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HOUSE BILL NO. 1922

Offered January 13, 2021
Prefiled January 10, 2021

A BILL to amend and reenact §§ 32.1-325, 32.1-351, 38.2-3407.5:1, 38.2-3451, and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.21, relating to coverage for reproductive health care services.

Patrons—Price, Bourne, Carr, Hope and Kory; Senators: Boysko and McClellan

Referred to Committee on Labor and Commerce

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325, 32.1-351, 38.2-3407.5:1, 38.2-3451, and 38.2-4319 of the Code of Virginia are amended and reenacted and the Code of Virginia is amended by adding a section numbered 38.2-3418.21 as follows:

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate contact information, including the best available address and telephone number, from each applicant for medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance directives and how the applicant may make an advance directive;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician, physician assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and

restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs;

24. A provision, when authorized by and in compliance with federal law, to establish a public-private long-term care partnership program between the Commonwealth of Virginia and private insurance companies that shall be established through the filing of an amendment to the state plan for medical assistance services by the Department of Medical Assistance Services. The purpose of the program shall be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for such services through encouraging the purchase of private long-term care insurance policies that have been designated as qualified state long-term care insurance partnerships and may be used as the first source of benefits for the participant's long-term care. Components of the program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and applicable federal guidelines;

25. A provision for the payment of medical assistance for otherwise eligible pregnant women during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3); ~~and~~

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. No health care provider who provides health care services through telemedicine services shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

For the purposes of this subdivision, "originating site" means any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of employment, or any public or private primary or secondary school or postsecondary institution of higher education at which the person to whom telemedicine services are provided is located*; and*

27. A provision for the payment of medical assistance for the following reproductive health care services for eligible individuals, when such services are medically necessary for the individual, regardless of whether such medical assistance is eligible for federal financial participation:

a. Well-woman care required by regulations of the Department, which shall be consistent with guidelines published by the U.S. Health Resources and Services Administration and the specific types of care recommended by the 2016 Final Report of the Women's Preventive Services Initiative.

b. Counseling for sexually transmitted infections, including human immunodeficiency virus and acquired immunodeficiency syndrome.

c. Screening for:
(1) Chlamydia;
(2) Gonorrhea;
(3) Hepatitis B;
(4) Hepatitis C;
(5) Human immunodeficiency virus and acquired immunodeficiency syndrome;
(6) Human papillomavirus;
(7) Syphilis;
(8) Anemia;
(9) Urinary tract infection;
(10) Pregnancy;
(11) Rh incompatibility;
(12) Gestational diabetes;
(13) Osteoporosis;
(14) Breast cancer; and
(15) Cervical cancer.

d. Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.

e. Screening and appropriate counseling or interventions for domestic and intimate partner violence.

f. Folic acid supplements.

g. Abortion.

h. Comprehensive support, including counseling and supplies, for breastfeeding.

i. Breast cancer chemoprevention counseling.

j. Any contraceptive drug, device, or product approved by the U.S. Food and Drug Administration prescribed by a health care provider, provided, however, that in cases in which a therapeutic equivalent of a specific contraceptive drug, device, or product has been approved by the U.S. Food and Drug Administration (FDA), the state plan may provide coverage for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product. In the case of hormonal contraception, the state plan shall provide for the payment of medical assistance for the dispensing of a 12-month supply of such hormonal contraception at one time.

Nothing in this subdivision shall (i) infringe upon an enrollee's choice of contraceptive drug, device, or product, and the Department shall not require prior authorization, step therapy, or other utilization control techniques for medically appropriate covered contraceptive drugs, devices, or products approved by the FDA or (ii) be construed to exclude the payment of medical assistance for drugs approved by the FDA as contraceptive drugs that are prescribed for reasons other than contraception or for prescription female contraceptives that are necessary to preserve the life or health of an eligible individual.

k. Voluntary sterilization.

l. As a single claim or combined with other claims for covered services provided on the same day:
(1) Patient education and counseling on contraception and sterilization; and
(2) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices, and products, including:
(a) Management of side effects;
(b) Counseling for continued adherence to a prescribed regimen;
(c) Device insertion and removal; and
(d) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the eligible individual's provider;

m. Any additional preventive services for women that are required to be covered without cost sharing under 42 U.S.C. § 300gg-13, as identified by the U.S. Preventive Services Task Force or the Health Resources and Services Administration of the U.S. Department of Health and Human Services as of January 1, 2017; and

n. Medical assistance for pregnant women that is authorized by Title XXI, § 2112, of the Social Security Act, 42 U.S.C. § 1397ll, for one year immediately postpartum.

