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HOUSE BILL NO. 2267

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Labor on February 2, 2017)

(Patron Prior to Substitute—Delegate Filler-Corn)

A BILL to amend and reenact § 2.2-2818.2 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.5:2 relating to health benefit plans; coverage for hormonal contraceptives.

Be it enacted by the General Assembly of Virginia:

1. That § 2.2-2818.2 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.5:2 as follows:

§ 2.2-2818.2. Application of mandates to the state employee health insurance plan.

A. As used in this section, "insurance mandate" means a mandatory obligation with respect to coverage, benefits, or the number or types of providers imposed on policies of accident and health insurance under Title 38.2. "Insurance mandate" does not include *(i)* an administrative rule or regulation imposing a mandatory obligation with respect to coverage, benefits, or providers unless that mandatory obligation was specifically imposed on policies of accident and health insurance by statute *or (ii) any obligation imposed on a health carrier by § 38.2-3407.5:2*.

B. Notwithstanding the provisions of § 2.2-2818, any law imposed under Title 38.2 that becomes effective on or after July 1, 2009, that provides for an insurance mandate for policies of accident and health insurance shall also apply to health coverage offered to state employees pursuant to § 2.2-2818.

C. If health coverage offered to state employees under § 2.2-2818 offers coverage in the same manner and to the same extent as the coverage required by an insurance mandate imposed under Title 38.2 or coverage that is greater than an insurance mandate imposed under Title 38.2, the coverage offered to state employees under § 2.2-2818 shall be considered in compliance with the insurance mandate.

§ 38.2-3407.5:2. Reimbursements for dispensing hormonal contraceptives.

A. As used in this section:

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement (MEWA), or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; short-term limited duration coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide a health benefit plan.

"Hormonal contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose.

"Provider" means a facility, physician or other type of health care practitioner licensed, accredited, certified or authorized by statute to deliver or furnish health care items or services.

B. Any health benefit plan that is amended, renewed, or delivered on or after January 1, 2018, that provides coverage for hormonal contraceptives shall cover up to a 12-month supply of hormonal contraceptives when dispensed or furnished at one time for a covered person by a provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies.

C. Nothing in this section shall be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

D. A health benefit plan that provides coverage for hormonal contraceptives, in the absence of clinical contraindications, shall not impose utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished by a provider or

pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies, to an amount that is less than a 12-month supply.

E. This section shall not be construed to exclude coverage for hormonal contraceptives as prescribed by a provider, acting within his scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

F. Nothing in this section shall be construed to require a health carrier to cover hormonal contraceptives provided by a provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies, that does not participate in the health carrier's provider network, except as may be otherwise authorized or required by state law or by the plan's policies governing out-of-network coverage.