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

COMMONWEALTH OF VIRGINIA
RICHMOND
2003

December, 2002

To: The Honorable Mark R. Warner
Governor of Virginia
And
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505, 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
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Mandated Health Insurance Benefits

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Introduction

Senate Bill 430 was passed by the 1999 General Assembly. It was effective 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 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, schizoeffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addiction.

The benefits for the biologically based mental illnesses may be different from benefits for other illnesses, conditions or disorders if the benefits meet the medical criteria necessary to achieve the same outcomes achieved by the benefits for any other illness, condition or covered disorder. However, the coverage for biologically based mental illnesses is to be neither different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, or co-payment and coinsurance factors.

The 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 it does not apply to (i) short-term travel, accident only, limited or specified disease policies, or (ii) short-term nonrenewable policies of not more than six months' duration, or (iii) policies, contracts, or plans in the individual market or small group markets to employers with 25 or fewer employees, or (iv) policies or contracts designed for persons eligible for Medicare or other similar coverage under state or

federal plans. The 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 1, 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 of 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 (VAPH) spoke to the bill. VAHP was also concerned about the preliminary data. VAHP expressed its 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%

Claims and Premiums Data for 2001

Information on the claims and premium impact of the mandate is from the reports filed by insurers and HMOs pursuant to § 38.2-3419.1. The information in the consolidated report is based on responses of 32 insurers and 21 HMOs. The insurers represent 44.5% of the Virginia accident and sickness insurance market, and the HMOs represent an additional 36.69% of the accident and sickness market in Virginia.

Reporting Year 2001

The following numbers identify the percentage of total average annual premium and the average percentage of total claims attributable to the mandate of coverage of biologically based mental illness for the 2001 reporting period.

Premium Impact

Group Coverage – Health Maintenance Organizations

Single Coverage: 1.00% of Average Annual Premium

Family Coverage: 0.97% of Average Annual Premium

Group Coverage - Insurers

Single Coverage: 1.60% of Average Annual Premium

Family Coverage: 1.30% of Average Annual Premium

Claims Impact

Group Coverage – Health Maintenance Organizations

Average percentage of total claims: 1.04%

Group Coverage – Insurers

Average percentage of total claims: 1.43%

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 MPHA 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.

Subsequent Legislation

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 have prohibited 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 have extended and expanded the existing mandate for mental parity that expired on September 30, 2001. The Congressional Budget Office (CBO) estimated that if S.543 were 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 were 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 did not require coverage for substance abuse or chemical dependency and exempted 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 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 was 2003. The bill was extended until 2002.

The House and Senate approved H.R. 5716 on November 15, 2002. The bill would extend the mental parity law until December 31, 2003. The bill was passed unanimously. The passage of H.R. 5716 is thought to preclude action on legislation introduced in 2002 by Senator Pete Domenici and the late Senator Paul Wellstone. The legislation they introduced would have required complete parity in the coverage of mental disorders.

The Advisory Commission reported in 2001 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.

The data reported in 2002 is consistent with the claims and premium cost data that was reported in 2001. The premium impact ranges from .97% of average annual premium for family coverage by HMOs to 1.60% of average annual premium for single coverage by insurers. The impact on claims is 1.04% for HMOs and 1.43% of total claims for insurers.