As used in this subdivision 27, "eligible individual" means an individual with reproductive health care needs who (i) is eligible for and enrolled in the medical assistance program or (ii) would be eligible to enroll in the medical assistance program but for 8 U.S.C. §§ 1611 and 1612.

An eligible individual shall not be denied or otherwise subjected to discrimination in the payment of medical assistance for reproductive health care services described in this subdivision 27 under the state plan on the basis of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age, or disability.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to 42 C.F.R. Part 1002.

5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of § 32.1-162.13.

For the purposes of this subsection, "provider" may refer to an individual or an entity.

E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

The Director may consider aggravating and mitigating factors including the nature and extent of any

adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to subsection D, the Director may determine the period of exclusion and may consider aggravating and mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of health care services under Medicaid and the Family Access to Medical Insurance Security Plan established under § 32.1-351.

4. Require any managed care organization with which the Department enters into an agreement for the provision of medical assistance services to include in any contract between the managed care organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the managed care organization's managed care plans. For the purposes of this subdivision:

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a managed care organization for the benefit of covered individuals.

"Pharmacy benefits manager" means a person that performs pharmacy benefits management.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-351. Family Access to Medical Insurance Security Plan established.

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals under the age of 19 when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title

XIX of the Social Security Act, as amended; (iii) are not covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91 (a) and (b)(1)); and (iv) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan. Eligible children, residing in Virginia, whose family income does not exceed 200 percent of the federal poverty level during the enrollment period shall receive 12 continuous months of coverage as permitted by Title XXI of the Social Security Act.

B. The Department of Medical Assistance Services shall also provide coverage for children and pregnant women who meet the criteria set forth in clauses (i) through (iv) of subsection A during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

C. Family Access to Medical Insurance Security Plan participants shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. The annual aggregate cost-sharing for all eligible children in a family at or below 150 percent of the federal poverty level shall not exceed 2.5 percent of the family's gross income. The nominal copayments for all eligible children in a family shall not be less than those in effect on January 1, 2003. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

D. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students. *The medical benefits required herein shall include reproductive health care services in accordance with the requirements of subdivision A 27 of § 32.1-325.* The mental health services required herein shall include intensive in-home services, case management services, day treatment, and 24-hour emergency response. The services shall be provided in the same manner and with the same coverage and service limitations as they are provided to children under the State Plan for Medical Assistance Services.

E. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1.

F. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this program does not substitute for private health insurance coverage.

G. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance. All eligible individuals, insofar as feasible, shall be enrolled in health maintenance organizations.

H. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Family Access to Medical Insurance Security Plan shall include a provision allowing a child's application to be filed by a parent, legal guardian, authorized representative or any other adult caretaker relative with whom the child lives. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. A single application form shall be used to determine eligibility for Title XIX or Title XXI of the Social Security Act, as amended, and outreach, enrollment, re-enrollment and services delivery shall be coordinated with the FAMIS Plus program pursuant to § 32.1-325. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by

contacting the local department of social services.

I. The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

J. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care.

K. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

L. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

M. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

N. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

O. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Centers for Medicare & Medicaid Services as Virginia's State Children's Health Insurance Program.

§ 38.2-3407.5:1. Coverage for prescription contraceptives.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis, shall offer and make available coverage thereunder for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive.

B. No insurer, corporation or health maintenance organization shall impose upon any person receiving prescription contraceptive benefits pursuant to this section any (i) copayment, coinsurance payment or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level receiving benefits for prescription drugs, or (ii) reduction in allowable reimbursement for prescription drug benefits.

C. The provisions of subsection A shall not be construed to:

1. Require coverage for prescription coverage benefits in any contract, policy or plan that does not otherwise provide coverage for prescription drugs;

2. Preclude the use of closed formularies, provided, however, that such formularies shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods; or

3. Require coverage for experimental contraceptive drugs not approved by the United States Food and Drug Administration.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or

specified disease 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, or to short-term nonrenewable policies of not more than six months' duration.

