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SENATE BILL NO. 95

Senate Amendments in [] - January 30, 2020

A BILL to amend and reenact §§ 38.2-3438, 38.2-3442, and 38.2-3451 of the Code of Virginia, relating to health insurance; essential health benefits; preventive services.

Patrons Prior to Engrossment—Senator Favola; Delegates: Kory and Samirah

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3438, 38.2-3442, and 38.2-3451 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for coverage under the health benefit plan.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

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

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd (e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA *as of January 1, 2019*: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or

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59 pathological condition.

60 "Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March
61 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage
62 to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long
63 as such plan maintains that status in accordance with federal law.

64 "Group health insurance coverage" means health insurance coverage offered in connection with a
65 group health benefit plan.

66 "Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the
67 extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees,
68 including both current and former employees, or their dependents as defined under the terms of the plan
69 directly or through insurance, reimbursement, or otherwise.

70 "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to
71 provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health
72 benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a
73 cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan"
74 does not include the "excepted benefits" as defined in § 38.2-3431.

75 "Health care professional" means a physician or other health care practitioner licensed, accredited, or
76 certified to perform specified health care services consistent with state law.

77 "Health care provider" or "provider" means a health care professional or facility.

78 "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a
79 health condition, illness, injury, or disease.

80 "Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth
81 and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver,
82 arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed
83 to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any
84 other entity providing a plan of health insurance, health benefits, or health care services.

85 "Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et
86 seq.).

87 "Health status-related factor" means any of the following factors: health status; medical condition,
88 including physical and mental illnesses; claims experience; receipt of health care services; medical
89 history; genetic information; evidence of insurability, including conditions arising out of acts of domestic
90 violence; disability; or any other health status-related factor as determined by federal regulation.

91 "Individual health insurance coverage" means health insurance coverage offered to individuals in the
92 individual market, which includes a health benefit plan provided to individuals through a trust
93 arrangement, association, or other discretionary group that is not an employer plan, but does not include
94 coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student
95 health insurance coverage shall be considered a type of individual health insurance coverage.

96 "Individual market" means the market for health insurance coverage offered to individuals other than
97 in connection with a group health plan.

98 "Managed care plan" means a health benefit plan that either requires a covered person to use, or
99 creates incentives, including financial incentives, for a covered person to use health care providers
100 managed, owned, under contract with, or employed by the health carrier.

101 "Network" means the group of participating providers providing services to a managed care plan.

102 "Open enrollment" means, with respect to individual health insurance coverage, the period of time
103 during which any individual has the opportunity to apply for coverage under a health benefit plan
104 offered by a health carrier and must be accepted for coverage under the plan without regard to a
105 preexisting condition exclusion.

106 "Participating health care professional" means a health care professional who, under contract with the
107 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
108 covered persons with an expectation of receiving payments, other than coinsurance, copayments, or
109 deductibles, directly or indirectly from the health carrier.

110 "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the
111 Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further
112 amended.

113 "Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of
114 coverage, based on the fact that the condition was present before the effective date of coverage, or if the
115 coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment
116 was recommended or received before the effective date of coverage. "Preexisting condition exclusion"
117 also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination
118 given to an individual, or review of medical records relating to the pre-enrollment period.

119 "Premium" means all moneys paid by an employer, eligible employee, or covered person as a
120 condition of coverage from a health carrier, including fees and other contributions associated with the

health benefit plan.

"Preventive services" means (i) evidence-based items or services for which a rating of A or B is in effect in the recommendations of the U.S. Preventive Services Task Force with respect to the individual involved; (ii) immunizations for routine use in children, adolescents, and adults for which a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is in effect with respect to the individual involved; (iii) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration with respect to infants, children, and adolescents; and (iv) evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration with respect to women. For purposes of this definition, a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

§ 38.2-3442. Preventive services.

A. Notwithstanding any provision of § 38.2-3406.1; or 38.2-3411.1; or any other section of this title to the contrary, a health carrier shall provide coverage for all of the following items and preventive services; and shall not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to the following items and services:

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force, with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration.

182 B. A health carrier is ~~not required to~~ *shall* provide coverage for any items or services *within the*
183 *scope of preventive services to the extent that they are* specified in any recommendation or guideline
184 described in subsection A after the recommendation or guideline is no longer issued pursuant to the
185 PPACA in effect on January 1, 2019.

186 C. A health carrier shall at least annually at the beginning of each new plan year or policy year
187 revise the preventive services covered under its health benefit plans pursuant to this section consistent
188 with the most current recommendations of the U.S. Preventive Services Task Force, the Advisory
189 Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the
190 guidelines with respect to infants, children, adolescents, and women evidence-based preventive care and
191 screenings by the Health Resources and Services Administration in effect at the time.

192 D. 1. A health carrier may impose cost-sharing requirements with respect to an office visit if an item
193 or service is billed separately or is tracked as individual encounter data separately from the office visit.

194 2. A health carrier shall not impose cost-sharing requirements with respect to an office visit if an
195 item or service is not billed separately or is not tracked as individual encounter data separately from the
196 office visit and the primary purpose of the office visit is the delivery of the item or service.

197 3. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or
198 service is not billed separately or is not tracked as individual encounter data separately from the office
199 visit and the primary purpose of the office visit is not the delivery of the item or service.

200 E. D. Nothing in this section shall preclude a health carrier that has a network of providers from
201 imposing cost-sharing requirements for items or services that are delivered by an out-of-network
202 provider.

203 F. E. This section shall apply to any health carrier providing individual or group health insurance
204 coverage, except for any grandfathered plan.

205 **§ 38.2-3451. Essential health benefits.**

206 A. Notwithstanding any provision of ~~§ 38.2-3431 or any other section of this title law~~ to the
207 contrary, a ~~health carrier~~ *any person* offering or providing a health benefit plan ~~providing individual or~~
208 ~~small group health insurance coverage, including (i) [short-term and] catastrophic health insurance~~
209 ~~policies, and policies that pay on a cost-incurred basis; (ii) association health plans; and (iii) plans~~
210 ~~provided by a multiple-employer welfare arrangement, shall provide that such coverage includes the~~
211 ~~essential health benefits as required by § 1302(a) of the PPACA.~~ The essential health benefits package
212 may also include associated cost-sharing requirements or limitations. No qualified health insurance plan
213 that is sold or offered for sale through an exchange established or operating in the Commonwealth shall
214 provide coverage for abortions, regardless of whether such coverage is provided through the plan or is
215 offered as a separate optional rider thereto, provided that such limitation shall not apply to an abortion
216 performed ~~(i)~~ *(a)* when the life of the mother is endangered by a physical disorder, physical illness, or
217 physical injury, including a life-endangering physical condition caused by or arising from the pregnancy
218 itself, or ~~(ii)~~ *(b)* when the pregnancy is the result of an alleged act of rape or incest.

219 B. The provisions of subsection A ~~regarding the inclusion of the PPACA-required~~ *requiring*
220 minimum essential pediatric oral health benefits shall be deemed to be satisfied for health benefit plans
221 made available in the small group market or individual market in the Commonwealth outside an
222 exchange, as defined in § 38.2-3455, issued for policy or plan years beginning on or after January 1,
223 2015, that do not include the ~~PPACA-required~~ minimum essential pediatric oral health benefits if the
224 health carrier has obtained reasonable assurance that such pediatric oral health benefits are provided to
225 the purchaser of the health benefit plan. The health carrier shall be deemed to have obtained reasonable
226 assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan
227 if:

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

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