REPORT OF THE

SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

TO THE HOUSE COMMITTEE ON COMMERCE AND LABOR AND THE SENATE COMMITTEE ON COMMERCE AND LABOR OF THE GENERAL ASSEMBLY OF VIRGINIA

COMMMONWEALTH OF VIRGINIA
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To: The House Committee on Commerce and Labor
and
The Senate Committee on Commerce and Labor
of the General Assembly of Virginia

The report contained herein has been prepared pursuant to § 2.2-2504 of the Code of Virginia.

This report documents the activities of the Special Advisory Commission on Mandated Health Insurance Benefits during the past twelve months.

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R. Lee Ware
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

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EX OFFICIO MEMBERS	
Alfred W. Gross, Commissioner of Insurance	
Robert Stroube, M.D., Commissioner of Health	

TABLE OF CONTENTS

AUTHORITY AND HISTORY

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) was created in 1990 to evaluate the social and financial impact and medical efficacy of existing and proposed mandated health insurance benefits and providers. Sections 2.2-2503 through 2.2-2505 of the Code of Virginia provide for the establishment and organization of the Advisory Commission. Section 2.2-2504 requires that the Advisory Commission report to the joint standing committees of the General Assembly having jurisdiction over insurance by December 1 of each year. This document has been prepared for submission to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Labor in accordance with the requirements of § 2.2-2504 of the Code of Virginia.

House Bill 195 – Health Maintenance Organizations Coverage of Chiropractic Services

The House Committee on Commerce and Labor referred House Bill 195 to the Advisory Commission during the 2004 Session of the General Assembly. House Bill 195 was introduced by Delegate Richard H. Black.

The Advisory Commission held a public hearing on October 18, 2004 in Richmond to receive public comments on House Bill 195. The bill's chief patron, spoke in favor of the bill, as did Counsel for the Virginia Chiropractic Association and two chiropractors. A representative of the Virginia Association of Health Plans (VAHP) spoke in opposition to the bill.

Written comments in support of the legislation were received from the Virginia Chiropractic Association and from three chiropractors. Written comments in opposition to the legislation were submitted by VAHP.

The original language of House Bill 195 amends and reenacts § 38.2-4312 of the Code of Virginia by adding a new subsection F. The new subsection provides that a contract between a Health Maintenance Organization (HMO), and a chiropractor shall be deemed to be unreasonably discriminatory if the contract does not provide for reimbursement, on terms consistent with those applicable to other participating providers, of all services which the chiropractor is authorized by law to provide in the Commonwealth when such services are covered under the enrollee's evidence of coverage.

The original bill requires HMOs to cover the services provided by a chiropractor if the chiropractor is authorized by law to provide the services in the Commonwealth and the services are covered under the enrollee's evidence of coverage. HMOs are not currently required to contract with chiropractors to provide the full range of services that chiropractors are licensed to provide. An HMO may contract only with physical therapists to provide physical therapy, although a chiropractor's license authorizes him/her to provide that service.

Delegate Black submitted substitute language to the Advisory Commission for review. The substitute language provides that HMOs cannot restrict, prohibit or exclude any service or services rendered by a chiropractor who is authorized by law to provide such service or services in Virginia if and when the HMO covers the same or similar service when rendered by a specialty physician or another class of provider. The coverage for services rendered by a chiropractor is not to be different or separate from covered services rendered by a specialty physician or other class of provider for deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, co-payment and coinsurance factors, or benefit year maximums for deductibles or co-payment and coinsurance maximums. The HMO can manage the frequency of the delivery of the

services rendered by a chiropractor provided that the same management is provided when the services are rendered by a physician or other class of provider.

On November 16, 2004, the Advisory Commission voted 7 to 2 to make no recommendation on House Bill 195. The Advisory Commission members were concerned that the language of the substitute bill needed further clarification. There was also concern that the complicated issues that the bill was attempting to address went beyond the issue of whether chiropractic care is a benefit that should be included in contracts in Virginia.

House Bill 294 – Coverage of Anorexia Nervosa and Bulimia Nervosa as Biologically Based Mental Illnesses

The House Committee on Commerce and Labor referred House Bill 294 to the Advisory Commission during the 2004 Session of the General Assembly. House Bill 294 was introduced by Delegate R. Lee Ware.

