Virginia Essential Health Benefits Benchmark Plan Review

Analysis of Selected Benefits to Evaluate for the Virginia EHB-Benchmark Plan for Benefit Year 2028

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Executive Summary

The Commonwealth of Virginia received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a revised Essential Health Benefit Benchmark Plan (EHB-BP) beginning in benefit year 2025. The Virginia General Assembly enacted a process by which the Health Insurance Reform Commission (HIRC) would periodically reassess the current EHB-BP, review potential plan changes, and make recommendations to the Virginia General Assembly on prospective future EHB-BPs.

To facilitate this review, the Virginia Bureau of Insurance (BOI) has contracted with the actuarial consulting firm NovaRest, Inc. to assist in identifying and analyzing benefit options for consideration by HIRC to be added to the Virginia EHB-BP. If HIRC decides to recommend changes to the Virginia EHB-BP, legislation would have to be enacted directing the BOI to file an application with CMS in 2026, containing the specified benefits to be effective for the benefit year 2028.

Our previous "Phase 1" report entitled "Review of Proposed Benefits to Evaluate for the Virginia EHB-Benchmark Plan for Benefit Year 2028" identified benefits for consideration for HIRC from a variety of sources and provided preliminary cost estimates based on prior work done by the BOI, NovaRest, or work completed in other states. This "Phase 2" report provides NovaRest's best estimate of benefit cost estimates for the benefits selected by HIRC for further analysis, including carrier estimates provided via a data call.

In addition, NovaRest finalized the estimate of available generosity at 1.7% of allowed claims costs, or $10.50 per member per month (PMPM), which reflects our best estimate of the value of benefits included in the Federal Employees Health Benefits Plan (FEHBP)[1] above the value of benefits available in the current EHB-BP. This is an increase from 1.5% of allowed claim costs estimated in the Phase 1 report due to calibration of models, updated demographic information, and updated allowed claims/membership information reported in carrier rate filings, specifically related to pricing the dental benefits included in the FEHBP plan. As routine adult dental was not considered in the generosity analysis in Virginia's prior EHB-BP application,[2] the benefit value was not finalized at the time of publication of the prior report.

Please note the estimated generosity reflects the limit of value Virginia can add to their EHB-BP without defraying the cost of additional benefits.

[1] Federal Employee Program (FEP) Blue Standard - the chosen comparison plan for the purpose this Phase 2 report.

[2] The Final 2025 HHS Notice of Benefit and Payment Parameters updated 45 CFR 156.115(d), allowing routine adult dental to be an EHB beginning January 1, 2027 and clarifying that it can be included in the generosity analysis.

A thorough discussion of each benefit selected for additional analysis is included in Appendix A. These benefits include:

1. Doula care services;
2. Fertility preservation for cancer;
3. Fertility treatment and diagnostic;
4. Hearing aids – all ages;
5. Pasteurized donated human breast milk (PDHM);
6. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute-onset Neuropsychiatric Syndrome (PANS); and
7. Polycystic Ovary Syndrome (PCOS).

ACA Benefit Rules

The Patient Protection and Affordable Care Act (ACA) requires that all non-grandfathered plans in the individual and small group markets (ACA plans) provide coverage in 10 benefit categories, which are known as the Essential Health Benefits (EHBs).[3] These categories include:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

To determine whether ACA plans are compliant with the EHBs, the United States Department of Health and Human Services (HHS) provides for state-specific EHB-BPs, which more specifically defines the benefits and services that are required to be covered. Each state selected its own EHB-BP for benefit years 2014 through 2016 and was required by HHS to select a new EHB-BP beginning with the benefit year 2017. Under new rules, HHS no longer dictates when states are required to select a new EHB-BP. Instead, a state would file an application to make an EHB-BP change if and when it desires to change its EHB-BP.

[3] "Information on Essential Health Benefits (EHB) Benchmark Plans." CMS.Gov. 17 Oct. 2024. www.cms.gov/marketplace/resources/data/essential-health-benefits. Accessed 14 Nov. 2024.

Generosity Available for EHB-BP

45 CFR § 156.111 indicates that for benefit years beginning on or after January 1, 2026, the EHB-BP must provide a scope of benefits that is more generous than the scope of benefits in the least generous comparison plan and less generous than the scope of benefits in the most generous comparison plan. The comparison plans can be:

1. Any of the base-benefit plan options available for the Virginia EHB-BP for the 2017 benefit year,[4]
    a. Largest non-grandfathered small group insurance products in Virginia's small group market:
        i. Anthem Health Plans of VA PPO
        ii. Anthem HealthKeepers HMO
        iii. Optima Vantage HMO
    b. Largest three state employee health benefit plans by enrollment:
        i. COVA Care
        ii. COVA Connect[5]
        iii. Kaiser Permanente
    c. Largest three national Federal Employees Health Benefits Plans (FEHBPs).
        i. Blue Cross and Blue Shield (BCBS) Federal Employee Program (FEP) Blue Standard
        ii. BCBS FEP Blue Basic
        iii. Government Employees Health Association (GEHA)
    d. Largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.
        i. This plan was not included in the consideration of EHB Benchmark Plan selection.[6]
2. The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in Virginia, with the following criteria:
    a. The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in Virginia;
    b. The plan provides minimum value;
    c. The benefits are not excepted benefits; and
    d. The benefits in the plan are from a benefit year beginning after December 31, 2013.

[4] Per 45 CFR § 156.100

[5] We understand COVA Connect is no longer available. Plans available to select as the EHB-BP for the 2017 benefit year were based on plans available for plan year 2015. COVA Connect was identified by based on prior analysis provided to NovaRest by the Virginia BOI in a file named "PwC drft chart _VA EHB Exhibits". We are not aware of the official name of this plan, although COVA Connect appears to have been affiliated with the Optima network per the file "About the Health Benefits Plans." Health Benefits Program Administration Manual. September 2011. https://www.dhrm.virginia.gov/docs/default-source/benefitsdocuments/ohb/handbooks/adminmanual/aboutthehealthbenefitsplans.pdf?sfvrsn=2. Accessed 29 Sept. 2025.

[6] Per e-mail from the Virginia BOI dated Sept 16, 2022, no documentation that suggested this plan was ever identified of considered.

The current EHB-BP is already more generous in scope than the least generous comparison plan, as benefits were added during the prior EHB-BP revision. We have not determined how much more generous the benefit is, although we do not believe this analysis is necessary unless Virginia is interested in removing benefits.

In the prior EHB-BP application, we determined the expected value of FEP Blue Standard is $3.41 PMPM more generous than the current EHB-BP, although $0.37 PMPM was added in additional benefits.[7] **Please note we only considered option #1 (the base-benefit plan options) in our generosity analysis. We did NOT consider the option #2 largest health insurance plan by enrollment within one of the five largest large group products.** It is our understanding that investigating option #2 is not required and is a more recent flexibility offered by CMS. Option #2 would not necessarily result in more value than option #1. We have leveraged prior work to determine the current expected value available to add benefits for the purposes of this report. If HIRC is interested in adding more benefits than allowed under option #1, further analysis (including an insurer data call) can be performed to determine if option #2 would provide any additional value. In the prior EHB-BP application that Virginia submitted, it utilized the base-benefit plan options in the generosity analysis; for consistency, we continued using option #1 again for this generosity analysis.

This left at least $3.04 PMPM (or 0.6% of allowed costs) in value. However, as noted in footnote 24 of the actuarial report in the prior EHB-BP application,[8] we did NOT include the value of routine adult dental services. Our interpretation was, because this benefit could not be an EHB by HHS rules, we did not believe we could consider their value. However, subsequent to this report, HHS released the "HHS Notice of Benefit and Payment Parameters for 2025," which clarified that states were not prohibited from considering the value of these benefits.[9] Furthermore, HHS removed the prohibition on routine adult dental services being EHBs.[10]

[7] "Information on Essential Health Benefits (EHB) Benchmark Plans: Virginia Essential Health Benefit Benchmark Plan Actuarial Report and Certification." CMS.Gov. 17 Oct. 2024. https://www.cms.gov/marketplace/resources/data/essential-health-benefits. Accessed 14 Nov. 2024

[8] Ibid.

[9] "In addition, such a finding only justifies the prohibition of designating certain benefits as EHB; it does not prohibit a State from including such benefits in their typicality analysis, to the extent such benefits are present among the set of typical employer plans designated by HHS. Put another way, nothing in regulation prohibits a State from including the quantitative value of routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia in its typicality analysis." Footnote: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS); Department of the Treasury. Final Rule.

[10] "We are finalizing the removal of the regulatory prohibition at [45 CFR] §156.115(d) on issuers from including routine non- pediatric dental services as an EHB beginning with PY 2027, which would provide States the option to add routine adult dental services as an EHB by updating their EHB-benchmark plans pursuant to [45 CFR] §156.111." Footnote: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025.

The FEHBP included coverage for routine adult dental services, including diagnostic imaging, oral evaluations, and preventive services. Therefore, we have increased the generosity available from $3.04 PMPM (or 0.6% of allowed costs) by $6.21 PMPM (or 1.1% of allowed costs), resulting in approximately $9.25 PMPM (or 1.7% of allowed costs).[11] This reflects an increase from the Phase 1 estimate of 1.5% which reflects a model refinement specifically related to the preliminary estimate of adult dental. As adult dental was not included in the prior application to CMS, a final best estimate was not determined prior to this analysis. The value of all other benefit differences has not changed.

