REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

HOUSE BILL 240 (1994) MANDATED OFFER OF COVERAGE FOR THE TREATMENT OF BREAST CANCER BY AUTOLOGOUS BONE MARROW OR STEM CELL TRANSPLANT

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 9

COMMONWEALTH OF VIRGINIA
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1995

COMMONWEALTH OF VIRGINIA

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October 21, 1994

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of House Bill 240 (1994 Session) regarding a proposed mandated offer of coverage for the treatment of breast cancer with high dose chemotherapy and autologous bone marrow or stem cell transplantation.

Respectfully submitted,

Clarence A. Holland
Chairman
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INTRODUCTION

House Bill 240 was referred to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) for evaluation by the Joint Commission on Health Care. House Bill 240 is patroned by Delegate Mary T. Christian and requires that insurers offer and make available coverage for the treatment of breast cancer with high dose chemotherapy and autologous bone marrow or stem cell transplantation.

On January 19, 1994, the Advisory Commission held a public hearing to receive comments from all interested parties regarding House Bill 240. Written comments were received prior to the public hearing from several interested parties. Twenty-four (24) speakers provided oral comments at the hearing.

SUMMARY OF THE PROPOSED LEGISLATION

House Bill 240 would add 38.2-3418.2 to the Code of Virginia to require each insurer, health services plan, and health maintenance organization to "offer and make available" coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow or stem cell transplant when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in such treatment. The bill requires that deductibles for this coverage under HMO contracts not be greater than for any other health care services and the copayment for the coverage is not to exceed the policy's standard copayment.

The provisions of the bill do not apply to short-term travel, accident only, limited or specified disease policies or short-term nonrenewable policies covering no more than six months.

SIMILAR MANDATES IN OTHER STATES

The state of New Hampshire mandated coverage for breast cancer treatment in 1992. The bill requires the coverage to be included in health insurance contracts. The legislation took effect January 1, 1993. The state of Florida has enacted legislation which mandates coverage for bone marrow transplants. The Florida law requires rules to be adopted by their Secretary of Health and Rehabilitative Services to specify the procedures that are to be accepted based on the recommendations of an advisory panel appointed by the secretary. The Florida law is not yet operational. Legislation was passed in Massachusetts that took effect on April 20, 1994 requiring insurers to cover bone marrow transplants for breast cancer patients.

TREATMENT OF CANCER BY AUTOLOGOUS BONE MARROW TRANSPLANT

For a number of years, cancer patients have been treated through the use of chemotherapy. With this treatment, certain types of cancer patients can be cured or

put in long-term remission. The chemotherapy drugs kill cancer cells. However, these drugs also kill the patient's bone marrow and therefore, limit the amount of chemotherapy that can be given.

In recent years, cancer centers have addressed this problem by using autologous bone marrow transplantation. Before the patient is given high dose chemotherapy, approximately a quart of bone marrow is removed from the patient's hips. This is called "harvesting" the bone marrow. The bone marrow that is taken from the patient's body is frozen at very low temperatures. After the high dose chemotherapy is administered and has cleared the patient's body, the "harvested" bone marrow is returned to the patient's body and it begins to make the vital blood elements.

Autologous bone marrow transplantation refers to procedures where the recipient is a self-donor as opposed to allogeneic bone marrow transplantation where the marrow comes from another donor. The use of autologous rather than allogeneic marrow avoids complications such as graft-versus-host disease and immuno-suppression. It also permits treatment of patients who do not have an appropriate HLA (human leukocyte antigen) matched donor.

STEM CELL TRANSPLANTATION

Peripheral blood stem cell transplantation (PBSCT) involves taking hematopoietic stem cells from the peripheral blood and reinfusing them to restore marrow hematopoiesis. PBSCT is sometimes used after high-dose chemotherapy or marrow ablative therapy that has destroyed diseased marrow in cancer patients.

