

**REPORT OF THE  
SPECIAL ADVISORY COMMISSION ON MANDATED  
HEALTH INSURANCE BENEFITS**

**HOUSE BILL 710  
MANDATED COVERAGE FOR  
RADIOISOTOPIC IMPLANTATION  
AS A TREATMENT FOR  
PROSTATE CANCER**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**HOUSE DOCUMENT NO. 25**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
1997**





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November 27, 1996

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 710 regarding a proposed mandate of coverage for radioisotopic implantation as a treatment for prostate cancer.

Respectfully submitted,

A handwritten signature in cursive script that reads "George H. Heilig, Jr.".

George H. Heilig, Jr.  
Acting Chairman  
Special Advisory Commission on  
Mandated Health Insurance Benefits



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## **INTRODUCTION**

The 1996 House Committee on Corporations, Insurance and Banking referred House Bill 710 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) to be reviewed prior to the 1997 Session of the General Assembly. House Bill 710 is patroned by Delegate Clarence E. Phillips.

The Advisory Commission held a public hearing on July 12, 1996, in Richmond to receive public comments on House Bill 710. In addition to the bill's chief patron, a prostate cancer patient who chose radioisotopic implantation as treatment for prostate cancer, and a urologist from the Eastern Virginia Medical School, spoke in favor of the bill. The prostate cancer patient and the urologist also submitted written testimony in favor of the bill. Representatives from the Health Insurance Association of America (HIAA) and the Virginia Manufacturers Association (VMA) spoke in opposition to the bill. A representative from Trigon Blue Cross Blue Shield (Trigon) responded to questions regarding a Blue Cross Blue Shield Association study on radioisotopic implantation. Written comments opposing the bill were received from HIAA, VMA, the Virginia Chamber of Commerce, Trigon, HealthKeepers, Inc., CIGNA HealthCare of Virginia, Inc., and the Virginia Association of Health Maintenance Organizations (VAHMO).

The Advisory Commission concluded its review of House Bill 710 on September 19, 1996.

## **SUMMARY OF PROPOSED LEGISLATION**

If enacted, House Bill 710 would amend and re-enact § 38.2-4319 and add § 38.2-3418.2:2 to the Code of Virginia to require 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 to provide coverage under any policy, contract or plan delivered, issued for delivery or renewed in Virginia for the treatment of prostate cancer by radioisotopic implantation. As currently drafted, the bill does not address coverage for prostate cancer screening.

## **RADIOISOTOPIC IMPLANTATION**

Amersham HealthCare, a radio-pharmaceutical manufacturing and research company, publishes a booklet entitled, "Another Therapeutic Approach to Prostate Cancer: Radioactive Seed Implantation" (1994) that explains that radioisotopic implantation (also known as internal radiation therapy or radiation seed therapy) is a treatment for prostate cancer during which tiny pellets, or

seeds, containing radioactive medication are implanted directly in the middle of the cancer. The pellets emit low-level radiation continuously. The procedure does not require a surgical incision. Using ultrasound as a guide, the seeds are injected with thin needles that pass into the prostate and area surrounding the prostate through the skin between the scrotum and rectum. Depending upon the size of the cancer, seeds may be left in place from one to seven days or permanently.

Amersham HealthCare and proponents report that one advantage to this procedure is a higher number of patients remaining cancer-free than those with either radical prostatectomy (total removal of the prostate gland) or external radiation therapy. Other advantages include: the procedure is normally done on an outpatient basis; the seeds can deliver two to three times more concentrated radiation to the prostate gland than external radiation; incontinence occurs in less than 5% of patients who have not had prior surgery; impotence occurs in less than 15% of patients under the age of 70, and the procedure is well-suited for older patients who are physically unable to withstand surgery or external radiation. Amersham HealthCare and opponents to House Bill 710 report that the disadvantages of the procedure are that there is no information yet available on the effectiveness of the implant treatment after 10 years, and that it is common for patients to experience problems with urination for several months after seed implantation.

