REPORT OF THE

JOINT SUBCOMMITTEE STUDYING THE CRIPPLED CHILDREN'S PROGRAM AND MANDATED HEALTH INSURANCE BENEFITS

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 38

COMMONWEALTH OF VIRGINIA
RICHMOND
1983

MEMBERS OF SUBCOMMITTEE

William T. Wilson, Chairperson

Linda J. Pasternak, Vice-Chairperson
Alson H. Smith, Jr.
Gladys B. Keating
Walter H. Emroch
Vincent F. Callahan, Jr.
Frank D. Hargrove
Willard J. Moody
Virgil H. Goode, Jr.
Frederick C. Boucher
Nathan H. Miller
George I. Dobbs
Stephen S. Perry, Jr.
James C. Roberts
James M. Thomson

STAFF

Legal and Research - Division of Legislative Services

Hugh P. Fisher, III - Research Associate
Cleola G. Wilkerson - Secretary

Administrative and Clerical

Office of Clerk, House of Delegates

Report of the
Joint Subcommittee Studying the Crippled Children's Program and Mandated Health Insurance Benefits

To: Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

January, 1983

INTRODUCTION

For the past decade the Commonwealth has enacted certain laws which stipulate that all health insurance policies or contracts issued in Virginia must provide insureds with certain benefits or coverages, termed "mandated benefits" or "mandated coverages." By the beginning of 1982 there were eight statutes in the Code of Virginia mandating that particular benefits be provided and five statutes in the Code mandating that particular benefits be made available by insurers for purchase by policyholders.

As the number of mandated benefits has increased, a growing number of persons have expressed the concern that mandated benefit laws might be a significant factor in the tremendous increase in health care costs during the last decade. Some individuals have expressed the opinion that the Commonwealth's mandated benefit laws should be repealed or that a statutory "freeze" against the adoption of any further mandates should be enacted.

On the other hand, many individuals have argued that while mandated benefits may result in some increase in health care costs, mandated benefits are essential if the citizens of the Commonwealth are to be assured of adequate health care coverage. Many proponents of mandated benefits have argued that additional health care coverages should be mandated by the General Assembly.

Several bills dealing with mandated benefits were introduced during the 1982 General Assembly Session. After considering those bills and the whole issue of mandated benefits, the Legislature decided that a comprehensive study of the mandated benefits issue should be conducted. Furthermore, the Legislature decided to enact a statutory "freeze" which provides that group policyholders do not have to purchase any additional coverages. This freeze was effected by the passage of Senate Bill No. 358 (Chapter 577 of the 1982 Acts of Assembly), which stipulates that any coverage, benefits, or services first mandated on or after July 1, 1982, must be offered as options to any new or renewal group policies or contracts. The other legislation dealing with mandated benefits introduced during the 1982 Session was defeated with the understanding that it, and the entire mandated benefits issue, would be studied by a joint subcommittee during 1982.

The language authorizing a study of the mandated benefits issue was incorporated into House Joint Resolution No. 90 of 1982, which had been originally drafted to allow a joint subcommittee to study the insurance-related problems of the State's Crippled Children's Program. The State Department of Health, the agency responsible for administering the Crippled Children's Program, had requested the study, because it feared that health insurers in the Commonwealth would enforce the so-called "exclusionary clauses" in their policies, under which those insurers can refuse to pay for services provided under federal, state or local laws. The department was concerned that if health insurers denied coverage to participants in the Crippled Children's Program, the Commonwealth would have to substantially increase its funding for that program in order to pay for the participants' health care costs.

The patron of House Joint Resolution No. 90, Delegate William T. Wilson of Covington, agreed to amend the resolution so as to allow a joint subcommittee of the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor to study both the insurance-related problems of the Crippled Children's Program and the issue of mandated health insurance benefits.

Attached as Appendix I of this report is a copy of House Joint Resolution No. 90 of 1982.

Members of the House of Delegates appointed to serve on the joint subcommittee were: William T. Wilson of Covington; Alson H. Smith, Jr. of Winchester; Gladys B. Keating of Fairfax; Walter H. Emroch of Richmond; Vincent F. Callahan, Jr. of Fairfax; and Frank D. Hargrove of Hanover.

Members of the Senate appointed to serve on the study group were: Willard J. Moody of Portsmouth; Virgil H. Goode, Jr. of Rocky Mount; Frederick C. Boucher of Abingdon; and Nathan H. Miller of Bridgwater.

The following individuals were appointed citizen members of the subcommittee: George I. Dobbs of Hampton; Linda J. Pasternak of Richmond; Stephen S. Perry, Jr. of Norfolk; and James C. Roberts of Richmond. James M. Thomson, Commissioner of Insurance for the Commonwealth, was appointed an ex-officio member of the subcommittee.

Hugh P. Fisher, III of the Division of Legislative Services served as professional staff to the subcommittee. The Clerk's Office of the House of Delegates performed administrative and clerical duties for the subcommittee.

WORK OF THE SUBCOMMITTEE

The subcommittee held lengthy meetings on August 26, October 18, December 1, and December 28, 1982. During those meetings the study group heard extensive testimony and received voluminous amounts of written statements and materials.

During the subcommittee's first meeting, Delegate Wilson was elected Chairperson and Ms. Pasternak was elected Vice-Chairperson. Also, the subcommittee heard testimony from Delegate James B. Murray of Earlysville and from representatives of the State Bureau of Insurance, the Life Insurance Company of Virginia, the American Council of Life Insurance, the Aetna Life and Casualty Company, and Blue Cross and Blue Shield. Most of the testimony delivered during the meeting was related to the mandated benefits issue. In addition, the subcommittee received a report from the Bureau of Insurance entitled "Health Insurance Mandated Benefits." During its deliberations the study group found this report's discussion of the following subjects to be very helpful:

(1) The charge to the subcommittee;

(2) House Joint Resolution No. 90;

(3) A summary of the issues;

(4) A brief discussion of the insurance-related problems of the Crippled Children's Program;

(5) A discussion of House Bill No. 272 of 1982;

(6) A summary of the benefits currently mandated under Virginia law;

(7) The actual statutes which mandate health insurance benefits;

(8) The bills relating to mandated benefits which were introduced during the 1982 General Assembly Session and a summary of each of those bills;

(9) The general arguments for and against mandating benefits;

(10) The arguments for and against retaining the benefits currently mandated under Virginia law; and

(11) The options available to the subcommittee.

Attached as Appendix II of this document is a copy of the report prepared by the Bureau of Insurance. Appendix III consists of a copy of the minutes of the August 26 subcommittee meeting, minus the attachments to the minutes.

At the October 18 meeting the study group heard extensive testimony regarding both the Crippled Children's Program and the mandated benefits issue. A representative of the State Department of Health testified that about a year and a half prior to the meeting an insurance carrier refused to pay the hospital charges of a child enrolled in the Crippled Children's Program. He also stated that health insurance policies in Virginia contain exclusionary clauses which allow insurers to deny coverage for services provided under federal, state or local laws.

Another representative of the Health Department testified that although the exclusionary clauses are not a major problem now, they could be in the future. He added that if insurance companies were to deny coverage to crippled children on a widespread basis, the impact on Health Department funds would be significant. Appendix IV of this report consists of a copy of the Health Department statement delivered during the October 18 meeting.

In reponse to the remarks made by Health Department representatives, spokesmen for the Life Insurance Company of Virginia and the Health Insurance Association of America testified that the issue addressed by the Health Department involves a basic policy determination by the Legislature as to whether the taxpayers or the policyholders of the Commonwealth should pay for the coverage which is subject to exclusionary clauses. Also testifying before the study group in regards to the exclusionary clause issue was a representative of the Neuropsychiatric Society of Virginia.

After considering the exclusionary clause issue, the subcommittee heard testimony regarding the mandated benefits issue. Comments concerning that issue were made by Delegate Mary A. Marshall of Arlington and by representatives of the Virginia Committee of the National Association of Private Psychiatric Hospitals, the Mental Health Association of Virginia, the Virginia Association of Community Services Boards, the Rappahannock Area Community Services Board, the Tidewater Psychiatric Institute, and the Virginia Chapter of the National Association of Social Workers.

Appendix V consists of some of the statements from proponents of mandated benefits the subcommitteee received during its deliberations. Appendix VI consists of a statement and position paper distributed by Blue Cross and Blue Shield of Virginia. Appendix VII is a statement submitted by the American Council of Life Insurance and the Health Insurance Association of America. Appendix VIII consists of the minutes of the October 18 meeting, minus the attachments to those minutes.

At its December 1 meeting the subcommittee learned that an agreement had been worked out by the health insurance industry and the State Department of Health regarding the application of exclusionary clauses against participants in the Crippled Children's Program. The agreement provides that Blue Cross and Blue Shield of Virginia and the Virginia members of the Health Insurance Association of America will not enforce the exclusionary clauses in their policies against participants in the Crippled Children's Program, while the Health Department will not initiate any action to eliminate exclusionary clauses. The agreement also provides that the interested parties will work to develop a long-term solution to the exclusionary clause issue.

By a unanimous vote the subcommittee agreed to support the agreement worked out by the health insurance industry and the Health Department. Attached as Appendix IX is a copy of correspondence setting forth the agreement.

During the December 1 meeting the study group also heard additional testimony concerning the mandated benefits issue. Testifying about that issue were representatives of the Richmond Business Medical Coalition, the Neuropsychiatric Society of Virginia, the Substance Abuse Program Directors of Virginia, the Mental Health Committee of the Virginia Hospital Association, the Virginia Committee of the National Association of Private Psychiatric Hospitals, the Medical Society of

Virginia, the Behavioral Sciences Consortium, the Virginia Chapter of the Association of Labor Management Administrators and Consultants on Alcoholism, the Greater Richmond Council on Alcoholism and Drug Abuse, the Virginia Association of Community Services Boards, the Virginia Psychological Association, the Virginia Academy of Clinical Psychologists, the State Department of Mental Health and Mental Retardation, the Virginia Manufacturers Association, the Health Insurance Association of America, the Metropolitan Life Insurance Company, the Aetna Life and Casualty Company, Blue Cross and Blue Shield of Virginia, and the Life Insurance Company of Virginia.

Also, during the December 1 meeting the study group heard testimony regarding House Bill No. 272 of 1982, which had been defeated during the 1982 General Assembly Session and incorporated into House Joint Resolution No. 90 as part of the subcommittee's work. House Bill No. 272 was introduced at the urging of the Bureau of Insurance due to the fact that the Bureau presently has authority to regulate only those group health contracts issued in the Commonwealth. Presently any health contracts issued outside Virginia are not subject to the requirements of Virginia law, even if Virginia residents are covered under such contracts. Thus, no health contract issued outside the Commonwealth has to include Virginia's mandated coverages, even if the contract insures some Virginia residents.

House Bill No. 272 would have required certificates of insurance provided to residents of the Commonwealth through group contracts delivered or issued for delivery outside the Commonwealth to provide benefits as required by Virginia law, unless the State Corporation Commission determines that certain benefits are not appropriate for the coverage provided.

A copy of House Bill No. 272 of 1982 is enclosed as Appendix X.

During the December 1 meeting representatives of the Aetna Life and Casualty Company and Blue Cross and Blue Shield of Virginia testified in opposition to the provisions of House Bill No. 272, and a representative of the Bureau of Insurance testified in support of such legislation.

At the conclusion of the meeting the subcommittee decided it had heard sufficient testimony regarding the mandated benefits issue. Therefore, the study group decided that at its next meeting it would only hear testimony concerning House Bill No. 272 and then formulate its recommendations regarding that bill and the mandated benefits issue. A copy of the minutes of the December 1 meeting, minus the attachments to those minutes, constitutes Appendix XI of this report.

At its December 28 meeting the subcommittee heard testimony concerning House Bill No. 272 from representatives of the Bureau of Insurance, the Aetna Life and Casualty Company, the Life Insurance Company of Virginia, the Virginia Psychological Association, and the Virginia Manufacturers Association. Attached as Appendix XII is a copy of the statement regarding House Bill No. 272 delivered by a representative of the Life Insurance Company of Virginia during the December 28 meeting.

After hearing considerable testimony the subcommittee decided it would not take a position either in favor of or against House Bill No. 272, due to insufficient data regarding the effects of enacting such legislation. Also, the study group decided that no statutes which mandate health insurance benefits should be repealed, nor should any additional mandated benefits or coverages be enacted.

Attached as Appendix XIII is a copy of the minutes of the December 28 subcommittee meeting, minus the attachments to those minutes.

RECOMMENDATIONS

The subcommittee makes the following recommendations to the Governor and the General Assembly:

(1) The agreement between the health insurance industry and the State Department of Health regarding the application of exclusionary clauses against participants in the Crippled Children's Program should be accepted. That agreement provides that Blue Cross and Blue Shield of Virginia and the Virginia members of the Health Insurance Association of America will not enforce the exclusionary clauses in their policies against participants in the Crippled Children's Program, while

the Health Department will not initiate any action to eliminate exclusionary clauses. The agreement also provides that the interested parties will work to develop a long-term solution to the exclusionary clause issue.

(2) No Virginia law which mandates health insurance benefits should be repealed, nor should any additional mandated benefits or coverages be enacted. The General Assembly should continue to support § 38.1-348.14 of the Code of Virginia, which provides that any new or existing group policy or contract holder shall be given the option to purchase any coverage or benefits first mandated on or after July 1, 1982.

REASONS FOR RECOMMENDATIONS

The subcommittee's first recommendation is that the agreement between the health insurance industry and the State Department of Health regarding the application of exclusionary clauses against participants in the Crippled Children's Program should be accepted. That agreement provides that Blue Cross and Blue Shield of Virginia and the Virginia members of the Health Insurance Association of America will not enforce the exclusionary clauses in their policies against participants in the Crippled Children's Program, while the Health Department will not initiate any action to eliminate exclusionary clauses.

The subcommittee received data from the State Department of Health which indicates that if all private insurance carriers were to enforce the exclusionary clauses in their health insurance policies, approximately $1,113,000 would have to be provided by the Commonwealth or other governmental sources in order to fund the Crippled Children's Program. Appendix XIV consists of the cost data furnished by the Health Department.

The subcommittee believes it would be very difficult in this age of revenue shortages to appropriate an additional $1,113,000 for the Crippled Children's Program. The study group heard testimony that federal participation in the Crippled Children's Program has been reduced, and the Commonwealth does not anticipate sufficient revenues to offset the reduction in federal funding. Therefore, the subcommittee believes it will be in the best interests of the State's taxpayers if the health insurance industry does not enforce exclusionary clauses against participants in the Crippled Children's Program.

Furthermore, the agreement between the health insurance industry and the Health Department means that legislation banning exclusionary clauses need not be considered. The subcommittee received testimony that apparently no states have prohibited the use of exclusionary clauses, and the study group would be reluctant to recommend that Virginia be the first state to enact such legislation. For these reasons the subcommittee recommends that the agreement be accepted and that the interested parties attempt to reach a long-term solution to the issue.

The subcommittee's second recommendation is that no Virginia law which mandates health insurance benefits should be repealed, nor should any additional mandated benefits or coverages be enacted.

Certain individuals testified before the study group that none of the Commonwealth's mandated benefits should be repealed, while numerous other individuals supported the continuation of specific mandates. (See Appendix V). Health care providers maintained that without mandating certain coverages and benefits, many persons would be without needed coverage. These proponents of mandated benefits argued that a major reason certain benefits and coverages were mandated in the first place was because insurers were not making the coverages available or else individuals who needed the coverage were not purchasing it. For example, numerous persons testified that if coverages for mental illness, alcoholism and drug addiction are not mandated, then many persons suffering from those illnesses will not have coverage.

Proponents of mandated benefits also testified that a repeal of such benefits would be a step back in the Commonwealth's social policy. Furthermore, they argued that mandated benefits are cost effective and can actually reduce overall health care costs by allowing individuals to seek treatment before a particular condition or disorder becomes severe.

Proponents also testified that the repeal of certain mandates would merely shift the cost for

treating certain conditions or illnesses from the policyholders to the taxpayers. They argued that if insurance does not cover conditions such as mental illness, alcoholism and drug addiction, then governments will have to expend additional funds to deal with those conditions. They also said that mandated benefits only slightly increase health insurance premiums, and the premium increases are more than offset by early intervention and the resulting benefits to society.

On the other hand, most representatives of the health insurance industry who testified before the subcommittee stated that their companies oppose mandating that any benefits or coverages must be provided. They argued that it would be best to let the free market operate so that each company could negotiate policy provisions with each policyholder. Furthermore, they said that if the General Assembly felt that the availability of a particular coverage was a problem, it could enact a statute which would provide that while all insurers would have to offer that coverage to their policyholders, each policyholder would have the option to either include or exclude that coverage from his policy. In other words, they said, rather than mandating that all policyholders must purchase a certain coverage, whether they want the coverage or not, it would be more appropriate to mandate only that the coverage be offered.

The opponents of mandated benefits also argued that the mandates significantly increase the cost of health insurance. They testified that while each mandate results in only a small increase in premiums (less than a dollar a month in most cases), the overall increase in utilization due to mandating benefits results in a significant increase in total health system costs.

In addition to the health insurance industry, several major employer groups, including the Virginia Manufacturers Association, the Virginia Retail Merchants Association, and the Richmond Business Medical Coalition, expressed opposition to some or all of the benefits and coverages which presently must be provided in the Commonwealth.

The subcommittee would point out that although the health insurance industry and several major employer groups testified in opposition to the mandating of benefits, many of those parties also testified that they have learned to live with the present Virginia mandates. They testified that they would be satisfied if the "freeze" stipulated in Code § 38.1-348.14 remained in force.

The subcommittee, too, urges continued support for that section, which provides that any new or existing group policy or contract holder shall be given the option to purchase any coverage or benefits first mandated on or after July 1, 1982.

The study group heard extensive testimony that the present Virginia mandates have aided and will continue to aid the physical and mental health of insureds in the Commonwealth. Also, the subcommittee realizes that the repeal of certain mandated benefit statutes merely would shift the cost for treating certain conditions and illnesses from the policyholders to the taxpayers. The study group feels that such a shift would not be good public policy in an age characterized by government revenue shortages.

Additionally, the study group realizes that mandated benefits are not the primary factor behind the huge increase in health care costs which has occurred over the last decade. The subcommittee received testimony which indicates that hospital charges and charges by health care providers play a more significant role in determining overall health care costs than do the number of mandated benefits. Also, testimony indicated that health insurance premiums would not decrease dramatically even if all the present Virginia mandates were repealed. For these reasons the subcommittee supports the continuation of the present Virginia mandated benefits.

However, it should be repeated that the study group also believes that no additional benefits should be mandated at the present time except possibly those benefits mandated as options to policyholders. The subcommittee recognizes that currently policyholders are paying high premiums for health insurance. The subcommittee feels it would be wrong in today's recessionary climate to require policyholders to pay the higher premiums which would result from the addition of any new mandates. The study group realizes that currently many individuals and employers are paying for certain coverages they do not want, and it would note that the enactment of additional mandates would require many financially strapped individuals and employers to pay for additional coverage they do not want.

Also, the subcommittee would point out that it received information from the health insurance

industry which indicates that the enactment of mandated benefits may appreciably increase health care costs. For example, the study group received information from a representative of the Health Insurance Association of America regarding the administrative cost to the Mutual of Omaha Insurance Company of implementing Virginia's mandated coverages for newborns, for mental illness, and for alcoholism and drug abuse. That representative testified that Mutual of Omaha said it had sent out approximately 15,000 renewal notices or riders concerning mandated coverage for newborns, at a cost of $5,800. For mental illness coverage the company sent out approximately 14,000 renewal notices or riders, at a cost of $5,460. For alcoholism and drug abuse coverage the company sent out about 8,000 renewal notices or riders, at a cost of $4,044. Therefore, the representative informed the subcommittee, the company incurred $15,304 in administrative costs due to implementing three of Virginia's mandated benefit statutes.

The study group also received information concerning the total extra cost which the Commonwealth's mandated benefit statutes have added to the health insurance policies issued by the Aetna Life and Casualty Company. The information the subcommittee received indicates that the total additional cost to Aetna's policies attributable to the Virginia mandates is 6.3% for an employee and 12.7% for an employee's dependents. The information further indicates that the average increase in premium costs attributable to the mandates is 9.5%. Correspondence relating to the figures furnished by the Health Insurance Association of America constitutes Appendix XV.

The study group also received data from Blue Cross and Blue Shield of Virginia which indicates that mandated benefits can play an appreciable role in increasing health care costs. For example, according to testimony presented by Blue Cross and Blue Shield, in 1978 the average charge per day by alcoholism treatment facilities in the Commonwealth was $60. In 1979, the year in which coverage for alcoholism treatment was mandated, the average charge per day rose to $115. And in 1980 the average charge per day was $170.

To cite another example, additional information presented to the study group by Blue Cross and Blue Shield of Virginia indicates that in 1979, the year in which the General Assembly mandated coverage for alcoholism treatment, the average length of stay in a psychiatric hospital for alcoholism treatment was 12.8 days for Blue Cross and Blue Shield subscribers. For 1980 the average length of stay was 20.5 days, which represents approximately a 60% increase over the previous year's figure. A representative of Blue Cross and Blue Shield told the subcommittee that the availablity of mandated coverage, not the medical needs of patients, accounted for that increase.

The subcommittee concludes that while mandated benefits are not the primary reason for the recent great increase in health care costs, such benefits may appreciably increase health care costs. For that reason, the study group concludes that it would be unwise for the General Assembly to enact any additional statutes at the present time which would mandate that benefits or coverages be provided.

CONCLUSION

The subcommittee expresses its appreciation to all parties who participated in its study.

The study group's recommendations have been offered only after carefully considering the testimony presented to it. The subcommittee believes the recommendations are in the best interests of the Commonwealth, and it encourages the General Assembly to adopt those recommendations.

AMENDMENT IN THE NATURE OF A SUBSTITUTE FOR HOUSE JOINT RESOLUTION NO. 90

(Proposed by the Senate Committee on Rules)

(Patron Prior to Substitute–Delegate Wilson)

Requesting the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor to study the insurance laws of Virginia relating to the operation of the Crippled Children's Program and the Virginia Medical Assistance Program operated by the Department of Health, and the laws of Virginia which mandate health insurance benefits.

