AMENDMENTS TO HOUSE BILL NO. 1050

Sponsor: REPRESENTATIVE BOYLE

Printer's No. 1064

Amend Bill, page 1, lines 7 through 18; pages 2 through 7, lines 1 through 30; page 8, line 1; by striking out all of said lines on said pages and inserting

Section 1. Short title.

This act shall be known and may be cited as the Health Insurance Preventive Services Coverage Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Cost sharing." The share of health care costs covered by an insurance policy that an enrollee pays out-of-pocket. The term includes deductibles, coinsurance, copayments and similar charges. The term does not include premium, a balance billed amount from an out-of-network provider or the cost of a noncovered service.

"Department." The Insurance Department of the Commonwealth.

"Enrollee." A policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a health insurance policy.

"Grandfathered health care plan." Individual or group health insurance coverage in which an individual was enrolled prior to the date of enactment of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), or as otherwise specified in 42 U.S.C. § 18011 (relating to preservation of right to maintain existing coverage).

"Health insurance policy." A policy, subscriber contract, certificate or plan issued by an insurer that provides medical or health care coverage. The term does not include any of the following:

(1) An accident only policy.

(2) A credit only policy.

(3) A long-term care or disability income policy.

(4) A specified disease policy.

(5) A Medicare supplement policy.

(6) A fixed indemnity policy.
(7) A dental only policy.
(8) A vision only policy.
(9) A workers' compensation policy.
(10) An automobile medical payment policy.
(11) A policy under which benefits are provided by the Federal Government to active or former military personnel and their dependents.
(12) A hospital indemnity policy.
(13) Any other similar policy providing for limited benefits.

"Insurer." An entity that offers, issues or renews a health insurance policy that provides medical or health care coverage by a health care facility or licensed health care provider and that is governed under any of the following:
(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including section 630 and Article XXIV of The Insurance Company Law of 1921.
(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.
(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).
(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Out-of-network provider." A provider who does not contract with an insurer to provide health care services to an enrollee under a health insurance policy.

Section 3. Preventive services coverage.

(a) Requirements.--
(1) An insurer offering, issuing or renewing a health insurance policy other than a grandfathered health care plan shall, at a minimum, provide coverage and may not impose any cost-sharing requirements for preventive services identified in paragraph (2), subject to modification of the preventive services required to be covered with no cost-sharing requirement in accordance with subsection (b).
(2) Preventive services required to be covered under this subsection include all of the following:
(i) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force as of the date of publication of the notice under section 8.
(ii) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved as of the date of publication of the notice under section 8.
(iii) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines

supported by the United States Health Resources and Services Administration as of the date of publication of the notice under section 8.

(iv) With respect to women, additional preventive care and screenings not described in subparagraph (i) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph as of the date of publication of the notice under section 8.

(b) Modification of preventive services.--

(1) The department may add or exempt one or more preventive services from the preventive services required to be covered without cost-sharing under this section by transmitting notice of an addition or exemption to the Legislative Reference Bureau for publication in the next available issue of the Pennsylvania Bulletin and shall:

(i) Post notice on the publicly accessible Internet website of the department.

(ii) Electronically send notice to the chairperson and minority chairperson of the Banking and Insurance Committee of the Senate and the chairperson and minority chairperson of the Insurance Committee of the House of Representatives.

(2) The department may not add a service unless the service is:

(i) An evidence-based item or service that has in effect a rating of "A" or "B" by the United States Preventive Services Task Force.

(ii) A recommended immunization by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(iii) Preventive care or screenings for women, infants, children or adolescents provided for in the comprehensive guidelines supported by the United States Health Resources and Services Administration.

(3) The department may exempt a service if the service is no longer:

(i) An evidence-based item or service that has in effect a rating of "A" or "B" by the United States Preventive Services Task Force.

(ii) A recommended immunization by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(iii) Preventive care or screenings for women, infants, children or adolescents provided for in the comprehensive guidelines supported by the United States Health Resources and Services Administration.

(4) Prior to adding or exempting a service as provided in paragraph (1), the department shall:

(i) Make available for a 15-day public review and comment period the proposed addition or exemption by

posting an announcement on the publicly accessible Internet website of the department.

(ii) Consider all of the following:

(A) Each public comment received under subparagraph (i).

(B) The potential escalation of the cost of health care services.

(C) Changes in medical evidence or scientific advancement.

