REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR CHILDHOOD IMMUNIZATIONS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 21

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 766 regarding mandatory coverage for all routine and necessary immunizations for newborn children.

Respected submitted,

Stephen H. Martin
Chairman
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INTRODUCTION

During the 1998 Session of the General Assembly, the Senate Committee on Commerce and Labor referred Senate Bill 715 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). Senate Bill 715 was introduced by Senator Jackson E. Reasor, Jr. The Advisory Commission did not schedule any meetings in 1998 because appointments were not completed. During the 1999 Session, Senate Bill 715 was reintroduced as Senate Bill 766 (SB 766), and Senator John S. Edwards was the patron.

The Advisory Commission held a hearing on January 28, 1999 in Richmond to receive public comments on SB 766. In addition to the patron, five speakers addressed the proposals. Representatives of the Virginia Department of Health, Virginia Chapter of the American Academy of Pediatrics, Medical Society of Virginia, and a registered nurse spoke in favor of the bill. A representative of the Golden Rule Insurance Company also provided comments on the bill. In addition, written comments in support of the bill were provided by the Virginia Association of School Nurses and the Virginia Chapter of the National Association of Nurse Practitioners and Associates, and a representative of Williams, Mullen, Christian and Dobbins. In addition, the Virginia Manufacturers Associations (VMA) submitted comments in opposition to SB 766. On April 6, 1999, four additional speakers addressed the proposals. The Virginia Association of School Nurses and the Virginia Chapter of the National Association of Nurse Practitioners and Associates, and a representative of Williams, Mullen, Christian and Dobbins spoke in favor of the bill. Representatives of the VMA and the Virginia Association of Health Plans spoke in opposition to the measure.

The Advisory Commission concluded its review on April 6, 1999.

SUMMARY OF PROPOSED LEGISLATION

Senate Bill 766 amends § 38.2-4319 and adds § 38.2-3411.3 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 all routine and necessary immunizations for newborn children.

The bill requires that benefits shall apply to immunizations administered to each newborn child from birth to 36 months of age. The bill also requires that benefits shall not be subject to any deductible, copayment, coinsurance, or other dollar limit provision in the policy or plan. The exemption shall be expressly

stated on the policy, plan, rider, endorsement, or other attachment providing the coverage. The bill defines "routine and necessary immunization" as immunization against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Commissioner of Health.

According to information from the Virginia Department of Health (VDH), Division of Immunization, the Commissioner of Health would prescribe additional vaccines recommended by the U.S. Public Health Service, Advisory Committee on Immunization Practices (ACIP). Varicella is one example of a vaccine recently added to the recommended immunization schedule by the ACIP.

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.

IMMUNIZATIONS

Immunizations (shots) protect children from diseases, including diphtheria, tetanus (lockjaw), pertussis (whooping cough), polio, hepatitis B, measles, mumps, rubella (German measles), haemophilus influenzae type b (Hib), and varicella (chicken pox). These diseases remain a risk to children who have not been properly immunized. All of these immunizations need to be given before children are two years old in order for them to be protected during their most vulnerable period. The American Academy of Pediatrics (AAP) provides a recommended childhood immunization schedule (see Appendix B), and many vaccines are given in a series.

The diphtheria-tetanus-pertussis (DTP) or diphtheria-tetanus-acellular-pertussis (DTaP) vaccine is given in a series of five shots. Some children may

experience side effects as a result of these series of shots; those children may be cranky and have redness or swelling at the site of the shot and low-grade fevers.

According to the 1997 Red Book: Report of the Committee on Infectious Diseases (Red Book) by the AAP, diphtheria usually occurs as membranous nasopharyngitis or obstructive laryngotracheitis. These local infections are associated with a low-grade fever. Life-threatening complications of diphtheria include upper airway obstruction caused by extensive membrane formation, myocarditis, and neurologic problems such as vocal cord paralysis. Sources of infection include discharges from the nose, throat, eyes, and skin lesions of infected persons. Transmission results primarily from intimate contact with a patient or carrier. Illness is most common in low socio-economic groups living in crowded conditions. Immunization for children from age two months to the seventh birthday should include five doses of diphtheria vaccine (see Appendix B). The initial three doses are given as DTaP or DTP, administered at two-month intervals, commencing at approximately two months of age. A fourth dose is recommended six to twelve months after the third dose, usually at fifteen to eighteen months of age. A fifth dose of DTaP or DTP is given before school entry (kindergarten or elementary school) at four to six years of age.

