**Health Insurance Reform Commission (HIRC) - June 30, 2021 Meeting**

**Bureau of Insurance Step-One Analysis**

**Legislative Bills – 2020 Session of the General Assembly**

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| **Bill Number** | **Title** | **Summary** | **Mandated Benefit or Provider** | **Possible Cost Defrayal** | **Comments** |
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| **HB 39** | Special enrollment, pregnancy | Carriers required to provide guaranteed coverage enrollment for a pregnant woman outside of the open-enrollment period | No | No | Federal regulation 45CFR 155.420 does not allow for special enrollment in qualified health plans (QHPs) because of pregnancy where a state is using the federal platform in its exchange. It is projected that Virginia will remain on the federal exchange platform until 2024. |
| **HB 59** | Licensing athletic trainers | Carriers required to reimburse services by athletic trainers | Yes – Provider | No | No determination of the applicability of an EHB is necessary since this is not a mandated benefit for coverage. |
| **HB 579** | Mammogram coverage expanded | Expands requirements of existing coverage under §38.2-3418.1, for example two annual low dose screenings for age 50 with family history. Carriers generally cover one annual screening. | Yes – Benefit | Yes | This mandate expands the existing Essential Health Benefits (EHB) currently in the EHB benchmark plan. The Bureau’s current understanding is that pursuant to § 38.2-6506 A 1 a QHP in the individual or small group would be prohibited from providing this coverage. There is a concern that § 38.2-6506 A 1 is discriminatory under federal law and could be preempted. If preempted or revised to require a QHP to provide the benefit, state defrayal would be required for the benefits required in addition to the current state mandate for coverage of mammograms. |
| **HB 645** | Diabetes, broader coverage | Expands requirements of existing coverage under §38.2-3418.10 to include prescribe insulin, special equipment, telemedicine self-help training and education. Diabetic benefits and services exempt from any deductible. | Yes - Benefit | Yes | This mandate expands the existing Essential Health Benefits (EHB) currently in the EHB benchmark plan. The Bureau’s current understanding is that pursuant to § 38.2-6506 A 1 a QHP in the individual or small group would be prohibited from providing this coverage. There is a concern that § 38.2-6506 A 1 is discriminatory under federal law and could be preempted. If preempted or revised to require a QHP to provide the benefit, state defrayal would be required for the benefits required in addition to the current state mandate for coverage for diabetics. |
| **HB 776** | Fertility preservation, cancer patients | QHPs required to provide certain coverages for fertility services that are excluded coverages in the Benchmark Plan. | Yes - Benefit | Yes | Coverage for this benefit is not an Essential Health Benefit (EHB) in the current EHB Benchmark Plan. As such, federal law would require the state to make defrayal payments for the cost of this benefit as it applies to qualified health plans (QHPs) offered through the state health benefit exchange (see below for further detail). Importantly, note that under Virginia law (§ 38.2-6506 A 1 of the Code), QHPs are currently prohibited from providing benefits in addition to EHB; therefore, there would be no defrayal cost to the state so long as QHPs do not provide this mandate. The BOI is concerned, however, that the provisions of this statute may run afoul of ACA requirements (see below for further detail). |
| **HB 1036** | Mental health screenings | Expands requirements of existing coverage under §38.2-3412.1 for mental health and substance use disorder services and EHB category. There is currently no requirement for mental health screenings for early detection or prevention of mental health. | Yes - Benefit | Yes | This mandate expands the existing Essential Health Benefits (EHB) currently in the EHB benchmark plan. The Bureau’s current understanding is that pursuant to § 38.2-6506 A 1 a QHP in the individual or small group would be prohibited from providing this coverage. There is a concern that § 38.2-6506 A 1 is discriminatory under federal law and could be preempted. If preempted or revised to require a QHP to provide the benefit, state defrayal would be required for the benefits required in addition to the current state mandate for coverage of mental health screenings. |
| **HB 1384** | Provider contract changes | Changes to provider contracts must be agreed to by provider in writing. | No | No | No determination of the applicability of an EHB is necessary since this is not a mandated benefit for coverage. |
| **SB 192** | Physical therapist office visit | Cost-sharing for physical therapist office visit cannot exceed the cost-sharing imposed for a physician or osteopath office visit. | No | No | No determination of the applicability of an EHB is necessary since this is not a mandated benefit for coverage. |
| **SB 423** | Hearing aids, coverage for minors | Provides for coverage of hearing aids and related services for children 18 years of age or younger without copayment or fee. | Yes – Benefit | Yes | Coverage for this benefit is not an Essential Health Benefit (EHB) in the current EHB Benchmark Plan. As such, federal law would require the state to make defrayal payments for the cost of this benefit as it applies to qualified health plans (QHPs) offered through the state health benefit exchange (see below for further detail). Importantly, note that under Virginia law (§ 38.2-6506 A 1 of the Code), QHPs are currently prohibited from providing benefits in addition to EHB; therefore, there would be no defrayal cost to the state so long as QHPs do not provide this mandate. The BOI is concerned, however, that the provisions of this statute may run afoul of ACA requirements (see below for further detail). The Bureau’s portion of the 2020 joint JLARC and Bureau review highlighted these questions about defrayal cost to the state. JLARC’s portion of the review determined there would be a fiscal impact. SB 423 also applies to fully insured large group plans resulting in a cost to the state employee health plans. Appropriation Act language stipulates SB 423 will not go into effect on July 1, 2021 if it is determined that the bill has a fiscal impact. |
| **SB 1086** | Infertility treatment, coverage for. | QHPs required to provide certain coverages for infertility treatments that are excluded services in the Benchmark Plans. | Yes - Benefit | Yes | Coverage for this benefit is not an Essential Health Benefit (EHB) in the current EHB Benchmark Plan. As such, federal law would require the state to make defrayal payments for the cost of this benefit as it applies to qualified health plans (QHPs) offered through the state health benefit exchange (see below for further detail). Importantly, note that under Virginia law (§ 38.2-6506 A 1 of the Code), QHPs are currently prohibited from providing benefits in addition to EHB; therefore, there would be no defrayal cost to the state so long as QHPs do not provide this mandate. The BOI is concerned, however, that the provisions of this statute may run afoul of ACA requirements (see below for further detail). |

