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Correspondence Memorandum

Date: February 15, 2021

To: Group Insurance Board

From: Tarna Hunter, Legislative Liaison
Office of the Secretary

Subject: Legislative Update

This memo is for informational purposes only. No Board action is required.

COVID-19 Related Legislation

2021 AB 1 includes the following provisions related to health insurance coverage under the Group Health Insurance Program (GHIP):

- **Cost Sharing** – Requires health plans to provide coverage of testing, treatment and vaccines of COVID-19 without imposing any copayment or coinsurance before June 30, 2021.

- **Prescription Drugs Coverage** – Prohibits requiring prior authorization for early refills of a prescription drug or otherwise restricting the period of time in which a prescription drug may be refilled and from imposing a limit on the quantity of prescription drugs that may be obtained if the quantity is no more than a 90-day supply. These prohibitions do not apply if the prescription drug is a controlled substance. The provision applies through June 30, 2021.

- **Out-of-Network Costs** – Prohibits health plans from requiring a member to pay more for a service, treatment, or supply provided by an out-of-network provider than the member would have to pay if the services were provided in-network. This prohibition applies to services received related to COVID-19 and applies if the member saw an out-of-network provider because a participating provider was not available. The prohibition is applicable until the conclusion of a national emergency declared by the U.S. President in response to COVID-19 or until June 30, 2021, whichever is earlier.

Reviewed and approved by Pam Henning, Assistant Deputy Secretary
Pamela L Henning
Electronically Signed 2/15/21

Board	Mtg Date	Item #
GIB	2.17.21	10E

2021 AB 1 was introduced by Speaker Vos and referred to the Assembly Committee on Health. The bill was amended multiple times and sent to the Governor for his signature. On February 5, 2021, the Governor vetoed the bill.

2021 AB 31 includes the following provisions related to health insurance coverage under the GHIP:

- **Cost Sharing** – Requires coverage of testing, treatment and vaccinations relating to COVID-19 without imposing any copayment or coinsurance before December 31, 2021.

- **Prescription Drugs Coverage** – Prohibits health plans from requiring prior authorization for early refills of a prescription drug or otherwise restricting the period of time in which a prescription drug may be refilled and from imposing a limit on the quantity of prescription drugs that may be obtained if the quantity is no more than a 90-day supply. These prohibitions do not apply if the prescription drug is a controlled substance. The provision applies through December 31, 2021.

- **Out-of-Network Costs** – Prohibits health plans from requiring a member to pay more for a service, treatment, or supply provided by an out-of-network provider than the member would have to pay if the services were provided in-network. This prohibition applies to services received related to COVID-19 and applies if the member saw an out-of-network provider because a participating provider was not available. The provision applies through December 31, 2021.

- **Healthcare Worker Cost Sharing** – Requires health plans cover frontline health care workers who have been diagnosed with or is under investigation of having COVID-19 or any other communicable disease without imposing any copayment or coinsurance. For purposes of required insurance coverage, the treatment that must be covered is any treatment that is medically necessary and reasonably related to COVID-19 or any other communicable disease or complications from COVID-19 or other communicable disease.

- **Telehealth Coverage** – Prohibits a health insurance policy or a self-insured health plan of the state or a county, city, village, town, or school district from denying coverage for a treatment or service provided through telehealth if that treatment or service is covered under the policy or plan when provided in person by a health care provider. This prohibition applies through December 31, 2021.

2021 AB 31 was introduced by Rep. Hintz and referred to the Assembly Committee on Health.

Other State Legislation

2021 SB 3 and **2021 AB 7** requires pharmacy benefit managers to be licensed with the Commissioner of Insurance or to have an employee benefit plan manager license. It establishes certain requirements for pharmacy benefit managers and certain health plans regarding interactions with pharmacies and pharmacists. The provisions in the bill regulating disclosures to consumers, cost sharing limitations and drug substitutions are already performed under the State's Group Health Insurance Program and therefore would have no impact on the program.

2021 SB 3 was introduced by Sen. Felzkowski and referred to the Senate Committee on Health. 2021 AB 7 was introduced by Rep. Schraa and referred to the Assembly Committee on Health.

On February 9, 2021, the Senate Committee on Health held a public hearing on 2021 SB 3. On February 11, 2021, the Senate Committee on Health held an executive session and recommended passage, as amended, 4-1. On February 10, 2021, the Assembly Committee on Health held a public hearing on 2021 AB 7. On February 11, the Committee held an executive session and recommended passage, as amended, 14-0.

2021 SB 40 and 2021 AB 34 includes the following requirements and limitations on health insurance coverage in the event the federal Patient Protection and Affordable Care Act no longer preempts state law on the topic.

- Health plans must accept every individual in this state who applies for coverage, regardless of whether any individual or employee has a preexisting condition.
- A health plan offered on the individual or small employer market or a self-insured governmental health plan may not vary premium rates for a specific plan on any basis except age, tobacco use, area in the state, and whether the plan covers an individual or a family.
- A health benefit plan or a self-insured governmental health plan may not impose a preexisting condition exclusion.
- A health benefit plan or a self-insured governmental health plan is prohibited from imposing an annual or lifetime limit on the dollar value of benefits under the plan.
- The Affordable Care Act exempts certain plans from complying with the act's provisions. Similarly, any health benefit plan that is exempt from a provision of the Affordable Care Act is exempt from complying with the corresponding provision of this bill.

2021 SB 40 was introduced by Sen. Jacque and referred to the Senate Committee on Insurance, Licensing and Forestry. 2021 AB 34 was introduced by Rep. Magnafici and referred to the Assembly Committee on Insurance.

I will be available at the February 17, 2021, Board meeting to answer any questions.