CHAPTER 1048

An Act to amend and reenact §§ 38.2-3418.21 and 38.2-3418.22 of the Code of Virginia, relating to Bureau of Insurance; essential health benefits benchmark plan selection.

[H 328]

Approved April 22, 2026

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3418.21 and 38.2-3418.22 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3418.21. Coverage for hearing aids and related services.

A. As used in this section:

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for ~~impaired human~~ hearing *loss* and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

B. Notwithstanding the provisions of § 38.2-3419, subdivision A 1 of § 38.2-6506, or any other provision of law, each insurer proposing to issue ~~individual or group~~ accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing ~~individual or group~~ accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hearing aids and related services for children 18 years of age or younger under any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth. The coverage shall include payment of the cost of one hearing aid per ~~hearing-impaired~~ ear *with hearing loss* every 24 months, up to $1,500 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above $1,500, with no financial or contractual penalty to the insured or to the provider of the hearing aid.

C. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment or fee, and no condition may be applied to the person that is not equally imposed upon all individuals in the same benefit category.

D. Coverage shall be available under this section only for services and equipment recommended by an otolaryngologist. Such recommended services and equipment may be provided or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist.

E. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2024.

F. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans or to short-term nonrenewable policies of not more than six months' duration. *The provisions of this section shall not apply to policies, contracts, or plans issued in the individual market or small group markets.*

G. The Commission shall not use any special fund revenues dedicated to its other functions and duties, including revenues from utility consumer taxes or fees from licensees regulated by the Commission or fees paid to the office of the clerk of the Commission, to fund the defrayal of costs for the coverage provided pursuant to subsection B as required by 42 U.S.C. § 18031 or any successor provision. The Commission shall not pay any funds beyond the moneys appropriated for the defrayal of costs related to such coverage. Appropriated funds remaining at year end shall not revert to the general fund but shall remain with the Commission for defrayal of costs related to this coverage.

§ 38.2-3418.22. Coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome.

A. As used in this section:

"Pediatric acute-onset neuropsychiatric syndrome" or "PANS" means a clinically defined disorder characterized by the sudden onset of obsessive-compulsive symptoms (OCD) or eating restrictions, concomitant with acute behavioral deterioration in at least two designated domains. Comorbid PANS symptoms may include anxiety, sensory amplification or motor abnormalities, behavioral regression, deterioration in school performance, mood disorder, urinary symptoms, or sleep disturbances. PANS does not require a known trigger, although it is believed to be triggered by one or more pathogens.

"Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" or "PANDAS" means a subset of PANS that has five distinct criteria for diagnosis, including (i) abrupt "overnight" OCD or dramatic, disabling tics; (ii) a relapsing-remitting, episodic symptom course; (iii) young

age at onset; (iv) presence of neurologic abnormalities; and (v) temporal association between symptom onset and Group A streptococcal infection. The five criteria of PANDAS are usually accompanied by similar comorbid symptoms as found in PANS.

B. Notwithstanding the provisions of § 38.2-3419 or subdivision A 1 of § 38.2-6506, each insurer proposing to issue ~~individual or group~~ accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing ~~individual or group~~ accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the prophylaxis, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome. Such coverage shall include coverage for treatment using antimicrobials, medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

C. No insurer, corporation, or organization providing coverage pursuant to this section shall (i) deny or delay the coverage required by this section because the enrollee previously received treatment, including the same or similar treatment, for these conditions or because the enrollee was diagnosed with or received treatment for his condition under a different diagnostic name, including autoimmune encephalopathy; (ii) limit coverage of immunomodulating therapies for the treatment of pediatric acute-onset neuropsychiatric syndrome and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections in a manner that is inconsistent with the treatment guidelines developed by a consortium convened for the purposes of researching, identifying, and publishing best practice standards for diagnosis and treatment of such syndrome or disorders that are accessible for medical professionals and are based on evidence of positive patient outcomes; (iii) require a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies for the treatment of pediatric acute-onset neuropsychiatric syndrome and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections; or (iv) deny coverage for out-of-state treatment if the service is not available within the Commonwealth.

D. Nothing in this section shall prevent an insurer, corporation, or organization from requesting treatment notes and the anticipated duration of treatment and outcomes.

E. Nothing shall preclude the undertaking of usual and customary procedures, including prior authorization, to determine the appropriateness of, and medical necessity for, treatment of PANDAS and PANS under this section, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan.

F. The coverage provided under this section shall not be more restrictive than or separate from coverage provided for any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors. *The provisions of this section shall not apply to policies, contracts, or plans issued in the individual market or small group markets.*

G. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2026, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

H. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under federal governmental plans.

2. That the provisions of the first enactment of this act shall become effective January 1 of the plan year for which the Centers for Medicare and Medicaid Services approves a new essential health benefits benchmark plan for the Commonwealth selected by the State Corporation Commission's Bureau of Insurance (the Bureau) that includes at least the coverage described in clauses (iv) and (vi) of the third enactment of this act. The Bureau shall certify in writing to the Virginia Code Commission when such contingency is met.

3. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall select a new essential health benefits benchmark plan for the Commonwealth for the 2028 plan year, or the soonest plan year thereafter as permitted by the Centers for Medicare and Medicaid Services, that includes, in addition to the essential health benefits package included in the existing benchmark plan, coverage for (i) doula care services under the same terms and conditions provided in Chapters 460 and 495 of the Acts of Assembly of 2024; (ii) the treatment of iatrogenic infertility, including standard fertility preservation procedures and services that are not considered experimental or investigational by the American Society for Reproductive Medicine or the American Society of Clinical Oncology and are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, including sperm

banking, oocyte banking, embryo banking, banking of reproductive tissues, and the storage of reproductive cells and tissues; (iii) the diagnosis and treatment of infertility, standard fertility preservation procedures, and embryo transfer under the same terms and conditions provided in Chapter 689 of the Acts of Assembly of 2025, including a maximum of three cycles per lifetime of assisted reproductive technology; (iv) hearing aids under the same terms and conditions provided in § 38.2-3418.21 of the Code of Virginia, as amended by this act, except that such coverage shall apply to all individuals regardless of age; (v) pasteurized donor human breast milk under the same terms and conditions proposed in Senate Bill 499 of the 2024 Regular Session of the General Assembly; (vi) the prophylaxis, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome under the same terms and conditions provided in § 38.2-3418.22 of the Code of Virginia, as amended by this act; and (vii) the treatment of polycystic ovary syndrome under the same terms and conditions proposed in House Bill 604 of the 2024 Regular Session of the General Assembly. If the federal regulations governing essential health benefits benchmark plans are proposed to be amended or are amended during the application for, submission of, or review of the Commonwealth's new essential health benefits benchmark plan, the Bureau shall notify the Chairs of the House Committee on Labor and Commerce, the Senate Committee on Commerce and Labor, and the Health Insurance Reform Commission and the Governor. If such regulations are amended in a manner requiring the Commonwealth's new essential health benefits benchmark plan to reduce or remove benefits such that an exercise of discretion is required, the Health Insurance Reform Commission shall recommend to the General Assembly which, if any, benefits should be reduced or removed.

4. That, notwithstanding any other provision of law, to the extent health benefits or any portion thereof described in § 38.2-3418.22 of the Code of Virginia, as amended by this act, are included in the Commonwealth's essential health benefits benchmark plan, the mandate to provide coverage of that health benefit or that portion of the health benefit shall not apply to the individual and small group markets.

5. That an emergency exists and, except as provided in the second enactment of this act, the provisions of this act are in force from its passage.