Additionally, this analysis was performed based on 2021 costs, consistent with the prior EHB-BP application (when the analysis was performed). Based on Virginia specific ACA carrier rate filings, average allowed costs in the Virginia ACA market increased from $540 PMPM to $613 PMPM from 2021 to 2024,[12] meaning 1.7% of allowed cost is now approximately $10.50 PMPM, based on 2024 Virginia allowed costs.

[11] Generosity analysis completed on 2021 basis to be consistent with prior analysis done for prior EHB-BP application. Based on 2021 experience average allowed claims ($540 PMPM) determined from the 2023 carrier rate filings, consistent with the prior generosity analysis done for the application for Virginia's EHB-BP effective 2025. Potential benefits to add are completed on a 2024 basis using 2026 carrier rate filings.

[12] Experience allowed claims from the carrier rate filings were used. 2021 allowed costs were actual experience reported in plan year 2023 rate filings (the most recent in the prior EHB-BP application), and 2024 allowed costs were actual experience reported in plan year 2026 rate filings (the most recent at the time of this report).

Benefits Identified for Consideration for Virginia's 2028 EHB-BP

The following benefits were identified from the prior Phase 1 report for further investigation. More detailed information on each benefit is included in Appendix A. Please note the total generosity available is 1.7% of allowed costs on 100% actuarial value (AV) basis, or approximately $10.50 PMPM.

Benefit	Estimated Cost (100% AV Basis, for CMS analysis)	Estimated Premium Increase (Determined by Virginia Carriers)	Level of Current Coverage
Doula care services	$0.22 PMPM or 0.04% of total allowed claims	0.00% to 0.15% premium increase	2 of 7 carriers indicate they will begin offering coverage in 2026
Fertility preservation	$0.36 PMPM or 0.06% of total allowed claims	0.00% to 0.60% premium increase	1 of 7 carriers indicated limited coverage[13] available in small group market only
Fertility treatment and diagnostic - (1) including artificial insemination but not in-vitro fertilization (IVF)	$0.98 PMPM or 0.16% of total allowed claims	0.01% to 1.44% premium increase	Fertility diagnostic covered by all carriers. Fertility treatment not including IVF covered by 2 of 7 carriers.

[13] Please see Appendix A – Fertility Preservation for Iatrogenic Infertility for more information. Available coverage limited to sperm retrieval, ovarian stimulation, medications, and 1 year cryopreservation storage available for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. We do not believe federal discrimination rules would permit coverage to be restricted to cancer.

Benefit	Estimated Cost (100% AV Basis, for CMS analysis)	Estimated Premium Increase (Determined by Virginia Carriers)	Level of Current Coverage
Fertility treatment and diagnostic - (2) including IVF for up to 3 cycles	$5.40 PMPM or 0.88% of total allowed claims[14]	Carriers were not asked to estimate this scenario. Estimate 0.01% to 3.60% premium increase[15]	Fertility diagnostic covered by all carriers. No carriers cover IVF on standard basis, though riders and buy-up available for 2 of 7 carriers
Fertility treatment and diagnostic - (3) including IVF no limit	$9.81 PMPM or 1.60% of total allowed claims	0.02% to 6.50% premium increase	Fertility diagnostic covered by all carriers. No carriers cover IVF on standard basis, though riders and buy-up available for 2 of 7 carriers.
Hearing aids (all ages)	$0.70 PMPM or 0.11% of total allowed claims	0.00% to 0.22% premium increase	Coverage for age 18 and younger required and cost is currently defrayed by Virginia. No carriers cover for over age 18.

[14] We have provided 3 scenarios for fertility treatment and diagnostic, in order of comprehensiveness. Scenario 2 provides all of the benefits in scenario 1. The cost of scenario 2, $5.40 PMPM includes the $0.98 PMPM in scenario 1. Similarly, scenario 3 provides all of the benefits in scenario 2 and adds additional IVF cycles. The cost of scenario 3, $9.81 PMPM includes the $5.40 PMPM in scenario 2. Please note fertility treatment and diagnostic does not include fertility preservation. Adding fertility treatment and diagnostic scenario 2 and fertility preservation would be $5.40 + $0.36 = $5.76

[15] Carriers were not asked to provide an estimate as we are unaware of any specific legislation or recommendations for infertility including a limit of 3 cycles of IVF. Carriers were asked to provide estimates of infertility benefits including and not including IVF, which NovaRest believes provides a low and a high estimate for infertility. NovaRest provided a scenario limiting IVF to 3 cycles based on research of clinical recommendations and other state legislation which NovaRest believes provides a reasonable medium estimate, for HIRC to consider. NovaRest estimates limiting IVF to 3 cycles would cost approximately 55% compared to unlimited cycles, therefore 0.01% to 3.60% of premium is estimated as 55% of the 0.02% to 6.50% premium increase reported by the carriers for unlimited coverage.

Benefit	Estimated Cost (100% AV Basis, for CMS analysis)	Estimated Premium Increase (Determined by Virginia Carriers)	Level of Current Coverage
Pasteurized donated human breast milk (PDHM)	$0.13 PMPM or 0.02% of total allowed claims	0.00% to 0.38% premium increase	1 of 7 carriers indicated limited[16] coverage available
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/ Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)	$0.17 PMPM or 0.03% of total allowed claims	0.00% to 0.10% premium increase	Coverage will be required and cost defrayed by Virginia beginning 2026
Polycystic Ovary Syndrome (PCOS)	$0.44 PMPM or 0.07% of total allowed claims	0.00% to 0.28% premium increase	All carriers indicate limited coverage available, in the individual and small group market.[17]
Total with Fertility Treatment and Diagnostic Option 1	**$3.00 PMPM or 0.48% of total allowed claims**	**0.01% to 3.41% premium increase**	
Total with Fertility Treatment and Diagnostic Option 2	**$7.42 PMPM or 1.20% of total allowed claims**	**0.03% to 5.44% premium increase**	
Total with Fertility Treatment and Diagnostic Option 3	**$11.83 PMPM or 1.92% of total allowed claims**	**0.04% to 8.36% premium increase**	

[16] Please see Appendix A – Pasteurized donated human breast milk (PDHM) for more information. Available coverage limited to the use of pasteurized donor human milk when medically necessary for low birth weight infants with documented birth weight of less than 1500 grams when the mother's own breast milk is unavailable or insufficient.

[17] Diagnostic, hormonal, and metabolic medically necessary treatment generally covered, while treatment for hair removal and fertility generally considered not medically necessary and not covered. We note the definition of medically necessary is not well specified and may vary between carriers.

Limitations

NovaRest has prepared this report in conformity with its intended use by individuals technically competent to evaluate our estimate of the proposed benefits. Any judgments about the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by reviewing a section or sections on an isolated basis may be incorrect. Appropriate staff can explain and/or clarify any matter presented herein. It is assumed that any report user will seek such explanations.

NovaRest has developed projections that conform to what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by the carrier, accounting practices, changes in federal and/or local taxation; and external economic factors, such as inflation rates, investment yields and ratings and inherent potential for normal random fluctuations in experience.

Reliance and Qualifications

I, Richard Cadwell ASA, MAAA, am an actuary with NovaRest, Inc. I am a member of the American Academy of Actuaries and meet that body's Qualification Standards to render this report. I am providing this report to you solely to communicate NovaRest's findings and analysis of the proposed benefit changes. The reliance of parties other than the Virginia HIRC and BOI on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we used public information, prior work done by/for Virginia, prior work done by other states, the carrier's statutory financials, and the carriers' rate filing information. We also made assumptions based on information from interviews with medical professionals and interested parties. We did not perform an independent investigation or verification. If this information is inaccurate, incomplete, or outdated, the findings and conclusions in this report may require revision. While we have relied on information without independent investigation or verification, the medical professionals we spoke to are fully qualified and knowledgeable.

This memorandum has been prepared per the applicable Actuarial Standards of Practice. We have no conflicts of interest in performing this review and providing this report.

Sincerely,



Richard Cadwell, ASA, MAAA

Appendix A: Benefits Identified for Consideration

We note that we have provided cost information on a PMPM or percentage of total allowed claims basis, per CMS guidance for completing an EHB-BP application. However, prescribing that carriers offer additional benefits will likely increase premiums as well. We also note that the premium change will impact carriers differently based on the populations enrolled, provider reimbursement rates, and other factors outside the scope of this report. This explains the range reported by the carriers.

Doula Care Services

Summary of Proposed Coverage

To analyze the impact of adding coverage for doula care to the EHB-BP, we modeled the required service after Virginia's Chapters 460 and 495 of the 2024 Acts of Assembly,[18] which include at least eight visits during the antepartum or postpartum period and support during labor and delivery, provided by a state-certified doula.

"Doula care services" are defined by Chapters 460 and 495 to mean:

1. Services to support pregnant individuals, improve birth outcomes, and support new mothers and families with culturally specific antepartum, intrapartum, and postpartum services, referrals, and advocacy;
2. Advocating for and supporting physiological birth, breastfeeding, and parenting for clients;
3. Supporting the antepartum, intrapartum, and postpartum periods with traditional comfort measures and educational materials, as well as assistance during the transition to parenthood in the initial postpartum period through home visits;
4. Empowering individuals and families with evidence-based information to choose best practices for birth, breastfeeding, and infant care;
5. Providing continuous support to the laboring individual until the birth of the baby at any location of delivery;
6. Referring clients to their appropriate provider for medical advice for care outside of the doula scope of practice;
7. Working as a member of the individual's multidisciplinary team; and
8. Offering evidence-based information on newborn and infant feeding, emotional and physical recovery from childbirth, and other issues related to the antepartum, intrapartum, and postpartum periods.

[18] "HB 935/SB 118 Health insurance; coverage for doula care services." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=hb935. Accessed 14 Nov. 2024.

