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SENATE BILL NO. 1397

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on January 30, 2023)

(Patron Prior to Substitute—Senator Surovell)

A BILL to amend and reenact §§ 30-342 and 30-343 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 30-343.1, relating to the Health Insurance Reform Commission; review of essential health benefits benchmark plan.

Be it enacted by the General Assembly of Virginia:

1. That §§ 30-342 and 30-343 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 30-343.1 as follows:

§ 30-342. Powers and duties.

The Commission shall have the following powers and duties:

1. Monitor the work of appropriate federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (the Act), including amendments thereto and regulations promulgated thereunder;

2. Receive information provided to the Commission pursuant to § 30-343 and, on the basis of such information, assess the implications of the Act's implementation on residents of the Commonwealth, businesses operating within the Commonwealth, and the general fund of the Commonwealth;

3. Consider the development of a comprehensive strategy for implementing health reform in Virginia, including recommendations for innovative health care solutions independent of the approach embodied in the Act that meet the needs of Virginia's citizens and government by creating an improved health system that will serve as an economic driver for the Commonwealth while allowing for more effective and efficient delivery of high quality care at lower cost;

4. Receive periodic reports from the Bureau of Insurance of the State Corporation Commission *(the Bureau)* pursuant to § 30-343 and recommend, *in accordance with the provisions of § 30-343.1,* health benefits required to be included within the scope of the essential health benefits provided under health insurance products offered in the Commonwealth, including any benefits that are not required to be provided by the terms of the Act;

5. Upon request of the Chairman of the House Committee on Labor and Commerce or Senate Committee on Commerce and Labor, assess proposed mandated benefits and providers as provided in § 30-343 and recommend whether, on the basis of such assessments, mandated benefits and providers be providers under health care plans offered through a health benefit exchange, outside a health benefit exchange, neither, or both;

6. Conduct other studies of mandated benefits and provider issues as requested by the General Assembly; and

7. Develop such recommendations as may be appropriate for legislative and administrative consideration in order to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

§ 30-343. Standing committees to request Commission assessment.

A. Whenever a legislative measure containing a mandated health insurance benefit or provider is proposed that is not identical or substantially similar to a legislative measure previously reviewed by the Commission within the three-year period immediately preceding the then-current session of the General Assembly, the Chair of the House Committee on Labor and Commerce or Senate Committee on Commerce and Labor having jurisdiction over the proposal shall (i) request that the Commission assess the proposal and (ii) send a copy of such request to the Bureau of Insurance of the State Corporation Commission (the Bureau). The Commission shall be given a period of 24 months to complete and submit its assessment. A report summarizing the Commission's assessment shall be forwarded to the Chairman of the standing committee that requested the assessment. For the purposes of this section, "mandated health insurance benefit or provider" has the same meaning as "state-mandated health benefit" provided in § 38.2-3406.1.

B. Upon receipt of a copy of such a request, the Bureau shall prepare an analysis of the extent to which the proposed mandate is currently available under qualified health plans in the Commonwealth and advise the Commission as to whether~~, on the basis of that analysis,~~ the applicable agency has determined or would likely determine, in accordance with applicable federal rules, that the proposed mandate exceeds the scope of the essential health benefits. The Bureau's analysis shall be advisory only and not binding upon the Commission, the Bureau, the State Corporation Commission, or any other parties. As used in this section, "applicable agency" means the governmental agency that in accordance

with applicable federal rules is responsible for identifying state-mandated benefits that are in addition to the essential health benefits. If the applicable federal rules require an agency of the Commonwealth to identify the state-mandated benefits that are in addition to the essential health benefits but do not identify a specific agency that is responsible for making such identification, the Bureau shall be the applicable agency. *Following the Bureau's analysis, the Commission shall determine if the proposed mandate shall be (i) considered as part of an essential health benefits benchmark plan review in accordance with the provisions of § 30-343.1, (ii) assessed jointly by the Bureau and the Joint Legislative Audit and Review Commission in accordance with subsection C, or (iii) considered in another manner by the Commission.*