Generalized tetanus is a neurologic disease, manifested by trismus and severe muscular spasms. It is caused by the neurotoxin produced by the anaerobic bacterium. Immunization for children from two months to the seventh birthday should include five doses of tetanus toxoid containing vaccine (see Appendix B). The initial three doses are given as DTaP or DTP vaccine, administered intramuscularly at two-month intervals, beginning at approximately two months of age. A fourth dose is recommended six to twelve months after the third dose, usually at fifteen to eighteen months of age. A fifth dose of DtaP or DTP is given before school entry (kindergarten or elementary school) at four to six years of age.

Pertussis begins with mild upper respiratory symptoms (catarrhal stage) and can progress to severe paroxysms of cough (paroxysmal stage), often with a characteristic respiratory whoop, followed by vomiting. Fever is absent or minimal. Infants born prematurely are particularly at increased risk of severe pertussis, resulting in hospitalization and sometimes death. The transmission occurs by close contact via respiratory secretions of patients with disease. A total of five doses of pertussis vaccine is recommended by school entry (see Appendix B). The first dose is given at two months of age, followed by two additional doses at intervals of approximately two months. The fourth dose is recommended at fifteen to eighteen months of age. The fifth dose is given before school entry (kindergarten or elementary school) at four to six years of age to protect these children from pertussis in ensuing years and to decrease transmission of the disease to younger children.

Polio is a disease that can paralyze some muscles of the body. Polio is spread by the fecal-oral and oral-oral (respiratory) routes. Infection is more common in infants and young children. The vaccine can be given by mouth or by injection as a series of four doses (see Appendix B). Currently, two poliovirus vaccines are licensed in the United States, inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). For children that are immunized with IPV only, the primary series consists of three doses. The first two doses should be given at one to two month intervals, beginning at two months of age (minimum age of six weeks). A third dose is recommended six to twelve months after the second dose. A supplemental dose of IPV should be given before the child enters school at four to six years of age. There are no common side effects other than redness or soreness at the site of the shot. For children that are immunized with OPV only, the first dose is administered when the infant is approximately two months old (minimum age of six weeks) and a second dose is given when the infant is four months old. A third dose is recommended when a child is six to eighteen months of age to complete the primary series. A supplementary dose of OPV should be given before the child enters school at four to six years of age.

Hepatitis B virus (HBV) is transmitted through blood or body fluids such as wounds, exudates, semen, cervical secretions, and saliva that are hepatitis B surface antigen (HbsAg) positive. Hepatitis B is a disease that can occur at any age and can lead to liver problems or even cancer. A combination of the Hepatitis B and Hib vaccine is now available and can be given as one vaccination series for infants who need both. The vaccine is given as a series of three shots beginning at birth (see Appendix B). Minor side effects of the shot include crankiness, soreness, and redness or swelling at the site of the shot.

The Hib vaccine protects infants against haemophilus influenzae type b, a major cause of spinal meningitis, a serious infection of the brain and spinal cord. It is given in a series of three or four shots (see Appendix B). The primary series consists of three doses given at two, four, and six months of age. A combination of the Hib and DTP vaccines is available and can be given as one vaccination series for infants who need both. A child may have redness or soreness at the site of the shot and may develop a mild fever.

The MMR vaccine protects against measles, mumps, and rubella. The diseases can cause rashes, swelling, and serious medical problems. The vaccine is given as a series of two shots. Reactions to the vaccine may include a mild rash, swelling of the lymph nodes in the neck or diaper area, low-grade fever, and drowsiness.

