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Health Insurance Oversight
Mandated Benefits

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12/20/2021

Mandated Benefits

2021 Federal Action

2021 CONG US HR 4311 was introduced in the House of Representatives on July 1, 2021. The proposed bill seeks to amend title XVIII of the Social Security Act to provide for coverage of dental, vision, and hearing care under the Medicare program.

2021 CONG US HRES 685 was introduced September 27, 2021. The proposed bill expresses support for the recognition of September 26, 2021, as ‘World Contraception Day’ and expressing the sense of the House of Representatives regarding global and domestic access to contraception.

2021 CONG US HR 5610 was introduced in the House of Representatives on October 19, 2021. The proposed bill seeks to streamline enrollment in health insurance affordability programs and minimum essential coverage, and for other purposes.

2021 State Action

In **Arizona**

2021 AZ H.B. 2274 (NS) was filed January 14, 2021. If passed, the proposed bill will require any insurer offering Medicare supplement insurance policies to persons who are at least sixty-five years of age must also offer Medicare supplement insurance policies to persons who are eligible for and enrolled in Medicare due to a disability or end-stage renal disease. All benefits and coverages that apply to a Medicare enrollee who is at least sixty-five years of age must also apply to a Medicare enrollee who is enrolled due to a disability or end-stage renal disease.

In **California**

2021 CA S.B. 473 (NS), a previously introduced bill, was amended March 10, 2021. If passed, this bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2022, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed $50 per 30-day supply of insulin, or $100 total per month, regardless of the amount or type of insulin needed to fill the enrollee's or insured's prescription or prescriptions. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

2021 CA A.B. 97 (NS), a previously introduced bill, was amended March 30, 2021. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin, if it is determined to be medically necessary. If passed, this bill would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription drug. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

2021 CA A.B. 114 (NS), a previously introduced bill, was amended May 24, 2021. 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 pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The Budget Act of 2018 appropriates $2,000,000 for the Whole Genome Sequencing Pilot Project, and requires the

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department to provide a grant to a state nonprofit organization for the execution of a one-time pilot project to investigate the potential clinical and programmatic value of utilizing clinical Whole Genome Sequencing in the Medi-Cal program. This bill would expand the Medi-Cal schedule of benefits to include rapid Whole Genome Sequencing, as specified, for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. The bill would authorize the department to implement this provision by various means without taking regulatory action.

2021 CA S.B. 293 (NS), a previously introduced bill, was amended March 18, 2021. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans, including mental health plans that provide specialty mental health services. Existing law requires the department to ensure that Medi-Cal managed care contracts include a process for screening, referral, and coordination with mental health plans of specialty mental health services, to convene a steering committee to provide advice on the transition and continuing development of the Medi-Cal mental health managed care systems, and to ensure that the mental health plans comply with various standards, including maintaining a system of outreach to enable Medi-Cal beneficiaries and providers to participate in and access Medi-Cal specialty mental health services under the mental health plans. With respect to specialty mental health services provided under the Early and Periodic Screening, Diagnostic, and Treatment Program, on or after January 1, 2022, this bill would require the department to develop standard forms, including intake and assessment forms, relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements pursuant to specified terms and conditions, and, for purposes of implementing these provisions, would require the department to consult with representatives of identified organizations, including the County Behavioral Health Directors Association of California.

2021 CA S.B. 535 (NS), a previously introduced bill, was amended July 8, 2021. Existing law requires an individual or group health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests. If passed, this bill would delete the references to individual or group health care service plan contracts and health insurance policies in those provisions. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for an enrollee or insured with advanced or metastatic stage 3 or 4 cancer. The bill would provide that its provisions do not limit, prohibit, or modify an enrollee's or insured's rights to biomarker testing as part of an approved clinical trial, as specified. With respect to health care service plans, the bill would specifically apply the provisions relating to biomarker testing to Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

2021 CA S.B. 523 (NS), a previously introduced bill, was amended July 8, 2021. Existing law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies. If passed, this bill, the Contraceptive Equity Act of 2021, would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost sharing or medical management restrictions. The bill would require health care service plans and insurance policies offered by public or private institutions of higher learning that directly provide health care services only to its students, faculty, staff, administration, and their respective dependents, approved on or after January 1, 2023, to comply with these contraceptive coverage requirements.

2021 CA A.B. 1542 (NS), a previously introduced bill, was amended July 7, 2021. If passed, this bill would, to the extent permitted under federal and state law, make treatment provided to a participant during the program reimbursable under the Medi-Cal program, if the participant is a Medi-Cal beneficiary and the treatment is a covered benefit under the Medi-Cal program. If treatment services are not reimbursable under the Medi-Cal program or through the participant's personal health care coverage, the bill would authorize funds allocated to the state from the 2021 Multistate Opioid Settlement Agreement, subject to an appropriation by the Legislature, to be used to reimburse those treatment services to the extent consistent with the terms of the settlement agreement and the court's final judgment.