PBSCT is sometimes an alternative therapy to ABMT for restoring bone marrow function after marrow destructive therapies. ABMT usually restores blood component formation immediately after marrow therapy, but it may be two or three weeks after the transplantation before there are an adequate number of white blood cells that help fight infection.

Stem cell transplantation is sometimes an addition to ABMT to assist in the regeneration of the bone marrow after the marrow destructive therapies. Some studies indicate PBSCT results in more rapid clinical recovery, including fewer hospital days and less infections. However, statements have been made that the number of patients studied is small and more data including long-term studies is desirable.

SAFETY AND EFFECTIVENESS OF ABMT

According to the National Center for Health Services Research and Health Care Technology (NCHSR) (now the Agency for Health Care Policy and Research), clinical trials employing ABMT have demonstrated that its use can successfully rescue some patients and provide complete hematologic recovery. In some cases of Hodgkin's disease, non-Hodgkin's lymphoma, neuroblastoma, and acute leukemia, a number of

patients who would not have been expected to survive conventional therapy have achieved long-term survival following ABMT. The clinical trials published to date, however, have not provided definitive evidence of the benefit of ABMT for the treatment of acute leukemia in relapse, chronic granulocytic leukemia, or solid tumors other than neuroblastoma.

The NCHSR is the federal agency that evaluates the safety and effectiveness of medical technologies being considered for coverage by Medicare and other federally funded programs such as CHAMPUS. NCHSR publication of research findings does not necessarily represent approval or official endorsement by the NCHSR or the U.S. Department of Health and Human Services.

Currently the medical community is divided on the use of ABMT for other types of cancer. There are studies demonstrating the positive use of ABMT including the *Technology Assessment of High-Dose Chemotherapy and Autologous Bone Marrow Support for Breast Cancer* prepared by Dr. William P. Peters of Duke University Medical Center, Dr. Marc E. Lippman of Georgetown University Medical Center, Dr. Gianni Bonandonna of Milan, Italy, Dr. Vincent T. DeVita, Jr. of Memorial Sloan Kettering Cancer Center in New York, Dr. James F. Holland of Mount Sinai School of Medicine, and Dr. Gary L. Rosner of Duke University Cancer Center. According to this assessment, the use of high dose chemotherapy and autologous bone marrow support for selected patients with breast cancer should no longer be considered investigational.

However, others in the medical field advise caution, particularly because of the fact that they consider the mortality rate for the treatment itself to be significant. One of the arguments against the use of ABMT in the treatment of certain types of cancer is that the outcome of many of the studies conducted is based on the short follow-up periods. It has been argued that the follow-up periods have not been sufficient to draw conclusions concerning survival following ABMT or to compare ABMT to alternative therapies. According to some, duration of disease-free survival following ABMT does not appear to be substantially longer than historical survival without ABMT.

The National Cancer Institute (NCI), the federal government's lead agency for research on cancer, has begun a study on breast cancer that will include 1,200 women nationally. They will be divided into two groups of 600 each. One group will receive ABMT with high dose chemotherapy and the other half will receive conventional dose chemotherapy. Each group will be documented carefully and evaluated over several years. Blue Cross and Blue Shield of Virginia is one of the participants in the study. According to the NCI, these studies are essential since only through formal, well-performed clinical trials can the effectiveness and toxicity of ABMT in breast cancer patients be determined.

The following statements were supplied to the Advisory Commission by NCI in January of 1994 regarding ABMT.

> Clinical trials of high dose chemotherapy with either autologous bone marrow transplantation (ABMT) or peripheral blood stem cell support for the treatment of patients with solid tumors are essential in determining the safety and efficacy of this procedure. Only through the conduct of well designed prospective studies can we determine if this approach is of benefit, and the specific diseases and specific patient subgroups for which it is appropriate.
>
> Currently, NCI sponsored clinical trials are carefully addressing this important issue, because for patients with solid tumors, more data are needed to definitively establish the role of ABMT as standard treatment in these disease settings. Although it is not within the mandate of the NCI to determine insurance coverage policy, we believe it is scientifically, financially, clinically necessary that formal demonstration of ABMT benefit occur prior to the unlimited dissemination of such a toxic and expensive therapy.

