

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

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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

179 physician or other licensed health care provider with prescriptive authority for the sole purpose of
180 monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

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

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

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

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

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

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

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

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

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

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

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

231 5. This subsection shall not apply to short-term travel, accident only, limited or specified disease
232 policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage
233 under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under
234 state or federal governmental plans.

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

239 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

301 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,
302 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.)
303 and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance
304 organization granted a license under this chapter. This chapter shall not apply to an insurer or health
305 services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200
306 et seq.) of this title except with respect to the activities of its health maintenance organization.

307 B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives
308 shall not be construed to violate any provisions of law relating to solicitation or advertising by health
309 professionals.

310 C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful
311 practice of medicine. All health care providers associated with a health maintenance organization shall
312 be subject to all provisions of law.

313 D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health
314 maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to
315 offer coverage to or accept applications from an employee who does not reside within the health
316 maintenance organization's service area.

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

320 **3. That the Department of Personnel and Training shall collect such data and perform such**
321 **analyses as are necessary to determine the effects, if any, on claims experience and costs of the**
322 **coverage required by the amendments to § 2.1-20.1 of this act. The Department shall submit its**
323 **findings in writing to the General Government Subcommittees of the House Appropriations and**
324 **Senate Finance Committees not later than December 1, 2001; December 1, 2002; and December 1,**
325 **2003, and to the Governor and the General Assembly.**

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

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