WHEREAS, the Crippled Children's and Medical Assistance (Medicaid) Programs are enabled under Title V and XIX, respectively, of the United States Social Security Act but are administered in the Commonwealth by the State Department of Health; and

WHEREAS, these programs provide a wide spectrum of medical care services, including hospitalization, to approximately 23,000 crippled children and 280,000 low-income citizens of the Commonwealth; and

WHEREAS, these programs traditionally have functioned as "last dollar," or guarantor, for the medical care services rendered to enrollees; and

WHEREAS, more than six million dollars per year has been paid for services covered under these programs by medical insurance policies for which premiums have been paid; and

WHEREAS, under Virginia law medical insurance policies may contain an exclusionary clause for services provided under federal, state, or local laws; and

WHEREAS, continued implementation of the exclusionary clause would cause the loss of millions of dollars of reimbursement received by the Commonwealth for enrollees in the Crippled Children's and Medicaid Programs; and

WHEREAS, reduction in the level of federal participation in the Crippled Children's and Medicaid programs has occurred; and

WHEREAS, the Commonwealth of Virginia does not anticipate sufficient revenues to offset the reduction in federal funding; and

WHEREAS, it is the intent of the General Assembly of Virginia that the expenditure of tax funds for medical care services be protected to the best extent possible; and

WHEREAS, the cost of all types of health insurance has increased dramatically in recent years; and

WHEREAS, presently the Code of Virginia mandates that all health insurance policies or contracts provide for certain benefits; and

WHEREAS, the testimony of the public has demonstrated the need for an objective analysis and study of the impact of such presently and proposed mandated coverages; and

WHEREAS, this issue is of sufficient importance to warrant study; and

WHEREAS, House Bills 272, 555, 716, and 721 and Senate Bill 191 were introduced at the 1982 Session of the General Assembly to modify, expand, contract or affect the scope of the provisions of Chapters 8 and 23 of Title 38.1; and

WHEREAS, Senate Bill 358 was introduced during the 1982 Session of the General Assembly to make optional the addition of any coverage, benefits or services first

mandated on or after July 1, 1982, to any group policy or contract holder and, as a result thereof, is entirely consistent with the purpose of the study directed by this Resolution; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor are requested to establish a joint subcommittee to study: (1) the insurance laws of the Commonwealth which relate to the implementation of the Crippled Children's and Medicaid Programs operated by the State Department of Health and (2) the requirements of §§ 38.1-348.1, 38.1-348.6, 38.1-348.7, 38.1-348.8, 38.1-348.10, 38.1-348.11, and 38.1-348.12; and the subject matter contained in House Bills 272, 555, 716, and 721 and Senate Bills 191 and 358, all introduced in the 1982 General Assembly, as well as the general subject matter of mandated coverages, benefits or services.

The joint subcommittee shall consist of fourteen members to be appointed as follows: six members shall be appointed from the House Committee on Corporations, Insurance and Banking by the Chairman of that Committee; four members shall be appointed from the Senate Committee on Commerce and Labor by the Chairman of that Committee; and four citizen members shall be appointed by the Chairmen of the above-mentioned Committees, two of whom shall represent carriers regulated under Title 38.1 and two of whom shall represent group health care providers of services or facilities, provided that these citizen members shall participate only in that part of the study concerning mandated health insurance benefits. The Commissioner of Insurance shall serve as an ex-officio member of the joint subcommittee. Citizen members shall be reimbursed for their reasonable and actual expenses incurred in the performance of their duties as members.

During its study, the joint subcommittee shall be assisted by the Bureau of Insurance, the Department of Health, and any other state agencies or bodies whose services the joint subcommittee desires to utilize.

The joint subcommittee shall complete its work and submit its findings, conclusions and recommendations to the Governor and the General Assembly not later than December 1, 1982.

The cost of conducting this study shall not exceed $8,500.

Official Use By Clerks

Agreed to By The House of Delegates		**Agreed to By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

APPENDIX II

Health Insurance Mandated Benfits

House Joint Resolution 90

Presented by
State Corporation Commission
Bureau of Insurance
James M. Thomson, Commissioner
August, 1982

Table of Contents

CHARGE TO THE JOINT SUBCOMMITTEE

The charge to the joint subcommittee, set forth in HJR 90, is twofold. First, the joint subcommittee is to study the insurance laws relating to the implementation of the Crippled Children's and Medicaid Programs. The main concern of this part of the study is the potential drain on revenues of the Commonwealth resulting from decreased federal funding coupled with increased health care costs. Due to exclusionary clauses for services provided under federal, state or local law allowed in health insurance policies, the Commonwealth is unable to obtain reimbursement for its spending, which will increase with the decrease in federal funding.

The second main area of study is health insurance mandated benefits. The joint subcommittee is to study existing mandated coverages provided under Article 2, Chapter 8, of Title 38.1. Further, the joint subcommittee is to study legislation introduced in the 1982 Session of the General Assembly pertaining to mandated benefits and the general subject matter of mandated benefits, coverages and services.

The work of the joint subcommittee is closely related to that of the recent Health Care Cost Containment Commission. The Commission was created under SJR 5 (1978 Session) with a broad mandate to study health care and health insurance costs. Under SJR 32 (1980 Session) the Commission's mandate was renewed and expressly extended to include the mandate benefits issue. The final report of the Commission, published in January 1982, included a specific recommendation for repeal of the "state-mandated insurance provisions." Three members of the Commission, including the Commissioner of Insurance, dissented from this recommendation.

1982 REGULAR SESSION

LD4144596

AMENDMENT IN THE NATURE OF A SUBSTITUTE FOR HOUSE JOINT RESOLUTION NO. 90

(Proposed by the Senate Committee on Rules)

(Patron Prior to Substitute--Delegate Wilson)

Requesting the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor to study the insurance laws of Virginia relating to the operation of the Crippled Children's Program and the Virginia Medical Assistance Program operated by the Department of Health, and the laws of Virginia which mandate health insurance benefits.

WHEREAS, the Crippled Children's and Medical Assistance (Medicaid) Programs are enabled under Title V and XIX, respectively, of the United States Social Security Act but are administered in the Commonwealth by the State Department of Health; and

WHEREAS, these programs provide a wide spectrum of medical care services, including hospitalization, to approximately 23,000 crippled children and 280,000 low-income citizens of the Commonwealth; and

WHEREAS, these programs traditionally have functioned as "last dollar," or guarantor, for the medical care services rendered to enrollees; and

WHEREAS, more than six million dollars per year has been paid for services covered under these programs by medical insurance policies for which premiums have been paid; and

WHEREAS, under Virginia law medical insurance policies may contain an exclusionary clause for services provided under federal, state, or local laws; and

WHEREAS, continued implementation of the exclusionary clause would cause the loss of millions of dollars of reimbursement received by the Commonwealth for enrollees in the Crippled Children's and Medicaid Programs; and

WHEREAS, reduction in the level of federal participation in the Crippled Children's and Medicaid programs has occurred; and

WHEREAS, the Commonwealth of Virginia does not anticipate sufficient revenues to offset the reduction in federal funding; and

WHEREAS, it is the intent of the General Assembly of Virginia that the expenditure of tax funds for medical care services be protected to the best extent possible; and

WHEREAS, the cost of all types of health insurance has increased dramatically in recent years; and

WHEREAS, presently the Code of Virginia mandates that all health insurance policies or contracts provide for certain benefits; and

WHEREAS, the testimony of the public has demonstrated the need for an objective analysis and study of the impact of such presently and proposed mandated coverages; and

WHEREAS, this issue is of sufficient importance to warrant study; and

WHEREAS, House Bills 272, 555, 716, and 721 and Senate Bill 191 were introduced at the 1982 Session of the General Assembly to modify, expand, contract or affect the scope of the provisions of Chapters 8 and 23 of Title 38.1; and

WHEREAS, Senate Bill 358 was introduced during the 1982 Session of the General Assembly to make optional the addition of any coverage, benefits or services first

mandated on or after July 1, 1982, to any group policy or contract holder and, as a result thereof, is entirely consistent with the purpose of the study directed by this Resolution; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor are requested to establish a joint subcommittee to study: (1) the insurance laws of the Commonwealth which relate to the implementation of the Crippled Children's and Medicaid Programs operated by the State Department of Health and (2) the requirements of §§ 38.1-348.1, 38.1-348.6, 38.1-348.7, 38.1-348.8, 38.1-348.10, 38.1-348.11, and 38.1-348.12; and the subject matter contained in House Bills 272, 555, 716, and 721 and Senate Bills 191 and 358, all introduced in the 1982 General Assembly, as well as the general subject matter of mandated coverages, benefits or services.

The joint subcommittee shall consist of fourteen members to be appointed as follows: six members shall be appointed from the House Committee on Corporations, Insurance and Banking by the Chairman of that Committee; four members shall be appointed from the Senate Committee on Commerce and Labor by the Chairman of that Committee; and four citizen members shall be appointed by the Chairmen of the above-mentioned Committees, two of whom shall represent carriers regulated under Title 38.1 and two of whom shall represent group health care providers of services or facilities, provided that these citizen members shall participate only in that part of the study concerning mandated health insurance benefits. The Commissioner of Insurance shall serve as an ex-officio member of the joint subcommittee. Citizen members shall be reimbursed for their reasonable and actual expenses incurred in the performance of their duties as members.

During its study, the joint subcommittee shall be assisted by the Bureau of Insurance, the Department of Health, and any other state agencies or bodies whose services the joint subcommittee desires to utilize.

The joint subcommittee shall complete its work and submit its findings, conclusions and recommendations to the Governor and the General Assembly not later than December 1, 1982.

The cost of conducting this study shall not exceed $8,500.

Official Use By Clerks

Agreed to By The House of Delegates		Agreed to By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the House of Delegates Clerk of the Senate

SUMMARY OF ISSUES

Mandated health care insurance coverage can have widespread economic and social consequences. Economic analysis focusses on escalating health care costs, elimination of consumer benefits by restricting alternative choices and the effect of indirectly subsidizing the cost of certain medical care services that otherwise might not be available. The social analysis concerning mandated benefits focusses on the failure of the marketplace to provide health care coverage in areas of perceived need and on the effect of mandated benefits on the level of health in the Commonwealth. Unfortunately, there is no simple way to reconcile the differing conclusions developed by these two forms of analysis. Regardless of the option selected, there will be costs, either economic or social.

The social and economic issues associated with mandated benefits can be broken down into six general areas of concern. These are availability of services, cost implications, availability of coverage, social welfare, contractual freedom, and consumer protection.

I. Availability of Services.

Mandated benefits affect the availability or supply of health care services. Advocates of mandated benefits argue that the benefits increase the availability of health care services. They contend that mandated benefits for some conditions, such as alcoholism and mental illness, increase the resources that society directs into specific areas of public concern. Mandated benefits foster development of mental health treatment facilities, alcoholism and drug abuse treatment facilities, intermediate care facilities and nursing homes. They also argue that coverage for non-physician practitioners increases the supply of health care services to the consumer. Opponents of mandated benefits agree that availability of health care services will increase. They argue, however, that this increase is forced on a system that, in an economic sense, has determined that the cost of the benefits is too great.

II. Cost Implications.

The services provided under some mandated coverage are expensive. The effect of mandating coverage for these services under all health policies is to eliminate the cost factor from the decision to use these services. Opponents of mandated benefits argue that the effect of eliminating this cost factor is to introduce a strong incentive to increase the frequency of use of the services provided under mandated coverages. The higher demand for those services is thought to result in disproportionate increases in the cost of those services. Opponents of mandated benefits argue that insurance premiums will rise to cover both the cost of the mandated coverage and any resulting inflation in health care costs in general. Advocates of mandated benefits agree that costs will be increased, but they argue that the increased cost is justified by compensating benefits to society.

III. Availability of Coverage.

The existence of mandated benefits affects the general availability of health insurance coverage. Advocates of mandated benefits argue that the existence of mandated benefits directly results in widespread availability of desirable coverages. They argue that many insurers would not offer these benefits without the mandated benefits laws. Opponents of mandated benefits argue first that those benefits would be made available by insurers if it were economically feasible to offer them, a condition that would indicate that consumers are willing, on a voluntary basis, to pay for such benefits. Further, they contend that if the benefits are not economically feasible, insurers should not be required to offer them. Opponents argue that mandated benefits may decrease demand for other needed coverage by forcing employers, who have limited resources, to reduce coverage in non-mandated areas. They argue further that increased premiums can make group policies so expensive for

employers that some employers may form self-insured groups to avoid the effect of mandated benefits laws and their higher costs.

IV. Social Welfare.

Advocates argue that mandated benefits raise the level of social welfare. Some conditions covered under mandated benefits have secondary effects both on the individual and on society. For example, alcoholism can lead not only to secondary illnesses such as cirrhosis of the liver, but also results in a loss of productivity to society. Advocates of mandated benefits contend that these benefits relieve society of the costs of secondary effects of covered conditions. Opponents of mandated benefits question whether these social ends might not be met more effectively by means other than mandated benefits. They contend that insureds who have no need for mandated coverages should not be burdened with the cost of providing those coverages for the segment of society that does need them. Additionally, although there may be benefits by preventing a loss of productivity, the cost of achieving the benefit must be considered. Perhaps a more direct approach, such as taxation, could accomplish the same objective but on a more equitable basis.

V. Contractual Freedom.

Opponents of mandated benefits contend that health insurers, group insureds and individual contract holders should all have the right to contract freely with minimal interference from the state. They argue that governmental involvement not only limits the choices of the parties, but also hinders development of new alternatives and products. They also contend that mandated benefits limit the employer's ability to shop comparatively for health insurance. Advocates of mandated benefits agree that mandated benefits limit freedom of choice, but argue that this limitation is justified by greater benefits to society.

VI. Consumer Protection

Advocates of mandated benefits perceive the benefits as a form of consumer protection. They contend that there is a legitimate concern that the consumer be protected from policies not containing certain coverages deemed to be socially desirable. Opponents of mandated benefits contend that the interests of consumers will be better served if market forces are allowed to operate freely.

Crippled Children's and Medicaid Programs

H.J.R. 90 directs that the joint subcommittee study the insurance laws of Virginia relating to the implementation of the Crippled Children's and Medicaid Programs operated by the State Department of Health. There are no insurance laws directly relating to these programs, but it appears that the intent of H.J.R. 90 appears to request that the joint subcommittee study the effect of legislation prohibiting exclusionary clauses in private insurance policies for services provided under federal, state or local laws.

Loss of federal funding is a significant impetus to this facet of the joint subcommittee's charge. Prohibition of exclusionary clauses may increase the rates charged for private health insurance. An important public policy question should be addressed by the study committee. If the legislature feels that some of Virginia's citizens should receive an important medical benefit, then should not the cost to provide the benefit be born by all its citizens through increased taxes? To require less than all of society to bear the cost of achieving this important goal is to spread the burden inequitably (increased premium for policyholders only).

OUT-OF-STATE GROUP POLICIES

Under current Virginia law, the Bureau of Insurance has regulatory authority only over those group contracts issued in Virginia. Those contracts issued elsewhere, even though residents of the Commonwealth may be covered under the group contract, are not subject to requirements of Virginia law. This "gap" in regulatory authority has resulted in an increasing number of Virginia residents becoming insured under contracts that are not subject to the protections of Virginia's laws and regulations.

House Bill 272, had it been enacted, would have extended the full protection of Virginia's laws and regulations to all group certificate holders in Virginia, regardless of where the master policy was issued. It would have required that all group coverage on Virginia residents comply with the laws and regulations that were designed for the protection of all residents of the Commonwealth.

Although the enactment of HB 272 would not have resulted in consistency among state regulations, it would have resulted in consistency of coverage among residents of the Commonwealth. HB 272 would have guaranteed that those benefits that the General Assembly has seen the need to mandate for the protection of Virginia residents would, in fact, be provided for all such residents. It would have prevented current attempts to avoid Virginia's requirements, which are, in many cases, more stringent than those of other states in the area of mandated benefits.

The strongest argument against enactment of legislation of this type would appear to be that many large multi-state groups, especially employee groups, would be placed in a position where employees in Virginia would be provided with benefits differing from those provided to employees in other states. Since many such contracts

are written as a result of collective bargaining agreements, a situation could conceivably arise which would not easily lend itself to a solution. However, an exception could be made for such groups if they are able to show to the satisfaction of the State Corporation Commission that they would be adversely affected.

A Summary of Benefits

Currently Mandated Under

Virginia's Insurance Law

Mandated Benefits

Statutorily mandated benefits can be divided into two categories: those mandating that a particular benefit be provided; and those mandating that a particular benefit be made available as an option.

In the first category are the following sections of the Insurance Code:

1. 38.1-347.1 - Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.
2. 38.1-348.1 - Continued coverage for dependent children.
3. 38.1-348.5 - Construction of policy generally; words "physician" and "doctor" to include dentist.
4. 38.1-348.6 - Coverage of newborn children required.
5. 38.1-348.7A - Coverages for mental, emotional or nervous disorders. (inpatient)
6. 38.1-348.10 - Exclusion or reduction of benefits for certain causes prohibited.
7. 38.1-348.11 - Conversion on termination of eligibility.
8. 38.1-348.13 - Coverage for victims of rape or incest.

In the second category are the following sections of the Insurance Code:

1. 38.1-348.7B - Coverages for mental, emotional or nervous disorders. (Outpatient)
2. 38.1-348.8 - Coverages for alcohol and drug dependence.
3. 38.1-348.9 - Optional coverage for obstetrical services.
4. 38.1-348.12: 1 - Deductibles and coinsurance options required.
5. 38.1-348.14 - Additional mandated coverage made optional to group policy or contract holder.

The Code sections listed above are summarizd as follows:

A. Mandated Coverages:

1. Section 38.1-347.1 - Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.

A. Applicability

Group, Individual, and "Blues"

B. Summary

Requires policies to provide coverage for services performed by licensed chiropractors, optometrists, opticians, psychologists, clinical social workers, podiatrists, and chiropodists.

C. Exceptions

Chiropractors excepted for "Blues"

Clinical Social Workers not covered unless specifically contracted for.

Medicaid

State funds

2. Section 38.1-348.1 - Continued coverage for dependent children.

A. Applicability

Group, Individual, Blanket, "Blues"

B. Summary

Requires all policies which provide coverage for dependent children, while the policy is in force, to continue such coverage beyond the contractual termination age for those dependent children who are and continue to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

(2) chiefly dependent upon the policyholder for support and maintenance.

Insurer may require continuing proof of incapacity and dependency. Must be submitted within 31 days of contractual termination age for each such child, and thereafter no more than once a year. Insurer may charge additional premium for continuing coverage, based on class of risk of the dependent child.

3. Section 38.1-348.5 - Construction of policy generally; word "physician" and "doctor" to include dentist.

A. Applicability

Group, Individual, Blanket, "Blues"

B. Summary

Requires definition of "physician" or "doctor" to include a dentist performing covered services if such services are within the scope of the dentist's professional license.

4. Section 38.1-348.6 - Coverage of newborn children required.

A. Applicability

Group, Individual and Blanket - expense incurred contracts only

"Blues" - only those contracts covering family members

B. Summary

Requires that benefits payable for covered children shall likewise be payable with respect to a newly born child of the insured or subscriber. Coverage must be from the moment of birth and shall cover injury and/or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Insurer may require payment of specific premium or fee in contract, and may further require that such premium or fee be paid, along with notification of birth, to the insurer within 31 days after birth in order to continue coverage beyond the initial 31 day period.

5. Section 38.1-348.7A - Inpatient coverages for mental, emotional, or nervous disorders.

A. Applicability

Group, Individual, and "Blues" - contracts providing expense incurred coverage and covering family members or Individual and Group service or indemnity type contracts, issued by nonprofit corporations, covering family members.

B. Summary

Requires coverage for inpatient treatment for mental, emotional or nervous disorders in a mental hospital or general hospital. Coverage may not be more restrictive than for any other illness, except that benefits may be limited to 30 days of active treatment per policy year.

If coverage is not provided under 348.8B, then coverage must include benefits for inpatient drug and alcohol rehabilitation and treatment necessary to restore the covered person to satisfactory emotional and physical health. Such care may be provided in a mental or general hospital or other licensed alcoholic rehabilitation facility. These benefits for alcohol and drug rehabilitation may be limited as follows:

(1) thirty days of active inpatient treatment per policy year;

(2) level of coverage may be different than that for other mental, emotional, or nervous disorders provided they cover the reasonable cost of necessary services or provide an $80 per day indemnity benefit;

(3) 90 days of active inpatient treatment during the covered person's lifetime.

6. Section 38.1-348.10 - Exclusion or reduction of benefits for certain causes prohibited.

A. Applicability

All group contracts, including "Blues"

B. Summary

Requires group policies and contracts to provide coverage or services even though such coverage or services may also be provided to a covered person under an individually underwritten and individually issued policy or contract providing exclusively for accident and sickness benefits for which the entire premium has been paid to the insurer by the insured or a family member, and irrespective of the premium payment method or premium discounts.

i.e. Prohibits group contracts from containing provisions that would affect benefits payable because of policies such as those described above.

7. Section 38.1-348.11 - Conversion on termination of eligibility.

A. Applicability

All group contracts, including "Blues" Hospital, Medical-Surgical, and/or Major Medical

B. Summary

Requires group contracts to provide a conversion privilege for covered persons whose eligibility for coverage under the group contract terminates; provided the person is not then eligible for Medicare or Medicaid benefits and that termination of eligibility was for a reason other than termination of the group policy itself.

The policyholder may elect either of two means of providing the conversion privilege for those covered by the group policy.

(1) Issuance by the insurer of a non-group policy, either individual or family, as appropriate, and provided the insurer offers such a policy for sale at that time. Cannot require evidence of insurability.

(a) application and payment of first premium must be made within 31 days after termination, and will begin from the termination date.

(b) premium for such policy to be at insurer's customary rate applicable to such policies, for the person's then risk class and attained age.

(c) the non-group policy shall not result in over-insurance, based on the insurer's underwriting standards then in effect.

(d) benefits under the non-group policy shall not duplicate any benefits paid for the same injury or sickness under the prior group policy.

OR

(2) continuation of coverage under the group policy for 90 days after termination of eligiblity.

(a) application to be made to group policyholder and payment of total premium for 90 days' coverage to group policyholder prior to termination.

(b) premium payable to be at insurer's rate applicable to group coverage during the 90 day period.

(c) available only to those covered continuously under group policy for at least 3 months immediately preceding termination of eligiblity.

8. Section 38.1-348.13 - Coverage for victims of rape or incest.

A. Applicability

Individual, Blanket, Group, and "Blues"

All contracts providing Hospital Expense, Medical Surgical Expense, or Hospital Confinement Indemnity provided such contracts provided benefits resulting from "accident" or "accidental injury".

B. Summary

Requires affected contracts to be construed to include benefits for pregnancy of the insured or subscriber to the same extent as for any other covered accident, provided:

(1) the pregnancy follows an act of rape that was reported to the police within 7 days following its occurrence; or

(2) in the case of a female under 13 years of age, the pregnancy follows an act of rape or incest that was reported to the police within 180 days following its occurrence.

B. "Make Available" coverages:

1. Section 38.1-348.7B - Outpatient coverages for mental, emotional or nervous disorders.

A. Applicability

Group Hospital, Group Major Medical, Group "Blues" specifically non-applicable to Blanket, Short term travel, Accident Only, Limited or Specified Disease, Conversion policies, Policies for those eligible for Medicare.

B. Summary

Requires that coverage be made available (i.e. optional), under those contracts providing outpatient benefits, additional benefits for outpatient treatment of mental, emotional, and nervous disorders.

Applicant/Policyholder has right to select alternative levels of benefits offered by the carrier.

