CHAPTER 194
FORMERLY
SENATE BILL NO. 98
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO INSURANCE AND THE REQUIREMENT OF COVERAGE FOR CERTAIN IMMUNIZATIONS AND PREVENTIVE SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by inserting a §3361 as follows:

"§3361. Recommended Immunizations.

(a) This section applies to any health carrier providing coverage under an individual or group health benefit plan.

(1) This section does not apply to grandfathered plan coverage.

(2) For purposes of this section, "grandfathered plan coverage" means 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.

(b) A health carrier shall provide coverage for the following items and services. A health carrier shall not impose any costs, such as a copayment, coinsurance or deductible with respect to the following items and services:

(1) Except as otherwise provided in this section, 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 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, 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, and 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; and

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

(c) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (b) after the recommendation or guideline is no longer described in subsection (b).

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

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

(f) A health carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to 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 provided for in comprehensive guidelines supported by the Health Resources and Services Administration in effect at the time.

(g) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section is billed separately or is tracked as individual encounter data separately from the office visit.

(h) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in this section 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.

(i) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section 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.

(j) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described herein that are delivered by an out-of-network provider.

(k) Nothing in this section precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described herein that are delivered by an out-of-network provider.

(l) Nothing in this section prohibits a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described herein to the extent not specified in the recommendation or guideline.

(m) Nothing in this section prohibits 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 in this section even if the treatment results from an item or service described herein."

Section 2. Amend §3558, Chapter 35, Title 18 of the Delaware Code by deleting it in its entirety and substituting in lieu thereof the following:

"§3558. Immunizations and Preventive Services.

(a) This section applies to any health carrier providing coverage under an individual or group health benefit plan.

(1) This section does not apply to grandfathered plan coverage.

(2) For purposes of this section, "grandfathered plan coverage" means 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.

(3) This section shall not apply to accident-only, specified diseases, hospital, indemnity, disability income or other fixed indemnity policies.

(b) A health carrier shall provide coverage for the following items and services. A health carrier shall not impose any costs, such as a copayment, coinsurance or deductible with respect to the following items and services:

(1) Except as otherwise provided in this section, 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 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, 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, and 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; and

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

(c) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (b) after the recommendation or guideline is no longer described in subsection (b).

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

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

(f) A health carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to 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 provided for in comprehensive guidelines supported by the Health Resources and Services Administration in effect at the time.

(g) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section is billed separately or is tracked as individual encounter data separately from the office visit.

(h) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in this section 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.

(i) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in this section 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.

(j) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described herein that are delivered by an out-of-network provider.

(k) Nothing in this section precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described herein that are delivered by an out-of-network provider.

(l) Nothing in this section prohibits a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described herein to the extent not specified in the recommendation or guideline.

(m) Nothing in this section prohibits 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 in this section even if the treatment results from an item or service described herein."

Section 3. This Act shall be effective for policies issuing or renewing after June 30, 2011.

Section 4. The provisions of this Act shall be of no force or effect if The Patient Protection and Affordable Care Act, Public Law 111-148 is declared unconstitutional by the Supreme Court of the United States.

Approved September 23, 2011