REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR INFANT HEARING SCREENINGS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 20

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH OF VIRGINIA

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SENATE

December 3, 1999

To: The Honorable James S. Gilmore, III
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 access the social and financial impact and the medical efficacy of 1999 Senate Bill 1043 regarding mandatory coverage of for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

Respected submitted,

Stephen H. Martin
Chairman
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INTRODUCTION

During the 1999 Session of the General Assembly, the Senate Committee on Commerce and Labor referred 1999 Senate Bill 1043 (SB 1043) to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). Senate Bill 1043 is patroned by Senator J. Randy Forbes.

The Advisory Commission held a hearing on June 1, 1999 in Richmond to receive public comments on SB 1043. In addition to the patron, seven speakers addressed the proposals. Representatives from the Virginia Society of Otolaryngology and Neck Surgery, the Virginia Speech and Hearing Association, the Children's Hearing Association, the Virginia Hospital and Healthcare Association (VHHA), and two concerned citizens spoke in favor of the bill. In addition, written comments in support of the bill were provided by VHHA, the Children's Hearing Foundation, the Children's Hospital for King's Daughters, and a concerned citizen. A representative of the Virginia Perinatal Association also provided comments on the bill.

The Advisory Commission concluded its review of SB 1043 on June 30, 1999.

SUMMARY OF PROPOSED LEGISLATION

Senate Bill 1043 amends § 38.2-4319 and adds § 38.2-3418.3 to the Code of Virginia in the chapter on accident and sickness insurance. The bill requires 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 subscription contracts; and each health maintenance organization providing a health care plan for health care services to provide coverage for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

The bill applies to contracts, policies, and plans delivered or issued for delivery or renewed after July 1, 1999. The bill does not apply to short-term travel, accident only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

The bill also amends § 2.1-20.1 of the Code of Virginia that addresses health coverage for state employees. The bill requires that state employee plans include coverage for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

The bill also amends § 32.1-325 of the Code of Virginia that applies to coverage provided by medical assistance services. The bill requires that the plan include a provision for payment of medical assistance for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

Some medical testing for children is already the subject of a mandated offer of coverage. Section 38.2-3411.1 of the Code of Virginia currently requires insurers to make available to individual or group accident and sickness insurance policyholders, as an option, coverage for child health supervision services. The term "child health supervision services" is defined as the periodic review of a child's physical and emotional status, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests. Coverage must include such services rendered at birth and ages two, four, six, nine, twelve, fifteen, and eighteen months and two, three, four, five, and six years. Child health supervision services cannot be subject to any copayment, coinsurance, deductible, or other dollar limit provision. In developing the premium rate charged for this coverage, insurers are required to take into consideration the expected cost of coverage, potential costs savings as a result of such coverage, a reasonable profit, and any other relevant information or data deemed appropriate by the State Corporation Commission. Finally, insurers or health services plans having fewer than 1,000 covered individuals in Virginia or less than $500,000 in premiums in Virginia are not required to offer and make available child health supervision services coverage.

BACKGROUND INFORMATION

During the 1998 Session of the General Assembly, House Bill 916, Senate Bill 585, and Senate Bill 591 were passed. They amended and reenacted §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia, relating to the Virginia Hearing Impairment Identification and Monitoring System. The bills require that the Virginia Hearing Impairment Identification and Monitoring System be revised to identify hearing loss at the earliest possible age among newborns and to provide early intervention for all infants identified as having a hearing impairment. The bills require all hospitals with neonatal intensive care services to provide all infants with a hearing screening test, whether or not the infant is at risk of hearing impairment, effective July 1, 1999. The screening would take place before the infant is discharged from the hospital. The bills also require hearing screening tests for all infants born in all hospitals, effective July 1, 2000.

In 1982, the Joint Committee on Infant Hearing and the American Academy of Pediatrics issued a "position statement" recommending identification of infants at risk for hearing loss in terms of specific risk factors and suggested a follow-up audiologic evaluation. In 1990, the position statement was modified to expand the list of risk factors and recommend a specific hearing screening

protocol. The 1994 position statement endorsed the goal of universal detection of infants with hearing loss as early as possible. The revised position statement recommended that all infants with hearing loss should be identified before three months of age and receive intervention by six months of age. The Joint Committee on Infant Hearing recommended the following factors to facilitate the establishment and maintenance of infant hearing programs: the development of a tracking system to ensure that newborns and infants identified with or at risk for hearing loss have access to evaluation, follow-up, and intervention services; systematic evaluation of techniques for identification and assessment, and intervention for hearing loss in infants; outcome studies to investigate the impact of early identification on the degree of literacy and communication competence achieved and to establish factors that contribute to outcome; and continued research into the prevention of hearing loss in newborns and infants.