Outpatient benefit shall consist of durational limits, dollar limits, deductibles and co-insurance factors that are not less favorable than for physical illness generally, except:

(1) Co-insurance factor need not exceed 50% of the co-insurance factor applicable for physical illness generally, if greater; and

(2) Maximum benefit for mental, emotional, and nervous disorders in the aggregate during any applicable benefit period may be limited to not less than $1,000.

If optional coverage is not provided under Section 38.1-348.8, then mental, emotional, and nervous disorders are construed as including physiological and psychological dependence upon alcohol and drugs. If, however, the insured or subscriber is offered and accepts coverage under 348.8, then alcohol and drug dependence is not included in the definition of mental, emotional and nervous disorders under 348.7.

2. Section 38.1-348.8 - Coverages for alcohol and drug dependence.

A. Applicability

Group policies which provide benefits on an expense incurred basis and cover family members. Group service and indemnity contracts issued by non-profit corporations which cover family members. Specifically non-applicable to Short-term travel, Accident only, Limited or Specified Disease, and Medicare Supplement.

B. Summary

Requires that coverage be made available (i.e. optional) for incapacitation by, or physiological or psychological dependence upon alcohol or drugs.

The benefit made available shall have no limits that are more restrictive than for any other illness and shall include as a minimum:

(1) inpatient treatment in any alcoholism or drug addiction facility and intermediate care facility for at least 45 days per policy year or calendar year; and

(2) outpatient treatment in any alcoholism or drug addiction facility consisting of a minimum of 45 sessions of individual, group, or family counseling during any given policy year or calendar year.

The types of facilities referred to are defined in the statute. Also, if the option under this Section is not accepted by the insured or subscriber, then alcoholism and drug addiction benefits are included under mental, emotional, and nervous disorders benefits pursuant to 348.7.

3. Section 38.1-348.9 - Optional coverage for obstetrical services.

A. Applicability

Group Hospital and Group Major Medical, including "Blues". Specifically non-applicable to Short-Term Travel, Accident Only, Limited or Specified Disease, Conversion policies, and Medicare Supplements.

B. Summary

Requires that coverage be made available (i.e. optional) for obstetrical services on an inpatient basis in a general hospital.

The benefit for obstetrical services shall include reimbursement for such services by a physician, based on the usual, customary and reasonable charges for such services determined in the same manner in which charges are developed for other medical and surgical procedures. The coverage shall have durational limits, dollar limits, deductibles and co-insurance factors that are not less favorable than for physical illness generally.

4. Section 38.1-348.12:1 - Deductibles and co-insurance options required.

A. Applicability

Individual, Blanket, Group and "Blues" - expense incurred type contracts only.

Specifically non-applicable to Short-Term travel, Accident Only, Limited or Specified Disease, Conversion policies, and Medicare Supplements.

B. Summary

Requires insurers to "make available" (i.e. optional) to potential insureds or contract holders one or more of the following options for deductibles and/or co-insurance.

(1) covered person pays first $100 of cost of services covered or benefits provided under the contract during a 12-month period.

(2) covered person pays 20% of first $1,000 of cost of services or benefits provided under the contract during a 12 month period.

(3) covered person pays first $100 and 20% of the next $1,000 of cost of services covered or benefits provided under the contract during a 12 month period.

(4) any other option providing higher deductibles, co-insurance, or cost-sharing, provided that, for individual policies, such options are not inconsistent with the minimum standards laws and regulations.

"Make available" means that the insurer or pre-paid service plan must disseminate information concerning the option or options to all potential insureds or contract holders at the same time and in the same manner as it does concerning other policies, contracts and options.

5. Section 38.1-348.14 - Additional mandated coverage made optional to group policy or contract holder.

A. Applicability

Group, Blanket, "Blues"

B. Summary

Requires that any coverage, benefits, or services first mandated on or after July 1, 1982 be offered as options to any new or renewed policies or contracts from that date forward. Mandated benefits first required prior to July 1, 1982 are not affected.

Current Virginia Law

Mandating Benefits

§ 38.1-347.1. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians. — Notwithstanding any provision of any policy of insurance, when such policy provides for reimbursement for any service which may be legally performed by a person licensed in this State for the practice of chiropractic, optometry, optician, psychology, clinical social work, podiatry or chiropody, reimbursement under such policy shall not be denied because such service is rendered by a person so licensed; provided, that the provisions of this section relating to chiropractic shall not apply to contracts issued by plans organized pursuant to chapter 11 (§ 32-195.1 et seq.) of Title 32; and provided further, that the provisions of this section relating to clinical social work services shall not apply unless insurance coverage for such services has been specifically contracted for under the policy, which coverage must be made available to the purchaser of such policy. Nothing in the provisions of this section shall apply to Medicaid, or any State fund. (1968, c. 588; 1973, c. 428; 1979, c. 13.)

Cross reference. — For section prohibiting certain subrogation provisions in hospitalization, medical, etc., policies, see § 38.1-342.2.

Editor's note. — Chapter 11 of Title 32, referred to in this section, was repealed by Acts 1979, c. 721. See now chapter 23 (§ 38.1-810 et seq.) of this title.

Applied in Virginia Academy of Clinical Psychologists v. Blue Shield, 501 F. Supp. 1232 (E.D. Va. 1980); Blue Cross v. Commonwealth, Va. , 269 S.E.2d 827 (1980).

§ 38.1-348.1. Coverage of dependent children. — Any blanket, group or individual policy delivered or issued for delivery in this State more than one hundred and twenty days after June twenty-eight, nineteen hundred seventy-four, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child during the continuance of such policy and while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the policyholder within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age; provided further that such insurer may charge an additional premium for and with respect to any such continuation of coverage beyond the limiting age of the policy with respect to such child, which premium shall be determined by the insurer on the basis of the class of risks applicable to such child. (1968, c. 411; 1974, c. 95.)

§ 38.1-348.5. Construction of policy generally; words "physician" and "doctor" to include dentist. — Every insurance policy or contract for prepaid medical, surgical or similar or related services, or any of such services, including, without limitation, any policy or contract within the scope of this article, article 2.1 (§ 38.1-362.1 et seq.) of this chapter and chapter 11 (§ 32-195.1 et seq.) of Title 32, shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended or modified by any rider, endorsement, or application attached to and made a part of the policy; provided, however, that the word "physician" or "doctor" when used in any accident or sickness policy, or other contract providing for the payment of medical, surgical, or similar services shall be construed to include a dentist performing such services within the scope of his professional license. (1968, c. 292.)

Editor's note. — Chapter 11 of Title 32, referred to in this section, was repealed by Acts 1979, c. 721. See now chapter 23 (§ 38.1-810 et seq.) of this title.

§ 38.1-348.6. Coverage of newborn children required. — All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, as to such family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered and issued for delivery, reissued, renewed or extended in this State on and after November one, nineteen hundred seventy-six. An insurance policy written before November one, nineteen hundred seventy-six shall be deemed to be reissued or renewed if the provisions of that policy or contract allow the insurer to change the terms of the policy or contract or adjust the premiums charged, and if a change or adjustment is made on or after November one, nineteen hundred seventy-six. (1975, c. 281; 1976, c. 342.)

Law Review. — For survey of Virginia law on insurance for the year 1974-1975, see 61 Va. L. Rev. 1759 (1975).

§ 38.1-348.7. Coverages for mental, emotional or nervous disorders. — A. All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a mental hospital or a general hospital, provide coverage for mental, emotional or nervous disorders, with limits that are not more restrictive than for any other illness except that such benefits may be limited to thirty days of active treatment in any policy

year. The thirty days of inpatient care specified in this section for mental, emotional or nervous disorders shall include benefits for drug and alcohol rehabilitation and treatment, whether such care be provided in a mental or general hospital or other licensed alcoholic rehabilitation facility, necessary to restore any covered person to satisfactory emotional and physical health: provided, however, that with respect to the benefits for alcoholic and drug rehabilitation only (i) the level of coverage available may be different from the coverage which is payable for the treatment of other mental, emotional and nervous disorders if such benefits cover the reasonable cost of necessary services, or provide an eighty dollar per day indemnity benefit, and (ii) such benefits may be limited to ninety days of active inpatient treatment in the covered person's lifetime. The requirements of this section shall apply to all insurance policies and subscriber 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 is made.

B. Every insurer which proposes to issue a group hospital policy or a group major medical policy in this State and every nonprofit hospital and medical service plan corporation which proposes to issue hospital, medical or major medical service plan contracts which provide coverage for the insured or the subscriber shall, in the case of outpatient benefits, make available additional benefits as specified herein for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for such policy or contract to select any alternative level of benefits as may be offered by the insurer or service plan corporation. Outpatient benefits shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that the coinsurance factor need not exceed fifty per centum of the coinsurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to not less than one thousand dollars.

This subsection B shall apply to policies or contracts delivered or issued for delivery in this State on or after November one, nineteen hundred seventy-seven; but shall not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion 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.

As used in this section, the following terms shall have the meanings indicated below.

(1) *"Outpatient benefits"* means only those payable for (i) charges made by a hospital for the necessary care and treatment of mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, (ii) charges for services rendered or prescribed by a physician, psychologist or clinical social worker duly licensed to practice in Virginia for the necessary care and treatment for mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, or (iii) charges made by a mental health treatment center, as defined herein, for the necessary care and treatment of a covered person provided in such treatment center.

(2) *"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 or a psychologist duly licensed to practice in Virginia and which facility is also: (i) licensed by the State, or (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.

C. *"Mental, emotional or nervous disorders"* as used in this section shall include physiological and psychological dependence upon alcohol and drugs: provided, however, that in instances where the optional coverage made available pursuant to § 38.1-348.8 B is accepted by or on behalf of the insured or subscriber and included in a policy or contract "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs. (1976, c. 355; 1977, cc. 603, 606; 1978, c. 349; 1979, cc. 13, 399.)

Editor's note. — Title XVIII of the Social Security Act, referred to in the second paragraph of subsection B, may be found in 42 U.S.C. §§ 1395 through 1395rr.

Law Review. — For survey of Virginia law on insurance for the year 1978-1979, see 66 Va. L. Rev. 321 (1980).

§ 38.1-348.8. Coverages for alcohol and drug dependence. — A. As used in this section:

1. *"Treatment"* includes diagnostic evaluation, medical, psychiatric and psychological care, counseling and rehabilitation for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs which is determined to be necessary by and is provided by a certified alcoholism counselor, certified drug counselor, professional counselor, psychologist, or social worker licensed or certified pursuant to chapter 28 (§ 54-923 et seq.) of Title 54, or by a licensed physician.

2. *"Alcoholism or drug addiction facility"* means a facility in which is provided a State-approved program for the treatment of alcoholism or drug addiction and which is (i) a facility licensed by the State Board of Health pursuant to chapter 16 of Title 32 (§ 32-297 et seq.) or by the State Mental Health and Mental Retardation Board pursuant to chapter 8 (§ 37.1-179 et seq.) or chapter 11 (§ 37.1-203 et seq.) of Title 37.1; (ii) an office or clinic of a licensed physician or clinical psychologist; (iii) a State agency or institution or (iv) a facility accredited by the Joint Commission on Accreditation of Hospitals.

3. *"Intermediate care facility"* means a duly licensed, residential public or private alcoholism or drug addiction facility which is not a hospital and which is operated primarily for the purpose of providing a continuous, structured twenty-four-hour-a-day State-approved program of inpatient treatment and care for inpatient alcoholics or drug addicts.

B. No group accident and sickness insurance policy providing coverage on an expense incurred basis and no group service or indemnity type contract issued by a nonprofit corporation which provides coverage of a family member of the insured or the subscriber, shall be delivered or issued for delivery in this State on or after July one, nineteen hundred seventy-eight, unless coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs as hereinafter provided was made available as an option. Such coverage made available as an option shall have no limits that are more restrictive than for any other illness and shall include as a minimum (i) treatment as an inpatient in any alcoholism or drug addiction facility and intermediate care facility for a minimum of forty-five days during any given policy year or calendar year, and (ii) outpatient treatment in any alcoholism or drug addiction facility consisting of a minimum of forty-five sessions of individual, group, or family counseling during any given policy year or calendar year.

C. The provisions of this section shall not be applicable to short-term travel, accident only, limited or specified disease, individual conversion 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. (1977, c. 606; 1978, c. 349.)

Editor's note. — Chapter 16 of Title 32, referred to in this section, was repealed by Acts 1979, c. 711. See now article 1 (§ 32.1-123 et seq.) of chapter 5 of Title 32.1.

Title XVIII of the Social Security Act, referred to in subsection C, may be found in 42 U.S.C. §§ 1395 through 1395rr.

§ 38.1-348.9. Optional coverage for obstetrical services. — Every insurer which proposes to issue a group hospital policy or a group major medical policy in this Commonwealth and every nonprofit hospital and medical service plan corporation which proposes to issue group hospital, group medical or group major medical service plan contracts which provide coverage for the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a general hospital, provide, as an option available to the group policyholder or the contract holder, coverage for obstetrical services, with reimbursement for obstetrical services by a physician to be based on the usual, customary and reasonable charges for such services determined according to the same formula by which such charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally.

This section shall apply to policies or contracts delivered or issued for delivery in this Commonwealth on or after July one, nineteen hundred seventy-eight; but shall not apply to short-term travel, accident only, limited or specified disease or individual conversion 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. (1978, c. 375.)

Editor's note. — Title XVIII of the Social Security Act, referred to near the end of the section, may be found in 42 U.S.C. §§ 1395 through 1395rr.

§ 38.1-348.10. Exclusion or reduction of benefits for certain causes prohibited. — No group policy of accident and sickness insurance, nor any group contract under a plan as provided in §§ 32-195.1 through 32-195.50 of the Code of Virginia, hereafter issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain any provision excluding or reducing the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued policy or contract which provides exclusively for accident and sickness benefits and for which the entire premium has been paid by the insured or a member of the insured's family or his guardian, irrespective of the method of premium payment, such as payroll deduction, to the insurer and regardless of any discount received on the premium by virtue of the insured's membership in any organization or his status as an employee. (1978, c. 496.)

The number of this section was assigned by the Virginia Code Commission, the number in the 1978 act having been 38.1-348.9.

Editor's note. — Sections 32-195.1 through 32-195.50, referred to in this section, were repealed by Acts 1979, c. 721. For present provisions covering the subject matter of repealed §§ 32-195.1 through 32-195.20, see §§ 38.1-810 through 38.1-833. For provisions as to health maintenance organizations, see §§ 38.1-863 through 38.1-891. For provisions concerning plans for future dental or optometric services, see §§ 38.1-892 through 38.1-914. For present provisions concerning health generally, see §§ 32.1-1 through 32.1-309.

§ 38.1-348.11. Conversion on termination of eligibility. — Every group hospital policy or group medical and surgical policy or group major medical policy of accident and sickness insurance, hereafter issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain language providing that if the insurance on a person covered under such a policy or contract ceases because of the termination of such person's eligibility for coverage other than due to termination of the group policy, prior to his or her becoming eligible for Medicare or Medicaid benefits, then such person shall be entitled (a) to have issued to him or her by the insurer, without evidence of insurability, a nongroup policy of accident and sickness insurance, either individual or family, whichever is appropriate, in the event that the insurer offers such policy, provided that application for such a policy shall be made, and the first premium paid to the insurer within thirty-one days after such termination and provided further that:

1. The premium on the policy shall be at the insurer's then customary rate applicable (i) to such policies, (ii) to the class of risk to which such person then belongs, and (iii) to his or her age attained on the effective date of the policy;

2. The policy of accident and sickness insurance will not result in over-insurance on the basis of the company's underwriting standards at the time of issue;

3. The benefits under the policy of accident and sickness insurance shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;

4. The provisions of subsection (a) of this section shall be effectuated in such a way as to result in continuous coverage during the thirty-one-day period for such insured; or (b) to have his or her present coverage under such policy or contract continued for a period of ninety days immediately following the date of the termination of such person's eligibility, without evidence of insurability, provided that application for such extended coverage shall be made to the group policyholder and the total premium for the ninety-day period paid to the group policyholder prior to such termination and provided, further, that the premium for continuing the group coverage shall be at the insurer's rate applicable to such group policy during the ninety-day period. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility. The policy holder may elect to include within the contract either the language of subsection (a) or the language of subsection (b). (1979, c. 97; 1982, c. 625.)

The 1982 amendment substituted "rate applicable to such group policy during the ninety-day period" for "then present rate applicable to such group policy" at the end of the first sentence of subdivision 4 and added the last sentence of that subdivision.

§ 38.1-348.12:1. Deductibles and coinsurance options required. — A. An insurer issuing accident and sickness insurance on an expense incurred basis or a prepaid hospital, medical, or surgical service plan shall make available in offering such coverage or contract to the potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first one hundred dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

2. Twenty percent of the first one thousand dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

3. The first one hundred dollars and twenty percent of the next one thousand dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision; however, such option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.1-362.14.

B. For the purposes of this section "make available" means that the insurer or prepaid service plan shall disseminate information concerning such option or options and make a policy or contract containing such option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer or prepaid service plan disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

C. This section shall apply to policies or contracts delivered or issued for delivery in this Commonwealth on or after March 18, 1981, and to group policies or contracts issued prior to that date at the first renewal thereof; but shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the United States Social Security Act or any other similar coverage under State or federal government plans. (1981, c. 322.)

Effective date. — This section is effective March 18, 1981.

§ 38.1-348.13. Coverage for victims of rape or incest. — A. All individual and group Hospital Expense, Medical-Surgical Expense, Major Medical Expense or Hospital Confinement Indemnity insurance policies issued by an insurance company and individual and group service, or any indemnity type of contracts providing hospital, medical, or surgical benefits issued by a non-profit corporation operating under chapter 23 (§ 38.1-810 et seq.) or 26 (§ 38.1-863 et seq.) of Title 38.1 which provide benefits as a result of an "accident" or "accidental injury" shall be construed to include benefits for pregnancy following an act of rape of an insured or subscriber which was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The seven-day requirement shall be extended to one hundred eighty days in the case of an act of rape or incest of a female under thirteen years of age.

B. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered and issued for delivery, reissued, renewed, or extended in this State on and after July one, nineteen hundred eighty-one. An insurance policy written before July one, nineteen hundred eighty-one, shall be deemed to be reissued or renewed if the provisions of that policy or contract allow the insurer to change the terms of the policy or contract or adjust the premiums charged, and if a change or adjustment is made on or after July one, nineteen hundred eighty-one. (1981, c. 42.)

§ 38.1-348.14. **Additional mandated coverage made optional to group policy or contract holder.** — Notwithstanding any other section of this title, any new or existing group policy or contract holder for whom coverage under an accident and sickness insurance policy is issued or renewed by an insurer or for whom coverage under a contract is issued or renewed by a plan licensed pursuant to Chapter 23 (§ 38.1-810 et seq.) of this title shall be given the option to purchase any coverage, benefits or services first mandated under this chapter on or after July 1, 1982, provided, further, all mandated coverages as of June 30, 1982, will not be affected. (1982, c. 577.)

SOURCE: Code of Virginia, Volume 6A (1981 Replacement Volume), The Michie Company, Charlottesville, Virginia.

Mandated Benefit Bills Presented

During the 1982 Regular Session

1982 REGULAR SESSION

LD1175131

HOUSE BILL NO. 272

Offered January 25, 1982

A BILL to amend and reenact §§ 38.1-98.1 and 38.1-328 of the Code of Virginia, which regulate the delivery of certain group insurance certificates in Virginia; enforcement of such provisions.

Patron—Wilson

Referred to the Committee on Corporations, Insurance and Banking

---

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.1-98.1 and 38.1-328 of the Code of Virginia are amended and reenacted as follows:

§ 38.1-98.1. Enjoining unlicensed foreign or alien companies from transacting business in State.—Whenever a foreign or alien insurance company not licensed to do an insurance business in this ~~State~~ *Commonwealth* shall engage in any insurance transaction or do any insurance business in this ~~State~~ *Commonwealth* , the Commission shall have jurisdiction and the powers of a court of equity to issue, on its own motion or on motion of any party in interest, temporary or permanent injunctions restraining such insurance company from engaging in any such insurance transaction or business.

For the purposes of this section, the following acts, effected by mail or otherwise, shall constitute the transacting of an insurance business in this ~~State~~ *Commonwealth* : (1) the issuance or delivery of contracts of insurance to residents of this ~~State~~ *Commonwealth* or to corporations authorized to do business therein; (2) the solicitation of applications for such contracts; (3) the collection of premiums, membership fees, assessments or other considerations for such contracts; or (4) the transactions of any other insurance business in connection with such contracts.

Process may be served in accordance with § 13.1-119 ~~of this Code~~ or any other manner prescribed by law.

This section shall not apply to any life insurance or annuity company organized and operated, without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual by issuing insurance and annuity contracts only to or for the benefit of such institutions and individuals engaged in the service of such institutions ; ~~provided~~ : Such company shall be deemed, as to all Virginia policyholders and contract holders, to have appointed the clerk of the Commission its attorney for service of process in Virginia, such appointment to be irrevocable and to bind the company and any successors in interest and to remain in effect as long as there is in force in this ~~State~~ *Commonwealth* any contract made by that company or any obligation arising therefrom ; ~~nor shall~~ . *The provision of* this section *shall not* apply to any insurance or annuity contracts issued by any such life insurance or annuity company ; ~~nor shall it apply~~ *or* to the following acts or transactions: (1) the procuring of a policy of insurance upon a risk within this ~~State~~ *Commonwealth* where the applicant is unable to procure coverage in the open market with a company or companies licensed to do business in this ~~State~~

Commonwealth and is otherwise in compliance with ~~article 3.1~~ *Article 5* (§ ~~38.1-314.1~~ *38.1-327.46* et seq.), ~~chapter 7~~ *Chapter 7.1* , Title 38.1; (2) contracts of reinsurance; (3) transactions in this ~~State~~ *Commonwealth* involving a policy lawfully solicited, written and delivered outside of this ~~State~~ *Commonwealth* covering only subjects of insurance not resident, located, or to be performed in this ~~State~~ *Commonwealth* at the time of issuance of such policy; (4) transactions in this ~~State~~ *Commonwealth* involving group or blanket insurance and group annuities where the group or blanket policy of such insurance or annuities was lawfully issued and delivered in a state where the company was authorized to transact business *, if the certificates of insurance provided under such group or blanket insurance meet the requirements of § 38.1-328* ; (5) the procuring of contracts of insurance issued to an "industrial insured" as hereinafter defined. For the purposes of this section an "industrial insured" is an insured (a) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer, (b) whose aggregate annual premiums for insurance on all risks total at least ~~twenty five thousand dollars~~ *$25,000* , and (c) who has at least twenty-five full-time employees

Nothing in this section shall apply to nonprofit Railroad Brotherhood or other similar fraternal organizations.