2021 CA S.B. 326 (NS), a previously introduced bill, was amended June 30, 2021. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires the above-described federal health care coverage market reforms to apply to a health care service plan, plan or health insurer, but conditions the operation of certain of these market reforms on the continued operation of PPACA or certain of its requirements. If passed, this bill would delete the conditional operation of the above-described provisions based on the continued operation of PPACA, the federal individual mandate, the federal coverage guarantee, and federal essential health benefits coverage requirements. By indefinitely extending the operation of these provisions, and thus indefinitely extending the applicability of a crime for a willful violation by a health care service plan, the bill would impose a state-mandated local program.

2021 CA A.B. 133 (NS) was adopted July 27, 2021. Existing law excludes specified optional services from coverage in the Medi-Cal program, including audiology services, optometric services, podiatric services, and incontinence creams and washes, among others.

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Notwithstanding this exclusion, existing law restores coverage for specified optional benefits, including audiology services, optometric services, podiatric services, and incontinence creams and washes. Existing law suspends these optional benefits on December 31, 2021, unless specified conditions occur. This bill will delete the provisions suspending these optional benefits. The bill will also extend eligibility for full-scope Medi-Cal benefits for a pregnant individual or targeted low-income child who is eligible for and is receiving health care coverage under the Medi-Cal program, or another related program, for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy, without conditioning the extended eligibility to a diagnosis of a maternal mental health condition.

2021 CA A.B. 342 (NS), a previously introduced bill, was amended July 5, 2021. Existing law requires individual and group health care service plan contracts and health insurance policies to provide coverage for all generally medically accepted cancer screening tests and requires those contracts and policies to also provide coverage for the treatment of breast cancer. Existing law requires an individual or small group health care service plan contract or health insurance policy to, at a minimum, include coverage for essential health benefits, which include preventive services, pursuant to the federal Patient Protection and Affordable Care Act. This bill would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for a colorectal cancer screening test, and would require the required colonoscopy for a positive result on a test or procedure to be provided without cost sharing, unless the underlying test or procedure was a colonoscopy.

2021 CA S.B. 497 (NS), a previously introduced bill, was amended August 16, 2021. Existing law requires unemployment compensation benefits administered by the Employment Development Department (EDD), child support payments made through the State Disbursement Unit of the Department of Child Support Services, and specified public assistance payments, including payments made under the California Work Opportunity and Responsibility to Kids (CalWORKs) program, that are directly deposited to an account of the recipient's choice to be deposited into a qualifying account. his bill would change the definition of qualifying account, including eliminating a prepaid card account and instead authorizing a prepaid account or a demand deposit or savings account offered by or through an entity other than an insured depository financial institution, as specified, that is not attached to an automatic credit or overdraft feature, unless the credit or overdraft feature has no fee, charge, or cost, or it complies with the requirements for consumer credit under the federal Truth in Lending Act. To the extent this bill would increase the responsibilities of counties in providing benefits under the CalWORKs program, the bill would impose a state-mandated local program.

2021 CA A.B. 97 (NS), a previously introduced bill, was amended August 17, 2021. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin, if it is determined to be medically necessary. his bill would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription drug, except as specified for a high deductible health plan, as defined. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

2021 CA S.B. 524 (NS) was enrolled September 7, 2021. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. This bill would prohibit a health care service plan, a health insurer, or the agent thereof from engaging in patient steering, as specified. The bill would define ‘patient steering’ to mean communicating to an enrollee or insured that they are required to have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy, as specified, or offering group health care coverage contracts or policies that include provisions that limit access to only pharmacy providers that are owned or operated by the health care service plan, health insurer, or agent thereof. The bill would provide that these provisions do not apply to certain entities, including an entity that is part of a ‘fully integrated delivery system,’ as specified.

2021 CA A.B. 347 (NS) was enrolled September 13, 2021. Existing law authorizes a health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, and authorizes a health care service plan to utilize step therapy consistent with Knox-Keene. Under existing law, if a health care service plan, health insurer, or contracted physician group fails to respond to a completed prior authorization request from a prescribing provider within a specified timeframe, the prior authorization request is deemed to have been granted. This bill clarifies that a health care service plan that provides coverage for prescription drugs may require step therapy, as defined, if there is more than one drug that is clinically appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified, supporting the provider's determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services to the enrollee or insured, based on specified criteria. The bill would authorize a health care provider or prescribing provider to appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request consistent with the health care service plan's or health insurer's current utilization management processes. The bill would authorize an enrollee or insured, or their designee or guardian, to appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request, as specified.

2021 CA A.B. 356 (NS) was enrolled September 13, 2021. The Radiologic Technology Act makes it unlawful for any licentiate of the healing arts to administer or use diagnostic, mammographic, or therapeutic x-ray on human beings in this state, unless that person is certified by the State Department of Public Health and acting within the scope of that certification. This bill would, notwithstanding those requirements, authorize the department to issue a physician and surgeon or a doctor of podiatric medicine a one-time, nonrenewable,

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temporary permit to operate, or supervise the operation of, fluoroscopic x-ray equipment if the physician and surgeon or the doctor of podiatric medicine meets specified criteria, including attesting under penalty of perjury of having at least 40 hours of experience using that equipment while not subject to the act. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program.