INFANT HEARING SCREENINGS

The position statement developed by the American Academy of Audiology (AAA) stated that the hearing of every infant should be screened before discharge from the hospital. Infant hearing screenings would identify those infants who need comprehensive audiologic follow-up. The AAA recommended that if hearing screenings cannot be made available for all newborn infants, at least those infants who are "at risk" for hearing loss because of conditions of pregnancy or birth should receive hearing screening.

A number of crucial factors often associated with the presence of hearing loss in infants have been identified. These factors include a family history of childhood deafness, congenital infections, anatomical malformations of the head and neck, low birth-weight, hyperbilirubinemia, bacterial meningitis, and severe asphyxia with low APGAR (Appearance, Pulse, Grimace, Activity, and Respiration) scores. Infants with an atypical neonatal course, including all infants cared for in an intensive care nursery, should be routinely screened for hearing prior to discharge.

The AAA noted that hearing loss in children is silent because children, especially infants and toddlers, cannot tell us that they are not hearing well. It is a handicap because, if undetected and untreated, hearing loss in children can lead to delays in speech and language development, social and emotional problems, and academic failure. It is important to identify infants with hearing loss before three months of age, because normal hearing is critical for speech and oral language development as early as the first six months of life. The identification of a child's hearing loss is often delayed because parents are unaware that their child, even a newborn infant, can receive an accurate hearing test. The AAA recommended that parents should insist that their child receive a full audiologic evaluation if they are concerned about their child's response to sound or if their child suffers from frequent ear infections.

According to the National Institutes of Health (NIH) 1993 Consensus Statement entitled, "Early Identification of Hearing Impairment in Infants and Young Children," delayed identification and management of severe to profound hearing impairment may impede the child's ability to adapt to life in a hearing world or in the deaf community. The NIH reported that during the past 30 years, infant hearing screening has been attempted with a number of different test methods, including cardiac response audiometry, respiration audiometry, alteration of sucking patterns, movement or startle in response to acoustic stimuli, various behavioral paradigms, and measurement of acoustic reflexes.

According to William F. Dolphin, Ph.D., assistant professor in the Departments of Biomedical Engineering and Biology at Boston University in "Overview of Evoked Response Audiometric Techniques: Auditory Screening and Diagnostics Using OAE and AEP," the NIH considers the preferred model for hearing screening to be a two-stage testing procedure combining otoacoustic emissions (OAE) and the auditory brainstem responses (ABR). For maximum efficacy, a screening procedure should begin with an OAE test. Those who have failed the initial screening should receive an ABR test as soon as possible, ideally prior to discharge.

The OAEs have become increasingly popular for the initial screening of newborns in recent years. The OAEs provide valuable information on a patient's cochlear integrity and retrocochlear function and, therefore, have a wide variety of applications beyond simple auditory screening. The OAEs have been found to be highly reliable indicators of hearing loss. The OAEs are sounds generated within the cochlea by the outer hair cells. The OAEs are not echoes, but are sounds generated by active processes taking place within the cochlea of healthy ears in response to acoustic stimulation. When a sound stimulus enters the ear, a traveling wave is generated which propagates along the basilar membrane within the cochlea. The resultant displacement causes excitation of the inner and outer hair cells located along the length of the basilar membrane. Due to an active feedback process, excitation of the outer hair cells results in the emission of a response which travels in a reverse direction from the cochlea back to the ear canal where it is measured using a very sensitive microphone. The OAE testing is painless, takes only minutes to administer and is conducted while the baby sleeps.