E. The provisions of this section shall be applicable to contracts, policies, or plans delivered, issued for delivery, or renewed in ~~this~~ *the* Commonwealth on and after July 1, 1997 *but prior to January 1, 2022. On and after January 1, 2022, contracts, policies, or plans delivered, issued for delivery, or renewed in the Commonwealth shall provide coverage for reproductive health services under § 38.2-3418.21.*

§ 38.2-3418.21. Coverage for reproductive health services.

A. As used in this section:

"Carrier" means an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a corporation providing individual or group accident and sickness subscription contracts; a health maintenance organization providing a health care plan for health care services; or any other 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.

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

"FDA" means the U.S. Food and Drug Administration.

"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; short-term travel, accident-only, or limited or specified disease policies or contracts; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare; 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.

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

"Religious employer" means an entity for which each of the following is true:

1. The inculcation of religious values is the purpose of the entity;

2. The entity primarily employs persons who share the religious tenets of the entity;

3. The entity serves primarily persons who share the religious tenets of the entity; and

4. The entity is a nonprofit organization as described in § 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code, as amended.

B. Notwithstanding the provisions of § 38.2-3419, each carrier shall provide coverage, under any health benefit plan sold or offered for sale by the carrier in the Commonwealth, for all of the following services, drugs, devices, products, and procedures:

1. Well-woman care prescribed by the Commission by rule consistent with guidelines published by the U.S. Health Resources and Services Administration and the specific types of care recommended by the 2016 Final Report of the Women's Preventive Services Initiative.

2. Counseling for sexually transmitted infections, including human immunodeficiency virus and acquired immunodeficiency syndrome.

3. Screening for:

a. Chlamydia;

b. Gonorrhea;

c. Hepatitis B;

d. Hepatitis C;

e. Human immunodeficiency virus and acquired immunodeficiency syndrome;

f. Human papillomavirus;

g. Syphilis;

h. Anemia;

i. Urinary tract infection;

j. Pregnancy;

k. Rh incompatibility;

l. Gestational diabetes;

m. Osteoporosis;

n. Breast cancer; and

o. Cervical cancer.

4. Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.

5. Screening and appropriate counseling or interventions for domestic and intimate partner violence.

6. Folic acid supplements.

7. Abortion.

8. Comprehensive support, including counseling and supplies, for breastfeeding.

9. Breast cancer chemoprevention counseling.

10. Any contraceptive drug, device, or product approved by the U.S. Food and Drug Administration prescribed by a health care provider, including pharmacy claims for reimbursement of all contraceptives approved for over-the-counter sale, subject to the requirements of § 38.2-3407.5:2. In cases in which a therapeutic equivalent of a specific contraceptive drug, device, or product has been approved by the U.S. Food and Drug Administration (the FDA), the health benefit plan may provide coverage for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product. If a contraceptive drug, device, or product covered by the health benefit plan is deemed medically inadvisable by a covered person's provider, the plan shall cover an alternative contraceptive drug, device, or product prescribed by the provider. A health benefit plan shall not infringe upon a covered person's choice of contraceptive drug, device, or product, and shall not require prior authorization, step therapy, or other utilization control techniques for medically appropriate covered contraceptive drugs, devices, or products approved by the FDA. Nothing in this section shall be construed to exclude the payment coverage, payment, or reimbursement of prescription drugs approved by the FDA as contraceptive drugs that are prescribed for reasons other than contraception or for prescription female contraceptives that are necessary to preserve the life or health of a covered person.

11. Voluntary sterilization.

12. As a single claim or combined with other claims for covered services provided on the same day:

a. Patient education and counseling on contraception and sterilization; and

b. Services related to sterilization or the administration and monitoring of contraceptive drugs, devices, and products, including:

(1) Management of side effects;

(2) Counseling for continued adherence to a prescribed regimen;

(3) Device insertion and removal; and

(4) Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the covered person's provider.

13. Any additional preventive services for women that are required to be covered without cost sharing under 42 U.S.C. § 300gg-13, as identified by the U.S. Preventive Services Task Force or the Health Resources and Services Administration of the U.S. Department of Health and Human Services as of January 1, 2017.

C. A carrier shall not impose any deductible, coinsurance, copayment, or other cost-sharing requirement on a covered person for the coverage required by this section, except (i) for coverage provided by subsection F and (ii) to the extent that coverage without cost-sharing would disqualify a high-deductible health benefit plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223. A carrier shall reimburse a provider for providing the services described in this section without any deduction for coinsurance, copayments, or any other cost-sharing amounts.

