

**REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS**

**MANDATED PARITY IN
THE COVERAGE OF
MENTAL DISORDERS**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



SENATE DOCUMENT NO. 41

**COMMONWEALTH OF VIRGINIA
RICHMOND
2000**

COMMONWEALTH OF VIRGINIA



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January 13, 2000

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 assess the social and financial impact and the medical efficacy of 1999 Senate Bill 430 and 1998 House Bill 1052 regarding parity in the coverage of mental disorders.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Stephen H. Martin".

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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TABLE OF CONTENTS

<u>SECTION</u>	<u>PAGE</u>
INTRODUCTION	1
SUMMARY OF SENATE BILL 430	2
CURRENT MENTAL HEALTH COVERAGE MANDATE	3
INPATIENT AND PARTIAL HOSPITALIZATION TREATMENT	4
OUTPATIENT TREATMENT	4
PREVIOUS STUDIES AND CHANGES TO THE STATUTE	4
COST OF MENTAL HEALTH CARE	6
PREMIUM IMPACT	7
CURRENT INDUSTRY COVERAGE	8
FEDERAL MENTAL HEALTH PARITY ACT OF 1996	9
COVERAGE IN OTHER STATES	10
REVIEW CRITERIA:	10
SOCIAL IMPACT	10
FINANCIAL IMPACT	13
MEDICAL EFFICACY	14
EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS	15
RECOMMENDATION	16
CONCLUSION	16
APPENDICES:	
A - 1999 SENATE BILL 430	A-1
B - 1998 HOUSE BILL 1052	B-1

INTRODUCTION

The House Committee on Corporations, Insurance and Banking referred House Bill 1052 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) during the 1998 Session of the General Assembly. Delegate A. Donald McEachin is the patron of House Bill 1052. The Senate Committee on Commerce and Labor referred Senate Bill 430 to the Advisory Commission during the 1998 Session of the General Assembly. Senator R. Edward Houck is the patron of Senate Bill 430. If enacted, the bills would amend and reenact § 38.2-3412.1 of Title 38.2 of the Code of Virginia to require any 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 (HMO) providing a health care plan for health care services to provide benefits for inpatient, partial hospitalization, medication management and outpatient treatment of a mental disorder that are not less favorable than benefits for any other illness, condition or disorder that is covered by such policy or contract. However, benefits for treatment of a mental disorder may be different from benefits of other illnesses, conditions, or disorders if such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other illness, condition or disorder that is covered by such policy or contract.

Coverage for mental disorders is to be neither different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, co-payment or coinsurance factors, and benefit year maximum for deductibles and co-payment and coinsurance factors.

The bills do not preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of mental disorders 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 bills define "mental disorder" as all medically recognized mental illnesses, as defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), as updated from time to time.

The bills do not apply to short-term travel, accident only, limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVII of the Social Security

Act, known as Medicare, or any other similar coverage under state or federal governmental plans. These bills apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on and after July 1, 1998, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

The 1999 General Assembly passed Senate Bill 430. The bill was amended prior to passage and before it was signed by the Governor. It will be effective on July 1, 2000. The Chairman of the Senate Committee on Commerce and Labor requested a review of this bill by the Advisory Commission.

The Advisory Commission held a hearing to receive public comments on August 24, 1999, in Richmond. Senator Houck and Delegate McEachin addressed the bills. In addition, comments were received from representatives of the National Alliance for the Mentally Ill, the Medical Society of Virginia, the Psychiatric Society of Virginia, the Washington Area Psychiatric Society, the Virginia Chapter of the International Association of Psychosocial Rehabilitation Services, the Virginia Association of Mental Health and the Richmond Pediatric Society. Also, four private citizens spoke in favor of the bill. Written comments in support of the bill were received from Virginians for Mental Health Equity (VMHE), and the Virginia Chapter of the International Association of Psychosocial Rehabilitation Services. Additionally, the Virginia Association of Health Plans (VAHP), by written comments, addressed the potential cost impact of Senate Bill 430. The Advisory Commission concluded its review on the bills on September 21, 1999.

SUMMARY OF SENATE BILL 430

Senate Bill 430 adds § 38.2-3412.1:01 and amends § 38.2-3412 (the existing mental health mandate provision) and § 38.2-4319 to make the requirement applicable to HMOs.