Proponents of the legislation believe that there have been significant changes in the effectiveness and efficacy of ABMT in the past two years. The changes include the development and use of drugs that allow the bone marrow to recover faster and the collection of stem cells from the peripheral block. They cite mortality rates, from 1993 experience at one major transplant center, as low as one to two percent for the procedure.

Those believing that ABMT is still experimental cite mortality rates from the ABMT procedure as being 10% while the mortality rates for conventional chemotherapy are 1%. Opponents of the legislation also stated that 30% of ABMT patients also have other serious complications that involve the lungs, liver, kidney and gastrointestinal tract and usually require high-cost, acute care.

PREVALENCE OF CANCER AND TREATMENT COSTS

Statistics from the American Cancer Society estimate that there will be 27,000 new cancer cases in Virginia in 1993 and 12,200 cancer deaths. New cases of breast cancer are projected to total 4,400. Projections for other types of cancers are: lung 4,200, colorectal 3,200, prostate 4,000, uterine 1,000, skin melanoma 750, oral 650, pancreas 600 and leukemia 600. The number of cases for which ABMT will be the recommended course of treatment is not known.

The NCI advises that bone marrow transplantation is a highly technical and expensive treatment, with costs usually in excess of $200,000, although costs may be as low as $70,000. Costs are incurred outside the hospital as well. Even though the actual hospital stay may be one to two months, patients may need to stay near the treatment center for an additional two to three months for follow-up care.

AVAILABILITY OF INSURANCE COVERAGE

Many insurance companies pay for ABMT treatment for some types of cancer, but not for others. When coverage is denied it is usually because the insurer considers ABMT to be experimental or investigative in the treatment of that particular type of cancer.

Blue Cross and Blue Shield of Virginia (BCBSVA) testified that it has offered, as an endorsement to its group policies, coverage for ABMT in the treatment of breast cancer since July 1, 1992. BCBSVA is currently seeking regulatory approval to make a similar endorsement available to individual policyholders. The insurer still considers the treatment to be experimental and is only offering the coverage pending the results of the NCI research.

STATE CORPORATION COMMISSION BUREAU OF INSURANCE SURVEY OF INSURER PRACTICES

On December 6, 1993 the State Corporation Commission Bureau of Insurance mailed surveys to 50 of the top writers of accident and sickness insurance in Virginia by premium volume. Several top writers were excluded from the survey because they were known to be inactive in the major medical and comprehensive health insurance markets. As of January 12, 1994, 34 (68%) of those insurers, health services plans, and health maintenance organizations surveyed had responded. Two respondents indicated that they are only active in specialty health insurance markets such as Medicare supplement and specified disease. These two insurers did not complete the survey and are not represented in the results presented below.

Of the 32 respondents active in the major medical and comprehensive health insurance markets in Virginia, 16 (50%) indicated that they routinely provide coverage to Virginia policyholders for medically necessary high-dose chemotherapy with autologous bone marrow transplantation (HDC-ABMT) in the treatment of breast cancer. Four (4) respondents (13%) reported that while they do not routinely provide such coverage, they do make it available on an optional basis to both individual and group policyholders. Two (2) respondents (6%) indicated that they only make the optional coverage available to group policyholders. The remaining 12 respondents (31%) reported that they do not routinely provide coverage for HDC-ABMT in the treatment of breast cancer or make such coverage available as an option.

Table 1 Coverage for ABMT in the Treatment of Breast Cancer

	Number of Respondents	Percent
Routinely Provided	16	50
Provided Only as an Option Available to All Policyholders	4	13
Provided Only as an Option Available to Group Policyholders	2	6
Not Routinely Provided or Made Available as an Option	10	31
Total	32	100

Twenty-six (26) of the 32 respondents also write health insurance outside of Virginia. Half (13) of these provide or offer coverage for HDC-ABMT in the treatment of breast cancer in these other jurisdictions. Each of these companies also provides coverage in Virginia.