D. Except as authorized under this section, a carrier shall not impose any restrictions or delays on the coverage required by this section. If an out-of-network provider provides services, drugs, devices, products, or procedures required by this section, the carrier shall cover the services, drugs, devices, products, or procedures without imposing any cost-sharing requirement on the covered person if:

1. There is no in-network provider to furnish the service, drug, device, product, or procedure that is geographically accessible or accessible in a reasonable amount of time, as determined by the Commissioner by rule; or

2. An in-network provider is unable or unwilling to provide the service in a timely manner.

E. This section does not require a carrier to cover:

1. Experimental or investigational treatments;

2. Clinical trials or demonstration projects;

3. Treatments that do not conform to acceptable and customary standards of medical practice; or

4. Treatments for which there is insufficient data to determine efficacy.

F. A carrier may offer to a religious employer a health benefit plan that does not include coverage

for abortion procedures that are contrary to the religious employer's religious tenets only if the carrier notifies in writing all employees who are eligible to be enrolled in the religious employer's health benefit plan of the procedures the employer refuses to cover for religious reasons.

G. If the Commissioner concludes that enforcement of this section may adversely affect the allocation of federal funds to the Commonwealth, the Commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

H. A carrier that is subject to this section shall make readily accessible to covered persons and potential covered persons, in a consumer-friendly format, information about the coverage described in this section. The carrier shall provide the information on its website and in writing upon request by a covered person or potential covered person.

I. A covered person shall not, on the basis of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in the coverage of or payment for reproductive health services by any carrier with respect to any health benefit plan issued or delivered in the Commonwealth. A violation of this subsection shall be considered an unfair trade practice under Chapter 5 (§ 38.2-500 et seq.).

J. The requirements of this section shall apply to all health benefit plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2022, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made thereto.

§ 38.2-3451. Essential health benefits.

A. Notwithstanding any provision of law to the contrary, any person offering or providing a health benefit plan providing individual or small group health insurance coverage, including (i) catastrophic health insurance policies, and policies that pay on a cost-incurred basis; (ii) association health plans; and (iii) plans provided by a multiple-employer welfare arrangement, shall provide that such coverage includes essential health benefits. Nothing in this section shall require a health benefit plan providing large group health insurance coverage to provide coverage for essential health benefits in a manner that exceeds the requirements of the PPACA as of January 1, 2019. The essential health benefits package may also include associated cost-sharing requirements or limitations. ~~No qualified health insurance plan that is sold or offered for sale through an exchange established or operating in the Commonwealth shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto, provided that such limitation shall not apply to an abortion performed (a) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (b) when the pregnancy is the result of an alleged act of rape or incest.~~

B. The provisions of subsection A requiring minimum essential pediatric oral health benefits shall be deemed to be satisfied for health benefit plans made available in the small group market or individual market in the Commonwealth outside an exchange, as defined in § 38.2-3455, issued for policy or plan years beginning on or after January 1, 2015, that do not include the minimum essential pediatric oral health benefits if the health carrier has obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan. The health carrier shall be deemed to have obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan if:

1. At least one qualified dental plan, as defined in § 38.2-3455, (i) offers the minimum essential pediatric oral health benefits and (ii) is available for purchase by the small group or individual purchaser; and

2. The health carrier prominently discloses, in a form approved by the Commission, at the time that it offers the health benefit plan that the plan does not provide the minimum essential pediatric oral health benefits.

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

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this 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 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, *and* 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 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, 38.2-3407.9 through 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1

through ~~38.2-3418.20~~ *38.2-3418.21*, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and Chapter 65 (§ 38.2-6500 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this 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 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, 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 seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, 2, and 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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

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

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

2. That the Department of Medical Assistance Services shall seek federal authority through waiver and state plan amendments under Title XIX and XXI of the Social Security Act to extend coverage for pregnant women with household incomes between 138 percent and 205 percent of the federal poverty level for one year immediately postpartum.

3. That the Department of Medical Assistance Services shall submit a State Plan Amendment and prepare necessary regulatory changes to allow for the dispensing of up to a 12-month supply of contraceptive drugs.

4. That the Board of Medical Assistance Services shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.