2021 CA S.B. 326 (NS) was enrolled September 10, 2021. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires the above-described federal health care coverage market reforms to apply to a health care service plan or health insurer, but conditions the operation of certain of these market reforms on the continued operation of PPACA or certain of its requirements. This bill would delete the conditional operation of the above-described provisions based on the continued operation of PPACA, the federal individual mandate, the federal coverage guarantee, and federal essential health benefits coverage requirements. By indefinitely extending the operation of these provisions, and thus indefinitely extending the applicability of a crime for a willful violation by a health care service plan, the bill would impose a state-mandated local program.

2021 CA A.B. 342 (NS) was enrolled September 7, 2021. Existing law requires individual and group health care service plan contracts and health insurance policies to provide coverage for all generally medically accepted cancer screening tests and requires those contracts and policies to also provide coverage for the treatment of breast cancer. Existing law requires an individual or small group health care service plan contract or health insurance policy to, at a minimum, include coverage for essential health benefits, which include preventive services, pursuant to the federal Patient Protection and Affordable Care Act. This bill would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for a colorectal cancer screening test, and would require the required colonoscopy for a positive result on a test or procedure to be provided without cost sharing, unless the underlying test or procedure was a colonoscopy. The bill would provide that it does not preclude a health care service plan or health insurer from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider.

CA LEGIS 470 (2021) was filed with the Secretary of State October 4, 2021. Existing law provides for the licensure and regulation of health facilities and clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is a crime. This bill will require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a screening test for hepatitis B and hepatitis C to the extent these services are covered under the patient's health insurance, based on the latest screening indications recommended by the United States Preventive Services Task Force, unless the health care provider reasonably believes certain conditions apply that include, among others, the patient lacks the capacity to consent to the screening test. The bill will also require the health care provider to offer the patient follow-up health care or refer the patient to a health care provider who can provide follow-up health care if the screening test is positive, as specified.

2021 CA S.B. 535 (NS) was approved October 6, 2021. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or group health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests. This bill would delete the references to individual or group health care service plan contracts and health insurance policies in those provisions. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for an enrollee or insured with advanced or metastatic stage 3 or 4 cancer. The bill would also prohibit those health care service plans or health insurance policies from requiring prior authorization for biomarker testing for cancer progression or recurrence in the enrollee or insured with advanced or metastatic stage 3 or 4 cancer. The bill would provide that its provisions do not limit, prohibit, or modify an enrollee's or insured's rights to biomarker testing as part of an approved clinical trial, as specified.

CA LEGIS 764 (2021) was filed with the Secretary of State October 9, 2021. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Among other things, PPACA requires applicable individuals to maintain minimum essential coverage, and imposes a shared responsibility penalty on an applicable individual who does not maintain minimum essential coverage. This provision is referred to as the individual mandate. This bill would delete the conditional operation of the above-described provisions based on the continued operation of PPACA, the federal individual mandate, the federal coverage guarantee, and federal essential health benefits coverage requirements. By indefinitely extending the operation of these provisions, and thus indefinitely extending the applicability of a crime for a willful violation by a health care service plan, the bill would impose a state-mandated local program.

CA LEGIS 436 (2021) was filed with the Secretary of State October 1, 2021. Existing law requires individual and group health care service plan contracts and health insurance policies to provide coverage for all generally medically accepted cancer screening tests and requires those contracts and policies to also provide coverage for the treatment of breast cancer. Existing law requires an individual or small group health care service plan contract or health insurance policy to, at a minimum, include coverage for essential health benefits, which include preventive services, pursuant to the federal Patient Protection and Affordable Care Act. This bill would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for a colorectal cancer screening test, and would require the required colonoscopy for a positive result on a test or procedure to be provided without cost sharing, unless the underlying test or procedure was a colonoscopy.

2021 CA S.B. 510 (NS) was adopted October 8, 2021. This bill requires a health care service plan contract or a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health care service plan contract or

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health insurance policy, to cover the costs for COVID-19 diagnostic and screening testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, and would prohibit that contract or policy from imposing cost sharing or prior authorization requirements for that coverage. The bill also requires a contract or policy to cover without cost sharing or prior authorization an item, service, or immunization intended to prevent or mitigate COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, that is recommended by the United States Preventive Services Task Force or the federal Centers for Disease Control and Prevention.

CA LEGIS 742 (2021) was filed with the Secretary of State October 9, 2021. Under existing law, if a health care service plan, health insurer, or contracted physician group fails to respond to a completed prior authorization request from a prescribing provider within a specified timeframe, the prior authorization request is deemed to have been granted. This bill would clarify that a health care service plan that provides coverage for prescription drugs may require step therapy, as defined, if there is more than one drug that is clinically appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified, supporting the provider's determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services to the enrollee or insured, based on specified criteria.

2021 CA S.B. 280 (NS) was adopted October 7, 2021. Existing law prohibits a health insurer or agent or broker from, directly or indirectly, from among other things, employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminating based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. This bill would require a large group health insurance policy issued, amended, or renewed on or after July 1, 2022, to cover medically necessary basic health care services, as defined. The bill would authorize the commissioner to adopt regulations to implement these provisions. The bill would require these provisions to apply to an individual, group, or blanket disability insurance policy if a specified condition is met. This bill would also, with respect to large group health insurance, prohibit an insurer and its officials, employees, agents, and representatives from directly or indirectly employing marketing practices or benefit designs that have the effect of discouraging the enrollment of individual on the above-described protected classifications. An insurer that violates this provision would be liable for an administrative penalty of not more than $2,500 for the first violation, and not more than $5,000 for the second. The bill would also subject an insurer that violates this provision with a frequency that indicates a general practice or commits a knowing violation to an administrative penalty of not less than $15,000, and not more than $100,000 for each violation.

