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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

## No. 2848 Session of 2022

INTRODUCED BY FIEDLER, KINKEAD, KENYATTA, MADDEN, HILL-EVANS, ISAACSON, SANCHEZ, KRAJEWSKI, HOHENSTEIN, DELLOSO, FITZGERALD AND A. DAVIS, SEPTEMBER 26, 2022

REFERRED TO COMMITTEE ON INSURANCE, SEPTEMBER 26, 2022

AN ACT

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," in casualty insurance, providing for coverage for abortion services.

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

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

Section 635.8. Coverage for Abortion Services.--(a) An insurer that issues, delivers or renews a health insurance policy or government program in this Commonwealth on or after the effective date of this section shall provide coverage for a drug, product or service.

(b) An insurer may not impose any of the following:

(1) Prior authorization, utilization review, step therapy requirements or any other restriction or delay on the coverage required under this section.

(2) A copayment, coinsurance, deductible or any other cost-sharing requirement for coverage required under this section.

(c) If the FDA has designated a therapeutic equivalent to another drug, product or service that is available under a policy or contract, an insurer shall include the original drug, product or service or, at a minimum, one therapeutic equivalent. If the FDA has not designated a therapeutic equivalent, the insurer shall cover the original drug, product or service.

(d) If a drug, product or service is deemed medically inadvisable by the insured's health care provider, the insurer shall provide coverage for a medically appropriate drug, product or service that is prescribed by the insured's health care provider without a copayment, coinsurance, deductible or other cost-sharing mechanism.

(e) If a drug, product or service is provided by an out-of-network health care provider, the insurer shall provide coverage without imposing a cost-sharing requirement on the insured if any of the following apply:

(1) There is no in-network provider to provide the drug, product or service that is geographically accessible or accessible in a reasonable amount of time as specified under 28 Pa. Code Ch. 9 Subch. H (relating to availability and access).

(2) An in-network provider is unable or unwilling to provide the drug, product or service in a timely manner.

(f) An insurer shall provide the same coverage for an insured under this section to the insured's covered spouse or

domestic partner and covered nonspouse dependent.

(g) An insurer that limits coverage of drugs, devices or other products in a formulary shall provide for coverage for a drug, product and service that is not in the formulary if, in the judgment of the health care provider, the formulary does not include a drug, device or other product that is medically necessary.

(h) An insurer shall establish and implement an easily accessible, transparent and sufficiently expedient process by which an insured may receive a drug, product and service not in the insurer's formulary in accordance with this section.

(i) An insurer may not discriminate in the delivery or coverage of drugs, devices or other products based on the covered person's actual or perceived race, color, national origin, sex, sexual orientation, gender identity or expression, age or disability.

(j) The department shall develop a timely and efficient process to respond to requests from employers seeking an exclusion from the coverage requirements under this section. An employer may request an exclusion from the coverage requirements under this section by submitting a written request to the department if the employer meets any of the following requirements:

(1) The employer is a not-for-profit organization that has the purpose of inculcating religious values.

(2) The employer primarily employs individuals who share the religious tenets of the employer.

(3) The employer primarily serves individuals who share the religious tenets of the employer.

(k) An employer that is granted an exclusion under

subsection (j) shall provide written notice to prospective insureds before their enrollment in the insurer's health insurance policy or government program. The written notice under this subsection shall list the drugs, devices or other products that the employer refuses to cover for religious reasons.

(l) If an employer is granted an exclusion under subsection (j), the following shall apply:

(1) An insured covered under the insurer shall have the right to directly purchase coverage for the cost of drugs, devices or other products from the insurer at the prevailing small group market rate, regardless of whether the insured is part of a small group market.

(2) The insurer shall provide written notice to insureds upon enrollment with the insurer of their right to directly purchase coverage for the cost of drugs, devices or other products under clause (1). The written notice under this clause shall also advise the enrollees of the additional premium for coverage of drugs, devices or other products.

(m) A prospective insured or insured who believes that the prospective insured or insured has been adversely affected by an act or practice of an insurer in violation of this section may file any of the following:

(1) A complaint with the Insurance Commissioner, who shall adjudicate the complaint consistent with 2 Pa.C.S. (relating to administrative law and procedure) and address the violation through means appropriate to the nature and extent of the violation, which may include a cease and desist order, injunctive relief, restitution, suspension or revocation of a certificate of authority or license, civil penalties and reimbursement of costs or reasonable attorney fees incurred by

the aggrieved individual in bringing the complaint.

(2) A civil action against the insurer in a court of competent jurisdiction, which, upon proof of the violation by a preponderance of the evidence, shall award appropriate relief to the aggrieved individual, including temporary, preliminary or permanent injunctive relief, compensatory or punitive damages, the costs of suit, reasonable attorney fees and reasonable fees for the aggrieved individual's expert witnesses. At any time before the rendering of a final judgment under this clause, the aggrieved individual may elect to recover, in lieu of actual damages, an award of statutory damages in the amount of five thousand dollars ($5,000) for each violation.

(n) As used in this section, the following words and phrases shall have the meanings given to them under this subsection:

"Department." The Insurance Department of the Commonwealth.

"Drug, product or service." Abortion as defined in 18 Pa.C.S. § 3203 (relating to definitions).

"FDA." The United States Food and Drug Administration.

"Government program." Any of the following:

(1) The medical assistance program under Subarticle (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the "Human Services Code."

(2) The Children's Health Insurance Program under Article XXIII-A.

"Health care provider." A person who is licensed, certified or otherwise approved by the Commonwealth to provide health care services.

"Health insurance policy." As follows:

(1) An individual or group health insurance policy, subscriber contract, certificate or plan that provides medical

or health care coverage by a health care facility or health care provider and is offered by or is governed under any of the following:

(i) Subarticle (f) of Article IV of the "Human Services Code."

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

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

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

(v) This act.

(2) The term does not include any of the following:

(i) A health benefit plan that is a grandfathered health plan as defined in section 1251 of the Patient Protection and Affordable Care Act (Public Law 111-148, 42 U.S.C. § 18011).

(ii) Any of the following types of insurance:

(A) Accident only.

(B) Fixed indemnity.

(C) Limited benefit.

(D) Credit.

(E) Dental.

(F) Vision.

(G) Specified disease.

(H) Medicare supplement.

(I) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

(J) Long-term care or disability income.

(K) Workers' compensation.

(L) Automobile medical payment.

"Insurer." An entity that issues an individual or a group health insurance policy or government program.

"Therapeutic equivalent." A drug, device or other product that meets all of the following criteria:

(1) The drug, device or other product can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling.

(2) The drug, device or other product is FDA-approved as safe and effective.

(3) The drug, device or other product is a pharmaceutical equivalent that:

(i) contains identical amounts of the same active drug ingredient in the same dosage form and route of administration; and

(ii) meets compendial standards or other applicable standards of strength, quality, purity and identity.

(4) The drug, device or other product is a bioequivalent that:

(i) does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) is shown to meet an appropriate bioequivalence standard if the drug, device or other product does present a known or potential bioequivalence problem.

(5) The drug, device or other product is adequately labeled.

(6) The drug, device or other product is manufactured in compliance with current good manufacturing practice regulations.

Section 2. This act shall effect in 60 days.