REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

Mandated Coverage for Training and Education in the Use of EEG Biofeedback Equipment and Techniques

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 36

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COMMONWEALTH OF VIRGINIA

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SENATE

January 9, 2001

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 to assess the social and financial impact and the medical efficacy of House Bill 653, regarding a proposed mandate of coverage for EEG biofeedback.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
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TABLE OF CONTENTS

INTRODUCTION

During the 2000 Session of the General Assembly, the House Committee on Corporations, Insurance and Banking referred House Bill 653 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). House Bill 653 was patroned by Delegate Alan A. Diamonstein. Delegate Diamonstein submitted amended language on August 29, 2000.

The Advisory Commission held a hearing on October 4, 2000 in Richmond to receive public comments on House Bill 653. In addition to the patron, a Ph. D. from Riverside Neurotherapy Services, and the president of a technology development and commercialization firm specializing in advanced feedback technology spoke in support of the bill. Written comments supporting House Bill 653 were received prior to the public hearing from concerned citizens and several professional counselors and licensed clinicians representing private and group practices. Representatives from the Virginia Academy of Clinical Psychologists, Shoney's/Captain D's Restaurants, the Virginia Association of Health Plans (VAHP), and the Health Insurance Association of America (HIAA) spoke in opposition to the bill. Written comments opposing the bill were received from the Virginia Manufacturers Association (VMA), HIAA, VAHP, and Blue Cross Blue Shield (Trigon). A representative of the Medical College of Virginia also provided comments on the bill.

The Advisory Commission concluded its review of the bill on December 14, 2000.

SUMMARY OF PROPOSED LEGISLATION

House Bill 653, as amended, required an accident and sickness insurance policy to provide coverage for EEG biofeedback as a treatment for attention deficit disorder, attention deficit hyperactivity disorder, depression, stress-related and anxiety disorders, Tourette's Syndrome, insomnia, migraine headaches, or epilepsy.

The amended bill limits application of EEG biofeedback to Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (AD/HD). It clarifies which medical professionals are qualified to diagnose the need for EEG biofeedback training and education. Once the appropriate evaluation has been completed and a diagnosis made, EEG biofeedback training will be provided by or under the direct supervision of a licensed health practitioner who is a certified EEG biofeedback clinician.

The amended bill also requires that benefits will be provided for EEG biofeedback training and education in the use of equipment and techniques as

prescribed and provided by a licensed medical doctor, doctor of osteopathy, or clinical psychologist.

House Bill 653 requires the EEG biofeedback clinician to be certified by the Biofeedback Certification Institute of America (BCIA) or a comparable organization accredited by the National Organization of Certifying Agencies. Treatment and training sessions may be provided in the office of a certified provider, or, in the home, when a one-time equipment purchase fee will be reimbursed.

The bill defines "EEG biofeedback" as electroencephalogram biofeedback or neurofeedback as a treatment for attention deficit disorder and attention deficit-hyperactivity disorder.

The bill applies to individual and group policies providing hospital, medial and surgical or major medical coverage on an expense-incurred basis and subscription contracts and health care plans provided by health maintenance organizations. The bill does not apply to short-term travel, accident only, limited or specified disease policies, or to policies or contracts designed for issuance to persons eligible for Medicare or similar coverage under state or federal governmental plans.

UTILIZATION OF EEG BIOFEEDBACK

Dr. Robert W. Thatcher, Ph.D., University of South Florida, College of Medicine Tampa, Florida, wrote in an article published in the Journal of Neurotherapy, Vol. 2(4): 8 – 39, 1998 that electroencephalograhic (EEG) biofeedback is an operant conditioning procedure whereby an individual modifies the amplitude, frequency or coherency of the neurophysiological dynamics of their own brain (Cohen, 1975; Blanchard and Epstein, 1978; Rosenfeld, 1990). The exact physiological foundations of this process are not well understood, however, the practical ability of humans and animals to directly modify their EEG through feedback is a well-established fact, wrote Dr. Thatcher.

EEG Biofeedback is a combination of science and technology that offers an alternative to replace or augment the use of medication in treating AD/HD. Clinical studies conducted in the last twenty-five years prove that through repeated training sessions using EEG biofeedback, children can learn to control their attentive state, according to John G. Berger, President, East 3, Ltd. The therapeutic application of EEG biofeedback is often referred to as "Neurotherapy."

A typical course of treatment usually includes an interview, health history, evaluation, and sometimes "booster" sessions.

The Association for Applied Psychophysiology and Biofeedback (AAPB) describes EEG Biofeedback as a painless, non-invasive procedure that measures brain wave activity with an electroencephalograph (EEG). The EEG Biofeedback equipment is connected to the individual with sensors that are placed on the scalp and ears. After the connection is complete, the individual's brainwave activity can be observed on a computer monitor.

A biofeedback therapist leads the patient in mental exercises to help the patient learn to change his brainwave activity. Clients are taught to play computerized games using their brainwave activity. Changes in patient brainwave activity are fed back to the individual through visual and/or auditory information by the computer. The patient is rewarded when he focuses, which produces high-frequency beta waves in the brain. The patient makes no progress (in the games) when low-frequency theta or lower-frequency alpha waves are produced in the brain, which are related to day-dreaming, loss of concentration and lack of attention.

Quantitative EEG research has shown identifiable brain wave patterns can differentiate AD/HD children from normal children with 90% accuracy, according to Roger deBeus, PhD., Clinical Psychology Resident, Riverside Health System.

ATTENTION DEFICIT /HYPERACTIVITY DISORDER (AD/HD)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines Attention Deficit/Hyperactivity Disorder (AD/HD) as a disorder that afflicts a person with inattentiveness, hyperactivity/impulsivity, or combination of inattention and hyperactivity/impulsivity. Children and adolescents with this disorder demonstrate short attention spans, frequent distractibility, poor retention of details, frequent boredom, sudden outbursts of physical and verbal aggression, and limited skills in problem solving and verbal memory. According to DSM-IV criteria, 2-8 % of school-age children in the United States have AD/HD (the average generally used is 3-5%). Research shows that, without effective treatment, AD/HD symptoms have a 50 percent chance of persisting into adolescence and may continue into adulthood.

Other criteria included in diagnosing AD/HD are (1) onset no later than age 7; (2) symptoms must be present in 2 or more situations (e.g., at school, work, and at home); (3) the disturbance causes clinically significant distress or impairment in social, academic, or occupational functioning and; (4) it does not occur exclusively during the course of Pervasive Developmental Disorders, Schizophrenia or other Psychotic Disorder, and is not better accounted for by Mood, Anxiety, Dissociative, or Personality Disorder.

According to The Merck Manual of Diagnosis and Therapy, 1999 edition, the etiology is unknown. The cause of AD/HD has been linked to social sources such as prenatal distresses, poor parenting, and improper diet. Other experts argue that AD/HD is a physiological disorder characterized by some structural or chemically-based neurotransmitter problem in the nervous system. Some scientists believe the disorder may be inherited, although Attention Deficit Disorder-like behavior can also be acquired through brain injury, exposure to toxins, or high fever.

There is no single test to diagnose AD/HD. Therefore, a comprehensive evaluation, including hearing and vision tests, is necessary to establish a diagnosis, rule out other causes, and determine the presence or absence of co-existing conditions. Psychiatrists, psychologists, pediatricians or family physicians and neurologists can diagnose AD/HD. However, with the exception of psychiatrists, each of these specialists cannot prescribe medications or provide counseling or training. Usually, a multi-modal approach to treatment is recommended.

AD/HD may co-exist with other disorders. As many as forty to sixty percent of children with AD/HD have at least one other major disorder, according to "Children and Adults with Attention-Deficit/Hyperactivity Disorder" (CHADD).

Traditionally, AD/HD is treated with stimulant drugs such as Methylphenidate (Ritalin), dextroamphetamine (Dexedrine or Dextrostat), or pemoline (Cylert). The American Psychiatric Association (APA) was concerned that medications are over prescribed in the treatment of AD/HD, and has presented guidelines for diagnosing children with AD/HD.

LICENSURE REQUIREMENTS FOR EEG BIOFEEDBACK CLINICIANS

The Virginia Board of Medicine reports that neither the EEG, PET (positron emission topography), nor MRI emit ionized radiation; therefore, licensing is not required. Currently, there are no state laws regulating training requirements for an EEG Biofeedback clinician.

Nationally, the Biofeedback Certification Institute of America (BCIA) offers a certification program in EEG Biofeedback. The certification is voluntary, and represents a tangible commitment to basic standards of education, experience and professional ethics. Candidates are required to hold a bachelor's or higher degree in a health care field from a regionally accredited academic institution. Individuals who do not have a degree may be eligible for certification through a special review.

A certification in EEG Biofeedback requires the candidate to complete forty hours of didactic education, two hundred-twenty hours of supervised EEG

biofeedback training, ten hours of personal EEG biofeedback training, two hundred hours of supervised clinical EEG biofeedback patient treatment, and ten hours of patient case conferences. A human anatomy or human physiology course is required, and a cognitive neuroscience course is recommended (not required). A written, comprehensive examination is required of all applicants.

The nationally recognized certification is renewable every five years and the certification credential is listed as "BCIAC."

EQUIPMENT

EEG Biofeedback and Applied Psychophysiological monitoring equipment can operate as a portable stand-alone unit or as a sophisticated, multi-channel computer-based system that integrates EEG and other modalities (skin temperature, muscle tension, respiration, or heart rate, etc.).

A proponent who is a co-developer of numerous biofeedback products and services indicated that EEG biofeedback instrumentation and equipment are considered Class II devices by the Food and Drug Administration (FDA). Class II devices are required to have a pre-market clearance number that is filed, accepted, and granted through the FDA, before the equipment can be sold for clinical use to health-care professionals or under the order of a health-care professional.

EEG equipment and instrumentation is designed to easily interface with other desktop or laptop computer equipment. The proponent stated that personal trainers, used mostly at home with personal computers, could range in cost from $40 to $2,000. Stand-alone, clinical grade equipment could range in cost from $750 to $2,000.

Most clinical practitioners use comprehensive units because of the many assessment/diagnostic capabilities, the ability to provide complete printouts that could be used for reporting back to the referring physician and third-party payers. These units range in cost from about $2,000 to $4,500.

SOCIAL IMPACT

The Virginia Department of Education (DOE) estimated the number of Virginia students with AD/HD at 49,252 in a 1991 report entitled "Provision of Services to Students with Attention Deficit Hyperactivity Disorder." The number represented 5% of the total number of students in Virginia (985,031) as of September 30, 1989.

A subsequent VDE Report of Children and Youth with Disabilities Receiving Special Education, Part B, for the 1998-1999 School Year reveals that

9,414 students received special services in the "OHI" category. However, VDE is not required to identify the student's disability.

The Substance Abuse and Mental Health Services Administration Database reported that 252,867 adult Virginians suffered with mental illness in 1990. The same source reported that in 1995, an estimated 790,359 children and adolescents (under age 18) were diagnosed with serious emotional disturbances.

"NIH Consensus Statement on Diagnosis and Treatment of ADHD," Volume 16, Number 2, dated November 16-18, 1998, asserts that since there is no special education category specifically for AD/HD children, these students are underserved. Also, there is currently no tracking or monitoring of children with AD/HD who are served outside of special education. Therefore, educational and mental health services will dispute responsibility for coverage of special educational services.

The Consensus Statement points out that there is a substantial out-of-pocket cost to families for services not covered by managed care or other health insurance. Mental health benefits are sometimes carved out of many policies, and access to treatment other than medication might be severely limited.

The Consensus Statement concluded, in part, that there is a considerable share of resources from the health care system and various social service agencies that is currently devoted to individuals with AD/HD. However, the services are delivered in a nonintegrated manner. Resource allocation based on better cost data leading to integrated care models needs to be developed for individuals with the disorder.

Roger deBeus, PhD., Riverside Neurotherapy Services, indicated the number of licensed health practitioners who are certified as EEG biofeedback clinicians in Virginia is less than ten. John Berger, Jr., President, East3, Ltd. indicated that there are approximately 1,500 EEG biofeedback practitioners in the United States.

Virginia Association of Health Plans (VAHP) argues that House Bill 653 would provide coverage for an extremely specialized treatment protocol, which has not been generally accepted or widely available in the marketplace. Also, approving this legislation would allow the limited number of providers to increase substantially.

EDUCATIONAL RIGHTS

The Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) guarantee children with disabilities a

free and appropriate public education. Both laws require that children with disabilities be educated to the maximum extent appropriately equal to children who do not have disabilities. Each program offers different criteria for eligibility, different available services, different procedures for implementing laws, and different procedural safeguards.

The most substantial difference between the two laws is that eligibility for IDEA mandates that a child have a disability requiring special education services, while eligibility for Section 504 may occur when the child needs special education or related services.

Generally, IDEA defines a "child with a disability" as child with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific disabilities. The definition also includes children, who by reason thereof, require special education and related services.

For children aged three through nine, IDEA defines a "child with a disability" as a child experiencing developmental delays, as defined by the state and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development; and who by reason thereof, needs special education and related services. This definition is used at the discretion of the state and local educational agencies.

IDEA (Part B) provides that children with AD/HD may be considered as having a disability solely on the basis of this disorder within the "Other Health Impaired" (OHI) category if the AD/HD is a chronic or acute health problem resulting in limited alertness, which adversely affects educational performance. Special education services must be provided in the least restrictive environment upon determination of eligibility. However, the OHI category includes other handicaps such as limited strength, vitality or alertness due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance. Therefore, special education students may or may not exhibit symptoms as outlined in House Bill 653.