§ 38.1-328. Scope of chapter.–The provisions of this chapter shall apply to all kinds or classes of insurance except annuities and ocean marine insurance; but such provisions shall not apply to *individual* life insurance policies and *individual* accident and sickness insurance policies, not issued for delivery nor delivered in this ~~State~~ *Commonwealth* , nor to contracts of reinsurance. *Notwithstanding any provisions of this title, certificates of insurance provided to residents of this Commonwealth through group contracts delivered or issued for delivery outside of this Commonwealth shall provide benefits which are reasonable in relation to the premiums charged and shall provide benefits as required by the laws of this Commonwealth unless the Commission determines that certain benefits are not appropriate for the coverage provided. The Commission shall have authority to enforce the provisions of this section under the enforcement provisions of Chapter 1 (§ 38.1-1 et seq.) of this title.*

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the House of Delegates	Clerk of the Senate

SUMMARY OF HOUSE BILL 272

RE: Proposed Changes in Requirements for Group Contracts Delivered Or Issued for Delivery Outside Virginia.

This is a proposed revision of the Code of Virginia regarding changes in the requirements for group contracts delivered or issued for delivery outside of Virginia but covering Virginia insureds.

Based on several complaints we received during the year, the Bureau of Insurance feel it is necessary to be able to apply Virginia insurance laws to policies covering Virginia insureds even though that policy may have been issued for delivery or delivered out of this State.

The current law allows companies to easily circumvent or Minimum Standards Regulations for both property and casualty and life and health, particularly the mandated benefits under the accident and health law, by issuing an out-of-state group policy and insuring insureds in Virginia by certificate.

Our proposed legislation would make our Virginia insurance laws apply to those with certificates just as though they were policies issued in Virginia.

Discussion

This would insure that mandated benefits required in our state be made available to Virginia residents when the group policy is issued in another state. Companies would be prevented from avoiding our minimal requirements standards on individual policies by forming out of state groups not subject to our authority.

The bill would provide regulators with extraterritorial authority. Because of this there may be opposition to the bill.

1982 REGULAR SESSION

LD0709305

HOUSE BILL NO. 555

Offered January 28, 1982

A BILL to amend the Code of Virginia by adding a section numbered 38.1-348.8:1. to require certain health insurance policies to provide coverage of rehabilitation services for physical disorders.

Patrons—Giesen, Slayton, and Hull

Referred to the Committee on Corporations, Insurance and Banking

---

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.1-348.8:1 as follows:

§ 38.1-348.8:1. Coverage of rehabilitation services for physical disorders.—All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and any type of individual and group service indemnity contract issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall provide coverage of rehabilitation treatment and services when rendered in a hospital, whether or not such hospital has surgical facilities.

Official Use By Clerks	
Passed By	
The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

SUMMARY OF HOUSE BILL 555

A new section 38.1-348.8:1 would require individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and any individual and group service indemnity contract issued by a non-profit corporation to provide coverage for rehabilitation services when rendered in a hospital, with or without surgical facilities. This would be a mandated benefit.

Discussion

This would provide insurance coverage for rehabilitation services in hospitals. Now claims for rehabilitation services can be denied on the basis that they were not provided in a hospital with surgical facilities. It is easier for the insurers to deny coverage on this basis rather than to determine whether the treatment was in connection with a covered accident or illness.

There may be opposition to this bill. This type of mandatory coverage could be costly.

Further, this bill should be reviewed in conjunction with H.B. 716 and 721.

1982 REGULAR SESSION

LD1654508

HOUSE BILL NO. 716

Offered January 29, 1982

A BILL to amend and reenact § 38.1-348.7 of the Code of Virginia, which requires certain insurance policies to cover mental, emotional and nervous disorders.

Patrons–Marshall, Slayton, Stambaugh, Almand, Plum, Keating, Parker, Terry, Callahan, Emroch, Marks, Bagley, R. M., Christian, Moss, Barry, and Giesen

---

Referred to the Committee on Corporations, Insurance and Banking

---

Be it enacted by the General Assembly of Virginia:

1. That § 38.1-348.7 of the Code of Virginia is amended and reenacted as follows:

§ 38.1-348.7. Coverages for mental, emotional or nervous disorders.–A. All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient *or outpatient* in a mental hospital or a general hospital, provide coverage for mental, emotional or nervous disorders, with limits that are not more restrictive than for any other illness except that such benefits may be limited to thirty days of active treatment in any policy year *and in the case of an outpatient may be limited to no less than $1,000 of benefits in any policy year* . The thirty days of inpatient *or outpatient* care specified in this section for mental, emotional or nervous disorders shall include benefits for drug and alcohol rehabilitation and treatment, whether such care be provided in a mental or general hospital or other licensed alcoholic rehabilitation facility, necessary to restore any covered person to satisfactory emotional and physical health ; ~~provided, however, that with~~ *With* respect to the benefits for alcoholic and drug rehabilitation only (i) the level of coverage available may be different from the coverage which is payable for the treatment of other mental, emotional and nervous disorders if such benefits cover the reasonable cost of necessary services, or provide an eighty dollar per day indemnity benefit, and (ii) such benefits may be limited to ninety days of active inpatient treatment in the covered person's lifetime. The requirements of this section shall apply to all insurance policies and subscriber 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 is made.

B. ~~Every insurer which proposes to issue a group hospital policy or a group major medical policy in this State and every nonprofit hospital and medical service plan corporation which proposes to issue hospital, medical or major medical service plan contracts which provide coverage for the insured or the subscriber shall, in the case of outpatient benefits, make available additional benefits as specified herein for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for such policy or contract to select any alternative level of benefits as may be offered by the insurer or service plan corporation. Outpatient benefits shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that the coinsurance factor need not exceed~~ fifty per

~~centum of the coinsurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to not less than one thousand dollars.~~

~~This subsection B shall apply to policies or contracts delivered or issued for delivery in this State on or after November one, nineteen hundred seventy-seven; but shall not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion 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.~~

As used in this section, the following terms shall have the meanings indicated below.

(1) "Outpatient benefits" means only those payable for (i) charges made by a hospital for the necessary care and treatment of mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, (ii) charges for services rendered or prescribed by a physician, psychologist or clinical social worker duly licensed to practice in Virginia for the necessary care and treatment for mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, or (iii) charges made by a mental health treatment center, as defined herein, for the necessary care and treatment of a covered person provided in such treatment center.

(2) "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 or a psychologist duly licensed to practice in Virginia and which facility is also: (i) licensed by the State, or (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.

C. "Mental, emotional or nervous disorders" as used in this section shall include physiological and psychological dependence upon alcohol and drugs; provided, however, that in instances where the optional coverage made available pursuant to § 38.1-348.8 B is accepted by or on behalf of the insured or subscriber and included in a policy or contract "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

SUMMARY OF HOUSE BILL 716

This bill would amend section 38.1-348.7 to require individual and group accident and sickness insurance policies providing coverage on an expense incurred basis, and individual and group service on indemnity type contracts issued by a non-profit corporation to include coverage for treatment as an outpatient in a mental or general hospital for mental, emotional or nervous disorders. (The current law - covers only inpatients). Such outpatient benefits would be limited to no less than $1,000 in any policy year. A provision requiring insurers providing outpatient benefits to make available benefits for outpatient care for mental, emotional and nervous disorders has been deleted.

Discussion:

This would mandate insurance coverage for inpatient treatment for mental, emotional disorders.

There may be opposition to this bill. These mandated benefits might be costly.

This bill should be reviewed in conjunction with H.B. 721 and H.B. 555.

1982 REGULAR SESSION

LD1872534

HOUSE BILL NO. 721

Offered January 29, 1982

A BILL to amend and reenact § 38.1-360 of the Code of Virginia, which exempts certain accident and sickness insurance policies from the application of certain statutes.

Patron--Murray

Referred to the Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.1-360 of the Code of Virginia is amended and reenacted as follows:

§ 38.1-360. Nonapplication to certain policies.--Nothing in this article shall apply to or affect (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein or when issued with or supplemental to a policy of motor vehicle liability insurance, as provided for in § 38.1-21 (2) to a coverage providing weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, provided such benefits are irrespective of legal liability of the insured or any other person, if such injury or death is caused by accident and sustained while in or upon, entering or alighting from, or through being struck by a motor vehicle; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance, except that the provisions of § § 38.1-347.1 ; *shall be applicable to such policies of insurance, but the policy or contract holder of a group policy shall have the option to include in the group policy or contract any of the coverages, contractual limitations and obligations otherwise required by §§* 38.1-348.1, 38.1-348.6, 38.1-348.7, 38.1-348.8, 38.1-348.10, 38.1-348.11 and 38.1-348.12 ~~shall be applicable to such policies of insurance~~ ; or (4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or (5) any policy of industrial sick benefit insurance.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the House of Delegates	Clerk of the Senate

SUMMARY OF HOUSE BILL 721

This bill provides for section 38.1-360 to be amended to allow a policy or contract holder of a group accident and sickness insurance policy to have the option of including coverages, contractual limitations and obligations required under sections 38.1-348.1, 38.1-348.6, 38.1-348.7, 38.1-348.8, 38.1-348.10, 38.1-348.11 and 38.1-348.12.

Discussion:

Making coverages now mandatory in group policies optional could reduce the costs of such insurance.

Opponents argue that mandatory coverages provide the consumer with some uniform and essential benefit regardless.

It should be noted that H.B. 716 proposes to mandate a coverage that this bill seeks to make optional. This bill should be reviewed in conjunction with H.B. 716 and H.B. 555.

1982 REGULAR SESSION

LD2541125

AMENDMENT IN THE NATURE OF A SUBSTITUTE FOR SENATE BILL NO. 191

(Proposed by the Senate Committee on Commerce and Labor)

(Patron Prior to Substitute—Senator Michie)

A BILL to amend and reenact §§ 38.1-347.1 and 38.1-824 of the Code of Virginia, regulating insurance policies that provide for reimbursement for services performed by certain practitioners.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.1-347.1 and 38.1-824 of the Code of Virginia are amended and reenacted as follows:

§ 38.1-347.1. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.— *A.* Notwithstanding any provision of any policy of insurance, when such policy provides for reimbursement for any service which may be legally performed by a person licensed in this State for the practice of chiropractic, optometry, optician, psychology, ~~clinical social work,~~ podiatry or chiropody, reimbursement under such policy shall not be denied because such service is rendered by a person so licensed; provided, that the provisions of this section relating to chiropractic shall not apply to contracts issued by plans organized pursuant to ~~chapter 11 (§ 32-195.1 et seq.) of Title 32~~ *Chapter 23 (§ 38.1-810 et seq.) of this title* ; ~~and provided further, that the~~ provisions ~~of this section relating to clinical social work services shall not apply unless~~ insurance ~~coverage for such services has been specifically contracted for under the policy, which coverage must be made available to the purchaser of such policy~~ . Nothing in the provisions of this section shall apply to Medicaid ; or any ~~State~~ *state* fund.

B. No insurance company authorized to do business in this Commonwealth shall offer a plan for furnishing prepaid medical and surgical, and similar or related services, or any of such services without making available optional coverage for services rendered by a clinical social worker or professional counselor licensed to render the services in the Commonwealth.

§ 38.1-824. Services of certain practitioners other than physicians to be covered.— *A.* No plan for furnishing prepaid medical and surgical, and similar or related services, or any of such services, shall fail or refuse, either directly or indirectly, to allow or to pay for such services, or any part thereof, rendered by any doctor of podiatry, doctor of chiropody, optometrist, optician ; *or* psychologist ; ~~or clinical social worker~~ duly licensed to practice in Virginia, to the holder of any contract or subscription contract issued under or pursuant to such plan if the services rendered (i) are services provided for by such contract or subscription contract ~~and, in the case of services by a clinical social worker, have been specifically contracted for by the holder of any such contract or subscription contract, which coverage must be made available to the holder of such~~ contract , and (ii) are services which the doctor of podiatry, doctor of chiropody, optometrist, optician ; *or* psychologist ; ~~or clinical social worker~~ is licensed to render in Virginia.

B. Each plan for furnishing prepaid medical and surgical, and similar or related services shall make available optional coverage for services rendered by a clinical social worker or professional counselor licensed to render the services in the Commonwealth.

SUMMARY OF SENATE BILL 191

This bill is designed to include professional counseling among reimbursable services under accident and sickness insurance policies (section 38.1-347.1) and prepaid hospitalization plans (section 38.1-824).

Discussion:

This bill would make professional counseling more accessible by providing for reimbursement by accident and sickness insurance and prepaid hospitalization plans for services performed by professional counselors. The current law provides for reimbursement of services performed by psychologists and clinical socia workers so adding professional counselors would give a person more choice of professional services.

However, it could be argued that professional counseling is not related to health treatment, either physical or mental, and could be regarded as elective and thus not qualified for coverage in insurance policies. As defined in the licensing law, section 54-932, a "professional counselor" is a person trained in counseling and guidance services with emphasis on individual and group guidance and counseling designed to assist individuals in achieving more effective personal, social, educational and career development and adjustment. This definition is so broad that it could include services not properly reimbursable under health insurance.

It should be noted that this bill, is identical to House Bill 865.

1982 REGULAR SESSION
ENGROSSED

SENATE BILL NO. 358

Senate Amendments in [ ] - February 10, 1982

A BILL to amend and reenact § 38.1-818 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.1-348.14, relating to to certain medical insurance plans.

Patron--Brault

Referred to the Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.1-818 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.1-348.14 as follows:

§ 38.1-348.14. Additional mandated coverage made optional to group policy or contract holder.--Notwithstanding any other section of this title, any new or existing group policy or contract holder for whom coverage under an accident and sickness insurance policy is issued or renewed by an insurer or for whom coverage under a contract is issued or renewed by a plan licensed pursuant to Chapter 23 of this title shall be given the option to purchase any coverage, benefits or services first mandated under this chapter on or after July 1, 1982 [*, provided, further, all mandated coverages as of June 30, 1982 will not be affected*].

§ 38.1-818. Application of certain provisions of law relating to insurance to hospital, medical or surgical plans; payments under plan.--Unless otherwise specifically provided, no provision of this title except this chapter and §§ 38.1-29, 38.1-44 to 38.1-57, 38.1-97.2, 38.1-99 to 38.1-104, 38.1-159 to 38.1-165, 38.1-166 to 38.1-169, 38.1-171, 38.1-173, 38.1-174 to 38.1-178, 38.1-179 to 38.1-217, 38.1-342.1, 38.1-342.2, 38.1-348.1, 38.1-348.6 through [~~38.1-348.12~~ *38.1-348.12:1*], *38.1-348.14,* 38.1-354.1, 38.1-360, 38.1-362.7 to 38.1-362.9, 38.1-362.10 to 38.1-362.16 as they apply to Medicare supplement policies, and 38.1-362.17 shall, insofar as they are not inconsistent with this chapter, apply to the operation of a plan. No payments shall be made by a plan to a person included in a subscription contract unless it be for breach of contract or unless it be for contractually included costs incurred by such person or for services received by such person and rendered by a nonparticipating hospital or physician.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

PROS AND CONS OF MANDATED BENEFITS IN GENERAL

A. Pro:

1) Availability of Services.

a) Mandated benefits increase the availability of health care services by drawing capital to underserved areas.

b) Mandated benefits encourage development of mental health treatment facilities, alcoholism and drug abuse treatment facilities, intermediate care facilities and nursing homes.

2) Cost Implications.

a) Mandated benefits reduce the costs of health care services by encouraging the use of potentially less costly options, such as outpatient treatment and the use of the services of non-physician practitioners.

b) Mandated benefits also provide savings by avoiding the costs of secondary effects of postponed treatment of covered conditions.

3) Availability of Coverage. Mandated benefits assure the availability of coverages deemed to be socially desirable, but which might not be available were they not mandated.

4) Consumer Protection. The existence of mandated benefits increases the likelihood that coverage conforms to the expectations of the consumer.

5) Social Welfare.

a) Mandated benefits raise the level of social welfare.

b) Mandated benefits help to relieve society of the secondary effects of covered conditions.

B. Cons:

1) Cost Implications. Mandated benefits increase costs for both health insurance and health care services.

a) These increased costs arise from increased use of services associated with mandated benefits. The incentive for increased use comes about because the cost of the service is eliminated as a factor in the decision to use the service.

b) Covered services may experience higher cost increases than noncovered services.

2) Availability of coverage. Mandated benefits may limit the availability of coverage.

a) Mandated benefits may limit the development of new coverage options.

b) Mandated benefits may force employers, who have limited resources, to reallocate resources to the mandated coverages and away from non-mandated coverages.

3) Freedom of Contract.

a) Mandated benefits inhibit freedom of contract.

b) Mandated benefits require that some groups and individuals maintain coverage they nether need nor want.

4) Social Welfare.

a) Mandated benefits provide coverage for narrow segments of the population at the expense of all insureds.

b) If the cost of these services is going to be spread, it should be spread equitably throughout society by taxation, rather than placed inequitably on the insurance buying public.

Mandated Benefits (Current Virginia Law)

38.1-347.1 Reimbursement for services performed by certain practitioners other than physicians.

Pro - Requires broader spectrum of services to be provided under health insurance contracts. Provides coverages for specified practitioners who were not traditionally covered by health insurance contracts.

If other practitioners are substituted for physicians the effect may be to reduce claims costs, because these practitioners generally charge less for their services than physicians.

Con - Requiring coverage for additional practitioners leads to increased use of services and therefore increased aggregate claims costs. As a result total premiums could increase, thwarting cost containment efforts.

Rationale - The intent of this law is to broaden the types of coverage available and to encourage the use of various practitioners. This provision provides the listed practitioners with a guarantee that coverage available under health insurance contracts would not be denied because they did not meet a definition in the contract more restrictive than this law allows.

38.1-348.1 Continued coverage for dependent children.

Pro - This provision requires coverage to be continued for a high risk group where it is questionable that coverage would be provided in absence of a mandate. Social welfare considerations may dictate the desirability of this provision.

Con - This benefit is contrary to cost containment efforts.

Rationale - This law is an attempt to protect dependents with certain conditions from having their insurance cease when their eligibility as a dependent under a family policy ceases. They might be uninsurable if they attempted to obtain coverage in the insurance marketplace. This law makes it certain that these dependents will have health insurance coverage that would otherwise not be available. It also protects the family of the child from the financial impact of attempting to provide for the child's continuing medical care.

38.1-348.5 Construction of policy generally; words "physician" and "doctor" to include dentist.

Pro - Same as 38.1-347.1 above.

Con - Same as 38.1-347.1 above.

Rationale - Same as 38.1-347.1 above.

38.1-348.6 Coverage of newborn children required.

Pro - Provides coverage for newborns during a high risk period. Parents often assumed that newborn coverage was present when it was not.

Con - This benefit is contrary to cost containment efforts. Insurers have at times been unwilling to write this coverage because the risk can be very great.

Rationale - The intent of this law is to protect a group by requiring health insurance to provide accident and sickness benefits for a child for the first 31 days after birth and to offer continuing coverage after 31 days. These expenses can be extremely high if the child is born with certain problems.

38.1-348.7 Coverages for mental, emotional or nervous disorders.

Pro - This law provides broadened coverage under a health insurance contract for mental, emotional, and nervous disorders including alcohol and drug dependency.

Con - This benefit is contrary to cost containment efforts.

Rationale - This coverage was intended to provide a socially desirable benefit not generally available under health insurance contracts and if available under contracts, administered differently by different insurers.

38.1-348.8 Coverages for alcohol and drug dependence.

Pro - This section mandates the availability of coverage for alcohol and drug dependence. This coverage is not readily available under the usual health insurance contract. Early treatment of such problems may minimize secondary problems associated with postponed treatment. Further, the social cost of those secondary problems can be very great.

Con - This benefit is contrary to cost containment efforts.

Rationale - The intent of this law is to assure that coverage for alcohol and drug dependence is available in the insurance marketplace. This section of the insurance code also provides that if this coverage is available the mandated benefits under Section 38.1-348.7 shall not include coverage for alcohol and drug dependence.

38.1-348.9 Optional coverage for obstetrical services.

Pro - Assures the availability of coverage for obstetrical services on all group policies issued in Virginia.

Con - This benefit is contrary to cost containment efforts.

Rationale - This section of the insurance code is intended to promote the use and availability of coverage for obstetrical services.

38.1-348.10 Exclusion or reduction of benefits for certain causes prohibited.

Pro - This section provides that if a person purchases individual health insurance coverage his group insurance coverage cannot reduce its benefits because of this additional coverage. This assures that a person buying individual health insurance will be able to receive the full benefits he paid for.

Con - This requirement is contrary to cost containment efforts. This requirement may be contrary to the principle of indemnity.

Rationale - This section of the insurance code was intended to protect an individual from receiving reduced group insurance benefits because he chose to purchase individual insurance.

38.1-348.11 Conversion on termination of eligibility.

Pro - This section provides that a person must have the right to continue his group insurance coverage for a limited period of time or to purchase an individual group insurance contract from his insurer. If an insured's health had deteriorated since the inception of the original group policy coverage might not be available otherwise.

Con - This benefit may produce an adverse selection problem.

Rationale - The intention is that when a person leaves coverage under a group insurance contract he be assured that he can obtain health insurance coverage.

38.1-348.12: 1 Deductibles and coinsurance options required.

Pro - This provision mandates that alternatives to complete first dollar coverage be available in the marketplace. This coverage is less expensive than complete first dollar coverage and promotes cost containment. Expands the individual's ability to contract for desired coverage.

Con - None

Rationale - The intention of this provision is to increase deductible options, thereby influencing pemiums.

38.1-348.13 Coverage for victims of rape or incest.

Pro - This section assures coverage for pregnancy resulting from rape or incest.

Con - This benefit is contrary to cost containment efforts.

Rationale - The intention of this code section is to provide a socially desirable benefit.

38.1-348.14 Additional mandated coverage made optional to group policy or contract holder.

Pro - This law provides that future mandated benefits will be optional rather than non-optional. This may be an effective cost containment tool.

Con - This provision may limit the legislature's ability to mandate coverages in the future.

Rationale - The intent of this law is to limit the proliferation of mandated benefits.

OPTIONS

1) Leave existing mandated benefits legislation in place. The effect of this option is to keep existing benefits on both a required and "make available" basis. Under section 38.1-348.14 (SB 358, 1982 Session), any new mandated benefits would be optional with the group insured.

2) Repeal all mandated benefits laws. The effect of this option would be to make offering of the benefits optional to the insurer.

3) Retain mandated benefits laws, but only on a "make available" basis. The effect of this option could be to make acceptance of the benefits optional to the group or individual policyholder.

4) Retain mandated benefit laws, but only on a required basis. The effect of this option would be to make all such benefits mandatory for all parties.

5) Retain mandated benefits laws selectively on either a required or "make available" basis.

6) Defer any action on mandated benefits pending further study.

APPENDIX III

Minutes
Joint Subcommittee Studying the
Crippled Children's Program and
Mandated Health Insurance Benefits
August 26, 1982
House Room 4 - State Capitol
2:00 p.m.

PRESENT:

William T. Wilson
Linda J. Pasternak
Walter Emroch
Alson H. Smith
Gladys B. Keating
Vincent Callahan, Jr.
Frank Hargrove
George I. Dobbs
Steven S. Perry, Jr.
James C. Roberts
James M. Thomson

ABSENT:

Willard J. Moody
Virgil H. Goode, Jr.
Frederick C. Boucher
Nathan H. Miller

STAFF:

Hugh P. Fisher, III

The meeting was called to order at 2:00 p.m. by the acting chairman, Delegate Wilson. The roll was called and a quorum ascertained. Delegate Wilson announced that the first order of business for the subcommittee was the election of a chairman and a vice-chairman.

It was moved and seconded that Delegate Wilson serve as chairman. There were no other nominations for chairman, and Delegate Wilson was unanimously elected to serve in that capacity. It was then moved and seconded that Ms. Linda Pasternak serve as vice-chairman. There were no other nominations for vice-chairman, and Ms. Pasternak was unanimously elected to serve in that capacity.

Delegate Wilson stated that the subcommittee was prepared to hear testimony, and he recognized Mr. Stephen J. Kaufmann, Deputy Commissioner for Regulatory Policy for the State Bureau of Insurance. Mr. Kaufmann noted that House Joint Resolution No. 90 of 1982 requested that the subcommittee study the following two issues: (1) the insurance laws of the Commonwealth which relate to the operation of the Crippled Children's and Medicaid Programs; and (2) the state's insurance laws which relate to mandated health insurance benefits.

When discussing the Crippled Children's Program, Mr. Kaufmann pointed out that health insurance policies typically contain exclusionary clauses, which deny payment for services provided under federal, state or local law.

He stated that the combination of decreased federal funding and increased health care costs could be a significant drain on the Commonwealth's resources. He pointed out that HJR No. 90 seems to request the subcommittee to consider the feasibility of legislation which would prohibit exclusionary clauses in private insurance policies for services provided under federal, state or local laws. Mr. Kaufmann said that the subcommittee might want to address the public policy issue of whether some of the cost of the Crippled Children's Program should be borne by the public (through higher taxes) or whether some of the cost of the program should be borne by policyholders (through increased premiums).

Mr. Kaufmann continued by stating that the issue of mandated health insurance benefits is considerably broader than the issue of the Crippled Children's Program. He pointed out that there are two types of provisions in the Virginia Code which relate to health insurance mandates: (1) those provisions which require health insurers to include certain coverages or services in all their contracts and policies; and (2) those provisions which require that health insurers make available certain coverages or services to all policyholders.

Mr. Kaufmann stated that the issue of mandated benefits is very controversial. Generally, he said, the insurance industry favors the repeal of all or most of the mandated coverages and services. He said that consumers tend to be apathetic regarding the mandated benefits issue and health care providers generally want to either retain the present mandates or possibly add more to the Code.

Mr. Kaufmann stated that mandated benefits are expensive and they do increase utilization. He noted that utilization is increased because many individuals view mandated benefits as being free.

Mr. Kaufmann continued by stating that the Bureau of Insurance has no position regarding either the Crippled Children's Program issue or mandated benefits. However, he said, the Bureau does believe that all certificate holders in Virginia should be covered by any mandates on the books, whether they are covered under a policy issued within or outside the Commonwealth. He noted that presently those contracts and policies issued outside Virginia are not subject to the requirements of Virginia law, even when residents of the Commonwealth are covered under such a contract or policy.

In response to a question from Delegate Wilson, Mr. Kaufmann stated that there is not a trend among the states to repeal mandated benefits. However, he said, there is a trend among some states to require the insurance companies to offer certain coverages, but to allow the policyholders the freedom to accept or reject the coverages.

In response to a question from Delegate Emroch, Mr. Kaufmann stated that if the mandated benefits provisions of the law were repealed, insurance rates would be lower than they would be with the mandates in effect. However, he said, he cannot estimate how much lower such rates would be.

The next speaker was Mr. Frank Sutherland, General Counsel of the Life Insurance Company of Virginia. Mr. Sutherland testified that his company would prefer that there be a free market in the health insurance business,

which would allow the companies to offer whatever coverages and benefits they deem appropriate. However, he said, in the absence of a free market, his company would favor a requirement that the coverages be made available but that each policyholder be free to accept or reject the coverages.

In response to a question posed by Delegate Wilson, Mr. Maurice Miller, an attorney representing Aetna Insurance Company, stated that when a group policy is issued to an employer, certificates are given to each employee. The certificate tells the employee what his coverages are, but does not tell him what coverages are excluded from his group policy. Mr. Miller added that the employee can purchase an individual policy to supplement the coverages in his group policy.

Mr. Kaufmann then stated that a study conducted in Maryland determined that although each mandated benefit costs each consumer less than one dollar a month, the total cost of that state's eighteen mandates is over $20 million a year.

Delegate Keating stated that the subcommittee needs information regarding the cost impact of each mandate. Mr. Kaufmann stated that the Bureau of Insurance does not have such information.

The next individual to testify before the subcommittee was Mr. Ron Sauders, Assistant General Counsel of the American Council of Life Insurance. Delegate Wilson asked Mr. Sauders why the industry cares what health insurance rates are, given that the public and employers must pay for such insurance. Mr. Sauders replied that the primary reason is the criticism the industry receives when rates go up.

Delegate Wilson asked if there is another reason why health insurers don't like mandated benefits. Mr. Sauders replied that administrative costs are increased when different benefits are mandated in different states, due to the fact that different forms must be designed for each state.

Mr. Sauders continued by stating that if rates for health insurance continue to increase at a significant rate, more and more employers will self-insure rather than purchase a basic policy through a carrier. He noted that the laws which mandate certain benefits and coverages apply to insurance companies and not to employers. Therefore, he said, employers who do not want to be subject to the mandated benefits provisions in the law can self-insure.

Regarding this issue, Mr. Maurice Miller stated that under the federal Employee Retirement Income Security Act (ERISA), states cannot force self-insurers to adopt mandated benefits. Delegate James B. Murray of Earlysville then noted that an employer is under no obligation to offer any health insurance to his employees.

Mr. Sauders said that because of ERISA and the increase in the number of self-insurers, the health insurance industry is at an unfair disadvantage. Delegate Wilson asked whether the provision of ERISA exempting self-insurers from state mandated benefit laws has been litigated. Mr. Sauders replied that it has been litigated in several states.

Replying to a question from Ms. Pasternak, Mr. Sauders said there is no doubt that the mandated benefits provisions is the main reason why increasing numbers of employers are self-insuring.

The next person to address the subcommittee was Delegate Murray. He stated that a major reason behind the recent great increases in health care costs are the increases in third party payments. Furthermore, he said, mandated benefit provisions drive up the cost of third party payments. Delegate Murray argued that existing mandated benefit provisions need to be repealed and the free market allowed to operate in the insurance industry. He added that the imposition of mandates presupposes that employers are irresponsible. He further stated that it is time that the Legislature assumed that employers in the Commonwealth are responsible.

In response to Delegate Murray's comments, Delegate Hargrove stated that the mandated coverages have been added gradually over the years and should not be repealed with one stroke of the pen. He stated that in his opinion each mandated benefit should be scrutinized in detail to determine the feasibility of repealing it.

Delegate Wilson added that each mandate should be analyzed from the standpoint of cost, administration and any other potential problems associated with it. Delegate Wilson requested that Mr. Sutherland of the Life Insurance Company of Virginia send the subcommittee a paper outlining his company's position and what his company believes will happen if each particular mandate is repealed.

The next individual to address the subcommittee was Ms. Shelley B. Spector, Legislative Affairs Representative for Group Hospitalization, Inc./Medical Services of D.C. (which is the Blue Cross and Blue Shield plan in Northern Virginia). Ms. Spector stated that in addition to considering which benefits should be mandated, the subcommittee also should consider the durational and dollar limits which should be attached to each mandate.

Ms. Spector said that she would be glad to inform the subcommittee as to her organization's position regarding specific mandated benefits. She referred the members to the mandates listed on page one under tab six of the report dealing with mandated benefits prepared by the Bureau of Insurance. Ms. Spector then commented on the mandates listed on that page.

Regarding Code § 38.1-347.1 (policy providing for reimbursement for services that may be performed by certain practitioners other than physicians), Ms. Spector stated that she did not have a position at the present time. However, she said, her organization does believe that increasing the types of providers who are reimbursed does increase utilization and costs. Furthermore, she said that her organization has data which shows that providers other than physicians who are reimbursed usually raise their charges so that they are comparable to the fees charged by physicians.

Regarding Code § 38.1-348.1 (continued coverage for dependent children), Ms. Spector said that this is a good mandate and there is no need to repeal it.

Concerning § 38.1-348.5 (construction of policy generally; words "physician" and "doctor" to include dentist), Ms. Spector said that she did not have a position on this at the present time.

Regarding § 38.1-348.6 (coverage of newborn children required), § 38.1-348.7 (coverages for mental, emotional or nervous disorders on an inpatient basis), and § 38.1-348.10 (exclusion or reduction of benefits for certain causes prohibited), Ms. Spector stated that her organization had no problems with these mandates.

Concerning § 38.1-348.11 (conversion on termination of eligibility), she noted that this statute was amended by the 1982 General Assembly. She said that her organization is satisfied with the statute as amended.

Regarding § 38.1-348.13 (coverage for victims of rape or incest), she said that her organization sees no need to repeal it.

Ms. Spector then stated that her organization is not opposed to the specific mandates which are already law, but it is opposed to the general concept of mandating benefits. She concluded by stating that her organization favors either continuing the present moratorium imposed by Senate Bill No. 358 of 1982 or else subjecting proposed new mandates to a more comprehensive review process than has been true in the past.

Delegate Wilson requested that Ms. Spector furnish the subcommittee with her remarks in writing. Delegate Wilson also requested that Mr. Z. C. Dameron of the Virginia Manufacturers Association poll some of his members to determine how they feel about mandated benefits. Delegate Wilson told Mr. Dameron that he would have an opportunity at a future meeting to address the subcommittee.

Mr. Maurice Miller then informed the subcommittee that he had copies with him of a 1980 report dealing with mandated benefits prepared by the Insurance Association of Connecticut. He provided each subcommittee member present with a copy of that report. For those members not present at the meeting, enclosed is a copy of the report.

After some discussion the subcommittee agreed by consensus that the members would be polled later regarding a future meeting date.

There being no further business, the meeting was adjourned.

APPENDIX IV

STATEMENT

OF

STATE HEALTH DEPARTMENT

BEFORE THE

HJR-90 JOINT SUBCOMMITTEE

2 P.M. 18 OCTOBER 1982

CAPITOL HOUSE ROOM 4

MR. CHAIRMAN, AND MEMBERS OF THE HJR-90 STUDY COMMITTEE, I AM BEDFORD H. BERREY, M.D., ASSISTANT COMMISSIONER, OFFICE OF HEALTH CARE PROGRAMS. WE ARE PLEASED TO BE ABLE TO OFFER THE HEALTH DEPARTMENT'S COMMENTS ON HOUSE JOINT RESOLUTION-90. I AM ACCOMPANIED TODAY BY R. DALE HUNSAKER, M.D., DIRECTOR OF THE DIVISION OF FAMILY HEALTH SERVICES; WILLARD R. FERGUSON, M.D., DIRECTOR, BUREAU OF CRIPPLED CHILDREN; MR. ROBERT TREIBLEY, ACTING DEPUTY DIRECTOR, VIRGINIA MEDICAL ASSISTANCE PROGRAM, AND MISS REBECCA MONROE, LEGISLATIVE STAFF ASSISTANT TO JAMES B. KENLEY, M.D., COMMISSIONER OF HEALTH.

BY WAY OF BRIEF REVIEW, ABOUT A YEAR TO A YEAR AND A HALF AGO A PRIVATE INSURANCE CARRIER REFUSED TO PAY HOSPITAL CHARGES BECAUSE THE CHILD WAS ENROLLED UNDER THE CRIPPLED CHILDREN PROGRAM. FROM THIS EXPERIENCE THE HEALTH DEPARTMENT LEARNED OF THE PREVELANCE OF THE EXCLUSIONARY CLAUSE AND BECAME CONCERNED ABOUT THE LONG RANGE FISCAL IMPACT. THE DEPARTMENT REQUESTED DELEGATE WILSON AND THE GENERAL ASSEMBLY FOR A STUDY WHICH CULMINATED IN THE HOUSE JOINT RESOLUTION-90.

HISTORICALLY, IT IS OUR UNDERSTANDING THAT PRIVATE INSURANCE POLICIES COVERING HOSPITAL ADMISSIONS HAVE HAD EXCLUSIONARY CLAUSES WITH RESPECT TO COVERAGE PROVIDED UNDER FEDERAL, STATE OR LOCAL LAWS. WE RESPECTFULLY DEFER TO THE BUREAU OF INSURANCE TO DISCUSS AND EXPLAIN THESE TECHNICALITIES. IT IS BEYOND OUR EXPERTISE.

THE BCC PROGRAM, AUTHORIZED BY TITLE V OF THE SOCIAL SECURITY ACT, STARTED IN 1935. FEDERAL REGULATIONS REQUIRED IT TO BE A LAST PAY PROGRAM. SINCE THE ENACTMENT OF PUBLIC LAW 97-35, THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981, THE CRIPPLED CHILDREN PROGRAM HAS BEEN FUNDED UNDER THE MATERNAL AND CHILD HEALTH BLOCK GRANT (SECTION 2191). FEDERAL REGULATIONS WERE WITHDRAWN SUBSEQUENT TO THE ENACTMENT OF PUBLIC LAW 97-35.

THE MEDICAID PROGRAM BEGAN IN VIRGINIA IN 1969 AND IS CONSIDERED A LAST PAY PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT. WITH RESPECT TO THE 1981 CHANGES IN MEDICAID LAW (PL 97-35) A PENALTY IS NOW IMPOSED ON THOSE STATES THAT DO NOT HAVE A THIRD PARTY LIABILITY RECOVERY PLAN IN OPERATION.

WHILE THE ISSUE AT THIS PARTICULAR MOMENT MAY NOT APPEAR TO BE CRITICAL, WE VIEW THE POTENTIAL AS QUITE SERIOUS. WITHOUT RECOVERY FROM THIRD PARTY CARRIERS, THE DEPARTMENT WILL BE REQUIRED TO REQUEST HIGHER APPROPRIATIONS OR REDUCE AND/OR REFUSE SERVICES TO SOME CRIPPLED CHILDREN.

In April, 1981, because of a projected budget shortfall, the State Health Department suspended hospital admissions for ten months for all but a very few children in the programs offered by the Bureau of Crippled Children. Hospital care was resumed in February, 1982. During that interval, a new State Plan was developed, public hearings were held and approval obtained from the State Board of Health. The changes in the State Plan will be of considerable value in keeping the program operating on a sound financial basis provided the department continues to receive the current level of federal and state funding and payment from third party carriers is not reduced. This notwithstanding, we believe exclusionary clauses are unfair to health care subscribers.

The Crippled Children's Program provides care for eligible children from the birth - 21 years through a multi-disciplinary team approach. Because of the expensive long-term nature of the corrective process in complex crippling conditions, crippled children services have not been limited to the usual recipient of health department services. Many families have some resources, including insurance, but can be readily overwhelmed by the long-term, expensive nature of the required corrections. BCC assures the completion of the corrective process by supplementing family funds with appropriated funds.

What concerns us is the working man or woman who has hospital coverage bought in good faith, either personally or

THROUGH HIS EMPLOYER, AND, THEN HAS A CHILD WITH A CONGENITAL DEFECT WHICH COULD NOT HAVE BEEN ANTICIPATED. IT SEEMS A BIT UNUSUAL, IF NOT UNREASONABLE, TO EXPECT THE TAXPAYER TO PAY THE ENTIRE COST OF CARE REQUIRED FOR SUCH A CHILD WHEN THE FAMILY HAS HEALTH INSURANCE.

IN CONCLUSION, MR. CHAIRMAN, THE HEALTH DEPARTMENT OBSERVES THAT HJR-90 AS FINALLY AGREED TO DURING THE 1982 LEGISLATIVE PROCESS HAS TWO ESSENTIAL ELEMENTS: (A) ONE ADDRESSES BCC AND MEDICAID; AND (B) THE OTHER IS RELATED TO MANDATED SERVICES. THE HEALTH DEPARTMENT URGES THAT THESE SEPARATE AND DISTINCT PARTS OF HJR-90 BE CONSIDERED INDEPENDENTLY. WE VIEW THEM AS SEPARATE ISSUES. PERHAPS THIS STUDY GROUP COULD BE DIVIDED TO STUDY EACH ISSUE, PRIOR TO DEVELOPING THE FINAL REPORT. AS HAS BEEN STATED, THE HEALTH DEPARTMENT IS CONCERNED NOT ONLY FOR TODAY BUT FOR THE FUTURE AS TAX DOLLARS BECOME MORE SCARCE AND IF THIRD PARTY CARRIERS CONTINUE TO BE EXEMPT FROM PAYING FOR SERVICES THE INSURED BELIEVED HE HAD PURCHASED. THE HEALTH DEPARTMENT STANDS READY TO ASSIST THE SUBCOMMITTEE IN ANY WAY IT CAN, AND URGES THAT OUR ISSUE RECEIVE THE EXPERT ATTENTION IT DESERVES.

IF THERE ARE QUESTIONS, MR. CHAIRMAN, THOSE OF US HERE FROM THE HEALTH DEPARTMENT WILL MAKE AN EFFORT TO ANSWER THEM OR PROVIDE WRITTEN RESPONSES.

APPENDIX V

TO: MEMBERS OF THE JOINT SUB-COMMITTEE STUDYING THE CRIPPLED CHILDREN'S PROGRAM AND MANDATED HEALTH INSURANCE BENEFITS OF THE VIRGINIA GENERAL ASSEMBLY.

PRESENTED BY: Craig L. Nuckles, Representing Substance Abuse Program Directors of Virginia

DATE: December 1, 1982

I am pleased to have the opportunity to speak to you today on an issue vital to the quality of life and the economics of the Commonwealth as well as the lives of thousands of its citizens.

There are several issues which have emerged as key elements in these discussions.

Many new treatment programs have emerged as a result of increased demand and legislation which provided access to the necessary health care. These programs were established under the Commonwealth's Certificate of Need process and operate under Virginia Rate Review regulations. Each of these programs will help hundreds of patients and families recover happy and productive lives.

Our legislature has followed an enlightened path in facing the problems created by the drinking driver. A critical element of the VASAP program is appropriate treatment for the alcoholic driver, upon whom punitive actions can have only minimal impact. The elimination of treatment would have a profound impact on Virginia's efforts to improve highway safety.

In these days and times, there is always a bottom line. To eliminate the legislative mandate would simply shift the currently shared public/private sector responsibilities to a system almost totally funded and operated by the state. The Science Management Corporation, studying

insurance benefits for alcoholism at the request of the Federal Government, found that optional coverage had no effect on treatment accessibility. Caps, particularly those not even approaching the average daily charge throughout the state will only serve to negate the benefits provided by the current mandates.

The required census reductions in State hospitals coupled with the decreased availability of State and Local Hospitalization dollars for detoxification have already reduced public sector alternatives. Eliminating benefits will not eliminate alcoholism. Virginian's will pay with tax dollars for increased legal problems, with their lives on the highways, and at the checkout line from industrial accidents and lost production times.

The choices are clear. Do we raise taxes to correct the social and financial complications created by this treatable illness, or do we allow employed individuals to take care of their treatment responsibilities through payment of health insurance premiums designed to care for them in times of sickness.

Thank you.

TO: MEMBERS OF THE JOINT SUB-COMMITTEE STUDYING THE CRIPPLED CHILDREN'S PROGRAM AND MANDATED HEALTH INSURANCE BENEFITS OF THE VIRGINIA GENERAL ASSEMBLY.

My name is John D.T. Hartman, Jr., Vice-President, Mental Health Services, Riverside Hospital, Newport News, VA. Today, I speak to you as a representative of the Mental Health Committee of the Council on Long Term Care and Mental Health of the Virginia Hospital Association.

It must be stated that whatever decision is reached by the General Assembly will not eliminate the problems of mental illness throughout the Commonwealth so therefore it becomes the task of this study commission to deal with how best the citizens of the Commonwealth can be served. The legislatures through the 70's felt not once but on multiple occasions that mandated coverage in the area of mental illness and chemical dependency was necessary based on the fact that insurance was not being offered. While it is realized that a mandated benefit limits freedom of choice in the market place, a limitation is justified where a specialized area is involved in which the average citizen is not well versed. This is no different than legislating other areas of insurance where it has been found that coverage does not exist such as automobiles, unemployment insurance, workman's compensation, and other areas.

Many Third Party representatives have requested repeal of mandated benefits because of its impact on the overall issue of health care costs. While this problem is very complex there are two existing mechanisms which will deal with increasing health care costs. These mechanisms are (1) Certificate of Need and (2) Rate Review. A third element or mechanism which could be implemented, not legislatively, is the area of peer review.

The current mechanism which exists for peer review is very expensive and at best subjective. The recommendations would be made that a mechanism be studied which would implement peer review on a voluntary basis.

A major concern for providers whether public or private is the fact that if Mandated Benefits for mental illness were eliminated then a large segment of the population of the Commonwealth would become medically indigent. This would mean that a person needing help would seek assistance from the public sector in greater numbers. At the present time the Commonwealth could not stand the additional burden of resources that would be required to render services to this population. The Commonwealth would also incur additional drain on resources through the court systems, corrections systems, and educational systems because of the unmet need. The mental health needs of Virginia citizens could only be met through a cooperative venture between public and private providers of services.

One item of consideration that has been presented before the committee is that out-patient services are much less expensive than in-patient services. This is totally true on a limited bases or when services are rendered for a short term period. However, I can state that in our area there have been many concerns voiced by employers over extended long term out-patient visits. In most cases a highly structured in-patient short term stay with high impact can be the effective method to change or begin the change for situational and environmentally induced cases. It is also a more effective method of rapid medication regulation. Without

mandatory benefits, this essential link of a total continuum of care could be eliminated.

It would be interesting to have presentations made by third party carriers on the comparison of how benefits have been reduced by adding the mandatory coverage. In informal discussions with various third party carriers, I have been told that benefits have actually become controlled by the 30 day limit since most of their coverages were of greater periods of time. This is a classic example where legislative minimums can also become maximums. Therefore, the amount of problem with mandatory benefits is probably more limited and less costly because of legislation instead of the reversed that has been presented to this committee on various occasions. By the same measurement, I would encourage this committee to recommend no more legislative moves such as "caps" or "ceilings" as these would become political considerations at every session of the legislature in which various groups would be appealing for change in both directions.

In closing as a representative of a provider group, I urge that you maintain the current mandated coverages for mental illness and chemical dependency. I also urge that before any additional legislation is considered for enactment that a great deal of study go into the project because of the complex issues involving many social and economic factors that effect not only private lives of citizens, but also the public resources of the Commonwealth.

THE GREATER RICHMOND COUNCIL
ON ALCOHOLISM & DRUG ABUSE
4206 SPRING HILL AVENUE o RICHMOND, VIRGINIA 23225 o PHONE 231-0608

NOV 23 RE C'D

November 18, 1982

Ms. Linda J. Pasternak
St. John Vianney Center
Route 2 Box 389
Richmond, Virginia 23233

Dear Ms. Pasternak:

On behalf of the Greater Richmond Council on Alcoholism and Drug Abuse, we would like to express our position in regards to the mandated insurance coverage as specified in Title 38.1 Sub-sections 348.7 and 348.8.

We feel very strongly that the mandated insurance should stay in effect. Any change to be considered should be in the direction of additional out-patient coverage. Our reasons for this position are:

1. Alcoholism is a disease and should be treated as any other disease.

2. Due to the nature of the disease, few if any persons would apply for optional coverage at an additional cost.

3. Treatment works and in our opinion prevents other more serious medical problems that could be far more costly.

4. We are positive the cost effectiveness is excellent.

It is therefore our position that mandated insurance for alcoholics and drug abusers should be continued and additional out-patient coverage considered.

Very truly yours,

W. Wardlaw Thompson
Co-Chairman

Marcia J. Lawton, PhD
Marcia J. Lawton, PHD
Co-Chairman

/c

October 18, 1982

VIRGINIA ASSOCIATION OF MENTAL HEALTH DIRECTORS

Testimony Provided to the Cost Containment Commission Regarding

Insurance Coverage for Outpatient Mental Health Services

Background

Between 1965 and 1980, per capita spending on health care increased 500%, from $181 to $941. Insurance companies, in an effort to reduce premiums, have focused in particular on the coverage of mental health services, an area that has always been controversial and misunderstood. Reductions or eliminations of outpatient mental health services have occurred or are being considered, because of the following:

1. Fear of Abuse of the coverage by policy holders.
2. Myths - for example, that mental illness is due to poor moral character.
3. Confidentiality requirements make utilization and effectiveness studies and overall accountability difficult for insurance companies to analyze, compared to studies of medical treatment.
4. The lack of "Face Validity" of effectiveness of treatment methods do not compare favorably in the eyes of the public with more technologically-advanced techniques of treating medical illnesses.
5. Lack of Constituency: Mental health consumers are not very vocal in demanding services, due to the stigma attached to treatment.

Increase in Health Care Costs

The real excesses of our health care system are not in mental health care. An HEW study concluded in 1978 that the health cost explosion was due mainly to changes in the size, complexity and cost of the service package represented by a day of hospital care or a physician visit. Also, the number of hospital laboratory tests recently increased 82% in 5 years, growing from 2.2 billion in 1972 to over 4 billion in 1977. This explosive growth in laboratory procedures was in spite of the fact that the number of patients hospitalized did not increase during that period of time.

Mental Health Services Reduce Overall Health Costs

In studies in different settings across the country an increasing body of knowledge has demonstrated that mental health care is associated with a reduction in the utilization of all medical services, especially more expensive types, even when the mental health contact is quite brief, i.e. less than five contacts. Studies have concluded that mental health services are related to:

- a decrease in visits to physicians,
- a decrease in expensive laboratory and X-ray tests,
- a reduction in length of stay in hospitals following general medical surgery,
- fewer medical problems after treatment.

In general, the higher the utilization of medical services prior to mental health contacts, the larger the decrease in the use of such services afterwards. Often these rates are lower than for groups of patients who have had no mental health contact.

Insurance Companies Pay for Mental Health Services in Other Ways

In 1975, 800,000 people were treated in mental hospitals, 900,000 people in general hospitals, 351,000 in V.A. hospitals, 200,000 in nursing homes, and 13 million mentally ill were treated by physicians other than psychiatrists. Estimates are that as many as 60 percent of all patients who visit physicians in general practice are for problems with no organic basis. Thus, insurance companies already pay for mental health services, but provided by those who are not specifically trained to offer those services.

Psychological Factors Influence the Cause and Treatment of Medical Problems

An enormous body of literature demonstrates that disease may be caused by or aggravated by emotional distress. In addition, stress can inhibit the body's ability to recover from illness and surgery, thereby lengthening the period of medical treatment and increasing its cost. By enabling the patient to learn how to better handle stress, psychotherapeutic procedures are a valuable addition to ordinary medical or surgical treatment.

Recommendation

In conclusion, a substantial body of professional and scientific literature has demonstrated that outpatient mental health services decrease overall medical care utilization and costs. Outpatient mental health services by qualified providers help resolve psychological conditions that influence the course and treatment of other medical problems, and are verifiable as an accepted and effective type of health service.

Therefore, the Virginia Association of Mental Health Directors proposes that it be mandatory for insurance companies writing policies in Virginia to provide coverage for outpatient mental health services. The limits of such coverage should be consistent with those limits associated with other health services, and should promote the use of the least restrictive and most cost-effective forms of treatment.

References

1. Towery, Sharfstein and Goldberg. The Mental and Nervous Disorder Utilization and Cost Survey; and Analysis of Insurance for Mental Disorders. American Journal of Psychiatry, September, 1980.

2. Sourcebook of Health Insurance Data. The Health Insurance Institute, Washington, D.C.

3. For Ayes Only: Legislating Mental Health Insurance Coverage in Your State. National Council for Community Mental Health Centers, Inc., 6101 Montrose Road, Rockville, Maryland.

DRS:et

Virginia Counselors Association

My name is Susan Leone. I am a licensed Professional Counselor. Today I am speaking for the Virginia Counselors Association, an organization of 1500 counselors who work in a variety of settings throughout the Commonwealth. Our membership consists of school counselors from elementary schools to college counseling centers, counselor educators and supervisors, and mental health counselors, licensed professional counselors in private practice and other mental health agencies. I am here to speak on behalf of the latter members and to clarify some mistaken notions regarding licensed professional counselors. I want to urge you to consider including licensed professional counselor in your recommendations regarding mandated health insurance benefits, specifically in those sections dealing with coverage for services by clinical psychologists or clinical social workers.

First, I want address the discussion of Senate Bill 191, contained in the State Corporation Commission's Bureau of Insurance, August 1982 report, Health Insurance Mandated Benefits, (p.49). The bill, the subject of some controversy in the Senate during the last session, would make the services of the professional counselor more accessible by providing for reimbursement for services performed by them. Since current laws provide for reimbursement for the services of psycholo-

gists and clinical social workers, this would give the public more choice of mental health services.

The discussion of the bill notes that "professional counseling is not related to health treatment, either physical or mental, and could be regarded as elective and thus would not be qualified for coverage in insurance policies." The report points out that the licensing law defining professional counseling is so broad as to include services not properly reimbursable under health insurance. "Achieving more effective social, personal , educational and career development", a description from the licensing law, is indeed within the realm of mental health services. Moreover, as recent studies in the area of stress haveindicated, the link between physical symptoms and social, personal, educational and/or career factors are indeed related. This is not to suggest that clearly defined career counseling would be a legitimate reimbursable service.

Reimbursement for all sevices of every professional counselor was not the intent of the bill. There are various ways in which legitimate health-related services can be provided with the cooperative efforts of clinical psychologists or physicians. Ongoing supervision or direct prescription from a physician are several methods to insure that the services are properly considered medical or physical health needs.

My colleagues from the Virginia Mental Health Counselors Association can provide some case study examples of medically

related services provided by a licensed professional counselor in private practice.

There are a number of reasons why we feel that licensed professional counselors should be considered in any future legislative recommendations from this subcommittee:

1) Licensed professional counselors would provide a wider choice of services for consumers.

2) Licensed professional counselors are licensed and regulated under the same board, the Board of Behavioral Sciences, as are clinical psychologists and clinical social workers.

3) Licensed professional counselors have a comparable level of training and provide similar services as the licensed clinical social worker and, in some cases, licensed clinical psychologists.

4) Excluding allied professionals with similar training and regulation by the same board from the Code could be considered discriminatory by limiting physician and consumer choice and tends to restrain trade.

5) Blue Cross/Blue Shield has offered their policy holders an option to receive treatment from licensed professional counselors.

6) Confusion exists because professional counselors are not included within the mandated benefits sections of the Code for the consumer as well as the insurance provider.

I'd like to point out that while some school counselors are licensed professional counselors for personal and professional reasons, there is no danger that a movement from this group will result in increased claims for nonmedical services. The group for which this legislation is directed include those mental health counselors who have a minimum of sixty graduate hours and supervised clinical experience and who work in mental health settings or are in private practice.

In closing, I urge you to leave existing mandated benefits legislation as it stands. Furthermore, I strongly recommend that you consider amending existing sections to include licensed professional counselor in those sections which include our allied professionals, clinical psychologists and clinical social workers.

Susan Dana Leone
License Professional Counselor
October 18, 1982

ADDRESS TO HOUSE JOINT RESOLUTION 90 STUDY COMMISSION
OCTOBER 18, 1982

Good afternoon members of the House Joint Resolution 90 Study Commission!

Mr. Chairman, I would like to thank you for the opportunity of being able to testify this afternoon. My name is Stuart Ashman - I am a physician and psychiatrist and the medical director of the Tidewater Psychiatric Institute with facilities in Norfolk, Virginia Beach and Chesapeake, Virginia.

I am here this afternoon to offer testimony to the study commission in regard to mandated minimum insurance coverages for the inpatient treatment of the mentally ill and the chemically dependent. My testimony will be on behalf of the almost 400 psychiatrist physician members of the Neuropsychiatric Society of Virginia which is the Virginia Branch of the American Psychiatric Association. I also speak for the approximately 10 to 15% of the citizens of Virginia who have been, are, or will be treated for a major mental illness at sometime in their lives <u>and</u> an almost equal number of Virginians who require treatment for alcoholism and other chemical dependency, <u>as well as</u> the much larger group of family members, employers, co-workers, and others significantly affected by these illnesses. The stigma still attached to mental illness and chemical dependency prevents most of these from speaking for themselves, and so the medical profession and especially the specialty of psychiatric medicine feels a responsibility to advocate for them.

I WOULD LIKE TO BEGIN WITH MY RECOMMENDATIONS AND THEN PROCEED TO MY REASONS FOR MAKING THEM.

THE NEUROPSYCHIATRIC SOCIETY OF VIRGINIA AGREES WITH THE CONCLUSION OF THE 1979 REPORT TO THE BUREAU OF INSURANCE BY DR. JOHN G. LARSON OF VIRGINIA COMMONWEALTH UNIVERSITY ENTITLED MANDATED HEALTH INSURANCE COVERAGE: A STUDY OF REVIEW MECHANISMS THAT THE CRITICAL NEED IS TO EXAMINE THE ADEQUACY OF HEALTH INSURANCE COVERAGE IN VIRGINIA AND THEN CONSIDER REVISION OF THE MINIMUM BENEFIT STANDARDS LAW. WE WISH TO RECOMMEND THAT UNTIL THIS STUDY COMMISSION OR SOME OTHER APPOINTED BY THE GENERAL ASSEMBLY CAN UNDERTAKE AND COMPLETE SUCH A COMPREHENSIVE AND IN DEPTH STUDY THAT THE CURRENT MANDATED COVERAGES WHICH REPRESENT THE END RESULT OF EXTENSIVE LEGISLATIVE DELIBERATION BY SEVERAL GENERAL ASSEMBLIES IN THE 1970'S BE CONTINUED. WE FURTHER RECOMMEND WITH THE LARSON REPORT THAT ANY PROPOSALS FOR NEW MANDATORY COVERAGES SHOULD BE EVALUATED ACCORDING TO UNIFORM CRITERIA SUCH AS THOSE SUGGESTED IN THAT REPORT AND BY A PROPERLY CONSTITUTED REVIEW MECHANISM. FINALLY, WE RECOMMEND THAT UNTIL THE COMPLETION OF THIS STUDY AND THE RECONSIDERATION OF THE MINIMUM BENEFITS STANDARDS LEGISLATION, THE MORITORIUM ON NEW MANDATORY COVERAGES VERSUS MANDATORY OPTIONS ENACTED BY THE 1982 GENERAL ASSEMBLY BE CONTINUED.

THE SUBJECT OF MANDATED HEALTH CARE INSURANCE IS A COMPLEX MATTER INVOLVING MANY SOCIAL AND ECONOMIC FACTORS, SOME OF WHICH I WOULD NOW LIKE TO BRIEFLY DISCUSS SO THAT YOU WILL BETTER UNDERSTAND WHY I MAKE THESE RECOMMENDATIONS.

FIRST, I WOULD LIKE TO DESCRIBE A CONCEPTUAL MODEL OF ECONOMIC MARKET FAILURE AND SUGGEST TO YOU THAT THIS MODEL PROVIDES A HIGHLY USEFUL FRAMEWORK WITHIN WHICH TO ASSESS THE

VALUE OF MANDATORY MINIMUM HEALTH INSURANCE COVERAGES FOR THE TREATMENT OF MENTAL ILLNESS AND CHEMICAL DEPENDENCY AS PUBLIC POLICY. SUCH AN ASSESSMENT REVEALS THAT, IN HEALTH INSURANCE MARKETS AS THEY ARE, INDIVIDUALS SHOULD NOT HAVE FREE CHOICE OF COVERAGE FOR PSYCHIATRIC AND CHEMICAL DEPENDENCY TREATMENT. THIS IS A STRONG STATEMENT WHICH SEEMS TO FLY IN THE FACE OF SOME OF OUR MOST CHERISHED VALUES, E.G. THAT INDIVIDUALS ARE THE BEST JUDGE OF THEIR OWN WELFARE. BUT OUR LEGISLATIVE HISTORY IS FULL OF EXAMPLES OF INDIVIDUAL FREEDOM BEING LIMITED IN THE INTEREST OF THE PUBLIC GOOD. PUBLIC POLICIES ALREADY INTERFERE, IN MANY WAYS, WITH CHOICE OF HEALTH INSURANCE COVERAGE. ELEVEN STATES DO NOT PERMIT RESIDENTS TO DECLINE PSYCHIATRIC AND CHEMICAL DEPENDENCY COVERAGE IN HEALTH INSURANCE. ALL STATES LIMIT CHOICE OF COVERED PROVIDER BY LICENSING STATUTES. THIRTY-ONE STATES FORBID INDIVIDUALS TO CHOOSE INSURANCE THAT ONLY COVERS SERVICES OF PHYSICIAN. AT THE FEDERAL LEVEL, MOST PROPOSED FORMS OF NATIONAL HEALTH INSURANCE SEVERELY RESTRICT CHOICE OF COVERAGE. AND THIS IS NOT LIMITED TO HEALTH INSURANCE. GOVERNMENT HAS ALSO FOUND IT IN THE PUBLIC INTEREST TO INTERFERE WITH FREEDOM OF CHOICE IN THE AREAS OF AUTOMOBILE LIABILITY INSURANCE, UNEMPLOYMENT INSURANCE AND WORKMEN'S COMPENSATION BENEFITS, TO MENTION ONLY A FEW.

IN ARGUING FOR MANDATORY INSURANCE BENEFITS, ONE MUST ADDRESS THE FOLLOIWNG POSITION: IF THE BENEFITS ARE WORTH THE COST, PEOPLE WILL BUY THEM FOR THEMSELVES; THE GOVERNMENT SHOULD NOT INTERFERE. INSURANCE FOR THIS TREATMENT IS AVAILABLE TO SOME PEOPLE ON A VOLUNTARY BASIS. WHY SHOULD THE GOVERNMENT TAKE THIS CHOICE AWAY BY MAKING IT MANDATORY?

THE ANSWER TO THE FOREGOING ARGUMENT -- THE JUSTIFICATION FOR PUBLIC ACTION -- MUST BE BASED ON THE SHORTCOMINGS OR FAILURES OF MECHANISMS THAT RELY ON VOLUNTARY BEHAVIOR IN MARKETS. THE SHORTCOMINGS OF MARKETS FOR PSYCHIATRIC AND CHEMICAL DEPENDENCY HEALTH INSURANCE ARE MANY. IMPORTANT FACTORS LIMITING RATIONAL VOLUNTARY BEHAVIOR IN THESE MARKETS ARE THE INABILITY OF BOTH INSURERS AND SUBSCRIBERS TO PREDICT RISK AND THE IGNORANCE, STIGMA, MYTHS AND DENIAL ATTACHED TO THESE ILLNESSES IN OUR CULTURE. THESE FACTORS ACTING TOGETHER LEAD TO MARKET FAILURE. BUYERS DO NOT EFFECTIVELY DEMAND APPROPRIATE COVERAGES AND SELLERS DO NOT OFFER COVERAGES RATIONAL BUYERS WOULD DEMAND.

PRIOR TO THE MANDATORY BENEFITS ENACTED IN THE 1970'S, THERE WAS A LIMITED MARKET IN VIRGINIA IN INSURANCE FOR PSYCHIATRIC TREATMENT. SUCH INSURANCE TYPICALLY HAD LOWER BENEFITS THAN THAT FOR OTHER FORMS OF MEDICAL CARE. THERE WAS VIRTUALLY NO MARKET IN INSURANCE FOR THE TREATMENT OF CHEMICAL DEPENDENCY. FOR MOST PEOPLE THE CHOICES WERE VERY LIMITED. SUCH POLICIES WERE EITHER UNAVAILABLE OR VERY EXPENSIVE.

MARKET FAILURE PROVIDES JUSTIFICATION FOR GOVERNMENT INTERVENTION. ADVERSE SELECTION IS A CAUSE OF MARKET FAILURE IN THE MARKET FOR INSURANCE COVERAGE OF TREATMENT FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY. INSURANCE AT ITS BEST IMPROVES EVERYONE'S WELFARE BY SPREADING RISKS; BUT ADVERSE SELECTION CAN INTERFERE WITH THE BENEFITS OF INSURANCE AND, AT TIMES, DESTROY THE MARKETABILITY OF INSURANCE ENTIRELY. ADVERSE SELECTION IS THE INSURER'S AND SUBSCRIBER'S IGNORANCE OF THE DEGREE OF RISK PRESENTED BY INDIVIDUAL POLICY HOLDERS COUPLED WITH THE SUBSCRIBER'S TENDENCY TO DENY THE RISK BECAUSE OF STIGMA. AN INSURER IS SUBJECT TO ADVERSE SELECTION

WHEN IT SETS PREMIUMS FOR A GROUP, AND A DISPROPORTIONATE NUMBER OF "BAD RISKS" IN THE GROUP CHOOSE TO BUY INSURANCE COVERAGE. FOR ANY GROUP THAT IS NOT PERFECTLY HOMOGENEOUS; SOME MEMBERS WILL HAVE GREATER RISKS, SOME AVERAGE, SOME LESS THAN THE AVERAGE, ALL PAYING THE SAME PREMIUM. IF DENIAL OF A DISTASTEFUL RISK BY BUYERS AND HIGH PREMIUMS SET DEFENSIVELY BY INSURERS LEAD TO ONLY KNOWN BAD RISKS BUYING INSURANCE, HEAVY UTILIZATION WILL LEAD TO EVEN HIGHER PREMIUMS FORCING OUT ALL BUT THE POOREST RISKS AND EVENTUALLY PREMIUMS TOO HIGH TO SELL INSURANCE.

ADVERSE SELECTION IS EVIDENT ONLY WHEN PEOPLE HAVE CHOICES. WHEN IT DOES OPERATE, HOWEVER, ADVERSE SELECTION ELIMINATES CHOICE BY MAKING INSURANCE IMPOSSIBLY EXPENSIVE. IN GENERAL, WITH INSURERS SETTING HIGH PRICES TO PROTECT THEMSELVES AGAINST ADVERSE SELECTION AND WITH THE TENDENCY OF SUBSCRIBERS TO DENY A DISTASTEFUL RISK, TOO FEW PEOPLE BUY INSURANCE. THERE IS A DIRECT AND SIMPLE SOLUTION TO THIS MARKET FAILURE -- COMPEL EVERYONE TO HAVE INSURANCE THROUGH MANDATE. THIS SEEMINGLY FORCES PEOPLE TO PURCHASE INSURANCE, BUT WHAT IT ACTUALLY DOES IS TO GIVE PEOPLE THE INSURANCE COVERAGE THEY WOULD HAVE PURCHASED IN A COMPETITIVE MARKET HAD INSURERS BEEN ABLE TO PRICE PROPERLY AND HAD THEY BEEN INFORMED AND RATIONAL BUYERS. PUTTING THIS SOLUTION IN ITS MOST FAVORABLE PROSPECTIVE: MANDATORY INSURANCE MIMICS THE RESULT OF A PERFECT MARKET. HERE, THEN, IS A CLEAR REASON TO SUPPORT MANDATORY INSURANCE; I.E. TO INTERVENE IN A DYSFUNCTIONAL MARKET SO THAT BOTH BUYERS AND SELLERS REALIZE THE ECONOMIC BENEFITS THEY WOULD SEEK AND ENJOY WERE THEY NOT SUBJECTED TO FACTORS LIMITING RATIONAL CHOICE AND VOLUNTARY BEHAVIOR.

BEYOND CORRECTING MARKET FAILURE, THE ARGUMENTS FOR THESE MANDATORY COVERAGES HAVE TO DO WITH SOCIAL BENEFITS FLOWING FROM THE USE OF THESE SERVICES WHICH GO FAR BEYOND THE BENEFIT TO THE INDIVIDUAL PATIENT. I REFER NOW TO THE DEMONSTRATED OFFSETS IN COSTS ATTRIBUTABLE TO THESE ILLNESSES IN OTHER AREAS OF HEALTH CARE, IN INDUSTRIAL PRODUCTIVITY AND IN THE CRIMINAL JUSTICE SYSTEM -- NOT TO MENTION THOSE COSTS IN LIFE, PHYSICAL AND EMOTIONAL PAIN AND FAMILY DYSFUNCTION, WITH ITS EFFECTS ON SUCCEEDING GENERATIONS, WHICH ARE INCALCULABLE IN ECONOMIC TERMS. THE STATE, ON BEHALF OF ITS CITIZENS, SHOULD CONSIDER THESE OFFSETS IN OTHER COSTS EVEN THOUGH THEY ARE NOT THE COSTS OF THE INSURANCE INDUSTRY ALONE.

THERE IS A FURTHER ARGUMENT FOR MANDATORY BENEFITS BASED ON A SOCIAL OBJECTIVE WHICH THE STATE RATHER THAN THE INSURANCE INDUSTRY HAS AN OBLICATION TO CONSIDER. A MAJOR OBJECTIVE OF ALL HEALTH POLICY IS TO PROVIDE FAIRLY FOR THE SICK. IN PART, THE ROLE OF MANDATORY INSURANCE IS TO PROVIDE A WAY FOR THE HEALTHY TO HELP THE SICK PAY THEIR MEDICAL BILLS. A FAIR MANDATORY INSURANCE PLAN REDISTRIBUTES PURCHASING POWER AWAY FROM PEOPLE WHO ARE GENERALLY HEALTHY TOWARDS THOSE WHO ARE GENERALLY LESS HEALTHY. THE STANDARD OF FAIR PRICES FOR THIS INSURANCE IS NOT A SET OF PREMIUMS PERFECTLY EXPERIENCED-RATED PERSON BY PERSON. IT IS FAIR FOR EACH PERSON TO PAY THE SAME PREMIUM, WHILE THOSE WHO ARE SICK MORE OFTEN RECEIVE A LARGER SHARE OF THE BENEFITS. AN INSURANCE PLAN BENEFITS ONLY A FEW EACH YEAR. THE DISTRIBUTION OF BENEFITS FROM FIRE, LIFE OR HOSPITALIZATION INSURANCE IS HIGHLY SKEWED. IF BENEFITS ARE DISTRIBUTED EVENLY, THERE IS NO RISK AND NO REASON TO INSURE AGAINST THE EXPENSE. THE QUESTION IS NOT WHETHER

CHARGES UNDER AN INSURANCE PLAN ARE DISTRIBUTED UNEVENLY, BUT WHETHER THIS UNEVEN DISTRIBUTION IS INEQUITABLE. STIGMA AND SOCIAL BIASES OPERATE HERE TO THE DETRIMENT OF THE PSYCHIATRIC AND CHEMICALLY DEPENDENT.