The Advisory Commission held a public hearing on October 18, 2004, in Richmond, to receive public comments on House Bill 294. Representatives from the National Institute of Mental Health and the Virginia Commonwealth University Health System Department of Child Psychiatry spoke in favor of the bill, as did a family physician, a licensed clinical social worker, and three concerned citizens. A representative from the VAHP spoke in opposition to the bill.

Written comments in support of the bill were provided by the Virginia Academy of Clinical Psychologists, the Virginia Commonwealth University Health System Department of Child Psychiatry, a licensed clinical social worker, a family physician and parent. Written comments from two parents, including a family physician also included information from VCU's Institute for Psychiatric and Behavioral Genetics, the National Institutes of Health and the National Institute of Mental Health, the Western Psychiatric Institute and Clinic of UPMC Presbyterian and the St. Joseph Medical Center. The information addressed the classification of anorexia nervosa and bulimia nervosa as biologically based mental illnesses. Written comments in opposition to House Bill 294 were provided by VAHP.

House Bill 294 would add anorexia nervosa and bulimia nervosa to the conditions listed in the definition of biologically based mental illnesses. Section 38.2-3412.1:01 of the Code of Virginia requires insurers proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on expense-incurred basis; corporations providing group subscription contracts; and HMOs providing health care plans to provide coverage for biologically based mental illnesses.

The section states that coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or

disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefits year or lifetime dollar limits, lifetime episodes or treatment limits, co-payment and coinsurance factors, and benefit year maximum for deductibles and co-payment and coinsurance factors.

The section states that nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

The section defines "biologically based mental illness" as any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addiction.

The section also states that benefits are not to be different or separate from coverage for any other illness, condition, or disorder for determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, co-payment and coinsurance factors, and benefit year maximums for deductibles and co-payment and coinsurance factors.

The section does not apply to short-term travel, accident only, limited or specified disease policies, short-term nonrenewable policies of not more than six months' duration, policies, contracts, or plans issued in the individual market or small group market to employers with 25 or fewer employees, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act (Medicare), or any other similar coverage under state or federal governmental plans.

Current coverage requirements applicable to insurers and health services plans for the treatment of anorexia nervosa and bulimia nervosa are addressed in § 38.2-3412.1 of the Code of Virginia. This section requires coverage for mental health and substance abuse services in individual and group policies and subscription contracts. At least 20 inpatient days and, 25 inpatient days are required for an adult and a child, respectively. Each inpatient day can be converted to 1.5 partial hospitalization days. Outpatient coverage must be included for adults and children for at least 20 visits.

Coverage requirements applicable to HMOs for the treatment of anorexia nervosa and bulimia nervosa are addressed in the Rules Governing Health Maintenance Organizations, 14 VAC 5-210-10, et seq. At least 30 days of inpatient

coverage per contract or calendar year are required, and at least 20 outpatient visits per member per year are required. The co-payment imposed on outpatient services may not be more than 50% of the cost of such services and may be limited by the HMO to a cost to the HMO of no less than $1,000 in any applicable benefit period.

On November 16, 2004, the Advisory Commission voted 6 to 3 to recommend against the enactment of House Bill 294. Some of the Advisory Commission members believed that more study should be performed to determine conclusively that anorexia nervosa and bulimia nervosa are biologically based conditions. Advisory Commission members were concerned that the cost of mandating such coverage could result in more Virginians being uninsured. There was particular concern about the potential impact of this bill on the premiums of small employer groups.

House Bill 469/Senate Bill 594 – Coverage for Prescription Contraceptives

The House Committee on Commerce and Labor referred House Bill 469 and the Senate Committee on Commerce and Labor referred Senate Bill 594 to the Advisory Commission for review during the 2004 session. Senate Bill 594 was introduced by Senator Janet D. Howell and its companion bill, House Bill 469 was introduced by Delegate Mitchell Van Yahres.

The Advisory Commission held a public hearing on October 18, 2004 in Richmond, to receive public comments on House Bill 469 and Senate Bill 594. In addition to the bill's patrons, comments in support of the bills were made by two physicians and a vice-president of the National Women's Law Center. A representative of the VAHP spoke in opposition to the bills. Written comments in support of the bills were received from Planned Parenthood Advocates of Virginia (PPAV), the American Association of University Women, the American Civil Liberties Union, Virginia American Federation of Labor, Congress of Industrial Organizations and Population Connections. Approximately 90 electronic messages were received in support of the bill. A petition with 3,000 signatures of support for the bills was presented to the Advisory Commission by PPAV.

House Bill 469 and Senate Bill 594 would amend § 38.2-3407.5:1 of the Code of Virginia, in the accident and sickness provisions chapter. The bills revise the language in the current section to require insurers to offer and make available coverage for prescribed drugs or devices approved by the U. S. Food and Drug Administration (FDA) for use as a contraceptive if the policy, contract or plan covers prescription drugs on an outpatient basis. The bills are applicable to insurers that issue individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis; corporations providing subscription contracts; and HMOs providing health care plans. The bill revises the section to require that coverage for such drugs or devices be included when there is outpatient prescription coverage.

The current section prohibits insurers, corporations, or HMOs from imposing any (i) co-payment, coinsurance payment or fee that is not equally imposed on all individuals in the same benefit category, class, coinsurance level or co-payment level for prescription drugs, or (ii) reduction in allowable reimbursement for prescription drugs.

The section does not require coverage for prescription drugs in a contract, policy or plan that does not otherwise cover prescription drugs; preclude the use of closed formularies provided the formularies include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods; or require coverage for experimental contraceptive drugs not approved by the U. S. FDA.

The section does not apply to short-term travel, accident only, limited or specified disease policies, or contracts designed for issuance to persons eligible for Medicare, or other similar coverage under state or government plans, or short-term nonrenewable policies of no more than 6 months. The current section applies to contracts, policies, or plans delivered, issued for delivery, or renewed in Virginia on or after July 1, 1997.

In 1996, House Bill 1233 (Mandated Coverage for Prescription Drugs) was reviewed by the Advisory Commission. At that time, the Advisory Commission concluded that coverage was generally available for those individuals who wanted it, and voted unanimously to not recommend enactment of House Bill 1233. The current requirement for prescription contraceptives coverage is included in § 38.2-3407.5:1 of the Code of Virginia and was introduced the following year.

On November 16, 2004, the Advisory Commission voted 6 to 3 to recommend against the enactment of House Bill 469 and Senate Bill 594. Advisory Commission members expressed concerns about the financial impact of an additional mandate and indicated that the current offer of coverage for prescription contraceptives is an appropriate way to address the coverage.

House Bill 619 - Coverage for Infertility Treatments

The 2004 House Committee on Commerce and Labor referred House Bill 619 to the Advisory Commission. House Bill 619 was introduced by Delegate Charles W. Carrico, Sr. House Bill 619 amends and reenacts §§ 2.2-2818 and 38.2-4319 of the Code of Virginia and adds § 38.2-3418.15 and requires each insurer, health services plan, and HMO to provide coverage for the treatment of infertility. The bill applies to insurers 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 HMO providing a health care plan for health care services. This bill also adds infertility treatment to the state employee health plan.

Coverage for the treatment of infertility must include the following procedures performed on a covered individual who is less than 50 years old: in vitro fertilization (IVF), embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), intracytoplasmic sperm injection, zygote intrafallopian transfers (ZIFT), and low tubal ovum transfer. The treatment shall be required only if the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows a complete oocyte retrieval, then two more oocyte retrievals shall be covered. "Treatment for infertility" does not include the reversal of a vasectomy or a tubal ligation.

The bill defines infertility as the inability to conceive after one year of unprotected sexual intercourse. The bill's provisions are not applicable to short-term travel, accident only, limited, or specified disease policies, or contracts designed for issuance to persons eligible for Medicare, or to short-term nonrenewable policies of not more than six months' duration.

Reimbursement for treatment of infertility must be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, deductibles, and coinsurance factors that are no less favorable than for physical illness generally.

The Advisory Commission held a public hearing on September 20, 2004 in Richmond to receive public comments on House Bill 619. In addition to the bill's chief patron, three interested parties spoke in favor of House Bill 619. One of the speakers represented Resolve, the National Infertility Organization; the second speaker was an obstetrician with The Jones Institute of Reproductive Medicine; and the final speaker was an economist who had experience with the infertility mandate in Massachusetts. Representatives of the VAHP and the National Foundation of Independent Business (NFIB) spoke in opposition to House Bill 619. In addition, several letters from private citizens were received by the Advisory Commission addressing House Bill 619. Seven of the letters expressed support for the bill, and three letters were received in opposition to the bill.