MEDICAL EFFICACY

Dr. Bela A. Sood, M.D., FAACAP, Director, Attention Deficit Disorders Clinic, Medical College of Virginia Hospitals, conducted a critical review of literature regarding EEG biofeedback and AD/HD. This review suggested that

efficacy had not been established utilizing the same rigorous criteria that is applied to other treatment modalities. Also, efficacy and related issues had not been appropriately discussed in a medical forum to engender a healthy debate.

Dr. Sood reports that the critical review of the literature finds that EEG biofeedback may be a credible treatment for neurobehavioral disorders, as it is unlikely that positive results obtained in the past two decades are merely a chance occurrence. However, in order to gain credibility, the field of EEG biofeedback has to design prospective studies using rigorous diagnostic criteria for AD/HD, with adequate sample sizes that have comparative treatment groups using standard treatments/waitlists controls and psychiatric control.

"NIH Consensus Statement on Diagnosis and Treatment of AD/HD," Volume 16, Number 2, dated November 16-18, 1998, concluded that AD/HD is a commonly diagnosed behavioral disorder of childhood that represents a costly major public health problem. There is evidence supporting the validity of the disorder, even though an independent diagnostic test for AD/HD does not exist. Further, many medical professionals cannot agree if AD/HD is a behavioral disorder or a mental condition, which presents a barrier to appropriate identification, evaluation, and treatment.

The Consensus Statement also states, and the AAP agrees, that more research is needed in every area to better define AD/HD. Research should include studies of cognitive development, cognitive processing, and attention/inattention in AD/HD; brain imaging studies before the initiation of medication and following the individual through young adulthood and middle age.

The Virginia Association of Health Plans opposes the bill due to lack of research to support the use of EEG biofeedback as an effective long-term treatment for AD/HD, and the potential impact such legislation could have on health care premiums. The "NIH Consensus Statement on Diagnosis and Treatment of ADHD," Volume 16, Number 2, dated November 16-18, 1998 states that other interventions (including biofeedback) have generated considerable interest and there are some controlled and uncontrolled studies using various strategies, the state of the empirical evidence regarding these interventions is uneven, ranging from no data to well-controlled trials.

A major study conducted in 1995 concluded that an EEG Biofeedback program could be an effective treatment for AD/HD where medication is ineffective, only partially effective, has unacceptable side effects, or where compliance with taking medication is low.

The study compared the results of 23 AD/HD patients treated with psychostimulant therapy to that of 23 AD/HD patients treated with biofeedback therapy and it was determined that symptoms were fully to partially remedied, and effects appeared permanent. Treatment lasted three to six months, and

there were no negative side effects. Occasionally, an AD/HD patient may require a "booster" session to reinforce learned skills.

The same study concluded that the EEG program is more expensive in the short run compared to the medication program. However, the cost differential may be declining due to better pretreatment assessment and more efficient treatment protocols. A study conducted by Othmer (1994) reports that training is successfully completed in 20 sessions for at least 30 percent of AD/HD patients. The EEG biofeedback program is a cost effective alternative to the long-term use of medication if it results in lasting symptom reduction, and particularly if the patient is one of the 60-70 percent who will not outgrow the disorder.

CURRENT INDUSTRY PRACTICES

The State Corporation Commission's Bureau of Insurance surveyed 60 of the top writers of accident and sickness insurance in Virginia in March 2000 regarding legislation to be reviewed by the Advisory Commission this year. Fifty companies responded by July 18, 2000. Twenty-four companies indicated that they have little to no applicable health insurance business in for in Virginia. Of the remaining, 26 companies completed the survey. Eight companies reported that they provided the coverage required by the original language in House Bill 653, under their standard benefit coverage. One company indicated that they provide the coverage for group contracts, but not individual contracts, under their standard benefit package. A second company subjected EEG biofeedback treatments to the mental illness limitations of 30 days inpatient treatment, and 52 days outpatient visits per year up to a maximum of $50 per visit. A third company provided coverage only for covered providers. And, another company covered EEG biofeedback for inpatients, but would not cover training and education. Fourteen companies said they did not provide the coverage.

FINANCIAL IMPACT

Respondents to a Bureau of Insurance survey provided cost figures that ranged from $.20 to $1.49 per month per standard individual policyholder. Cost figures were between $.01 and $2.23 per month per standard group certificate to provide the coverage required by House Bill 653. Insurers providing coverage on an optional basis provided cost figures between $.66 to $3.96 per month per standard individual policy, and between $.01 and $5.94 per month per standard group certificate.

Forty to fifty sessions at a cost of $75 to $100 or more per session is required to train a child to become attentive according to John Berger, Jr., President, East3, Ltd. Also, EEG Biofeedback is not economically feasible for the vast majority of families. The New England Journal of Medicine (JAMA)

confirmed last year that Americans spent $10.3 billion dollars on alternative health care.

The NIH Consensus Statement reports that national public school expenditures on behalf of students with AD/HD may have exceeded $3 billion in 1995.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners and the National Insurance Law Service, EEG Biofeedback is not a mandated health insurance benefit in any state

REVIEW CRITERIA

SOCIAL IMPACT

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

No information was presented as to the number of Virginians using EEG biofeedback.

VAHP indicates in a written statement that only four individuals in the Commonwealth of Virginia are certified to provide biofeedback services.

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

Of the 26 companies that completed the Bureau of Insurance survey, eight companies reported that they provided the coverage required by the original language in House Bill 653, under their standard benefit coverage. One company indicated that they provide the coverage for group contracts, but not individual contracts, under their standard benefit package. A second company subjected EEG biofeedback treatments to the mental illness limitations of 30 days inpatient treatment, and 52 days outpatient visits per year up to a maximum of $50 per visit. A third company provided coverage only for covered providers. And, another company covered EEG biofeedback for inpatients, but would not cover EEG biofeedback training and education.

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.*

Some coverage is available; however, inconsistencies among insurers leave some without coverage, or with limited coverage. A change in circumstances may require a family to change carriers, and benefits may also change. Treatment may be provided under one carrier if the diagnosis is classified as a medical condition. However, under another carrier, the treatment may be denied if the condition is classified as a learning disability. Or, a third company may provide limited treatment if the condition is classified as a mental condition.

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.*

Some coverage is available; however, inconsistencies among insurers leave some policyholders without coverage. John Berger, Jr., President, East3, Ltd. listed non-reimbursed costs of $75-$100 per session for 40 to 50 sessions ($3,000 to $5,000 total costs).

"NIH Consensus Statement on Diagnosis and Treatment of ADHD," Volume 16, Number 2, dated November 16-18, 1998 points out that there is a substantial out-of-pocket cost to families for services not covered by managed care or other health insurance. Mental health benefits are sometimes carved out of many policies, and access to treatment other than medication might be severely limited.

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

The level of public demand for this coverage is unknown. EEG biofeedback may be overlooked as an alternative treatment if the disorder is masked by other conditions. Differential diagnosis is difficult since many other physical and psychological conditions share characteristics with AD/HD. There is considerable debate that some patients are classified as possessing a learning disability, conduct disorders, or anti-social behaviors when, in fact, they have AD/HD.

AAPB states that more than 700 groups nationwide are using EEG biofeedback as a treatment modality for AD/HD.

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

The VAHP opposes the bill because it would require health plans to provide coverage for an extremely specialized treatment protocol which has not been generally accepted and is not widely available in the marketplace.

Written comments from nine proponents support House Bill 653. Several supporters indicate improvement, either a decrease in medication or no further need for medication, after utilization of EEG biofeedback.

As with many health insurance benefits, it is accepted that many policyholders are not knowledgeable of specific terms of their coverage until they are diagnosed with a condition or disease that requires specific treatment.

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.

The Advisory Commission is not aware of any such findings of a state health planning agency or appropriate health system agency relating to the social impact of EEG biofeedback as a treatment modality.

The Virginia Department of Education (DOE) estimated the number of Virginia students with AD/HD at 49,252 in a 1991 report entitled "Provision of Services to Students with Attention Deficit Hyperactivity Disorder." This number represented 5% of the total number of students in Virginia (985,031) as of September 30, 1989.

The Individuals with Disabilities Education Act (IDEA), Part B, provides that children with AD/HD may be considered as having a disability solely on the basis of this disorder within the "Other Health Impaired" (OHI) category. The AD/HD must be a chronic or acute health problem resulting in limited alertness, which adversely affects educational performance. Special education services must be provided in the least restrictive environment upon determination of eligibility. However, the OHI category includes other handicaps as limited strength, vitality or alertness due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance. Therefore, students may or may not exhibit disorders as outlined in House Bill 653.