Other State Coverage

Rhode Island is the only state to require doula coverage by both Medicaid and private insurance.[19] Eight states have signed legislation into law requiring expanded doula care coverage by private health plans, with half of these states signing legislation in 2024. However, in the case of Virginia, the legislation required reenactment in the 2025 Session to become effective. Since that did not occur, there are now only seven states that are intending to expand doula coverage to varying degrees within the private markets: Rhode Island, Louisiana, Utah, California, Colorado, Illinois, and Delaware. Twenty-seven states and the District of Columbia have implemented or are in the process of implementing Medicaid services for doula care.[20]

Legislative History of Coverage in Virginia

HB 935was introduced on January 9, 2024 and referred to the House Committee on Labor and Commerce;[21] SB 118 was introduced on January 4, 2024 and referred to the Senate Committee on Commerce and Labor.[22] Each bill passed both houses of the Virginia General Assembly, but owing to differences between the bills, HB 935 was sent to a conference committee, which conformed the bill's text to SB 118. The conference report for HB 935 was agreed to by both houses. These bills were signed by the Governor on April 4, 2024 as Chapters 460 and 495 of the 2024 Acts of Assembly. While enacted bills normally take effect on first day of July following the adjournment of the General Assembly session at which the bills were enacted,[23] the second enactment clause of Chapters 460 and 495 contains a reenactment clause that requires the 2025 Session of the General Assembly to reenact the bills' provisions in order for them to become effective. The bills were not introduced during the 2025 Session; therefore, the provisions regarding doula care in Chapter 460 and 495 are not effective as of the date of this report.

[19] Chen, Amy. "State of the States (November 2024): Efforts to Expand Access to Doula Care in Medicaid and Private Insurance." Birthing Advocacy Doula Trainings. https://www.badoulatrainings.org/blog/state-of-the-states-efforts-to-expand-access-to-doula-care-in-medicaid-and-private-insurance. Accessed 19 Mar. 2025.
[20] Ibid.
[21] "HB 935 Health insurance; coverage for doula care services." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=hb935. Accessed 14 Nov. 2024.
[22] "SB 118 Health insurance; coverage for doula care services." Legislative Information System, https://legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=sb118. Accessed 23 Sept. 2025.
[23] "Section 13. Effective date of laws." Va. Const. art. IV, § 13. law.lis.virginia.gov/constitution/article4/section13. Accessed 8 Nov. 2024.

Current Prevalence of Coverage in Virginia

The EHB-BP does not discuss doula care services. Maternity and newborn care is included as one of the mandatory 10 EHB categories. However, our understanding is that doula care services are generally separate from the maternity and newborn care defined by the EHB-BP.[24]

BOI conducted an assessment of two bills—HB 1538 and SB 1273 from the 2023 Regular Session—mandating doula care services pursuant to subsection B of § 30-343 of the Code of Virginia. Based on a survey of carriers, it was determined that there is no level of coverage for non-public plans of doula care services provided by a state-certified doula.[25]

Our carrier data call also confirmed doula care services are generally not covered. However, two carriers did indicate they will begin covering doula care services in plan year 2026 for both the individual and small group market. One indicated services will "involve non-medical professionals providing continuous physical, emotional, and informational support to individuals before, during, and after childbirth." The other carrier indicated the individual market will include "Doula services with up to 8 visits are covered under the maternity/pregnancy benefit for PY26" while in the small group market doula services will be a standard benefit.

Multiple carriers express concern related to the credentialing process for doulas, or if there are sufficient certified doulas.

One carrier indicated that they anticipate coverage of doula care services will lead to a reduction in morbidity and mortality rates, although no other carriers indicated any potential savings.

[24] From the Virginia EHB-BP Maternity Services: "Covered Services include services needed during a pregnancy and for services needed for a miscarriage. Covers maternity care, and maternity-related checkups. Prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary." Additionally, covered maternity services do include "professional and facility services for childbirth including use of the delivery room and care for deliveries, in a Facility or the home, including the services of an appropriately licensed nurse midwife, coverage includes delivery and all Inpatient services for maternity care."

[25] "Health Insurance Reform Commission (HIRC) - September 20, 2023 Meeting Bureau of Insurance Step-One Analysis 2022 Session of the Virginia General Assembly." https://studiesvirginiageneralassembly.s3.amazonaws.com/meeting_docs/documents/000/001/782/original/HIRC_Step_Ones_Chart_September_2023_(1).docx?1695240938. Accessed 11 Mar. 2025.

Estimate Cost of Adding Coverage to the EHB-BP

We estimate that approximately 8,200 pregnancies would be covered by Virginia ACA plans annually.[26]

According to a National Institute of Health (NIH) study, about 6% of women gave birth with doula support.[27] We estimate that approximately 500 births from enrollees in Virginia ACA plans currently utilize doula care annually, although it is likely not covered so they would be paying out-of-pocket. The NIH study also found, among those without doula support, 59% were aware of doula services, and 27% wanted a doula but did not have one.[28] We estimate if doula care services were covered by Virginia ACA plans, we estimate another 1,300 births would utilize doula care services, for a total of 1,800 births that would be covered by Virginia ACA plans.

Fees for doula care services average approximately $1,000 to $1,500.[29,30,31]

We estimate adding doula care services represents approximately 0.04% at 100% actuarial value or $0.22 PMPM towards Virginia's available generosity value. This is within the preliminary 0.01% to 0.07% provided in the Phase 1 preliminary estimate. This is also within the range of 0.00% to 0.14% of allowed claims reported in the data call issues to Virginia ACA carriers.

It is important to note adding required benefits will also likely cause an increase to premiums. This is separate from the generosity analysis required by CMS presented above. The premium increase would be determined by each Virginia ACA carrier separately. According to the data call we expect premiums would increase from 0.00% to 0.12% in the individual market, and 0.02% to 0.15% in the small group market.

[26] 684,000 current enrollees in Virginia individual and small group ACA plans per 2026 Virginia carrier rate filings. Assume 24% women of childbearing years based on Census Bureau "Annual Estimates of the Resident Population by Single Year of Age and Sex for Virginia: April 1, 2020 to July 1, 2024." Fertility rate 53.6 per 1,000 women ages 15-44. MarchofDimes. "Fertility Rate: Virginia, 2013-2023." March of Dimes | PeriStats, https://www.marchofdimes.org/peristats/data?reg=99&top=2&stop=1&lev=1&slev=4&obj=1&sreg=51. Accessed 1 Sep. 2025.
[27] Kozhimannil KB, Attanasio LB, Jou J, Joarnt LK, Johnson PJ, Gjerdingen DK. Potential benefits of increased access to doula support during childbirth. Am J Manag Care. 1 Aug. 2024
[28] Ibid.
[29] Ibid.
[30] Knocke, Kathleen, et al. "Doula Care and Maternal Health: An Evidence Review." ASPE Office of Health Policy. 13 Dec. 2022, https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf. Accessed 20 Nov. 2024.
[31] Ibid.

Fertility Preservation for Iatrogenic Infertility

Infertility caused by medical diagnosis, act, or treatment is commonly known as iatrogenic infertility.[32] Radiation and chemotherapy are among the medical treatments that may impact a person's fertility.[33,34] Treatment after negative fertility side effects from medical treatment may be expensive and may not be effective in restoring a person's fertility. However, in many cases, fertility preservation services can be performed before receiving medical treatment that may result in iatrogenic infertility. This proactive approach may allow a person to maintain their ability to conceive after receiving necessary medical treatment.

We note that this benefit was previously indicated as "fertility preservation for cancer". However, we believe this violates federal discrimination laws by restricting the benefit to a specific condition without a clinical basis. To comply with federal discrimination rules, we believe the benefit cannot be restricted to a cancer diagnosis, although that is likely the most common underlying condition.

Summary of Proposed Coverage

To analyze the impact of adding coverage of fertility preservation for iatrogenic infertility to the EHB-BP, we modeled the required service after Virginia's SB 333 from the 2024 Regular Session.[35] Coverage includes standard fertility preservation procedures and services that:

1. Are not considered experimental or investigational by the American Society for Reproductive Medicine or the American Society of Clinical Oncology; and
2. 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:
    a. sperm banking;
    b. oocyte banking;
    c. embryo banking;
    d. banking of reproductive tissues; and
    e. storage of reproductive cells and tissues.

We note that we did not see SB 333 address or prescribe a specific length of time the storage of reproductive cells and tissues would be covered, and we assume it would be indefinite until either used or a member is no longer able to use the stored reproductive cells and tissues.

[32] Campo-Engelstein L. For the sake of consistency and fairness: why insurance companies should cover fertility preservation treatment for iatrogenic infertility. Cancer Treat Res. 2010;156:381-8. doi: 10.1007/978-1-4419-6518-9_29. PMID: 20811849; PMCID: PMC3086472. Accessed 20 Nov. 2024.

[33] "Fertility Issues in Girls and Women with Cancer." National Cancer Institute, 9 May 2024, www.cancer.gov/about-cancer/treatment/side-effects/fertility-women. Accessed 20 Nov. 2024.

[34] "Fertility Issues in Boys and Men with Cancer." National Cancer Institute, 9 May 2024, www.cancer.gov/about-cancer/treatment/side-effects/fertility-men. Accessed 20 Nov. 2024.

[35] "SB 333 State plan for medical assistance services; fertility preservation treatments, etc." Legacy Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=sb333. Accessed 18 Nov. 2024.

Other State Coverage

As of September 30, 2024, approximately 17 other states require some form of fertility preservation benefits.[36] States that cover fertility preservation and are geographically close to Virginia include Kentucky, Maryland, Delaware, and the District of Columbia.

