YEAR-END REPORT - 2019

Published 23-Dec-2019
HPTS Issue Brief 12-23-19.21

Health Policy Tracking Service - Issue Briefs
Health Insurance Oversight
Mandated Benefits

Authored by Jeffrey Karberg, J.D., a contributing writer and member of the Maryland bar.

12/23/2019

2019 Federal Action

2019 CONG US S 2102 was introduced in the Senate on July 11, 2019. The purpose of the bill is to provide funding for programs and activities under the SUPPORT for Patients and Communities Act. The bill states that a group health plan (other than a self-insured plan) or a health insurance issuer offering group or individual health insurance coverage must not impose any cost-sharing requirement under the plan or coverage with respect to at least one brand or generic version of opioid overdose reversal drug.

2019 CONG US HR 4159 was introduced August 2, 2019. The proposed bill seeks to amend the Health Insurance Portability and Accountability Act to ensure coverage for individuals with preexisting conditions.

2019 State Action

In **Arkansas**

2019 AR H.B. 1074 (NS) was adopted February 4, 2019. The bill will require newborn screening for spinal muscular atrophy. The bill also mandates that insurance policies cover newborn screening for spinal muscular atrophy.

2019 AR H.B. 1727 (NS) was filed March 6, 2019. The proposed bill is an act to mandate coverage by an insurer for intraoperative neurophysiological monitoring.

2019 AR S.B. 252 (NS) was adopted April 17, 2019. The bill is an act to provide for insurance coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection and pediatric acute-onset neuropsychiatric syndrome.

In **California**

2019 CA A.B. 844 (NS), a previously introduced bill, was amended March 5. If passed, this bill would establish an independent, nonpartisan body to advise the Governor and Legislature on the financial impact of proposed mandated hospital services and activities. The bill would require the chair of a policy or fiscal committee that will consider a bill proposing mandated hospital services or activities to ensure that the bill is forwarded to the body to estimate its financial impacts, and would require a bill's author to prepare detailed background information regarding the proposal. The bill would require the body to prepare an analysis estimating the costs of the proposed legislation and analyzing specified information, including the results of research demonstrating the efficacy of the proposed mandated service or activity compared to alternatives, to provide that analysis to the appropriate policy and fiscal committees not later than 60 days after receiving the request, and to post that analysis on the internet. The bill would authorize the body to engage professional consultants and to execute contracts and interagency agreements in order to assess legislation and prepare analyses. The bill would also make related findings and declarations.

2019 CA S.B. 78 (NS) was adopted June 27, 2019. Existing law requires the State Department of Public Health to approve or deny an application submitted by a general acute care hospital or an acute psychiatric hospital to the department's centralized applications unit within specified deadlines and further requires the department to develop a centralized applications advice program and an automated application system. Existing law provides that the resources necessary to implement these requirements be made available, upon appropriation by the Legislature, from the Internal Departmental Quality Improvement Account. This bill would delete the provision specifying that the resources necessary to implement these requirements be made available, upon appropriation by the Legislature, from the Internal Departmental Quality Improvement Account. This bill would rename the CARE Services Program the HIV Care

Program. The bill would, commencing April 1, 2020, require the State Department of Public Health to apply the same financial eligibility requirements for the purposes of administering the HIV Care Program as those set forth for the AIDS Drug Assistance Program.

2019 CA S.B. 583 (NS) was adopted October 2, 2019. Existing law requires a health care service plan or health insurer to provide coverage for routine patient care costs related to a clinical trial for cancer, including, among other things, health care services required for the clinically appropriate monitoring of the investigational item or service. Existing law requires the clinical trial to either be exempt from a federal new drug application or be approved by a specified federal agency. This bill will expand required coverage for clinical trials under a plan contract or insurance policy to include a clinical trial relating to the prevention, detection, or treatment of a life-threatening disease or condition, as defined, and include a clinical trial funded by, among others, a qualified nongovernmental research entity. The bill will also prohibit a plan contract or insurance policy from, among other things, discriminating against an enrollee or insured for participating in an approved clinical trial. The bill would authorize a plan or insurer to require a qualified enrollee or insured to participate in a clinical trial and to restrict coverage to an approved clinical trial in this state, unless the clinical trial is not offered or available through a participating provider in this state.

2019 CA S.B. 163 (NS) was enrolled September 13, 2019. Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), requires group health plans and health insurance issuers that provide both medical and surgical benefits and mental health or substance use disorder benefits to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. Existing state law subjects nongrandfathered individual and small group health care service plan contracts and health insurance policies that provide coverage for essential health benefits to those provisions of the MHPAEA. This bill would revise the definition of behavioral health treatment to require the services and treatment programs provided to be based on behavioral, developmental, relationship-based, or other evidence-based models. The bill would remove the exception for health care service plans and health insurance policies in the Medi-Cal program, consistent with the MHPAEA.

2019 CA A.B. 577 (NS) was adopted October 12, 2019. Existing law requires a health care service plan and a health insurer, at the request of an enrollee or insured, to provide for the completion of services by a terminated or nonparticipating provider if the enrollee or insured is undergoing a course of treatment for one of specified conditions, including a serious chronic condition, at the time of the contract or policy termination or the time the coverage became effective. This bill, for purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition, from the individual's treating health care provider, require completion of covered services for that condition, not exceeding 12 months, as specified. By expanding the duties of health care service plans, the bill would expand the scope of an existing crime, thereby imposing a state-mandated local program.

