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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 478 Session of 2011

INTRODUCED BY KULA, DeLUCA, GOODMAN, MAHONEY, BRENNAN, V. BROWN, CALTAGIRONE, COHEN, DALEY, DAVIS, FREEMAN, GEORGE, GIBBONS, HALUSKA, JOSEPHS, KOTIK, LONGIETTI, MANN, McGEEHAN, MUNDY, M. O'BRIEN, PASHINSKI, PAYTON, READSHAW, K. SMITH AND WAGNER, MARCH 1, 2011

REFERRED TO COMMITTEE ON INSURANCE, MARCH 1, 2011

AN ACT

Providing for health care coverage; and imposing penalties.

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 Care 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.

"Department." The Insurance Department of the Commonwealth.

"Facility." An institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers,

skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

"Grandfathered plan coverage." Coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with Federal regulations.

"Group health insurance coverage." Health insurance coverage offered in connection with a group health plan.

"Group health plan." An employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829) to the extent that the plan provides medical care and includes items and services paid for as medical care to current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

"Health benefit plan."

(1) A policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. The term includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, except as otherwise exempted under this definition.

(2) The term does not include:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) The term does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Other similar, limited benefits specified in Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996.

(4) The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(5) The term does not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1882(g)(1)).

(ii) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

(iii) Similar supplemental coverage provided to coverage under a group health plan.

"Health care professional." A physician, certified nurse midwife, dentist, podiatrist, nurse, nurse practitioner, chiropractor or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider." A health care professional or a facility.

"Health carrier." A company or health insurance entity licensed in this Commonwealth to offer or issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is governed under this act or any of the following:

(1) Article XXIV of the act of May 17, 1921 (P.L.682, No.284), known as 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) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or Ch. 63 (relating to professional health services plan corporations).

"Health maintenance organization." An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee.

"Individual health insurance coverage." Health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance. A health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.

"Managed care plan." A health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

"Medical care." Amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of

affecting any structure or function of the body.

(2) Transportation primarily for and essential to medical care under paragraph (1).

(3) Insurance covering medical care under paragraphs (1) and (2).

"Network." The group of participating health care professionals providing services to a managed care plan.

Section 3. Coverage for preventive items and services.

(a) Requirement.--A health carrier shall provide coverage for all of the following items and services and may not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) Except as provided under subsection (b), evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010, with respect to the individual involved.

(2) Immunizations for routine use in children, adolescents and adults 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. For purposes of this paragraph:

(i) A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention.

(ii) A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women and to the extent not described under paragraph (1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(b) Cessation.--

(1) (i) A health carrier shall not be required to provide coverage for items or services specified in any recommendation or guideline described under subsection (a) after the recommendation or guideline is no longer described under subsection (a).

(ii) Other provisions of Federal or State law may apply in connection with a health carrier's ceasing to provide coverage for the items or services, including section 2715(d)(4) of the Public Health Services Act, which requires a health carrier to give 60 days advance notice to a covered person before any material modification will become effective.

(2) For purposes of subsection (a) and for the purpose of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in November 2009 are not considered to be current.

(c) Revision.--A health carrier shall, at least annually at the beginning of each new plan year or policy year, revise the preventive services covered under its health benefit plans under

this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time of the revision.

Section 4. Coverage for office visits in conjunction with preventive items and services.

(a) Cost-sharing.--Except as provided under subsection (b), a health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described under section 3:

(1) Is billed separately or is tracked as individual encounter data separately from the office visit.

(2) Is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(b) Cost.--A health carrier may not impose cost-sharing requirements with respect to an office visit if an item or service described under section 3 is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

Section 5. Preventive items and services delivered by out-of-network providers.

(a) Benefits not required.--Nothing in this act shall require a health carrier that has a network of providers to provide benefits for items and services described under section

3 that are delivered by an out-of-network provider.

(b) Cost-sharing.--Nothing under section 3 shall preclude a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described under section 3 that are delivered by an out-of-network provider.

Section 6. Reasonable medical management.

Nothing in this act shall prevent a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described under section 3 to the extent not specified in the recommendation or guideline.

Section 7. Additional services.

Nothing in this act shall prohibit a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described under section 3 even if the treatment results from an item or service described under section 3.

Section 8. Enforcement.

(a) Penalties and remedies.--Upon a determination by hearing that this act has been violated, the commissioner may pursue one or more of the following courses of action:

(1) Issue an order requiring the person in violation to cease and desist from engaging in the violation.

(2) Suspend or revoke or refuse to issue or renew the certificate or license of the person in violation.

(3) Impose a civil penalty of not more than $5,000 for each violation.

(4) Impose any other penalty or remedy deemed appropriate by the commissioner, including restitution.

(b) Other remedies.--The enforcement remedies imposed under this section shall be in addition to any other remedies or penalties that may be imposed by statute. Violations of this article are deemed and defined by the commissioner to be an unfair method of competition and an unfair or deceptive act or practice under the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

Section 9. Applicability.

(a) Applicability.--Except as provided under subsection (b), this act shall apply to a health carrier providing coverage under an individual or group health benefit plan.

(b) Exception.--This act shall not apply to grandfathered plan coverage.

Section 10. Regulations.

The department shall promulgate regulations necessary to implement this act.

Section 20. Effective date.

This act shall take effect in 60 days.