No. 54

AN ACT

HB 646

To provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies and subscriber contracts of health plan corporations, nonprofit health service plans and certificates issued by fraternal benefit societies to facilitate public understanding and comparison, to eliminate provisions contained in individual accident and health insurance policies and subscriber contracts of health plan corporations and nonprofit health service plans and certificates issued by fraternal benefit societies which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of accident and health coverages.

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

Section 1. Short Title.—This act shall be known and may be cited as the "Individual Accident and Sickness Insurance Minimum Standards Act."

Section 2. Definitions.—(a) As used in this act:

"Accident and health insurance" means insurance written under section 202(a)(1) and (2) (other than life insurance and annuities) and section 202(c)(2) of The Insurance Company Law of 1921 and 40 Pa. C.S. § 6526, other than credit accident and health insurance.

"Forms" means policies, contracts, riders, endorsements, and applications subject to approval by the Insurance Commissioner, under section 354 of The Insurance Company Law of 1921 or section 11 of the Voluntary Nonprofit Health Service Act of 1972, or 40 Pa. C.S. §§ 6124 and 6329.

"Policy" means the entire contract between the insurer and the insured, including the policy, riders, endorsements and the application, if attached, and also includes subscriber contracts issued by health plan corporations, nonprofit health service plans and certificates issued by fraternal benefit societies.

(b) Health plan corporations, nonprofit health service plans and fraternal benefit societies shall be deemed to be engaged in the business of insurance.

Section 3. Standards for Policy Provisions.—(a) The Insurance Commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosures for their sale for individual policies of accident and health insurance and subscriber contracts of health plan corporations and nonprofit health service plans and certificates issued by fraternal benefit societies and required disclosures for their sale. These regulations shall be in addition to applicable laws of this Commonwealth and may cover but shall not be limited to:

(1) terms of renewability;
(2) initial and subsequent conditions of eligibility;
(3) non-duplication of coverage provisions;
(4) coverage of dependents;
(5) pre-existing conditions;
(6) termination of insurance;
(7) probationary periods;
(8) limitations;
(9) exceptions;
(10) reductions;
(11) elimination periods;
(12) requirements for replacement;
(13) recurrent conditions; and
(14) the definition of terms, including but not limited to, the following: "hospital," "accident," "sickness," "injury," "physician," "accidental means," "total disability," "partial disability," "nervous disorder," "guaranteed renewable," and "non-cancellable."

(b) The Insurance Commissioner may issue regulations that specify prohibited policy provisions not otherwise specifically prohibited by statute which in the opinion of the Insurance Commissioner are unjust, unfair, or unfairly discriminatory to the policyholder, subscriber, any person insured under the policy, or beneficiary.

Section 4. Minimum Standards for Benefits.—(a) The Insurance Commissioner shall issue regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies of accident and health insurance and subscriber contracts of health plan corporations and nonprofit health service plans and certificates issued by fraternal benefit societies:

(1) basic hospital expense coverage;
(2) basic medical-surgical expense coverage;
(3) hospital confinement indemnity coverage;
(4) major medical expense coverage;
(5) disability income protection coverage;
(6) accident only coverage;
(7) specified disease or specified accident coverage; and
(8) supplemental coverage shall be permitted for all preceding categories of coverages with the exception of paragraph (7).

(b) Nothing in this section shall preclude the issuance of any policy or contract which combines two or more of the categories of coverage enumerated in paragraphs (1) through (7) of subsection (a).

(c) No policy or contract shall be delivered or issued for delivery in this State which does not meet the prescribed minimum standards for those categories of coverage listed in paragraphs (1) through (8) of subsection (a) which are contained within the policy or contract unless the Insurance Commissioner finds that such policy or contract will not be unjust, unfair or unfairly discriminatory to the policyholder, subscriber, any person

insured under the policy, or beneficiary. Changes to a policy or contract required by regulations promulgated pursuant to this act, including changes to premium rates applicable thereto, shall be permitted by endorsement or rider unless the commissioner shall determine that such change or changes substantially alters the policy or contract.

(d) Notwithstanding any other provision of this act or regulations promulgated hereunder, any policy or contract submitted for approval which does not meet the prescribed minimum standards for those categories of coverage listed in paragraphs (1) through (8) of subsection (a) which are contained within the policy or contract may be approved if, in the opinion of the Insurance Commissioner, such policy or contract is not unjust, unfair, or unfairly discriminatory to the policyholder, subscriber, any person insured under the policy or beneficiary.

(e) The Insurance Commissioner shall issue regulations prescribing the method of identification of policies and contracts based upon coverages provided.

Section 5. Outline of Coverage.—(a) In order to provide for full and fair disclosure in the sale of individual accident and health insurance policies or subscriber contracts of a health plan corporation or a nonprofit health service plan or certificates issued by fraternal benefit societies, except for supplemental policies sold on the debit plan, and except for riders or amendments to policies or contracts, no such policy or contract shall be delivered or issued for delivery in this State unless the outline of coverage described in subsection (b) either accompanies the policy or is delivered to the applicant at the time application is made.

(b) The Insurance Commissioner shall issue regulations prescribing the format and contents of the outline of coverage required by subsection (a). "Format" means style, arrangement, and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage shall include, in a form understandable to a person of average intelligence and education:

(1) a statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in section 4;

(2) a description of the principal benefits and coverage provided in the policy or contract;

(3) a statement of the exceptions, reductions and limitations contained in the policy or contract;

(4) a statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and

(5) a statement that the outline is a summary of the policy or contract issued or applied for and that the policy or contract should be consulted to determine governing contractual provisions.

Section 6. Pre-existing Conditions.—(a) Notwithstanding the provisions of section 618(A)(2) of The Insurance Company Law of 1921, if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without

any questions concerning the insured's health history or medical treatment history, the policy must cover any loss occurring after 12 months from any pre-existing condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract shall not include wording that would permit a defense based upon pre-existing conditions. Changes to policies or contracts required under this section, including changes to premium rates applicable thereto, shall be permitted by endorsement or rider.

Section 7. Effective Dates of Regulations; Hearings.—All regulations promulgated under this act, including those relating to section 4(c), shall specify an effective date applicable to policies or benefit riders delivered or issued for delivery in this Commonwealth on or after said effective date which shall not be less than 365 days after their adoption or promulgation. All regulations promulgated pursuant to this act shall be issued in accordance with the applicable provisions of the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law." Public hearings shall be held prior to the promulgation of any such regulation, including a verbatim transcript and cross-examination of all witnesses in accordance with applicable rules of procedure, unless such regulation or amendment is insubstantial. The order promulgating any such regulation shall contain findings and the reasons for the regulation; provided that this section shall not create or permit any right of action at law or equity not otherwise authorized or permitted under the law of the Commonwealth. Copies of such orders shall be mailed to those appearing of record at the hearing.

APPROVED—The 18th day of May, A. D. 1976.

MILTON J. SHAPP