## **CURRENT INDUSTRY PRACTICES**

The State Corporation Commission's Bureau of Insurance (Bureau) surveyed 50 of the top writers of accident and sickness insurance in Virginia regarding three bills to be reviewed by the Advisory Commission this year. Thirty-four companies responded to the survey by April 19, 1996. With regard to House Bill 710, eight indicated that they do little or no applicable health insurance business in Virginia and, therefore, could not provide the information requested. Of the 26 respondents that completed the survey, eighteen (69%) reported that they currently provide the coverage required by House Bill 710 to their Virginia policyholders. Two respondents indicated that coverage is provided if the procedure is medically necessary and not investigational. Eight indicated that they do not provide coverage for radioisotopic implantation.

## **FINANCIAL IMPACT**

Respondents to the Bureau survey provided cost figures between \$0.05 and \$2.00 per month per group certificate holder and between \$0.25 and \$2.00 per month per individual policyholder to provide coverage for radioisotopic implantation. Several insurers indicated that they were unable to provide cost figures because the monthly premium cost was insignificant or negligible. Others responded that the procedure was not coded in a manner that allowed

separate identification from other cancer treatments. Cuna Mutual Insurance Society indicated that they have received only one claim for this procedure and that the cost figures they provided were based on that claim. A representative from Trigon indicated that when they did cover radioisotopic implantation, it constituted less than 1% of the company's overall claims costs.

Respondents to the Bureau survey indicating that they do not currently provide coverage for radioisotopic implantation estimated that the proposed mandate would cost between \$0.05 and \$0.13 per month per group certificate holder and between \$0.05 and \$1.50 per month per individual policyholder to provide coverage for radioisotopic implantation. One respondent indicated that the proposed mandate would cost group certificate holders \$150.00 per month. Respondents to the survey provided cost figures between \$0.13 and \$150.00 per month per group certificate holder and between \$0.05 and \$2.70 per month per individual policyholder if the proposed mandate was enacted on an optional basis.

The Medical College of Virginia Department of Radiation Oncology states that the estimated cost for radioisotopic implantation is approximately \$4,100 per treatment. This cost figure does not include the physician(s) fees, inpatient hospital care, or diagnostic tests. The radioactive seeds constitute the largest percentage of the cost at approximately \$2,100. Dr. Deborah Kuban, of the Eastern Virginia Medical School, who currently performs the procedure, provided a cost figure of \$12,000. A prostate cancer patient, who selected radioisotopic implantation, estimated that the total cost of the procedure was \$17,000.

## **MEDICAL EFFICACY**

The efficacy of radioisotopic implantation for the treatment of prostate cancer is challenged by some insurers. Healthkeepers of Virginia asserts that they do not cover radioisotopic implantation for the treatment of prostate cancer because they consider the treatment to be experimental. CIGNA HealthCare of Virginia asserts that their research indicates that, compared with external-beam radiation, evidence is not available to indicate that radioisotopic implantation offers improved health outcomes for patients who have localized prostate cancer. Originally, Trigon expressed concern that there is an increased risk of gastrointestinal and genitourinary morbidity. Trigon recently re-evaluated its policy on radioisotopic implantation. Based on information provided by the Blue Cross Blue Shield Association, Trigon informed the Advisory Commission that it reversed its position and began covering radioisotopic implantation effective September 12, 1996.

Proponents of the bill argued that radioisotopic implantation for the treatment of prostate cancer is at least as effective as radical prostatectomy and external beam radiation, especially with the latest technological advances in

ultrasound. The American College of Radiology (ACR) indicated that they consider radioisotopic implantation to be an effective treatment for prostate cancer. The ACR notes that unlike radical prostatectomy, the procedure carries less risk of impotence and urinary incontinence and does not require lengthy hospitalization. Dr. Kuban explained in written comments that radioisotopic implantation has been performed since the 1970's. She further explained that the side effects associated with radioisotopic implantation are less severe than those associated with both radical prostatectomy and external beam radiation. A study published in the August 28, 1996 edition of the *Journal of the American Medical Association* reports that radical prostatectomy results in a high 10-year survival rate among men with all tumor grades. The report concluded, however, that alternate treatment strategies should not be discounted. The study found that it is difficult to determine which treatment for prostate cancer is best for the patient without taking the patient's age and overall health into account.