Legislative History of Coverage in Virginia

SB 333 was introduced on January 9, 2024, and referred to the Senate Committee on Education and Health where it continued to the 2025 legislative session on February 8, 2024.[37] The last day for committees to act on legislation continued from the 2024 Regular Session was November 18, 2024;[38] no action was taken on SB 333 by this deadline.

Current Prevalence of Coverage in Virginia

Fertility preservation services are not specifically excluded from the EHB-BP but are not explicitly discussed. Infertility treatment and drugs used in assisted reproductive technology (ART) procedures to achieve conception are specifically excluded from the EHB-BP, and it is our understanding that some of the drugs used in assisted reproductive technology procedures are also used in fertility preservation.

Our carrier data call also confirmed fertility preservation are generally not covered. One carrier in the small group market indicated "fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer" is covered, but only one year of storage is included.

No carriers indicated any anticipated savings. One carrier expressed general concerns regarding fertility preservation as an EHB representing a high-cost benefit with potential implications for premium increases across the membership.

[36] "Insurance Coverage by State." Resolve: The National Infertility Association, September 30, 2024, resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/#:~:text=Iatrogenic%20infertility%20means%20an%20impairment,as%20other%20pregnancy%2Drelated%20benefits. Accessed October 10, 2024.

[37] "SB 333 State Plan for Medical Assistance Services; Fertility Preservation Treatments, etc." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?251%2Bsum%2BSB333. Accessed 18 Nov. 2024.

[38] "HJ 48 General Assembly; 2024 Session schedule." Legislative Information System. legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=hj48. Accessed 12 Nov. 2024.

Estimate Cost of Adding Coverage to the EHB-BP

Using U.S. Census data[39] and the 2026 Virginia rate filings, we assume approximately 310,000 enrollees in the individual and small group ACA markets between ages 15-44, which we further assume are the primary reproductive years. The World Health Organization International Agency for Research on Cancer estimates approximately 147,000 new cases of cancer in the United States for 2025, for ages 15-44.[40] Applying these rates, we estimate approximately 310 potential new iatrogenic infertility cases annually in Virginia. We assume approximately 50% of those would pursue fertility preservation with commercial coverage.[41] This results in approximately 155 who would pursue fertility preservation services annually, assuming approximately $1,100 in costs for males and $13,000 in costs for females.[42]

Additionally, there we expect the benefit to include coverage for storage of fertility samples. SB 333 did not specify a timeline, so we estimated the average duration as 10.5 years based on census average age data[43] and a durational analysis of usage based on the estimated number of annual users of fertility preservation services. We also assumed a $630 annual storage cost for both male and female samples.[44]

We estimate adding fertility preservation for iatrogenic infertility and storage represents approximately 0.06% at 100% actuarial value (0.03% for fertility preservation and 0.03% for undefined storage years) or $0.36 PMPM towards Virginia's available generosity value. We believe limiting the storage years to 5 years or 10 years would reduce the storage cost from 0.03% to 0.01% or 0.02% respectively.

[39] Annual Estimates of the Resident Population by Single Year of Age and Sex for Virginia: April 1, 2020 to July 1, 2024 (SC-EST2024-SYASEX-51). U.S. Census Bureau, Population Division. Accessed 1 June 2025.
[40] "Estimated number of new cases from 2022 to 2025, Incidence, Both sexes, age [15-44]. All cancers." World Health Organization International Agency for Research on Cancer. https://gco.iarc.fr/tomorrow/en/dataviz/tables?populations=840&single_unit=5000&age_start=3&age_end=8&types=0&years=2025&sexes=0&cancers=39. Accessed 1 Sep. 2025.
[41] Sauerbrun-Cutler MT, Rollo A, Gadson A, Eaton JL. The Status of Fertility Preservation (FP) Insurance Mandates and Their Impact on Utilization and Access to Care. J Clin Med. 2024 Feb 14;13(4):1072. doi: 10.3390/jcm13041072. PMID: 38398385; PMCID: PMC10889224.
[42] Hoffhower, Hillary. "More women are freezing their eggs to delay having kids — but the process costs thousands of dollars and still might not work. Here's what you should know." Business Insider. 15 Jan. 2020. https://www.businessinsider.com/how-much-does-it-cost-to-freeze-your-eggs-2020-1. Accessed 15 Aug. 2025.
[43] Annual Estimates of the Resident Population by Single Year of Age and Sex for Virginia: April 1, 2020 to July 1, 2024 (SC-EST2024-SYASEX-51). U.S. Census Bureau, Population Division. Accessed 1 June 2025.
[44] Hoffhower, Hillary. "More women are freezing their eggs to delay having kids — but the process costs thousands of dollars and still might not work. Here's what you should know." Business Insider. 15 Jan. 2020. https://www.businessinsider.com/how-much-does-it-cost-to-freeze-your-eggs-2020-1. Accessed 15 Aug. 2025.

This is above the preliminary 0.00% to 0.04% provided in the Phase 1 preliminary estimate. The reasons for the increase are higher assumed costs for fertility preservation and storage costs and using Virginia-specific census data. This is within the range of 0.00% to 0.65% of allowed claims reported in the data call issues to Virginia ACA carriers. We note two carriers provided higher estimates than the others (0.49% and 0.65%). If these were removed the range would be 0.00% to 0.10%.

It is important to note adding required benefits will also likely cause an increase to premiums. This is separate from the generosity analysis required by CMS presented above. The premium increase would be determined by each Virginia ACA carrier separately. According to the data call we expect premiums would increase from 0.00% to 0.60% in the individual market, and 0.00% to 0.10% in the small group market.

Fertility Treatment and Diagnostic

According to the NIH, infertility refers to a couple's inability to conceive after one year of regular unprotected sex, or after six months if the woman is over age 35.[45]

Summary of Proposed Coverage

HB 1609 was introduced in the 2025 General Assembly session and requires HIRC to consider in its 2025 review of the EHB-BP coverage for infertility diagnosis and treatment, fertility preservation, and embryo transfer. HB 560, with similar requirements, was discussed during the 2024 session but was ultimately left in the House Committee on Appropriations.

An important note is that members who opt to use fertility preservation benefits, which is also being considered as discussed separately in this report, would need intrauterine insemination (IUI) or an ART such as IVF to use the stored sample.

Infertility coverage is a broad topic, which can be summarized in the following categories:

1. Diagnostic and testing;
2. Fertility treatment;
    a. Non-assisted reproductive technology (NART) treatments
        i. Fertility treatments where eggs or embryos are not handled, including primarily behavioral interventions and IUI among others.
    b. ART treatments (as IVF is the most common, we may use ART and IVF interchangeably in this report)
        i. Fertility treatments where the eggs or embryos are handled, including primarily IVF among others.
        ii. May also be extended to donor transfers and genetic testing to identify potential genetic abnormalities.
3. Fertility preservation; and
4. Fertility drugs.

[45] "About Infertility and Fertility." Eunice Kennedy Shriver National Institute of Child Health and Human Development, U.S. Department of Health and Human Services, 9 Apr. 2020, www.nichd.nih.gov/health/topics/infertility/conditioninfo. Accessed 18 Nov. 2024.

Coverage in Other States

At least 21 other states have some form of infertility coverage, including 15 states whose coverage includes IVF.[46]

Six states that surround Virginia require some form of infertility services. As discussed above, Kentucky, Maryland, and Delaware include coverage for fertility preservation. Maryland and Delaware also cover infertility treatment, including IVF. Ohio and West Virginia also cover infertility services such as infertility services, but do not appear to require IVF or fertility preservation.

Legislative History of Coverage in Virginia

HB1609 was introduced January 3, 2025, and passed the House of Delegates on January 31, 2025.[47] It was then introduced to the Senate February 3, 2025, where it passed with amendment February 18, 2025. The Senate amendment was agreed to by the House on February 19, 2025 and the enrolled bill was communicated to the Governor on March 11, 2025. The Governor returned the bill to the House with a recommended amendment, which the House rejected on April 2, 2025. The Governor signed the bill on May 2, 2025, which was accompanied by an explanation for his signature,[48] as Chapter 689 of the 2025 Acts of Assembly.

Current Prevalence of Coverage in Virginia

The EHB-BP currently includes coverage for diagnostic and testing services such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, as well as treatment for underlying medical conditions that cause infertility.[49] The EHB-BP explicitly states that fertility treatments such as artificial insemination (e.g., IUI) and IVF are not a covered service. Additionally, infertility drugs defined as "[d]rugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT))" are excluded.

The data call to carriers confirmed diagnostic services are covered but fertility treatments are generally not covered. Two carriers indicated coverage for fertility treatment including IUI. However, no carriers indicate coverage for ART/IVF. Two carriers indicate riders or buy-up coverage is available to cover fertility treatment.

One carrier expressed concern about fertility treatment as a high-cost benefit and the impact on member premiums.

No carriers expressed any anticipation of premium savings.

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[46] "Insurance Coverage by State." Resolve: The National Infertility Association, 30 Sep. 2024, resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/#:~:text=Iatrogenic%20infertility%20means%20an%20impairment,as%20other%20pregnancy%2Drelated%20benefits. Accessed 10 Oct. 2024.

[47] "HB1609 Essential health benefits benchmark plan; Commission to consider coverage for infertility treatment." Legislative Information System, https://lis.virginia.gov/bill-details/20251/HB1609 . Accessed 20 Mar. 2025.

[48] Ibid.

