REPORT OF THE

# SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

TO THE GOVERNOR AND THE GENERAL ASSEMBLY AND 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.

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

# SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

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| Alfred W. Gross, Commissioner of Insurance | |
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## 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 2.2-2503 requires that the Advisory Commission report to the Governor and the General Assembly on the interim activity and the work of the Commission no later than the first day of the regular session of the General Assembly.

**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 health maintenance organizations (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 Hospital 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.

Delegate Marshall later requested that the bill not be heard in 2005. He indicated that he did not plan to reintroduce the bill.

**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.

Delegate Marshall later requested that the bill not be heard in 2005. He indicated that he did not plan to reintroduce the bill.

## House Bill 1936 – Coverage for Morbid Obesity

The House Committee on Commerce and Labor referred House Bill 1936 to the Advisory Commission during the 2005 Session of the General Assembly. House Bill 1936 was introduced by Delegate John M. O'Bannon.

The Advisory Commission held a hearing on July 19, 2005 in Richmond to receive public comments on House Bill 1936. In addition to the patron, Senator Benjamin J. Lambert, III and Delegate Melanie L. Rapp, two surgeons and seven concerned citizens spoke in favor of the bill. Representatives from the Virginia Association of Health Plans (VAHP), Virginia Manufacturers Association (VMA), Virginia Chamber of Commerce (VCC), National Federation of Independent Business (NFIB), and Anthem Blue Cross Blue Shield spoke in opposition to the bill. A representative from the Virginia Department of Human Resource Management also commented on House Bill 1936.

Written comments in support of the bill were provided by Commonwealth Surgeons Ltd., Virginia Bariatric Society, the Medical Society of Virginia, Virginia Commonwealth University Medical Center, and Macaulay & Burtch, P.C, and fourteen concerned citizens. The VAHP, Virginia Chamber of Commerce, and Anthem Blue Cross Blue Shield (Anthem) submitted comments in opposition to the bill.

House Bill 1936 would amend § 38.2-3418.13 and § 38.2-4319 in the Code of Virginia. The bill also would amend § 2.2-2128 that addresses health care coverage for state employees. The bill revises the language in the current section to require 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 health maintenance organizations (HMOs) providing health care plans to include coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. The bill applies to insurance policies, contracts, and plans delivered, issued for delivery, or renewed on or after July 1, 2005.

During the 1999 Session of the General Assembly, the Senate Committee on Commerce and Labor referred a similar bill to the Advisory Commission. Senate Bill 770 was introduced by Senator Benjamin Lambert, III. There was concern that the original language of the bill was broad and did not limit the types of treatment that would be covered for morbid obesity. The amended bill submitted by Senator Lambert required the offer of coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity. The amended bill defined "morbid obesity" as (i) a weight which is at least 100

pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, or (ii) a body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such co-morbidity. As used in the bill, "BMI" equals weight in kilograms divided by height in meters squared. The amended bill was applicable to state employees.

The Advisory Commission voted on August 24, 1999 to recommend that Senate Bill 770 be enacted, as amended (Yes-5, No-2). The proponents and opponents of the bill recognized the risks associated with morbid obesity. The Advisory Commission believed that the amended bill covered a valid medical condition and that the amended bill addressed many of the concerns raised by the interested parties. The report was printed as Senate Document No. 33. The amended language was introduced in the 2000 Session of the General Assembly and enacted in July 2000.

Section 38.2-3418.13 requires accident and sickness insurance policies to offer coverage for treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the NIH as effective for the long-term reversal of morbid obesity. The section applies to individual and group policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis and subscription contracts and health care plans provided by HMOs. The section applies to policies, contracts and plans delivered or issued for delivery or renewal after July 1, 2000.

The section requires that reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. The section also requires that coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness. Insurers may not restrict access to surgery for morbid obesity based upon dietary or any other criteria not approved by the NIH.

The section defines "morbid obesity" as a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables. The section also defines "morbid obesity" as a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such co-morbidity. BMI equals weight in kilograms divided by height in meters squared.

