PRINTER'S NO. 3871

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2558 Session of 2020

INTRODUCED BY DeLUCA, ZABEL, KINSEY, FREEMAN, PASHINSKI, GALLOWAY, SCHWEYER, BRADFORD, YOUNGBLOOD, ROZZI, LEE, WARREN, ROEBUCK AND SANCHEZ, MAY 28, 2020

REFERRED TO COMMITTEE ON INSURANCE, MAY 28, 2020

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, further providing for health insurance coverage for certain children of insured parents and providing for coverage for essential health benefits, for prohibition on lifetime and annual limits on essential health benefits and for exclusions for preexisting conditions.

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

Section 1. Section 617.1(A) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:

Section 617.1. Health Insurance Coverage for Certain Children of Insured Parents.--(A) An insurer that issues, delivers, executes or renews group health care insurance in this

Commonwealth under which coverage of a child would otherwise terminate at a specified age shall, at the option of the [policyholder] policyholder's insured employe, provide coverage to a child of an insured employe beyond that specified age, up through and including the age of [29] 25, at the insured employe's expense, and provided that the child meet all of the following requirements:

(1) Is not married.

(2) Has no dependents.

(3) Is a resident of this Commonwealth or is enrolled as a full-time student at an institution of higher education.

(4) Is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program, including benefits under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

* * *

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

Section 635.8. Coverage for Essential Health Benefits.--(a) A health insurance policy offered, issued or renewed in this Commonwealth shall include coverage for essential health benefits.

(b) Notwithstanding any other provision of law, the provisions of this section providing greater protections to individuals insured under a health insurance policy shall be construed to supersede any law relating to a requirement of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), except to the extent this section prevents the application of a requirement of the Patient Protection and

Affordable Care Act.

(c) This act shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Insurance Department or the Federal Government, this act shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Insurance Department or the Federal Government, this act shall apply to any policy issued or renewed on or after one hundred eighty days after the effective date of this section.

(d) The Insurance Department may promulgate regulations necessary for the implementation and administration of this section.

(e) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Essential health benefits" means health care services and benefits in the following categories:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn health care.

(5) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease

management.

(10) Pediatric services, including, but not limited to, oral and vision care.

"Health insurance policy" means 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 policies:

(1) Accident only.

(2) Credit only.

(3) Long-term care or disability income.

(4) Specified disease.

(5) Medicare supplement.

(6) Tricare, including a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

(7) Fixed indemnity.

(8) Dental only.

(9) Vision only.

(10) Workers' compensation.

(11) Automobile medical payment under 75 Pa.C.S. (relating to vehicles).

"Health insurer" means an entity licensed by the Insurance Department with accident and health authority to issue a policy, subscriber contract, certificate or plan that provides medical or health care coverage that is offered or governed under any of the following:

(1) This act, including, but not limited to, section 630 and Article XXIV.

(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) or 63 (relating to professional health services plan corporations).

Section 635.9. Prohibition on Lifetime and Annual Limits on Essential Health Benefits.--(a) A health insurance policy offered, issued or renewed in this Commonwealth shall not establish a lifetime limit or annual limit of the dollar amount on essential health benefits for an individual.

(b) Notwithstanding any other provision of law, the provisions of this section providing greater protections to individuals insured under a health insurance policy shall be construed to supersede any law relating to a requirement of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), except to the extent this section prevents the application of a requirement of the Patient Protection and Affordable Care Act.

(c) This act shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Insurance Department or the Federal Government, this act shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Insurance Department or the Federal Government, this act shall apply to any policy issued or renewed on or after one hundred eighty days after the effective date of this section.

(d) The Insurance Department may promulgate regulations necessary for the implementation and administration of this section.

(e) As used in this section, the following words and phrases

shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Essential health benefits." Health care services and benefits in the following categories:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn health care.

(5) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including, but not limited to, oral and vision care.

"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 policies:

(1) Accident only.

(2) Credit only.

(3) Long-term care or disability income.

(4) Specified disease.

(5) Medicare supplement.

(6) Tricare, including a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

(7) Fixed indemnity.

(8) Dental only.

(9) Vision only.

(10) Workers' compensation.

(11) Automobile medical payment under 75 Pa.C.S. (relating to vehicles).

"Health insurer." An entity licensed by the Insurance Department with accident and health authority to issue a policy, subscriber contract, certificate or plan that provides medical or health care coverage that is offered or governed under any of the following:

(1) This act, including, but not limited to, section 630 and Article XXIV.

(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) or 63 (relating to professional health services plan corporations).

Section 635.10. Exclusions For Preexisting Conditions.--(a) A health insurer shall be prohibited from discriminating against a qualified individual or a qualified group based on a preexisting medical condition.

(b) Methods of discriminating based on preexisting medical conditions shall include:

(1) refusing to sell, offer or issue a health insurance policy to a qualified individual or a qualified group due to a preexisting medical condition;

(2) selling, offering or issuing a health insurance policy to a qualified individual or a qualified group that excludes coverage for a preexisting medical condition;

(3) considering a qualified individual's or qualified group's prior medical history in the medical underwriting

process;

(4) requiring or requesting a qualified individual or a qualified group to provide information regarding prior medical history as part of the health insurer's application or enrollment process; or

(5) any other method or action of a health insurer that the Insurance Commissioner deems a limitation or exclusion of benefits based on the fact that a preexisting medical condition was present before the effective date of coverage, or, if coverage is denied, the date of the denial, under a qualified individual's or a qualified group's health insurance policy.

(c) This section shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Insurance Department or the Federal Government, this section shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Insurance Department or the Federal Government, this section shall apply to any policy issued or renewed on or after one hundred eighty days after the effective date of this section.

(d) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Government program." Any of the following:

(1) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Human Services Code."

(2) A program under Article XXIII-A.

"Health insurance policy." Any individual or group health, sickness or accident policy, or subscriber contract or certificate offered, issued or renewed by a health insurer. The term does not include any of the following types of insurance:

(1) Accident only.

(2) Fixed indemnity.

(3) Limited benefit.

(4) Credit.

(5) Dental.

(6) Vision.

(7) Specified disease.

(8) Medicare supplement.

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

(10) Long-term care or disability income.

(11) Workers' compensation.

(12) Automobile medical payment.

"Health insurer." An entity that issues a health insurance policy and is subject to the following:

(1) this act, including, but not limited to, section 630 and Article XXIV;

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Preexisting medical condition." A physical or mental condition, including, but not limited to, a disease, an illness, an injury, pregnancy or a genetic defect for which medical advice, diagnosis, care or treatment has been recommended or

received prior to the effective date of coverage.

"Qualified group." Any of the following:

(1) A group of qualified individuals covered or applying for coverage under the same health insurance policy.

(2) A group of individuals covered under an employer sponsored group health insurance policy.

"Qualified individual." Any of the following:

(1) An individual who is under nineteen (19) years of age.

(2) An individual who:

(i) is covered or applying for coverage under a health insurance policy; and

(ii) has had health coverage under a health insurance policy or government program for at least nine months of the twelve consecutive month period immediately preceding the date of application or enrollment.

Section 3. The amendment of section 617.1(A) of the act shall apply to either of the following that occurs 60 days after the effective date of this act:

(1) entering into a contract; or

(2) renewing a contract.

Section 4. This act shall take effect as follows:

(1) The following shall take effect in 60 days:

(i) The amendment of section 617.1(A) of the act.

(ii) Section 3 of this act.

(2) The addition of sections 635.8, 635.9 and 635.10 of the act shall take effect in 30 days.

(3) The remainder of this act shall take effect immediately.