2019 CA A.B. 651 (NS) was adopted October 7, 2019. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services. This bill requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee, insured, or subscriber (individual) receives covered services from a noncontracting air ambulance provider, the individual must pay no more than the same cost sharing that the individual would pay for the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount. The bill also provides that an individual would not owe the noncontracting provider more than the in-network cost-sharing amount for services. The bill authorizes a noncontracting provider to advance to collections only the in-network cost-sharing amount that the individual has failed to pay. The bill authorizes a health care service plan, health insurer, or provider to seek relief in any court for the purpose of resolving a payment dispute, and would not prohibit a provider from using a health care service plan's or health insurer's existing dispute resolution processes. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

2019 CA S.B. 583 (NS) was adopted October 2, 2019. Existing law requires a health care service plan or health insurer to provide coverage for routine patient care costs related to a clinical trial for cancer, including, among other things, health care services required for the clinically appropriate monitoring of the investigational item or service. Existing law requires the clinical trial to either be exempt from a federal new drug application or be approved by a specified federal agency. This bill expands required coverage for clinical trials under a plan contract or insurance policy to include a clinical trial relating to the prevention, detection, or treatment of a life-threatening disease or condition, as defined, and include a clinical trial funded by, among others, a qualified nongovernmental research entity. The bill also:

• would prohibit a plan contract or insurance policy from, among other things, discriminating against an enrollee or insured for participating in an approved clinical trial;

• authorize a plan or insurer to require a qualified enrollee or insured to participate in a clinical trial, as specified, and to restrict coverage to an approved clinical trial in California, unless the clinical trial is not offered or available through a participating provider in California.

2019 CA A.B. 744 (NS) was adopted October 13, 2019. Under existing law, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward. Existing law requires a Medi-Cal patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward to be notified of the right to receive interactive communication with a distant specialist physician, optometrist, or dentist, and authorizes

a patient to request that interactive communication. This bill deletes those interactive communication provisions, and would instead specify that face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for any health care services provided by store and forward. The bill also:

• require a contract between a health insurer and a health care provider for an alternative rate of payment to specify that the health care service plan or health insurer reimburse a health care provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan or health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment; and

• authorize a health care service plan or health insurer to offer a contract or policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, subject to specified limitations.

2019 CA A.B. 174 (NS) was adopted October 12, 2019. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law, until January 1, 2023, requires the Exchange, among other duties, to administer an individual market assistance program to provide health care coverage financial assistance to California residents with household incomes at or below 600% of the federal poverty level. This bill will, until January 1, 2023, require the board of the Exchange to develop and prepare biannual public reports for the purpose of informing the California Health and Human Services Agency, the Legislature, and the public about the enrollment process for the individual market assistance program. The bill would require the reports to contain specified information, including, among other things, the number of applications received for the program during the reporting period and the disposition of those applications.

2019 CA A.B. 1004 (NS) was adopted September 30, 2019. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for any individual under 21 years of age who is covered under Medi-Cal. This bill requires screening services provided as an EPSDT benefit include developmental screening services for individuals zero to 3 years of age, inclusive, and would require Medi-Cal managed care plans to ensure that providers who contract with these plans render those services in conformity with specified standards. The bill also requires the department to ensure a Medi-Cal managed care plan's ability and readiness to perform these developmental screening services, and to adjust a Medi-Cal managed care plan's capitation rate.

2019 CA S.B. 600 (NS) was adopted October 12, 2019. Existing law requires every health care service plan contract to provide enrollees with basic health care services. Existing law defines basic health care services to include, among other things, physician services and hospital inpatient and ambulatory care services. Existing law requires specified group health care service plan contracts issued, amended, or renewed on or after January 1, 1990, to offer coverage for the treatment of infertility, as defined, except in vitro fertilization. This bill clarifies that, when a covered treatment may cause iatrogenic infertility to an enrollee, standard fertility preservation services are a basic health care service and are not within the scope of coverage for infertility treatment, as described above. The bill would state that these provisions are declaratory of existing law. The bill would state that these provisions do not apply to Medi-Cal managed care health care service plan contracts or any entity that contracts with the State Department of Health Care Services to deliver health care services pursuant to the Medi-Cal program.

2019 CA A.B. 1494 (NS) was adopted October 12, 2019. Under existing law, in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. Existing law, for purposes of payment for covered treatment or services provided through telehealth, prohibits the department from limiting the type of setting where services are provided for the patient or by the health care provider. This bill provides that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a proclamation declaring a state of emergency. The bill authorizes the department to apply this provision to services provided by another enrolled fee-for-service Medi-Cal provider, clinic, or facility during or immediately following a state of emergency. The bill also requires that telehealth services, telephonic services, and other specified services be reimbursable when provided by one of those entities during or immediately following a state of emergency.

In **Connecticut**

2019 CT S.B. 15 (NS), a previously introduced bill, was amended April 2, 2019. If passed, the bill will require health insurance coverage for motorized wheelchairs, including, but not limited to, used motorized wheelchairs, repairs to motorized wheelchairs and replacement batteries for motorized wheelchairs.

2019 CT S.B. 317 (NS), a previously introduced bill, was amended April 2, 2019. If passed, the bill will require health insurance coverage for certain surgical procedures performed to treat severe obesity.

2019 CT H.B. 5627 (NS), a previously introduced bill, was amended April 2, 2019. If passed, the proposed bill will allow children, stepchildren and other dependent children to retain dental insurance coverage under their parents' insurance policies until they attain the age of twenty-six or obtain substitute coverage through an employer.