The section does not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for people eligible for Medicare or

other similar state or government plans, or short-term nonrenewable policies of not more than 6 month’s duration.

On August 17, 2005, the Advisory Commission voted to recommend against the enactment of House Bill 1936 (Yes-6, No-4). The Advisory Commission expressed the need to balance the public good with the cost of the mandate, including the cost savings potential of the treatment for morbid obesity. The members acknowledged the difficulties associated with morbid obesity expressed by the advocates of House Bill 1936. They believed that the evidence is at least fairly persuasive that the conditions attached with co-morbidity are very expensive and in a number of cases have either been relieved or eliminated entirely by treatments for morbid obesity that would be covered by the bill. However, some members were concerned with the financial impact of this bill regarding the potential increase in the costs of insurance premiums and the increasing number of uninsureds in Virginia.

**House Bill 2077: Coverage for Habilitative Services for Children**

House Bill 2077 was introduced by Delegate Kenneth R. Plum during the 2005 General Assembly Session. House Bill 2077 amends and reenacts §38.2-4319 and amends the Code of Virginia by adding §38.2-3418.15. The new section would require health insurers, HMOs, and corporations providing health care coverage subscription contracts to provide coverage for habilitative services for persons younger than 19 years.

The bill defines "habilitative services" as "treatments and services to enhance the ability of a child with a congenital or genetic birth defect to function, including occupational therapy, physical therapy, and speech therapy."

The bill provides that coverage for habilitative services cannot include services that would be considered medically necessary early-intervention services as outlined in § 38.2-3418.5. The bill also states that an insurer, corporation, or health maintenance organization subject to this section shall not be required to provide reimbursement for habilitative services delivered through early intervention or school services. And, each insurer, corporation, or health maintenance organization subject to this section shall provide notice annually to its insured and enrollees about the coverage required under this section.

On July 13, 2005, Delegate Plum requested the Advisory Commission to strike House Bill 2077 from the agenda because further research is needed in this area. The lead proponent was interested in amending the bill language and clarifying specific definitions. On July 19, 2005, the Advisory Commission accepted Delegate Plum's decision to rescind House Bill 2077.

## HOUSE BILL 2525 – COVERAGE FOR AMBULANCE SERVICES

The House Committee on Commerce and Labor referred House Bill 2525 to the Advisory Commission during the 2005 Session of the General Assembly. House Bill 2525 was introduced by Delegate John M. O'Bannon.

The Advisory Commission held a public hearing on July 19, 2005 in Richmond, to receive public comments on House Bill 2525. In addition to the patron, three representatives of the Virginia Ambulance Association, one concerned citizen, and a representative of the Virginia Association of Volunteer Rescue Squads spoke in favor of the bill. Representatives from the VAHP, NFIB, and Anthem spoke in opposition to the bill.

Written comments in support of the bill were provided on behalf of The Virginia Ambulance Association (VAA). The VAHP, Virginia Chamber of Commerce, and Anthem submitted written comments in opposition to the bill.

House Bill 2525 would amend § 38.2-3407.9 in the Code of Virginia. The bill would require insurers to provide coverage for ambulance services involving the transportation of a covered person to an acute care facility, trauma center, or burn facility, when such transportation is medically appropriate as a result of the covered person's sustaining an urgent or life-threatening injury, burn, or other medical emergency, including, but not limited to, a heart attack or stroke. The bill would apply 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; corporations providing individual or group accident and sickness subscription contracts; and HMOs providing health care plans for health care services. A decision by ambulance personnel that an injury, burn, or medical emergency is urgent or life-threatening shall be presumptive of the reasonableness and necessity of the transport to such a facility or center, unless there is clear evidence of a violation of the American College of Surgeon's Triage Guidelines. The coverage must provide reimbursement for the usual and customary cost of ambulance services.

The bill applies to policies, contracts, or plans delivered, issued for delivery, reissued, or extended in the Commonwealth on or after July 1, 2005, or at any time thereafter when a 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 contracts designed for persons eligible for coverage under Title XVIII of the Social Security Act (Medicare), or any other similar coverage under state or federal government plans, nor to short-term nonrenewable policies of not more than six months' duration.