In **Colorado**

2021 CO H.B. 1276 (NS), a previously introduced bill, was amended June 3, 2021. If passed, the bill will require a health benefit plan issued or renewed on or after January 1, 2023, to provide coverage for nonpharmacological treatment as an alternative to opioids. The required coverage must include, at a cost-sharing amount not to exceed the cost-sharing amount for a primary care visit for nonpreventive services and without a prior authorization requirement, at least 6 physical therapy visits, 6 occupational therapy visits, 6 chiropractic visits, and 6 acupuncture visits per year. The bill will also require an insurance carrier (carrier) that provides prescription drug benefits to provide coverage, beginning January 1, 2023, for at least one atypical opioid that is approved by the federal food and drug administration (FDA) for the treatment of acute or chronic pain, which coverage must be at the lowest cost-sharing tier of the carrier's formulary with no requirement for step therapy or prior authorization. Additionally, a carrier cannot require step therapy for any additional FDA-approved atypical opioids.

2021 CO H.B. 1068 (NS) was adopted July 6, 2021. The bill relates to health insurance coverage for an annual mental health wellness examination performed by a qualified mental health care provider.

In **Connecticut**

2021 CT H.B. 5013 (NS), a previously introduced bill, was amended March 22, 2021. The proposed bill seeks to alter the manner in which the General Assembly enacts new mandated health insurance benefits.

2021 CT S.B. 842 (NS), a previously introduced bill, was amended May 10, 2021. If passed, this bill will require the comptroller to establish a fully insured group health insurance and pharmacy plan for multiemployer plans, nonprofit employers, and smaller employers. Under the bill, a ‘small employer’ is an employer with 50 or fewer employees; it excludes nonstate public employers (i.e., municipalities). Coverage offered under the bill must generally comply with all existing state insurance laws and health insurance benefit mandates, except where noted below. The bill has conflicting provisions regarding the nature of the health insurance plan the comptroller must establish.

2021 CT H.B. 6626 (NS), a previously introduced bill, was amended May 14, 2021. The proposed bill seeks to provide health insurance coverage for breast health benefits. This bill expands coverage requirements for mammograms, ultrasounds, and magnetic resonance imaging (MRIs) of an insured's breasts under certain commercial health insurance policies. It also requires the policies to cover breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions. As under existing law, the bill prohibits the policies from imposing cost sharing (coinsurance, copayments, deductibles, or other out-of-pocket expenses) for the covered services. This cost-sharing prohibition applies to all affected policies, but it only applies to high deductible health plans (1) to the extent federal law permits and (2) so long as it does not disqualify a medical or health savings account from preferable tax treatment.

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2021 CT H.B. 6622 (NS), a previously introduced bill, was amended May 27, 2021. The proposed bill is an act relating to prescription drug formularies and lists of covered drugs.

In **Florida**

2021 FL S.B. 530 (NS) was engrossed March 18, 2021. The bill authorizes certain health care practitioners to provide a specified educational pamphlet to patients in an electronic format. The bill also prohibits health insurance policies from requiring that treatment with an opioid analgesic drug product or abuse-deterrent opioid analgesic drug product be attempted and have failed before authorizing the use of a nonopioid-based analgesic drug product.

2022 FL H.B. 79 (NS) was filed September 9, 2021. If passed, the bill states that health insurers issuing an individual policy that provides major medical or similar comprehensive coverage to an insured or a family member of an insured must provide coverage for a hearing aid for an insured child 21 years of age or younger who is diagnosed with hearing loss by a licensed physician or a licensed audiologist and for whom the hearing aid is prescribed as medically necessary. Coverage for a hearing aid prescribed to a child younger than 18 years of age must require the hearing aid to be prescribed, fitted, and dispensed by a licensed physician or a licensed audiologist. Coverage for a hearing aid prescribed to a child between 18 and 21 years of age, inclusive, must require the hearing aid to be fitted and dispensed by a licensed physician, a licensed audiologist, or a licensed hearing aid specialist.

2022 FL S.B. 498 (NS) was filed October 14, 2021. The bill provides a definition of the term ‘hearing aid’. The bill also:

• requires certain individual health insurance policies to provide coverage for hearing aids for children 21 years of age or younger under certain circumstances;

• specifies health care providers who may prescribe, fit, and dispense the hearing aids;

• requires certain individual health maintenance contracts to provide coverage for hearing aids for children 21 years of age or younger under certain circumstances.

2022 FL S.B. 564 (NS) was filed October 20, 2021. The bill prohibits health maintenance organizations from excluding coverage for certain cancer treatment drugs. The bill also:

• prohibits insurers and health maintenance organizations from excluding coverage for certain drugs on certain grounds;

• specifies a requirement for the prior authorization form adopted by the Financial Services Commission by rule;

• specifies requirements for, and restrictions on, health insurers and pharmacy benefits managers relating to prior authorization information, requirements, restrictions, and changes.