Proponents submitted information describing a five-year study conducted by the Northwest Tumor Institute in Seattle, Washington. The study consisted of 111 patients with early stage prostate cancer treated since 1988. At its completion, the study showed that 100% of the patients were disease-free in the prostate after five years, and that complications were very low. Researchers found that there were no reports of incontinence in men participating in the study who had no prior prostate surgery. The five-year study also shows that the "biochemical and biopsy results following . . . seed implant therapy are superior to those of external beam radiation and are comparable to that achieved with radical prostatectomy surgery at five years." Dr. Kuban submitted information noting that prostate implant is an ideal therapeutic option for patients with small tumors who desire radiation as treatment for their cancer, but for whom external beam therapy is a major physical hardship.

#### **SIMILAR LEGISLATION IN OTHER STATES**

According to information published by the National Association of Insurance Commissioners and the National Insurance Law Service, five states (Colorado, Delaware, Georgia, North Carolina, and West Virginia) mandate coverage for expenses associated with screening for prostate cancer (see Appendix B). Currently no state requires mandatory coverage for a specific treatment for prostate cancer.

## REVIEW CRITERIA

### SOCIAL IMPACT

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

The American Cancer Society (ACS) estimates that there will be 7,400 new cancer cases in Virginia in 1996. The "Cancer Journal for Clinicians" (1993) reports that 3.7% of patients selected radioisotopic implantation as treatment for prostate cancer in 1984. That number declined to 1.5% in 1990. A representative from Trigon indicated that when they covered the procedure, it constituted less than 1% of the company's overall claims cost.

Amersham Healthcare reports that physicians at about 400 clinical sites nationwide are now performing radioisotopic implantation. Proponents note that seed implants have been performed for over 20 years in the United States. One proponent noted that the medical facility in Virginia at which she works has been performing the procedure for a year and a half. She further noted that 25 patients had been treated using this procedure at their facility.

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

Of the 26 respondents that completed the Bureau's survey, 18 reported that they currently provide the coverage required by House Bill 710 to their Virginia policyholders. The VAHMO reported in written comments that a survey of its members found that only three of the plans indicated that radioisotopic implantation was not included as a covered service or benefit. Trigon reported that they ceased coverage for the procedure in 1995 when a Blue Cross Blue Shield Association study raised concerns about the increase in gastrointestinal and genitourinary morbidity in patients receiving this treatment, but have since begun covering the procedure again.

- 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.*

Proponents contended that coverage is generally not available and that patients are often forced to choose a less desirable form of treatment that is covered by their insurer or pay entirely out-of-pocket. Opponents indicated that coverage is available for several other forms of treatments that are viewed as more effective and with better outcomes. One proponent contended that many

patients become aware of this procedure, but must choose another form of treatment because their insurer will not cover radioisotopic implantation.

- 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.*

The Medical College of Virginia Department of Radiation Oncology states that the estimated cost for radioisotopic implantation is approximately \$4,100 per treatment. This cost figure does not include the physician(s) fees, inpatient hospital care, or diagnostic tests. The radioactive seeds constitute the largest percentage of the cost at approximately \$2,100. A prostate cancer patient provided information that the estimated entire cost of his procedure was \$17,000 plus other costs. The prostate cancer patient did not provide details of the other costs associated with the procedure. A urologist who performs the procedure provided an estimated cost of \$12,000, about \$5,000 less than a prostatectomy. Proponents contend that the cost of implantation is about one-half of the cost associated with radical prostatectomy and two-thirds of that associated with external beam radiation therapy.

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

The ACS's "Cancer Facts & Figures - 1996" estimates that 317,100 men in the United States will be diagnosed with prostate cancer in 1996. The ACS also reports that there will be an estimated 7,400 new cancer cases in Virginia in 1996. The "Cancer Journal for Clinicians" (1993) reports that only 3.7% of patients used radioisotopic implantation as treatment for prostate cancer in 1984. That number declined to 1.5% in 1990. A urologist speaking in support of the bill noted that the procedure had been performed 25 times in the past year and a half at the Eastern Virginia Medical School.