2019 CT H.B. 6095 (NS), a previously introduced bill, was amended April 2, 2019. If passed, the proposed bill will modify required health insurance coverage for detoxification and substance abuse services.

2019 CT H.B. 5213 (NS), a previously introduced bill, was amended May 28, 2019. The proposed bill seeks to expand required health insurance coverage for hearing aids to individuals older than twelve years of age.

2019 CT H.B. 7159 (NS) was enrolled June 26, 2019. The bill requires that no life insurance or annuity policy or contract shall be delivered, issued for delivery, renewed or continued in this state that excludes coverage solely on the basis of receipt of a prescription for naloxone, commonly referred to as an opioid antagonist, or any naloxone biosimilar or naloxone generic, nor shall any application, rider or endorsement to such policy or contract be used in connection therewith that excludes coverage solely on the basis of receipt of such a prescription, biosimilar or generic.

In **Delaware**

2019 DE H.B. 220 (NS) was engrossed June 30, 2019. The bill includes the following requirement for health benefit plans providing coverage for prescription drugs must place at least 1 formulation of a medication-assisted treatment on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

• Buprenorphine;

• Naltrexone;

• Naloxone; and

• A product containing both buprenorphine and naloxone.

A health benefit plan that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an opioid treatment program as specified.

DE LEGIS 199 (2019) was adopted August 13, 2019. The bill requires any health benefit plan that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an opioid treatment program.

In **Florida**

2020 FL S.B. 298 (NS) was filed September 17, 2019. The proposed bill seeks to prohibit health insurance policies from requiring that treatment with an opioid analgesic drug product be attempted and have failed before authorizing the use of a nonopioid-based analgesic drug product.

2020 FL S.B. 706 (NS) was filed October 30, 2019. The proposed bill seeks to require Medicaid managed care plans to submit an annual report to the Agency for Health Care Administration relating to parity between mental health and substance use disorder benefits and medical and surgical benefits. The bill also:

• requires certain entities transacting individual or group health insurance or providing prepaid health care to comply with specified federal provisions that prohibit the imposition of less favorable benefit limitations on mental health and substance use disorder benefits than on medical and surgical benefits; and

• revises the standard for defining substance use disorders.

In **Georgia**

2019 GA H.B. 99 (NS) was adopted May 6, 2019. The bill states that the legislature recognizes the need for employers and individuals to have the opportunity to choose among group and individual health insurance plans that are more affordable and flexible than standard market policies of accident and sickness insurance and the need to increase the availability of health insurance coverage by authorizing the transaction of this type of plan or policy by accident and sickness insurers licensed to transact business in this Georgia. This bill will require insurers providing major medical coverage to offer policies that contain all state mandated health benefits as well as policies that contain the limited selection of certain specified state mandated health benefits provided, however, employees in group plans or individuals may choose pursuant to this chapter among new health insurance plans offered by insurers that either include all state mandated health benefits or include the specified limited state mandated health benefits.

In **Hawaii**

2019 HI S.B. 1034 (NS) was introduced January 18, 2019. The proposed bill clarifies that the existing health insurance mandate for coverage of low-dose mammography includes coverage for digital mammography and breast tomosynthesis.

2019 HI H.B. 1269 (NS) was introduced January 24, 2019. The proposed bill clarifies the professionals who may administer autism treatment under mandated insurance coverage establish by Luke's Law.

2019 HI H.B. 481 (NS), a previously introduced bill, was amended February 4, 2019. If passed, the proposed bill will amend the existing health insurance mandate to specify that coverage of low-dose mammography includes coverage for digital mammography and breast

tomosynthesis. The bill will also require the State Auditor to perform analysis of new benefits to determine if a statutory sunrise analysis requirement and federal requirements to defray costs of new mandate has been triggered.

2019 HI H.C.R. 21-19 (NS) was filed February 20, 2019. The continuing resolution requests the state auditor to conduct a sunrise analysis of mandating health care coverage for cannabidiol oil derived from industrial hemp.

2019 HI H.C.R. 93-19 (NS) was introduced March 8, 2019. The proposed bill requests the auditor to assess the social and financial effects of requiring health insurers to provide coverage for clinical victim support services for victims of sexual violence and abuse.

2019 HI H.C.R. 21-19 (NS) was introduced February 28, 2019. The proposed bill requests the state auditor to conduct a sunrise analysis of mandating health care coverage for cannabidiol oil derived from industrial hemp.

2019 HI S.B. 1043 (NS), previously introduced bill, was amended March 15, 2019. If passed, the proposed bill will require the Auditor to conduct a study on whether health insurers, mutual benefit societies, and health maintenance organizations should provide health insurance coverage for a comprehensive category of reproductive health services, drugs, devices, products, and procedures.

2019 HI H.R. 88-19 (NS) was introduced March 8, 2019. If passed, the proposed bill will request the auditor to assess the social and financial effects of requiring health insurers to provide coverage for clinical victim support services for victims of sexual violence and abuse.

2019 HI S.C.R. 171-19 (NS) was adopted April 23, 2019. The bill requests the auditor to assess the social and financial effects of requiring health insurers to provide coverage for clinical victim support services for victims of sexual violence and abuse.

2019 HI H.B. 1453 (NS) was Adopted June 25, 2019. The bill authorizes the Department of Health to establish fees for ground transportation to medical facilities and for provision of emergency medical services that do not include transport. Authorizes transportation by ambulance to medical facilities other than hospital emergency departments. Authorizes Medicaid programs to provide coverage for health care provided by emergency medical services personnel.