C. Upon request of the Commission, the Bureau and the Joint Legislative Audit and Review Commission shall jointly assess the social and financial impact and the medical efficacy of the proposed mandate, which assessment shall include an estimate of the effects of enactment of the proposed mandate on the costs of health coverage in the Commonwealth, including any estimated additional costs that the Commonwealth may be responsible for pursuant to § 1311(d)(3)(B) of the Patient Protection and Affordable Care Act should the proposed mandate ultimately be determined by the applicable agency to be a benefit that exceeds the scope of the essential health benefits. Upon completion of the assessment by the Bureau and the Joint Legislative Audit and Review Commission, the Commission may make a recommendation regarding its support of or opposition to the enactment of the proposed mandate. The Commission's recommendation may address whether the proposed mandate should be provided under health care plans offered through a health benefit exchange or outside a health benefit exchange.

The Commission shall be given a period of 24 months to complete and submit its assessment. A report summarizing the Commission's study shall be forwarded to the Governor and the General Assembly.

D. Whenever a legislative measure containing a mandated health insurance benefit or provider is identical or substantially similar to a legislative measure previously reviewed by the Commission within the three-year period immediately preceding the then-current session of the General Assembly, the standing committee may request the Commission to study the measure as provided in subsection A.

§ 30-343.1. Review of essential health benefits benchmark plan.

A. As used in this section:

"Bureau" means the Bureau of Insurance of the State Corporation Commission.

"Essential health benefits benchmark plan" or "benchmark plan" has the same meaning as "EHB-benchmark plan" provided in 45 C.F.R. § 156.20.

B. The Commission, in coordination with the Bureau, shall conduct a review of the essential health benefits benchmark plan in 2025 and every five years thereafter in accordance with 45 C.F.R. § 156.111 and this section.

C. Prior to any review year, the Bureau shall convene a workgroup of relevant stakeholders to discuss and make recommendations regarding any potential changes to the benchmark plan. Workgroup members shall have demonstrated and acknowledged expertise in assisting or advocating for those enrolled in individual or small group health coverage, health benefit plan design, actuarial science, population health, or patient advocacy. Factors to be considered by the workgroup shall include (i) coverage denial rates of uncovered benefits under the current benchmark plan; (ii) utilization of mandated benefits; (iii) the projected impact of a proposed mandate on the prevalence of medical need, the intensity of that medical need, and the disproportionate disease burden borne by different subpopulations; (iv) the projected cost of each proposed mandate; and (v) other data as determined by the workgroup. Additionally, for any referred legislation the Commission has chosen to be considered in the benchmark plan review, the Bureau shall complete an assessment of such legislation that includes an estimate of the effects of including the proposed mandate as part of the benchmark plan on the costs of health coverage in the Commonwealth. The Bureau shall submit the findings and any recommendations of the workgroup and any assessments of proposed mandates to the Commission by March 31 of the review year.

D. By June 30 of any review year, the Commission shall determine if an application will be made for a change to the benchmark plan and shall identify any potential benefit changes to the benchmark plan for further analysis. In making its determination and identifying any potential benefit changes, the Commission may consider (i) the findings and recommendations of the workgroup, (ii) any referred legislation the Commission has chosen to be considered in the benchmark plan review and the Bureau's assessment of such legislation, and (iii) public comment. If the Commission determines that an application will be made for a change to the benchmark plan, the Commission shall identify any potential benefit changes for further analysis.

E. The Bureau shall conduct an actuarial analysis of any benefit changes identified by the Commission and present such analysis to the Commission by September 30 of such review year.

F. By December 31 of any review year, the Commission shall determine which, if any, potential benefit changes shall be included in a new benchmark plan. The Commission shall make a

recommendation to the General Assembly in the form of a bill at the next regular session of the General Assembly that directs the Bureau to select a new benchmark plan that includes any such changes.

G. During the review year, the Commission shall conduct public hearings to solicit feedback from consumers and other interested parties regarding any potential benefit changes to the benchmark plan. At least two public hearings shall be held prior to the Commission's determination required by subsection D. If the Commission has determined that an application for a new benchmark plan will be made for a change to the benchmark plan, at least two additional public hearings shall be held prior to selection of a new benchmark plan required by subsection F. Such hearings shall be adequately advertised and planned and shall include an opportunity for the public to participate both in person and remotely.

H. The Bureau shall establish and maintain a website to convey relevant information to the public related to any benchmark plan review.