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HOUSE BILL NO. 21

Offered January 10, 2018

Prefiled November 24, 2017

A BILL to amend and reenact §§ 38.2-3407.5:1 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.18, relating to coverage for certain health care services, drugs, devices, products, and procedures related to reproductive health.

Patrons—Kory, Rasoul, Ayala, Delaney, Guzman, Hope, Hurst, Levine and Roem

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3407.5:1 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 38.2-3418.18 as follows:

§ 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~~ *from* July 1, 1997, *until January 1, 2019. On and after January 1, 2019, contracts, policies or plans delivered, issued for delivery or renewed in the Commonwealth shall provide coverage for reproductive health services under § 38.2-3418.18.*

§ 38.2-3418.18. Coverage for reproductive health services.

A. As used in this section, unless the context requires a different meaning:

"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.

"Contraceptives" means health care services, drugs, devices, products, or medical procedures to prevent a pregnancy.

"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; 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 employer:

1. Whose purpose is the inculcation of religious values;

2. That primarily employs persons who share the religious tenets of the employer;

3. That primarily serves persons who share the religious tenets of the employer; and

4. That is a nonprofit organization under § 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code.

"Reproductive health services" means all of the following services, drugs, devices, products, and procedures:

1. Well-woman preventive visits consistent with guidelines published by the U.S. Health Resources and Services Administration.

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

3. Screening for:

a. Chlamydia;

b. Gonorrhea;

c. Hepatitis B;

d. Hepatitis C;

e. Human immunodeficiency virus and acquired immune deficiency 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 tobacco use and for domestic and interpersonal violence.

6. Folic acid supplements.

7. Breastfeeding support, counseling, and supplies.

8. Counseling regarding the use of preventive medications (chemoprevention) to reduce breast cancer risk in women at high risk of developing breast cancer.

9. Any contraceptive drug, device, or product approved by the U.S. Food and Drug Administration, subject to all of the following:

a. If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the U.S. Food and Drug Administration, a health benefit plan shall provide at its option coverage either for the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested drug, device, or product;

b. If a contraceptive drug, device, or product covered by the health benefit plan is deemed medically inadvisable by the covered person's provider, the health benefit plan shall cover an alternative contraceptive drug, device, or product prescribed by the provider;

c. A health benefit plan shall pay pharmacy claims for reimbursement of all contraceptive drugs available for over-the-counter sale that are approved by the U.S. Food and Drug Administration; and

d. A health benefit plan may not infringe upon a covered person's choice of contraceptive drug, device, or product and may not require prior authorization, step therapy, or other utilization control

techniques for medically appropriate covered contraceptive drugs, devices, or other products approved by the U.S. Food and Drug Administration.

10. Voluntary sterilization.

11. 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 (i) management of side effects; (ii) counseling for continued adherence to a prescribed regimen; (iii) device insertion and removal; and (iv) provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgment of the covered person's provider.

12. 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.

"Reproductive health services" does not include abortion services, provided that such exclusion shall not apply to an abortion performed (i) 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 (ii) when the pregnancy is the result of an alleged act of rape or incest.

B. Notwithstanding the provisions of § 38.2-3419, each carrier shall provide coverage, as provided in this section, for reproductive health services under any health benefit plan sold or offered for sale by the carrier in the Commonwealth.

C. A health benefit plan may not impose on a covered person a deductible, coinsurance, or copayment or any other cost-sharing requirement on the coverage required by this section.

D. A provider shall be reimbursed for providing the reproductive health services required to be covered under this section without any deduction for coinsurance, copayments, or any other cost-sharing amounts.

E. Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section.

F. This section does not prohibit a carrier from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for the coverage of reproductive health services, other than coverage required by subdivision 9 of the definition of reproductive health services in subsection A, if the techniques:

1. Are consistent with the coverage requirements of this section; and

2. Do not result in the wholesale or indiscriminate denial of coverage for a reproductive health service.

G. This section does not exclude coverage for contraceptive drugs, devices, or products prescribed by a provider, acting within the provider's scope of practice, for:

1. Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or

2. Contraception that is necessary to preserve the life or health of a covered person.

H. This section does not require a health benefit plan to cover:

1. Experimental or investigational treatments;

2. Clinical trials or demonstration projects, except as provided in § 38.2-3418.8 or 38.2-3453;

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.

I. If a reproductive health service required to be covered by this section is provided by an out-of-network provider, the health benefit plan shall cover the reproductive health service without imposing any cost-sharing requirement on the covered person if:

1. There is no in-network provider to furnish the reproductive health service that is geographically accessible or accessible in a reasonable amount of time, as determined by the Commission by rule consistent with requirements for provider networks; or

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

J. A carrier may offer to a religious employer a health benefit plan that does not include coverage for contraceptives that are contrary to the religious employer's religious tenets only if the carrier notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives the employer refuses to cover for religious reasons.

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

L. 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 of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products, and procedures within the scope of reproductive health services. The carrier shall provide the information on the carrier's website and in writing upon request by a covered person or potential covered person.

M. 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.) and subject to the penalties contained in that chapter.

N. 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, 2019, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made thereto.

§ 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, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 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, 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.), and 5.1 (§ 38.2-1334.3 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, §§ 38.2-1800 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 38.2-3407.19, 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 ~~38.2-3418.17~~ *38.2-3418.18*, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 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, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 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, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 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, 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.), and 5.1 (§ 38.2-1334.3 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, F 2, and F 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, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 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, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 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.