REPORT OF THE SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR EARLY INTERVENTION SERVICES

(HOUSE BILL 2715, 1997)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 33

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December 12, 1997

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 (Advisory Commission) to assess the social and financial impact and the medical efficacy of House Bill 2715, regarding mandatory coverage for early intervention services.

This report is respectfully submitted on behalf of the remaining members of the Advisory Commission.

Jean W. Cunningham

Member, Virginia House of Delegates
Special Advisory Commission on
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INTRODUCTION

During the 1997 Session of the General Assembly, the House Committee on Corporations, Insurance and Banking referred House Bill 2715 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). House Bill 2715 was patroned by Delegate Mary T. Christian.

The Advisory Commission held a hearing on July 29, 1997, in Richmond to receive public comments on House Bill 2715. In addition to the patron, eight speakers addressed the proposal. Representatives from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Virginia Chapter of the American Academy of Pediatrics and The Virginia Pediatric Society, The Chesapeake Center, Inc., and three concerned citizens spoke in favor of the bill. Representatives of the Virginia Association of Health Maintenance Organizations (VAHMO) and the Virginia Chamber of Commerce spoke in opposition to the measure. A representative of Kaiser Permanente also provided comments on the bill.

Written comments in support of the bill were provided by representatives from the DMHMRSAS, the Association of Virginia Early Intervention Programs, the Speech and Hearing Association of Virginia, the Virginia Occupational Therapy Association, the Virginia Physical Therapy Association, the Richmond Area Association for Retarded Citizens, Parent-Infant Program with Henrico Area Mental Health and Retardation Services, the Virginia Chapter of the American Academy of Pediatrics and The Virginia Pediatric Society, Family Practice Associates, Inc., Children's Hospital, Henrico Area InterAgency Coordinating Councils, The Children's Center and fourteen interested families. In addition, the VAHMO, the Virginia Chamber of Commerce, Trigon Blue Cross Blue Shield, and the Virginia Manufacturers Association submitted comments in opposition to House Bill 2715.

The Advisory Commission concluded its review of House Bill 2715 on August 27, 1997.

SUMMARY OF PROPOSED LEGISLATION

The bill requires an accident and sickness insurance policy to provide coverage for medically necessary early intervention services. The bill applies to individual and group policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis and subscription contracts and health care plans provided by health maintenance organizations. The bill applies to policies, contracts and plans delivered or issued for delivery or renewal after July 1, 1997. The bill does not apply to short-term travel, accident

only, limited or specified disease policies, or to short-term nonrenewable policies of less than six months.

The bill defines "early intervention services" as medically necessary services provided through Part H of the federal Individuals with Disabilities Education Act (IDEA) designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. The bill provides that "medically necessary services" are those services designed to help an individual attain or retain the capability to function appropriately within his environment, and shall include services which enhance functional ability without effecting a cure. Provision of these services shall include speech and language therapy, occupational therapy, physical therapy, psychological counseling, and adaptive equipment.

The patron of the bill submitted amended language for consideration by the Advisory Commission. The amended bill includes three changes. It clarifies which early intervention services are to be covered by limiting the bill to medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices. The amended bill limits children eligible to receive coverage for these services to those certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. The amended bill also clarifies that the definition of "medically necessary services" is to be applied only to the limited services for eligible children.

PRIOR REVIEW OF THIS ISSUE

The Joint Subcommittee Studying Early Intervention Services for Handicapped Infants and Toddlers authored a report pursuant to 1991 House Joint Resolution No. 380. The report was published as 1991 House Document No. 59. The subcommittee found that early intervention services were of vital importance, would prevent or mitigate numerous problems and the subcommittee endorsed Virginia's continued participation in Part H of the IDEA. Part H is a discretionary five-year federal grant program that provides early intervention services to infants and toddlers with disabilities and their families. The IDEA provides a program for states to plan, develop and implement a statewide comprehensive, coordinated, interagency system of early intervention services. The subcommittee recommended full implementation of Part H to increase the availability and accessibility of services. The subcommittee found that early intervention would prevent the development of more serious and costlier

problems, and found the Part H Program to be a unique and useful program with the potential to benefit disabled children and their families.

On June 4, 1997, President Clinton signed Public Law 105-17, the reauthorization of the IDEA, effective July 1, 1998. One of the changes is the organizational structure of the law. Instead of the previous Parts A-H (Part H referenced infants and toddlers with disabilities), the new IDEA has Parts A-D, and Part C refers to infants and toddlers with disabilities.

EARLY INTERVENTION SERVICES

The IDEA early intervention program entitles eligible children and their families to certain services. Early intervention services include the following:

- *Multidisciplinary evaluation and assessment* by two or more professionals (therapists, physicians, educators, social workers, etc.) and the child's family;

- *Individualized Family Service Plan (IFSP) process* involves negotiation among team members, including the family, regarding outcomes and services that meet the developmental needs of the child and the needs of the family related to enhancing the child's development;

- *Service coordination* to assist and enable eligible children and their families to receive the rights, procedural safeguards, and the service that are needed;

- *Mediation and due process*, available if family members and staff disagree as to eligibility or appropriate services; and

- *IFSP services,* once a child is determined eligible for Part H (see Appendix B), an IFSP team will determine which services are deemed necessary for that individual child and family. Services can include:

* physical therapy
* speech-language pathology
* assistive technology devices and services
* service coordination services
* transportation and related costs
* family training, counseling and home visits
* nutrition services
* medical services (for diagnosis/evaluation only)
* occupational therapy
* audiology
* psychological services
* social work services
* vision services
* special instruction

Sections 2.1-760 through 2.1-768 of the Code of Virginia provide the framework for Virginia's Early Intervention Services System and charge the participating state agencies with the following: establishing a statewide system

of early intervention services in accordance with state and federal statutes and regulations; identifying and maximizing coordination of all available public and private resources for early intervention services; and developing and implementing formal state interagency agreements that define the financial responsibility and service obligations of each participating agency for early intervention services. The responsibilities of the agencies also include: establishing procedures for resolving disputes and addressing any additional matters necessary to ensure collaboration; consulting with the lead agency in the promulgation of regulations to implement the early intervention services system, including developing definitions of eligibility and services; carrying out decisions resulting from the dispute resolution process; providing assistance to localities in the implementation of a comprehensive early intervention services system in accordance with state and federal statutes and regulations; and requesting and reviewing data and reports on the implementation of early intervention services from counterpart local agencies.

DMHMRSAS is the lead agency for administering Virginia's Early Intervention Services System. In addition, the following agencies participate in the implementation of Part H: Department of Health (VDH), Department of Education (DOE), Department of Social Services (DSS), Department for the Visually Handicapped (DVH), Department of Medical Assistance Services (DMAS), Department for the Deaf and Hard-of-Hearing (VDDHH), the Department for the Rights of Virginians with Disabilities (DRVD), and the Bureau of Insurance of the State Corporation Commission.

The mission of the Virginia Interagency Coordinating Council (VICC) is to promote and coordinate early intervention services in the Commonwealth as required by Part H of the IDEA. Members of the VICC include parents, providers of early intervention services and state agency representatives working together to advise and offer guidance in planning the comprehensive system of early intervention in order to enhance the capacity of families to meet the needs of their infants and toddlers with disabilities. The DMHMRSAS provides staff support to the VICC and the five VICC subcommittees. The subcommittees of the VICC are: (1) family support and advocacy (2) public awareness (3) local/regional direct services (4) personnel training and development and (5) administrative. Virginia's Early Intervention Services consists of forty local interagency coordinating councils (LICCs). LICCs enable early intervention service providers to establish working relationships that increase the efficiency and effectiveness of early intervention services. LICC members include parents, service providers, and local representatives of the participating state agencies.

SOCIAL IMPACT

Virginia's efforts to identify and serve all Part H eligible children and their families have contributed significantly to the increasing number of children receiving early intervention services. DMHMRSAS estimated in 1997 that 9,189 infants and toddlers with disabilities and their families are potentially eligible to receive IDEA early intervention services annually. Virginia served 4,430 infants and toddlers under IDEA early intervention programs in 1996, representing 48% of all potentially eligible children and families. The primary service settings for the children and families receiving Part H services are their homes or early intervention centers or classrooms.

FINANCIAL IMPACT

During a November 25, 1996 meeting of the Joint Subcommittee, Studying Early Intervention for Infants and Toddlers with Disabilities (HJR 511), two speakers addressed the effects of private insurance reimbursement on the Part H system for early intervention services in Virginia. The speakers stated that private insurance companies are limiting coverage for children with developmental disabilities. The limits include exclusions due to developmental disability, lifetime maximums, and no coverage for Part H free-to-family services. These limitations are viewed as shifting the costs to local governments and as a result early intervention services are delayed due to their high cost. The speakers recommended insurance reimbursement for medically-necessary Part H services (occupational therapy, physical therapy, speech therapy, and psychological counseling) and that the cost of early intervention services not be applied toward the child's lifetime maximum.

The local early intervention service providers have reported that an increasing number of private health insurers are denying coverage of or imposing limitations on medically necessary early intervention services due in part to the existence of the federal IDEA Early Intervention Program.

According to data reported by the local Part H council, it is estimated that the average annual cost per child in the IDEA early intervention program is $2,100 for physical therapy, occupational therapy, speech and language therapy, and assistive technology devices.

CURRENT INDUSTRY PRACTICES

The State Corporation Commission's Bureau of Insurance surveyed fifty of the top writers of accident and sickness insurance in Virginia regarding House Bill 2715. Thirty-five companies responded by the deadline of May 2, 1997. Five insurers indicated that they write little or no applicable health insurance policies in Virginia and, therefore, could not provide the information requested. Of the thirty companies responding to the survey, ten reported that they currently provide the coverage required by House Bill 2715.

Respondents to a Bureau of Insurance survey provided cost figures that ranged from $.01 to $1.00 per month per standard individual policyholder and from $.23 to $1.00 per month per standard group certificate holder to provide the coverage required by House Bill 2715. Insurers providing coverage on an optional basis provided cost figures between $.73 and $5.00 per month per individual policyholder and between $.24 and $5.00 per month per group certificate holder for the coverage.

In its written comments on this subject, Guardian Life Insurance Company of America stated that coverage for early intervention services is provided as long as it is medically necessary. The company noted the cost of this coverage represents all mental health, durable medical equipment, occupational, physical and speech therapy claims of children aged 3 years or younger. Two companies responded that reimbursement for early intervention services is provided if medically necessary, and the provider of the service is licensed in the state and acting within the scope of that license.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners and the National Insurance Law Service, two states (Connecticut and Massachusetts) currently require coverage for early intervention services. New York has provisions regarding early intervention services but not a mandate.

Connecticut requires coverage for at least five thousand dollars annually for medically necessary early intervention services provided as part of an individualized family service plan (a written plan for providing early intervention services to an eligible child and the child's family).

Massachusetts requires coverage for eligible persons for appropriate medically necessary early intervention services including occupational, physical and speech therapy, nursing care and psychological counseling; provided, however, that the determination of appropriate medical necessity shall be made

by the dependent's primary care physician. The amount insurers are required to reimburse for costs of such early intervention services is subject to a maximum benefit of $3,200 per year per child and an aggregate benefit of $9,600 over the total enrollment period.

New York requires that municipalities providing early intervention services maximize access to third-party reimbursement where it is available. The insurance law in New York prohibits insurers issuing accident and health insurance policies from charging against any maximum, annual or lifetime limits benefits paid for early intervention services provided to a covered person as a part of an IFSP.

REVIEW CRITERIA

SOCIAL IMPACT

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

DMHMRSAS estimated in 1997 that 9,189 infants and toddlers with disabilities and their families are potentially eligible to receive IDEA early intervention services annually. Virginia served 4,430 infants and toddlers under IDEA early intervention programs in 1996, representing 48% of all potentially eligible children and families.

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

A 1997 survey of early intervention programs estimated that 22.4% of all children and families received early intervention services under the IDEA have health insurance. It was reported that only 41.7% of the children covered by private health insurance are in commercial plans governed by state law, and 58.3% are in commercial plans governed by the federal Employee Retirement Income Security Act (ERISA) and not by state law.

In a 1997 State Corporation Commission Bureau of Insurance survey of the top fifty writers of accident and sickness insurance in Virginia, thirty companies currently writing applicable business in Virginia responded. Of that number, ten companies (33%) already provide the coverage required by House Bill 2715.

In written comments on this subject, Guardian Life Insurance Company of America stated that the coverage for early intervention services is provided as

long as it is medically necessary. Two additional companies indicated that reimbursement for early intervention services is provided if medically necessary, and the provider of service is licensed in the state and acting within the scope of that license.

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 stated that early intervention services deemed to be developmentally necessary must be provided under IDEA to all eligible children and families, regardless of whether or not the family possesses insurance coverage for these services or whether their private health insurers or health maintenance organizations (HMO) reimburse for these services. However, the lack of insurance coverage can delay the receipt of services.

The federal IDEA early intervention funds may be used to pay for services after all other potential public (including local and state) funds and private (including private insurance, donations, and family fees) funds have been accessed. IDEA early intervention funds may not be used to satisfy a financial commitment for services that would otherwise have been paid from another public or private source but for the enactment of IDEA.

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.*

Proponents stated that when there are families without private health insurance or with private health insurance that does not cover medically necessary IDEA early intervention services, localities determine the family's portion of costs using ability to pay mechanisms such as sliding fee scales. In many instances, the amount the family owes based on this method exceeds the co-payment amounts required of families whose private health insurance covers these services. This places a greater financial burden on such families in terms of out-of-pocket expenses.

In written comments, one insurer noted that by accepting federal funds, the state assumed the obligation to pay for early intervention services, at least some of which apparently go beyond the traditional coverage of health insurance.

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

Data for 1995 demonstrated that approximately 32% of all infants and toddlers served under IDEA early intervention programs received occupational therapy services, 53% received physical therapy services, 42% received speech-language pathology services, and 3% received assistive technology services and/or devices.

Assuming that these percentages remain fairly constant and that all potentially eligible children were served, approximately 2,940 would need occupational therapy, 4,870 would need physical therapy, 3,859 would need speech-language pathology services, and 276 would need assistive technology services and/or devices.

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

DMHMRSAS estimated in 1997 that 9,189 infants and toddlers with disabilities and their families are potentially eligible to receive IDEA early intervention services annually. Virginia served 4,430 infants and toddlers under IDEA early intervention programs in 1996, representing 48% of all potentially eligible children and families.

Proponents expressed concern that approximately ten years ago, third-party payers were partners in seeing that young children with disabilities received the necessary services to assist them in gaining the skills they needed to move, communicate and learn. At that time, approximately 80% of the services were reimbursed. Currently, insurers have gradually decreased coverage for children receiving Part H services down to approximately 20% of the services billed.

Parents report seeing stricter limitations on coverage. For example, one insurer will only approve physical therapy for a period of 90 days. Proponents argued that a 90-day coverage per incident per lifetime may be appropriate for an adult recovering from a stroke; however, it is not appropriate for a child with a disability. Parents also reported denials based on medical necessity.

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.

The Joint Subcommittee Studying Early Intervention Services for Handicapped Infants and Toddlers authored a report pursuant to 1991 House Joint Resolution No. 380. The report was published as 1991 House Document No. 59. The subcommittee found that early intervention services were of vital importance, would prevent or mitigate numerous problems and the subcommittee endorsed Virginia's continued participation in Part H of the IDEA.

The subcommittee recommended full implementation of Part H to increase the availability and accessibility of services. The subcommittee found that early intervention would prevent the development of more serious and costlier problems, and found the Part H Program to be a unique and useful program with the potential to benefit disabled children and their families.

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 House Bill 2715 would either increase or decrease the cost of early intervention services.