45 CFR 155.170 requires:

* A benefit mandated by state action on or after January 1, 2012, other than for purposes of federal requirements is considered in addition to essential health benefits (EHB).
* States have the authority to identify which required benefits are in addition to EHB pursuant to federal requirements.
* The State must make defrayal payments to the enrollee or the carrier for the cost of benefits in addition to EHB.

By July 1, 2022, states are required under 45 CFR 156.111 (f) to report to CMS all state mandate benefit imposed on or before December 31, 2011, and that are still in effect, and any state mandated benefits imposed after December 31, 2011. This report is to be updated annually.

§ 38.2-6506 A 1 of the Code of Virginia prohibits qualified health plans (QHPs) – which are plans offered through the Individual or Small Group exchange (and the off-exchange version of those plans) - from providing state-mandated benefits that are in addition to EHB, meaning no QHPs are permitted to include any benefits in addition to EHB if those benefits are mandated by state law imposed on or after January 1, 2012. Thus, state defrayal would not be required.

**However**, CMS has cautioned states “that imposing different benefit mandates depending on a plan’s status as a QHP or because it is sold through the Exchange may violate section 1252 of the Affordable Care Act. Under this section, State standards or requirements implementing, or related to standards or requirements in Title I of the ACA must be applied uniformly within a given insurance market. Thus, if a State requires that non-QHPs in the individual or small group market provide any benefits, under section 1252, the State must require QHPs sold through the Exchange in that same market to provide those same benefits, and consistent with our earlier stated policy at § 155.170(a)(2), States would generally be required to defray the cost of QHPs providing the required benefits if they were required through State action taking place after December 31, 2011.”[[1]](#footnote-1)

New or revised benefits may be required of QHPs without the state being required to defray costs by revising the EHB benchmark plan. Here you will find a CMS [FAQ](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf) that provides information on state defrayal determination and selecting a new EHB benchmark plan.

1. March 8, 2016 Notice of Benefit and Payment Parameters (81 FR 12337) [↑](#footnote-ref-1)