No. 185

AN ACT

HB 2065

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," requiring a conversion privilege in certain group accident and sickness policies and notification of certain employe organizations in the event of termination of group accident and sickness insurance contracts.

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

Section 1. Section 621.2, act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," is amended by adding a subsection to read:

Section 621.2. Group Accident and Sickness Insurance.—* * *

(d) A group policy delivered or issued for delivery in this State which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, but not a policy which provides indemnity benefits or benefits for specific diseases or for accidental injuries only, shall provide that an employe or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a policy of health insurance (hereafter referred to as the converted policy). An employe or member shall not be entitled to have a converted policy issued to him if termination of his insurance under the group policy occurred because he failed to pay any required contribution, or any discontinued group coverage was replaced by similar group coverage within thirty-one days. Issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than thirty-one days after such termination.

(2) The converted policy shall be issued without evidence of insurability.

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy,

to the class of risk to which such person then belongs and to his age attained on the effective date of the individual policy.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employe or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(i) (I) such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or

(II) such person is eligible for similar benefits (whether or not covered therefore) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(III) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or Federal law; and

(ii) the benefits provided under the sources referred to in subclause (i)(I) for such person or benefits provided or available under the sources referred to in subclauses (i)(II) and (III) for such person together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner prior to their use in denying coverage.

(7) A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered thereunder as to whether:

(i) he is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(ii) he is covered for similar benefits under any arrangement of coverage for individuals in a group whether on an insured or uninsured basis; or

(iii) similar benefits are provided for or are available to such person, pursuant to or in accordance with the requirements of any state or Federal law. The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person insured thereunder for the following reasons only:

(I) Either the benefits provided under the sources referred to in clause (7)(i) and (ii) for such person or benefits provided or available under the sources referred to in clause (7)(iii) for such person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer standards on file with the commissioner, or the converted policyholder fails to provide the requested information.

(II) Fraud or material misrepresentation in applying for any benefits under the converted policy.

(III) Eligibility of the insured person for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or Federal law providing for benefits similar to those provided by the converted policy.

(IV) Other reasons approved by the commissioner.

(8) An insurer shall not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(9) The converted policy shall not exclude a pre-existing condition not excluded by the group policy. However, the converted policy may provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance thereunder. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy shall not exceed those that would have been payable had the individual insurance under the group policy remained in force and effect.

(10) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employe or member for basic hospital or surgical expense insurance, the employe or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

(i) Plan A:

(I) hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in metropolitan areas of this State, for a maximum duration of seventy days;

(II) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(III) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars ($800); or

(ii) Plan B:

(I) hospital room and board daily expense benefits in a maximum dollar amount equal to seventy-five per centum (75%) of the maximum

dollar amount determined for Plan A, for a maximum duration of seventy days;

(II) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(III) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of six hundred dollars ($600); or

(iii) Plan C:

(I) hospital room and board daily expense benefits in a maximum dollar amount equal to fifty per centum (50%) of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days;

(II) miscellaneous hospital benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(III) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of four hundred dollars ($400).

The maximum dollar amounts in Plan A shall be determined by the commissioner and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. The maximum dollar amounts in Plans A, B and C shall be rounded to the nearest multiple of ten dollars ($10).

(11) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employe or member for major medical expense insurance, the employe or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(i) A maximum benefit at least equal to either, at the option of the insurer in paragraph (I) or (II):

(I) The smaller of the following amounts: the maximum benefit provided under the group policy or a maximum payment of two hundred fifty thousand dollars ($250,000) per covered person for all covered medical expenses incurred during the covered person's lifetime.

(II) The smaller of the following amounts: the maximum benefit provided under the group policy or a maximum payment of two hundred fifty thousand dollars ($250,000) for each unrelated injury or sickness.

