House Bill 1445 (2020, Price) - Reproductive health services.

House Bill 1445 (2020, Price) requires the Commonwealth's medical assistance services program (Medicaid) and health benefit plans to cover an array of health care services, drugs, devices, products, and procedures related to reproductive health. The bill was continued to the 2021 Session of the General Assembly by the Committee on Health, Welfare and Institutions.

Medicaid

HB 1445 directs the State Board for Medical Assistance Service to amend the state plan for the payment of medical assistance for a reproductive health care program to provide reimbursement for certain reproductive health services, drugs, devices, products, and procedures for eligible individuals. The bill defines "eligible individual" as an individual with a reproductive health care need who (i) is eligible for and enrolled in the Commonwealth's program of medical assistance services, (ii) would be eligible to enroll in the Commonwealth's program of medical assistance services but for the provisions of 8 U.S.C. § 1611 or 1612, or (iii) is eligible for and enrolled in the FAMIS Plan developed pursuant to Title XXI of the Social Security Act.

HB 1445 requires the Department of Medical Assistance Services to reimburse the cost of medically necessary reproductive health services, drugs, devices, products, and procedures for eligible individuals regardless of whether the eligible individual or the service, drug, device, product, or procedure is eligible for federal financial participation. The bill also provides that an eligible individual shall not be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the coverage of or payment for reproductive health services because of the eligible individual's actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age, or disability.

Health Benefit Plans

HB 1445 adds a new section, § 38.2-3418.18, to the Code of Virginia requiring every carrier to provide coverage for certain reproductive health services, drugs, devices, products, and procedures under any health benefit plan sold or offered for sale in the Commonwealth. A "carrier" is defined as 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 State Corporation Commission that contracts or offers to contract to provide a health benefit plan. However, 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 if the carrier notifies in writing all employees who are eligible to be enrolled in the health benefit plan of the procedures the employer refuses to cover for religious reasons.

HB 1445 prohibits carriers from imposing any deductible, coinsurance, copayment, or other cost-sharing requirement on a covered person for the required reproductive health coverage, but it allows a carrier to impose cost-sharing requirements for certain services provided to a covered person covered by a health plan issued to a religious employer or 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. HB 1445 also prohibits a carrier from imposing restrictions or delays on coverage for reproductive health services and requires a carrier to cover the cost of a service, drug, device, product, or procedure provided by an out-of-network provider without imposing any cost-sharing requirement on the covered person if (i) 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 of Insurance (the Commissioner) by rule, or (ii) an in-network provider is unable or unwilling to provide the service in a timely manner. However, nothing in the new section requires a carrier to cover experimental or investigational treatments, clinical trials or demonstration projects, treatments that do not conform to acceptable and customary standards of medical practice, or treatments for which there is insufficient data to determine efficacy.

HB 1445 provides that a covered person may not 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 on the basis of the covered person's actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age, or disability. The bill requires carriers to make information about coverage for reproductive health services, drugs, devices, products, and procedures readily accessible to covered persons and potential covered persons, in a consumer-friendly format, on its website and in writing upon request of a covered person or potential covered person. The requirements of HB 1445 apply to all health benefit plans delivered, issued for delivery, reissued, or extended in the Commonwealth on or after January 1, 2021, or at any time thereafter when any term of the health benefit plan was changed or any premium adjustment was made thereto.

Subsection G of the new § 38.2-3418.18, as set out in HB 1445, provides that if the Commissioner concludes that enforcement of this section may adversely affect the allotment of federal funds to the Commonwealth, the Commissioner may grant an exemption to the requirements of the new section, but only to the minimum extent necessary to ensure continued receipt of federal funds.

<u>Covered Reproductive Health Services, Drugs, Devices, Products, and Procedures</u>

The reproductive health services, drugs, devices, products, and procedures required to be provided through the state plan for medical assistance and health benefits plans pursuant to HB 1445 are:

Well-woman care consistent with the guidelines of the U.S. Health Resources and Services Administration and the 2016 Final Report of the Women's Preventive Service Initiative
Counseling for sexually transmitted infections, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)

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Screening for: chlamydia, gonorrhea, hepatitis B, hepatitis C, HIV/AIDS, human papillomavirus (HPV), syphilis, anemia, urinary tract infection, pregnancy, Rh incompatibility, gestational diabetes, osteoporosis, breast cancer, and cervical cancer
Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutation is indicated and, if so indicated, counseling related to the BRCA1 or BRCA2 genetic mutation
Screening and appropriate counseling or interventions for domestic and interpersonal violence
Folic acid supplements
Abortion
Comprehensive support, including counseling and supplies, for breast feeding
Counseling for breast cancer chemoprevention
Contraceptive drugs, devices, and products approved by the U.S. Food and Drug Administration (FDA), subject to the following: 1. If the FDA has approved a therapeutic equivalent of a contraceptive drug, device, or product, the 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. 2. If the eligible individual's health care provider determines that a specific contraceptive drug, device, or product is medically inadvisable, the plan shall cover an alternative contraceptive drug, device, or product approved by the FDA. 3. The plan shall not infringe upon an enrollee'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 produces approved by the FDA. 4. The provisions of subdivision A 27 of § 32.1-325, added to the Code of Virginia by HB 1445, shall not be construed to exclude coverage, payment, or reimbursement for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of an eligible individual. In the case of the state plan for medical assistance, the program must comply with the requirements imposed on health benefits plans under § 38.2-3407.5:2 of the Code of Virginia. In the case of a health benefit plan, the plan must provide for reimbursement of pharmacy claims for all contraception approved for over-the-counter sale, subject to the requirements of § 38.2-3407.5:2 of the Code of Virginia.
Voluntary sterilization
As a single claim or as combined with other claims for covered services provided on the same day:

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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 management of side effects, counseling for continued adherence to a prescribed regimen, device insertion and removal, and provision of alternative contraceptive drugs, devices, and products deemed medically appropriate in the judgment of the eligible individual's provider.
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 U.S. Health Resources and Services Administration as of January 1, 2017.
In the case of the state plan for medical assistance only, medical assistance for pregnant women that is authorized by 42 U.S.C. § 1397ll for 180 days immediately postpartum.