[49] Covered services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Estimate Cost of Adding Coverage to the EHB-BP

We estimated the number of members using 2023 American Community Survey (ACS) household data was used to identify married couple and cohabitating opposite sex and same-sex households,[50] census data,[51] and 2026 rate filing information. We assume 13.5% of couples have trouble conceiving after 12 months[52] and another 15% of couples with a prior condition which can cause infertility, based on a CDC definition.[53] This includes:

1. 6% due to endometriosis;[54]
2. 4% due to pelvic inflammatory disease;[55]
3. 2% due to very painful periods;[56]
4. 1% due to more than one miscarriage;[57] and
5. 1% due to suspected male condition.[58]

We also account for those using preserved samples for fertility preservation from the durational analysis discussed in that section.

[50] U.S. Census Bureau, U.S. Department of Commerce. "Coupled Households by Type." American Community Survey, ACS 1-Year Estimates Detailed Tables, Table B11009, 2023, Virginia. Accessed 1 June 2025.
[51] Annual Estimates of the Resident Population by Single Year of Age and Sex for Virginia: April 1, 2020 to July 1, 2024 (SC-EST2024-SYASEX-51) . U.S. Census Bureau, Population Division. Accessed 1 June 2025.
[52] "How common is infertility?" National Institute of Health. February 8, 2018. https://www.nichd.nih.gov/health/topics/infertility/conditioninfo/common. Accessed 30 Sep. 2021.
[53] "Infertility FAQs." Centers for Disease Control and Prevention. April 13, 2021. https://www.cdc.gov/reproductivehealth/infertility/index.htm. Accessed 30 Sep. 2021. It is unclear whether there is overlap between the number of couples who have trouble conceiving after 12 months and those with demonstrated conditions. If there is overlap, our estimate may be overstated.
[54] Fuldeore MJ, Soliman AM. Prevalence and Symptomatic Burden of Diagnosed Endometriosis in the United States: National Estimates from a Cross-Sectional Survey of 59,411 Women. Gynecol Obstet Invest. 2017;82(5):453-461. doi: 10.1159/000452660. Epub 2016 Nov 8. PMID: 27820938. Accessed 30 Sep. 2021.
[55] Kreisel K, et al. Prevalence of Pelvic Inflammatory Disease in Sexually Experienced Women of Reproductive Age — United States, 2013–2014. MMWR Morb Mortal Wkly Rep 2017;66:80–83. DOI: http://dx.doi.org/10.15585/mmwr.mm6603a3External. Accessed 30 Sep. 2021.
[56] Ju, Hong et al. "The prevalence and risk factors of dysmenorrhea." Epidemiologic reviews vol. 36 (2014): 104-13. doi:10.1093/epirev/mxt009. Accessed 30 Sep. 2021.
[57] "Pregnancy after miscarriage: What you need to know" May Clinic. https://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/pregnancy-after-miscarriage/art-20044134#:~:text=Miscarriage%20is%20usually%20a%20one,20%20percent%20after%20one%20miscarriage. Accessed 11 Sep. 2025.
[58] Grigorian, Areg et al. "National analysis of testicular and scrotal trauma in the USA." Research and reports in urology vol. 10 51-56. 10 Aug. 2018, doi:10.2147/RRU.S172848. Accessed 30 Sep. 2021.

We relied on an NIH study of people pursuing fertility treatment to determine the average cost of fertility treatment (trended to 2024 at 6% annually).[59] The fertility treatment options were categorized by the following:

1. Medications only, assume $2,808 cost per cycle;[60]
2. IUI-Clomiphene,[61] assume $686 cost per cycle; [62]
3. IUI-Gonadotropins,[63] assume $4,943 cost per cycle;[64] and
4. ART, assume $20,000 per cycle including medications.[65]

The number of cycles is based on the NIH study, which was for an 18-month period.[66] We made no adjustment was made to convert to a 12-month period, instead opting to use the study's data as-is for a conservative estimate.

The probability of treatment is based on the NIH study.[67] The NIH study only provided the probability of the most invasive treatment received. We split the probability evenly among scenarios of people pursuing less invasive treatments first. For example, for IUI-Gonadotropins we split the ultimate probability into three scenarios: IUI-Gonadotropins only, medications only then IUI-Gonadotropins, and medications only then IUI-Clomiphene then IUI-Gonadotropins.

The diagnosis was based on the NIH study.[68] The average cost per diagnosis was the cost of treatment times number of cycles weighed by probability of treatment. The average cost was the weighted average cost by diagnosis weighted by the probability of diagnosis.

[59] Katz, Patricia et al. "Costs of infertility treatment: results from an 18-month prospective cohort study." Fertility and sterility vol. 95,3 (2011): 915-21. doi:10.1016/j.fertnstert.2010.11.026. Accessed 1 Dec. 2021.
[60] Dupree, James M. "Insurance coverage of male infertility: what should the standard be?" Translational andrology and urology vol. 7,Suppl 3 (2018): S310-S316. doi:10.21037/tau.2018.04.25. Accessed 1 Dec. 2021.
[61] "Clomiphene." Medline Plus. September 15, 2017. https://medlineplus.gov/druginfo/meds/a682704.html#:~:text=Clomiphene%20is%20used%20to%20induce,the%20ovaries%20and%20be%20released. Accessed 1 Dec. 2021.
[62] Fertility Within Reach Handbook
[63] "Gonadotropins." Drugs.com. https://www.drugs.com/drug-class/gonadotropins.html. Accessed 1 Dec. 2021.
[64] IUI with clomiphene plus $400 for gonadotropins per "IUI vs. IVF" Extend Fertility. September 3, 2020. https://extendfertility.com/iui-vs-ivf/. Accessed 11 Sept. 2025.
[65] "Fact Sheet: In Vitro Fertilization (IVF) Use Across the United States." HHS. March 13, 2024. https://www.hhs.gov/about/news/2024/03/13/fact-sheet-in-vitro-fertilization-ivf-use-across-united-states.html. Accessed 9 Sep. 2025.
[66] Katz, Patricia et al. "Costs of infertility treatment: results from an 18-month prospective cohort study." Fertility and sterility vol. 95,3 (2011): 915-21. doi:10.1016/j.fertnstert.2010.11.026. Accessed 11 Sep. 2025.
[67] Ibid.
[68] Ibid.

Fertility benefits can be structured in many ways that have significantly different values. We have analyzed the following 3 scenarios (1) fertility treatment benefits including IUI, but not ART (2) fertility treatment benefits including IUI and ART up to 3 cycles per lifetime and (3) fertility treatment benefits including IUI and ART without limits.

1. We estimate adding fertility treatment benefits including IUI but not ART represents approximately 0.16% at 100% actuarial value or $0.98 PMPM towards Virginia's available generosity value. This is above the preliminary 0.04% to 0.10% provided in the Phase 1 preliminary estimate, primarily due to Virginia's demographic information and updated service cost information. This is also within the range of 0.01% to 1.55% of allowed claims reported in the data call issues to Virginia ACA carriers. We note the1.55% was an outlier, and not including provided a range of 0.01% to 0.73%.
    a. According to the data call we expect premiums would increase from 0.01% to 1.44% in the individual market, and 0.01% to 0.90% in the small group market.
2. We estimate adding fertility treatment benefits including IUI and ART up to 3 cycles per lifetime represents approximately 0.88% at 100% actuarial value or $5.40 PMPM towards Virginia's available generosity value. This is above the preliminary 0.05% to 0.7% provided in the Phase 1 preliminary estimate, primarily due to Virginia's demographic information and updated service cost information. We did not ask the carriers to estimate this particular scenario, so we do not have their estimated range of allowed claims or premium impact. Carriers were not asked to provide an estimate as we are unaware of any specific legislation or recommendations for infertility including a limit of 3 cycles of IVF. Carriers were asked to provide estimates of infertility benefits including and not including IVF, which NovaRest believes provides a low and a high estimate for infertility. NovaRest provided a scenario limiting IVF to 3 cycles based on clinical studies[69,70] and other state legislation[71] which NovaRest believes provides a reasonable medium estimate for HIRC to consider.

[69] Luke B, Brown MB, Wantman E, Lederman A, Gibbons W, Schattman GL, Lobo RA, Leach RE, Stern JE. Cumulative birth rates with linked assisted reproductive technology cycles. N Engl J Med. 2012 Jun 28;366(26):2483-91. doi: 10.1056/NEJMoa1110238. PMID: 22738098; PMCID: PMC3623697.
[70] Abuzeid MI, Bolonduro O, La Chance J, Abozaid T, Urich M, Ullah K, Ali T, Ashraf M, Khan I. Cumulative live birth rate and assisted reproduction: impact of female age and transfer day. Facts Views Vis Obgyn. 2014;6(3):145-9. PMID: 25374657; PMCID: PMC4216980.
[71] "In what states is IVF covered by insurance?: A comprehensive guide for HR leaders." Maven. June 21, 2024. https://www.mavenclinic.com/post/in-what-states-is-ivf-covered-by-insurance. Accessed 29 Sept. 2025.

3. We estimate adding fertility treatment benefits including IUI and ART without limits represents approximately 1.60% at 100% actuarial value or $9.81 PMPM towards Virginia's available generosity value. This is above the preliminary 0.6% to 1.0% provided in the Phase 1 preliminary estimate, primarily due to Virginia's demographic information and updated service cost information. This is also within the range of 0.04% to 6.5% of allowed claims reported in the data call issues to Virginia ACA carriers. We note that the 6.5% was an outlier, and not including provided a range of 0.04% to 1.9%.
    a. According to the data call we expect premiums would increase from 0.06% to 6.5% in the individual market, and 0.02% to 6.5% in the small group market.

Hearing Aids – All Ages

Summary of Proposed Coverage

To analyze the impact of adding coverage for hearing aids for all ages to the EHB-BP, we modeled the required service after Virginia's Chapter 473 of the 2023 Acts of Assembly,[72] but expanded to all ages.[73] Required coverage included one hearing aid per hearing-impaired ear, every 24 months. Please note if added as an EHB, dollar limits (i.e. the $1,500 cap) would not be permitted. Therefore, our analysis does not include a cap on the cost of the hearing aids.

Other State Coverage

Currently, at least 27 states require coverage of hearing aids for children[74] and six states require coverage of hearing aids for all ages.[75] We note coverage requirements vary by state and are not necessarily what is proposed for Virginia.

Legislative History of Coverage in Virginia

Chapter 473 was enacted on July 1, 2023, and applies to any policy, contract, or plan delivered, issued, or renewed on or after January 1, 2024.[76] We are unaware of bills discussing hearing aids for all ages.

Current Prevalence of Coverage in Virginia

Hearing aids are specifically excluded from the EHB-BP and are unlikely to be covered for those over 18 in the individual and small group ACA market. A carrier data call is likely required to determine the number of carriers covering hearing aids for those over 18 in the ACA market.

[72] "SB 1003 Health insurance; mandated coverage for hearing aids for minors." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=231&typ=bil&val=sb1003. Accessed 18 Nov. 2024.
[73] To comply with federal EHB discrimination rules, we believe the benefit cannot be EHB and be restricted to minors.
[74] "State Insurance Mandates for Hearing Health/Hearing Aids." American Academy of Audiology, Feb. 2022, www.audiology.org/wp-content/uploads/2022/02/State-Hearing-Health-Insurance-Mandates-2022.pdf. Accessed 18 Nov. 2024.
[75] "A State-by-State Guide for Hearing Aid Insurance." Hearing Like Me, 11 Nov. 2019, www.hearinglikeme.com/hearing-aid-insurance/. Accessed 18 Nov. 2024. This source shows five states that require hearing aid coverage for all ages, and North Dakota changed their EHB-BP to include this same coverage.
[76] "Chapter 473." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?231%2Bful%2BCHAP0473. Accessed 18 Nov. 2024.

However, Chapter 473 was enacted and applies to any health policy, contract, or plan delivered, issued for delivery, or renewed in Virginia on and after January 1, 2024.[77] Therefore, hearing aid coverage is currently provided to enrollees 18 and younger. This coverage is considered a benefit "in addition to the EHB," meaning Virginia defrays $0.10 PMPM for each member of a qualified health plan (QHP) who requires hearing aids. If added to the EHB-BP, our understanding is that Virginia would not be required to defray this cost.[78]

Our carrier data call also confirmed hearing aids for those over age 18 are not covered by any individual or small group ACA carriers.

One carrier indicated hearing aid coverage would likely have high utilization among older members, which they believe is a key demographic for ACA plans and which they expect to drive premium membership across the membership.

One carrier indicated they believe hearing aid coverage could result in long term positive impact on delay of cognitive decline and some mental health disorders such as depression.

Estimate Cost of Adding Coverage to the EHB-BP

Hearing age usage was assumed to vary between 1%[79] and 2.3%[80] by age. Covered lives were determined from 2026 carrier rate filings, and age distribution from census data.[81] We assume $2,000 per pair of hearing aids,[82] which appear to have a 5 year lifespan, and are typically replaced between 3 and 7 years,[83,84] although we assumed replacement consistent with the bill language which provides for one hearing aid per hearing-impaired ear every 24 months.

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[77] Ibid.

[78] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS); Department of the Treasury. Final Rule. Accessed 18 Nov. 2024.

[79] "Hearing Aids For Children." American Speech-Language-Hearing Association. https://www.asha.org/practice-portal/professional-issues/hearing-aids-for-children/?srsltid=AfmBOoqn3aSbO-WMOrfRU3zEZFk-kLGlEznfe97ioJtwkSxex_tKzbaC&utm_source=chatgpt.com. Accessed 9 Sep. 2025.

[80] "Hearing Difficulties Among Adults: United States, 2019." CDC. July 2021. https://www.cdc.gov/nchs/products/databriefs/db414.htm?utm_source=chatgpt.com. Accessed 9 Sep. 2025.

[81] Annual Estimates of the Resident Population by Single Year of Age and Sex for Virginia: April 1, 2020 to July 1, 2024 (SC-EST2024-SYASEX-51) . U.S. Census Bureau, Population Division. June 2025

[82] Watson, Angela Mae. "Hearing Aids: How Much Do Prescription and Over-the-Counter Devices Cost?" GoodRx. August 16, 2022. https://www.goodrx.com/health-topic/ear/hearing-aid-cost?srsltid=AfmBOopYVqUyxCcYvYT73LnI5NBJlZqv4itlIVEgnT9Ur1erNk3-zkPs&utm_source=chatgpt.com. Accessed 9 Sep. 2025.

[83] "5 Factors That Affect How Long Hearing Aids Last." Associated Audiologists. https://www.hearingyourbest.com/5-factors-that-affect-how-long-hearing-aids-last/?utm_source=chatgpt.com. Accessed 9 Sep. 2025.

[84] Goad, Kimberly. "5 Signs You Need to Replace Your Hearing Aids." April 14, 2022. https://www.aarp.org/health/conditions-treatments/when-to-replace-hearing-aids//?utm_source=chatgpt.com. Accessed 9 Sep. 2025.

We estimate adding hearing aid coverage represents approximately 0.11% at 100% actuarial value or $0.70 PMPM towards Virginia's available generosity value. This is slightly higher than the preliminary 0.09% provided in the Phase 1 preliminary estimate due to higher expected cost of hearing aids. While the mandated benefit would limit hearing aids to $1,500, dollar limits are not permitted for EHBs. This is also within the range of 0.00% to 0.22% of allowed claims reported in the data call issues to Virginia ACA carriers.

It is important to note adding required benefits will also likely cause an increase to premiums. This is separate from the generosity analysis required by CMS presented above. The premium increase would be determined by each Virginia ACA carrier separately. According to the data call we expect premiums would increase from 0.00% to 0.22% in the individual market, and 0.01% to 0.22% in the small group market.

Pasteurized donated human breast milk (PDHM)

Breast milk is associated with short-term and long-term medical and neurodevelopmental advantages and is recommended for approximately six months after birth.[85] However, in cases where a mother's milk is unavailable or insufficient to meet an infant's needs, pasteurized human-donated breast milk (PHDM) provides many nutritional and immunological benefits.[86]

Summary of Proposed Coverage

To analyze the impact of adding coverage for PHDM to the EHB-BP, we modeled the required service after Virginia's SB 499 from the 2024 Regular Session.[87] In addition to licensing requirements and medical assistance for the state plan, the bill requires coverage for expenses incurred in providing PDHM for a covered person under the age of six months with other certain criteria.

Other State Coverage

Currently, at least 14 states and the District of Columbia have implemented legislation addressing Medicaid or commercial insurance coverage for PDHM, and at least seven additional states (including Virginia) have introduced legislation.[88] The state of Washington recently added this benefit to their EHB-BP.[89]

Legislative History of Coverage in Virginia

Coverage for PDHM was introduced during the 2019 Regular Session with companion bills HB 2049[90] and SB 1650[91], and the bills were referred to HIRC. HIRC recommended these bills receive an assessment pursuant to subsection C of § 30-343 of the Code of Virginia, which was performed by the Virginia BOI and the Joint Legislative Audit and Review Commission (JLARC).

More recently, SB 499, which required coverage for donor breast milk, was introduced on January 9, 2024, and passed the Senate unanimously on February 13, 2024.[92] The bill was tabled in the House Committee on Appropriations on February 28, 2024.

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[85] Meek JY, Noble L; Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. Pediatrics. 2022;150(1):e2022057988. Accessed 5 Nov. 2024.
[86] Tran HT, Nguyen TT, Mathisen R. The use of human donor milk. BMJ. 17 Nov. 2020;371:m4243. doi: 10.1136/bmj.m4243. PMCID: PMC7673198. Accessed 5 Nov. 2024.
[87] "SB 499 Health insurance; coverage for donor human milk." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=sb499. Accessed 5 Nov. 2024.
[88] Rose AT, Miller ER, Butler M, Eden C, Kim JH, Shah SI, Patel RM. US state policies for Medicaid coverage of donor human milk. J Perinatol. 2022 Jun;42(6):829-834. doi: 10.1038/s41372-022-01375-9. Epub 2022 Apr 4. PMID: 35379899; PMCID: PMC8979482. Accessed 5 Nov. 2024.
[89] Washington 2026 EHB-Benchmark Plan Information. Appendix B Actuarial Report in Application. https://www.cms.gov/marketplace/resources/data/essential-health-benefits. Accessed 9 Sep. 2025.
[90] "HB 2049 Electric Utilities; Eliminates Customer Credit Reinvestment Offsets." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?211%2Bsum%2BHB2049. Accessed 18 Nov. 2024.
[91] "SB 1650 Health Insurance; Coverage for Donated Human Breast Milk." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?191%2Bsum%2BSB1650. Accessed 18 Nov. 2024.
[92] "SB 499 Health insurance; coverage for donor human milk." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=sb499. Accessed 18 Nov. 2024.

During the 2025 Regular Session, SB 1186 was introduced on January 8, 2025, and passed the Senate unanimously on January 31, 2025. The bill was left in House Committee on Appropriations on February 18, 2025.

Current Prevalence of Coverage in Virginia

The EHB-BP documents do not currently exclude PDHM but do not state it is covered.

Our carrier data call also confirmed PDHM is generally not covered. One carrier indicated coverage is available for PDHM only when medically necessary for low-birth-weight infants with documented birth weight of less than 1500 grams when the mother's own breast milk is unavailable or insufficient.

One carrier indicated concerns on increasing member premiums.

No carriers indicated that they anticipate any potential cost savings or health care quality improvement.

Estimate Cost of Adding Coverage to the EHB-BP

We estimate approximately 1,400 very preterm babies who would likely require PDHM,[93] which is consistent with JLARC's previous analysis.[94] We assumed an average weight of 2.6 for preemie[95], estimated 90 days of use at $95 per day.[96] [97] [98]

We estimate adding PDHM represents approximately 0.02% at 100% actuarial value or $0.13 PMPM towards Virginia's available generosity value. This is above the preliminary 0.01% provided in the Phase 1 preliminary estimate based on updating underlying cost, infant, and age assumptions. This is also within the range of 0.00% to 0.44% of allowed claims reported in the data call issues to Virginia ACA carriers. We note this is a wide range provided by carriers, with one carrier estimating 0.44% and another estimating 0.20%. However, this analysis has been studied by Virginia previously at an even lower cost, and we note the state of Washington added this benefit to their EHB-BP also using a 0.02% allowed cost.[99] We believe our estimated is sufficiently supported.

[93] https://www.marchofdimes.org/peristats/data?reg=99&top=2&stop=1&lev=1&slev=4&obj=1&sreg=51
[94] "Health Insurance Mandate Review: Donated Human Breast Milk HB2049 & SB1650 (2019)." Joint Legislative Audit and Review Commission. December 6, 2021.
[95] Miles, K. (n.d.). How fast is your baby growing? See how fetal weight and height change by week during pregnancy. Retrieved from https://www.babycenter.com/pregnancy/your-body/growth-chart-fetal-length-and-weight-week-by-week_1290794. Accessed 1 Sept. 2025.
[96] "Milk for Healthy Newborns: Receive Milk." Mothers' Milk Bank of North Texas, texasmilkbank.org/receive-milk/milk-for-healty-newborns.html. Accessed 1 Sept. 2025.
[97] St-Onge, M., Chaudhry, S., & Koren, G. (2015). Donated breast milk stored in banks versus breast milk purchased online. Canadian family physician Medecin de famille canadien, 61(2), 143–146.Accessed 1 Sept. 2025.
[98] Dutton, J. (2011). Liquid Gold: The Booming Market for Human Breast Milk. Retrieved from https://www.wired.com/2011/05/ff-milk/. Accessed 1 Sept. 2025.
[99] Washington 2026 EHB-Benchmark Plan Information. Appendix B Actuarial Report in Application. https://www.cms.gov/marketplace/resources/data/essential-health-benefits. Accessed 9 Sep. 2025.

It is important to note adding required benefits will also likely cause an increase to premiums. This is separate from the generosity analysis required by CMS presented above. The premium increase would be determined by each Virginia ACA carrier separately. According to the data call we expect premiums would increase from 0.00% to 0.38% in the individual market, and 0.00% to 0.20% in the small group market.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) / Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)

PANS is defined as "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."[100] It may be caused by a pathogen, but does not require a known trigger. Symptoms can include anxiety, sensory amplification or motor abnormalities, behavioral regression, deterioration in school performance, mood disorder, urinary symptoms, and/or sleep disturbances.

PANDAS is a subset of PANS, caused by a strep infection and has "5 distinct criteria for diagnosis, including abrupt "overnight" OCD or dramatic, disabling tics; a relapsing-remitting, episodic symptom course; young age at onset (average of 6–7 years); presence of neurologic abnormalities; and temporal association between symptom onset and Group A strep (GAS) infection."[101]

Treatment for PANDAS/PANS is generally similar and includes psychological, behavioral, and psychopharmacologic interventions to provide symptom improvement and improve functioning.[102]

Summary of Proposed Coverage

We modeled the required service after Virginia's HB 513 (2024)[103] and Virginia's HB1641 (2025).[104] Coverage would include antibiotic treatment, medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy (IVIG).

Other State Coverage:

Eleven states have passed PANS/PANDAS health insurance laws[105] including Illinois, Delaware, Arkansas, Minnesota, New Hampshire, Massachusetts, Indiana, Maryland, Rhode Island, Oregon, and Colorado.

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[100] "What Is PANS/PANDAS?" Pandas Physician Network, 1 Mar. 2024, www.pandasppn.org/what-are-pans-pandas/. Accessed 20 Nov. 2024

[101] Ibid.

[102] Thienemann, MD et al. Clinical Management of Pediatric Acute-Onset Neuropsychiatric Syndrome: Part I—Psychiatric and Behavioral Interventions. Journal of Child and Adolescent Psychopharmacology. Volume 27, Number 7, 2017. Mary Ann Liebert, Inc. Pp. 566-573. Accessed 18 Nov. 2024.

[103] "HB 513 Medical assistance services and health insurance; state plan for payment for PANDAS and PANS." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=hb513. Accessed 4 Nov. 2024.

[104] "HB 1641 State plan for medical assistance services and health insurance; pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome." Legislative Information System, https://lis.virginia.gov/bill-details/20251/HB1641. Accessed 29 Sept. 2025.

[105] "States with PANS Insurance Laws." CalCoaltion, www.calcoalition.com/states-with-pans-insurance-coverage. Accessed 4 Nov. 2024.

Legislative History of Coverage in Virginia

HB 513 was introduced on January 8, 2024, and was left in the House Committee on Labor and Commerce on February 13, 2024.[106] A similar bill, HB 1641, was introduced in the 2025 Regular Session and was approved by the Governor as Chapter 8 of the 2025 Acts of Assembly and will mandate coverage for the prophylaxis, diagnosis, and treatment of PANDAS/PANS effective January 1, 2026.[107]

Current Prevalence of Coverage in Virginia

Chapter 8 of the 2025 Acts of Assembly requiring coverage for PANDAS/PANS will be effective January 1, 2026. Therefore, this would be considered a mandated benefit in addition to the EHB, which will require defrayal by Virginia. [108,109]

One carrier expressed concern about adding coverage due to the impact on member premiums.

No carriers indicated that they anticipate any premium savings or improvements to health care quality.

Estimate Cost of Adding Coverage to the EHB-BP

The exact number of people treated for PANDAS and PANS is unknown because most cases go undiagnosed.[110] JLARC estimates 0.004% to 0.14% prevalence in the general population using Virginia Medicaid enrollment data. Of children already exhibiting some symptoms, research literature estimates prevalence to be between 0.04% to 0.8%. Based on these prevalence rates, less than 100 to approximately 2,500 children in Virginia are estimated to have PANS/PANDAS.[111] We assume 200 children annually receive treatment.

[106] "HB 513 Medical Assistance Services and Health Insurance; State Plan for Payment for PANDAS and PANS." Legislative Information System, legacylis.virginia.gov/cgi-bin/legp604.exe?241%2Bsum%2BHB513. Accessed 18 Nov. 2024.
[107] "Virginia Requires Coverage for PANDAS/PANS." NFP. June 3, 2025. https://www.nfp.com/insights/virginia-requires-coverage-for-pandaspans/#:~:text=On%20March%2018%2C%20Gov.,%2Dcoverage%2Dfor%2Dpandaspans/. Accessed 11. Sep. 2025.
[108] (N.d.). Retrieved from https://lis.virginia.gov/bill-details/20251/HB1641/text/HB1641. Accessed 12 Mar. 2025.
[109] Costs are largely driven by IVIG therapy. "Guidance on PANDAS/PANS Mandated Coverage." May 14, 2025. https://www.scc.virginia.gov/media/sccvirginiagov-home/regulated-industries/insurance/insurance-companies/life-health-companies/aca-rate-amp-form-filing-information/PANDAS_PANS-ac.pdf. Accessed 29 Sept. 2025.
[110] "Statistics." PANDAS Network, 24 Mar. 2023, pandasnetwork.org/get-involved/statistics/. Accessed 20 Nov. 2024
[111] Joint Legislative Audit and Review Commission. "Health Insurance Mandate Review: PANS/PANDAS HB513 (2024)." 9 Dec. 2024. Health Insurance Reform Commission Briefing. Accessed 12 Mar. 2025.

NovaRest has previously estimated the impact coverage for PANDAS/PANS treatment in another state, which included interviews with a doctor specializing in PANDAS/PANS. It is our understanding that most children would receive relatively antibiotics, medication such as NSAIDs, and behavioral counseling as a treatment for PANDAS/PANS. These are relatively inexpensive and are generally covered, at least in the short term, by insurance carriers. The cost would come from extended use of these treatments, as well as the use of more expensive treatments such as IVIG (approximately $10,000 per treatment, [112] of which several treatments may be required) and plasma therapy (which may be even more expensive than IVIG[113]), which are used in more severe cases.

Utilization of treatment coverage for PANDAS/PANS may increase because of mandated coverage for services and therapies that some carriers deem experimental, the prohibition on step-therapy for PANDAS/PANS treatment, and coverage for out-of-state treatments. Based on previous discussions we had with the specialist physician, we assume all children with PANDAS/PANS would undergo antibiotic treatment, NSAIDs, and CBT. We assume about 40% use SSRIs, 20% would use corticosteroids, 15% would use IVIG, and a very small amount (about 1%) would use plasmapheresis, also based on this discussion.

It is important to note, however, that immunomodulating medicines, plasma exchange, and IVIG are also treatments used for other conditions such as certain cancers. Under federal discrimination rules, the EHB-BP cannot restrict coverage without a clinical reason; therefore, adding coverage may extend the scope beyond PANDAS/PANS, which would result in usage for other conditions and would result in higher premiums.