Subsection A of the bill requires 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 subscription contracts; and HMOs providing health care plans to provide coverage for biologically based mental illnesses. A "biologically-based mental illness" is defined 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 illnesses 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 benefits for the biologically-based mental illnesses may be different from benefits for other illnesses, conditions or disorders if the benefits meet the medical criteria necessary to achieve the same outcomes achieved by the benefits for any other illness, condition or covered disorder. However, the coverage for biologically-based mental illnesses is to be neither different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, or co-payment and coinsurance factors.

The bill does not preclude the undertaking of usual and customary procedures to determine the medical necessity and appropriateness of treatment, provided that all medical necessity and appropriateness determinations are made in the same manner as for other illnesses, conditions, or disorders.

Subsection F of the bill provides that it does not apply to (i) short-term travel, accident only, limited or specified disease policies, or (ii) short-term nonrenewable policies of not more than six months' duration, or (iii) policies, contracts, or plans in the individual market or small group markets to employers with 25 or fewer employees, or (iv) policies or contracts designed for persons eligible for Medicare or other similar coverage under state or federal plans. The bill also amends § 2.1-20.1 in the requirements of coverage for state employees to include similar language.

The bill amends existing § 38.2-3412.1 to provide that § 38.2-3412.1 does not apply to "biologically-based mental illnesses" as defined in § 38.2-3412.1:01 unless coverage for mental illness is not otherwise available pursuant to § 38.2-3412.1:01.

The bill has a delayed effective date of January 1, 2000 and a "sunset" provision under which the law will expire on July 2, 2004. Prior to that date, the Advisory Commission is to conduct a study to determine the effects, if any, of the coverage required under § 38.2-3412.1:01 on claims experience for and costs of policies, contracts, or plans. The Advisory Commission is required to submit its written report no later than December 1 of 2001, 2002, and 2003.

CURRENT MENTAL HEALTH COVERAGE MANDATE

Section 38.2-3412.1 of the Code of Virginia requires that individual and group accident and sickness policies and subscription contracts providing coverage on an expense-incurred basis must provide coverage for inpatient, partial hospitalization and outpatient mental health treatment at the following levels:

INPATIENT AND PARTIAL HOSPITALIZATION TREATMENT

- Treatment for an adult as an inpatient for a minimum of 20 days per policy or contract year;
- Treatment for a child or adolescent as an inpatient for a minimum of 25 days per policy or contract year;
- Up to ten days of inpatient benefits may be converted, when medically necessary, to partial hospitalization coverage at a rate of one and one-half days per one day of inpatient coverage for adults, children, or adolescents; and
- Limits on the inpatient and partial hospitalization coverage are not to be more restrictive than for any other illness, except as indicated above.

OUTPATIENT TREATMENT

- Coverage for a minimum of 20 outpatient visits for an adult, child or adolescent per policy or contract year;
- Benefit limits are to be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five visits shall be at least 50%;
- Medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of benefit; and
- If all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum.

PREVIOUS STUDIES AND CHANGES TO THE STATUTE

A task force composed of representatives of health care providers, insurers, the business community, relevant state agencies, and other organizations was created in 1989 to study the adequacy of insurance benefits for people receiving treatment for all mental disabilities. Based on the recommendations of the task force, House Bill 1329 (1991) was introduced to

revise coverage for outpatient treatment for mental health. The Advisory Commission also reviewed Senate Joint Resolution 206, which requested the Advisory Commission to study the need for parity in coverage for mental and physical illnesses. The Advisory Commission chose to study House Bill 1329 and Senate Bill 206 concurrently. Based on its review, the Advisory Commission voted to recommend that § 38.2-3412 of the Code of Virginia be revised to include benefits for partial hospitalization and outpatient treatment in 1992.

Senate Bill 368 was introduced during the 1994 Session of the General Assembly. It required insurers to provide benefits for inpatient and outpatient treatment of a mental disorder that are not less favorable than benefits for any other illness, condition, or disorder covered by a policy or contract and was referred to the Advisory Commission. The bill required that deductibles, benefit year or lifetime durational limits, lifetime dollar limits, lifetime episodes of treatment limits, co-payments and coinsurance factors, and benefit year maximums for deductibles not be different or separate from coverage for any other illness. Senate Bill 368 also required individual accident and sickness policies to provide coverage for outpatient substance abuse services consistent with existing requirements for group policies and contracts for outpatient mental health and substance abuse services.