Of the 32 respondents active in the major medical and/or comprehensive health insurance markets in Virginia, 13 (41%) indicated that they routinely provide coverage to Virginia policyholders for medically necessary high-dose chemotherapy with stem cell transplantation (HDC-SCT) in the treatment of breast cancer. Four (4) respondents (13%) reported that while they do not routinely provide such coverage, they do make it available on an optional basis to both individual and group policyholders. Two (2) respondents (6%) indicated that they only make the optional coverage available to group policyholders. The remaining 13 respondents (41%) reported that they do not routinely provide coverage for HDC-SCT in the treatment of breast cancer or make such coverage available as an option.

Table 2 Coverage for Stem Cell Transplant in the Treatment of Breast Cancer

	Number of Respondents	Percent
Routinely Provided	13	41
Provided Only as an Option Available to All Policyholders	4	13
Provided Only as an Option Available to Group Policyholders	2	6
Not Routinely Provided or Made Available as an Option	13	41
Total	32	100

Of the 26 respondents that also write health insurance outside of Virginia, 10 (40%) routinely provide or offer coverage for HDC-SCT in the treatment of breast cancer in those other states. Each of these companies also provides such coverage in Virginia.

Twenty-nine (29) respondents (91%) indicated that they do routinely provide coverage to Virginia policyholders for medically necessary HDC-ABMT and HDC-SCT in the treatment of certain conditions other than breast cancer. The conditions for which coverage is provided varied among respondents.

REVIEW CRITERIA

SOCIAL IMPACT

a. *The extent to which the treatment or service is generally utilized by a significant portion of the population.*

Statistics from the American Cancer Society estimate 27,000 new cancer cases in Virginia in 1993 and 12,200 cancer deaths. New cases of breast cancer are projected to total 4,400. Projections for other types of cancers are: lung 4,200, colorectal 3,200, prostate 4,000, uterine 1,000, skin melanoma 750, oral 650, pancreas

600, and leukemia 600. National projections are currently that one out of every nine women will have breast cancer.

The number of cases for which ABMT will be the recommended course of treatment is not known. ABMT is, however, sometimes the recommended treatment for patients with advanced breast cancer. ABMT is also utilized for treatment of Hodgkin's disease, non-Hodgkin's lymphoma, neuroblastoma, and acute leukemia. Clinical trials have also been conducted utilizing ABMT for treatment for acute leukemia in relapse, chronic granulocytic leukemia or solid tumors other than neuroblastoma.

Proponents of the proposed legislation estimate that on an annual basis approximately 260 women in Virginia who would need this treatment would be covered by insurance.

b. The extent to which insurance coverage for the treatment or service is already available.

Coverage for ABMT varies according to the type of cancer being treated. Some insurers reimburse for ABMT for specific types of cancer. Some insurers consider treatment of breast cancer by ABMT a covered service, but many consider it to be "experimental" or "investigative" and deny payment.

The responses to the SCC 1993 Survey of 50 writers of accident and sickness insurance indicate that at least 16 of the largest writers in Virginia routinely cover the treatment.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

The expense of ABMT is often prohibitive for many citizens. Nationally costs can be in excess of $200,000, although in Virginia at least one hospital estimates a cost of approximately $70,000. The Health Insurance Association of America estimates the average cost to be $120,000. Proponents cited costs in 1993 ranging from $40,000 to $120,000 for in hospital care.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

In addition to the high cost of treatment, costs are also incurred outside of the hospital. The inpatient time in the hospital may be one to two months. The patient may need to stay near the treatment site another two or three months for follow up care.

The patient and family members must also have funds for these expenses and may also lose earnings during this period of time.