Section 38.2-3407.9 of the Code of Virginia currently states that if an accident and sickness insurance policy provides coverage for ambulance services, any

person providing such services to a person covered under the policy shall receive reimbursement for the services directly from the issuer of policy, when the issuer of the policy is presented with an assignment of benefits by the person providing the services.

The statute states that no (i) 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, (ii) corporations providing individual or group accident and sickness subscription contracts, or (iii) HMO providing health care plans for health care services shall establish or promote an emergency medical response and transportation system that encourages or directs access by a person covered under such policy, contract or plan in competition with or in substitution of an emergency 911 system or other state, county or municipal emergency medical system for ambulance services. An entity subject to this provision may use transportation outside an emergency 911 system or other state, county or municipal emergency medical system for services that are not ambulance services.

The statute defines "ambulance services" as the transportation of any person requiring resuscitation or emergency relief or where human life is endangered, by means of any ambulance, rescue or life-saving vehicle designed or used principally for such purposes. The term includes emergency medical services (EMS) ambulances and mobile intensive care units.

The statute also states that no (i) 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, (ii) corporations providing individual or group accident and sickness subscription contracts, or (iii) HMO providing a health care plan for health care services shall require a person covered under such policy, contract or plan to obtain prior authorization before accessing an emergency 911 system or other state, county or municipal emergency medical system for ambulance services.

On August 17, 2005, the Advisory Commission voted unanimously (Yes -10, No – 0) to recommend against the enactment of House Bill 2525. The members of the Advisory Commission believe that based on the information reviewed, reimbursement for ambulance services is available, and a mandate is not necessary at this time.

**Senate Bill 1049 – Coverage for the Treatment of Developmental Delay**

The Senate Committee on Commerce and Labor referred Senate Bill 1049 to the Advisory Commission during the 2005 session. Senate Bill 1049 was introduced by Senator Frank Wagner. The bill requires 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 individual or group accident or sickness subscription contracts and HMOs providing a health care plan to offer and made available the treatment of developmental delay for children from birth to age five. The bill applies to policies, contracts and plans delivered, issued for delivery or renewed on and after July 1, 2005. Coverage for the treatment of development delay shall not include services that would be covered as medically necessary early intervention services pursuant to § 38.2-3418.5. The bill further states that an insurer, corporation or HMO may assess a separate or additional charge or premium for the coverage.

The bill defines "developmental delay" as a material delay in a child's achievement for one or more developmental milestones, including speech and language, fine and gross motor skills, and personal and social skills, as diagnosed by a physician through the administration of a formal screening test, such as the Denver II Developmental Screening Test, and includes developmental delay resulting from pervasive developmental disorders including autistic disorder or autism, Asperger's disorder, Rett's disorder, and childhood disintegrative disorder.

The bill required treatments for developmental delay to include diagnostic evaluation, education, behavioral therapy, medication, music therapy, physical therapy, and speech therapy. Coverage for treatment of developmental delay would not include services that are covered as medically necessary early intervention services for children from birth to age three pursuant to § 38.2-3418.5. The provisions of the bill do 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 not more than 6 months' duration.

The Advisory Commission held a hearing on August 17, 2005 in Richmond to receive public comments on Senate Bill 1049. Six citizens spoke in support of the bill. One speaker spoke on behalf of the Autism Society of America, Northern Virginia Chapter. Written comments supporting Senate Bill 1049 were received prior to the public hearing from eight concerned citizens, parents and relatives of children with autistic spectrum disorders. One written comment in support of Senate Bill 1049 was from a representative of the Virginia Board for People with Disabilities, Partners in Policymaking. The VAHP submitted correspondence opposing Senate Bill 1049. Also, a representative from VAHP spoke in opposition to the bill, as did representatives from the NFIB, representing small business owners.

The Advisory Commission also voted on Senate Bill 1049 on August 17, 2005. The Advisory Commission voted (9 to 1) to recommend against mandating an offer of coverage for the treatment of developmental delay. The Advisory Commission recommended that the General Assembly establish a committee or task force to determine a clearer, more narrowly defined bill.