Department of Planning and Budget
2025 General Assembly Session
State Fiscal Impact Statement

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Bill Number: SB 1186 S1 **Patron:** Carroll Foy
Bill Title: Health insurance; coverage for donor human milk, penalty

Bill Summary: The substitute bill prohibits any person from establishing or operating a donor human milk (DHM) bank, as defined in the bill, without first obtaining a license from the State Health Commissioner and makes it a Class 6 felony for any person to establish or operate a DHM bank in the Commonwealth without obtaining such license. The bill directs the State Board of Health to establish a regulatory and statutory scheme for the licensure and regulation of DHM banks operating or doing business in the Commonwealth. The bill also directs the Commissioner to implement and enforce numerous regulations relating to the issuance, renewal, denial, suspension, and revocation of such licenses. The bill specifies procedures relating to disciplinary actions, application fees, and inspections and interviews related to such DHM banks.

The bill requires health insurers, corporations providing health care coverage subscription contracts, and health maintenance organizations to provide coverage for expenses incurred in the provision of pasteurized DHM. The bill specifies that the requirement applies if the covered person is an infant younger than 12 months corrected age, as defined in the bill, (i) who lacks access to his mother's breast milk, (ii) for whom a licensed health care provider has issued an order for the provision of such milk, and (iii) who meets one of the medical criteria enumerated in the bill. The bill applies to policies, contracts, and plans delivered, issued for delivery, or renewed on or after January 1, 2027. The bill also requires the state plan for medical assistance services to include a provision for payment of medical assistance services incurred in the provision of pasteurized DHM.

The substitute bill contains an enactment clause that delays the effective date of its provisions to July 1, 2026.

Budget Amendment Necessary: Yes **Items Impacted:** 288, 292
Explanation: Funding is required for programs under the Virginia Department of Health (VDH) and Department of Medical Assistance Services (DMAS) in the current biennium. The Department of Human Resource Management (DHRM) and State Corporation Commission (SCC) will require a budget amendment in the next biennium.

Fiscal Summary: The proposed legislation will require expenditures for which agencies are not currently appropriated. See table and fiscal analysis below. The statement has been revised to include the information provided by SCC.

General Fund Expenditure Impact:

Agency	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030
DHRM (129)	-	-	$300,000	$300,000	$300,000	$300,000
VDH (601)	-	$425,000	$45,000	$45,000	$45,000	$45,000
DMAS (602)	-	$250,000	$6,389,242	$6,708,704	$7,044,139	$7,396,346
SCC (171)	-	-	$90,680	$369,970	$377,365	$384,915
TOTAL	**-**	$675,000	$6,824,922	$7,423,674	$7,766,504	$8,126,261

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Nongeneral Fund Expenditure Impact:

Agency	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030
DHRM (129)	-	-	$300,000	$300,000	$300,000	$300,000
VDH (601)	-	-	-	-	-	-
DMAS (602)	-	$750,000	$6,840,758	$7,182,796	$7,541,936	$7,919,033
SCC (171)	-	-	$1,275	$5,205	$5,310	$5,415
TOTAL	**-**	$750,000	$7,142,033	$7,488,001	$7,847,246	$8,224,448

Fiscal Analysis:

Department of Human Resource Management
DHRM reports that the fiscal impact of this bill on state employee health insurance costs to be $600,000 ($300,000 general fund). The agency provided the following assumptions: cost of about $15,000 per year per infant, six percent inflation, five percent of COVA infants would utilize the benefit, and the expected duration would be three months. Although there is a cost to the state health plan, DHRM does not expect changes to the rates funded in the introduced bill.

Virginia Department of Health
VDH estimates that there will be a fiscal impact to implement the provisions of this bill. VDH's Office of Licensure and Certification (OLC) has an online application system for its existing licensure programs for medical care facility providers (e.g., hospitals, home care organizations, etc.). This system automates much of the previous manual licensing processes, includes electronic payment options, and brings transparency to licensing operations for applicants and the public. The proposed legislation would require VDH to modify its OLC application portal to create a new provider type for DHM banks with applications for an initial license, renewed license, or key changes in licensing record (e.g., change of location, change of capacity). VDH's information technology vendor has estimated a one-time cost of $425,000 in FY 2026 to support changes to its OLC application portal and an annual cost of $45,000 for added operation, maintenance, and post-deployment enhancement support associated with a new provider type.

Since VDH is aware of only one accredited milk bank in Virginia, the inspection burden is anticipated to be limited to one facility at the present time. VDH has indicated that the inspections of the milk banks could be absorbed by an existing staff; therefore, no new positions would be required at this time. VDH estimates that it would be able to absorb regulatory costs associated to license and monitor the one existing facility in Virginia. Hospitals are generally providing DHM at their own expense for babies in the pediatric intensive care units (PICUs) and neonatal intensive care units (NICUs). It is expected that the introduction of this bill may change this situation, potentially adding approximately 45 facilities with a NICU, PICU, or both as DHM banks. At this time, however, it cannot be determined how many facilities may seek licensure in the future. VDH also anticipates that the number of facilities required to be licensed may increase due to the provision in the bill that requires entities who operate or do business within the Commonwealth that collect, store, sell, distribute, or pasteurize DHM and human milk-derived products to meet the licensing standards and requirements for

DHM banks. Should the number of facilities increase, there may be increased demand on VDH resources which would necessitate additional positions.