A subsequent DOE report, "Report of Children and Youth with Disabilities Receiving Special Education," indicates that in the 1998-1999 school year 9,414 students, between the ages of three and twenty-two, received special services in the "OHI" category of the IDEA. Because DOE is not required to identify a student's disability, it is unknown the number of AD/HD children included in the 9,414 who may be eligible for this coverage.

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.*

In a June 19, 2000 Newsweek article entitled, "On the Track with Neurofeedback," Jim Robbins writes that as schools begin to offer the technique (EEG biofeedback) to students, and the cost of the equipment decreases, cost of treatment should decline. The writer believes that the EEG biofeedback systems are simple to use, and as practitioners lease units to patients, allowing for at home training, costs will decrease.

The Virginia Manufacturers Association (VMA) and Trigon, in written statements, contend that mandated treatments and services beyond those that may be clinically indicated will increase health insurance costs and increase the ranks of the uninsured.

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

The Virginia Academy of Clinical Psychologists is concerned with ensuring proper and necessary oversight by the physician regarding the use of home-based systems. The organization is unaware of any efficacy studies comparing biofeedback results in a doctor' s office or clinical setting as compared to a home based system.

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

Proponents of the bill make the argument that the need for alternatives to either replace or augment the use of medication in treating attention problems is obvious. In a cost comparison between medication and neurofeedback, John Berger reports that the approximate cost of neurofeedback with current technology is $3,600 for a 3-6 month treatment regimen. The results appear to be permanent. The average annual cost of medication is approximately $538

(excluding physician fees). However, the treatment may continue indefinitely, and the results are not permanent. Despite the apparent appeal as a non-invasive technology that facilitates the creation of a lasting skill, EEG biofeedback is almost unheard of outside of the wealthiest segment of the population because of its immediate cost. Also, required office visits during school/work hours make this alternative inconvenient. EEG biofeedback is not economically feasible for the vast majority of families needing the treatment.

Others questioned why insurers would pay for a more expensive treatment if there is no conclusive report regarding the efficacy of EEG biofeedback.

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.*

It is unlikely that the proposed coverage would significantly affect the number and types of providers of the mandated treatments because it is apparent that some insurers already provide such coverage and because the number of insureds needing such treatment is relatively small.

Opponents argue that despite the limited number of providers at this time, it is reasonable to expect the number to increase substantially if the mandate were enacted. Moreover, increased utilization of this service can be expected.

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.*

The respondents to the State Corporation Commission Bureau of Insurance survey provided cost figures required by the original bill language that ranged from $.01 to $2.23 per month per standard individual policyholder and group certificate holder. Insurers providing coverage on an optional basis provided cost figures from $.01 to $3.96 per month per individual policyholder and group certificate holder.

An increase in the administrative expenses of insurance companies and the premium and administrative expenses for policyholders is anticipated because of the expenses associated with such things as policy redesign, form filing, claims processing systems and marketing, and other administrative requirements. It is anticipated that the proposed mandate would increase claims costs because those individuals currently paying out-of-pocket will immediately be covered.

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

Proponents anticipate overall savings in total health care costs because of a reduction in "conventional" medical costs.

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

A proponent who is a practicing educational psychologist from Surrey, BC Canada, and certified by BCIA indicates that the efficacy of EEG biofeedback is undeniable. She states that its side effects are minimal to none, and symptom improvements shown in a relatively short period of time are significant. She believes a major advantage of EEG biofeedback over medication management is that the brain learns more efficient patterns which it maintains (there is no washout effect). Also, the technique has been used as a treatment for learning problems for more than twenty years. There are numerous published reports, and solid theoretical foundation on neuronal regulation written by clinical neurophysiologists. Lastly, the litigation history of EEG biofeedback is virtually non-existent.

Although traditional treatments are successful, the concern about the use of psychotropic drugs in the pediatric population has encouraged the search for alternative therapies. William Sears, M.D. and Lynda Thompson, Ph.D. wrote in "The A.D.D. Book" that in 1995, 1.5 million children in the United States (2.8 percent of schoolchildren) age five to eighteen were being treated with Ritalin. From 1990 to 1995, the number of children on AD/HD drugs tripled in the United States. In Canada between 1990 to 1995, the use of Ritalin increased three to four times according to a 1996 publication by Health Canada.

Proponents argue that psychostimulant medications may be effective in the short-term treatment for attention-related disorders, but they fail to correct the underlying behavioral elements of AD/HD over the long-term. Also, these medications have significant side effects such as, headaches, tics, insomnia, loss of appetite, weight loss and elevated heart rate. Furthermore, the medications may not prove to be 100 percent effective. Nor, is the future affect of these medications on young children known at this time.

