REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

Coverage for Biologically Based Mental Illnesses

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 7

COMMONWEALTH OF VIRGINIA
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SENATE OF VIRGINIA

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November 30, 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 §§ 9-298,9-299 and § 38.2-3412.1:01 of the Code of Virginia.

This report documents a review conducted by the Special Advisory Commission on Mandated Health Insurance Benefits on the effects of coverage required for biologically based mental illnesses as required by Senate Bill 430 (1999).

Respectfully submitted,

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

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Introduction

Senate Bill 430 was passed by the 1999 General Assembly. It was effective on January 1, 2000. The law requires insurers proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing group subscription contracts; and health maintenance organizations (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 a biologically based mental illnesses, as they apply to adults and children: schizophrenia, schizoaeffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addition.

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 law 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 provides that the law 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 employers, or (iv) policies or contracts designed for persons eligible for Medicare or other similar coverage under state or federal plans. The law also amends § 2.1-20.1 in the requirements of coverage for state employees to include similar language.

The law 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 law has a "sunset" provision under which it 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, 2001, 2002 and 2003.

Claims and Premium Data for 2000

A public hearing was held in Richmond on September 26, 2001 to allow interested parties to address the bill and its impact. Preliminary information was presented to the Advisory Commission from the initial reports filed by insurers pursuant to § 38.2-3419.1. The preliminary information was based on reports from 16 HMOs and 32 insurers.

A number of Advisory Commission members voiced concerns about the preliminary information. One member also had concerns about the data on the impact of the current federal parity requirements. A representative of the Virginia Association of Health Plans (VAHP) spoke to the bill. VAHP was also concerned about the preliminary data. VAHP expressed their willingness to work with the Bureau of Insurance on the information. There was no testimony in support of or against retaining the bill.

Information was subsequently added to the consolidated reports from 2 HMOs and 5 insurers. Additional changes were made to the preliminary data to reflect follow-up changes to individual reports by several HMOs and programming changes that corrected calculations for family premium figures.

Reporting Year 2000

The following numbers identify the percentage of average annual premium and the average percentage of total claims attributable to the mandate for coverage of biologically based mental illness for the 2000 calendar year reporting period. These percentages were compiled from individual reports submitted by licensed carriers in Virginia, as required by § 38.2-3419.1 of the Code of Virginia.

PREMIUM IMPACT

Group Coverage – Health Maintenance Organizations

Single Coverage: 1.06% of Average Annual Premium

Family Coverage: 1.10% of Average Annual Premium

Group Coverage – Insurers

Single Coverage: 1.57% of Average Annual Premium

Family Coverage: 1.49% of Average Annual Premium

CLAIMS EXPERIENCE

Group Coverage – Health Maintenance Organizations

Average percentage of total claims: 1.25%

Group Coverage – Insurers

Average percentage of total claims: 1.15%

FEDERAL LEGISLATIVE ACTIVITY

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 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.

The General Accounting Office (GAO) reported to the Senate Committee on Health, Education and Pensions (HELP) on the implementation and effect of the Federal Mental Health Parity Act of 1996. The GAO reported its findings to the committee on May 18, 2000. The GAO surveyed 863 employers in 26 states that did not have parity laws. The GAO reported that 86% of the employers reported compliance with the 1996 legislation. However, many of them restrict mental health coverage in number of visits as an outpatient or hospital days when compared to coverage for physical illnesses. According to information provided to the subcommittee by the Federal Office of Personnel Management, the Federal Employees Health Benefits Program (FEHBP), the mental parity requirement has resulted in an average premium increase of 1.64% for fee for service plans and 0.3% for HMO's.

Mental Health Equitable Treatment Act

The Mental Health Equitable Treatment Act of 2001, (S.543) was introduced by Senator Domenci for himself and Senators Wellstone, Specter, Kennedy, Chafee, Dodd, Cochran, Reed, Reid Warner, Grassley, Roberts, Durbin and Johnson in March of 2001.

The Mental Health Equitable Treatment Act of 2001 would prohibit group health plans and group health insurers that provide both medical and surgical benefits and mental health benefits from having mental health benefits that are different from those used for medical surgical benefits. S.543 would extend and expand the existing mandate for mental parity that expired on September 30, 2001. The CBO estimates that if S.543 is enacted, it would increase premiums for group insurance by an average of 0.9%. This does not include the responses of insurers, employers and workers to the higher premiums.

Mental illnesses are defined in the bill as all categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revisions (DSM IV-TR). S.543 does not require coverage for substance abuse or chemical dependency and exempts small businesses with 50 or less employees.

The Mental Health Equitable Treatment Act passed the HELP Committee on August 6, 2001, but it was not considered on the floor of the Senate before the current law sunset on October 1, 2001. Senators Wellstone and Domenici have offered the provisions of the Act as an amendment to the Senate Labor Health and Human Services, Education Appropriations bill. The effective date of the bill on this amendment is 2003. The bill would not impact federal spending in the 2002 fiscal year with a 2003 effective date.

RECOMMENDATION

The Advisory Commission believes that more information on the financial impact of the mandate of parity for biologically based mental illnesses should be reviewed prior to any change in the current requirement. Information reported for the first full calendar year indicates an impact on claims of an average of 1.15% to 1.25% of total claims. The premium impact, as reported, ranges from 1.06% to 1.57% of average annual premiums. The initial reports are consistent with federal figures. Preliminary information on the impact on state employee coverage is also consistent with the figures although state employees claims are lower.

A report on the premium costs and claims related to this mandate is required in 2002 and 2003. The Advisory Commission believes that the information that will be available in those years will provide an accurate basis to evaluate the impact of the mandate.

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

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

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.