House Bill 1223, which required individual policies and contracts to meet the same requirements as group policies and contracts for outpatient mental health and substance abuse services, was also referred to the Advisory Commission for review during 1994. The Advisory Commission supported the creation of a second task force to review both Senate Bill 368 and House Bill 1223 after a suggestion by the patron of Senate Bill 358.

The second task force studying parity in the coverage of mental health treatment was created by the Advisory Commission and continued by Senate Joint Resolution (1995). The task force was composed of mental health consumers and providers, members of the business community, governmental representatives, and representatives of the insurance industry. The task force was charged with reviewing the adequacy of mental health coverage to achieve consensus on what constitutes adequate mental health and substance abuse health insurance benefits.

The task force completed its work in the fall of 1995 and presented its findings and recommendations to the Advisory Commission on November 20, 1995. A public hearing was held and five members of the task force spoke in favor of the findings and recommendations. No one spoke in opposition to the findings and recommendations of the task force.

Section 38.2-3412.1 was amended in 1996 based on the second task force's recommendations to require individual policies and contracts to meet the

same requirements as group policies and contracts for outpatient mental health and substance abuse services. The benefit limits are to be no more restrictive than for physical illness except that coinsurance after five outpatient visits in any year must be at least 50%. In addition, if all covered expenses for an outpatient visit apply toward any deductible required by a policy or contract, the visit shall not count toward the visit benefit maximum set forth in the policy or contract.

COST OF MENTAL HEALTH CARE

According to a report prepared by the National Alliance for the Mentally Ill (NAMI), spending for behavioral health fell 54% between 1988 and 1997, while total health care spending fell by just 7%. In 1988, behavioral health care accounted for 6.1% of total health spending. By 1997, behavioral health care accounted for 3.1%. The report attributed most of the savings to the rise of managed care, which requires patients to obtain permission before using health services and decreases payments to hospital and doctors. New medications have also led to new and less expensive treatments.

A February 1998 National Underwriter article entitled, "Increased Mental Health Access May Tame Disability Claims," references a 1997 study conducted by UNUM Life Insurance Company of American, of Portland, Maine. The study reported that employers with the least restrictive outpatient mental health plans experienced a mental disability claims rate four times lower than those employers with more restrictive plans. The study was based on responses collected from almost 300 companies in the United States.

The U.S. Department of Health and Human Services (HHS) recently conducted a study of the characteristics of state parity laws, actuarial estimates of the costs of parity, and estimates of premium increases due to full parity. The HHS study, "The Cost and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits," found that state parity laws have had a small effect on premiums. Cost increases have been lowest in systems with tightly managed care and generous baseline benefits. The study also found that the low costs of adopting parity requirements allowed employers to keep employee health care contributions at the same level they were before parity. The HHS reported that previous actuarial predictions of premium increases due to mental health and substance abuse parity ranged from 3.2% to 11.4%, primarily due to differences in their assumptions. The HHS study did not find support for these assumptions. Based on an updated actuarial model, full parity for mental health and substance abuse services is estimated to increase costs by 3.4% on average.

In those instances where there was an increase in premiums, the increases varied according to the type of plan. The study found that fee-for-service and preferred provider organizations would have had a 5% premium

increase. In contrast, HMOs that tightly managed care would have had a 0.6% premium increase.

The National Advisory Mental Health Council (NAMHC) reported in its 1997 interim report that “the introduction of parity in combination with managed care can result in lowered costs and lower premiums (or at most modest cost increases) within the first year of parity implementation.” The NAMHC also noted that parity in the absence of managed care may result in claim and premium increases.

The NAMHC explained that its findings did not support earlier concerns about potentially high financial costs caused by parity. Prior estimates were based on fee-for-service models that are no longer valid for a market dominated by managed care. The NAMHC concluded that the effects on mental health service costs and access will depend largely on the extent of managed care and parity already in place in those states where parity is required.