(ii) Payment of benefits at the rate of eighty per centum (80%) of covered medical expenses which are in excess of the deductible, until twenty per centum (20%) of such expenses in a benefit period reaches one thousand dollars ($1,000), after which benefits will be paid at the rate of one hundred per centum (100%) during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty per centum (50%).

(iii) A deductible for each benefit period which, at the option of the insurer, shall be:

(I) the sum of the benefits deductible and one hundred dollars ($100); or

(II) a cash deductible, not to exceed one thousand dollars ($1,000); or

(III) the greater of the benefits deductible or five hundred dollars ($500); or

(IV) the corsponding deductible in the group policy.

The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or Federal law and, if pursuant to clause (12), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by subclause (i)(II), the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars ($100) or less, and not less than six months if the deductible exceeds one hundred dollars ($100).

(iv) The benefit period shall be each calendar year when the maximum benefit is determined by subclause (i)(I) or twenty-four months when the maximum benefit is determined by subclause (i)(II).

(v) The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A and the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a one thousand two hundred dollars ($1,200) maximum benefit.

(12) The conversion privilege required by this act shall, if the group insurance policy insures the employe or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in clauses (10) and (11). At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in clauses (10) and (11), provide a policy of comprehensive medical expense benefits without first dollar coverage. Said policy shall conform to the requirements of clause (11): Provided, however, That an insurer electing to provide such a policy shall make available a low deductible option, not to exceed one hundred dollars ($100), a high deductible option between five hundred dollars ($500), and one thousand dollars ($1,000), and a third deductible option midway between the high and low deductible options.

(13) The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by this act.

(14) In the event coverage would be continued under the group policy on an employe following his retirement prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had his insurance terminated at retirement by reason of termination of employment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon his eligibility for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or Federal law providing for benefits similar to those provided by the converted policy.

(16) The conversion privilege shall also be available:

(i) to the surviving spouse, if any, at the death of the employe or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents coverage following the employe's or member's death, at the end of such continuation;

(ii) to the spouse of the employe or member upon termination of coverage of the spouse, while the employe or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

(iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in clause (10) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in clause (10).

(18) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

Each certificate holder in the insured group shall be given written notice of such conversion privilege and its duration within fifteen days before or after the date of termination of group coverage, provided that if such notice be given more than fifteen days but less than ninety days after the date of termination of group coverage, the time allowed for the exercise of such privilege of conversion shall be extended for fifteen days after the giving of

such notice. If such notice be not given within ninety days after the date of termination of group coverage, the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days. Written notice by the contract holder given to the certificate holder or mailed to the certificate holder at his last known address, or written notice by the insurer mailed to the certificate holder at the last address furnished to the insurer by the contract holder, shall be deemed full compliance with the provisions of this clause for the giving of notice. A group contract issued by an insurer may contain a provision to the effect that notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

(20) Where the contract holder is the employer of the certificate holder, the insurer shall also give written notice of termination of the group contract to any organization or organizations representing such certificate holder for the purpose of collective bargaining, and the employer shall provide to the insurer a written list of such organizations within ten days after the date the policy is issued and thereafter within ten days of the beginning or termination of representation by any such organization of any certificate holder or holders, which list shall identify the collective bargaining unit and the group insurance contract to which the request relates. There shall be no liability on the part of, and no cause of action of any nature shall arise, against any labor organization representing the employes of a contract holder for the purposes of collective bargaining due to any action it takes or fails to take as to the written notice required to be given by the insurer under this clause unless shown to have been done in bad faith with malice in fact by any such organization.

Compliance or non-compliance with the provisions of this clause shall in no way affect the rights, duties or obligations of the contract holder, insurer or certificate holder as otherwise set forth in this act.

(21) A converted policy which is delivered outside this State may be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

* * *

Section 2. Clause (21) of subsection (d) of section 621.2, added by section 1 of this act shall take effect in one year; the remainder of this act shall take effect in 180 days.

APPROVED—The 9th day of July, A. D. 1976.

MILTON J. SHAPP