In **Hawaii**

2021 HI H.C.R. 13 (NS) was filed January 22, 2021. The resolution requests the auditor to conduct a social and financial assessment of proposed mandatory health insurance coverage.

2021 HI S.B. 827 (NS) was introduced January 22, 2021. If passed, the proposed bill will increase the categories of women required to be covered for mammogram screenings. The bill will also require the existing health insurance mandate for coverage of low-dose mammography to include digital mammography and breast tomosynthesis.

2021 HI S.B. 435 (NS) was introduced January 22, 2021. If passed, the proposed bill will require the State, in a declared public health emergency, to provide diagnostic and antibody tests free of charge to persons who are unable to pay for tests. Mandates health insurance coverage for diagnostic and antibody tests in the event of a declared public health emergency.

2021 HI S.B. 218 (NS) was introduced January 22, 2021. If passed, the proposed bill will prohibit a health care insurer, mutual benefit society, or health maintenance organization from requiring an insured, subscriber, member, or enrollee diagnosed with stage two through stage four cancer to undergo step therapy prior to covering the insured for the drug prescribed by the insured's health care provider, under certain conditions, for health insurance policies and contracts issued or renewed after 12/31/2021.

2021 HI S.B. 827 (NS), a previously introduced bill, was amended February 19, 2021. If passed, the bill willincrease the categories of women required to be covered for mammogram screenings. The bill will also require:

• the existing health insurance mandate for coverage of low-dose mammography to include digital mammography and breast tomosynthesis;

• health care providers to be reimbursed at rates accurately reflecting the resource costs specific to each service, including any increased resource cost after January 1, 2021.

2021 HI S.B. 827 (NS), a previously introduced bill, was amended March 4, 2021. If passed, the bill will increase the categories of women required to be covered for mammogram screenings. Requires the existing health insurance mandate for coverage of low-dose mammography to include digital mammography and breast tomosynthesis. Defines ‘digital breast tomosynthesis'. Requires health care providers to be reimbursed at rates accurately reflecting the resource costs specific to each service, including any increased resource cost after January 1, 2021.

In **Illinois**

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2021 IL H.B. 2948 (NS) was introduced February 19, 2021. The proposed bill relates to eligibility for health savings accounts. The bill also provides that an HSA-eligible high deductible health plan is exempt from specified requirements but only until the deductible has been met and only to the extent necessary to allow the policy to satisfy specified federal criteria. In provisions concerning coverage for screening by low-dose mammography, provisions concerning coverage for contraceptives, and provisions concerning coverage for whole body skin examination, removes provisions stating that the mandates do not apply to required coverage to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to specified federal law.

2021 IL H.B. 33 (NS) was adopted July 23, 2021. The bill provides that a company authorized to transact life insurance in Illinois may not:

• cancel, terminate, or refuse to renew an individual's life insurance policy because of that individual's participation in a substance use disorder treatment or recovery support program;

• charge an individual a different rate for life insurance coverage because of that individual's participation in a substance use disorder treatment or recovery support program;

• deny a claim by a beneficiary because of an individual's participation in a substance use disorder treatment or recovery support program; or

• ask an insured whether he or she is participating or has participated in a substance use disorder treatment or recovery support program.

The bill also contains provisions regarding confidentiality by providing that the new provisions do not prohibit a company authorized to transact life insurance in Illinois from:

• refusing to insure, refusing to continue to insure, limiting the amount, extent, or kind of coverage available to an individual, or charging a different rate for the same coverage on the basis of that individual's physical or mental condition regardless of the underlying cause of such condition; or

• inquiring about a physical or mental condition, even if that condition was caused by or is related in any manner to a substance use disorder.

2021 IL H.B. 711 (NS) was adopted August 19, 2021. The bill creates the Prior Authorization Reform Act. The bill provides requirements concerning disclosure and review of prior authorization requirements, denial of claims or coverage by a utilization review organization, and the implementation of prior authorization requirements or restrictions. The bill also provides:

• requirements concerning a utilization review organization's obligations with respect to prior authorizations in nonurgent circumstances, urgent health care services, and emergency health care services;

• that a utilization review organization shall not require prior authorization under specified circumstances;

• requirements concerning the length of prior authorizations; and

• that health care services are automatically deemed authorized if a utilization review organization fails to comply with the requirements of the Act.

2021 IL S.B. 967 (NS) was adopted October 8, 2021. The bill requires an individual or group policy of accident and health insurance or managed care plan to provide coverage for pregnancy and newborn care regarding essential health benefits.

IL LEGIS 102-665 (2021) was approved October 8, 2021. The act is called the Improving Health Care for Pregnant and Postpartum Individuals Act. The bill requires that insurers must allow hospitals separate reimbursement for a long-acting reversible contraceptive device provided immediately postpartum in the inpatient hospital setting before hospital discharge. The payment must be made in addition to a bundled or Diagnostic Related Group reimbursement for labor and delivery. The bill also requires insurers to provide coverage for pregnancy and newborn care regarding essential health benefits.

In **Indiana**

2021 IN H.B. 1405 (NS) was adopted April 29, 2021. If passed, the bill will allow the office of the secretary of family and social services to apply for a Medicaid state plan amendment to allow school corporations to seek Medicaid reimbursement for medically necessary, school based Medicaid covered services that are provided under federal or state mandates.

