OTHER THAN THE EMPLOYER. THE
27 TERM "EMPLOYEES," AS USED HEREIN, SHALL BE DEEMED TO INCLUDE THE
28 OFFICERS, MANAGERS AND EMPLOYEES OF THE EMPLOYER, THE INDIVIDUAL
29 PROPRIETOR OR PARTNER, IF THE EMPLOYER IS AN INDIVIDUAL
30 PROPRIETOR OR PARTNERSHIP, THE OFFICERS, MANAGERS AND EMPLOYEES

1 OF SUBSIDIARY OR AFFILIATED CORPORATIONS, THE INDIVIDUAL
2 PROPRIETORS, PARTNERS AND EMPLOYES OF INDIVIDUALS AND FIRMS, IF
3 THE BUSINESS OF THE EMPLOYER AND SUCH INDIVIDUAL OR FIRM IS
4 UNDER COMMON CONTROL THROUGH STOCK OWNERSHIP, CONTRACT OR
5 OTHERWISE. THE TERM "EMPLOYES," AS USED HEREIN, MAY INCLUDE
6 RETIRED EMPLOYES. A POLICY ISSUED TO INSURE EMPLOYES OF A PUBLIC
7 BODY MAY PROVIDE THAT THE TERM "EMPLOYES" SHALL INCLUDE ELECTED
8 OR APPOINTED OFFICIALS.

9 * * *

10 SECTION 5. SECTION 635.4(A)(6)(I) OF THE ACT OF MAY 17, 1921
11 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921,
12 ADDED JUNE 10, 2009 (P.L.5, NO.2), IS AMENDED TO READ:

13 SECTION 635.4. MINI-COBRA SMALL EMPLOYER GROUP HEALTH
14 POLICIES.--(A) A GROUP POLICY IN EFFECT OR DELIVERED OR ISSUED
15 FOR DELIVERY IN THIS COMMONWEALTH ON OR AFTER THE EFFECTIVE DATE
16 OF THIS SECTION BY AN INSURER WHICH INSURES EMPLOYES AND THEIR
17 ELIGIBLE DEPENDENTS FOR HOSPITAL, SURGICAL OR MAJOR MEDICAL
18 INSURANCE SHALL PROVIDE THAT COVERED EMPLOYES, OR ELIGIBLE
19 DEPENDENTS WHOSE COVERAGE UNDER THE GROUP POLICY WOULD OTHERWISE
20 TERMINATE BECAUSE OF A QUALIFYING EVENT, SHALL BE ENTITLED TO
21 CONTINUE THEIR HOSPITAL, SURGICAL OR MAJOR MEDICAL COVERAGE
22 UNDER THAT GROUP POLICY SUBJECT TO THE FOLLOWING TERMS AND
23 CONDITIONS:

24 * * *

25 (6) (I) CONTINUATION OF COVERAGE UNDER THE GROUP POLICY FOR
26 ANY COVERED EMPLOYEE OR ELIGIBLE DEPENDENT SHALL TERMINATE UPON
27 FAILURE TO SATISFY PARAGRAPH (2) OR, IF EARLIER, AT THE FIRST TO
28 OCCUR OF THE FOLLOWING:

29 (A) [THE] THE END DATE, DETERMINED AS THE LATER OF THE
30 FOLLOWING:

1 (I) NINE MONTHS AFTER THE DATE THE COVERED EMPLOYEE'S OR
2 ELIGIBLE DEPENDENT'S COVERAGE UNDER THE GROUP POLICY WOULD HAVE
3 TERMINATED BECAUSE OF A QUALIFYING EVENT; OR

4 (II) IF, DURING THE PENDENCY OF A COVERED EMPLOYEE'S OR
5 DEPENDENT'S RECEIPT OF CONTINUATION OF COVERAGE UNDER A GROUP
6 POLICY, THE DEPARTMENT PUBLISHES A NOTICE IN THE PENNSYLVANIA
7 BULLETIN STATING THAT A FEDERAL PREMIUM ASSISTANCE PROGRAM IS IN
8 EXISTENCE, INCLUDING PREMIUM ASSISTANCE UNDER THE AMERICAN
9 RECOVERY AND REINVESTMENT ACT OF 2009 (PUBLIC LAW 111-5, 123
10 STAT. 115) OR ANY SUCCESSOR EXTENSION ACT, THE MAXIMUM NUMBER OF
11 MONTHS FOR WHICH THE PROGRAM WOULD MAKE PREMIUM ASSISTANCE
12 AVAILABLE TO THE COVERED EMPLOYEE OR ELIGIBLE DEPENDENT BECAUSE
13 OF THE QUALIFYING EVENT, TAKING INTO ACCOUNT ALL PRIOR MONTHS OF
14 THE CONTINUATION OF COVERAGE FROM AND AFTER THE DATE OF THE
15 QUALIFYING EVENT.