The ABR testing is the gold-standard of evoked response audiometry and is the most widely used electrophysiological assessment technique for audiometric evaluation. When presented with a supra threshold acoustic stimulus, cells within the auditory pathway of a listener are excited. This excitation, which spreads from the peripheral to more central auditory structures, results in the discharge of large numbers of neurons within the pathway. If this neural activity is time-locked to an acoustic stimulus, the synchronized discharge of large neuronal assemblies produces electrical deflections which can be

recorded in the far field from the scalp surface. The ABRs are very short latency microvolt potentials evoked by acoustic stimuli. These potentials are recorded using computer average techniques with electrodes located centimeters from the active tissue. The ABR is a series of five to seven patterned and identifiable waves, usually evoked in response to clicks or short tone bursts. As neural excitation moves through the auditory pathway, from the nerve and at least through the midbrain, the resultant electrical potentials are measured from the scalp. The test is painless and takes approximately five minutes to administer to a quiet and cooperative baby. Babies that pass the ABR screening are discharged, but should be flagged for rescreen at three to six months. Babies that failed the ABR screen are referred for diagnostic evaluation. The purpose of the diagnostic evaluation is twofold: (1) to verify the existence and to determine the type and severity of hearing impairment; and (2) to initiate a remediation program for the child and family.

The 1994 position statement developed by the Joint Committee on Infant Hearing stated that when hearing loss is identified and evaluated, early intervention services should be provided in accordance with the Individuals with Disabilities Education Act (IDEA), Part C Public Law 102-119 (formerly PL 99-457). A multidisciplinary evaluation will be completed to determine eligibility and to assist in developing an individualized family service plan (IFSP) to describe the early intervention program. The multidisciplinary evaluation and assessment of an infant identified with a hearing loss should be performed by a team of professionals working in conjunction with the parent or caregiver. The professionals include, depending on the needs of the individual, a physician with expertise in the management of early childhood otologic disorders, a speech-language pathologist, an audiologist, and a sign language specialist. The audiologist should have expertise in the assessment of infants and young children to determine type, degree, symmetry, stability, and configuration of hearing loss, and to recommend amplification devices appropriate to the child's needs such as hearing aids, personal frequency modulation systems, vibrotactile aids or cochlear implants. The team will develop a program of early intervention services (an IFSP) based on the child's unique strengths and needs that is consistent with the family's resources, priorities, and concerns related to enhancing the child's development.

SOCIAL IMPACT

In 1988, the AAA reported that in the United States, one child in 1,000 will be born with profound deafness and two additional children in 1,000 will acquire deafness in early childhood. They noted that infants who need intensive medical care in the newborn period are at particular risk for hearing loss and that one child in fifty in intensive care nurseries is hearing impaired. It is estimated that 10% of all children will develop transient hearing loss related to ear infections, the most common infectious disease of childhood, during the period from birth

through eleven years of age. The AAA reported that 10% to 15% of children who were administered hearing screenings at school failed because they could not hear within normal limits.

Information provided to staff by the Virginia Department of Health (VDH), Division of Child and Adolescent Health, estimated that 250 to 500 children are born each year in Virginia with a hearing loss. They reported that there are 70 hospitals with birthing facilities, including three military facilities, located in Virginia. Thirty-three of the 67 hospitals, excluding military facilities, screen all infants prior to discharge.

Information provided to staff by the Virginia Department for the Deaf and Hard of Hearing indicated that there were 563,434 individuals with severe hearing loss residing in Virginia in 1995, of whom 65,515 were considered to be profoundly deaf. Hearing impairment is twenty times more prevalent than other birth defects such as phenylketonuria (PKU), sickle cell anemia, and hypothyroidism for which screenings are routinely conducted at birth.

FINANCIAL IMPACT

During a 1998 teleconference, Scott Grosse, Ph.D. of the CDC provided the VDH with cost implications of Universal Newborn Hearing Screening in Virginia. He projected that the cost of hearing screenings in Virginia would range from $15 to $30 per infant. Six providers were contacted and provided cost figures for an ABR and OAE testing. The costs ranged from $119 to $325 for an ABR test and $50 to $185 for an OAE procedure. The cost of one hearing aid can range from $600 to $3,000.

The Executive Board of the Educational Audiology Association (EBEAA) provided a 1994 comparison of the annual cost of regular education and special education for children in the state of Colorado who have identified hearing impairments. The cost of educating a child with a hearing loss in a regular education setting with no special education services was $4,065. The cost of educating a child with a hearing loss in the most restrictive setting of a residential school was $31,139. The costs for serving a child from birth through two years of age in a statewide early home intervention program or a special education preschool were $2,600 and $8,194 respectively.