In **Kansas**

2021 KS H.B. 2157 (NS) was introduced January 27, 2021. The proposed bill seeks to establish restrictions on the use of step therapy protocols by health insurance plans.

In **Kentucky**

2021 KY S.B. 19 (NS) was introduced January 5, 2021. If passed, the proposed bill will:

• require the commissioner of insurance to establish a database of billed health care service charges;

• require an insurer to reimburse for unanticipated out-of-network care;

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• prohibit balance billing from a provider who has been reimbursed as required;

• provide for an independent dispute resolution program to review reimbursements provided for unanticipated out-of-network care; and

• allow unregulated health plans to opt-in to requirements; require insurers to provide certain notices in an explanation of benefits.

2021 KY H.B. 95 (NS) was introduced January 5, 2021. The proposed bill seeks to cap the cost-sharing requirements for prescription insulin at $30 per 30 day supply.

2021 KY H.B. 117 (NS) was introduced January 5, 2021. The proposed bill seeks to require health benefit plans that provide benefits for prescription drugs to include coverage for the mailing or delivery of covered prescription drugs to insureds. The bill also provides that that the coverage must not be subject to higher copayments, fees, or other cost-sharing requirements.

2021 KY H.B. 77 (NS) was introduced January 5, 2021. If passed, the bill will:

• require certain health insurance policies to provide coverage for an annual mental health wellness examination of at least 45 minutes provided by a mental health professional;

• require the coverage to be no less extensive than coverage for medical and surgical benefits; require the coverage to comply with the Mental Health Parity and Addiction Equity Act of 2008; and

• provide that coverage shall not be subject to cost-sharing requirements.

In **Louisiana**

2021 LA S.R. 97 (NS) was enrolled May 26, 2021. The bill is a resolution to urge and request the Department of Insurance to form a task force to study, jointly with the Louisiana Department of Health, the causes of infertility in women and the desirability and feasibility of mandating insurance coverage for fertility treatments for women.

In **Massachusetts**

2021 MA S.D. 2144 (NS) was introduced February 19, 2021. The proposed bill relates to mandated benefits. If passed, the bill will require the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years, the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system.

2021 MA S.D. 702 (NS) was introduced February 4, 2021. The proposed bill is an act seeking to provide access to full spectrum addiction treatment services.

In **Michigan**

2019 MI H.B. 6519 (NS) was introduced December 16, 2020. If passed, the bill will require coverage for the dispensing of a 12-month supply of birth control.

In **Minnesota**

2021 MN S.F. 146 (NS) was engrossed February 4, 2021. The proposed bill relates to the mandated health benefit proposals evaluation process modification.

In **Missouri**

2021 MO H.B. 209 (NS) was prefiled December 1, 2020. The proposed bill seeks to modify provisions relating to the use of credit information when underwriting insurance contracts. The bill states that insurers must not use a credit report or insurance credit score as a factor in underwriting or take any adverse action based on a credit report or insurance credit score against a person currently insured under an existing insurance contract with the insurer.

In **New Jersey**

2020 NJ S.B. 3800 (NS), a previously introduced bill, was amended June 10, 2021. If passed, the proposed bill will require certain health insurers, Medicaid, NJ FamilyCare, SHBP, and SEHBP to cover opioid antidote without imposing prior authorization requirements.

2020 NJ A.B. 1708 (NS), a previously introduced bill, was amended June 21, 2021. If passed, the bill will require workers' compensation, PIP, and health insurance coverage for the medical use of cannabis under certain circumstances. The bill states that modern medical research has discovered a beneficial use for cannabis in treating or alleviating the pain or other symptoms associated with certain medical conditions, as found by the National Academy of Sciences' Institute of Medicine in March 1999. In addition, a

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rigorous review by the National Academies of Sciences, Engineering, and Medicine in 2017 of more than 10,000 scientific abstracts published since 1999 concerning the health impacts of cannabis reveals that there is conclusive or substantial evidence that cannabis is effective in the treatment of chronic conditions such as glaucoma, chronic pain, multiple sclerosis, and chemotherapy-induced nausea and vomiting. Additionally, as the opioid crisis continues across the country and in New Jersey, access to medical cannabis may help save lives by presenting a safe alternative to riskier opioids.

2020 NJ A.B. 5703 (NS) was adopted July 2, 2021. The billrequires certain health insurers, Medicaid, NJ FamilyCare, SHBP, and SEHBP to cover naloxone without imposing prior authorization requirements.

In **New York**

2021 NY S.B. 2974 (NS) was introduced January 26, 2021. If passed, the proposed bill willmandate commercial insurance coverage of peer support services as part of treatment for substance use disorder. Every policy providing medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services and also including peers certified by the office of mental health and peer support services provided by a certified recovery peer advocate as defined by the office of addiction services and supports. Such coverage must not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

2021 NY S.B. 5425 (NS) was introduced March 4, 2021. The proposed bill seeks to enact the ‘Unemployment Insurance Liability Act’; requires that employers that have relocated out of New York State continue to contribute to the unemployment insurance fund when former employees of the employer are receiving benefits for two quarters. It also will mandate that employers must identify all employees being terminated as a result of the relocation and include the amount of weekly wages paid to such individuals as part of the final quarterly payroll report submitted to the department of insurance.

