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HOUSE BILL NO. 1174

Offered January 17, 2012

A BILL to amend and reenact § 38.2-4300 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.2:1, relating to health insurers; offering health insurance policies that do not provide coverage for abortion services.

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Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4300 of the Code of Virginia is amended and reenacted and the Code of Virginia is amended by adding a section numbered 38.2-3407.2:1 as follows:

§ 38.2-3407.2:1. Requirement to offer plans that do not provide abortion coverage.

A. As used in this section:

"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, a hospital or medical service policy or certificate, a hospital or medical service plan contract, or a 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 insurance policy" means an individual or group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; an accident and sickness subscription contract providing health insurance coverage for eligible individuals; or a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services.

"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; 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)).

B. A health insurer that offers, sells, or issues a health insurance policy in the Commonwealth that provides coverage for abortion services shall also offer for sale in the Commonwealth a health insurance policy with substantively identical terms and conditions except that it does not provide coverage for abortion services.

C. A health insurance policy that does not provide coverage for abortion services shall (i) provide coverage for the costs of services of a physician and other services incurred in providing medical assistance to preserve the life of a pregnant woman provided every possible measure shall be taken to preserve the life of the unborn child of the pregnant woman or (ii) reimburse the costs of services incurred in providing medical treatment to address previous fetal demise or intrauterine fetal death.

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

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of the Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than $50,000 nor more than $500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) ~~of this title~~. In the case of a health maintenance organization that has contracted with the Commonwealth to furnish basic health services to recipients of medical assistance under Title XIX of

the United States Social Security Act pursuant to § 38.2-4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325. *"Basic health care services" may, but shall not be required to, provide coverage for abortion services; however, plans that do not provide coverage for abortion services shall (i) provide coverage for the costs of services of a physician and other services incurred in providing medical assistance to preserve the life of a pregnant woman provided every possible measure shall be taken to preserve the life of the unborn child of the pregnant woman or (ii) reimburse the costs of services incurred in providing medical treatment to address previous fetal demise or intrauterine fetal death.*

"Copayment" means an amount an enrollee is required to pay in order to receive a specific health care service.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate or individual or group agreement or contract issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in the Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least 90 percent of total costs of health care services.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Limited health care services" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Net worth" or "capital and surplus" means the excess of total admitted assets over the total liabilities of the health maintenance organization, provided that surplus notes shall be reported and accounted for in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practice and procedures manuals.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees and to hold those enrollees harmless from payment with an expectation of receiving payment, other than

copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee, or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.