PREMIUM IMPACT

Information about the financial impact of existing mandates in Virginia is reported as required by § 38.2-3419.1. House Document 6 (1999) “The Financial Impact of Mandated Health Insurance Benefits and Providers” contains information from the 1997 reporting year.

The information that was reported and the information reported by responding companies relevant to the coverage of mental disorders is displayed in the following tables. The figures shown represent the percentage of the overall average premium that was reported by all the companies for the mandate category indicated.

Premium Impact on Individual Contracts

Single Coverage

Men/Emotional/Nervous	Inpatient	2.12%
Men/Emotional/Nervous	Partial Hospitalization	.45
Men/Emotional/Nervous	Outpatient	1.69
Alcohol & Drug	Inpatient	.49
Alcohol & Drug	Partial Hospitalization	.30
Alcohol & Drug	Outpatient	.79

Family Coverage

Men/Emotional/Nervous	Inpatient	2.30
Men/Emotional/Nervous	Partial Hospitalization	.17
Men/Emotional/Nervous	Outpatient	2.89
Alcohol & Drug	Inpatient	.75
Alcohol & Drug	Partial Hospitalization	.29
Alcohol & Drug	Outpatient	.45

Premium Impact on Group Contracts

Single Coverage

Men/Emotional/Nervous	Inpatient	5.11%
Men/Emotional/Nervous	Partial Hospitalization	.31
Men/Emotional/Nervous	Outpatient	3.06
Alcohol & Drug	Inpatient	2.40
Alcohol & Drug	Partial Hospitalization	.11
Alcohol & Drug	Outpatient	1.32

Family Coverage

Men/Emotional/Nervous	Inpatient	2.96
Men/Emotional/Nervous	Partial Hospitalization	.33
Men/Emotional/Nervous	Outpatient	1.94
Alcohol & Drug	Inpatient	1.25
Alcohol & Drug	Partial Hospitalization	.14
Alcohol & Drug	Outpatient	.54

CURRENT INDUSTRY COVERAGE

Staff surveyed fifty of the top writers of accident and sickness insurance in Virginia regarding House Bill 1052 in 1998. Thirty-nine companies responded by April 24, 1998. Seven companies indicated that they write little or no applicable health insurance policies in Virginia and could not provide the information requested. Of the 32 respondents that completed the survey, four indicated that

they currently provide coverage for mental health that is at the same level as physical illnesses. Twenty-eight respondents indicated that they did not provide the coverage for mental health at the same level as physical illnesses.

None of the companies completing the survey indicated that they provided the coverage specified in House Bill 1052 and Senate Bill 430 to their individual policyholders on an optional basis. Four companies provided the coverage specified in House Bill 1052 and Senate Bill 430 to their group policyholders on an optional basis.

Seven respondents to the Bureau of Insurance survey provided cost figures of between \$0.13 and \$11.07 per month per standard individual policy to provide parity in the coverage of mental health coverage. United Healthcare of Virginia indicated that it would cost \$22.83 per month to provide the proposed coverage to its individual policyholders. Fourteen respondents indicated that it would cost from \$0.13 to \$26.89 per month per standard group certificate to provide the coverage specified in House Bill 1052 and Senate Bill 430. United Healthcare of Virginia responded that it would cost \$61.18 per month to provide the proposed coverage to its group certificate holders.

In 1999, the companies were re-surveyed regarding House Bill 1052. Twenty-four respondents completed the survey. Five companies indicated that they provide the coverage required by the bill in their standard contracts. One company includes the coverage in its group contracts but not the individual contracts. The other 16 companies do not provide the coverage required by House Bill 1052.

According to a May, 1998 Daily Press article entitled, "Managed Care Contributes to Health Savings," NAMI, in conjunction with several other groups, released a report regarding a new study on mental health trends. The study found that in 1997, 48% of health plans imposed limits on the number of outpatient visits each year. The limit was usually 20 per year. The study found that nearly half of the plans that imposed a limit on outpatient visits in 1988 allowed 50 per year. The study also found that only 17% of the plans allowed 50 visits in 1997. In 1997, 57% of plans imposed a limit on the number of days a patient could be treated in a hospital. In 1988, only 38% had a limit.