2021 NY S.B. 5690 (NS) was introduced March 16, 2021. The proposed bill relates to prohibiting insurance companies from imposing co-payments for treatment at an opioid treatment program. If passed, the bill will require every policy providing coverage for treatment at an opioid treatment program shall not impose a co-payment fee during the course of treatment on any insured for such treatment.

2021 NY A.B. 6409 (NS) was introduced March 17, 2021. If passed, the bill will requiremanaged care providers to annually provide each participant in their programs with a written list of mail-order pharmacies with which the managed care provider has a contract for coverage of prescription drugs.

2021 NY A.B. 6810 (NS) was introduced April 08, 2021. If passed, the proposed bill will require managed care providers that provide coverage for prescription drugs to provide coverage for home delivery of any covered prescription by any non-mail-order retail pharmacy in the managed care provider network.

2021 NY S.B. 6733 (NS) was introduced May 13, 2021. If passed, the bill will health insurers to provide coverage for opioid antagonists and devices.

2021 NY S.B. 6574 (NS), a previously introduced bill, was amended June 1, 2021. If passed, the bill will require blanket health insurance policies to provide coverage for outpatient treatment by licensed mental health practitioners (mental health counsellors, marriage and family therapists, creative arts therapists and psychoanalysts).

2021 NY S.B. 24 (NS) was introduced January 6, 2021. If passed, the bill will enact the ‘Give Kids a Chance - Carter's Law’, mandating health insurance coverage for congenital anomalies. In the bill, the term ‘treatment’ includes inpatient and outpatient care and services performed to improve or restore body function, or performed to approximate a normal appearance, as a result of a congenital anomaly and must not include cosmetic surgery. Inpatient and outpatient care and services must include treatment to any and all missing or abnormal body parts, including teeth, the oral cavity, and their associated structures, that would otherwise be provided under the plan or coverage for any other injury and sickness.

2021 NY S.B. 1588 (NS) was introduced January 13, 2021. The proposed bill relates to coverage for certain prescription drugs in Medicaid managed care programs. Managed care providers must cover medically necessary prescription drugs in the anti-depressant, anti-retroviral, antirejection, seizure, epilepsy, endocrine, hematologic, immunologic and atypical antipsychotic therapeutic class classes, including non-formulary drugs, upon determination by the prescriber. If the prescriber, after consulting with the managed care provider, determines that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted, the prescriber's determination shall be final. However, the prescriber's determination shall not be final:

• where the drug approved by the managed care provider is a generic drug and even if the prescriber has indicated that the prescription must be dispensed as written; or

• if it is for the use of a drug that is not consistent with food and drug administration-approved labeling or supported by one or more official Compendia references, including, but not limited to, the American Hospital Formulary Service (AHFS), the DRUGDEX Drug Information System and the United States Pharmacopeia.

2021 NY A.B. 2392 (NS) was introduced January 19, 2021. The proposed bill seeks to prevent an insurance or managed care company from including in any insurance or managed care contract any provisions that require a dentist to provide services to a covered person

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at a fee set by or at a fee subject to the approval of the insurer or managed care entity unless such services are covered under the person's dental plan.

2021 NY S.B. 1720 (NS) was introduced January 14, 2021. The proposed bill seeks to 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.

2021 NY S.B. 6306 (NS), a previously introduced bill, was amended August 2, 2021. The proposed billRelates to determining whether the state can claim federal financial participation for coverage of and payment for certain evidence-based mobile medical applications. In light of the promise of evidence-based mobile medical applications for the treatment of patients with substance use and opioid use disorders during the coronavirus pandemic, this legislation would require that the New York state department of health seek guidance from the Centers for Medicare and Medicaid Services relative to a coverage and reimbursement pathway for evidence-based mobile medical applications, in order to accelerate access to such therapies for enrollees.

2021 NY S.B. 7424 (NS) was introduced October 8, 2021. If passed, the proposed bill will require insurance coverage for the HALO breast pap test to detect risk of developing breast cancer.

NY LEGIS 436 (2021)was approved October 8, 2021. The bill relates to the coverage of ostomy supplies in the child health plus program.

In **North Carolina**

2021 NC S.B. 594 (NS), a previously introduced bill, was amended June 23, 2021. The proposed bill states that if the Department of Health and Human Services specifically identifies a controlled substance contained other than an opioid or benzodiazepine as a controlled substance covered by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy, then the controlled substance is a covered substance under this section.

In **North Dakota**

ND LEGIS H.B. 1139 (2021) was approved March 31, 2021. The bill relates to the termination of coverage for Opioid therapy and benzodiazepine duration limits. The bill prohibits organizations from paying for opioid therapy that exceeds ninety morphine milligram equivalents of opioid medication per day, or more than a seven-day supply of an opioid medication within any single outpatient transaction during the initial thirty-day period of opioid therapy.

ND LEGIS S.B. 2130 (2021) was approved April 21, 2021. The bill relatesto the scope of health insurance mandates. The bill states that unless expressly provided otherwise, an accident and health insurance policy health coverage mandate does not apply to an accident and health insurance policy that is a specified high-deductible health plan if the mandate would cause the policy to fail to qualify as a high-deductible health plan under this federal law.