Testimony before the Advisory Commission included many statements regarding the need to accept and solicit donations to obtain the funds necessary for treatment.

e. *The level of public demand for the treatment or service.*

The estimate of new cancer cases in Virginia for 1993 is 27,000. The number of cases for which ABMT will be the recommended course of treatment is not known, however, proponents believe the number of breast cancer patients needing ABMT will be approximately 260. 4,400 new cases of breast cancer were expected.

f. *The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.*

Demand for coverage exists among those currently in need of this treatment as well as those projected to have a possible need in the future. Public awareness of different medical treatments is usually limited.

Many providers support the request for this type of coverage although not all providers believe ABMT is effective for all types of cancer.

g. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

No information was received regarding the interest of collective bargaining organizations in negotiating for the inclusion of this coverage.

h. *Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

No health agency findings regarding the social impact of this proposal were presented during this review.

FINANCIAL IMPACT

a. *The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.*

The exact cost of the proposed coverage is unknown. ABMT treatment currently costs between $70,000 and $200,000. Proponents cited average figures of $40,000 to

$120,000 for in hospital costs. BCBSVA currently charges $5 per month per person for its offer of coverage for community rated groups. The cost for the optional coverage is $2.86 per month per family for the BCBSVA experience rated groups.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

It has not been argued that inappropriate use of ABMT will increase if the proposal is enacted. The possible adverse impact of ABMT would logically eliminate the unnecessary use of the procedure. Appropriate use of the procedure would be likely to increase with the availability of insurance coverage.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

ABMT is an alternative for conventional chemotherapy treatments. Proponents sometimes make the argument that ABMT, although more expensive than one course of traditional treatment, in the long run may be less expensive because subsequent conventional treatments can be avoided that would otherwise be required in the absence of ABMT.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

One opponent of the mandate cautioned that in some states outpatient facilities are being developed that are not equipped to deal with all of the possible complications of ABMT and stem cell transplants.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

Insurers generally make the argument that administrative expenses increase whenever a mandate is enacted. Insurers have also made the argument that any increase in the dollar amount of claims paid will be passed on to policyholders. BCBSVA indicated its offer of coverage to groups costs approximately $5 per month per person for certificate holders for its community rated groups. And, $2.86 per month per family for its experience rated groups.

f. The impact of coverage on the total cost of health care.

The total cost of health care may be affected somewhat if policyholders obtain coverage for ABMT. However, a number of individuals currently obtain funds for the procedure through charities and personal pleas.

MEDICAL EFFICACY

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

Proponents of the mandate make the argument that the medical efficacy of this treatment is established. There are a number of studies that have shown positive results when ABMT is used for a number of diagnoses that insurers still consider to be experimental. Proponents make the argument that any cancer treatment is somewhat experimental because of the difference in individual responses. Proponents also point to the fact that it is the attending physician who makes the recommendation for the procedure and that for some patients it is the only chance for a cure.

One of the vocal opponents of the mandate takes the position that ABMT for breast cancer does not result in long-term survival or disease free remission that is higher than for those treated with high dose conventional chemotherapy. Opponents also pointed to the clinical trials currently being sponsored by the National Cancer Institute. Opponents make the point that there is still considerable debate on the safety of high dose chemotherapy with ABMT compared to standard chemotherapy for the treatment of advanced or poor prognosis breast cancer.

Opponents of the mandate took the position that the Commonwealth should not require insurance coverage for a procedure that has not been proven safe and effective.

Previously, opponents described the technical assessments that they conduct before making a decision to include coverage for a particular procedure. Opponents outlined the information that is reviewed and the layers of review that are performed and noted that as new data becomes available, assessments are revised.

One of the major opponents of the mandate summarized the current knowledge of the use of ABMT for breast cancer as having a high initial response rate with unknown durability. The opponent contends that there is no difference in survival or disease-free remission for those treated with high dose or conventional chemotherapy. But, the up front mortality and morbidity for those undergoing high dose chemotherapy is substantially higher (ten percent for ABMT and only one percent for traditional therapy).