The Advisory Commission voted unanimously (9-0) to recommend against the enactment of House Bill 619 on October 18, 2004. Advisory Commission members expressed concern for consumers who are unable to conceive and would benefit from the provisions of House Bill 619, but indicated that the expense of infertility treatments and the unknown number of attempts of treatment needed to achieve pregnancy would directly increase health insurance costs. There was concern that the mandate might increase the number of uninsureds because some groups and individuals would no longer be able to afford the cost of health care coverage.

House Bill 935 – Consumer Choice Plans

The House Committee on Commerce and Labor referred House Bill 935 to the Advisory Commission during the 2004 session of the General Assembly. House Bill 935 was introduced by Delegate Danny W. Marshall III. House Bill 935 adds §§ 38.2-3419.2 through 38.2-3419.8 to the Code of Virginia accident and sickness provisions chapter and amends §§ 38.2-4319 and 38.2-4214 of the Code of Virginia to make the bill applicable to HMOs.

The bill creates a "Consumer Choice Benefits Plan", defined in the bill as:

"*an accident and sickness insurance policy or plan, issued on either an individual or group basis, that in whole or in part, does not offer or provide state mandated health benefits, but that provides creditable coverage as defined in § 38.2-3431. Consumer choice benefits plan includes any such plan offered by a health services plan or HMO*."

"State-mandated health benefits" is defined in the bill as:

"*coverage required under this title or other laws of Virginia to be provided in an individual or group policy for accident and sickness insurance or a contract for a health related condition that: 1. Includes coverage for specific health coinsurance, co-payments, or any annual or lifetime maximum benefit amounts or; 3. Includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care. For purposes of this article, "state-mandated health benefits" does not include benefits that are mandated by federal law or standard provisions or rights required under this title or other laws of the Commonwealth to be provided in an individual, or group policy for accident and sickness insurance that are unrelated to specific health illnesses, injuries, or conditions of an insured."*

The bill provides that insurers, health services plans, or HMOs may offer one or more consumer choice benefit plans. Any consumer choice benefit plan must include services of the mandated providers in §§ 38.2-3408 and 38.2-3410; coverage for cancer screenings in §§ 38.2-3418.1, 38.2-3418.1:2, 38.2-3418.7 and 38.2-3418.7:1 (mammograms, pap smears, PSA testing and colorectal cancer screening).

The plans must also include the prohibition against discrimination set out in § 38.2-508.4 of the Code of Virginia (genetic information on privacy), and they must comply with the certificate of quality of assurance requirements in § 32.1-137.2 of the Code of Virginia. The mandates of coverage for newborn, adopted, and dependent children, and mental health and substance abuse services, and coverage for diabetes are also required (§§ 38.2-3409, 38.2-3411, 38.2-3411.2, 38.2-3412.1, 38.2-3412.1:01, and 38.2-3418.10.)

The amended bill includes a requirement for coverage of early intervention services in § 38.2-3418.5 of the Code of Virginia.

The offer of coverage for child health supervision services (well child care), and obstetrical services pursuant to §§ 38.2-3411.1 and 38.2-3414 and the option to convert under § 38.2-3416 must also be included. The bill has requirements for a notice that must be included in the written application for the plan that explains that fewer mandates are included in the plan. The plans must include a notice in bold type on each document that all state mandates are not included. The bill also requires a disclosure statement and a provision that the SCC may adopt rules necessary to implement the bill.

An insurer or health services plan that offers one or more consumer choice plans must offer at least one policy with state-mandated benefits. A HMO must offer at least one evidence of coverage that includes state-mandated benefits.

The premium rates for the plans issued as individual coverage are subject to review and approval by the SCC to the same extent as other individual rates, and premium rates for plans issued as group coverage must be filed for informational purposes. The bill does not grant the SCC any power or authority to determine, fix, prescribe or promulgate the rates for individual or group coverage under the article.

Written comments in opposition to the bill were received from the Virginia Quality Health Care Network on behalf of 19 organizations. The Virginia Breast Cancer Foundation, the Hemophilia Association of the Capital Area, the Speech-Language Hearing Association of Virginia, the Virginia Hemophilia Advisory Board and twelve private citizens also submitted comments opposed to the bill. Written comments in favor of consideration of the bill were received from the Virginia House and Health Care Association.

House Bill 935 was scheduled for public hearing before the Advisory Commission on September 20, 2004. Delegate Marshall requested that the bill be removed from the agenda for the meeting. The Advisory Commission deferred the bill until 2005 in response to Delegate Marshall's request.

House Bill 1216 – Coverage for Inborn Errors of Metabolism

The House Committee on Commerce and Labor referred House Bill 1216 to the Advisory Commission during the 2004 Session of the General Assembly. House Bill 1216 was introduced by Delegate R. Steven Landes.

The Advisory Commission held a public hearing on October 18, 2004, in Richmond, to receive public comments on House Bill 1216. Three concerned citizens spoke in favor of the bill. A representative from the VAHP spoke in opposition to the bill.

Written comments in support of the bill were provided by staff of the Virginia Commonwealth University Health Systems Pediatric Specialty, the Virginia Dietetic Association, and by four concerned citizens. Written comments in opposition to House Bill 1216 were provided by VAHP.

House Bill 1216 would add § 38.2-3418.15 to the Code of Virginia, requiring insurers 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; corporations providing subscription contracts; and HMOs providing health care plans to provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

"Inborn error of metabolism" is defined in the bill as:

> A rare, genetically determined biochemical disorder in which a specific *enzyme deficiency produces a metabolic block that may have pathogenic consequences at birth or later in life. The "inborn error of metabolism" is (i) present at birth, (ii) if left untreated, results in mental retardation or death, and (iii) requires the consumption of special medical formulas."*

The term "Special medical formulas"is defined in the bill as:

> *"nutritional substances that are (i) prescribed by a health professional with appropriate prescriptive authority; (ii) specifically designed and formulated to be consumed or administered internally under the supervision of such health professional, and (iii) specifically designed, processed or formulated to be distinct in one or more nutrients that are present in natural food, and (iv) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or limited capacity to metabolize certain nutrients contained in ordinary foodstuffs."*

The bill states that "special medical foods" shall not include food items naturally low in protein that may be purchased in the marketplace without an order from a health professional.

The bill requires benefits for diagnosing, monitoring, and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs, nutritional management and special medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status if prescribed by a health care professional legally authorized to prescribe or provide such items under law or regulation.

The bill provides that coverage is only required if (i) the special medical formulas are prescribed by a health professional with appropriate prescriptive authority, (ii) the prescriber or the treating physician furnishes supporting documentation to the insurer, corporation, or HMO that the special medical formula is required to treat an inborn error of metabolism that, without such treatment, leads to malnutrition or malabsorption due to inflammation, protein sensitivity, or inborn errors of digestion, and (iii) the special medical formula is the primary source of nutrition as certified by the treating physician by diagnosis.

A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of the insurance title, may require such health care professional to be a member of the plan's provider network if the network includes sufficient health care professionals that are qualified by specific education, experience, and credentials, to provide the covered benefits as described in the section.

The bill prohibits insurers, corporations, or HMOs from imposing co-payments, fees, policy year or calendar-year, or durational benefit limitations or maximums for benefits for benefits or services that are not equally imposed on all individuals in the same benefit category.

The bill applies to insurance policies, contracts, and plans delivered, issued for delivery, reissued, extended in the Commonwealth on or after July 1, 2005, or at any time thereafter when the term is changed or a premium adjustment is made.

The bill does not apply to short-term travel, accident only, limited or specified disease policies, or individual conversion policies or contracts, nor to policies or contracts for persons eligible for coverage under Title XVIII of the Social Security Act (Medicare), or any other similar coverage under state or federal governmental plans.

During the 1999 Session of the General Assembly, The House Committee on Corporations, Insurance and Banking referred two similar bills to the Advisory Commission. House Bill 2197 and House Bill 2199 were introduced by Delegate Robert F. McDonnell. House Bill 2197 related to coverage for any low protein foods prescribed for treatment of inborn errors of amino acid metabolism, such as phenylketonuria (PKU), maple syrup urine disease (MSUD), and homocystinuria (HCU). House Bill 2199 related to coverage for any medical formula that eliminates specific amino acids for the treatment of inborn errors of metabolism, such as having PKU, MSUD, and HCU. On November 22, 1999, the Advisory Commission voted unanimously to recommend that House Bill 2197 and House Bill 2199 not be enacted. At that time, the Virginia Department of Health (VDH) was charging families no more than 2% of their gross income for medical formulas. The Advisory Commission recommended that a mechanism for payment of the foods and formulas be provided either through expansion of the VDH program to include food or a tax credit for families. The 2000 report of the study was printed as House Document No. 67.

During the 2002 Session of the General Assembly, the House Committee on Commerce and Labor referred a similar bill to the Advisory Commission. House Bill 84 was introduced by Delegate Robert D. Orrock, Sr. House Bill 84 related to coverage for the expense of polypeptide-based or amino acid-based formulas whose protein source has been extensively or completely hydrolyzed. On January 8, 2003, the Advisory Commission voted (9-1) to recommend that House Bill 84 not be enacted. The Advisory Commission believed that the need for assistance for persons requiring polypeptide-based or amino-acid based formulas was significant, but thought that it should not be a mandated insurance benefit. The Advisory Commission believed that the funding for the current Virginia Department of Health program for individuals with metabolic disorders should be increased and the program should be expanded to cover persons requiring polypeptide-based or amino-acid based formulas. The Advisory Commission recognized that in the economic environment at that time, the funding for program expansion might not be available. The Advisory Commission believed, however, that expansion of the program to include the additional disorders was the best alternative and that it should be pursued in the future.

On November 16, 2004, the Advisory Commission voted unanimously (9 to 0) to recommend that House Bill 1216 not be enacted. There was recognition of the need for assistance for individuals with inborn errors of metabolism, and for their families. Advisory Commission members acknowledged the relatively small number of individuals affected and suggested that increased funding for the conditions should be directed to the VDH.

House Bill 1362 – Moratorium on Mandated Health Insurance Benefits

The House Committee on Commerce and Labor referred House Bill 1362 to the Advisory Commission during the 2004 session of the General Assembly. The bill was introduced by Delegate Danny W. Marshall, III. The bill amends and reenacts § 2.2-2503 of the Code of Virginia relating to the Advisory Commission and amends the Insurance Code by adding § 38.2-3419.2, relating to a moratorium on new mandated health insurance benefits. House Bill 1362 provides that there shall be a moratorium on new health insurance mandates until July 2009.

Written comments in favor of consideration of HB 1362 were received from the Virginia Hospital and Health Care Association.

House Bill 1362 was scheduled for public hearing before the Advisory Commission on September 20, 2004. Delegate Marshall requested that the bill be removed from the agenda for the meeting. The Advisory Commission deferred the bill until 2005 in response to Delegate Marshall's request.

House Bill 1422 - Coverage for Ovarian Cancer Screening and Annual Mammograms

House Bill 1422 was referred to the Advisory Commission for review by the House Committee on Commerce and Labor during the 2004 Session of the General Assembly. House Bill 1422 was introduced by Delegate Jackie Stump.

House Bill 1422 would amend and reenact §§ 2.2-2818, 32.1-325, 38.2-3418.1, and 38.2-4319 of the Code of Virginia and would add a section numbered § 38.2-3418.15 relating to mandated coverage for ovarian cancer screening and revising the current requirements for mammograms.

The bill applies to the state employees' health benefits plan, plans issued by the Virginia Department of Medical Assistance Services pursuant to Title XIX of the Social Security Act, and to insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical or surgical, or major medical coverage on an expense-incurred basis; as well as each corporation providing individual or group accident and sickness subscription contracts; and each HMO providing a health care plan. The bill requires coverage for one screening mammogram to persons age 35 through 39, one such mammogram annually to persons age 40 through 50 and over, and permits a benefit limitation of $50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The bill also requires that policies, plans, and contracts shall include coverage for ovarian cancer screenings, specifically screening with the CA-125 blood test for detection and diagnosis of ovarian cancer, for individuals who are at risk for such cancer or who exhibit persistent undiagnosed symptoms that may be attributed to ovarian cancer. The bill applies to policies, contracts, or plans delivered, issued for delivery or renewed in the Commonwealth on and after July 1, 2004, and further requires that insurers, corporations, and HMOs shall not impose upon any person receiving benefits pursuant to the bill, any co-payment or fee, and that no condition may be applied to the person that is not equally imposed upon all individuals in the same benefit category.

The bill does not apply to short-term travel, accident only, limited or specified disease policies, or to policies or contracts designed for issuance to persons eligible for Medicare or similar coverage under state or federal governmental plans, or short-term non-renewable policies of not more than six months' duration.

A public hearing for HB 1422 was scheduled for September 20, 2004. The patron of the bill, Delegate Jackie Stump, requested the bill not be heard and indicated that he did not want to pursue the legislation in the 2005 session.