While the proposal gives the State Board of Health the authority to collect fees in connection with its licensure program, because the known population of regulants is one, the agency would be unable to set reasonable fees commensurate with the cost of the program. Therefore, the expenditures associated with this bill would need to be supported by the general fund at least until a stable population of regulants is established. It is unclear if VDH will be able to implement the regulations by the timeframes prescribed in the bill without additional authority, i.e. emergency regulations.

Department of Medical Assistance Services

The bill requires the DMAS to provide coverage for expenses incurred in the provision of DHM. The requirement applies if the covered person is an infant under one year of age, the milk is obtained from a DHM bank that meets quality guidelines established by VDH, and a licensed medical practitioner has issued an order for an infant who satisfies certain criteria. The bill's provisions are expected to apply to both Medicaid and Family Access to Medical Insurance Security (FAMIS) Plan for infants.

DMAS reports that the cost of DHM is covered within the hospital inpatient payment for babies receiving care in neonatal intensive care units (NICU); however, Virginia, does not cover DHM costs once an infant is discharged from the hospital (i.e. outpatient costs). Based on information from the American Academy of Pediatrics, the average cost of pasteurized DHM is assumed to be $5.00 per ounce. Assuming, on average, approximately 35 ounces of breast milk per baby is used each day, the average daily cost of providing outpatient DHM is approximately $175. As this is a new service, there is no way to readily project the number of children that would receive DHM or length of time DHM may be utilized on an outpatient basis. National data and scholarly articles report a wide range of potential utilization expectations related to the use of DHM. For the purposes of this statement, DMAS estimates that, on average, 200 eligible infants each day could utilize DHM between leaving the hospital and less than one year of age. However, this assumption is a general estimate, and the actual number will largely depend on how many children meet the bill's eligibility criteria. Based on these assumptions and FY 2024 data, the estimated baseline cost of providing DHM for eligible infants would be approximately $1.1 million each month or $12.6 million annually. It is estimated that this amount would grow by approximately five percent in subsequent years. In addition, it is estimated that 7.9 percent of infants would be covered under FAMIS with the rest covered by Medicaid (ratio of FAMIS to Medicaid newborns in FY 2024).

The provisions of the bill related to an effective date of January 1, 2027, do not appear applicable to medical assistance services. As such, Medicaid and CHIP coverage of DHM would coincide with the bill's effective date of July 1, 2026. Given the delayed enactment, it is assumed that DMAS will have sufficient time to establish the service and a full year of medical assistance costs are assumed in FY 2027. As such, based on these assumptions, a general estimate of this bill's impact on Medicaid and FAMIS medical costs is $13.2 million ($6.4 million general fund) in FY 2027 ($12.6 million + five percent growth).

DMAS also estimates a cost of $1.0 million ($0.3 million general fund) in FY 2026 for administrative costs, including one-time changes to DMAS' Medicaid Enterprise Systems to allow coverage of DHM. System costs are eligible for an enhanced federal match rate.

State Corporation Commission

Because coverage for DHM is in addition to the essential health benefits (EHBs) contained in the EHB benchmark plan, federal law (45 C.F.R. § 155.170) requires the state to defray the cost of this additional benefit by making payments to health carriers for claims paid under the new additional benefit. Payments are distributed on a quarterly basis; for example, carriers would receive defrayal payments for claims occurring from January to March in the following calendar quarter. Because of this lag in payments, appropriations in FY 2027 would only be needed to cover a single quarter (payment issued in Q4 for claims occurring in Q3). Payments for claims occurring in FY2027 Q4 would not be distributed until Q1 of FY2028. The annual defrayal payment amount, which is paid from the general fund, is based on the previous analysis of the Bureau of Insurance (BOI) as presented to the Health Insurance Reform Commission in 2021 and adjusted based on enrollment changes in the individual market and for inflation using the Consumer Price Index medical care index. BOI does caution that since defrayal payments are based on actual claims, the amount of general fund appropriations may need to be adjusted once it begins receiving claims data for DHM from health carriers. In addition to the defrayal amounts from the general fund, BOI estimates that it would need nongeneral fund appropriations for a contract actuary ($5,000) for claims data. BOI also estimates that defrayal payments would annually take 80 hours ($6,015, reflecting hourly rate and a multiplier to capture fringe benefits and overhead) of a policy advisor's time; however, the cost of these hours can be absorbed within existing resources. The estimated expenses are based on BOI's historical experience in making defrayal payments for the state-mandated health benefit of hearing aids for minors.

SCC estimates the bill's fiscal impact to total $91,955 in FY 2027, due to the coverage mandate being effective January 1, 2027, and payments not being issued until the fourth quarter of the fiscal year. All subsequent fiscal years reflect a full year's worth of payments. Beginning FY 2028, the total annual estimated impact is $375,170 and is adjusted annually for inflation (two percent) in the expenditure tables above. Since defrayal payments are based on actual claims, the amount of general fund appropriations may need to be adjusted once claims data is received for DHM.

Other: The introduced budget includes language in Item 288 that requires a reserve amount be appropriated for new Medicaid initiatives. In addition to the cost of the initiative, the reserve equals the difference between the general fund appropriated for the initiative in FY 2026 and the highest annual general fund cost of the initiative over the next six fiscal years. While not reflected in the table above, the reserve amount is estimated at $7.8 million general fund for the initiative required by this bill. Act language also delays initiative implementation until the reserve requirement is met.