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SENATE BILL NO. 642

FLOOR AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by Delegate Marshall, R.G.
on March 4, 2010)

(Patron Prior to Substitute—Senator Reynolds)

A BILL to amend and reenact §§ 38.2-3406.1 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.16, relating to health insurance; mandated benefits in policies offered by small employers; application to health maintenance organizations.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3406.1 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.16, as follows:

§ 38.2-3406.1. Application of requirements that policies offered by small employers include state-mandated health benefits.

A. As used in this section:

"Eligible individual" means an individual who is employed by a small employer and has satisfied applicable waiting period requirements.

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis or, a corporation that provides accident and sickness subscription contracts, or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

"Small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed at least two but not more than 50 eligible individuals on business days during the preceding calendar year and who employs at least two eligible individuals on the date a policy under this section becomes effective.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, 38.2-3418.16, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. ~~For~~ Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; and a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, which shall include services for autism spectrum disorder pursuant to § 38.2-3418.16, that is offered, sold, or issued by a health insurer to a small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit, except for:

- a. Coverage for mammograms pursuant to § 38.2-3418.1;
- b. Coverage for pap smears pursuant to § 38.2-3418.1:2;
- c. Coverage for PSA testing pursuant to § 38.2-3418.7; and
- d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1; and
- e. Coverage for autism spectrum disorder pursuant to § 38.2-3418.16.

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60 2. May include any, or none, of the state-mandated health benefits as the health insurer and the small
61 employer shall agree.

62 Notwithstanding any provision of this section to the contrary, if any plan authorized by this section
63 includes and offers health care services covered by the plan that may be legally rendered by a health
64 care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services
65 when rendered by such provider. Unless otherwise provided in this section, this provision shall not
66 require any benefit be provided as a covered service.

67 C. Any application and any enrollment form used in connection with coverage under this section
68 shall prominently disclose that the policy ~~or~~, contract, *or evidence of coverage* is not required to provide
69 state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that
70 the policy ~~or~~, subscription contract, *or evidence of coverage* does not provide, and shall clearly describe
71 all eligibility requirements.

72 D. A policy form ~~or~~, subscription contract, *or evidence of coverage* issued under this section to a
73 small employer shall prominently disclose any and all state-mandated health benefits that the policy ~~or~~,
74 subscription contract, *or evidence of coverage* does not provide. Such disclosure shall also be included
75 in certificate forms or other evidences of coverage furnished to each participant. Health insurers
76 proposing to issue forms providing coverage under this section shall clearly disclose the intended
77 purposes for such policies ~~or~~, contracts, *or evidences of coverage* when submitting the forms to the
78 Commission for approval in accordance with § 38.2-316.

79 E. The Commission shall adopt any regulations necessary to implement this section.

80 § 38.2-3418.16. *Coverage for autism spectrum disorder.*

81 A. *Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue group accident*
82 *and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on*
83 *an expense-incurred basis; each corporation providing group accident and sickness subscription*
84 *contracts; and each health maintenance organization providing a health care plan for health care*
85 *services shall, as provided in this section, provide coverage for the diagnosis of autism spectrum*
86 *disorder and the treatment of autism spectrum disorder in individuals from age two through age six,*
87 *subject to the annual maximum benefit limitation set forth in subsection K. If an individual who is being*
88 *treated for autism spectrum disorder becomes seven years of age or older and continues to need*
89 *treatment, this section does not preclude coverage of treatment and services. In addition to the*
90 *requirements imposed on health insurance issuers by § 38.2-3436, an insurer shall not terminate*
91 *coverage or refuse to deliver, issue, amend, adjust, or renew coverage of an individual solely because*
92 *the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum*
93 *disorder.*

94 B. *For purposes of this section:*

95 "Applied behavior analysis" means the design, implementation, and evaluation of environmental
96 modifications, using behavioral stimuli and consequences, to produce socially significant improvement in
97 human behavior, including the use of direct observation, measurement, and functional analysis of the
98 relationship between environment and behavior.

99 "Autism spectrum disorder" means any pervasive developmental disorder, including (i) autistic
100 disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v)
101 Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of
102 the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

103 "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or
104 tests to diagnose whether an individual has an autism spectrum disorder.

105 "Habilitative or rehabilitative care" means professional, counseling, and guidance services and
106 treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or
107 restore, to the maximum extent practicable, the functioning of an individual.