In **Oregon**

2021 OR H.B. 3045 (NS) was adopted July 27, 2021. The bill relates to mental health drugs.

In **Pennsylvania**

2021 PA H.B. 162 (NS), a previously introduced bill, was amended August 11, 2021. The proposed bill is an act prohibiting discrimination in certain insurance policies based on certain drugs.

2021 PA H.B. 2017 (NS) was introduced October 27, 2021. The proposed bill seeks to providing for coverage for inpatient and outpatient pasteurized donor human milk. If passed, every health insurance policy that provides pregnancy-related benefits must provide coverage for the use of pasteurized donor human milk in inpatient settings, as deemed medically necessary and medically prescribed, subject to all of the following conditions:

• the covered person is a child under the age of twelve (12) months based on that child's gestationally corrected age;

• the pasteurized donor human milk is obtained from a milk bank licensed in Pennsylvania in accordance with the act of February 12, 2020 (P.L.13, No.7), known as the ‘Keystone Mother's Milk Bank Act’ ;

• the child's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the child's needs or the maternal breast milk is contraindicated; and

• pasteurized donor human milk has been determined to be medically necessary in the child who exhibits one or more of specified requirements.

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In **Rhode Island**

2021 RI H.B. 6035 (NS) was introduced February 26, 2021. If passed, the bill will require every individual or group health insurance contract effective on or after January 1, 2022, to provide coverage to the insured and the insured's spouse and dependents for all FDA-approved contraceptive drugs, devices and other products, voluntary sterilization procedures, patient education and counseling on contraception and follow-up services as well as Medicaid coverage for a twelve (12) month supply for Medicaid recipients.

2021 RI S.B. 769 (NS), a previously introduced bill, was amended June 1, 2021. If passed, this act would require a health plan to cover clinically appropriate and medically necessary residential or inpatient services, including detoxification and stabilization services, for the treatment of mental health disorders, including substance use disorders. A health plan must not require preauthorization prior to a patient obtaining such services provided certain notifications are provided to the health plan within forty-eight hours (48) of admission. This act would also provide that such coverage shall not be subject to concurrent utilization review during the first twenty-eight (28) days of the residential or inpatient admission.

In **Virginia**

2020 VA S.B. 1473 (NS) was introduced January 22, 2021. The proposed bill seeks to define, for the purposes of the requirement that the Chair of the House Committee on Labor and Commerce or Senate Committee on Commerce and Labor refer certain legislation regarding a mandated health insurance benefit or provider to the Health Insurance Reform Commission for review, 'mandated health insurance benefit or provider' as coverage required to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that:

• includes coverage for specific health care services or benefits;

• places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

• includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care.

2020 VA S.B. 1473 (NS) was enrolled February 26, 2021. The bill provides that, for the purposes of the requirement that the Chair of the House Committee on Labor and Commerce or Senate Committee on Commerce and Labor refer certain legislation regarding a mandated health insurance benefit or provider to the Health Insurance Reform Commission for review, 'mandated health insurance benefit or provider' means coverage required under the laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that:

• includes coverage for specific health care services or benefits;

• places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

• includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care.

In **Washington**

WA LEGIS 273 (2021) was approved May 12, 2021. The bill requires hospitals to provide a person who presents to an emergency department with symptoms of an opioid overdose, opioid use disorder, or other adverse event related to opioid use with opioid overdose reversal medication upon discharge, unless the treating practitioner determines in their clinical and professional judgment that dispensing or distributing opioid overdose reversal medication is not appropriate or the practitioner has confirmed that the patient already has opioid overdose reversal medication. If the hospital dispenses or distributes opioid overdose reversal medication it must provide directions for use.

In **West Virginia**

2021 WV S.B. 583 (NS) was introduced March 5, 2021. The proposed bill seeks to increase required medical coverage for autism spectrum disorders. The bill, if passed, requires coverage for such diagnosis, evaluation and treatment of autism spectrum disorders, for individuals ages 18 months to 18 years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such policy must provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

2021 WV H.B. 335 (NS) was enrolled October 20, 2021. The bill relatesrelating to COVID-19 immunizations requirements for employment in the public and private sectors by providing for exemptions. The bill:

• establishes a process and an exemption for medical contraindications;

• establishes a process and an exemption for those with religious beliefs that prevent an employee or prospective employee from taking a COVID-19 vaccine; and

• prohibits discrimination for exercising an exemption

In **Wisconsin**

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2021 WI S.B. 499 (NS) was introduced August 5, 2021. If passed, the bill will require certain cost reporting by manufacturers of brand-name and generic drugs. The bill requires a manufacturer to notify the Department of Health Services and the Office of the Commissioner of Insurance if it is

• increasing the wholesale acquisition cost of a brand-name drug on the market in Wisconsin by more than 25 percent over a 24-month period;

• intending to introduce in Wisconsin a brand-name drug that has an annual wholesale acquisition cost of $30,000 or more;

• increasing the wholesale acquisition cost of a generic drug on the market in Wisconsin by more than 25 percent or by more than $300 during any 12-month period; or

• intending to introduce in Wisconsin a generic drug that has an annual wholesale acquisition cost of $3,000 or more.

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