The American Psychiatric Association (APA) and the NIMH share mutual concerns regarding the need to ensure appropriate use of medications to treat mental illnesses in children.

Opponents cite a lack of research to support the use of EEG biofeedback as an effective long-term treatment modality. "NIH Consensus Statement on Diagnosis and Treatment of ADHD," Volume 16, Number 2, dated November 16-18, 1998 states that other interventions (including biofeedback) have generated considerable interest and there are some controlled and uncontrolled studies using various strategies, the state of the empirical evidence regarding these interventions is uneven, ranging from no data to well-controlled trials.

A member of the medical community who works with this segment of the population conducted a critical review of literature regarding EEG biofeedback and AD/HD. This review suggested that more scientifically rigorous studies are needed to establish EEG biofeedback as a tool to diagnose and treat AD/HD. The critical review concluded that EEG biofeedback has some merit and bears further investigation by well designed studies.

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.*

According to Dr. Bela Sood, the premise of EEG biofeedback as a treatment modality for AD/HD is, that children can be trained via biofeedback to alter the proportion of their theta to beta (i.e. reduce the theta/beta ratio, increase their sensorimotor rhythm (SMR) and beta activity). By doing so they undo the hypothesized flaw leading to clinical symptoms. As they achieve improved capacity to control their EEG and steer EEG frequencies in the desirable direction, an improvement in attention span, goal-directed activity, and reduced hyperactivity is seen.

Dr. Sood suggests that EEG biofeedback is a time sensitive process and that response is slow to appear. In view of the expense involved (equipment, sessions) and length of treatment involved, behavioral change should be maintained long after treatment stops.

"NIH Consensus Statement on Diagnosis and Treatment of AD/HD," Volume 16, Number 2, dated November 16-18, 1998 concluded that AD/HD is a commonly diagnosed behavioral disorder of childhood that represents a costly major public health problem. However, many medical professionals cannot agree if AD/HD is a behavioral disorder or a mental condition, which presents a barrier to appropriate identification, evaluation, and treatment.

House Bill 653 addresses the medical need of treating individuals with attention deficit disorder and attention deficit hyperactivity disorder. The benefit is consistent with the role of health insurance, although it is not considered conventional medicine. There is some concern that treatment provisions under House Bill 653 could be addressed by the education system.

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

Proponents have stated that EEG biofeedback is not a cure for AD/HD. However, there is an increasing body of evidence to support the conclusion that EEG biofeedback leads to normalization of behavior and can enhance the long-term academic performance, social functioning, and overall life adjustment of the AD/HD patient.

The Virginia Manufacturers Association presented written comments opposing the legislation. The VMA questioned if mandating EEG biofeedback is a protection against financial catastrophe, or a payment mechanism for less expensive treatment.

Proponents believe that making EEG biofeedback coverage mandatory will increase availability of treatment to those who could not ordinarily afford the out-of-pocket expense.

Opponents believe that the continual mandating of additional benefits is not good public policy and can have the ultimate effect of making health care too costly for individuals and small businesses least able to afford it.

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

The cost of a mandated offer of coverage would be expected to be higher than a mandate to include EEG biofeedback due to adverse selection by those who had reason to believe they might need such treatment in the future. In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insured. Therefore, it is possible that many insureds would not benefit from such a requirement.

RECOMMENDATION

The Advisory Commission voted on House Bill 653 at its December 14, 2000 meeting. The vote was 6 to 1 to recommend that House Bill 653 not be enacted.

CONCLUSION

The Advisory Commission received information indicating that EEG biofeedback, as a treatment modality for attention deficit disorder and attention deficit hyperactivity disorder, has some merit. However, areas of concern where the review process was inconclusive centered on patient costs and physician risk issues relating to clinical monitoring of the patient. The role of the public education system as a point of service was a concern, also.

The Advisory Commission was especially concerned that the medical community could not agree on treatment effectiveness, and that the efficacy of the treatment itself remains so much in doubt.

The Advisory Commission believed that since no other state has mandated such coverage, Virginia should not be the first state to initiate such a requirement. And, with a number of questions and concerns remaining unresolved, the Advisory Commission concluded that more research and study by the medical community is needed before EEG biofeedback is mandated for coverage in Virginia.

003337724

HOUSE BILL NO. 653

Offered January 20, 2000

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia, as it is currently effective and as it will become effective, and to amend the Code of Virginia by adding a section numbered 38.2-3418.12, relating to health care coverage; EEG biofeedback.

Patron—Diamonstein

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia, as it is currently effective and as it will become effective, is amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.12 as follows:

§ 38.2-3418.12. Coverage for EEG biofeedback.

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 EEG biofeedback as provided in this section.

B. Such coverage shall include benefits for training and education in the use of EEG biofeedback equipment and techniques. To qualify for coverage under this section, EEG biofeedback training and education shall be prescribed and provided by a licensed health care professional.

C. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category.

D. For the purposes of this section, "EEG biofeedback" means electroencephalogram biofeedback or neurofeedback prescribed as a treatment for attention deficit disorder, attention deficit-hyperactivity disorder, depression, stress-related and anxiety disorders, Tourette's Syndrome, insomnia, migraine headaches, or epilepsy.

E. The requirements of this section shall apply to all policies, contracts, and plans delivered, issued for delivery, reissued, extended or renewed in this Commonwealth on and after July 1, 2000, or any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. The provisions of this section shall not apply to (i) short-term travel, accident-only, limited or specified disease policies; (ii) 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; or (iii) short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. (Effective until July 1, 2004) 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.), §§ 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 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.11~~ *38.2-3418.12*, 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.), Chapter 58 (§ 38.2-5800 et seq.) and Chapter 59 (§ 38.2-5900 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.

§ 38.2-4319. (Effective July 1, 2004) 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.), §§ 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 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.11~~ *38.2-3418.12*, 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.), Chapter 58 (§ 38.2-5800 et seq.) and Chapter 59 (§ 38.2-5900 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.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

HOUSE BILL NO. 653

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by Delegate Diamonstein

on _____)

(Patron Prior to Substitute—Delegate Diamonstein)

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia, as it is currently effective and as it will become effective, and to amend the Code of Virginia by adding a section numbered 38.2-3418.14, relating to health care coverage; EEG biofeedback.

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia, as it is currently effective and as it will become effective, is amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.14 as follows:

§ 38.2-3418.14. Coverage for EEG biofeedback.

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 EEG biofeedback as provided in this section.

B. Such coverage shall include benefits for training and education in the use of EEG biofeedback equipment and techniques. To qualify for coverage under this section, EEG biofeedback training and education shall be deemed necessary by a licensed medical doctor, doctor of osteopathy or clinical psychologist.

C. Once an appropriate evaluation has been completed and a diagnosis made by a licensed provider as defined in subsection B, EEG biofeedback training will be provided by or

under the direct supervision of a licensed health practitioner who is a certified EEG biofeedback clinician. Certification for the purpose of this section is defined as successful completion of all educational and training requirements of the Biofeedback Certification Institute of America (BCIA) or comparable organization accredited by the National Organization of Certifying Agencies.

D. When EEG biofeedback treatment and training sessions are provided in the office of a provider certified under subsection C, no fee for use of training equipment will be reimbursed. When home training has been determined to be appropriate by a provider certified under subsection C, a one-time equipment purchase fee will be reimbursed.

E. The frequency of individual training sessions necessary to complete a full course of training shall be determined by the provider certified under subsection C. Reimbursement for each training session shall not exceed the standard hourly rate of the licensed, certified provider.

F. For the purposes of this section, "EEG biofeedback" means electroencephalogram biofeedback or neurofeedback prescribed as a treatment for attention deficit disorder and attention deficit hyperactivity disorder.

G. The requirements of this section shall apply to all policies, contracts, and plans delivered, issued for delivery, reissued, extended or renewed in this Commonwealth on and after July 1, 2001, or any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

H. The provisions of this section shall not apply to (i) short-term travel, accident-only, limited or specified disease policies; (ii) 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; or (iii) short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. (Effective until January 1, 2001) 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, 38.2-209 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.), §§ 32.2-1017 through 38.2-1023, §§ 38.2-1057, 38.2-1306 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 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3418.14, 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 52 (§ 38.2-5200 et seq.) Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 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.

E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4319. (Effective January 1, 2001 until July 1, 2004) 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, 38.2-209 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.), §§ 32.2-1017 through 38.2-1023, §§ 38.2-1057, Articles 2 (§ 38.2-1306 et seq.), 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 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3418.14, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, 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 52 (§§ 38.2-5200 et seq.), Chapter 55 (§§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and § 38.2-5903 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.

E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4319. (Effective July 1, 2004) 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, 38.2-209 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.), §§ 38.2-1017 through 38.2-1023 §§ 38.2-1057, Articles 2 (§ 38.2-1306 et seq.), 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 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.12, 38.2-3418.14, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, 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 52 (§§ 38.2-5200 et seq.), Chapter 55 (§§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 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.

E. For purposes of applying this section, "insurer" when used in a section cited in subsection A of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

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