H.663 – possible amendments for HHS discussion

Possible amendments to Sec. 1, 8 V.S.A. § 4099c:

§ 4099c. REPRODUCTIVE HEALTH EQUITY IN HEALTH INSURANCE COVERAGE

(a) As used in this section, "health insurance plan" means any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this State by a health insurer, as defined by 18 V.S.A. § 9402**, or by a pharmacy benefit manager on behalf of a health insurer**. The term shall not include benefit plans providing coverage for a specific disease or other limited benefit coverage.

(b) A health insurance plan shall provide coverage for outpatient contraceptive services including sterilizations, and shall provide coverage for the purchase of all prescription contraceptives and prescription contraceptive devices approved by the federal Food and Drug Administration, except that a health insurance plan that does not provide coverage of prescription drugs is not required to provide coverage of prescription contraceptives and prescription contraceptive devices. A health insurance plan providing coverage required under this section shall not establish any rate, term, or condition that places a greater financial burden on an insured or beneficiary for access to contraceptive services, prescription contraceptives, and prescription contraceptive devices than for access to treatment, prescriptions, or devices for any other health condition.

(c) A health insurance plan shall provide coverage without any deductible, coinsurance, co-payment, or other cost-sharing requirement **for at least one drug,**

device, or other product ~~**all drugs, devices, and other products**~~ within each method of contraception for women identified by the U.S. Food and Drug Administration (FDA) and prescribed by an insured's health care provider.

(1) The coverage provided pursuant to this subsection shall include patient education and counseling by the patient's health care provider regarding the appropriate use of the contraceptive method prescribed.

(2)(A) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, a health insurance plan may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing.

(B) If an insured's health care provider recommends a particular service or FDA-approved drug, device, or other product for the insured based on a determination of medical necessity, the health insurance plan shall defer to the provider's determination and judgment and shall provide coverage without cost-sharing for the drug, device, or product prescribed by the provider for the insured.

(d) A health insurance plan shall provide coverage for voluntary sterilization procedures for men and women without any deductible, coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

(e) A health insurance plan shall provide coverage without any deductible, coinsurance, co-payment, or other cost-sharing requirement for clinical services

associated with providing the drugs, devices, products, and procedures covered under this section and related follow-up services, including management of side effects, counseling for continued adherence, and device insertion and removal.

(f)(1) A health insurance plan shall provide coverage for a supply of prescribed contraceptives intended to last over a 12-month duration, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider. The health insurance plan shall reimburse a health care provider or dispensing entity per unit for furnishing or dispensing a supply of contraceptives intended to last for 12 months.

(2) This subsection shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

(g) Benefits provided to an insured under this section shall be the same for the insured's covered spouse and other covered dependents.

Possible new section regarding mandatory reporter law:

Sec. X. 33 V.S.A. § 4913 is amended to read:

§ 4913. REPORTING CHILD ABUSE AND NEGLECT; REMEDIAL ACTION

(a) A mandated reporter is any:

* * *

(2) individual who is employed by a school district or an approved or recognized independent school, or who is contracted and paid by a school district or an approved or recognized independent school to provide student services, including any:

(A) school superintendent;

(B) headmaster of an approved or recognized independent school as defined in 16 V.S.A. § 11;

(C) school teacher;

(D) student teacher;

(E) school librarian;

(F) school principal; and

(G) school guidance counselor;

* * *

(l) A mandatory reporter as described in subdivision (a)(2) of this section shall not be deemed to have violated the requirements of this section solely on the basis of distributing or making available over-the-counter contraceptive devices and products to secondary school students in accordance with 16 V.S.A. § 132 or 18 V.S.A. § 12, or both.