In **Illinois**

2019 IL S.B. 187 (NS) filed January 30, 2019. If passed, the proposed bill will amend the Illinois Act on the Aging. The bill seeks to expand the Community Care Program to provide services to all persons, regardless of age, who have Alzheimer's disease or a related disorder as defined under the Alzheimer's Disease Assistance Act.

2019 IL S.B. 637 (NS) was engrossed April 11, 2019. The bill requires that coverage for custom prosthetic and orthotic devices under the fee-for-service medical assistance program and under any Medicaid managed care plan must be no less favorable than the terms and conditions that apply to substantially all medical and surgical benefits provided under the fee-for-service medical assistance program or the Medicaid managed care plan.

In **Indiana**

2019 IN S.B. 162 (NS) was prefiled December 28, 2018. If passed, the proposed bill will require state employee health plans, Medicaid, policies of accident and sickness insurance, and health maintenance organization contracts to provide coverage for chronic pain management. The bill will also require a practitioner to prescribe other forms of treatment for certain chronic pain before prescribing an opioid. Finally, the bill will require the office of Medicaid policy and planning to apply for any Medicaid state plan amendment necessary to provide the coverage.

2019 IN S.R. 69 (NS) was introduced April 4, 2019. The proposed bill is a senate resolution urging the legislative council to assign to the appropriate study committee the topic of mandated insurance coverage for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).

In **Kansas**

2019 KS H.B. 2120 (NS) was introduced January 31, 2019. The proposed bill seeks to establish restrictions on the use of step therapy protocols by health insurance plans.

In **Louisiana**

2019 LA H.B. 143 (NS) was introduced April 8, 2019. The proposed bill states that any health insurance issuer providing coverage for anatomical gifts, organ transplants, or related treatment and services must not do any of the following:

• deny coverage to a covered person solely on the basis of the person having a disability;

• deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the specified requirements;

• penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or nonmonetary incentives to an attending provider, to induce such provider to furnish care to an insured or enrollee in a manner inconsistent with requirement; or

• reduce or limit coverage benefits to a patient for the medical services or other services related to organ transplantation performed pursuant to the stated requirements as determined in consultation with the attending physician and patient.

2019 LA H.B. 308 (NS) was introduced April 8, 2019. The proposed bill relates to dollar amount limits on health insurance benefits; to prohibit lifetime limits. The proposed law requires any health coverage plan to provide coverage without any lifetime limit or annual limit on the dollar amount of benefits for any individual. The proposed law applies only to covered benefits that are either of the following:

• included among the covered benefits of the base-benchmark plan selected for the state of Louisiana for calendar year 2019; or

• required as a state mandated health benefit pursuant to the Louisiana Insurance Code.

2019 LA H.B. 526 (NS) was engrossed May 2, 2019. The bill relates to requirements for medical assistance program coverage of opioid use disorder medications. The bill also provides for the prohibition against prior authorization or step therapy requirements for opioid use disorder medications. The bill also:

• requires the listing of buprenorphine/naloxone on certain preferred drug list; and

• prohibits the exclusion of coverage of prescriptions and services under certain circumstances.

2019 LA H.B. 526 (NS) was engrossed May 2, 2019. The bill relates to requirements for medical assistance program coverage of opioid use disorder medications. The bill also provides for the prohibition against prior authorization or step therapy requirements for opioid use disorder medications. The bill also:

• requires the listing of buprenorphine/naloxone on certain preferred drug list; and

• prohibits the exclusion of coverage of prescriptions and services under certain circumstances.

In **Maryland**

2019 MD H.B. 15 (NS) was introduced January 9, 2019. If passed, the bill will require the Maryland Medical Assistance Program, beginning on January 1, 2020, to provide services for certain pediatric autoimmune neuropsychiatric disorders under certain circumstances. The bill will also require insurers, nonprofit health service plans, and health maintenance organizations that provide certain health insurance benefits under certain insurance policies or contracts to provide coverage for certain diagnosis, evaluation, and treatment of certain pediatric autoimmune neuropsychiatric disorders.

2019 MD H.B. 697 (NS) adopted May 13, 2019. The bill requires the Maryland Health Insurance Coverage Protection Commission to establish a workgroup to carry out the finding and declaration of the General Assembly that it is in the public interest to ensure that the health care protections established by the federal Affordable Care Act continue to protect Maryland residents in light of continued threats to the federal Affordable Care Act.

In **Massachusetts**

2019 MA REG TEXT 527434 (NS) became effective August 9, 2019. The regulation requires that as soon as practicable, but prior to the effective date of any changes in benefits provided by Medicare, Massachusetts laws regarding mandated health benefits and/or by the Medicare Supplement Insurance Policy, every Issuer must file with the Division, in accordance with applicable filing procedures, any appropriate riders, endorsements or Policy forms needed to accomplish such Medicare Supplement Insurance modifications. Any such riders, endorsements or Policy forms must provide a clear description of the Medicare Supplement benefits provided by the Policy.

In **Michigan**

2019 MI S.B. 612 (NS) was introduced October 29, 2019. The proposed bill states that if the health insurance policy requires a prior authorization with respect to any benefit, the insurer or its designee utilization review organization must make any current prior authorization requirement conspicuously posted and readily accessible on the insurer's public website. The current prior authorization requirements must be described in detail, written in easily understandable language, and readily available to the health provider at the point of care. The prior authorization requirements must be based on peer-reviewed clinical review criteria.