The "1996 Position Statement of the Directors of Speech and Hearing Programs in State Health and Welfare Agencies" stated that it is well recognized that the early identification of congenital hearing loss is paramount to normal speech and language, psychosocial, academic, and vocational development in children. In that position statement, the National Institute on Deafness and Other Communication Disorders reported that hearing, speech and language disorders cost the United States economy an estimated $30 billion annually in lost

productivity, special education, and medical expenses. The preventive and early intervention activities, such as the early detection of hearing loss, according to this report, have the potential to eliminate approximately 25% of those annual expenditures.

CURRENT INDUSTRY PRACTICES

The State Corporation Commission's Bureau of Insurance recently surveyed fifty of the top writers of accident and sickness insurance in Virginia regarding each of the bills to be reviewed by the Advisory Commission this year. Twenty-nine companies responded by April 9, 1999. Five indicated that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested. Of the 24 respondents that completed the survey, 10 reported that they currently provide the coverage required by SB 1043.

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.04 to $1.00 per month per standard individual policyholder and from $.04 to $1.00 per month per standard group certificate to provide the coverage required by SB 1043. Insurers providing coverage on an optional basis provided cost figures of $.34 to $3.00 per month per individual policyholder and from $.05 to $3.00 per month per group certificate holder for the coverage.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners and the National Insurance Law Service, three states currently require coverage for infant hearing screenings. Indiana requires state employee health plans, insurance policies, and group contracts that provide maternity benefits to pay for the tests required under the newborn screening programs, such as infant hearing loss testing. Indiana also established the Newborn Hearing Screening and Intervention Advisory Board to provide advice and recommendations on issues concerning hearing impairments. Maryland requires certain carriers to provide coverage for the hearing screening of newborns provided by a hospital before discharge. Massachusetts requires coverage for the cost of hearing screening tests to be performed before an infant is discharged from a hospital or birthing center.

Eleven states, including Virginia, have passed some type of legislation to require that all infants receive a hearing screening prior to discharge from the hospital.

California requires the Department of Health Services, in consultation with a representative of participating neonatal intensive care units, to establish a system to screen all newborns and infants for hearing loss. The state wants to create and maintain a system of assessment and follow-up services for newborns and infants identified by the screenings in approved neonatal intensive care units participating in the California Children's Services Program.

Colorado required all hospitals to implement a program by July 1, 1997 to educate parents of newborns about the importance of early identification of hearing loss followed by appropriate intervention. The state encourages all hospitals to implement hearing screenings voluntarily for all newborns.

Connecticut requires the Department of Health to implement and operate a program of early identification of infant hearing impairment based on risk factors. Parents are to be notified of such infants at risk, be informed about resources available for further testing and treatment, and be made aware about financial assistance available through the Department of Health Services. The state requires any health care institution providing childbirth services to include newborn hearing screenings as a part of its standard care by July 1, 2001.

Hawaii requires the Department of Health to provide a statewide comprehensive and coordinated interdisciplinary program of early hearing impairment screening, identification, and follow-up for children and their families. The plan applies to children from birth to 36 months of age.

Kansas requires that every child born be administered a screening examination for detection of significant hearing loss. The test must be given three to five days after normal births and five to eight days after premature births, unless a different time period is medically indicated. The informed consent of parents or guardians is necessary for the examination.

Mississippi requires all newborn children in a hospital to be evaluated to determine if any child has a hearing impairment. The State Department of Health is required to track all infants who do not pass the newborn screening test, to establish an advisory committee, and to assure the best possible outcome for infants and toddlers identified through the program.

Rhode Island requires every newborn infant to be evaluated for the detection of a hearing impairment. The cost of the testing is paid to the Department of Health by the hospital or health care facility where the birth occurred.

Utah created an Advisory Committee for Identification of Infant Hearing Loss and requires hospitals to evaluate every newborn infant for detection of hearing loss using auditory brainstem response, evoked otoacoustic emissions, or other approved technology approved by the advisory committee.

West Virginia requires every newborn infant to be evaluated for the detection of a hearing impairment using procedures approved by the State Division for Health.

Wyoming requires that every newborn be given medical examinations for detection of major hearing defects. The examinations must be given three to five days after normal births and five to eight days after premature births, unless a different time period is medically indicated. The informed consent of parents or guardians is necessary for the examination.

REVIEW CRITERIA

SOCIAL IMPACT

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

In 1988, the AAA reported that in the United States, one child in 1,000 will be born with profound deafness and two additional children in 1,000 will acquire deafness in early childhood. They noted that infants who need intensive medical care in the newborn period are at particular risk for hearing loss and that one child in fifty in intensive care nurseries is hearing impaired.

Information provided by the Virginia Department of Health (VDH), Division of Child and Adolescent Health estimated that 250 to 500 children are born each year in Virginia with a hearing loss. Information provided by the Virginia Department for the Deaf and Hard of Hearing, there were 563,434 individuals with severe hearing loss residing in Virginia in 1995, of whom 65,515 were considered to be profoundly deaf.

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

In a 1999 State Corporation Commission's Bureau of Insurance survey of the top fifty writers of accident and sickness insurance in Virginia, twenty-four companies currently writing applicable business in Virginia completed the survey. Of that number, ten companies (42%) provide the coverage required by SB 1043.

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.*

According to information provided by the VDH, its data (Virginia Hearing Impairment Identification and Monitoring System) is based on information that was reported to them voluntarily. There are no reporting requirements for persons performing follow-up screening or testing on infants and young children. The VDH indicated that based on its data, 49% of infants needed follow-up examinations for calendar year 1997 and 44% of infants needed follow-up examinations for 1998.

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 most auditory aids and speech therapy sessions are denied by the insurance companies, and parents find themselves postponing treatment for their hearing-impaired child. They believe that insurance companies need to realize the benefits of early intervention and provide coverage for audiological services and hearing aid devices, so that the parents will not postpone obtaining the best and earliest treatment available.

During a 1998 teleconference, Scott Grosse, Ph.D. of the CDC provided the VDH with cost implications of Universal Newborn Hearing Screening in Virginia. He projected that the cost of hearing screenings in Virginia would range from $15 to $30 per infant. Six providers were contacted and provided cost figures for an ABR and OAE testing. The costs ranged from $119 to $325 for an ABR test and $50 to $185 for an OAE procedure. The cost of one hearing aid can range from $600 to $3,000.

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

The Virginia Department of Health (VDH), Division of Child and Adolescent Health estimated that 250 to 500 children are born each year in Virginia with hearing loss. According to the Virginia Department for the Deaf and Hard of Hearing, there were 563,434 individuals with severe hearing loss residing in Virginia in 1995 and 65,515 were considered to be profoundly deaf.

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

Seven patients testified at the public hearing in favor of Senate Bill 1043. Proponents stated that without reasonable insurance coverage for infant hearing screenings and all necessary follow-up diagnostic audiological examinations, there is great risk of significant delay in appropriate diagnosis and subsequent treatment and intervention for hearing loss resulting in life-long irreversible problems for each hearing-impaired child.

The VHHA, representing the hospitals and health systems in Virginia, stated that with early intervention, children are prevented from having delays in language acquisition that could result in social, emotional, cognitive, and academic problems. The VHAA made the argument that society cannot depend on hospitals to absorb additional costs or the consumers' ability to pay out-of-pocket for these services.

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

No information was received from collective bargaining organizations addressing potential interest in negotiating privately for inclusion of this coverage in group contracts.

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.*

In 1996, the University of Colorado at Boulder (University) was awarded the Maternal and Child Health Improvement Grant for Universal Hearing Screening. Virginia, through the Department of Health, is one of seventeen states that will be working with the University over the next four years to achieve the goal of early identification, intervention and treatments of hearing loss.

A study by the University's Department of Speech, Language and Hearing Sciences, demonstrated positive outcomes in speech, language and cognitive development for infants with hearing losses who are identified before six months of age. Children demonstrated larger expressive vocabularies, higher expressive language scores, and higher language comprehensive scores than those whose hearing loss was identified after the age of six months.

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 the cost of treatments would increase or decrease over the next five years because of insurance coverage.

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

The appropriate use of the service may increase if insurance policies provide coverage for infant hearing screenings and all necessary follow-up diagnostic audiological examinations, especially follow-up testing performed on those infants that fail the initial screening.

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 of the bill make the argument that the testing for infant hearing screenings and all necessary follow-up diagnostic audiological examinations may be a substitute for more expensive services, including the cost of providing services for the hearing-impaired and residential schools for the deaf.

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.*

The number and type of providers of the mandated service are not expected to increase over the next five years as a result of this bill.

