No. 1992-148

AN ACT

SB 1087

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 coverage for mammographic examinations; providing for long-term care insurance; providing for limits, disclosure and performance standards; prescribing additional powers and duties of the Insurance Commissioner and the Insurance Department; and providing for a uniform health insurance claim form.

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

Section 1. Section 632 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, added July 7, 1989 (P.L.228, No.37), is amended to read:

Section 632. Coverage for Mammographic **[Examination]** ***Examinations.***—All group ***or individual*** health or sickness or accident insurance policies providing hospital or medical/surgical coverage and all group ***or individual*** subscriber contracts or certificates issued by any entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), this act, the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," **[or]** the act of July 29, 1977 (P.L.105, No.38), known as the "Fraternal Benefit Society Code," ***or an employe welfare benefit plan as defined in section 3 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.)*** providing hospital or medical/surgical coverage shall also provide coverage for mammographic **[examination]** ***examinations***. The minimum coverage required shall include all costs associated with a mammogram every year for women **[50]** ***40*** years of age or older and with any mammogram based on a physician's recommendation for women under **[50]** ***40*** years of age. ***Prior to payment for a screening mammogram, insurers shall verify that the screening mammography service provider is properly licensed by the department in accordance with the act of July 9, 1992 (P.L.449, No.93), known as the "Mammography Quality Assurance Act."*** Nothing in this section shall be construed to require an insurer to cover the surgical procedure known as mastectomy or to prevent application of deductible or copayment provisions contained in the policy or plan.

Section 2. Article XI of the act is repealed.

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

ARTICLE XI.
LONG-TERM CARE.

Section 1101. Statement of Purpose.—The purpose of this article is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Section 1102. Scope of Article.—This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance or nursing home insurance need not meet the requirements of this article.

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

"Applicant." The term includes the following:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

"Certificate." Any certificate issued under a group long-term care insurance policy which has been delivered or issued for delivery in this Commonwealth.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Functionally necessary." The appropriateness of services directed to address the individual's inability to perform tasks required for daily living, as defined through regulation, and the individual's need for continuous care or supervision.

"Group long-term care insurance." A long-term care insurance policy which is delivered or issued for delivery in this Commonwealth and issued to any of the following:

(1) Employers or labor organizations or a trust or to the trustees of a fund established by employers or labor organizations for employes or former employes or for members or former members of the labor organizations.

(2) Any professional, trade or occupational association for its members or former or retired members if the association:

(i) is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance.

(3) An association or a trust or the trustee of a fund established or maintained for the benefit of members of associations. To qualify under this paragraph:

(i) The insurer of the association or associations must file evidence with the commissioner that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance, have been in active existence for at least one year and have a constitution and bylaws which provide that:

(A) the association or associations hold regular meetings not less than annually to further purposes of the members;

(B) except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) the members have voting privileges and representation on the governing board and committees.

(ii) Thirty (30) days after filing, the association or associations will be deemed to satisfy organizational requirements unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in clauses (1), (2) and (3) of this section, subject to a finding by the commissioner that:

(i) the issuance of the group policy is not contrary to the best interest of the public;

(ii) the issuance of the group policy would result in economies of acquisition or administration; and

(iii) the benefits are reasonable in relation to the premiums charged.

"Long-term care insurance." Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense-incurred, indemnity, prepaid or other basis for functionally necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. The term includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term includes group and individual policies or riders issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations or similar organizations. The term does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage or limited benefit health coverage.

"Medically necessary." The appropriateness of treatment of the insured's condition, including nonmedical support services, based on current

standards of acceptable medical practice. The term may exclude benefits for care or services which are primarily for the convenience of the insured or the person's physician.

"Policy." Any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

Section 1104. Limits of Group Long-term Care Insurance.—No group long-term care insurance coverage may be offered to a resident of this Commonwealth under a group policy issued in another state to a group described in clause (4) of the definition of "group long-term care insurance" in section 1103 unless the Commonwealth or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this Commonwealth has made a determination that such requirements have been met.

Section 1105. Disclosure and Performance Standards for Long-term Care Insurance.—(a) The department may adopt regulations, that include standards for full and fair disclosure setting forth the manner, content and required disclosures, for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(b) No long-term care insurance policy may:

(1) be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) contain a provision establishing a new waiting period, in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) contain coverage for skilled nursing care only or contain coverage that provides significantly more skilled care than coverage for lower levels of care.

(c) (1) No long-term care insurance policy or certificate may use a definition of "preexisting condition" which is more restrictive than a definition of "preexisting condition" that means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

Section 1106. Commissioner's Duties.—The commissioner may extend the limitation periods set forth in section 1105 as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

Section 1107. Underwriting Standards.—The definition of the term "preexisting condition" under section 1105(c) does not prohibit an insurer from using an application form designed to elicit the complete health history of the applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in section 1105(c)(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in section 1105(c)(2).