In **Missouri**

2019 MO S.B. 514 (NS) was adopted July 11, 2019. The bill states that “urgent health care service” must include services provided for the treatment of substance use disorders. Medication-assisted treatment (MAT) must include pharmacologic therapies. A formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, must include:

• Buprenorphine tablets;

• Methadone;

• Naloxone;

• Extended-release injectable naltrexone; and

• Buprenorphine/naloxone combination.

In **New Hampshire**

2019 NH S.B. 279 (NS), a previously introduced bill, was amended June 5, 2019. If passed, the bill will require insurers issuing or renewing group health insurance policies to cover fertility treatment.

2019 NH H.B. 692 (NS) was adopted July 19, 2019. This bill authorizes the Medicaid managed care program to provide dental benefits to covered persons. Under this bill, the commissioner of the department of health and human services shall convene a working group to develop a value-based dental benefit. The Department of Health and Human Services, in consultation with the working group, must prepare a plan for the implementation of an adult dental benefit into a value-based care platform. Each plan must include, at a minimum, a detailed description of the following:

• eligibility and enrollment covered benefits and scope of services;

• cost benefit analysis including projected expenditures and anticipated cost savings;

• transition planning;

• credentialing;

• quality metrics and outcome measurements;

• patient safety; and

• the incorporation of the services into a value-based care platform to achieve the legislative intent of providing value, quality, efficiency, innovation, and savings.

2019 NH S.B. 4 (NS) was adopted July 12, 2019. The bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009 in statute. The bill prohibits health carriers from imposing any preexisting condition exclusion with respect to coverage in the individual, small group, or large group market.

2019 NH S.B. 251 (NS) was approved August 2, 2019. The bill requires that for life, life annuity, or disability coverage, refusing to insure or to continue to insure, or limiting the amount, extent, or kind of coverage based on the applicant who is also the proposed insured having filled a prescription for an opioid antagonist, when that prescription is not relevant to the applicant's health, but rather is designed to promote the health of someone else. For any such prescription, the carrier must inquire with the applicant as to the reason for the prescription and may request documentation that verifies the applicant's response prior to issuing an underwriting decision.

In **New Jersey**

2018 NJ S.B. 3571 (NS) was introduced March 7, 2019. The proposed bill seeks to require health benefits coverage for rapid diagnostic testing for influenza A and B viruses.

2018 NJ S.B. 3378 (NS) was adopted May 8, 2019. The bill Prohibits health benefits coverage for certain non-medically indicated early elective deliveries under Medicaid program, SHBP, and SEHBP. The legislature stated a finding that data strongly demonstrates that early elective deliveries-scheduled cesarean sections or medical inductions performed prior to 39 weeks of gestation without medical necessity-carry risks to both babies and mothers. The bill also states that no provider will be approved for reimbursement by the Division of Medical Assistance and Health Services in the Department of Human Services under Medicaid for a non-medically indicated early elective delivery performed at a hospital on a pregnant woman earlier than the 39th week of gestation on or after the ten month period following the effective date of this section. During the ten month period following the effective date of this bill, the Division of Medical Assistance and Health Services in the Department of Human Services must provide accessible educational materials to inform pregnant women, their support networks, and Medicaid providers about the risks of non-medically indicated early elective delivery.

2018 NJ S.B. 3970 (NS) was introduced June 20, 2019. The bill requires every policy providing coverage for prescription drugs subject to a co-payment, coinsurance or deductible must charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

• proportional between the cost sharing for a 30-day supply and the amount of drugs the patient was prescribed; or

• equivalent to the cost sharing for a full 30-day supply of the opioid drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the 30-day supply.

In **New Mexico**

2019 NM REG TEXT 532460 (NS) was published August 27, 2019. The regulation requires all multiple employer welfare arrangements (MEWAs) covering New Mexico residents or insurance companies offering coverage through MEWAs must provide all mandated benefits and consumer protections, compliant with state and federal law, consistent with the product type and the market in which the employer member is a part, that is, a self-employed individual will have an individual policy, a small business will have a small group policy, and a large employer will have a large group policy.

In **New York**

2019 NY A.B. 102 (NS) was prefiled January 2, 2019. The proposed bill relates to insurance coverage for opioid medications. The bill requires every policy providing medical, major medical or similar comprehensive-type coverage, or coverage for prescription drugs must provide coverage of opioid medications and prescription drugs. Coverage must continue to be provided during the entire period of time the medications and drugs are prescribed or administered by an authorized prescriber or administrator. An insurance company must not charge a different rate for any medication in the opioid class.

2019 NY S.B. 1345 (NS) was introduced January 14, 2019. If passed, the bill will require the New York state health care quality and cost containment commission to issue a report considering the impact on health insurance costs and quality of legislation requiring coverage of long term and chronic Lyme disease and other tick-borne diseases.

2019 NY S.B. 1492 (NS) was introduced January 15, 2019. If passed, the bill will require health insurers to provide coverage for opioid antagonists and devices.

2019 NY A.B. 2844 (NS) was introduced January 25, 2019. If passed, the proposed bill will create a health benefit and cost commission to conduct a comprehensive review of all current mandated benefits and an accurate cost analysis of proposed benefits.

2019 NY A.B. 2871 (NS) was introduced January 28, 2019. If passed, the proposed bill will mandate certain testing in connection with pregnancy and fertility treatment. The bill will also require insurance policies to provide coverage for certain testing in connection with fertility treatment.