FEDERAL MENTAL HEALTH PARITY ACT OF 1996

In 1996, the federal government enacted the Mental Health Parity Act (MHPA) to require that all group health insurers that offer mental health benefits place the same annual or lifetime benefit cap on mental health coverage as with physical health coverage for all covered individuals. The law was effective January 1, 1998. The law exempts employers with fewer than 50 employees. If,

after implementing parity for at least six months, a plan experiences an increase in costs of 1% or more, the plan may claim an exception from the parity provisions.

The MHPA does not require employers to provide mental health benefits, nor does it affect the terms and conditions of mental health coverage such as visits, days, and cost sharing. The MHPA does not apply to substance abuse benefits.

COVERAGE IN OTHER STATES

According to information provided by the National Association of Insurance Commissioners, the National Insurance Law Service, and NAMI, there are currently 23 states that mandate coverage for some form of parity in the coverage of mental health. Of those 23, 6 states require that insurers make coverage available. At least 35 states have some type of mandate for coverage for mental health conditions.

Although several states' statutes indicate that coverage for mental illness is to be equal to that of physical illness, some states' statutes include inside limits to the coverage. One state mandates that annual and lifetime limits and out-of-pocket expense limits must be the same. However, the number of inpatient hospitalization days and outpatient visits may be limited and co-payments and deductibles are not required to be the same as for physical illnesses. Another state requires coverage for mental illnesses to be subject to the same coinsurance, co-payment, and deductible factors as that of physical illnesses. However, coverage may also be subject to a separate lifetime frequency cap not applied to physical illnesses.

A number of states, including Colorado, Connecticut, Maine, New Hampshire, South Dakota, and Nevada, include the term "biologically-based illness," or list "biologically-based illness," in the parity requirement.

REVIEW CRITERIA

SOCIAL IMPACT

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

Estimates of the national prevalence rate of persons being affected by a mental disorder vary from 15% to 20% of the population (one in every five

American families). Up to half of those with a mental disorder do not try to obtain treatment.

Information from the Department of Mental Health, Mental Retardation and Substance Abuse Services indicates that Virginia's estimated prevalence rate of serious mental illness among adults is 5.4%. The department estimates that 272,186 adults in Virginia have had a serious mental illness during the past year. The statewide estimated prevalence of serious emotional disturbance among children and adolescents is from 9% to 11%, with 5% to 7% exhibiting extreme impairment. The department estimates that 81,890 to 100,088 children and adolescents have had a serious emotional disturbance. Between 45,495 and 63,692 of these children and adolescents have had extreme impairment.

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

Mental health coverage is mandated in § 38.2-3412 of the Code of Virginia. The mandate requires a minimum of 20 inpatient days per policy or contract year for an adult and a minimum of 25 inpatient days per child per policy or contract year. Ten of the days of inpatient care may be converted to partial hospitalization. A minimum of 20 outpatient visits is also required for adults or children per policy or contract year.

Proponents of the legislation acknowledge that some level of coverage is generally available, but take the position that coverage for all medically necessary care is not available. In response to a 1999 survey by the Bureau of Insurance, five of twenty-four responding insurers (20.8%) indicated that they currently provide the coverage required under House Bill 1052.

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.*

According to Consumer Reports magazine (November 1995), fewer than one-third of American adults suffering from a mental or addictive disorder obtain professional help. Two reasons given for not seeking treatment are a lack of coverage or a lack of comprehensive coverage and the negative social stigma attached to mental illness.

The proponents of the legislation also discussed the co-payments of up to 50% for mental health care as opposed to 20% for most medical and surgical care. Testimony at the public hearing included comments regarding a lack of

coverage requiring patients to receive inpatient care in state facilities when other care would have been more appropriate.

- 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.*

Proponents make the argument that when there is no coverage, some patients receive less care than is necessary because they cannot afford to pay for all the care out of pocket. Receiving less therapy or medication than necessary can result in a relapse for the patient.

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

Virginians for Mental Health Equity noted that only 20% of those with a treatable mental illness actively look for treatment. It is estimated by the Department of Mental Health, Mental Retardation and Substance Abuse Services that there are 272,186 adults and 80,000 to 100,000 children and adolescents in Virginia with a serious mental illness or emotional disturbance.