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

The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment are unknown. Patients diagnosed with prostate cancer have several treatment options from which to choose, depending upon the age of the patient, the stage of the cancer, and personal preference. In written comments submitted by one proponent, several physicians who perform radioisotopic implantation, and the American College of Radiology, contend that the procedure is an effective treatment for prostate cancer and encourage insurers to consider covering the procedure.

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

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

- 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 information or findings of the state health planning agency or the appropriate health system agency regarding the social impact of the mandated benefit 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.*

No information was provided by either proponents or opponents that would suggest that enactment of this bill would either increase or decrease the cost of treatment for radioisotopic implantation for the treatment of prostate cancer.

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

It is anticipated that the appropriate use of the treatment would increase with the proposed mandate. A doctor speaking in favor of the bill stated that the mandate would increase utilization of radioisotopic implantation. However, utilization of other treatments, such as radical prostatectomy and beam radiation, would decrease. She noted that there would not be an increase in utilization of radioisotopic implantation among those men who would not normally receive treatment for their prostate cancer.

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

Radioisotopic implantation is only one of several available treatments for prostate cancer. One opponent indicated that insurers generally do not code prostate cancer treatments separately and, therefore, could not determine if the treatment was more costly than others. Proponents contend that the cost of implantation is about one-half of the cost associated with radical prostatectomy and two-thirds of that associated with external beam radiation therapy. A urologist who performs the procedure noted in oral comments that radioisotopic implantation costs about \$5,000 less than a prostatectomy.

- 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.*

It is possible that the number of providers of the proposed mandated treatment may increase if coverage for radioisotopic implantation causes an increase in utilization of the treatment. However, the number of insureds needing such treatment appears to be relatively small.

- 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.*

An increase in the administrative expenses of insurance companies and the premiums and administrative expenses for policyholders is anticipated because of the expenses associated with policy redesign, form filing, claims processing systems and marketing, and other administrative requirements. Trigon reported that if House Bill 710 is enacted, the claims cost should be minimal since the number of persons who would receive treatment should be a small percentage of the insured population.

Several insurers expressed concern that mandating radioisotopic implantation would increase the premium costs associated with health insurance for existing policyholders, and that the uninsured and small businesses would be even less likely to afford coverage.

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

The total cost of health care is not expected to be significantly affected.



## 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.*

Opponents contend that radioisotopic implantation has not been proven to be consistently effective when compared to other less expensive forms of treatment for prostate cancer. CIGNA HealthCare of Virginia (CIGNA) indicated that the Technology Evaluation Program developed by Blue Cross Blue Shield Association reports that when compared with external-beam radiation therapy, there is no available evidence to indicate that radioisotopic implantation offers improved health outcomes of patients who have localized prostate cancer. HealthKeepers stated in written comments that Trigon's HMOs do not cover radioisotopic implantation because they consider the treatment to be experimental.

Originally, Trigon stated that research provided by the Blue Cross Blue Shield Association raised concern about the increase in gastrointestinal and genitourinary morbidity in seed transplant patients. Based on new information provided by the Blue Cross Blue Shield Association, Trigon reversed its position and began covering radioisotopic implantation effective September 12, 1996.

Proponents submitted the results of a recent study conducted by the Northwest Tumor Institute (NTI) in which patients participating in the study received seed implants to treat prostate cancer. The five-year study concluded that no local tumors reoccurred, and that all participants were disease-free at the end of the study. According to information submitted by proponents, the five-year NTI study showed that complications were low. There were no reports of incontinence in men who had no prior prostate surgery.

- 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.*

House Bill 710 addresses the medical need of treating prostate cancer through the use of radioisotopic implantation. The coverage is consistent with the role of health insurance. Opponents argue that mandating coverage for a treatment that has not been proven effective is detrimental to the health care insurance industry. Trigon asserts in its written comments that the social impact of mandating the provision of radioisotopic implantation for prostate cancer includes the basic public policy question of whether benefit design should be legislated. Trigon also expressed concern over the dilemma created when mandates are enacted that do not cover the self-insured or the uninsured.

