No. 2000-132

AN ACT

HB 550

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," providing for payment of life insurance benefits and for coverage requirements for insulin and other blood sugar controlling agents; further providing for inclusion of health maintenance organizations in conversion notifications; changing the expiration date of an article; further defining "long-term care insurance"; defining "prepaid home health or personal care service policy"; further defining "insurer" and "person" for purposes of insurance holding companies; and further providing for standards and management of an insurer within a holding company system.

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

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 411B. Payment of Benefits.—(a) Except as set forth in subsection (b), life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date the benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured and the death benefits are not paid within thirty days after satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

(b) Notwithstanding section 6 of the act of May 11, 1949 (P.L.1210, No.367), referred to as the Group Life Insurance Policy Law, this section shall apply to all life insurance policies except variable insurance policies.

(c) The term "left on deposit" shall mean a specific settlement option provided within the life insurance policy under which the death benefit proceeds are retained by the insurer for the beneficiary and are credited with a specific rate of interest.

Section 2. Section 634(e) of the act, added October 16, 1998 (P.L.784, No.98), is amended to read:

Section 634. Reimbursement for Diabetic Supplies.—* * *

(e) The coverage required under this section shall be subject to the annual deductibles, ***copayments*** or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

Section 3. Sections 1009-A and 1012-A of the act, added November 4, 1997 (P.L.492, No.51), are amended to read:

Section 1009-A. Conversion Policies.—(a) Notification of the conversion privilege shall be included with each certificate of coverage issued under section 621.2(d) ***and with any HMO subscriber agreement.*** Each certificate holder in an insured group ***and each HMO subscriber*** shall be given written notification of the conversion privilege and its duration within a period beginning fifteen (15) days before and ending thirty (30) days after the date of termination of the group coverage. The certificate holder or the holder's dependent ***and the HMO subscriber or the subscriber's dependent*** shall have no less than thirty-one (31) days following notification to exercise the conversion privilege. Written notification provided by the contract holder and supplied to the certificate holder ***or subscriber*** or mailed to the certificate holder's ***or subscriber's*** last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section.

(b) The premium rates for individuals who purchase a comparable group conversion policy offered pursuant to applicable law shall be limited to one hundred twenty per centum (120%) of the approved premium rates for comparable group coverage.

Section 1012-A. Expiration.—This article shall expire on December 31, **[2000]** ***2003***.

Section 4. Section 1103 of the act, added December 15, 1992 (P.L.1129, No.148), is amended 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:

"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 ***or prepaid home health or***

personal care service policy 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.

"Prepaid home health or personal care service policy." A policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this Commonwealth to provide home health or personal care services whereby coverage for home health or personal care services is conditioned upon certification of either cognitive impairment or the inability to perform activities of daily living. This term shall not include home health or personal care services administered through a local area agency on aging or as a government service or provided by a nonprofit association, organization or corporation other than a nonprofit health, hospital or medical service corporation.

Section 5. The definitions of "insurer" and "person" in section 1401 of the act, amended or added December 18, 1992 (P.L.1519, No.178) and February 17, 1994 (P.L.92, No.9), are amended to read:

Section 1401. Definitions.—As used in this article the following words and phrases shall have the meanings given to them in this section:

* * *

"Insurer." Any ***health maintenance organization, preferred provider organization,*** company, association or exchange authorized by the Insurance Commissioner to transact the business of insurance in this Commonwealth except that the term shall not include:

(1) the Commonwealth or any agency or instrumentality thereof;

(2) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision;

(3) fraternal benefit societies; or

(4) nonprofit medical and hospital service associations.

[The term shall include health maintenance organizations as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."]

* * *

"Person." An individual, a corporation, a partnership, ***a limited liability company,*** an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert. The term shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

* * *

Section 6. Section 1405(a)(2)(i) of the act, amended February 17, 1994 (P.L.92, No.9), is amended to read:

Section 1405. Standards and Management of an Insurer within a Holding Company System.—(a) * * *

(2) The following transactions involving a domestic insurer and any person in its holding company system may not be entered into unless the insurer has notified the department in writing of its intention to enter into such transaction at least thirty (30) days prior thereto or such shorter period as the department may permit and the department has not disapproved it within such period:

(i) Sales, purchases, exchanges, loans or extensions of credit, guarantees **[or]**, investments, **[including]** ***pledges of assets or*** assets to be received by the domestic insurer as contributions to its surplus, provided that, as of the thirty-first day of December next preceding, such transactions are equal to or exceed the lesser of five per centum (5%) of the insurer's admitted assets or twenty-five per centum (25%) of surplus as regards policyholders.

* * *

Section 7. (a) Except as provided in subsection (b), the addition of section 411B of the act shall apply to insurance policies issued or renewed on or after the effective date of this act.

(b) Unless there is a policy provision to the contrary, the addition of section 411B of the act shall apply to policies in existence on the effective date of this act.

Section 8. This act shall take effect as follows:

(1) The amendment of sections 1009-A and 1012-A 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 20th day of December, A.D. 2000.

THOMAS J. RIDGE