Proponents cited current results from the Duke University Bone Marrow Transplant Program and other current studies. It is their position that the current mortality rates and survival rates should be given due consideration. Proponents cited the improvements in treatment results as being indicative of the refined treatment process. Physicians also testified as to the decrease in the mortality rate from the procedure itself and the increase in disease free survival. 1993 calendar year results for Duke University were cited as a 1% mortality rate for the procedure.

b. *If the legislation seeks to mandate coverage of an additional class of practitioners:*

1) *The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.*

Not applicable.

2) *The methods of the appropriate professional organization that assure clinical proficiency.*

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

a. *The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.*

The proposed mandate of coverage addresses a medical need and is consistent with the role of health insurance.

b. *The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.*

Proponents see the need for the coverage outweighing the potential cost of the benefit. They point to those usually in need of ABMT being women between the ages of 30 and 54. Many of those in need have young children to raise. They acknowledge that every treatment available cannot be paid for every individual. However, they believe that this treatment should not be denied.

Opponents stressed the unproven efficacy of the treatment. A spokesman for Blue Cross and Blue Shield of Virginia indicated that the cost of their endorsement that would provide ABMT coverage for breast cancer only, would be $5 per person per month ($60 per year) for community rated groups (2 to 49 employees) and $2.86 per month per family for experience rated groups.

c. *The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.*

The proposal is a mandated option. However, some proponents have requested that the coverage be required.

A 1986 survey conducted for the State Corporation Commission found that 83% of families that were insured for health care obtained that coverage through employment. In a group setting, the individual insureds do not have the option to select coverage. That decision is made by the group policyholder. Therefore, a mandated option of coverage may not reach many of the citizens who would desire the coverage.

Opponents of mandates make the argument that administrative expenses will not be reduced by "offering" coverage and that insurers are more susceptible to adverse selection with a mandated offering.

RECOMMENDATION

The Special Advisory Commission on Mandated Health Insurance Benefits hereby recommends to the Governor and the General Assembly of Virginia that House Bill 240 (1994) requiring the offer of coverage for the treatment of cancer by high dose chemotherapy with autologous bone marrow or stem cell transplant be enacted with certain technical amendments. The technical amendments clarify that the mandated offer of coverage is limited to treatment for breast cancer.

CONCLUSION

The Advisory Commission recognizes that the effectiveness of ABMT has increased since a proposal to mandate coverage was evaluated by the Advisory Commission in May of 1992. In view of the increased effectiveness of the treatment, and the impact a lack of coverage has on Virginia citizens, the Advisory Commission supports the enactment of House Bill 240.

1994 SESSION

LD0061148

HOUSE BILL NO. 240

Offered January 17, 1994

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.2, relating to accident and sickness insurance; bone marrow transplants.

Patrons—Christian, Brickley, Armstrong, Ball, Barlow, Behm, Connally, Cooper, Copeland, Crittenden, Croshaw, Crouch, Cunningham, Darner, DeBoer, Diamonstein, Dillard, Fisher, Giesen, Grayson, Hamilton, Hargrove, Jackson, Johnson, Jones, D. C., Jones, J.C., Keating, Melvin, Morgan, Parrish, Puller, Purkey, Robinson, Spruill, Stump, Van Landingham, Van Yahres, Wagner and Way; Senators: Andrews, Calhoun, Houck, Howell, Lambert, Lucas, Marsh, Maxwell, Miller, Y.B., Norment, Quayle, Robb, Stolle, Trumbo, Waddell and Woods

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Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.2 as follows:

§ 38.2-3418.2. Coverage for bone marrow transplants.

A. 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 offer and make available coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after January 1, 1995, for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

B. Such health care service shall not be subject to any greater deductible than any other health care service provided by the health maintenance organization. The copayment required of the enrollee shall not exceed the standard copayment required by the insured's policy for such health care service.

C. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1310, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3411.2, 38.2-3418.1, *38.2-3418.2,* 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.