

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act to amend and reenact §§ 38.2-3438, 38.2-3442, and 38.2-3451 of the Code of Virginia, relating*
3 *to health insurance; essential health benefits; preventive services.*

4 [S 95]

5 Approved

6 **Be it enacted by the General Assembly of Virginia:**

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

9 **§ 38.2-3438. Definitions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

57 "Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March
 58 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage
 59 to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long
 60 as such plan maintains that status in accordance with federal law.

61 "Group health insurance coverage" means health insurance coverage offered in connection with a
 62 group health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

116 "Premium" means all moneys paid by an employer, eligible employee, or covered person as a
 117 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.

B. A health carrier is ~~not required to~~ *shall* provide coverage for any items or services *under the most current recommendations and guidelines within the scope of preventive services specified in any recommendation or guideline described in subsection A after the recommendation or guideline is no longer as required by the PPACA as in effect on January 1, 2019.*

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

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

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

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

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

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

§ 38.2-3451. Essential health benefits.

A. Notwithstanding any provision of ~~§ 38.2-3431 or any other section of this title law~~ to the contrary, a health carrier ~~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 the essential health benefits ~~as required by § 1302(a) of the PPACA. 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 ~~(i)~~ (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 ~~(ii)~~ (b) when the pregnancy is the result of an alleged act of rape or incest.

B. The provisions of subsection A ~~regarding the inclusion of the PPACA-required~~ *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 ~~PPACA-required~~ 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 ~~that are required under the PPACA~~ 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 ~~PPACA-required~~ minimum essential pediatric oral health benefits.