Measles is an acute disease characterized by fever, cough, coryza, conjunctivitis, an erythematous maculopapular rash, and a pathognomonic enanthem (Koplik spots). Measles is transmitted by direct contact with infectious droplets. Measles vaccine should be given in a MMR combination to children at

twelve to fifteen months of age (see Appendix B). A second dose of MMR is recommended at school entry at four to six years of age, in accordance with the recommendation for routine measles vaccination.

Mumps is a systemic disease, characterized by swelling of the salivary glands. However, approximately one-third of infections do not cause clinically apparent salivary gland swelling. The virus is spread by direct contact via the respiratory route and the infection occurs throughout childhood. Mumps vaccine should be given as MMR routinely to children at twelve to fifteen months of age (see Appendix B). A second dose of MMR is recommended at school entry at four to six years of age, in accordance with recommendations for routine measles vaccination.

Rubella is usually a mild disease, characterized by an erythematous, maculopapular, discrete rash, generalized lymphadenopathy, and slight fever. Rubella vaccine is currently recommended to be administered in combination with measles and mumps vaccine (MMR) when a child is twelve to fifteen months of age and at school entry at four to six years (see Appendix B).

Varicella is a highly contagious disease that can cause high fever and an uncomfortable rash. The primary infection results in chickenpox. Varicella vaccine is recommended when a child is twelve to eighteen months of age (see Appendix B). The vaccine may be given simultaneously with MMR vaccine, but separate syringes and injection sites must be used. Reactions to the shot may include redness or soreness at the site of the shot and a mild fever.

The Red Book states that a lapse in the immunization schedule does not require reinstitution of the entire series. If a dose of DTaP or DTP, poliovirus vaccine (IPV or OPV), Hib, or hepatitis B vaccine is missed, immunizations should be given at the next visit as if the usual interval had elapsed. The charts of children in whom immunizations have been missed or postponed should be flagged to remind health care providers to complete immunization schedules at the next available opportunity.

SOCIAL IMPACT

According to an article in the Journal of Rural Health, "Public-sector Immunization Coverage in 11 States: The Status of Rural Areas," reported that more than 30% of two-year olds in the United States have not received four doses of DTP vaccine, three doses of the polio vaccine, and one dose of the MMR vaccine. These vaccinations are referred to as the basic 4:3:1 immunization series by the Centers for Disease Control and Prevention (CDC). Economic issues affect immunization delivery through the increasing cost of vaccines and the availability of government funding to provide vaccines for indigent children. Provider-specific barriers include missed opportunities to

immunize children during office visits. Parental factors such as lack of knowledge about immunizations and misconceptions about adverse reactions are also factors in under-immunization.

The VDH, Division of Immunization stated that the National Immunization Survey conducted by the CDC for the period January 1, 1997 through December 31, 1997 reported that 73% of Virginia's two-year old children are appropriately immunized for their age.

The CDC, Morbidity and Mortality Weekly Report (MMWR) 1996, stated that after more than an eight-year interval without a documented, domestically acquired infection with toxigenic C. diphtheriae, an epidemic focus was found in an American Indian community in South Dakota in 1996 and two cases of diphtheria were reported.

The MMWR stated that in the United States, the 1996 goal for the number of cases of tetanus disease among children and adolescents aged less than fifteen years was zero. Of the 36 cases of tetanus reported in 1996, none were reported among children less than fifteen years of age.

Pertussis can occur at any age. The MMWR reported that 7,796 cases of pertussis occurred in 1996. The highest number of reported cases continues to be among children of age one year or less; however, pertussis cases among adolescents and adults are increasingly being reported to the CDC. In 1996, 44% of all reported pertussis cases occurred among persons older than ten years.

The MMWR stated that since 1980, a total of 143 confirmed cases of indigenously acquired paralytic poliomyelitis in the United States have been associated with oral polio vaccine. In September 1996, the CDC adopted the ACIP recommendations for a sequential vaccination schedule of inactivated poliovirus vaccine followed by oral poliovirus vaccine. Five cases of paralytic poliomyelitis were reported in 1996.

Chronic HBV infection with persistence of hepatitis B surface antigen (HbsAg) occurs in as many as 90% of infants infected by perinatal transmission; in 30% of children one to five years old infected after birth; and 5% to 10% of older children, adolescents, and adults with HBV infection. The MMWR reported a total of 10,637 cases of hepatitis B occurred in 1996.

The MMWR stated that a total of 508 cases of measles were reported in the United States in 1996. The largest outbreaks occurred among school-age children in states with no requirements, or partial requirements, for school children to receive a second dose of measles-containing vaccine. In 1996, a total of 751 cases of mumps and 238 cases of rubella were reported in the United States.

FINANCIAL IMPACT

Four providers were contacted and provided cost figures for vaccinations included in the childhood immunization schedule. The costs ranged from $24 to $90 per vaccination and injection. The costs would be paid out-of-pocket for individuals without health coverage including immunization. The total cost for the immunizations covered by the legislation would range from $585 to $838 for each newborn child from birth to thirty-six months of age.

Information provided by the Agency for Health Care Policy and Research (AHCPR) article entitled "Availability of Free Vaccine and Other Factors Affect Likelihood of Timely Childhood Immunizations" stated that concerns about financial barriers to vaccination led to the development of the Vaccine for Children (VFC) program. The federal government provides free vaccines to states for distribution to public health departments and participating physicians' offices through the VFC program. The VFC program provides states with free vaccines for children who are Medicaid eligible, uninsured, Native American, or Native Alaskan. The program also provides free vaccines to insured children, if their insurers do not cover vaccines and if the children are vaccinated at public health clinics.

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 each of the bills to be reviewed by the Advisory Commission in 1998. Thirty-nine companies responded by April 24, 1998. Six 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 33 respondents that completed the survey, 29 reported that they currently provide the coverage required by SB 766.

Respondents to the Bureau of Insurance survey provided cost figures that ranged from $.10 to $1.80 per month per standard individual policyholder and from $.08 to $2.26 per month per standard group certificate to provide the coverage required by SB 766. Insurers providing coverage on an optional basis provided cost figures from $1.98 to $3.67 per month per individual policyholder and from $.73 to $2.94 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, thirteen states (Colorado, Georgia, Kansas, Louisiana, Missouri, Nebraska, New Jersey, North Dakota, New Mexico, Oklahoma, Pennsylvania, Texas, and West Virginia) require coverage for childhood immunizations (see Appendix C).

REVIEW CRITERIA

SOCIAL IMPACT

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

The VDH, Division of Immunization stated that the National Immunization Survey conducted by the CDC for the period January 1, 1997 through December 31, 1997 reported that 73% of Virginia's two-year-old children are appropriately immunized for their age. The VDH reported that the number of school-aged children (kindergarten – twelfth grade) in 1997 was 1,076,094.

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

The State Corporation Commission's Bureau of Insurance surveyed fifty of the top writers of accident and sickness insurance in Virginia. Thirty-three companies currently writing applicable business in Virginia responded. Of that number, twenty-nine (88%) already provide the coverage required by SB 766 to their Virginia policyholders.

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.*

Insurers contend that coverage is generally available. The VFC program provides states with free vaccines for children who are Medicaid eligible, uninsured, Native American, or Native Alaskan. The program also provides free vaccines to insured children if their insurers do not cover vaccines and the children are vaccinated at the local health departments.

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.*

Four providers were contacted and provided cost figures for vaccinations included in the childhood immunization schedule. The costs ranged from $24 to $90 per vaccination and injection. The costs would be paid out-of-pocket for individuals without health coverage. The total cost for the immunizations would range from $585 to $838 for each newborn child from birth to thirty-six months of age.

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

The VDH stated that a law was passed in 1983 in Virginia that requires all school-aged children to be fully immunized by school entry (four to six years of age). They reported that approximately 99% of children are being immunized by school entry.