ARGUMENTS, THEN, IN SUPPORT OF THESE MANDATORY COVERAGES ARE BASED ON THE ISSUES OF ADVERSE SELECTION AND FAILURE IN PRIVATE INSURANCE MARKETS, OFFSETS IN THE SOCIAL COSTS, AND THE FAIRNESS IN THE DISTRIBUTION OF BURDEN AND BENEFIT BETWEEN THE HEALTHY AND THE SICK.

ONE LAST POINT -- THE LAST DECADE IN VIRGINIA SAW A MAJOR SHIFT IN THE LOCUS OF TREATMENT FOR THE MENTALLY ILL AND THE CHEMICALLY DEPENDENT FROM LARGE STATE INSTITUTIONS TO COMMUNITY-BASED PROGRAMS WHICH WERE OFTEN MORE COST-EFFECTIVE AND COST-EFFICIENT THESE SAME YEARS SAW A SHIFT IN THE LOCUS OF TREATMENT FROM THE PUBLI SECTOR TO THE PRIVATE SECTOR OF THE ECONOMY WITH THE RESULTANT SHIFTS IN COSTS. THE MANDATORY COVERAGES ENACTED IN THE 1970'S WERE STRONG, SUCCESSFUL INCENTIVES TO THE PRIVATE SECTOR TO MAKE THE NECESSARY INVESTMENT TO PROVIDE THESE SERVICES, AND THESE INVESTORS RELIED ON THE CONTINUANCE OF THESE COVERAGES TO AMORTIZE THOSE INVESTMENTS. OBVIOUSLY, AS THE NEED FOR THESE SERVICES WOULD CONTINUE, IRRESPECTIVE OF THE FUNDING MECHANISM, REPEAL OF MANDATORY BENEFITS WOULD SIMPLY SHIFT THE COST FOR SUCH SERVICES BACK TO THE STATE BUDGET.

IN CONCLUSION AND IN SUMMARY, I WOULD LIKE TO REITERATE THE COMPLEXITY OF THIS MATTER AND THE NEED FOR EXTENSIVE STUDY AND INPUT IN ORDER THAT THE GENERAL ASSEMBLY CAN CONTINUE TO ACT IN THE BEST INTEREST OF ALL VIRGINIANS. TO THIS END, THE NEUROPSYCHIATRIC SOCIETY OF VIRGINIA RECOMMENDS THE ESTABLISHMENT

OF A CONTINUING STUDY AND REVIEW BODY WHOSE MAJOR CHARGE WOULD BE A COMPREHENSIVE STUDY OF THE ADEQUACY OF HEALTH INSURANCE COVERAGE IN VIRGINIA AND THE RECOMMENDATION OF AMENDMENTS TO THE MINIMUM BENEFIT STANDARDS LAW IF NECESSARY. CURRENTLY MANDATED COVERAGES AND ANY OTHERS NECESSARY TO FILL GAPS IN COVERAGE COULD BE ADDED TO THIS LAW. PENDING THE COMPLETION OF THIS WORK, WE RECOMMEND CONTINUING THE PRESENT MANDATED COVERAGES AND THE ESTABLISHMENT OF A PROPERLY CONSTITUTED REVIEW MECHANISM TO CONSIDER ANY PROPOSALS FOR NEW MANDATED COVERAGES ACCORDING TO UNIFORM CRITERIA SIMILAR TO THOSE SUGGESTED IN THE 1979 LARSON REPORT TO THE BUREAU OF INSURANCE. ALL SUCH NEW MANDATES, IF APPROVED, SHOULD BE MANDATORY OPTIONS RATHER THAN MANDATORY COVERAGES AS PER THE RESOLUTION OF THE 1982 GENERAL ASSEMBLY.

I APPRECIATE YOUR COURTEOUS ATTENTION AND THE OPPORTUNITY TO MAKE THIS INPUT ON THE PART OF THE NEUROPSYCHIATRIC SOCIETY OF VIRGINIA. I WOULD NOW BE GLAD TO ATTEMPT TO ANSWER ANY QUESTIONS THAT YOU MIGHT HAVE.

POSITION OF VIRGINIA STATE AFL-CIO ON HOUSE JOINT RESOLUTION 90

REGARDING MANDATED COVERAGE IN GROUP INSURANCE POLICIES

The AFL-CIO strongly opposes any attempts to repeal any mandated benefits now required in group health insurance contracts by the Insurance Laws of Virginia.

Among the mandated benefits now required are coverage of newborn children; in-patient coverage for mental disorders, including alcoholism and drug dependency, and coverage for certain dependent children. Section 38.1-348.

The repeal of mandatory coverage for mental disorders, and alcohol and drug dependency, would have an adverse effect on many Virginia citizens who are dependent upon such coverage to enable them to obtain care. The repeal would also affect funding of mental health, mental retardation, and substance abuse services now provided and which face severe fiscal restraints.

The repeal of this coverage would also adversely affect such programs as Medicaid, which would end up having to supply the funds to individuals in need of this type of treatment.

We in the labor movement are of course extremely concerned by the skyrocketing costs of medical care in this country. As an alternative to cutting benefits, however, the AFL-CIO supports the enactment of health care cost controls. Several states have already adopted cost containment measures. We would support legislation which would bar hospitals and nursing homes from raising charges higher than the rise in the overall cost of living index for two years. Physicians' fees would also be held to present levels under Medicare, Medicaid and private insurance programs, with increases allowed only to cover overhead costs as reflected in the cost-of-living index. The same principle would be applied to laboratory and X-ray services.

After two years, a prospective budgeting system would be mandatory for hospitals and nursing homes, and physicians' fees would be negotiated with the

state agency administering the program, as would contracts with health maintenance organizations.

What we are saying basically is this: the profit motive in the health care field is out of hand. It is unconscionable in a society with the resources of the United States, that people should have to go without needed health care services. The only way to reduce the suffering of consumers, the poor, and working people, is to do something to control the profits of the health care providers.

In sum, we are opposed to abolishing mandatory benefits as a way of reducing health care costs. We respectfully request that this Committee look into other avenues, such as the concept of health care cost containment.

REPORT TO THE JOINT SUB-COMMITTEE PURSUANT TO HJR-90

Submitted By

The Virginia Committee of the National Association of

Private Psychiatric Hospitals

Presented by:

Joe W. King, M.D., F.A.P.A.

Acting President, Virginia Committee, NAPPH

October 18, 1982

My name is Joe W. King. I am a medical doctor licensed by the Commonwealth of Virginia and a practicing psychiatrist in Richmond. I am Medical Director of the Psychiatric Institute of Richmond. I am Acting President of the Virginia Committee of the National Association of Private Psychiatric Hospitals. The Virginia Committee of the National Association of Private Psychiatric Hospitals is made up of representatives from each of the fourteen Virginia member hospitals of the NAPPH. I very much appreciate the opportunity to meet with this important sub-committee of the Virginia legislature studying mandated health insurance coverage in the Commonwealth of Virginia.

The Virginia Committee of the National Association of Private Psychiatric Hospitals thoughtfully and unanimously opposes the repeal of mandated mental health and substance abuse benefits. We recommend that a continuing forum be established, either by legislation or by a body to be appointed by the Governor of the Commonwealth of Virginia whereby there can be a study mechanism in the entire field of health care benefits. These studies, I would respectfully submit, must include indepth and cooperative input from all parties involved: The citizen consumer, the health care provider and the third party payor. It is our position that without such preparation, fragmented and stop-gap legislation will come into being which will not solve the terribly complex and far-reaching problems that mandated health care benefits attempt to address.

The history of the enactment of mandated health care benefits legislation is well known to each of you. We should recall that the position of the Virginia General Assembly in the 1970's regarding mandated benefits was that the needs of the Virginia citizen consumer were not being met in the health care service areas of mental or nervous disorders, as well as of alcohol and drug dependence. Further, the Commonwealth of Virginia instituted in the 1970's a number of programs and studies to face and meet the deplorable conditions existing for the mentally ill or substance abusing Virginia citizen consumer. These studies resulted in the adoption of the mandated health care legislation being reconsidered by your sub-committee.

Also, as a result of the establishment of the need for high quality health care in Virginia, the private sector of medicine in the mental health field moved to establish and adequately staff the several private psychiatric hospitals that are now available to the working Virginia citizen consumer. The goals of these treatment centers is to properly, humanely and adequately treat the mentally ill and/or drug abusing child, adolescent or adult in the Commonwealth. It is our intense concern, that should mandated health care benefit legislation be reversed, so might the movement to proper, humane and adequate treatment be reversed to the deplorable conditions that preceded the establishment of this private sector of health care.

Furthermore, we respectfully submit to you that the seriously mentally ill and/or drug abusing child, adolescent or adult in Virginia is going to require treatment. If the private sector of medicine is prevented from providing this treatment, the public sector of mental health facilities will be inundated with the mentally disabled of the Commonwealth. The results of such a phenomena can be appreciated by again looking at the studies of the 1970's. Costs will be increased and efficiency and maximum treatment potential will be decreased. The public supported mental health facilities will be over-crowded, and their staff will be over-taxed.

It is our position that our collective efforts should be toward cost containment and quality assurance in the private sector; the careful licensing, accreditation and ongoing peer review within the private sector; and a commitment by the private sector towards the most efficient, humane and comprehensive treatment of the mentally ill of the Commonwealth of Virginia. Cost containment and quality assurance are required and appropriate responsibilities of any licensed psychiatric hospital in Virginia. Accreditation by the Joint Commission for the Accreditation of Hospitals is a prerequisite for membership in the National Association of Private Psychiatric Hospitals of which the Virginia Committee of the NAPPH is a part. Peer review is the responsibility of each specialty of medicine. In addition, third party payors monitor the appropriateness of the delivery of medical care to their consumers. Also, in the Commonwealth of Virginia all hospital charges are reviewed by a Rate Review Commission. We are convinced beyond a doubt that with these several review mechanisms in place, proper utilization of health care benefits is assured.

Your task is not enviable. Your decision will be far-reaching in its impact. The issues are complex and touch upon legal, ethical and moral fibers within each of us. I thank you for your time and attention and pledge the resources of the Virginia Committee of the National Association of Private Psychiatric Hospitals to your assistance at any time.

Thank you.

STATEMENT

FOR THE

JOINT LEGISLATIVE COMMITTEE ON

MANDATED INSURANCE (HJR 90)

COMMONWEALTH OF VIRGINIA

GENERAL ASSEMBLY

OCTOBER 18, 1982

GIVEN BY:

H. RICK SAMPSON

DIRECTOR OF MENTAL HEALTH SERVICES

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Mandated coverage for inpatient mental health care should remain in effect due to the following:

1. From the point of view of the consumer confronting the marketplace, clearly the availability of 3rd party coverage contributes to

   - the availability of a variety of modalities of care from which the consumer can choose. Such a system allows for competition in the marketplace with resultant improved quality of care available to all.

   - the investment of large 3rd party providers in the system leads to improved quality control via peer review, cost-benefit analysis and utilization studies.

   - removal of such coverage will create dual systems of care - one for the well-to-do or well-insured; another for the middle class and impoverished. If the current system is any indication of the potential results, such a descriminatory system of care will greatly contribute to recidivism, patient abuse and less-effective care. State facilities are already understaffed and find it difficult to provide minimal medical treatment. Increasing their census, through removing options for many people, at a time when these - some institutions - are under pressure to decrease census is clearly contradictory and has potential devastating effects.

   The final question for the consumer remains one of choice in a free marketplace. The proposed to eliminate coverage will just as surely eliminate the marketplace.

2. Removal of mandatory coverage for mental health inpatient care does not seem justified as a cost containment strategy.

   A. Studies concluded that mental health services are related to:

      - decrease in visits to physicians
      - decrease in expensive lab and x-ray tests
      - reduction in length of hospital stay following surgery
      - fewer medical problems

   B. Insurance companies pay for mental health care any way:

      - in 1975, 13 million people with mental illness were treated by physicians other than psychiatrists. In effect, the proposal will simply shift mental health care from the trained to the untrained.

   C. Never been demonstrated that 3rd party payments have increased for mental health care out of proportion to uses in other medical costs.

3. Therapeutically:

   - 3rd party coverage involves co-payment which supports client's investment in therapy.

   - choice and independence are significant therapeutic issues as is self-support. 3rd party coverage is preceived as legitimate by clients - financial assistance and bad debt approaches enhance learned helplessness.

4. Removal of 3rd party coverage in the mental health area is clearly descriminatory and works against a group of people with little if any political power.

Presentation to

Joint Subcommittee Studying

Health Insurance Mandated Benefits

Under Article 2, Chapter 8, of Title 38.1

House Joint Resolution 90

Presented By:

The Department of Mental Health and Mental Retardation

October 18, 1982

INTRODUCTION

As a result of rapidly increasing costs of providing medical services SJR 5 passed by the 1978 General Assembly created the Health Care Cost Containment Commission. This Commission, known as the Willey Commission (chaired by the Honorable Edward E. Willey, President pro tempore of the Senate), made a comprehensive study of the subject for two years and the study was extended for two additional years by SJR 32 in 1980 with the Commission charge to include a study of mandated insurance benefits.

Among the final recommendations of this commission was number 4 which recommended that the Commonwealth repeal the state mandated insurance provision.

Recommendation number 4 was opposed by the Honorable Edward E. Willey, chairman and others and dissenting opinion were written by the Commissioner of Insurance (the Honorable James M. Thompson); the Commissioner of the Department of Mental Health and Mental Retardation, (Dr. Joseph J. Bevilacqua), Senator Adelard L. Brault, Senator Elmo G. Cross, Jr. Delegate George Grayson and Delegate Johnny S. Joannou joined in a dissenting opinion.

Several Bills were introduced in the 1982 session of the General Assembly which addressed mandated benefits in health insurance coverages.

H.B. 272 addressed changes in requirements effecting group contracts delivered or issued for delivers outside the Commonwealth.

H.B. 555 which proposed to add a mandated coverage of rehabilitation for "physical disorders".

H.B. 716 which proposed to add certain "out patient" coverages for "mental emotional or nervous disorders...".

H.B. 721 which proposed to make existing mandated coverages optional rather than required.

S.B. 191 which proposed to expand the professionals whose services are covered to include "professional counselors".

S.B. 358 which proposed to make any future mandated services optional. This bill did not remove any mandated services effective prior to July 1, 1982.

There was clear evidence in the 1982 General Assembly that all members were concerned about the high costs of medical services as well as the rising costs of providing health insurance. All members of the House of Delegates and members of the Senate showed extreme interest in containing rising costs but were unable to find a perfect solution to this most complex problem. Out of the six bills introduced which addressed "mandated coverage" only one was passed. S.B. 358 which passed allowed all mandated services then in effect to continue and would make any additional mandates optional.

Philosophically, the Department of Mental Health & Mental Retardation continues to enthusiastically support the mandates which provide for services to those suffering from mental, emotional or nervous disorders and inclusive of treatment for citizens with physiological and psychological dependance upon alcohol and drugs. Although many sincere persons are of the opinion that "the removal of mandated services" would reduce health care costs, the Department of Mental Health & Mental Retardation is convinced that such removal would merely transfer the relatively small additional cost from health insurance to the General Fund for providing these most vital services. We feel that a continuation of mandated coverage is a proper "collective assumption of the risks" by all persons having health insurance coverage. Philosophically, mandated services are consistent with the basic principal of all insurance and tax concepts in that it is a "collective responsibility of all policy holders (or tax payers) to "pool their resources so as to meet an unanticipated need of costly consequences". We support the position that the "advantages" of mandated services far outweight the liabilities (slightly higher costs).

STATEMENT OF ISSUES

1. Will the removal of presently mandated Mental Health, Mental Retardation and Substance Abuse services from health care insurance coverage significantly lower health care costs?

   Mandated services only slightly increase health care insurance costs; however, we agree that these modest increases are made worthwhile by cost effective early intervention.

2. Can mandated services actually be cost effective?

   We believe that early attention and professional help can prevent costly secondary effects resulting from inattention in the early stages of mental, emotional or nervous disorder and substance abuse problems.

3. What legislative actions would help curtail the increased cost of health care insurance?

   The placing of "caps" or maximums on certain mandated coverages might be considered so long as such caps were reasonable and did not prevent the services from being offered. Such "caps" could be established with necessary georgraphic differentials so as to establish health costs which would be consistent with high or low costs in a particular area. These "caps" would be confined to coverages in the event your Joint Subcommittee confirmed allegations of cost abuse.

4. What would the removal of mandated services cost our Department?

   To provide present services, the State Department of Mental Health and Mental Retardation could lose approximately $5.1 million per year in its hospitals and training centers and approximately $1.2 million per year from Chapter 10 services within the community (these amounts are actually collected per year from insurance sources). These are conservative figures since many of the Community Services Boards are just

commencing a concentrated effort towards such collections and their receipts from these sources should continue to increase.

RECOMMENDATIONS OF POSITION

The Department of Mental Health and Mental Retardation Recomends:

1. That present mandated coverages for mental, emotional or nervous disorders and substance abuse services be continued.

2. That consideration be given by the Commission to extend some additional coverage for the outpatient substance abuser with an annual maximum cost. Our agency firmly believes that outpatient coverage, especially in the substance abuse area, could be extremely cost effective by substituting the reasonable costs of outpaitent care for some costly inpatient care. Presently, outpatient coverage is optional.

3. If there are abuses by some few providers of health care services, our agency will support the establishment of reasonable "caps" or maximums with the hope that such containment of costs could assure a continuation of mandated services in our field of responsibility.

In conclusion the Department of Mental Health and Mental Retardation believes that continuation of mandated mental, emotional or nervous disorder and substance abuse services are cost effective by early intervention in these areas of need; we believe that by the inclusion of our mission's services tends to stress its importance as a vital health care need and helps to remove the stigma which is still tragically attached to mental health and substance abuse treatment. The number of citizens who need such help increases each year and during our life span most families will have at least one member who will critically need the services presently mandated. Without coverage, many of them may suffer grave consequences. We are aware of the magnitude of the assignment given to your Joint Subcommittee and know your conclusions will reflect your dedication to betterment of man. Thank you.

APPENDIX VI

LAW OFFICES
THOMAS & FISKE
A PROFESSIONAL CORPORATION
310 SOUTH BOULEVARD
POST OFFICE BOX 14515
RICHMOND, VIRGINIA 23221
TELEPHONE (804) 355-8646

510 KING STREET, SUITE 200
POST OFFICE BOX 820
ALEXANDRIA, VIRGINIA 22313
TELEPHONE (703) 836-8400

October 15, 1982

The Honorable William T. Wilson
Chairman, Joint Subcommittee on
Health Insurance and Mandated Benefits
228 N. Maple Avenue
Covington, Virginia 24426

Re: Health Insurance Mandated Benefits
House Joint Resolution 90

Dear Delegate Wilson:

Please be kindly advised that I represent Blue Cross and Blue Shield of Virginia.

At your request, please find enclosed a position paper entitled: Blue Cross and Blue Shield of Virginia Mandated Coverages, Benefits, and Service House Joint Resolution No. 90, prepared on behalf of Blue Cross and Blue Shield of Virginia for the Joint Subcommittee on Health Insurance Mandated Benefits, Virginia General Assembly.

As Blue Cross and Blue Shield of Virginia indicated during the 1982 legislative session, its position is that future mandated benefits should be optional to the contract holder. As you may be aware, Virginia Code Section 38.1-384.14 provides:

> Section 38.1-348.14. Additional mandated coverage made optional to group policy or contract holder. - Notwithstanding any other section of this title, any new or existing group policy or contract holder, for whom coverage under an accident and sickness insurance policy is issued or renewed by an insurer or for whom coverage under a contract is issued or renewed by a plan licensed pursuant to Chapter 23 of this title shall be given the option to purchase any coverage, benefits or services first mandated under this chapter on or after July 1, 1982, provided, further, all mandated coverages as of June 30, 1982, will not be affected."

It is the basic position of Blue Cross and Blue Shield of Virginia, consistent with Virginia Code § 38.1-348.14, that any mandated coverage in the future should be in the form of a mandated offering. Moreover, Blue Cross and Blue Shield of Virginia would recommend to the Joint Study Commission the following:

1. That the Study Commission endorse Va. Code § 38.1-348.14, whereby future mandated benefits will be made available for purchase at the group's option;

2. That the Study Commission recommend to the 1983 General Assembly that, for the purposes of Va. Code § 38.1-348.14, group coverage be defined to mean groups of fifty or more subscribers or policyholders, or such other number as the carrier may use to rate a group or its own health care experience;

3. That the Study Commission recommend to the 1983 General Assembly that mandated benefits for non-group subscribers and subscribers in groups of fifty or less, where in either case, they are individually or community-rated, be made available at the carrier's option;

4. That the Study Commission recommend to the 1983 General Assembly that any mandated benefits legislation introduced into the General Assembly be accompanied by an "economic impact analysis" as to the expected cost of the benefit and its impact on health care costs as a whole;

5. That the Study Commission recommend that, except where enacted as emergency legislation pursuant to the Rules of the General Assembly, that no new mandated benefits legislation be made effective sooner than one year from the date of enactment.

Blue Cross and Blue Shield of Virginia is also strongly opposed to House Bill 272 introduced in the 1982 legislative session. This bill deals with the concept of "extraterritorialty." Basically, Blue Cross and Blue Shield of Virginia opposes this concept 272 for these reasons:

House Bill 272:

(i) Places multi-state employee groups in a position where employees in Virginia would be provided with benefits differing from those provided to employees in other states;

(ii) Extends the laws of Virginia extra-territorially; other states may do likewise resulting in chaos;

(iii) Renders it difficult, if not impossible, for the State Corporation Commission, Bureau of Insurance, to regulate and enforce the law;

(iv) Denies the right of the out-of-state employer to choose his own range of benefits for his employees, i.e., it provides an incentive for that out-of-state employer not to hire an employee of a state with extra-territorial laws, especially if the employer is on that state's border;

(v) Encourages an employer to self-insure. Pursuant to the E.R.I.S.A. pre-emption (Federal Act, 1974) self-insured employers are exempt from state regulations pertaining to insurance;

(vi) Results in the employer having to provide unequal benefits to his employees;

(vii) Restricts the employer's bargaining power with labor unions at the bargaining table by requiring additional benefits not subject to regulation; and

(viii) Is, perhaps, unconstitutional, as a violation of Article IV, Section 1, United States Constitution (The "Full Faith and Credit" Clause).