2019 NY A.B. 2773 (NS) was introduced January 25, 2019. The proposed bill seeks to require health insurers to provide coverage for opioid antagonists and devices.

2019 NY A.B. 5969 (NS) was introduced February 20, 2019. The proposed bill seeks to prohibit health insurers from requiring insureds purchase prescribed drugs from mail order pharmacy.

2019 NY A.B. 6010 (NS) was introduced February 26, 2019. If passed, the proposed bill will provide that the New York state health care quality and cost containment commission must:

• evaluate each mandated benefit;

• investigate current practices of health plans with regard to the mandated benefit;

• investigate the potential premium impact of repealing and/or modifying the mandated benefits on all segments of the insurance market;

• hold at least two public hearings; and

• submit a report to the legislature.

2019 NY S.B. 1507 (NS) was adopted April 12, 2019. The bill enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2019-2020 state fiscal year. The bill:

• extends the National Diabetes Prevention Program and relates to supplemental Medicaid managed care payments and the inclusion in standard coverage of medically tailored meals and medical nutrition therapy for certain persons and applied behavioral analysis treatment for those with autism spectrum disorder;

• relates to guaranteed availability, pre-existing conditions and employee welfare funds;

• relates to actuarial value requirements and essential health benefits;

• relates to coverage for medically necessary abortions and exceptions thereto;

• relates to prescription drug coverage;

• relates to discrimination based on sex and gender identity; and

• relates to insurance coverage of in vitro fertilization and other fertility preservation treatments.

2019 NY S.B. 5426 (NS) was introduced April 30, 2019. The proposed bill will, if passed, mandate commercial insurance coverage of peer support services as part of treatment for substance use disorder.

2019 NY A.B. 7566 (NS) was introduced May 9, 2019. The proposed bill seeks to mandate commercial insurance coverage of peer support services as part of treatment for substance use disorder.

In **North Carolina**

2019 NC H.B. 934 (NS) was enrolled June 25, 2019. The purpose of this bill is to authorize access to and use of experimental treatments for patients with a terminal illness. The bill will:

• establish conditions for use of experimental treatment; to prohibit sanctions of health care providers solely for recommending or providing experimental treatment;

• clarify duties of a health insurer with regard to authorized experimental treatment;

• prohibit certain actions by State officials, employees, and agents; and

• restrict certain causes of action arising from experimental treatment.

2019 NC S.B. 86 (NS), a previously introduced bill, was amended August 2, 2019. The bill seeks to establish standards for association health plans and multiple employer welfare arrangements. The bill states that Association Health Plans are subject to the Affordable Care Act's “group health plan” requirements, which means Association Health Plans cannot deny individuals coverage if they

have preexisting conditions, cannot impose annual and lifetime limits on certain benefits, and must provide free access to certain preventative services. Additionally, new federal Department of Labor regulations regarding Association Health Plans allow for states to provide greater opportunities for small businesses and self-employed individuals with no employees to access health benefit plans while still providing health insurance consumers with the coverage protections established by the foregoing legislation and other provisions of federal law.

2019 NC H.B. 655 (NS), a previously introduced bill, was amended September 18, 2019. The proposed bill is an act to provide health coverage to residents of North Carolina under the NC Health Care for working families program and to establish the North Carolina Rural Access to Healthcare grant program. The benefit package designed by the Department of Health and Human Services (DHHS) must be similar to the coverage provided under North Carolina's 2017 Essential Health Benefits Benchmark Plan and the Blue Cross and Blue Shield of North Carolina Blue Options Preferred Provider Organization (PPO) Plan and must comply with applicable federal requirements governing Alternative Benefit Plans. The benefit package designed by DHHS must also focus on preventive care and participant wellness. Prepaid Health Plans must manage the benefits for the population covered by the NC Health Care for Working Families program through capitated contract.

In **North Dakota**

2019 ND H.B. 1028 (NS) was prefiled January 2, 2019. The proposed bill relates to public employees retirement system self-insurance plans for health benefits coverage. Insurers providing coverage in North Dakota for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, is presumed to be subject to the jurisdiction of the commissioner unless the person shows that while providing such services person is subject to the jurisdiction of another agency.

2019 ND H.B. 1063 (NS) was prefiled January 2, 2019. The proposed bill will, if passed, create an Act relating to duration limits for opioid therapy, benzodiazepine, and muscle relaxants.

2019 ND H.C.R. 3026 (NS) was introduced January 22, 2019. The bill is a concurrent resolution urging Congress and the Internal Revenue Service to allow states to determine health benefit coverage requirements without jeopardizing health savings account eligibility.

In **Ohio**

2019 OH H.B. 292 (NS) was introduced June 19, 2019. The proposed bill seeks to establish and operate the Ohio Health Care Plan to provide universal health care coverage to all Ohio residents. The health care plan includes a requirement that the executive director, in consultation with the technical and medical advisory board, must determine the duties of the administrator of quality assurance. Those duties shall include the following:

• studying and reporting on the efficacy of health care treatments and medications for particular conditions;

• identifying causes of medical errors and devising procedures to decrease medical errors;

• establishing an evidence-based formulary;

• identifying treatments and medications that are unsafe or have no proven value;

• establishing a process for soliciting information on medical standards from providers and consumers.

2019 OK S.B. 1017 (NS) was filed January 24, 2019. The proposed bill seeks to modify the type of coverage requirement applicable to Oklahoma Employees Health Insurance Plan. If passed, the bill will require any health insurance mandate to also apply to the Oklahoma Employees Health Insurance Plan.

In **Oklahoma**

2019 OK H.B. 2652 (NS) was prefiled January 24, 2019. The bill states that any health plan, including the State and Education Employees Group Health Insurance plan, offered, issued or renewed in Oklahoma on or after January 1, 2020, must provide coverage for complementary and alternative medicine.

2019 OK S.B. 993 (NS) was adopted May 16, 2019. The bill relates to “short-term, limited-duration insurance” policies. The bill states that short term limited duration insurance policies must not be required to contain one or more of the mandated accident and health insurance benefits otherwise required by certain specified Oklahoma Statutes. Short term limited duration insurance policies must also include the definitions of individual accident and health insurance with respect to major medical benefits and standard provisions or rights of coverage.

In **Pennsylvania**

2019 PA S.B. 841 (NS), a previously introduced bill, was amended October 28, 2019. The proposed bill provides for the Health Care Cost Containment Council. The bill states that the council must, upon the request of the appropriate committee chairman in the Senate and in the House of Representatives or upon the request of the Secretary of Health or the Secretary of Human Services, provide information on the proposed mandated health benefit pursuant to certain specifications. The General Assembly declares that proposals for mandated health benefits or mandated health insurance coverage should be accompanied by adequate, independently certified

documentation defining the social and financial impact and medical efficacy of the proposal. To that end, the council, upon receipt of such requests, is hereby authorized to conduct a preliminary review of the material submitted by both proponents and opponents concerning the proposed mandated benefit. If, after this preliminary review, the council is satisfied that both proponents and opponents have submitted sufficient documentation necessary for a specified review the council is directed to contract with individuals, pursuant to the specified selection procedures for vendors (relating to contracts with vendors), who will constitute a Mandated Benefits Review Panel to review mandated benefits proposals and provide independently certified documentation, as provided.

2019 PA H.B. 572 (NS) was introduced March 7, 2019. The proposed bill is an act providing for insurance coverage for patient costs associated with cancer clinical trials. The proposed bill states that a carrier is not obligated to pay any costs, other than routine care costs, that are directly associated with a cancer clinical trial that is offered in Pennsylvania and in which the subscriber, insured or enrollee participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

• the treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in this Commonwealth, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes specified criteria;

• the treatment is being provided as part of a study being conducted in a Phase I, Phase II, Phase III or Phase IV cancer clinical trial;

• the treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following;

• the proposed treatment or study has been reviewed and approved by an institutional review board of an institution in this Commonwealth;

• the personnel providing the treatment or conducting the study are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise;

• there is no clearly superior, noninvestigational treatment alternative; and

• the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.

In **Pennsylvania**

2019 PA S.B. 841 (NS), a previously introduced bill, was amended October 28, 2019. The proposed bill provides for the Health Care Cost Containment Council. The bill states that the council must, upon the request of the appropriate committee chairman in the Senate and in the House of Representatives or upon the request of the Secretary of Health or the Secretary of Human Services, provide information on the proposed mandated health benefit pursuant to certain specifications. The General Assembly declares that proposals for mandated health benefits or mandated health insurance coverage should be accompanied by adequate, independently certified documentation defining the social and financial impact and medical efficacy of the proposal. To that end, the council, upon receipt of such requests, is hereby authorized to conduct a preliminary review of the material submitted by both proponents and opponents concerning the proposed mandated benefit. If, after this preliminary review, the council is satisfied that both proponents and opponents have submitted sufficient documentation necessary for a specified review the council is directed to contract with individuals, pursuant to the specified selection procedures for vendors (relating to contracts with vendors), who will constitute a Mandated Benefits Review Panel to review mandated benefits proposals and provide independently certified documentation, as provided.

2019 PA H.B. 572 (NS) was introduced March 7, 2019. The proposed bill is an act providing for insurance coverage for patient costs associated with cancer clinical trials. The proposed bill states that a carrier is not obligated to pay any costs, other than routine care costs, that are directly associated with a cancer clinical trial that is offered in Pennsylvania and in which the subscriber, insured or enrollee participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

• the treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in this Commonwealth, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes specified criteria;

• the treatment is being provided as part of a study being conducted in a Phase I, Phase II, Phase III or Phase IV cancer clinical trial;

• the treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following;

• the proposed treatment or study has been reviewed and approved by an institutional review board of an institution in this Commonwealth;

• the personnel providing the treatment or conducting the study are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise;

• there is no clearly superior, noninvestigational treatment alternative; and

the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.

In **Rhode Island**

2019 RI H.B. 5146 (NS) was introduced January 17, 2019. If passed, this act would require health insurance coverage for annual pediatric mental health examinations when determined to be medically necessary and ordered by a physician or pediatrician and/or any court order with jurisdiction of children from the age of ten years up to age eighteen years for policies issued on or after January 1, 2020.

2019 RI H.B. 5420 (NS) was introduced February 14, 2019. If passed, the proposed bill is an act that would mandate coverage for all blood testing services offered in this state in all accident and sickness, nonprofit hospital service corporation, nonprofit medical service corporation and health maintenance organization (HMO) health insurance policies issued on or renewed on or after January 1, 2020.

2019 RI H.B. 5916 (NS) was introduced March 28, 2019. The proposed bill is an act that would establish the Rhode Island health insurance market stability and consumer protection act in order to update state law to reflect current insurance standards, practice and regulation to maintain market stability, including using current rating factors, continuing the use of a medical loss ratio standard, and providing coverage for benefits consistent with all applicable federal and state laws and regulations. Consumer protections contained in the act would include current requirements to:

• ban pre-existing condition exclusions;

• limit annual insurance coverage caps; and

• cover of preventive services without patient cost sharing, coverage of essential health benefits and provide summaries of benefits for consumers.