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

The Virginia Chapter of the American Academy of Pediatrics, Medical Society of Virginia, and a nurse practitioner spoke in favor of the bill. One physician testified that of all his patients who have insurance, only 5% do not have coverage for immunizations.

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.*

The VDH stated that the federally qualified health clinics provide immunizations for the underinsured children that are Medicaid eligible. The VDH reported that approximately 70% of the eligible children are enrolled in the health departments throughout the Commonwealth. The VDH indicated that a multitude of factors such as poverty, missed opportunities, and urbanization probably

affected the 27% of the eligible children that are not immunized. However, some providers stopped providing immunizations because of the potential liability, and the difficulty of obtaining the vaccines and complying with the requirements of the VFC program.

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.*

It is not anticipated that the cost for childhood immunizations would be significantly impacted by the proposed mandate.

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

It is unlikely that the proposed mandate would significantly increase the inappropriate use of services because immunizations are administered according to the recommended schedule.

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

It is not anticipated that mandatory coverage for childhood immunizations will serve as an alternative for more expensive service. However, appropriate immunizations may result in the savings of the cost of treatment of any of the illnesses that immunizations cover.

Proponents testified that SB 766 would save insurance companies thousand of dollars per day for costs associated with hospitalization, intensive care units, and doctor fees rather than having the companies pay for treatments after the child acquires the disease.

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.*

Some 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 filing, claims processing systems, and marketing.

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

The impact on the total cost of health care is not expected to be significant because the majority of the insurers currently provide the coverage required by SB 766.

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.*

The Red Book stated that in the United States, immunizations have sharply curtailed or practically eliminated diphtheria, measles, mumps, pertussis, rubella, tetanus, and Hib diseases.

The Red Book stated that universal immunization with diphtheria toxoid is the only effective control measure. This is proven by the rarity of the disease in countries in which high rates of immunization with diphtheria toxoid have been achieved. As a result of high immunization rates, exposure to persons with diphtheria or to carriers is less frequent now than in the past.

Widespread immunization with pertussis vaccine since the 1940s is primarily responsible for the current low morbidity and mortality rates of pertussis in the United States. Based on household studies of young children in the United States exposed to pertussis, the efficacy of whole-cell pertussis vaccine for children who received at least three doses is estimated to be 50% to 90% depending upon the case definition.

The Red Book noted that both the OPV and IPV in their recommended schedules are highly immunogenic and effective in preventing poliomyelitis. Also, the effectiveness of OPV has been demonstrated by its success in the United States and in many other areas of the world in interrupting the circulation of wild-type poliovirus.

Hepatitis B vaccines licensed in the United States have a 90% to 95% efficacy in preventing HBV infection and clinical hepatitis B among susceptible in children and adults. Studies of children immunized at birth to prevent perinatal HBV infection have demonstrated continued efficacy for at least eight years.

The childhood immunization program in the United States has resulted in a greater than 99% reduction in the reported incidence of measles. Since 1963 when measles vaccine was first licensed, the incidence of measles has decreased dramatically in all age groups.

Rubella was once an epidemic disease, occurring in six to nine-year cycles. Most cases occurred in children, before the widespread use of rubella vaccine. The incidence of rubella in the United States has declined by approximately 99% from the pre-vaccine era. The risk of acquiring rubella has declined sharply in all age groups.

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.*

SB 766 addresses the medical need of providing children with immunizations. The benefit is consistent with the role of health insurance, although traditional health insurance was designed to cover treatment of illnesses and not preventive measures.

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

Insurers responding to the Bureau of Insurance survey provided cost figures that ranged from $.10 to $1.80 per month per standard individual policyholder and from $.08 to $2.26 per month per standard group certificate to provide the coverage required by SB 766. Insurers providing coverage on an optional basis provided cost figures from $1.98 to $3.67 per month per individual policyholder and from $.73 to $2.94 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 (10 – Yes, 1 - No) on April 6, 1999 to recommend that SB 766 not be enacted.

