

## Review Process for Mandated Benefit Proposals by the Special Advisory Commission on Mandated Health Insurance Benefits



- Bureau of Insurance (BOI) staff supported the Advisory Commission (JLARC was later added to provide support).
- Written Notice of the Advisory Commission Meeting disseminated to Members and Interested Parties to allow for submission of written testimony on bills referred to the Advisory Commission by Standing Committees prior to the date of the meeting.
- At Public Hearing, oral testimony, additional written material and BOI staff analyses were presented. Proponents, opponents, other Interested Parties, and State Agencies had the opportunity to speak on the bills.
- At its next meeting, the Advisory Commission voted on a recommendation as to whether or not to recommend enactment of the bill and forwarded report drafted by BOI with recommendation to the Standing Committee.

## Information Generally Presented by the Bureau of Insurance Staff on Proposed Mandates in Staff Analysis Reports



- Description of the proposed benefit and any previous review of similar proposals
- Responses addressing the social impact, financial impact and medical efficacy of proposals
- Information on the extent to which insurers already offer the proposed benefit Virginia
- Premium impact/estimates on Virginia insureds on mandating the benefit
- Cost for the benefit in the absence of insurance (if available)
- Coverage requirements in other states
- Technical issues identified with the bill

## Senate Bill 275 – Cost-Sharing for HIV Prevention Medication for Victims of Sexual Assault



- Revises the current mandate of coverage for benefits for pregnancy after an act of rape or incest (§ 38.2-3418). Adds a provision that applies to policies, contracts, or plans that include coverage of medication prescribed to prevent HIV.
- Prohibits insurers that already cover medication to prevent HIV from imposing any cost-sharing requirements for the HIV-prevention medication for victims of sexual assault.
- The prohibition of cost-sharing applies if the insured does not report the sexual assault to the police but (i) the insured participates in an exam under the Sexual Assault Nurse Examiner Program/equivalent program, and (ii) the results of the exam indicate a high probability that the sexual assault has resulted in the transmission of HIV.
- The determination of sexual assault is addressed in the Crimes and Offenses Generally title. May be difficult to determine the number of victims of sexual assault to whom the bill applies because victims of sexual assault are often not reported as such to insurers.

## House Bill 1185 – Reimbursement for Inpatient Treatment for Mental Health and Substance Abuse Services



- Revises the current mandate of coverage of mental health and substance abuse services benefit; adds language to address the process of determining the medical necessity of care and the level of care that should be provided to an insured.
- Provides that “due consideration” be given to the treating provider’s recommendation when determining if inpatient treatment is medically necessary. Cannot base a denial of coverage for inpatient treatment or partial hospitalization on a subjective evaluation of the imminence of the insured’s suicide risk or risk of danger to others “if the evaluation is inconsistent with the assessment by the attending health care provider.
- Provides that an insurer must pay for treatment at the outpatient rate for inpatient care if they deny coverage for inpatient care and the insured receives inpatient care when there is a valid coverage denial.
- HB 1185 does not include definitions or criteria for significant terms: “due consideration;” “subjective evaluation;” “imminence of the individual’s suicide risk or danger to others;” and “validly denies coverage.”

## Essential Health Benefits and Mandated Benefit Proposals



- The Affordable Care Act requires non-grandfathered plans that are offered in the individual and small group markets to cover a core package of items and services referred to as Essential Health Benefits (EHBs). The requirement applies to plans issued on and off the Exchange.
- Each state has a benchmark plan that covers EHBs. The benchmark plan for Virginia is the former KeyCare 30 plan offered by Anthem plus Medicaid CHIP (Smiles) for the pediatric dental benefit; and the FEDVIP for the pediatric vision benefit.
- After the establishment of the EHBs through selection of the Benchmark plan, ACA Section 1311(d) (3) (b) permits a state, at its option, to require insurers to offer additional benefits to EHBs. However, the state must make payments to the individual enrollee or the issuer of the plan on behalf of the enrollee, to defray the cost of any additional benefits.

# Associated Costs with HB 1185 and SB 275



- House Bill 1185 revises the current mandate of coverage for mental health and substance abuse services. Also addresses the level of care that should be provided to an insured. The cost associated with this revision, if any, has not been determined.
- Senate Bill 275 prohibits any cost-sharing requirements for HIV-prevention medications for sexual assault victims. The cost associated with this revision , if any, has not been determined.