(D) The potential for discrimination against individuals by reason of health status or health status-related factors, race, religion, nationality or ethnic group, age, sex, occupation, place of residence or marital status.

(5) An addition or exemption under paragraph (1) shall apply as follows:

(i) For a health insurance policy for which either rates or forms are required to be filed with the department, to a policy for which a form or rate is first filed on or after the notice.

(ii) For a health insurance policy for which neither rates nor forms are required to be filed with the department, to a policy issued or renewed 180 days after the publication of the notice.

(iii) For an exemption of a service on the grounds of a potential danger to patients, at a time established by the commissioner sooner than the time provided in subparagraphs (i) and (ii).

(c) Construction regarding preventive services coverage.--Nothing in this section shall be construed to:

(1) Prohibit an insurer from providing coverage for preventive services in addition to those designated under this act.

(2) Prohibit an insurer from denying coverage for preventive services not designated under this act.

(3) Prevent an insurer from utilizing value-based insurance designs.

(4) Diminish any other law that limits cost sharing for a health care service.

Section 4. Construction.

(a) Actions of insurer.--Subject to subsection (b), nothing in this act shall:

(1) Require an insurer that has a network of providers to provide benefits for items or services described in section 3 that are delivered by an out-of-network provider.

(2) Preclude an insurer that has a network of providers from imposing cost-sharing requirements for items or services described in section 3 that are delivered by an out-of-network provider.

(b) Coverage and cost-sharing.--If an insurer does not have in its network a provider who can provide an item or service

described in section 3, the insurer shall cover the item or service when performed by an out-of-network provider and may not impose cost-sharing with respect to the item or service.

(c) Reasonable medical management techniques.--Nothing in this act shall prevent an insurer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in section 3 to the extent not specified in the relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, an insurer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment or setting for coverage of a recommended preventive health service.

Section 5. Regulations.

The department may promulgate regulations as may be necessary and appropriate to carry out the provisions of this act.

Section 6. Enforcement.

(a) Penalties.--Upon satisfactory evidence of the violation of any section of this act by an insurer or any other person, one or more of the following penalties may be imposed at the commissioner's discretion:

(1) Suspension or revocation of the license of the offending insurer or other person.

(2) Refusal, for a period not to exceed one year, to issue a new license to the offending insurer or other person.

(3) A fine of not more than $5,000 for each violation of this act.

(4) A fine of not more than $10,000 for each willful violation of this act.

(b) Limitations.--

(1) Fines imposed against an individual insurer under this act may not exceed $500,000 in the aggregate during a single calendar year.

(2) Fines imposed against any other person under this act may not exceed $100,000 in the aggregate during a single calendar year.

(c) Additional remedies.--The enforcement remedies imposed under this subsection are in addition to any other remedies or penalties that may be imposed under any other applicable law of this Commonwealth, including:

(1) The act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. Violations of this act shall be deemed to be an unfair method of competition and an unfair or deceptive act or practice under the Unfair Insurance Practices Act.

(2) The act of December 18, 1996 (P.L.1066, No.159), known as the Accident and Health Filing Reform Act.

(3) The act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act.

(d) Administrative procedure.--The administrative provisions of this section shall be subject to 2 Pa.C.S. Ch. 5 Subch. A

(relating to practice and procedure of Commonwealth agencies). A party against whom penalties are assessed in an administrative action may appeal to Commonwealth Court as provided in 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

Section 7. Repeals.

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

Section 8. Notice.

The commissioner shall transmit notice to the Legislative Reference Bureau for publication in the next available issue of the Pennsylvania Bulletin if any of the following occur:

(1) The Congress of the United States repeals, in whole or in part, 42 U.S.C. § 300gg-13 (relating to coverage of preventive health services).

(2) A court of the United States with competent jurisdiction abrogates, vacates or invalidates, in whole or in part, 42 U.S.C. § 300gg-13.

(3) The executive branch of the United States refuses to enforce, or repeals a regulation implementing, in whole or in part, 42 U.S.C. § 300gg-13.

Section 9. Implementation.

The implementation of this act shall be limited to the provisions necessary to achieve a substitute coverage requirement for the portion or portions of 42 U.S.C. § 300gg-13 (relating to coverage of preventive health services) that are impacted by the occurrence of any of the events described in section 8.

Section 10. Effective date.

This act shall take effect as follows:

(1) The following shall take effect immediately:

(i) Section 8.

(ii) Section 9.

(iii) This section.

(2) The remainder of this act shall take effect upon publication of the notice in section 8.