CONCLUSION

The Advisory Commission believes that there is compelling evidence that 82% of the insured children are being immunized by the target age and that Virginia has a 98% to 99% compliance rate with the immunization requirements by school entry. The immunizations can be administered by a physician or the local health departments at no cost under the VFC program.

Insurance coverage for immunizations is currently available to many Virginians because of the current mandated offer of coverage for child health supervision services in § 38.2-3411.1. Additionally, the majority of insurers responding to a Bureau of Insurance survey indicated that they include coverage for immunizations in their standard contracts. The Advisory Commission believes that lack of insurance coverage for immunizations is not widespread and that the rate of immunization of Virginian's pre-school children would not increase significantly because of a mandate of coverage.

994632655

SENATE BILL NO. 766

Offered January 13, 1999

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 38.2-3411.3, relating to health care coverage; childhood immunizations.

Patrons—Edwards, Couric, Gartlan, Hawkins, Holland, Houck, Howell, Lambert, Lucas, Marsh, Maxwell, Miller, Y.B., Mims, Puckett, Reynolds, Saslaw, Ticer, Trumbo, Whipple and Woods; Delegates: Abbitt, Bennett, Cranwell, Davies, DeBoer, Hull, Johnson, Melvin, Moran, Phillips, Plum, Shuler, Tate, Thomas and Woodrum

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Referred to Committee on Education and Health

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 38.2-3411.3 as follows:

§ 38.2-3411.3. Coverage for childhood immunizations.

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 all routine and necessary immunizations for newborn children under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

B. The required benefits shall apply to immunizations administered to each newborn child from birth to thirty-six months of age.

C. The required benefits shall not be subject to any deductible, copayment, coinsurance or other dollar limit provision in the policy or plan. Such exemption shall be expressly stated on the policy, plan, rider, endorsement, or other attachment providing such coverage.

D. For the purpose of this section, "routine and necessary immunizations" means immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Commissioner of Health.

E. The provisions of this section shall 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, 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, 38.2-203, 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, *38.2-3411.3*, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.7, 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

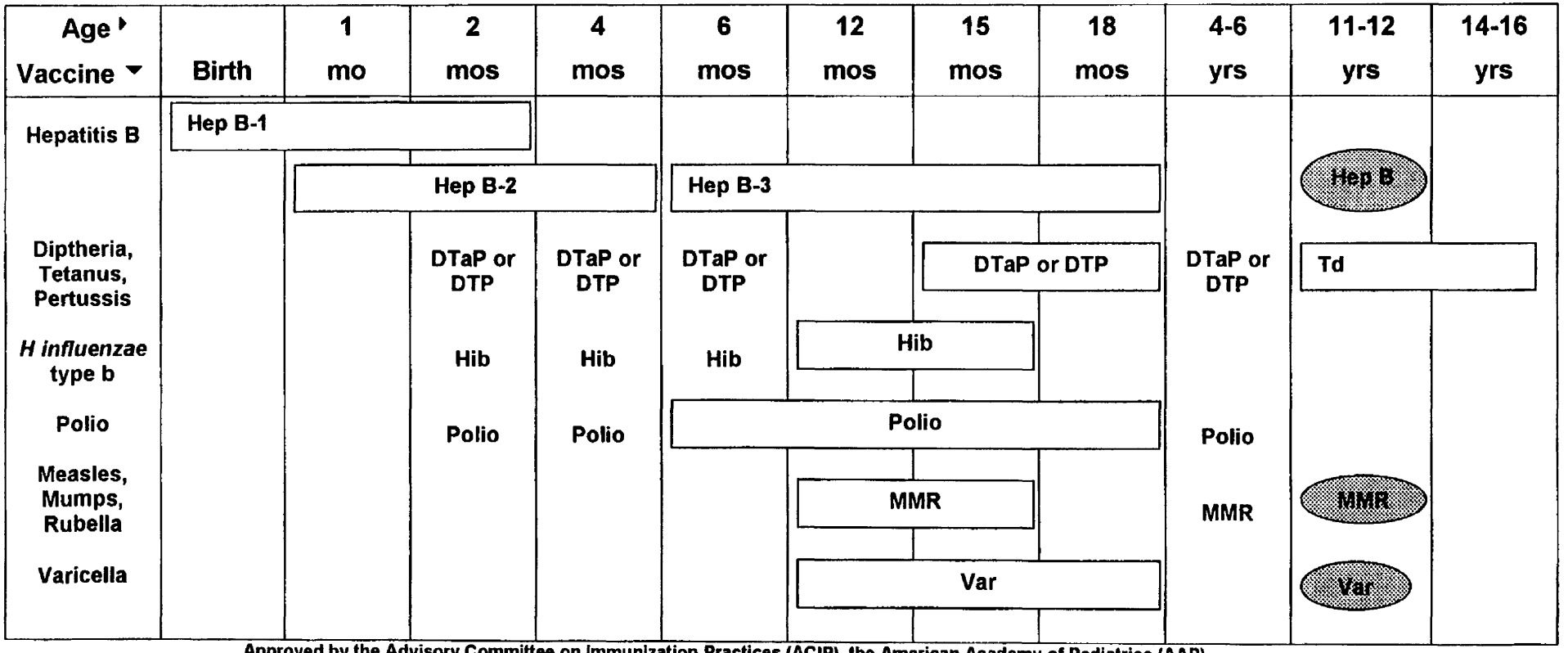
shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