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

Representatives of the National Alliance for the Mentally Ill, the Medical Society of Virginia, the Psychiatric Society of Virginia, the Washington Area Psychiatric Society, the Virginia Chapter of the International Association of Psychosocial Rehabilitation Services, the Virginia Association of Mental Health, and the Richmond Pediatric Society spoke in support of parity in the coverage of mental health care. Four citizens also spoke in support of the bill.

- g. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts is unknown.

- 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.*

Proponents cited the membership of the 1995 Mental Health Insurance Parity Task Force. The task force membership included representatives of insurers, businesses, mental health professionals, consumer groups, state agencies, and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Proponents also cited a study conducted pursuant to Senate Joint Resolution No. 107 (1992). One of the study findings was that approximately 18,000 with health coverage obtained care from the public sector, because their mental health care needs exceeded their coverage. Proponents also cited findings of the joint subcommittee established under House Joint Resolution No. 240 (1996) that changes in health coverage were necessary.

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.*

The mandate of parity in the treatment of biologically-based mental illnesses is not expected to increase or decrease the cost of treatment.

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

VHME makes the point that although the appropriate use of the treatments may increase, the overall cost of health care will decrease. They believe that illnesses related to psychological factors that currently may be treated by primary care practitioners will be reduced with appropriate mental health care.

Proponents point to reductions in health costs for substance abuse. They noted that the Minnesota Alcohol and Drug Authority reported that for chemically dependent clients, the state saved approximately \$22 million in annual health care costs by providing treatment. They also cited data from California's Department of Alcohol and Drug Programs that, in California, for every \$1 spent on treatment, an average of \$7 was saved.

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

VMHE contends that access to appropriate treatment will reduce the cost of medical care that then will then not be necessary. They believe the treatment of the underlying disorder will reduce or eliminate the need for medical care.

- 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 coverage is not expected to significantly affect the number and types of providers.

- 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.*

In 1998, seven insurers in Virginia estimated a monthly cost of from \$0.13 to \$11.07 for an individual policy to provide the coverage required under House Bill 1052. Fourteen respondents estimated costs of from \$0.13 to \$26.89 per month for group certificates.

The HHS study on the costs and effects of parity for mental health benefits estimated that for full parity, the premium increase would average 3.6%.

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

The total cost of health care is not expected to be significantly affected. Proponents believe that there will be some offset of the cost of treatment for the physical illnesses that result from lack of mental health care.

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 demonstrative the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.*

The two primary methods of treating mental illness, according to VHME, are behavioral treatment, which includes psychotherapy, and biological treatment, which includes medications. Usually, medication is used in combination with psychotherapy.

The 1994 Task Force Report stated, in part:

The efficacy of many treatments for mental disorders is comparable to that in other branches of medicine. For example, controlled studies have demonstrated that treatment intervention for schizophrenia, panic disorder, bipolar disorder, obsessive-compulsive disorder and major depression result in significant improvement for 60% to 80% of all patients. In contrast, the improvement rate for angioplasty and atherectomy, two commonly performed surgical procedures, are less than 60%.

Research continues on treatment of mental illness and substance abuse disorders, and new treatments are expected to increase effectiveness rates in the near future.

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.

Parity in the treatment of mental health addresses a medical need and is consistent with the role of health insurance. Many people acknowledge that there should be no distinction in treatment coverage for illnesses that are manifested in mental conditions. Proponents believe that equivalent coverage is necessary to eliminate discrimination against people with mental illnesses.

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

The proponents of the legislation believe that the cost of Senate Bill 430 will be low, less than \$1 per month. The U.S. Department of Health and Human Services used an updated model and actuarial assumptions in its 1998 study and estimated that full parity would increase premiums an average of 3.6%.

- c. *The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.*

It is expected that the cost of a mandated offer of coverage would be higher because the cost would rest on only those who select the coverage. In the case of group policies and contracts, the group contract holder makes the purchase decision, not the individual insured.

RECOMMENDATION

The Advisory Commission voted on the bills on September 21, 1999. The vote was 8 to 1, with one abstention, in favor of enacting the provisions of Senate Bill 430. The Advisory Commission voted to recommend corrections to the bill to reflect the original intent. These additions were noted because of the apparent conflict with federal provisions in the Health Insurance Portability and Accountability Act, regarding application of the bill to groups with 2 to 25 employees. There is also a conflict in the language that exempts individual coverage from the bill.