108 "Pharmacy care" means medications prescribed by a licensed physician and any health-related
109 services deemed medically necessary to determine the need or effectiveness of the medications.

110 "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the
111 state in which the psychiatrist practices.

112 "Psychological care" means direct or consultative services provided by a psychologist licensed in the
113 state in which the psychologist practices.

114 "Therapeutic care" means services provided by licensed or certified speech therapists, occupational
115 therapists, physical therapists, or clinical social workers.

116 "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the
117 following care prescribed, provided, or ordered for an individual diagnosed with autism spectrum
118 disorder by a licensed physician or a licensed psychologist who determines the care to be medically
119 necessary: (i) habilitative or rehabilitative care, (ii) pharmacy care, (iii) psychiatric care, (iv)
120 psychological care, and (v) therapeutic care.

121 "Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a

licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

C. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, an insurer, corporation, or health maintenance organization shall have the right to request a review of that treatment not more than once every 12 months unless the insurer, corporation, or health maintenance organization and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be covered under the policy, contract, or plan.

D. Coverage under this section will not be subject to any visit limits, and shall be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

E. Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of autism spectrum disorder under this section, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan.

F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited, or specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration; (iii) policies, contracts, or plans issued in the individual market or small group markets to employers with 50 or fewer employees; or (iv) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

G. The requirements of this section shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2011, and to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on or after such date.

H. Any coverage required pursuant to this section shall be in addition to the coverage required by § 38.2-3418.5 and other provisions of law. This section shall not be construed as diminishing any coverage required by § 38.2-3412.1:01. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

I. Notwithstanding the provisions of § 2.2-2818.2, this section shall not apply to health coverage offered to state employees pursuant to § 2.2-2818 or to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, teachers, and retirees pursuant to § 2.2-1204 until July 1, 2015.

J. Notwithstanding any provision of this section to the contrary:

1. An insurer, corporation, or health maintenance organization is exempt from providing coverage for habilitative or rehabilitative care required under this section and not covered by the insurer, corporation, or health maintenance organization as of December 31, 2010, if:

a. An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner of Insurance that:

(1) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization for the most recent experience period of at least one year's duration, the costs associated with coverage of habilitative or rehabilitative care required under this section, and not covered as of December 31, 2010, exceeded one percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(2) Those costs solely would lead to an increase in average premiums charged of more than one percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization employs; and

b. The Commissioner approves the certification of the actuary;

2. An exemption allowed under subdivision 1 shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization shall again provide coverage for habilitative or rehabilitative care required under this section;

183 3. An insurer, corporation, or health maintenance organization may claim an exemption for a
184 subsequent year, but only if the conditions specified in subdivision 1 again are met; and

185 4. Notwithstanding the exemption allowed under subdivision 1, an insurer, corporation, or health
186 maintenance organization may elect to continue to provide coverage for habilitative or rehabilitative
187 care required under this section.

188 K. Coverage under this section will be subject to an annual maximum benefit of \$35,000, unless the
189 insurer, corporation, or health maintenance organization elects to provide coverage in a greater
190 amount.

191 § 38.2-4319. Statutory construction and relationship to other laws.

192 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
193 chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218
194 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through
195 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.),
196 §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1,
197 § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of
198 Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800
199 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1,
200 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1,
201 38.2-3418.1 through 38.2-3418.15 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500,
202 subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1
203 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5
204 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.),
205 Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health
206 maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer
207 or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42
208 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance
209 organization.

210 B. For plans administered by the Department of Medical Assistance Services that provide benefits
211 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title
212 except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136,
213 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229,
214 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through
215 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1,
216 Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et
217 seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et
218 seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and
219 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F
220 of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14,
221 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500,
222 subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1
223 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.),
224 Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to
225 any health maintenance organization granted a license under this chapter. This chapter shall not apply to
226 an insurer or health services plan licensed and regulated in conformance with the insurance laws or
227 Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health
228 maintenance organization.

229 C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives
230 shall not be construed to violate any provisions of law relating to solicitation or advertising by health
231 professionals.

232 D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful
233 practice of medicine. All health care providers associated with a health maintenance organization shall
234 be subject to all provisions of law.

235 E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health
236 maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to
237 offer coverage to or accept applications from an employee who does not reside within the health
238 maintenance organization's service area.

239 F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and
240 B of this section shall be construed to mean and include "health maintenance organizations" unless the
241 section cited clearly applies to health maintenance organizations without such construction.