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 the administrative expenses for policyholders is anticipated because of the expenses associated with such things as policy redesign, form filings, claims processing systems, and marketing.

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

The National Institute on Deafness and Other Communication Disorders reported that hearing, speech and language disorders cost the United States economy an estimated $30 billion annually in lost productivity, special education, and medical expenses. The preventive and early intervention activities, such as the early detection of hearing loss, have the potential to eliminate approximately 25% of those annual expenditures.

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.

Dr. Dolphin stated that the OAE and ABR tests are complimentary and measure different aspects of hearing. The OAE provides valuable information on a patient's cochlear integrity and retrocochlear function and has a wide variety of applications beyond simple auditory screening. The ABR testing is the gold-standard of evoked response audiometry and is the most widely used electrophysiological assessment technique for audiometric evaluation.

A study was performed on the effects of early identification of hearing loss on the development and language abilities of deaf and hard-of–hearing infants. The study compared toddlers whose hearing loss was identified at or before six months of age with those whose hearing loss was identified after the age of six months. The results from the study indicated that children whose hearing loss was identified at or before six months of age demonstrated larger expressive vocabularies, higher expressive language scores, and higher language comprehensive scores than those whose hearing was identified after the age of six months.

According to the AAP, significant hearing loss is one of the most common major abnormalities present at birth and if undetected, it will impede speech, language, and cognitive development.

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.*

Senate Bill 1043 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 in a hearing world or in the deaf community.

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

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.04 to $1.00 per month per standard individual policyholder and from $.04 to $1.00 per month per standard group certificate to provide the coverage required by SB 1043. Insurers providing coverage on an optional basis provided cost figures of $.34 to $3.00 per month per individual policyholder and from $.05 to $3.00 per month per group certificate holder for the coverage.

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

In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insured.

RECOMMENDATION

The Advisory Commission voted unanimously (No – 0, Yes – 6) on June 30, 1999 to recommend that language requiring the benefits in SB 1043 be added in § 38.2-3411.1 of the Code of Virginia, regarding coverage for child health supervision services.

CONCLUSION

The Advisory Commission believes that it would be appropriate to add language to the existing requirements of an offer of coverage for child health supervision services to require those services to include infant hearing screenings and any necessary follow-up diagnostic audiological examinations.

The Advisory Commission concluded that based on the information received during its review, the costs for providing coverage for infant hearing screenings and all necessary follow-up diagnostic audiological examinations are not considered significant when compared to the costs of providing early intervention, special education programs, and residential schools for the deaf. It was demonstrated that medical costs increase with longer duration prior to identification of hearing loss and that educational costs increase significantly with the intensity of services.

990819657

SENATE BILL NO. 1043

Offered January 20, 1999

A BILL to amend and reenact §§ 2.1-20.1, 32.1-325 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to health care coverage; infant hearing screenings.

Patron—Forbes

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-20.1, 32.1-325 and 38.2-4319 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8 as follows:

§ 2.1-20.1. Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. a. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

b. In order to be considered a screening mammogram for which coverage shall be made available under this section:

(1) The mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

(2) The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

(3) The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics

and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. Such appeals process shall include a separate expedited emergency appeals procedure which shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care.

5. Include coverage for early intervention services. For 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 which enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. 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.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there may be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears.

12. Include coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American

Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. Include coverage for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and beneficiaries thereof. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $2,500 for the individual and an amount not in excess of $2,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for

the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma or breast cancer and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

9. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

10. A provision for payment of medical assistance for annual pap smears;

11. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

12. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

13. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the

purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen; ~~and~~

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast~~.~~*; and*

16. A provision for payment for medical assistance for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured. The Board shall also initiate such cost containment or other measures as are set forth in the appropriations act. The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

Before the Board acts on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, the Board shall examine the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

The Board's regulations shall incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

B. The Director of Medical Assistance Services is authorized to administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

C. The Director of Medical Assistance Services is authorized to enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

The Director may refuse to enter into or renew an agreement or contract with any provider which

has been convicted of a felony. In addition, the Director may refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

D. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

E. The Department shall include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

F. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by this subsection. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 38.2-3418.8. Coverage for infant hearing screening and related diagnostics.

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 such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999, for infant hearing screenings and all necessary follow-up diagnostic audiological examinations.

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

§ 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, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225,

38.2-229, 38.2-232, 38.2-305, 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, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 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, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 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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with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
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