16 (B) [IF] IF THE EMPLOYEE OR MEMBER FAILS TO MAKE TIMELY
17 PAYMENT OF A REQUIRED PREMIUM CONTRIBUTION, THE END OF THE
18 PERIOD FOR WHICH CONTRIBUTIONS WERE MADE[;].

19 (C) [THE] THE DATE ON WHICH THE GROUP POLICY IS TERMINATED.

20 * * *

21 SECTION 6. THE ACT IS AMENDED BY ADDING A SECTION TO READ:
22 SECTION 635.5. CONTINUATION OF COVERAGE REINSTATEMENT.--
23 SUBJECT TO THE LIMITATIONS OF SECTION 635.4(A)(2) AND THE
24 REQUIREMENTS OF THIS SECTION, A COVERED EMPLOYEE OR ELIGIBLE
25 DEPENDENT WHOSE CONTINUATION OF COVERAGE TERMINATED UPON THE
26 EXPIRATION OF A PERIOD OF MONTHS AS PROVIDED IN SECTION 635.4(A)
27 (6)(I)(A) PRIOR TO THE EFFECTIVE DATE OF THIS SECTION SHALL HAVE
28 THE RIGHT TO REINSTATE CONTINUATION OF COVERAGE FOR AN
29 ADDITIONAL PERIOD OF SIX MONTHS COMMENCING ON THE EFFECTIVE DATE
30 OF THIS SECTION. REINSTATEMENT SHALL BE AVAILABLE TO THE COVERED

EMPLOYEES AND DEPENDENTS UNDER THE SAME TERMS AND CONDITIONS
APPLICABLE TO COVERED EMPLOYEES AND COVERED DEPENDENTS WHO LOST
COVERAGE UNDER A PLAN DUE TO A QUALIFYING EVENT ON THE EFFECTIVE
DATE OF THIS SECTION, INCLUDING THE NOTICE AND ELECTION
PROCEDURE DESCRIBED IN SECTION 635.4(A)(4)(II), (III), (IV) AND
(V) AND THE PREMIUM CONTRIBUTION REQUIREMENTS OF SECTION
635.4(A)(5).

SECTION 7. THE DEFINITION OF "LONG-TERM CARE INSURANCE" IN
SECTION 1103 OF THE ACT, AMENDED JULY 17, 2007 (P.L.134, NO.40),
IS AMENDED AND THE SECTION IS AMENDED BY ADDING DEFINITIONS TO
READ:

Section 1103. Definitions.--As used in this article, the
following words and phrases shall have the meanings given to
them in this section:

* * *

"Benefit trigger." A contractual provision in the insured's
policy of long-term care insurance conditioning the payment of
benefits on a determination of the insured's ability to perform
activities of daily living and on cognitive impairment. For the
purposes of a qualified long-term care insurance contract as
defined in section 7702B of the Internal Revenue Code of 1986
(Public Law 99-514, 26 U.S.C. § 7702B), the term shall include a
determination by a licensed health care practitioner the insured
is a chronically ill individual.

* * *

"Independent review organization." An organization that
conducts independent reviews of long-term care benefit trigger
decisions.

"Long-term care insurance." Any insurance policy or rider
advertised, marketed, offered or designed to provide

1 comprehensive coverage for each covered person on an expense-
2 incurred, indemnity, prepaid or other basis for functionally
3 necessary or medically necessary diagnostic, preventive,
4 therapeutic, rehabilitative, maintenance or personal care
5 services provided in a setting other than an acute care unit of
6 a hospital. The term includes a policy, rider or prepaid home
7 health or personal care service policy [which provides for
8 payment of benefits based upon cognitive impairment or the loss
9 of functional capacity]. The term includes group and individual
10 policies or riders issued by insurers, fraternal benefit
11 societies, nonprofit health, hospital and medical service
12 corporations, health maintenance organizations or similar
13 organizations. The term does not include any insurance policy
14 which is offered primarily to provide basic Medicare supplement
15 coverage, basic hospital expense coverage, basic medical-
16 surgical expense coverage, hospital confinement indemnity
17 coverage, major medical expense coverage, disability income
18 protection coverage, accident-only coverage, specified disease
19 or specified accident coverage or limited benefit health
20 coverage.

21 * * *

22 Section 2 8. The act is amended by adding sections to read: ←

23 Section 1111.1. Appealing An Insurer's Determination the
24 Benefit Trigger Is Not Met.--(a) An authorized representative
25 is authorized to act as the covered person's personal
26 representative within the meaning of 45 CFR § 164.502(g)
27 (relating to uses and disclosures of protected health
28 information: general rules) promulgated under the administrative
29 simplification provisions of the Health Insurance Portability
30 and Accountability Act of 1996 (Public Law 104-191, 110 Stat.

1 1936) and means the following:

2 (1) a person to whom a covered person has given express
3 written consent to represent the covered person in an external
4 review;

5 (2) a person authorized by law to provide substituted
6 consent for a covered person; or

7 (3) a family member of the covered person or the covered
8 person's treating health care professional only when the covered
9 person is unable to provide consent.

10 (b) If an insurer determines the benefit trigger of a long-
11 term care insurance policy has not been met, it shall provide a
12 clear, written notice to the insured and the insured's
13 authorized representative, if applicable, of the following:

14 (1) The reason the insurer determined the insured's benefit
15 trigger has not been met.

16 (2) The insured's right to internal appeal under subsection
17 (c) and the right to submit new or additional information
18 relating to the benefit trigger denial with the appeal request.

19 (3) The insured's right to have the benefit trigger
20 determination reviewed under the independent review process
21 under subsection (d) after the exhaustion of the insurer's
22 internal appeal process.

23 (c) The insured or the insured's authorized representative
24 may appeal the insurer's adverse benefit trigger determination
25 by sending a written request to the insurer, along with any
26 additional supporting information, within one hundred twenty
27 (120) calendar days after the insured and the insured's
28 authorized representative, if applicable, received the insurer's
29 benefit determination notice. The internal appeal shall be
30 considered by an individual or group of individuals designated

1 by the insurer provided the individual making the internal
2 appeal decision may not be the same individual who made the
3 initial benefit determination. The internal appeal shall be
4 completed and written notice of the internal appeal decision
5 shall be sent to the insured and the insured's authorized
6 representative, if applicable, within thirty (30) calendar days
7 of the insurer's receipt of the necessary information upon which
8 a final determination can be made:

9 (1) If the insurer's original determination is upheld upon
10 internal appeal, the notice of the internal appeal decision
11 shall describe additional internal appeal rights offered by the
12 insurer. Nothing in this section shall require the insurer to
13 offer internal appeal rights other than those described in this
14 subsection.

15 (2) If the insurer's original determination is upheld after
16 the internal appeal process has been exhausted and new or
17 additional information has not been provided to the insurer, the
18 insurer shall provide a written description of the insured's
19 right to request an independent review of the benefit
20 determination as described in subsection (d) to the insured and
21 the insured's authorized representative, if applicable.

22 (3) As part of the written description of the insured's
23 right to request an independent review, an insurer shall include
24 the following or substantially equivalent language:

25 We have determined that the benefit eligibility criteria
26 ("benefit trigger") of your (policy) (certificate) has not
27 been met. You may have the right to an independent review of
28 our decision conducted by long-term care professionals who
29 are not associated with us. Please send a written request for
30 independent review to us at (address). You must inform us, in

1 writing, of your election to have this decision reviewed
2 within 120 days of receipt of this letter. Listed below are
3 the names and contact information of the independent review
4 organizations approved or certified by your state insurance
5 department's office to conduct long-term care insurance
6 benefit eligibility reviews. If you wish to request an
7 independent review, please choose one of the listed
8 organizations and include its name with your request for
9 independent review. If you elect independent review, but do
10 not choose an independent review organization with your
11 request, we will choose one of the independent review
12 organizations for you and refer the request for independent
13 review to it.

14 (4) If the insurer does not believe the benefit trigger
15 decision is eligible for independent review, the insurer shall
16 inform the insured, the insured's authorized representative, if
17 applicable, and the department in writing and include in the
18 notice the reasons for its determination of independent review
19 ineligibility.

20 (5) The appeal process described in this subsection does not
21 include a notice requirement as to the availability of new long-
22 term care services or providers.

23 (d) (1) The insured or the insured's authorized
24 representative may request an independent review of the
25 insurer's benefit trigger determination after the internal
26 appeal process outlined in subsection (c) has been exhausted. A
27 written request for independent review may be made by the
28 insured or the insured's authorized representative to the
29 insurer within one hundred twenty (120) calendar days after the
30 insurer's written notice of the final internal appeal decision

is received by the insured and the insured's authorized representative, if applicable.

(2) The cost of the independent review shall be borne by the insurer.

(3) (i) Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the Commonwealth. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

(ii) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(A) The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section.

(B) The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer.

(C) The review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

1 (iii) If the insured or the insured's authorized
2 representative has new or additional information not previously
3 provided to the insurer, whether submitted to the insurer or the
4 independent review organization, the information shall first be
5 considered in the internal review process, as set forth in
6 subsection (c).

7 (A) While this information is being reviewed by the insurer,
8 the independent review organization shall suspend its review and
9 the time period for review is suspended until the insurer
10 completes its review.

11 (B) The insurer shall complete its review of the information
12 and provide written notice of the results of the review to the
13 insured and the insured's authorized representative, if
14 applicable, and the independent review organization within five
15 (5) business days of the insurer's receipt of the new or
16 additional information.

17 (C) If the insurer maintains its denial after such review,
18 the independent review organization shall continue its review
19 and render its decision within the time period specified in
20 subparagraph (ix). If the insurer overturns its decision
21 following its review, the independent review request shall be
22 considered withdrawn.

23 (iv) The insurer shall acknowledge in writing to the
24 insured, the insured's authorized representative, if applicable,
25 and the department the request for independent review has been
26 received, accepted and forwarded to an independent review
27 organization for review. The notice will include the name and
28 address of the independent review organization.

29 (v) Within five (5) business days of receipt of the request
30 for independent review, the independent review organization

1 assigned under this paragraph shall notify the insured and the
2 insured's authorized representative, if applicable, the insurer
3 and the department it has accepted the independent review
4 request and identify the type of licensed health care
5 professional assigned to the review. The assigned independent
6 review organization shall include in the notice a statement the
7 insured or insured's authorized representative may submit in
8 writing to the independent review organization within seven (7)
9 days following the date of receipt of the notice additional
10 information and supporting documentation the independent review
11 organization should consider when conducting its review.

12 (vi) The independent review organization shall review all of
13 the information and documents received under subparagraph (v)
14 that have been provided to the independent review organization.
15 The independent review organization shall provide copies of the
16 documentation or information provided by the insured or the
17 insured's authorized representative to the insurer for its
18 review if it is not part of the information or documentation
19 submitted by the insurer to the independent review organization.
20 The insurer shall review the information and provide its
21 analysis of the new information under subparagraph (viii).

22 (vii) The insured or the insured's authorized representative
23 may submit, at any time, new or additional information not
24 previously provided to the insurer but pertinent to the benefit
25 trigger denial. The insurer shall consider the information and
26 affirm or overturn its benefit trigger determination. If the
27 insurer affirms its benefit trigger determination, the insurer
28 shall promptly provide the new or additional information to the
29 independent review organization for its review along with the
30 insurer's analysis of the information.

1 (viii) If the insurer overturns its benefit trigger
2 determination:

3 (A) The insurer shall provide notice to the independent
4 review organization and the insured, the insured's authorized
5 representative, if applicable, and the commissioner of its
6 decision.

7 (B) The independent review process shall immediately cease.

8 (ix) The independent review organization shall provide the
9 insured, the insured's authorized representative, if applicable,
10 the insurer and the department written notice of its decision
11 within thirty (30) calendar days from receipt of the referral
12 referenced in paragraph (3)(ii). If the independent review
13 organization overturns the insurer's decision, it shall:

14 (A) Establish the precise date within the specific period of
15 time under review the benefit trigger was deemed to have been
16 met.

17 (B) Specify the specific period of time under review for
18 which the insurer declined eligibility, but during which the
19 independent review organization deemed the benefit trigger to
20 have been met.

21 (C) For qualified long-term care insurance contracts,
22 provide a certification the insured is a chronically ill
23 individual. The certification shall be made only by a licensed
24 health care practitioner as defined in section 7702B(c)(4) of
25 the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C.
26 § 7702B(c)(4)).

27 (x) The decision of the independent review organization
28 regarding whether the insured met the benefit trigger shall be
29 subject to appeal to a court of competent jurisdiction within
30 sixty (60) days of receipt of notice of the independent review

organization's decision. There shall be a rebuttable presumption in favor of the decision of the independent review organization.

(xi) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions and is intended to be admissible in a proceeding only to the extent it establishes the eligibility of benefits payable.

(xii) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, if the independent review organization upholds the insurer's decision.

(xiii) The department shall utilize the criteria established by the National Association of Insurance Commissioners for its guidelines for Long-Term Care Independent Review Entities in certifying entities to review long-term care insurance benefit trigger decisions.

(xiv) The department shall accept another state's certification of an independent review organization, provided the state requires the independent review organization to meet substantially similar qualifications as those established by the National Association of Insurance Commissioners.

(xv) The department shall maintain and periodically update a list of approved independent review organizations.

(e) The department shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

(1) Has on staff or contracts with a qualified and licensed health care professional in an appropriate field, such as

physical therapy, occupational therapy, neurology, physical medicine or rehabilitation, for determining an insured's functional or cognitive impairment to conduct the review.

(2) Shall not be related to or affiliated with an entity previously providing medical care to the insured.

(3) Utilizes a licensed health care professional who is not an employee of the insurer or related to the insured.

(4) Shall not receive compensation of any type that is dependent on the outcome of the review and shall not utilize a licensed health care professional who receives compensation of any type that is dependent on the outcome of the review.

(5) Is approved or certified by the Commonwealth to conduct the reviews if the Commonwealth requires the approvals or certifications.

(6) Provides a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. The fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

(7) Provides the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

(8) Has on staff or contracts with a licensed health care practitioner as defined under section 7702B(c)(4) of the Internal Revenue Code of 1986 who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

(f) Each certified independent review organization shall comply with the following:

(1) Maintain written documentation establishing the date it

1 receives a request for independent review, the date each review
2 is conducted, the resolution, the date the resolution was
3 communicated to the insurer and the insured, the name and
4 professional status of the reviewer conducting the review in an
5 easily accessible and retrievable format for the year in which
6 it received the information plus two calendar years.

7 (2) Be able to document measures taken to appropriately
8 safeguard the confidentiality of the records and prevent
9 unauthorized use and disclosures under applicable Federal and
10 State law.

11 (3) Report annually to the department by June 1 in the
12 aggregate and for each long-term care insurer the following:

13 (i) The total number of requests received for independent
14 review of long-term care benefit trigger decisions.

15 (ii) The total number of reviews conducted and the
16 resolution of the reviews such as the number of reviews that
17 upheld or overturned the long-term care insurer's determination
18 the benefit trigger was not met.

19 (iii) The number of reviews withdrawn prior to review.

20 (iv) The percentage of reviews conducted within the
21 prescribed timeframe set forth in subsection (c)(3).

22 (v) The other information the department may require.

23 (4) Report immediately to the department a change in its
24 status which would cause it to cease meeting a qualification
25 required of an independent review organization performing
26 independent reviews of long-term care benefit trigger decisions.

27 (g) Nothing in this section shall limit the ability of an
28 insurer to assert rights an insurer may have under the policy
29 related to:

30 (1) An insured's misrepresentation.

1 (2) Changes in the insured's benefit eligibility.

2 (3) Terms, conditions and exclusions of the policy other
3 than failure to meet the benefit trigger.

4 (h) The department shall compile and maintain a list of
5 certified, qualified long-term care insurance independent review
6 organizations and shall publish the list on its Internet website
7 and annually in the Pennsylvania Bulletin by July 1.

8 (i) This section shall not apply to long-term care insurance
9 claims made under a group long-term care insurance policy that
10 is governed by the Employee Retirement Income Security Act of
11 1974 (Public Law 93-406, 88 Stat. 829), referred to as ERISA.

12 Section 1111.2. Prompt Payment of Clean Claims.--(a) Within
13 thirty (30) business days after receipt of a claim for benefits
14 under a long-term care insurance policy or certificate, an
15 insurer shall pay the claim if it is a clean claim or send a
16 written notice acknowledging the date of receipt of the claim
17 and one of the following:

18 (1) the insurer is declining to pay all or part of the claim
19 and the specific reason for denial; or

20 (2) additional information is necessary to determine if all
21 or part of the claim is payable and the specific additional
22 information that is necessary.

23 (b) Within thirty (30) business days after receipt of the
24 requested additional information, an insurer shall pay a claim
25 for benefits under a long-term care insurance policy or
26 certificate if it is a clean claim or send a written notice the
27 insurer is declining to pay all or part of a claim and the
28 specific reason or reasons for denial.

29 (c) If an insurer fails to comply with subsection (a) or
30 (b), the insurer shall pay interest at the rate of one per

1 centum (1%) per month on the amount of the claim that should
2 have been paid but remains unpaid forty-five (45) business days
3 after the receipt of the claim with respect to subsection (a) or
4 all requested additional information with respect to subsection
5 (b). The interest payable under this subsection shall be
6 included in a late reimbursement without requiring the person
7 who filed the original claim to make an additional claim for the
8 interest.

9 (d) The provisions of this section shall not apply to where
10 the insurer has reasonable basis supported by specific
11 information the claim was fraudulently submitted.

12 (e) A violation of section 1111.1 or this section by an
13 insurer if committed flagrantly and in conscious disregard of
14 the provisions of this act or with frequency sufficient to
15 constitute a general business practice shall be considered a
16 violation of the act of July 22, 1974 (P.L.589, No.205), known
17 as the "Unfair Insurance Practices Act." A violation of section
18 1111.1 or this section is deemed an unfair method of competition
19 and an unfair deceptive act or practice pursuant to the "Unfair
20 Insurance Practices Act."

21 (f) As used in this section the following words and phrases
22 shall have the meanings given to them in this subsection:

23 "Claim" means a request for payment of benefits under a
24 policy in effect regardless of whether the benefit claimed is
25 covered under the policy or terms or conditions of the policy
26 have been met.

27 "Clean claim" means a claim that has no defect or
28 impropriety, including any lack of required substantiating
29 documentation, such as satisfactory evidence of expenses
30 incurred, or a particular circumstance requiring special

1 treatment that prevents timely payment from being made on the
2 claim.

3 ~~Section 3. The provisions of this act shall apply to benefit~~ ←

4 SECTION 9. REPEALS ARE AS FOLLOWS: ←

5 (1) THE GENERAL ASSEMBLY DECLARES THAT THE REPEAL UNDER
6 PARAGRAPH (2) IS NECESSARY TO EFFECTUATE THE ADDITION OF
7 SECTION 354.6 OF THE ACT.

8 (2) SECTION 2(3) OF THE act of May 11, 1949 (P.L.1210,
9 No.367), referred to as the Group Life Insurance Policy Law,
10 is repealed.

11 SECTION 10. THIS ACT SHALL APPLY AS FOLLOWS:

12 (1) THE PROVISIONS OF SECTION 1111.1 OF THE ACT SHALL
13 APPLY TO BENEFIT trigger requests made on or after 60 days
14 after the effective date of this act.

15 ~~Section 4. This act shall take effect in 60 days.~~ ←

16 (2) THE ADDITION OF SECTION 635.5 OF THE ACT SHALL APPLY ←
17 RETROACTIVELY TO JULY 10, 2009.

18 SECTION 11. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

19 (1) THE AMENDMENT OF SECTION 403-B(E) OF THE ACT SHALL
20 TAKE EFFECT SEPTEMBER 24, 2010.

21 (2) THE AMENDMENT OR ADDITION OF SECTIONS 1103 AND
22 1111.1 OF THE ACT SHALL TAKE EFFECT IN 60 DAYS.

23 (3) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT
24 IMMEDIATELY.