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
RICHMOND
DECEMBER 2007

January 4, 2008

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

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505 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, Jr.
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

MEMBERS OF THE GENERAL ASSEMBLY	
Delegate R. Lee Ware, Jr.	Senator Harry B. Blevins
Delegate Kathy J. Byron	Senator H. Russell Potts, Jr.
Delegate Clarke N. Hogan	
Delegate William R. Janis	
MEMBERS APPOINTED BY THE GOVERNOR	
Elnora Allen	
Angela Benton	
Peter J. Bernard	
Dorothy S. Broderson	
Dr. Renard Charity	
Dr. James F. Childress	
Phyllis L. Cothran	
Joe Kelliher	
Bette O. Kramer (resigned 10/07)	
Laura Lee Viergever	
EX OFFICIO MEMBERS	
Alfred W. Gross, Commissioner of Insurance	
Robert B. Stroube, M.D., Commissioner of Health	

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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 2156 – SECOND OPINION EVALUATIONS FOR PRIMARY MALIGNANT BRAIN TUMORS AT NATIONAL CANCER INSTITUTE COMPREHENSIVE CANCER CENTERS

The House Committee on Commerce and Labor referred House Bill 2156 to the Advisory Commission during the 2007 Session of the General Assembly. House Bill 2156 was introduced by Delegate John M. O'Bannon III.

The Advisory Commission held a public hearing on July 18, 2007 in Richmond to receive public comments on House Bill 2156. Delegate O'Bannon and Delegate John S. Reid spoke in favor of the bill. Two concerned citizens also spoke in favor of the bill. A representative of the Virginia Association of Health Plans (VAHP) spoke in opposition to the bill. Written comments in support of the bill were received from the Cullather Brain Tumor Quality of Life Center at St. Mary's Hospital (Cullather Center), Delegate Paula J. Miller, and Dr. Michael Friedman, President and CEO of City of Hope National Medical Center. Written comments in opposition to the bill were submitted by VAHP.

House Bill 2156 would add Section 38.2-3418.15 to the Accident and Sickness Provisions Chapter of the Insurance Code and would amend Section 38.2-4319 in the Health Maintenance Organizations (HMOs) Chapter to make the provisions applicable to HMOs.

The bill applies to insurers that issue individual or group accident and sickness policies that provide hospital, medical and surgical coverage on an expense incurred basis, corporations providing individual or group accident and sickness subscription contracts, and each HMO providing health care plans for health care services. The bill requires that insurers, corporations, and HMOs provide coverage for a second opinion evaluation of a primary malignant brain tumor at a medical center designated by the National Cancer Institute (NCI) as a comprehensive cancer center.

The bill prohibits insurers, corporations and HMOs from imposing a copayment, fee, policy year or calendar year, or durational benefit limitation or maximum that is not equally imposed on all individuals in the same category. The bill applies to all policies, contracts, and plans delivered, issued for delivery, reissued, or extended in Virginia on and after January 1, 2008 or when there is a change in any term of the policy, contract or plan or any change is made in the premium.

The bill does not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, or policies or contracts designed for issuance to people eligible for Medicare, or any other similar coverage under state or federal plans.

The Advisory Commission voted on September 20, 2007 to recommend against the enactment of House Bill 2156 (Yes-5, No-4). The Advisory Commission members recognized the expertise available at NCI comprehensive cancer centers. However, the Advisory Commission had concerns about the need to require the proposed coverage from one type of facility when coverage for second opinions for primary brain tumors is currently available at many facilities in the state for most Virginians with health care coverage. Two NCI cancer centers that treat brain cancer patients are located in Virginia and many Virginians with coverage have access to NCI comprehensive cancer centers in other states.