Section 1108. Prior Institutionalization.—No long-term care insurance policy shall:

(1) condition eligibility for any benefits on a prior stay in an institution or a prior chronic condition;

(2) condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) condition eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

Section 1109. Loss Ratios.—The department may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

Section 1110. Right to Return.—Individual long-term care insurance policyholders and group certificate holders who contribute to the cost of their long-term care coverage shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. Long-term care insurance policies and applicable group certificates shall have a notice, prominently printed on the first page of the policy or certificate, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Section 1111. Outline of Coverage Provisions.—(a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) The department shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(c) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(d) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(e) The outline of coverage shall include all of the following:

(1) A description of the benefits and coverage provided in the policy.

(2) A statement of the exclusions, reductions and limitations contained in the policy.

(3) A statement of the terms under which the policy or certificate may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions.

(5) A description of the terms under which the policy or certificate may be returned and premium refunded.

(6) A brief description of the relationship of cost of care and benefits.

Section 1112. Authority to Promulgate Regulations.—The department shall promulgate reasonable regulations to establish minimum standards for marketing practices, agent compensation arrangements, agent testing, penalties and reporting practices for long-term care insurance.

Section 1113. Marketing and Advertising Prohibited.—No policy may be advertised, marketed or offered as long-term care or nursing home insurance unless it complies with the provisions of this article.

Section 1114. Penalties.—In addition to any other penalties provided by the laws of this Commonwealth, an insurer or agent found to have violated requirements relating to the regulations of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty of up to three times the amount of any commissions paid for each policy involved in the violation or ten thousand dollars ($10,000), whichever is greater.

Section 1115. Applicability.—This article shall apply to all policies delivered or issued for delivery in this Commonwealth on or after the effective date of this article.

ARTICLE XII.
UNIFORM HEALTH INSURANCE CLAIM FORM.

Section 1201. Definitions.—As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Department." The Insurance Department of the Commonwealth.

"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, a professional nurse, a 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, including any preferred provider organization subject to section 630.

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

(4) The act of July 29, 1977 (P.L.105, No.38), known as the "Fraternal Benefit Society Code."

"Public health care coverage." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

"Supplemental major medical." Any major medical contract which supplements a contract or contracts providing hospitalization and ~~medical surgi~~cal benefits.

Section 1202. Forms for Health Insurance Claims.—(a) Each health insurance claim form processed or otherwise used by an insurer, including those used by the Department of Public Welfare for public health care coverage, shall be the uniform claim form developed by the department. The claim form shall be identical in form and content except as provided in subsection (c). The department shall, in consultation with the Department of Public Welfare, insurers and health care providers or their representatives, first consider the feasibility of utilizing the UB-82/HCFA-1450 and HCFA-1500 forms, or their successors, as a uniform claim form. If these forms are deemed to be unsatisfactory, the department shall, in consultation with the Department of Public Welfare, insurers and health care providers or their representatives, develop a uniform claim form for use by all insurers, the Department of Public Welfare's public health care coverage program and health care providers. The uniform claim form shall contain blank spaces at appropriate places in the document for approved additional information requests under subsection (c).

(b) The feasibility study and subsequent development of the uniform claim form shall be complete within one hundred eighty (180) days of the effective date of this article. All insurers, the Department of Public Welfare's public health care coverage program and health care providers shall be required to use the uniform claim form within one hundred twenty (120) days after the uniform claim form is developed. The department may consider a request from the Department of Public Welfare for an extension in meeting the implementation schedule of this section.

(c) (1) Subject to the procedure contained in clause (2), an insurer may request that a claimant provide departmentally approved additional information which is not requested on the uniform claim form.

(2) An insurer may request departmental approval of additional information requests to be printed in the blank spaces on the uniform claim form, and on subsequent pages if necessary, by submitting a written request to the department. Such a request shall be deemed approved by the department if not disapproved within sixty (60) days after receipt of the request. A disapproval shall be subject to the procedures under 2 Pa.C.S. (relating to administrative law and procedure).

(d) In the case of vision and dental claim forms and in the case of supplemental major medical claim forms, utilization of the uniform claim form shall be at the discretion of the individual insurer.

Section 1203. Rules and Regulations.—The department may promulgate rules and regulations to administer and enforce this article.

Section 1204. Penalties.—On satisfactory evidence of a violation of this article by an insurer, the Insurance Commissioner may:

(1) Order that the insurer cease and desist from the violation.

(2) Impose a fine of not more than five hundred dollars ($500) for each violation.

Section 1205. Federal Compliance.—In the event the Federal Government enacts a uniform claim form for mandatory use by all insurers and the Department of Public Welfare's public health care coverage program, the department shall adopt the Federal form for use by all insurers, the Department of Public Welfare's public health care coverage program and health care providers within ninety (90) days of the enactment of the Federal legislation or the effective date included in the Federal act, whichever is later.

Section 4. All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 5. This act shall take effect as follows:

(1) The addition of Article XII of the act shall take effect immediately.

(2) This section shall take effect immediately.

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

APPROVED—The 15th day of December, A. D. 1992.

ROBERT P. CASEY