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.

Recommended Childhood Immunization Schedule
United States, January – December 1998

Vaccines are listed under the routinely recommended ages. Bars indicate range of acceptable ages for immunization. Catch-up immunization should be done during any visit when feasible. Shaded ovals indicate vaccines to be assessed and given if necessary during the early adolescent visit.



Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

COVERAGE FOR CHILDHOOD IMMUNIZATIONS IN OTHER STATES

STATE	CITATION	SUMMARY
Colorado	10-16-104	Mandated coverage for childhood immunizations.
Georgia	§§ 33-30-4.5 (group) 33-29-3.4 (indiv.) 290-5-37-.03 (HMOs)	Mandated benefit for periodic review of child's physical and emotional Status, including immunizations, from birth through age 5. No deductible, commissioner may provide exclusions or coinsurance amounts.
Kansas	§ 40-2,102	Mandated coverage for immunizations to age 5.
Louisiana	§ 22:215.14	Mandated coverage for immunizations to age 6.
Missouri	376.1215	Provide coverage for immunizations of a child from birth to five years of age as provided by department of health regulation.
Nebraska	§ 44-784	Provides coverage for a dependent child under six years of age shall provide coverage for childhood immunizations.
New Jersey	17:48-6m (Hospital Serv. Corp.) 17:48E-35.10 (Health Serv. Corp.) 17B:27-46.11 (Group)	Provides benefits for all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health.
North Dakota	26.1-36-09.4	Provide coverage for prenatal care visits for a covered person and recommended immunizations and well child visits for a covered person from birth to the age of five years.
New Mexico	§§ 59A-22-34.3 59A-23B-3 59A-46-38.2	Provide coverage for childhood immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics.

COVERAGE FOR CHILDHOOD IMMUNIZATIONS IN OTHER STATES

STATE	CITATION	SUMMARY
Oklahoma	36 § 6060.4	Provide coverage for each child of the insured, from birth through the date such child is eighteen years of age for immunizations.
Pennsylvania	§ § 40-39-321 to 40-39-328	Requires coverage for child immunizations. Coinsurance provisions apply same as other services, exempt from deductibles.
Texas	I.C. Art. 21.53F	Requires benefit for childhood immunizations from birth through the date the child is six years of age.
West Virginia	33-15-17 (Accident & Sickness) 33-16-12 (Group Acc. & Sick.) 33-25-8c (Health Care Corp.) 33-16A-15 (Group) 33-25A-8c (HMOs)	Coverage for child immunization services. This coverage will cover all costs associated with immunizations, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration.