PRINTER'S NO. 3453

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2467 Session of 2024

INTRODUCED BY KHAN, BURNS, HADDOCK, FRIEL, HILL-EVANS, BURGOS, FREEMAN, PIELLI, PROBST, GUENST, SANCHEZ, GIRAL, CIRESI, OTTEN, D. WILLIAMS, CEPEDA-FREYTIZ, SHUSTERMAN, BOROWSKI, KENYATTA, KINKEAD, WAXMAN, DELLOSO, MERSKI, O'MARA, PARKER AND DALEY, JUNE 28, 2024

REFERRED TO COMMITTEE ON INSURANCE, JUNE 28, 2024

AN ACT

1 Amending the act of December 15, 1982 (P.L.1291, No.292),
2 entitled "An act To provide for the reasonable
3 standardization and minimum loss ratios of coverage and
4 simplification of terms and benefits of group medicare
5 supplement accident and health insurance policies or group
6 subscriber contracts of health plan corporations and
7 nonprofit health service plans; to facilitate public
8 understanding and comparison of such policies; to eliminate
9 provisions contained in such policies which may be misleading
10 or confusing in connection with the purchase thereof or with
11 the settlement of claims; and to provide for full disclosure
12 in the sale of such coverages to persons eligible for
13 medicare by reason of age," further providing for
14 definitions; and providing for open enrollment.

15 The General Assembly of the Commonwealth of Pennsylvania
16 hereby enacts as follows:
17 Section 1. The definition of "medicare supplement policy" in
18 section 2 of the act of December 15, 1982 (P.L.1291, No.292),
19 known as the Medicare Supplement Insurance Act, is amended and
20 the section is amended by adding a definition to read:
21 Section 2. Definitions.
22 The following words and phrases when used in this act shall

have, unless the context clearly indicates otherwise, the meanings given to them in this section:

* * *

"Creditable coverage." As defined in 29 U.S.C. § 1181(c)(1) (relating to increased portability through limitation on preexisting condition exclusions).

* * *

"Medicare supplement policy." A [group] policy of accident and health insurance or group subscriber contract of health plan corporations and nonprofit health service plans delivered or issued for delivery in this Commonwealth which is advertised, marketed or designed primarily to supplement coverage for the hospital, medical or surgical expenses of persons eligible for medicare by reason of age. This term does not include:

(1) a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

(2) a policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

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

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

(iii) has been in existence for at least two years prior to the date of its initial offering of such policy

or plan to its members.

Section 2. The act is amended by adding a section to read:

Section 4.1. Open enrollment.

(a) The following shall apply:

(1) An insurer may not deny or condition the issuance or effectiveness of a medicare supplement policy, individual medicare supplement policy or certificate available for sale in this Commonwealth or discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant.

(2) In the case of a group policy, an insurer may condition issuance on whether an applicant is a member or is eligible for membership in the insured group.

(b) An insurer shall issue a policy and coverage shall begin no later than one month of receiving an application and payment of the premium for the first month of coverage.

(c) If an applicant, as of the date of application, has had a continuous period of creditable coverage of at least six months, the insurer may not exclude benefits based on a preexisting condition.

(d) If an applicant, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the insurer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Insurance Commissioner shall specify the manner of the reduction under this subsection.

(e) Except as otherwise provided under this section, subsection (a) shall not be construed as preventing the

1 exclusion of benefits under a policy, during the first six
2 months, based on a preexisting condition for which the
3 policyholder or certificate holder received treatment or was
4 otherwise diagnosed during the six months before it became
5 effective.
6 Section 3. This act shall take effect in 60 days.