2019 RI S.B. 738 (NS), a previously introduced bill, was amended May 16, 2019. If passed, this bill would establish the Rhode Island health insurance market stability and consumer protection act in order to update state law to reflect current insurance standards, practice and regulation to maintain market stability, including using current rating factors, continuing the use of a medical loss ratio standard, and providing coverage for benefits consistent with all applicable federal and state laws and regulations. Consumer protections contained in the act include current requirements to:

• ban pre-existing condition exclusions;

• limit annual insurance coverage caps;

• cover preventive services without patient cost sharing, coverage of essential health benefits and provide summaries of benefits for consumers.

In **Texas**

2019 TX H.B. 805 (NS), a previously introduced bill, was amended April 30, 2019. The proposed bill states that it has been suggested that the process to be granted access by the U.S. Food and Drug Administration (FDA) to unapproved drugs that are in the clinical trial phase is arduous and lengthy and comes at a phase of illness when most terminally and chronically ill patients do not have the time to wait. This bill seeks to set out the Medical Freedom Act to allow patients with severe chronic diseases to safely and more quickly access experimental treatments that are not yet approved by the FDA.

In **Vermont**

2019 VT H.B. 524 (NS) was enrolled June 11, 2019. This bill proposes to implement Vermont's individual mandate to maintain health insurance coverage. It would also codify in State law certain health insurance consumer protections, including a ban on preexisting condition exclusions and a requirement to provide coverage for dependents up to 26 years of age. The bill would require looking through the structure of an association to provide health insurance plans based on the size of each underlying employer. It would prohibit licensed brokers from accepting payment for enrolling Vermont residents in certain health expense-sharing arrangements and would require the Green Mountain Care Board to quantify the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premiums. The bill would also direct the Agency of Human Services to develop strategies for increasing the affordability of health insurance and to evaluate options for the future of Vermont's health insurance markets.

In **Virginia**

2018 VA S.B. 1132 (NS) was prefiled December 29, 2018. The proposed bill relates to reproductive health services. If passed, the bill will require health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health, including:

• contraception and women's preventive health services identified by the Health Resources and Services Administration of the U.S. Department of Health and Human Services or the women's preventive services initiative as of January 1, 2017;

• screening to determine whether counseling and testing related to the BRCA1 or BRCA2 genetic mutations is indicated and testing and genetic counseling related to the BRCA1 or BRCA2 genetic mutations if indicated;

• abortion to the extent permitted by applicable law; and

• voluntary sterilization.

The proposed bill also requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of the costs of a reproductive health care program providing reimbursement for medically necessary reproductive health care services, drugs, devices, products, and procedures for eligible individuals.

2018 VA S.B. 1240 (NS) was enrolled February 18, 2019. The bill authorizes health insurance carriers to offer short-term, limited-duration health plans. Short-term, limited-duration health plans are defined as plans that have an expiration date that is less than 12 months after the original effective date of the contract, policy, or plan and, taking into account renewals or extensions, have a duration that does not exceed 36 months. Short-term health plans are required to include a specified disclaimer.

2018 VA S.B. 1178 (NS) was enrolled February 18, 2019. The bill relates to health carriers and nurse practitioners. The bill requires health insurers and health services plan providers whose policies or contracts cover services that may be legally performed by licensed nurse practitioners to provide equal coverage for such services when rendered by a licensed nurse practitioner. The bill contains an enactment that exempts the measure from the requirement that the Health Insurance Reform Commission review any legislative measure containing a mandated health insurance benefit or provider.

In **Washington**

2019 WA S.B. 5840 (NS) was introduced February 6, 2019. The proposed bill is an act relating to requiring maintenance of minimum essential health care coverage.

2019 WA S.B. 5781 (NS) was introduced January 31, 2019. The proposed bill relates to health insurance mandates in the individual and small group markets. The proposed bill states that commercial health benefit plans offered in the individual and small group markets are exempt from all state mandated benefits beyond those required by the federal government as the ten essential health benefits.

2019 WA S.B. 5805 (NS) was introduced February 4, 2019. The proposed bill seeks to make state law consistent with selected federal consumer protections in the patient protection and affordable care act.

2019 WA S.B. 5805 (NS), a previously introduced bill, was amended February 19, 2019. The bill seeks to make state law consistent with selected federal consumer protections in the patient protection and affordable care act. The bill includes a provision requiring the commissioner to submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate.

2019 WA H.B. 1870 (NS) was enrolled April 8, 2019. The bill relates to making state law consistent with selected federal consumer protections in the patient protection and affordable care act.

In **Wisconsin**

2019 WI S.B. 37 (NS) was introduced February 15, 2019. The bill requires certain health plans to guarantee access to coverage. The bill also:

• prohibits plans from imposing preexisting condition exclusions; prohibits plans from setting premiums or cost-sharing amounts based on a health status-related factors;

• prohibits plans from setting lifetime or annual limits on benefits;

• requires plans to cover certain essential health benefits; and

• requires coverage of certain preventive services by plans without a cost-sharing contribution by an enrollee.

The bill requires health insurance policies and governmental self-insured health plans to cover certain preventive services and to provide coverage of those preventive services without subjecting that coverage to deductibles, copayments, or coinsurance. The preventive services for which coverage is required are specified in the bill.