We estimate adding PANDAS/PANS treatments represents approximately 0.03% at 100% actuarial value or $0.21 PMPM towards Virginia's available generosity value. This is within the preliminary 0.01% to 0.04% provided in the Phase 1 preliminary estimate. This is also within the range of 0.00% to 0.08% of allowed claims reported in the data call issues to Virginia ACA carriers.

It is important to note adding required benefits will also likely cause an increase to premiums. This is separate from the generosity analysis required by CMS presented above. The premium increase would be determined by each Virginia ACA carrier separately. According to the data call we expect premiums would increase from 0.00% to 0.10% in the individual market, and 0.00% to 0.07% in the small group market.

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[112] Delaware HB 386 An Act To Amend Title 18, Title 29, And Title 31 Of The Delaware Code Relating To Coverage For Treatment Of Pediatric Autoimmune Neuropsychiatric Disorders Associated With Streptococcal Infections And Pediatric Acute Onset Neuropsychiatric Syndrome. Fiscal note. 2018. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiP6Pzlt4SJAxXtrokEHfEuLVAQFnoECBUQAQ&url=https%3A%2F%2Flegis.delaware.gov%2Fjson%2FBillDetail%2FGetPdfDocument%3FfileAttachmentId%3D114996&usg=AOvVaw3lwWoNdd_8KVzdCGabEyQy&opi=89978449. Accessed 20 Nov. 2024.

[113] Heatwole C, Johnson N, Holloway R, Noyes K. Plasma exchange versus intravenous immunoglobulin for myasthenia gravis crisis: an acute hospital cost comparison study. J Clin Neuromuscul Dis. Dec. 2011;13(2):85-94. doi: 10.1097/CND.0b013e31822c34dd. PMID: 22361692; PMCID: PMC3291869. Accessed 18 Nov. 2024.

Polycystic Ovary Syndrome (PCOS)

PCOS is an umbrella term used to describe a collection of symptoms associated with certain classic hormone imbalances.[114] The World Health Organization (WHO) estimates that 116 million women worldwide have PCOS, and it is one of the most common ovulatory disorders, accounting for 85% of all cases.

Summary of Proposed Coverage

To analyze the impact of adding coverage for PCOS to the EHB-BP, we modeled the required service after Virginia's HB 604 (2024).[115] Coverage includes:

1. Treatment by a licensed physician or health care provider, including by a gynecologist, endocrinologist, primary care physician, pediatrician, nurse practitioner, dermatologist, or infertility specialist;
2. Treatment of hair and skin issues related to PCOS, including electrolysis, laser hair removal, and acne and hair loss treatments;
3. Treatment for metabolic issues related to PCOS;
4. Treatment for mental health issues related to PCOS provided by a licensed or certified mental health professional; and
5. If recommended by a licensed physician or healthcare provider, treatment and support services related to mental health, nutrition management, metabolic health, diabetes prevention, cardiovascular disease prevention, and other lifestyle management support by healthcare professionals, including by a licensed dietician, nutritionist, exercise physiologist, therapist, or other healthcare professionals.

Legislative History of Coverage in Virginia

HB 604 was introduced on January 9, 2024, and was tabled by the House Committee on Labor and Commerce on January 25, 2024. This same committee referred the bill to HIRC for an assessment pursuant to subsection B of § 30-343 of the Code of Virginia.[116] This assessment was conducted by the Virginia BOI and was presented to HIRC at its meeting on June 17, 2025.

Current Prevalence of Coverage in Virginia

The EHB-BP does not specifically discuss coverage for PCOS services, including electrolysis or laser hair removal. However, we expected most services were already covered in the Phase 1 report. Based on the data call, carriers confirmed that most treatments noted above are already covered with exceptions for treatment of hair and skin issues related to PCOS and fertility services.

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[114] "Polycystic Ovary Syndrome (PCOS)." Yale Medicine, Yale Medicine, 28 Oct. 2022, www.yalemedicine.org/conditions/polycystic-ovary-syndrome#:~:text=Experts%20estimate%20that%205%20to,have%20not%20yet%20started%20menstruation. Accessed 18 Nov. 2024.

[115] "HB 604 Health insurance; coverage for polycystic ovary syndrome." Legislative Information System, https://legacylis.virginia.gov/cgi-bin/legp604.exe?ses=241&typ=bil&val=hb604. Accessed 18 Nov. 2024.

[116] "HB 604 Health Insurance; Coverage for Polycystic Ovary Syndrome." Legacy Legislative Information System, https://legacylis.virginia.gov/cgi-bin/legp604.exe?241+ful+HB604. Accessed 18 Nov. 2024.

One carrier indicated "metabolic issues" should be more clearly defined in the language to ensure consistent coverage. Another carrier expressed concerns around impact on member premiums.

No carriers indicated any anticipated premium savings.

Estimate Cost of Adding Coverage to the EHB-BP

Yale Medicine estimate 5% to 10% of women aged 18 to 44 have PCOS.[117] We estimate approximately 22,000 members in the Virginia individual and small group ACA markets have PCOS.[118]

Of these, approximately 75% have unwanted hair,[119] 55% have hair loss,[120] and 22% have severe acne.[121] This is approximately 16,500 who may pursue hair removal treatments, 12,000 who may pursue hair loss treatment, and 5,000 who may pursue acne treatments.

We are assuming coverage for hair loss and acne treatments using drugs that are already commonly covered. Therefore, we estimate that laser hair removal and electrolysis are the primary drivers of cost.

[117] "Polycystic Ovary Syndrome (PCOS)." Yale Medicine, Yale Medicine, 28 Oct. 2022, www.yalemedicine.org/conditions/polycystic-ovary-syndrome#:~:text=Experts%20estimate%20that%205%20to,have%20not%20yet%20started%20menstruation. Accessed 20 Nov. 2024.

[118] Approximately 684,000 current enrollees from 2025 Virginia carrier rate filings, approximately 43% of Virginia 65 and under population are women aged 18-44 from 2024 Census Vintage population estimate and assume 7.5% have PCOS (average of 5 to 10% from Yale Medicine in prior footnote).

[119] "Hirsutism: What It Is, in Women, Causes, PCOS & Treatment." Cleveland Clinic, 1 May 2024, my.clevelandclinic.org/health/diseases/14523-hirsutism. Accessed 20 Nov. 2024.

[120] Futterweit, Walter. "A Patient's Guide: Management of Hair Loss in Polycystic Ovary Syndrome." Contemporary OB/GYN, 11 Oct. 2011, www.contemporaryobgyn.net/view/patients-guide-management-hair-loss-polycystic-ovary-syndrome. Accessed 20 Nov. 2024.

[121] Caporuscio, Jessica. "PCOS, Acne, and Acne Treatment: What to Know." Medical News Today, MediLexicon International, 3 May 2020, www.medicalnewstoday.com/articles/pcos-acne#:~:text=Polycystic%20ovary%20syndrome%20(PCOS)%20is,people%20who%20have%20the%20condition. Accessed 20 Nov. 2024.

Electrolysis is the only permanent hair loss treatment per the U.S. Food and Drug Administration.[122] Treatment may take eight to 12 sessions, for $50 to $700 per session.[123] Laser hair removal is less painful and expensive, but will require treatments indefinitely, approximately every 15 weeks[124] for $35 to $400 per session.[125] We were unable to find specific usage, but assume two-thirds use laser hair removal as it is less expensive and painful.[126]

We estimate adding PCOS coverage represents approximately 0.07% at 100% actuarial value or $0.44 PMPM towards Virginia's available generosity value. This is slightly lower than the preliminary 0.08% to 0.20% provided in the Phase 1 preliminary estimate based on updated Virginia carrier and census data. This is also within the range of 0.00% to 0.33% of allowed claims reported in the data call issues to Virginia ACA carriers.

It is important to note adding required benefits will also likely cause an increase to premiums. This is separate from the generosity analysis required by CMS presented above. The premium increase would be determined by each Virginia ACA carrier separately. According to the data call we expect premiums would increase from 0.00% to 0.28% in the individual market, and 0.00% to 0.22% in the small group market.

[122] "Electrolysis: Definition & Treatment." Cleveland Clinic, 1 May 2024, my.clevelandclinic.org/health/treatments/8306-electrolysis. Accessed 20 Nov. 2024.
[123] "How Many Electrolysis Hair Removal Treatments Will I Need?" 2pass Clinic, 17 Dec. 2018, 2pass.clinic/en/article/how-many-electrolysis-hair-removal-treatments-will-i-need. Accessed 20 Nov. 2024.
[124] "Laser Hair Removal Is Ideal for Women with PCOS (and Here's Why!)." Laser Aesthetic Center, 17 Dec. 2019, www.laser-aesthetic-center.com/laser-hair-removal-for-pcos/#:~:text=Laser%20Hair%20Removal%20For%20PCOS&text=Typically%2C%20women%20suffering%20from%20PCOS,be%20required%20on%20the%20face. Accessed 20 Nov. 2024.
[125] Rhinehart, Charlene. "How Much Does Laser Hair Removal Cost?" GoodRx, 9 July 2024, www.goodrx.com/health-topic/dermatology/laser-hair-removal-cost. Accessed 20 Nov. 2024.
[126] Peter, Dr. Lian. "Laser Hair Removal for PCOS: Is It Right For You?" Dr. Lian Beauty, 16 Oct. 2023, drlianbeauty.com/laser-hair-removal-for-pcos-is-it-right-for-you-2/#:~:text=Which%20is%20better%20for%20PCOS,on%20this%20type%20of%20hair. Accessed 20 Nov. 2024.