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

In written comments, DMHMRSAS stated that the definition of House Bill 2715 includes a requirement of medical necessity. The medical necessity requirement provides consistency of interpretation and limitations of coverage. The appropriate use of services might increase, but the inappropriate treatment would not. The definition of medical necessity also has the potential of promoting overall cost savings.

Opponents raised concerns that the bill contained vague language such as "designed to help," "function appropriately within his/her environment," "enhance functional ability without effecting a cure." Opponents believed that the wording of House Bill 2715 would spawn disputes between enrollees, providers, and insurers. Opponents contend that the extent of the services is

broad, the duration is indefinite, and the exemption from the lifetime cap is particularly inappropriate.

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

Proponents stated that insurance coverage for the provision of these services through the early intervention program may help to reduce or eliminate the inappropriate or unnecessary use of more costly methods, such as in-patient hospitalizations and institutionalization, which insurance is more likely to cover.

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 services may increase if coverage for early intervention services causes an increase in utilization of the services. However, the number of insureds needing such services 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.*

Respondents to a Bureau of Insurance survey provided cost figures that ranged from $.01 to $1.00 per month per standard individual policyholder and from $.23 to $1.00 per month per standard group certificate holder to provide the coverage required by House Bill 2715. Insurers providing coverage on an optional basis provided cost figures between $.73 and $5.00 per month per individual policyholder and between $.24 and $5.00 per month per group certificate holder for the coverage.

An increase in the administrative expenses of insurance companies is anticipated because of the expenses associated with such things as policy redesign, form filings, claims processing systems and marketing, and other administrative requirements.

Opponents of the bill stated that "medically necessary" is a broad term with no defined limits. With no regulatory oversight proposed in the legislation, such terminology leaves health care insurers with no protection from the assessments of the early childhood intervention industry. Opponents believe that the cost of coverage will be affected.

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

Proponents believe that the total cost of health care will decrease because of the provision of medically necessary early intervention services. Proponents believe that failing to emphasize the importance of these services and their benefits may result in higher costs to insurers in the long run.

Proponents stated that over the past decade, a shift from remedial care to preventive care has been emphasized. Proponents believe that preventing serious conditions that require long-term care and more costly treatments is a better approach to overall health and well-being, resulting in greater cost savings.

Opponents noted in written comments that the language in the bill prohibits insurers and HMOs from applying the costs for the benefits provided to an insured or enrollee's contractual lifetime maximum. This could add to the total cost of health care.

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 stated in written comments that in the context of infants and toddlers with disabilities, occupational therapy is therapeutic intervention using purposeful activity to develop or achieve the highest possible level of independence. Physical therapy serves to identify, assess, evaluate, and treat disabling movement disorders. These disorders may be the result of a congenital or genetic condition, birth trauma, injury or illness. The goal of physical therapy is to minimize the inability to perform functional, developmental activities in a typical manner. Speech and language therapy is the use of assessment, evaluation and facilitation of purposeful activities to develop or achieve the highest possible level of communication. Assistive technology devices are those that are prescribed or recommended by the treating physician or therapist and enhance development or assist the child in engaging in activities of daily living more independently.

Physicians surveyed report these therapies, devices and services have the following outcomes: prevention of contractures and deformities (69%); increased endurance for physical activity (63%); improved postural alignment (49%); prevention of the need for orthopedic surgery (19%); maintained

functional abilities (69%); improved feeding (50%); increased rate of motor milestone attainment (32%); improved fine motor skills (30%); increased cognitive development (17%); increased independence (86%); and increased the ability to profit from educational experiences at school (61%).

No information was received that questioned the medical efficacy of the proposed coverage.

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 2715 addresses a medical need and is consistent with the role of health insurance. The coverage would help an individual attain or retain the capability to function appropriately within his environment. It includes services which enhance functional ability without effecting a cure.

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

Opponents believe that the continual mandating of additional benefits is not good public policy and can have the ultimate effect of making health care too costly for individuals and small businesses least able to afford it.

Opponents also believe that the effect of this legislation would shift the financial burden of an obligation from the state to that portion of the health insurance system subject to state regulation.

Proponents believe that the cost of the mandate is not considered expensive, particularly when compared to the benefits provided and the need for the early provision of treatment.

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

Proponents state that a relatively small percentage of all infants and toddlers will actually have a disability necessitating this kind of coverage, and most families would probably not request the coverage if it was optional. When a child needing early intervention services is born, the family could be faced with waiting for an open enrollment period to change their coverage. Those individuals covered under group contracts may not have the opportunity to accept or reject the coverage because the group policyholder, most often the employer, would make the decision.

RECOMMENDATION

The Advisory Commission voted (6 - No, 4 - Yes) on August 27, 1997 against recommending passage of House Bill 2715.

CONCLUSION

The Advisory Commission concluded that based on the information received during its review, some coverage for early intervention services is available. A mandate of coverage passed in Virginia may reach less than half of the insured children now receiving early intervention services because Virginia insurance laws would not be applicable to many of the policies providing coverage to those receiving services. Concerns were also raised regarding language in the bill to prohibit the policy or lifetime maximums from applying to the mandated coverage.

978045148

HOUSE BILL NO. 2715

Offered January 20, 1997

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 38.2-3418.3, relating to accident and sickness insurance; coverage for early intervention services.

Patrons—Christian, Bennett, Bloxom, Crittenden, Darner, Deeds, Grayson, Hargrove, Johnson, Jones, D.C., Jones, J.C., Keating, Lovelace, Moore, Morgan, Phillips, Plum, Puller, Putney, Robinson, Shuler, Spruill and Woodrum; Senators: Lambert, Marsh and Miller, Y.B.

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 38.2-3418.3 as follows:

§ 38.2-3418.3. Coverage for early intervention services.

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 for medically necessary early intervention services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1997.

B. For the purpose of this section, "early intervention services" means medically necessary services provided through Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.) designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. "Medically necessary services" are those services designed to help an individual attain or retain the capability to function appropriately within his environment, and shall include services which enhance functional ability without effecting a cure. Provisions of these services shall include speech and language therapy, occupational therapy, physical therapy, psychological counseling, and adaptive equipment.

C. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

D. 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, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, *38.2-3418.3*, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 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.

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

APPENDIX B

Eligibility for Early Intervention Services in Virginia

I. Infants and toddlers with at least a 25% developmental delay in one or more of the following areas:

1. **cognitive development** (thinking skills);
2. **physical development** (including the way muscles work, vision and hearing);
3. **communication** (understanding what is said or communicating what is wanted);
4. **social or emotional development** (ability to interact with others and express feelings); or
5. **adaptive development** (doing things independently like eating and helping to dress self).

OR

Children without a 25% developmental delay who are developing atypically in:

1. **sensory-motor responses** (muscle tone, limitations in joint range of motion, atypical reflexes, poor quality of movement patterns or skill performance, oral motor difficulties including feeding)
2. **emotional development** (delay in achieving expected emotional milestones, social interactions, or distress that does not respond to comforting by caregivers)
3. **behavioral disorders** that interfere with the acquisition of developmental skills.

OR

II. Children who have a diagnosed physical or mental condition with a high probability of resulting in a developmental delay even though no delay currently exists. These include, but are not limited to:

1. seizures/significant encephalopathy;
2. significant central nervous system anomaly;
3. severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage;
4. symptomatic congenital infection;
5. effects of toxic exposure to alcohol or drugs;
6. myelodysplasia;
7. hearing loss;
8. visual disability;
9. chromosomal abnormalities, including Down's Syndrome;
10. brain or spinal cord trauma;
11. inborn errors of metabolism;
12. microcephaly;
13. severe attachment disorder;
14. failure to thrive; or
15. at the discretion of the multidisciplinary team, other physical or mental conditions.

HB-2715
Amendment in the Nature of a Substitute

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 38.2-3418.3 as follows:

§ 38.2-3418.3. Coverage for early intervention services.

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 for medically necessary early intervention services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

B. For the purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. §1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance

Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

C. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer, corporation or health maintenance organization to or on behalf of the insured or member during the insured's or member's lifetime.

D. 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, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3418.3, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, 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 an 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 or accept applications from an employee who does not reside within the health maintenance organization's service area.