CONCLUSION

The Advisory Commission believes that the provisions of Senate Bill 430, as enacted, address an area of concern that remains in coverage for mental health care. The Advisory Commission believes that, with technical corrections to address the original intent of those involved regarding individual coverage and to comply with federal requirements, the bill represents a reasonable compromise on this issue.

VIRGINIA ACTS OF ASSEMBLY -- 1999 RECONVENED SESSION

CHAPTER 941

REENROLLED

An Act to amend and reenact §§ 2.1-20.1, 38.2-3412.1 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3412.1:01, relating to health insurance; state health care plan; mental health coverage.

[S 430]

Approved April 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-20.1, 38.2-3412.1 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3412.1:01 as follows:

§ 2.1-20.1. Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. a. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

b. In order to be considered a screening mammogram for which coverage shall be made available under this section:

(1) The mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

(2) The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

(3) The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage 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 National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics

and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. Such appeals process shall include a separate expedited emergency appeals procedure which shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services which enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there may be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears.

12. Include coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American

Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. a. *Include coverage for biologically based mental illness.*

b. *For purposes of this subdivision, a "biologically based mental illness" is 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 alcoholism addiction.*

c. *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, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.*

d. *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.*

e. *In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.*

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and beneficiaries thereof. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan established by the Department shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

§ 38.2-3412.1. Coverage for mental health and substance abuse services.

A. As used in this section:

"Adult" means any person who is nineteen years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health, Mental Retardation and Substance Abuse Services Board pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of nineteen years.

"Inpatient treatment" means mental health or substance abuse services delivered on a twenty-four-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" means treatment for mental, emotional or nervous disorders.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" means treatment for alcohol or other drug dependence.

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or

substance abuse counselor employed by a facility or program licensed to provide such treatment.

B. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty-five days per policy or contract year.

3. Up to ten days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein which provides inpatient benefits in excess of twenty days per policy or contract year for adults or twenty-five days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to short-term travel, accident only, limited or specified disease policies or contracts, nor to 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.

C. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of twenty visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least fifty percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to 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.

D. The provisions of this section shall not be applicable to "biologically based mental illnesses," as defined in § 38.2-3412.1:01, unless coverage for any such mental illness is not otherwise available pursuant to the provisions § 38.2-3412.1:01.

~~D.~~ E. The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment made.

§ 38.2-3412.1:01. Coverage for biologically based mental illness.

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 biologically based mental illnesses.

B. Benefits for biologically based mental illnesses may be different from benefits for other illnesses, conditions or disorders if such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other illness, condition or disorder that is covered by such policy or contract.

C. 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, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

D. 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.

E. For purposes of this section, a "biologically based mental illness" is 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 alcoholism addiction.

F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies, (ii) short-term nonrenewable policies of not more than six months' duration, (iii) policies, contracts, or plans issued in the individual market or small group markets to employers with 25 or fewer employees, or (iv) 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.

§ 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, 38.2-3412.1:01, 38.2-3411.2, 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.

2. That the provisions of this act amending and reenacting §§ 38.2-3412.1 and 38.2-4319 of the Code of Virginia and amending the Code of Virginia by adding a section numbered 38.2-3412.1:01 shall become effective on January 1, 2000.

3. That the Department of Personnel and Training shall collect such data and perform such analyses as are necessary to determine the effects, if any, on claims experience and costs of the coverage required by the amendments to § 2.1-20.1 of this act. The Department shall submit its findings in writing to the General Government Subcommittees of the House Appropriations and Senate Finance Committees not later than December 1, 2001; December 1, 2002; and December 1, 2003, and to the Governor and the General Assembly.

4. That the Special Advisory Commission on Mandated Health Insurance Benefits, pursuant to its authority under Chapter 34 (§ 9-297 et seq.) of Title 9 of the Code of Virginia, shall collect such data, perform such studies, and convene such public hearings as are necessary to determine the effects, if any, of the coverage required under §§ 38.2-3412.1:01, 38.2-3412.1 and 38.2-4319 pursuant to this act on claims experience for and costs of policies, contracts or plans, and shall submit a written report of its findings regarding the same to the Governor and the General Assembly not later than December 1, 2001; December 1, 2002; and December 1, 2003.

