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HOUSE BILL NO. 2738

Offered January 17, 2025

A BILL to amend and reenact § 38.2-3412.1 of the Code of Virginia, relating to health insurance; coverage for mental health and substance abuse disorders; generally accepted standards of care.

Patrons—Sickles, Torian, Bennett-Parker, Keys-Gamarra, LeVere Bolling, Price, Shin and Watts

Referred to Committee on Labor and Commerce

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412.1 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3412.1. Coverage for mental health and substance use disorders.

A. As used in this section:

"Adult" means any person who is 19 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 Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of 19 years.

"Crisis receiving center" means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, and crisis stabilization services.

"Generally accepted standards of mental health or substance use disorder care" means evidence-based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties including psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Sources reflecting "generally accepted standards of mental health or substance use disorder care" include peer-reviewed scientific studies and medical literature reflecting the consensus of the field, consensus guidelines and recommendations of nonprofit health care provider professional associations and specialty societies, and nationally recognized clinical practice guidelines reflecting the consensus of the field, including patient placement criteria, clinical practice guidelines, guidelines and recommendations of federal government agencies, and drug labeling approved by the U.S. Food and Drug Administration.

"Inpatient treatment" means mental health or substance abuse services delivered on a 24-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 24-hour per day, state-approved program of inpatient substance abuse services.

"Medically necessary" means, with respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating such disorder, including minimizing the progression of such disorder, in a manner that is in accordance with generally accepted standards of mental health or substance use disorder care; clinically appropriate in terms of type, frequency, extent, site, and duration; and not defined primarily for the economic benefit of an insurer.

"Medication management visit" means a visit no more than 20 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" or "mental health benefits" means benefits with respect to items or services for mental health conditions as defined under the terms of the health benefit plan. Any condition defined by the health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.

"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.

"Mobile crisis response services" means services licensed by the Department of Behavioral Health and

59 Developmental Services to provide for rapid response to, assessment of, and early intervention for individuals
60 experiencing an acute mental health crisis that are deployed at the location of the individual.

61 "Network adequacy" means access to services by measure of distance, time, and average length of referral
62 to scheduled visit.

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

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

74 "Residential crisis stabilization unit" means a community-based, short-term residential program licensed
75 by the Department of Behavioral Health and Developmental Services to provide short-term assessment,
76 observation, support, and crisis stabilization for individuals who are experiencing an acute mental health
77 crisis.

78 "Substance abuse services" or "substance use disorder benefits" means benefits with respect to items or
79 services for substance use disorders as defined under the terms of the health benefit plan. Any disorder
80 defined by the health benefit plan as being or as not being a substance use disorder shall be defined to be
81 consistent with generally recognized independent standards of current medical practice.

82 "Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care,
83 and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered
84 by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center,
85 a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional
86 counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical
87 nurse specialist. Treatment for physiological or psychological dependence on alcohol or other drugs shall also
88 include the services of counseling and rehabilitation as well as services rendered by a state certified
89 alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope
90 of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed
91 to provide such treatment.

92 B. Except as provided in subsections C and D, group and individual health insurance coverage, as defined
93 in § 38.2-3431, shall provide coverage for mental health and substance use disorder benefits *for children,*
94 *adolescents, and adults.* Such benefits shall be in parity with the medical and surgical benefits contained in
95 the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008
96 (MHPAEA), P.L. 110-343, even where those requirements would not otherwise apply directly, *and shall*
97 *apply the definitions of "generally accepted standards of mental health or substance use disorder care" and*
98 *"medically necessary" provided in subsection A for any determination of medical necessity, prior*
99 *authorization, or utilization review under such coverage. In conducting utilization review involving decisions*
100 *within the scope of generally accepted standards of mental health or substance use disorder care, no insurer*
101 *providing such coverage shall apply criteria that are different from, additional to, conflicting with, or more*
102 *restrictive than the criteria set forth in such generally accepted standards.* Coverage required under this
103 subsection shall include mobile crisis response services and support and stabilization services provided in a
104 residential crisis stabilization unit or crisis receiving center to the extent that such services are covered in
105 other settings or modalities, regardless of any difference in billing codes.

106 C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue to
107 provide benefits in accordance with subsection B or continue to provide coverage for inpatient and partial
108 hospitalization mental health and substance abuse services as follows:

109 1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center,
110 alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy
111 or contract year.

112 2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health
113 treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of
114 25 days per policy or contract year.

115 3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be
116 converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a
117 child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall
118 be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of
119 coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in

120 excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or
121 adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

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

124 5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to
125 policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social
126 Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

127 D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either continue
128 to provide benefits in accordance with subsection B or continue to provide coverage for outpatient mental
129 health and substance abuse services as follows:

130 1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided in
131 each policy or contract year.

132 2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of
133 benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit
134 beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

135 3. For the purpose of this section, medication management visits shall be covered in the same manner as a
136 medication management visit for the treatment of physical illness and shall not be counted as an outpatient
137 treatment visit in the calculation of the benefit set forth herein.

138 4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or
139 substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not
140 count toward the outpatient visit benefit maximum set forth in the policy or contract.

141 5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to
142 policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social
143 Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

144 E. The requirements of this section shall apply to all insurance policies and subscription contracts
145 delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy or
146 contract is changed or any premium adjustment made.

147 F. The provisions of this section shall not apply in any instance in which the provisions of this section are
148 inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

149 G. The Bureau of Insurance, in consultation with health carriers providing coverage for mental health and
150 substance use disorder benefits pursuant to this section, shall develop reporting requirements regarding
151 denied claims, complaints, appeals, and network adequacy involving such coverage set forth in this section.
152 By November 1 of each year, the Bureau shall compile the information for the preceding year into a report
153 that ensures the confidentiality of individuals whose information has been reported and is written in
154 nontechnical, readily understandable language. The Bureau shall include in the report a summary of all
155 comparative analyses prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) that the Bureau
156 requested during the reporting period. This summary shall include the Bureau's explanation of whether the
157 analyses were accepted as compliant, rejected as noncompliant, or are in process of review. For analyses that
158 were noncompliant, the report shall include the corrective actions that the Bureau required the health carrier
159 to take to come into compliance. The Bureau shall make the report available to the public by, among such
160 other means as the Bureau finds appropriate, posting the reports on the Bureau's website and submit the
161 report to the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor.