HEALTH SECURITY ACT

Act of Jul. 2, 1996, P.L. 514, No. 85 Cl. 40

AN ACT

Providing for certain health insurance benefits to aid the health and well-being of mother and child following the birth of a child; and prohibiting certain practices by insurers.

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 Health Security 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:

"Covered dentist services." Dental services for which reimbursement is available under an insured's policy, regardless of whether the reimbursement is contractually limited by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation or alternative benefit payment. (Def. added Oct. 24, 2012, P.L.1472, No.186)

"Health insurance policy." Any individual or group health insurance policy, contract or plan which provides medical or health care coverage by any health care facility or licensed health care provider on an expense-incurred service or prepaid basis and which is offered by or is governed under any of the following:

Act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

Subarticle (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

Act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

Act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

Act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

A nonprofit corporation subject to 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

"Insurer." Any entity that issues an individual or group health insurance policy, contract or plan described under the definition of "health insurance policy" in this section.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 3. Postpartum coverage standards.

(a) General rule.--Every health insurance policy that provides maternity benefits and is delivered, issued, executed or renewed in this Commonwealth on or after the effective date of this act shall provide coverage for a minimum of 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following Caesarean delivery.

(b) Other lengths of stay.--In addition to the coverage in subsection (a), a health insurance policy may also provide for a shorter length of stay, but only if the treating or attending

physician determines that the mother and newborn meet medical criteria for safe discharge contained within guidelines developed by or in cooperation with treating physicians which recognize treatment standards, including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum and postpartum course of the mother and infant; the gestational stage, birth weight and clinical condition of the infant; the demonstrated ability of the mother to care for the infant postdischarge; and the availability of the postdischarge follow-up care to verify the condition of the infant and mother within 48 hours after discharge.

(c) Home health care visits.--The health insurance policy shall provide coverage for at least one home health care visit within 48 hours after discharge when discharge occurs prior to the times set forth in subsection (a). Such visits shall be made by a licensed health care provider whose scope of practice includes postpartum care. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the provider. The health insurance policy shall not include any copayment, coinsurance or deductible amount for any postpartum home health care visits.

Section 4. Refusal to contract or compensate.

An insurer shall not refuse to contract with or compensate for covered services an otherwise eligible provider or nonparticipating provider solely because the provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of the provider's patients.

Section 4.1. Fees for noncovered dentist services.

An insurer's contract with a dentist may not require that the dentist provide services to the insurer's insureds at a fee set by the insurer unless those services are covered dentist services.

(4.1 added Oct. 24, 2012, P.L.1472, No.186)

Compiler's Note: Section 3 of Act 186 of 2012 provided that section 4.1 shall apply to insurance policies issued or renewed on or after the effective date of section 3.

Section 5. Effective date.

This act shall take effect in 60 days.