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
2004

January 6, 2004

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
Special Advisory Commission on
Mandated Health Insurance Benefits

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TABLE OF CONTENTS

Executive Summary

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 organization (HMO's) providing health care plans to provide coverage for biologically based mental illnesses.

A "biologically based mental illnesses" is defined as "any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning." Specifically, the following diagnoses are defined as biologically based mental illnesses, as they apply to adults and children: schizophrenia, schizoaeffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addiction.

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 month's 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 § 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 2001, 2002 and 2003.

A public hearing was held on September 15, 2003. Staff presented preliminary data from reports submitted by insurers and HMO's. A representative of Virginians for Mental Health Equity Spoke in favor of the legislation. No one spoke in opposition to the mandate.

The Advisory Commission voted unanimously (9 to 0) on November 17, 2003 to recommend that the coverage required by Senate Bill 430 (1999) continue to be mandated for inclusion in group policies. The Advisory Commission believes that the claim and cost data on the impact of the legislation in the past three years indicate an acceptable additional cost.

Introduction

Senate Bill 430 was passed by the 1999 General Assembly. It was effective January 1, 2000. The law requires insurers to provide coverage for biologically based mental illnesses. The law applies to 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, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addiction.

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

The 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 these coverage requirements do 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 of the Code of Virginia to provide that § 38.2-3412.1 of the Code does not apply to "biologically based mental illnesses" as defined in § 38.2-3412.1:01 of the Code unless coverage for mental illness is not otherwise available pursuant to § 38.2-3412.1:01 of the Code.

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 of the Code 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 of the Code. 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.[1]

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 Premium 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 of the Code. 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. [2]

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%

A public hearing was held in Richmond on December 11, 2002. No interested parties addressed the bill. Staff presented information for reporting year 2001.

Claims and Premium Data for 2002

Information on the claims and premium impact is from the reports filed by insurers and HMOs pursuant to § 38.2-3419.1 of the Code. The information in these consolidated figures is based on responses of 28 insurers and 19 HMOs.

Reporting Year 2002

The following numbers identify the percentage for total average annual premium and the average percentage of total claims attributable to the mandate of coverage of biologically based mental illnesses. [3]

Premium Impact

Group Coverage – Health Maintenance Organizations

Single Coverage: 0.90% of Average Annual Premium

Family Coverage: 0.94% of Average Annual Premium

Group Coverage - Insurers

Single Coverage: 1.09% of Average Annual Premium

Family Coverage: 1.06% of Average Annual Premium

Claims Impact

Group Coverage – Health Maintenance Organizations

Average percentage of total claims: 1.19%

Group Coverage – Insurers

Average percentage of total claims: 1.16%

A public hearing was held in Richmond on September 15, 2003. Staff presented preliminary data from reports submitted by insurers and HMO's. A representative of Virginias for Mental Health Equity spoke in favor of the legislation. No one spoke in opposition to the mandate.

Recommendation

The Advisory Commission voted unanimously (9 to 0) on November 17, 2003 to recommend that the coverage required by Senate Bill 430 (1999) continue to be mandated for inclusion in group policies. The Advisory Commission believes that the claim and cost data on the impact of the legislation in the past three years indicate an acceptable additional cost. The benefits to insureds in need of coverage for biologically based mental illnesses extend to families, communities and the Commonwealth.

End Notes

1. The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 Code of Virginia: 2000 Reporting Period. 2002 House Document No. 10, Annual Report of the State Corporation Commission.

2. The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 Code of Virginia: 2001 Reporting Period. 2003 House Document No. 8, Annual Report of the State Corporation Commission.

3. The Financial Impact of Mandated Health Insurance Benefits and Providers 2002 Reporting Period. 2004, Report Document No. 1, Annual Report of the State Corporation Commission.