In information submitted to the Advisory Commission, one proponent wrote that every man faced with prostate cancer should be well informed of all treatment options. The proponent went on to say that men should have this option available to them because it is the only treatment which offers a cure and leaves men anatomically, physiologically and psychologically intact in an amazingly high percentage of cases.

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

Respondents to the Bureau survey provided cost figures of between \$0.05 and \$2.00 per month per group certificate holder and between \$0.25 and \$2.00 per month per individual policyholder to provide coverage for radioisotopic implantation. One proponent contends that the cost of seed implant is about one-half the cost of radical prostatectomy and two-thirds the cost of external beam radiation therapy only. He contended further that the shortened recovery period is cost-effective for both the family and the insurer. Information provided by proponents indicated that radioisotopic implantation is a one-time outpatient procedure that requires about one hour to receive the treatment.

Trigon submitted materials that indicated that the financial impact of mandating coverage for radioisotopic implantation on claims costs should be

minimal since the number of persons who would receive treatment would be a small percent of the insured population.

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

It is expected that the cost of a mandated offer of coverage would be higher because of adverse selection by those who had reason to believe they might need such treatment in the future. In the case of group coverage, the decision whether to select the optional coverage or not would be made by the master contract holder and not the individual. Therefore, it is possible that many insureds would not benefit from such a requirement.

## **RECOMMENDATION**

The Advisory Commission recommends that House Bill 710 not be enacted. The Advisory Commission voted (Yes-7, No-1) to adopt this position on September 19, 1996.

## **CONCLUSION**

Radioisotopic implantation is one of several available options available for the treatment of prostate cancer. Some insurers indicated that they exclude coverage for this procedure because the treatment is considered experimental, less effective than other treatment options, or harmful to the patient's health. The largest health insurer in Virginia, by premium volume, recently re-evaluated its policy on radioisotopic implantation to include coverage for the procedure. The Advisory Commission, believing that this legislation was initiated because of the coverage decision of that insurer, decided that a mandate was unnecessary following the insurer's decision to once again cover the procedure.

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**HOUSE BILL NO. 710**

Offered January 22, 1996

A *BILL to amend and reenact § 38.2-4319 of Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.2:2, relating to accident and sickness insurance; coverage of radioisotopic implantation for treatment of prostate cancer.*

Patron—Phillips

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 38.2-3418.2:2 as follows:**

*§ 38.2-3418.2:2. Coverage for radioisotopic implantation for treatment of prostate cancer.*

*A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, for the treatment of prostate cancer by radioisotopic implantation.*

*B. 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 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2:2, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 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 et seq.) 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.*

*C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.*

*D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.*

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**MANDATED COVERAGE FOR PROSTATE SCREENING  
IN OTHER STATES**

<b>STATE</b>	<b>CITATION</b>	<b>SUMMARY</b>
Colorado	§ 10-16-104 (individual and group) (1996)	Coverage for annual prostate screening for men over the age of 50 years and men over the age of 40 who are in a high-risk category; not subject to policy deductibles. Screening includes a prostate-specific antigen blood test (PSA) and a digital rectal examination.
Delaware	Title 18 § 3552 (group) (1988/1993)	Coverage for annual or routine screening for men 50 years or older; subject to deductibles and coinsurance. Screening includes a PSA test.
Georgia	§ 33-29-3.2 (individual) § 33-30-4.2 (group) (1990/1992)	Coverage for a PSA test, according to the standards set by the American College of Pathologists; subject to deductibles and coinsurance.
North Carolina	§ 58-51-58 (individual and group) § 58-67-77 (HMOs) § 58-65-93 (nonprofits) (1993)	Coverage for screening when recommended by a physician; subject to deductibles and coinsurance. Coverage includes a PSA or equivalent tests.
West Virginia	§ 33-15-15 (individual) § 33-16C-4 (group) (1991/1994)	Coverage for medical and laboratory services in connection with annual checkups for prostate cancer in men age 50 and older; subject to deductibles and copayments.



