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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1448 Session of 1991

INTRODUCED BY MICHLOVIC, DURHAM, MURPHY, DeWEESE, CAPPABIANCA, KOSINSKI, FAJT, BELFANTI, RITTER, BLAUM, KENNEY, GEIST, TIGUE, STEIGHNER, FLICK, FOX, MARKOSEK, JOHNSON, MELIO, PRESTON, THOMAS, COWELL, DALEY, VEON, JAMES, DeLUCA, HECKLER, E. Z. TAYLOR, PETRONE, TRELLO, KUKOVICH, BISHOP, JOSEPHS, McGEEHAN, NAHILL, BILLOW, BELARDI, PISTELLA, TANGRETTI, VAN HORNE AND LEVDANSKY, MAY 15, 1991

REFERRED TO COMMITTEE ON INSURANCE, MAY 15, 1991

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing for optional benefits for the treatment of mental disorders.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding an article to read:

ARTICLE VI-B.

OPTIONAL BENEFITS FOR THE TREATMENT

OF MENTAL DISORDERS.

Section 601-B. Legislative Intent.--In recognition of the present limitations on flexible treatment of mental disorders under health care benefit plans, the General Assembly declares its intent to encourage the appropriate, individualized, cost-effective treatment of mental disorders. Health care benefits for medically necessary therapeutic treatment options shall be available as an alternative to inpatient care to the extent of the dollar and value-of-service limits of the coverage for mental disorders in the health care benefit plan, so as to assure flexible, effective treatment of mental disorders. To the extent possible, a portion of inpatient benefits shall be preserved. Where consistent with the therapeutic treatment plans, less expensive therapeutic services shall be preferred.

Section 602-B. Definitions.--As used in this article the following words and phrases shall have the meanings given to them in this section:

"Health care benefit plan." Any health or sickness or accident insurance policy providing hospital or medical or surgical coverage and any subscriber contract or certificate issued by an entity which provides hospital or medical/surgical coverage which is subject to this act, to the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act"; to the act of July 29, 1977 (P.L.105, No.38), known as the "Fraternal Benefit Society Code"; or to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Inpatient services." The provision of necessary therapeutic services twenty-four (24) hours a day in a treatment facility according to individualized treatment plans.

"Mental disorder." A clinically significant behavioral or

psychological syndrome or pattern occurring in a person which is associated with a painful symptom; which is associated with impairment in an important area of functioning; which is associated with a significantly increased risk of suffering death, pain, disability or important loss of freedom; and which is considered a manifestation of a behavioral, psychological or biological dysfunction in the person. The term excludes a psychological syndrome or pattern that is merely an expectable response to a particular event; deviant behavior that is not a symptom of a behavioral, psychological or biological dysfunction; and a conflict between an individual and society that is not a symptom of a behavioral, psychological or biological dysfunction. Use of the term does not imply that mental disorders are unrelated to physical or biological factors or processes.

"Optional benefits." Outpatient services, partial hospitalization, inpatient services provided in other than hospital settings and other types of services in lieu of inpatient services covered under a health care benefit plan.

"Outpatient services." A nonresidential treatment modality which is provided on an ambulatory basis to patients with mental disorders and shall be construed to include necessary therapeutic services carried out according to an individualized treatment plan.

"Partial hospitalization services." The provision of necessary therapeutic services to patients according to an individualized treatment plan. Partial hospitalization patients require less than twenty-four (24) hours a day care but more intensive and comprehensive services than are offered in outpatient care. Partial hospitalization is provided on a

planned and regularly scheduled basis for a minimum of three (3) hours but less than twenty-four (24) hours in any one day.

"Severe mental disorder." Acute, chronic or recurrent mental disorder. The term includes organic mental disorders, schizophrenic disorders, disorders known as bipolar disorders and recurrent major depression.

"Treatment facility." A facility licensed by the Department of Health or the Department of Public Welfare.

Section 603-B. Optional Benefits.--Any individual covered under a health care benefit plan providing for the treatment of mental disorders may elect optional benefits. Optional benefits shall not exceed the dollar value or value-of-service unit, whichever is applicable, limits of inpatient services provided for coverage of mental disorders under the health care benefit plan. Decisions concerning optional benefits management shall be considered when consistent with the therapeutic treatment plan. Use of alternative benefits may not be required if they are inconsistent with the therapeutic treatment plan.

Section 604-B. Administrative Costs.--All costs associated with the implementation of this article, including the costs of review and appeal, shall be recovered through premiums.

Section 605-B. Lifetime Maximum Benefits.--An individual electing optional benefits for the treatment of severe mental disorders under section 603-B shall be eligible for renewability of lifetime limits imposed by the health care benefit plan for the treatment of mental disorders in the same manner in which benefit limitations are renewed for medical disorders other than mental disorders.

Section 606-B. Eligibility to Receive Reimbursement.--An individual eligible to receive reimbursement for services

provided during treatment of mental disorders is limited to:

(1) Treatment facilities licensed by the Department of Health or the Department of Public Welfare.

(2) Licensed health care professionals who are currently eligible to receive reimbursement.

Section 607-B. Regulations.--The Insurance Commissioner may promulgate regulations reasonably necessary to carry out the purposes of this article.

Section 608-B. Preservation of Certain Benefits.--Nothing in this article shall prevent a health care benefit plan from offering optional benefits for conditions other than mental disorders, including behavioral and psychological conditions which are not attributable to a mental disorder but which may appropriately be the focus of professional attention or treatment. Nothing in this article shall prevent a health care benefit plan from offering benefits under its health care benefit plan for conditions which have a demonstrable organic origin.

Section 609-B. Conduct of Managed Care Review Process and Administration of Optional Benefits.--A health care benefit plan must be submitted to the Insurance Commissioner for approval of the criteria to be applied by the plan or its subsidiaries or subcontractors prior to granting authorization for the use of optional benefits. Review criteria must contain a description of the process for application and consideration of the optional benefits, as well as the rights of the subscribers, dependent beneficiaries and practitioners to appeal denial of benefits decisions. The plan must identify participants in the review process, establish time frames for implementation of the application and appeal process and provide safeguards to prevent

inappropriate release of confidential information provided by the practitioner with the written informed consent of the beneficiary and patient.

Section 2. The addition of Article VI-B of this act shall apply to insurance policies issued or renewed on or after the effective date of this act.

Section 3. This act shall take effect in 120 days.