HOUSE BILL 2426 AND SENATE BILL 991 – REPEALS OF THE MANDATED OFFER OF COVERAGE FOR BONE MARROW TRANSPLANTS OR STEM CELL TRANSPLANTS

The House Committee on Commerce and Labor referred House Bill 2426 to the Advisory Commission during the 2007 Session of the General Assembly. House Bill 2426 was introduced by Delegate Kathy J. Byron.

The Senate Committee on Commerce and Labor referred Senate Bill 991 to the Advisory Commission during the 2007 Session of the General Assembly. Senate Bill 991 was introduced by Senator Harry B. Blevins.

The Advisory Commission held a hearing on July 18, 2007 in Richmond to receive public comments on House Bill 2426 and Senate Bill 991. In addition to the patron of House Bill 2426, Delegate Kathy J. Byron, a representative of the VAHP spoke in favor of the bills. Written comments in support of the bills were provided by the Virginia Breast Cancer Foundation (VBCF) and VAHP. A member of the Advisory Board of Massey Cancer Center who is also a cancer survivor spoke against House Bill 2426 and Senate Bill 991. A physician on the staff of Virginia Commonwealth University (VCU) Massey Cancer Center provided expert testimony at the September 20, 2007 meeting.

If enacted, House Bill 2426 would repeal in its entirety § 38.2-3418.1:1 in the Code of Virginia. Senate Bill 991 would amend § 38.2-3418.1:1 in the Code of Virginia by removing the mandated offer of coverage requirement for dose-intensive chemotherapy/autologous bone marrow transplants, but would continue to require companies to offer and make available coverage of stem cell transplants for the treatment of breast cancer.

Section 38.2-3418.1:1 is applicable to 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. The section requires that coverage be made available for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, NCI protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

The section requires that copayments for this coverage under policies, contracts or plans should not be greater than for any other coverage, and coverage shall be subject to the same deductible as any other coverage. A different deductible may be offered and made available. The section does not apply to short-

term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

Section 2.2-2818 requires coverage for state employees for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the NCI.

The Advisory Commission voted on September 20, 2007 to recommend the enactment of House Bill 2426 (Yes-7, No-2). The members voted unanimously (Yes-9, No-0) to recommend the enactment of Senate Bill 991 and conform it to House Bill 2426. The Advisory Commission believes that based upon the information presented, high-dose intensive chemotherapy/autologous bone marrow transplants or stem cell transplants are currently not considered the standard of care for the treatment of breast cancer. The members believe that a mandate is no longer needed. Patients have opportunities to participate in clinical trials to obtain these procedures if their particular condition warrants the treatments and they meet the requirements of a clinical trial because of the mandated coverage of clinical trials in Section 38.2-3418.8.

HOUSE BILL 2877 - COVERAGE FOR HUMAN PAPILLOMAVIRUS VACCINATIONS

The House Committee on Commerce and Labor referred House Bill 2877 to the Advisory Commission during the 2007 Session of the General Assembly. House Bill 2877 was introduced by Delegate A. Donald McEachin.

The Advisory Commission held a hearing on September 20, 2007 in Richmond to receive public comments on House Bill 2877. Written comments included the signatures of 21 supporters of the bill. The VAHP addressed the Advisory Commission and submitted written comments in opposition of House Bill 2877.

House Bill 2877 would amend and reenact § 38.2-4319 of the Code of Virginia and add § 38.2-3418.15, which would mandate coverage for the cost of human papillomavirus (HPV) vaccinations. The bill requires insurers proposing to 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 subscription contracts; and HMOs providing health care plans to provide coverage for the cost of HPV vaccinations for women in accordance with recommendations of the Center of Disease Control's Advisory Committee on Immunization Practices.

The bill prohibits insurers, corporations, or HMOs from imposing any copayment, fee, policy year or calendar year, or other durational limit or maximum for benefits or services that is not equally imposed on all individuals in the same benefit category.

The bill applies to policies, contracts or plans delivered, issued for delivery, reissued, or extended on or after January 1, 2008, or at any time thereafter when any term of the policy, contract or plan is changed or premium adjustments are made. The bill does not apply to short-tem travel, accident only, limited or specified disease, or individual conversion policies or contracts, or policies or contracts designed for issuance to persons eligible for Medicare, or similar coverage under government plans.

The Advisory Commission voted unimously on November 29, 2007 to recommend against enacting House Bill 2877 (Yes- 0 , No- 10). The members of the Advisory Commission believe that based on information reviewed, there already exists a wide availabilty of coverage through private and public providers, as well as a wide level coverage from insurers.

SENATE BILL 931 - COVERAGE FOR PROSTHETIC DEVICES AND COMPONENTS

The Senate Committee on Commerce and Labor referred Senate Bill 931 to the Advisory Commission during the 2007 Session of the General Assembly. Senate Bill 931 was introduced by Senator Patricia Ticer.

The Advisory Commission held a public hearing on September 20, 2007 in Richmond to receive public comments on Senate Bill 931. In addition to the patron, Senator Ticer, a representative of Virginia Prosthetics, Roanoke, Virginia and a national spokesperson from the Amputee Coalition of America (ACA) addressed the Advisory Commission. Thirty amputees and family members also commented on Senate Bill 931. Over one hundred concerned citizens attended the public hearing in support of Senate Bill 931. Written comments were received from three orthotic and prosthetic companies and from seventeen concerned citizens. More than 250 signatures were submitted in support of Senate Bill 931. Representatives from the VAHP and the Virginia Chamber of Commerce (VCC) spoke against Senate Bill 931. The VAHP submitted written comments in opposition to the bill.

The bill requires insurers proposing to 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 subscription contracts; and HMOs providing health care plans for health care plans to provide coverage for the cost of prosthetic devices and components, if the treating physician certifies that the medical necessity of the prosthetic device and components as a proposed course of treatment, at a minimum, equals the coverage provided under the federal Medicare program.

The bill defines “component” as the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. “Limb” is defined as an arm, hand, leg, foot, or any portion of an arm, hand, leg, or foot. “Prosthetic device” is defined as an artificial device to replace a limb in whole or in part, or to replace an eye, if required because of a change in the patient’s physical condition, as set forth in 42 U.S.C. § 1395x(s)(9).

The insurer, corporation or HMO may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components, in the same manner that prior authorization is required for any other covered benefit. The insurer, corporation or HMO may require that prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device or component be provided by a vendor designated by that insurer.

The bill proposes coverage that would include the fitting, repair, or replacement of a prosthetic device or components, or both, if the fitting, repair, or replacement is determined to be medically necessary. A fitting, repair, or replacement necessitated by the negligence of proper care and maintenance or by

an abusive act committed by the individual having the prosthetic device shall not be covered. Also, coverage shall not be required for a prosthetic device that is designed exclusively for athletic purposes.

The bill prohibits insurers, corporations, or HMOs from imposing any copayment, coinsurance, or deductible amounts, or any policy year or calendar year, lifetime, or other durational limit or maximum for benefits or services that is not equally imposed on terms and services covered under the policy, contract or plan. The bill applies to policies, contracts, or plans delivered, issued for delivery, reissued, or extended on or after January 1, 2008 or at any time thereafter when any term of the policy, contract or plan is changed or premium adjustments are made.

The bill does not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, or policies or contracts designed for issuance to persons eligible for Medicare, or similar coverage under government plans.

The Advisory Commission members voted on November 29, 2007 to recommend the enactment of Senate Bill 931 (Yes-6, No-4). The Advisory Commission members discussed the changing needs of health care, the increase of health care costs, maintaining affordable health care and health insurance, and the cross-section of the population impacted by Senate Bill 931. The Advisory Commission concluded that coverage for prosthetic devices and components would significantly impact an individual's quality of life and improve his or her health. The Advisory Commission believed that the benefits of the proposal compare favorably to the cost of providing the coverage, and the bill should therefore be enacted.