5. That the provisions of this act shall expire on July 1, 2004.

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HOUSE BILL NO. 1052

Offered January 26, 1998

A BILL to amend and reenact § 38.2-3412.1 of the Code of Virginia, relating to accident and sickness insurance; mental health coverage.

Patrons—McEachin, Darner, Davies, Hull, Jackson, Spruill, Tate, Van Yahres and Watts

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412.1 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3412.1. Coverage for mental health and substance abuse services.

A. As used in this section:

~~"Adult" means any person who is nineteen years of age or older.~~

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health, Mental Retardation and Substance Abuse Services Board pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 or (ii) a state agency or institution.

~~"Child or adolescent" means any person under the age of nineteen years.~~

"Inpatient treatment" means mental health or substance abuse services delivered on a twenty-four-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient substance abuse services.

~~"Medication management visit" means a visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.~~

"Mental disorder" means all medically recognized mental illnesses, as defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), as updated from time to time.

"Mental health services" means treatment for mental, emotional or nervous disorders.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

~~"Substance abuse services" means treatment for alcohol or other drug dependence.~~

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological

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HB1052

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are, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor employed by a facility or program licensed to provide such treatment or by a licensed substance abuse treatment professional.

B. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty-five days per policy or contract year.

3. Up to ten days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in §16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein which provides inpatient benefits in excess of twenty days per policy or contract year for adults or twenty-five days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to short-term travel, accident only, limited or specified disease policies or contracts, nor to 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.

C. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of twenty visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least fifty percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to 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.

APPENDIX B

1 ~~D. The requirements of this section shall apply to all insurance policies and subscription contracts~~
2 ~~delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or~~
3 ~~contract is changed or any premium adjustment made.~~

4 B. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or
5 group accident and sickness insurance policies providing hospital, medical and surgical, or major
6 medical coverage on an expense-incurred basis; each corporation providing individual or group
7 accident and sickness subscription contracts; and each health maintenance organization providing a
8 health care plan for health care services shall provide benefits for inpatient, partial hospitalization,
9 medication management and outpatient treatment of a mental disorder that are not less favorable
10 than benefits for any other illness, condition or disorder that is covered by such policy or contract;
11 however, benefits for treatment of a mental disorder may be different from benefits for other illnesses,
12 conditions or disorders if such benefits meet the medical criteria necessary to achieve the same
13 outcomes as are achieved by the benefits for any other illness, condition or disorder that is covered
14 by such policy or contract.

15 C. Coverage for mental disorders shall neither be different nor separate from coverage for any
16 other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime
17 durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits,
18 copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and
19 coinsurance factors.

20 D. Nothing shall preclude the undertaking of usual and customary procedures to determine the
21 appropriateness of, and medical necessity for, treatment of mental disorders under this option,
22 provided that all such appropriateness and medical necessity determinations are made in the same
23 manner as those determinations made for the treatment of any other illness, condition or disorder
24 covered by such policy or contract.

25 E. This section shall not apply to short-term travel, accident only, limited or specified disease
26 policies or contracts, nor to policies or contracts designed for issuance to persons eligible for
27 coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar
28 coverage under state or federal governmental plans.

29 F. The requirements of this section shall apply to all insurance policies, subscription contracts,
30 and health care plans delivered, issued for delivery, reissued, or extended after July 1, 1998, or at
31 any time when term of the policy or contract is changed or any premium adjustment made.

Passed By		Official Use By Clerks		Passed By The Senate	
The House of Delegates					
without amendment	<input type="checkbox"/>			without amendment	<input type="checkbox"/>
with amendment	<input type="checkbox"/>			with amendment	<input type="checkbox"/>
substitute	<input type="checkbox"/>			substitute	<input type="checkbox"/>
substitute w/amdt	<input type="checkbox"/>			substitute w/amdt	<input type="checkbox"/>
Date: _____		Date: _____			
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Clerk of the House of Delegates		Clerk of the Senate			