Blue Cross and Blue Shield of Virginia appreciates this opportunity to express our views on these subjects.

Sincerely yours,

Philip S. Marstiller

PSM/jy
Enclosure
cc: James M. Thompson, Esquire
Commissioner of Insurance

BLUE CROSS AND BLUE SHIELD OF VIRGINIA

MANDATED COVERAGES, BENEFITS, AND SERVICE

HOUSE JOINT RESOLUTION NUMBER 90

I. Introduction

Traditionally the benefits, cope of coverage, providers to be reimbursed, etc., contained in health insurance products and health plans have been determined by "market place" decisions. Insurors generally determined what types of products, levels of coverage, etc., they would offer based on: (1) what they felt the market desired and (2) what they felt they could provide from an underwriting standpoint and consistent with their corporate philosophy and legal authority. Purchasers also had a significant input into the types of coverages made available in the market place. This has been particularly true of larger groups and collectively bargained plans.

Increasingly since the late 1960's, motivated by a variety of reasons and forces, state governments have become involved in the decision-making process as to what coverages would be offered in the market place. This trend -- referred to as mandated coverage or mandated benefits -- has grown dramatically over the past decade. It is the most prevalent and among the most difficult legislation faced by health insurers. Proponents of such initiatives tend to be special interest health care groups. While consistently opposed by insurors, third party payors have provided limited and questionable data in countering such proposals. These is limited knowledge or awareness of the real impact of such legislation on: the insurer, the market place, the purchaser, the utilization of services, the cost of care, distribution of services, the quality of care, fraud or abuse, the emergence of other technologies or modalities, et al.

II. Background

Mandated coverages are not new to the insurance industry. Early mandated coverage legislation can be found beginning in the late-1960s. However, it was not until the early and mid-1970s that this trend really began to evidence itself. Since the mid-1970s, this trend has accelerated drastically. As an example, in 1970, only one state mandated out-of-hospital care; in 1973 the number was 4; in 1976 the number was 12; and by 1979 the number had grown to 19. In the mandatory reimbursement of certain practitioners, in 1970 one state had a law dealing with this subject; 1973 at least 10 states had; in 1976 at least 27 states had; and by 1979, 32 states had enacted some legislation dealing with reimbursement of practitioners. Some states have addressed the issue of mandated coverages by passing minimum standards or model benefits legislation. Most often, however, mandated coverage legislation is dealt with on an ad hoc or in a piecemeal fashion.

The earliest mandated coverage initiatives tended to be those requiring reimbursement of certain nonphysician practitioners (chiropractors, podiatrists, dentists, clinical psychologists). Most of these groups felt disenfranchised by the third-party payor/insuror provider relationships prevalent among Blue Cross and Blue Shield plans and, not surprisingly, were the main proponents of the initiatives.

Currently chiropractors are eligible for reimbursement in nearly three dozen states; psychologists in approximately two and one-half dozen states. Other early mandated coverage initiatives were undertaken to address glaring gaps and omissions in health insurance coverage.

Two movements in the late-1960s and 1970s precipitated substantial amount of mandated coverage activity. The first of these was in the 1960s with emphasis on alcohol and drug usage. The second is an evolving view of both the needs and treatment of the mentally ill. In both of these instances, the medical treatments and coverages afforded had previously been provided primarily at public expense or out-of-pocket. In fact, many traditional insurance policies specifically excluded treatment for alcohol or drug abuse or for any treatment rendered in state facilities. The mechanism by which public monies were allocated to address these needs -- primarily the grant-and-aid process -- tended to create a whole new industry of treatment centers, of professionals or paraprofessionals, nonmedical providers, and new modalities of care. As it became apparent that the demand for these services exceeded the resources that were being provided in the public sector, practitioner groups, state officials, mental health advocates, et al., pressed for inclusion of these coverages in traditional private third party contracts. Hence, mandated coverage initiatives in the mid-1970s and through the early-1980s have been dominated by demand for fuller mental health and fuller substance abuse coverages.

The health care cost "crisis" of the late-1970s gave rise to a whole new group of mandated coverages and the rationalizations employed in seeking such legislation. Specifically, advocates of outpatient care, ambulatory surgical centers, community mental health centers, home health care, hospice care, etc., new practitioners such as nurse practitioners, physician extenders, psychologists, etc., advocated they could provide many equivalent services at

less cost. In addition, as groups were beginning to realize the full potential of political activism in the mid 1970's, they also began to realize the potential of mandated coverages. Equal rights groups pushed for fuller coverage for pregnancy. Pro-abortion and anti-abortion forces sought legislation providing, respectively, fuller coverages for abortions or forbidding abortion altogether. Advocates for the mentally retarded and handicapped pressed for legislation which barred insurors from discriminating against them in terms of coverage, underwriting criteria, and/or cost of coverage. Virginia is not atypical.

In Virginia, in 1973, psychologists, optometrists, and opticians were added to the list of those prividers for whom coverage must be provided if the services of physicians are covered. Coverage for newborn care was mandated in 1976. Also in 1976, 30 days of inpatient treatment for nervous and mental disorders was required. In 1978, nervous and mental coverage was expanded to include alcohol and drug rehabilitation in a hospital or alcoholic rehabilitation facility. On July 1, 1979, clinical social workers joined the list of mandated practitioners, but with the priviso that their services be made available to those individuals and groups desiring their level of care. In 1979, the offer of a non-group program or 90-day extension of group coverage was required of an employer in those instances where an employee left the group or was terminated. Coinsurance and deductible options and coverage for victims of rape or incest were added in 1981. Significantly, in 1982, all future coverages mandated were to be made available to those groups wishing to purchase them.

III. Contributing Factors

There are a number of factors underlying the trends and the pressures which brought about mandated coverage legislation. They depend upon the perspective from which they are viewed -- that of insuror, the legislator, the provider, the employer, or the interest group. John G. Larson, Ph.D. of the Department of Health Administration, MCV School of Allied Health Professions, examined a number of these factors in his 1979 mandated coverage report to the Virginia Bureau of Insurance. Set forth below are eight of what Dr. Larson perceived as the more salient reasons for rapid growth of mandated coverage legislation.

1. Incomplete Health Insurance Coverage

While Blue Cross and Blue Shield is not as culpable as many other insurors, there is a long history of instances where third party payors have not sought to provide comprehensive health coverage but rather have sought frequently to avoid costly pay-outs. An example was the policies which specifically precluded coverage for newborns until after they were 15 days old and who, even then, might be subject to preexinsting condition clauses. The tendency was to try to minimize potential losses. Instead of responding to changes in terms of the modes of care and new technologies or new perceived needs, the tendency was to stay with traditional coverages and to accept gaps in coverage or incomplete coverage.

2. A Change in the Concept of "Health Insurance"

Perhaps a corollary of #1, there has been a drastic change in the perception of health insurance. It is no longer perceived as insurance per se (that is protection against the unexpected high-risk and high-cost items) but it is now seen as a "third party payment mechanism" or a full payment mechanism. The advent of Medicare and Medicaid, and the growth of Blue Cross, Blue Shield, and HMO "first dollar coverage" has contributed to this perception.

3. Expanded Definition of Health and Health Care

The World Health Organization defines health as a "state of complete physical, mental and social well being and not merely the absence of disease or infirmity." If indeed the common acceptance of, or expectations for health follows this definition, then it is also reasonable to expect that coverages will include benefits not only for accident, disease, or disease prevention, but will extend into the areas of "social well being" as well. For example, in Massachusetts there has been mandated coverage legislation covering psychological testing and adjustment testing in the schools. In other states,home care or out-of-hospital acute care services has been mandated. Certainly home health care coverage lends itself to this expanded definition when it includes homemaker services, meals on wheels, and other non-medically oriented services. Clearly the problem is that traditional health insurance has come to be viewed as including a number of concerns only tangentially related to illness or injury.

4. Expanded Number and Types of Licensed Practitioners

In addition to chiropractors, podiatrists, and psychologists, the 1970s witnessed a growth in drug rehab counselors, midwives, physician assistants, speech therapists, occupational therapists, naturopaths, acupuncturists, etc. These individuals began to seek licensure and certification standards. In many cases, their expectations and desire for equal footing, as well as for remuneration and independence, prompted them to look for direct third party payment. In addition they have become politically active and have tended, as most groups have, to use the political route as opposed to the market to achieve their goals. These allied health practitioners have been frustrated and have become more openly hostile toward the traditional medical care providers, professionals, and modalities of care. Each believes that his group cannot maximize its full potential under current industry limitations.

5. An Anti-Physician or Anti-Provider Sentiment

While physicians as individuals are still held in high regard in most public polls, the medical community itself is subject to a anti-physician or anti-provider bias. No doubt much of this is due to a frustrated response to rising health care costs. Regardless of the merits or of the validity, this trend has worked to the benefit of allied practitioners who have claimed they can render a service cheaper. Traditional hospital or physician opposition to mandated coverages, even if motivated out of the most genuine of concerns for quality of care, nonetheless has been suspect.

6. Health Care Insurors Viewed as Agents for Social Change

Many policy makers clearly view the health insurance industry as a convenient mechanism for social change. Some advocates would utilize the health insurance system as a means to redistribute income. Others would use it to control health care cost by "injecting competition among providers." Still others would use it as an agent for social change with respect to equal rights, abortion, or affirmative action issues to help the handicapped or minorities. Still others (and this is particularly true in rural states) have advocated that mandated coverages of new practitioners would help the distribution of medical care services. And finally, others would suggest that the health insurance industry, via mandated benefits or mandated coverages, is an appropriate vehicle by which to address particular social needs: the needs of the aged, the needs of the unemployed, the needs of the near poor, etc.

7. Federal Government

Perhaps one of the more powerful motivating forces in the last few years has been the federal government. One has only to look at the 1978 Pregnancy Discrimination Act; ERISA; Medigap standards; 1978 Medicare-Medicaid Amendments which recognized physician assistants and nurse practitioners for direct reimbursement in shortage areas; amendments to the Federal Employee Program (FEP) which provided reimbursement of allied health practitioners in shortage areas; the FEP reimpursement of psychologists and chiropractors; CHAMPUS's reimbursement of ministerial counselors and social workers; a plethora of bills which would have Medicare reimburse social workers, home health care agencies and hospice

care; the Presidential Commission on Mental Health which recommends that states mandate fuller mental health coverage; and the National Institute of Health whose agencies fund and actually design model state benefit packages and legislation. All of these have contributed to the growth of mandated coverage legislation at the state level. There is every indication that such activity will in fact increase precipitously over the next few years.

8. Fiscal Crisis in Government

Perhaps the most ominous of contributing factors to the growth of mandated coverage legislation is the current "fiscal crisis" in state and federal governments, a trend of which this joint study commission is well aware. The move to balance the budget at the federal level and increasingly tighter state governmental budgets have caused governments to examine seriously the means by which to defray some of their ongoing program costs. Mandated coverage legislation provides not only states but the federal government a mechanism by which this may be accomplished. One has only to look at the example of the level for decreasing federal funds (in real dollars) going into community mental health centers, alcohol and drug programs, and emergency medical services, to realize that these programs have to look for funds by which to continue to operate. The result clearly has been that these programs and their sponsors begin to look to private third party payors.

IV. Costs

Benefit Costs

In October 1977, the Maryland Blue Cross and Blue Shield Plan estimated the cost of offering eighteen programs mandated by legislation at $39 million per year. While benefits differ, Virginia currently mandates eighteen coverages, practitioners, etc., affecting Blue Cross and Blue Shield plans operating in the Commonwealth.

In 1980, Blue Cross and Blue Shield of Virginia calculated the cost of selected mandated benefits for its then 1.4 million subscribers. The annual cost of the benefits (each of which is described in more detail in Annex A) was as follows:

	Type of Service	Annual Cost
1.	30 days inpatient nervous and mental coverage.	$8,500,000
2.	30 days of alcohol and drug abuse included in nervous and mental coverage. (a)	675,000
3.	Practitioners other than physicians (posiatrists, chiropodists, etc.)(a)	1,000,000
4.	Make available social worker and outpatient nervous and mental coverage. (b)	4,000,000

(a) Items 2 and 3 are actuarial computations. Actual benefit experience was not available at the time.

(b) Expenses for optional coverage for social workers and outpatient nervous and mental services are those which would be incurred if all persons eligible for coverage elected the benefits.

In 1981, the federal government transfered to the private sector a significant portion of its $1.8 billion estimated annual Medicare expenditure for renal dialysis and kidney transplants. More recently, Contress passed legislation which will shift the cost of insuring active employees aged 65 to 70 from Medicare to the private sector. The effects of these last mandates are still being assessed.

From all of this, one thing is clear - both nationwide and in Virginia - the cost of mandated coverages is borne, in the main, by employers. Experts agree that the cost of additional mandated benefits is the increased cost of doing business in a mandated benefits state. The employer must build upon this base of mandated benefits before he structures his program in the manner he both desires and can afford. In most cases, mandated benefits bear little relation to one another and, even when enacted for the most worthwhile of purposes, present the employer with a patchwork of benefits which represent another individual's idea of how a benefit program should be structured or how the spiraling cost of health care ought to be controlled. In no state in which a benefit has been mandated has that benefit been shown to have impacted the cost of health care in any measurable way.

Interestingly, the area in which the inroads are being made is in the marketplace - employers are seeking solutions to their own problems of escalating health care

costs. Group purchasers are demanding accountability from insurance carriers and from the facilities and professional practitioners who render services to group participants. They are designing programs which encourage the use of lower cost facilities through novel and meaningful incentives (cash awards, days off, etc.). Employers are cutting back on the high cost inpatient services and increasing coverage for outpatient surgery, laboratory, and x-ray services. They are engaging consultants to analyze trends. They are following more closely the route of their health care dollar. In short, the market itself is determining what works and what does not work. The health care system is undergoing a fundamental re-orientation. The true "third party payor" - the employer - is making his beliefs and desires known through consumer advisory committees to insurance companies, local business and medical coalitions, state study commissions and, in a more direct manner, through self-insurance programs.

Health Systems Costs

The impact of mandated benefits on the health care delivery system itself is the single topic over which the various factions have engaged in the liveliest debate. From the outset proponents of mandated coverages have pointed to the likelihood of increased competition, redistribution of the same health care dollar, decreased per limit or per visit cost, and similar agruments. In many instances, the insurance industry has countered theory with theory. Much of the reason for the theoretical plain on which debate is conducted lies in the nature of the delivery system itself. Most experts will agree that the health care system does not react to traditional rules in traditional ways. What may stimulate competition in one industry does not stimulate competition in the

health care system. Of greatest significance, the consumer does not react in the same manner when he becomes involved (usually involuntarily) in what he views as an industry trading in the dual commodities of health and life.

In short, no adequate industry model exists. As a result, it is difficult to generalize about the impact of a given set of benefits on a system as complex as health care. These are several areas, however, in which the increased availability of services seems to bear some relation to increased costs.

The state law requiring health insurers to provide benefits for 30 days of inpatient alcohol and drug rehabilitation services became effective on July 1, 1979.

A year before the law was passed, there were approximately 300 licensed and certified substance abuse treatment beds in Virginia. Currently, there are more than 1000 approved beds - a three-fold increase. This figure does not include existing or proposed psychiatric facility beds,some of which are used for treating substance abuse patients. A more detailed analysis of inpatient psychiatric benefits is included at Annex B.

The state law which required that licensed clinical social worker coverage be made available also became effective on July 1, 1979.

In 1978, the Plan's usual, customary, and reasonable charge ("UCR") for one hour of outpatient therapy rendered by a licensed clinical social worker was

$20.00 per hour; a physician's charge for the same service was $45.00. In 1979, the UCR for the same social worker's service was still $20.00. In 1980 it increased to $45.00 and, in 1981 became all but indistinguishable from, and was merged into, the prevailing rate for physicians and psychologists. In 1981, the same charge for all three was $65.00 per hour. As of April, 1982, the UCR allowance for one hour of psychotherapy by a licensed clinical social worker, a physician, and a psychologist was $70.00 per hour. In four years, the social workers' allowance increased 250%. During the same period, the physician's and psychologist's allowance increased 57%. The situation is not unique to Virginia. In 1979, Blue Cross and Blue Shield of Colorado reported that, after having offered a psychiatric social worker benefit, psychiatric social worker fees (then $55.00 to $60.00 per hour) were approaching the level of psychiatrist's fees. Dr. Larson again noted the phenomena in his 1979 mandated benefits report.

At the last session of the Virginia General Assembly, a bill was offered which would mandate a minimum of $1,000 for outpatient treatment of nervous and mental disorders.

In July of this year, the Norfolk Ledger-Star carried in an article about cost over-runs in the CHAMPUS program, including figures reflecting the cost of psychiatric care, which, according to the article, accounted for nearly half the CHAMPUS expenditures in the Tidewater area. During the period 1978 to 1981, the money spent for inpatient psychiatric care increased 163% ($6.7 million to $17.6 million), while the number of admissions rose only 20%. During the same period, the cost of outpatient psychiatric care increased 196 percent from $712,600 to somewhat in excess of $2.1 million. At the very least, the

government's figures raise doubts as to whether the increased utilization of outpatient psychiatric services reduce the need for, and overall cost of, inpatient admissions.

As yet, no one has measured the impact of the increased number of providers entering the health care field. As Dr. Larson points out in his study, health care practitioners are not drawn to underserved areas by the mandate of third-party payment. In point of fact, practitioners may find it profitable to work in over-supplied areas because of the mandate and the resultant increase in the health care consumer's purchasing power. In short, by concentrating facilities and providers in the higher cost areas, mandated coverages may achieve the opposite result from that intended.

ADMINISTRATIVE COSTS

At today's rates, the cost to mail one piece of paper describing a newly added benefit or amending all individual and group subscriber's contracts is $_____. Add to this the cost of modifying automated claims systems, hiring and training new staff, printing promotional material and claims forms, advising and training facility and provider staffs, and insuring that policies, certificates, and contracts for newly enrolled subscribers and groups are filed with the regulatory authorities and available for use on the effective date of coverage. In most instances, a carrier will allow from six months to a year to design, evaluate, and bring a major new product on-line. In many cases, it has been the practice in Virginia to enact a mandated benefit in February or March and to make it effective the July 1st immediately following. Time, effort, and cost are compressed into a very few months, none of which, in most cases, had been anticipated or allocated for in the quarter in which expended. No one has yet put a figure on the total cost of diverting resources to field a mandated benefit nor has anyone

measured the cost of decreased responsiveness to customers, and providers, other needs during the period immediately before and after a benefit of this nature becomes effective. It is clear, however, that, as with the employer, increased administrative cost to bring a mandated benefit (or annual series of benefits) into being is a cost of doing business, both to the insurer and the group, in a mandated benefits state.

V. CONCLUSIONS

Blue Cross and Blue Shield of Virginia believe that mandated benefits cost the group, the subscriber, and the Plan a great deal of money. The Plan endorses the reasoned approach to mandated benefit legislation endorsed by the Insurance Association of Connecticut in its October 23, 1980, report to the Connecticut General Assembly (a copy of which has been previously furnished the study commission members). In addition, the Plan proposes for the joint study commission's review the following:

1. The study commission endorse Virginia Code Section 38.1-348.48 whereby future mandated benefits will be made available for purchase at the group's option.
2. The study commission recommend to the General Assembly that, for the purposes of Virginia Code Section 38.1-348.14, group coverage be defined to mean group's of 50 or more subscribers or policyholders, or such other number as the carrier may use to rate a group or its own health care experience.
3. Mandated benefits for non-group subscribers and subscribers in groups of 50 or less, where in either case, they are individually or community-rated, be made available at the carrier's option.

4. The study commission recommends to the General Assembly that any mandated benefits legislation introduced into the General Assembly be accomplished by an "economic impact analysis" as to the expected cost of the benefit and its impact on health care cost as a whole.

5. The study commission recommends that, except where enacted as emergency legislation pursuant to the rules of the General Assembly, no new mandated benefits legislation be made effective sooner than one year from the date of enactment.

Case Study #1 - Inpatient Psychiatric Benefits

Legislature mandated 30 days of inpatient care - 1976

Supposition: Inpatient days/1000 participants and average daily charges have increased dramatically since that time; as a result, total claims payments for psychiatric care have increased substantially.

I. Covered Charges (Total Plan)

	General Acute Hospitals	Private Psychiatric Hospitals
1976	$ 126,144,998	$ 7,415,755
1977	143,882,456	7,423,643
1978	159,958,652	8,225,300
1979	194,909,659	8,420,327
1980	235,449,861	12,741,396
1981	277,484,700	17,245,776
*1982	299,831,920	19,428,958

*(6 months annualized)

% Change 1976 - 1982	+ 137.69%	+ 162.00%
Compound Annual % Change	+ 15.52%	+ 17.41%

The magnitude of growth in covered charges for psychiatric hospitals was 24.3% more than that of general acute hospitals for the same six year period. This faster growth rate for payments to psychiatric facilities could have resulted from two factors:

The average covered charges/day grew faster than at general acutes or the inpatient days per 1000 covered subscribers (participants) grew faster, or a combination of both.

The next two tables show these two factors over the 1976 - 1982 period.

II. Average Covered Charge Per Day:

	General Acute Hospitals	Psychiatric Private Hospitals
1976	$ 145.42	$ 112.53
1977	169.00	123.65
1978	195.99	143.38
1979	226.58	171.56
1980	264.97	195.28
1981	315.68	247.78
*1982 (YTD)	362.92	270.43
% Change 1976 - 1982	+ 149.57%	+ 140.32%
Compund Annual % Change	+ 16.47%	+ 15.73%

The growth rate in average per day covered charges for psychiatric hospitals is only slightly under that of general acute hospitals. Therefore, patient day costs at psychiatric hospitals are not accountable for the larger % increase in total claims payments to those facilities.

Next, we will examine total patient days paid, which combined with average covered charges per day, result in total covered charges paid.

III. Total Inpatient Days Paid:

	General Acute	Psychiatric (Pvt.)
1976	867,463	65,900
1977	851,380	60,037
1978	816,178	57,369
1979	860,213	49,619
1980	888,590	65,248
1981	878,997	69,602
1982 YTD Annualized	826,170	71,844
% Change 1976 - 1982	- 4.76%	+ 9.02%
Compound Annual % Change	- 0.81%	+ 1.45%

Despite the fact that inpatient days paid for both types of hospitals have gone up and down over the period, 1982 figures show that general acute days reduced significantly where psychiatric days increased significantly since 1979.

Total inpatient days is not the most precise way to examine utilization, however, because participant growth or reduction is not reflected. Therefore, we should look at inpatient days per 1000 participants shown on the next page.

IV. Inpatient days per 1000 Plan Participants reflect both the admission rate and the length of stay. It is the ultimate utilization indicator.

	General Acute Hospitals	Psychiatric Private Hospitals
1976	642.53	48.81
1977	618.33	43.60
1978	570.18	40.08
1979	569.18	32.83
1980	572.85	42.06
1981	570.94	45.21
1982 (YTD) Annualized	538.43	46.82
% Change 1976 - 1982	- 16.2%	- 4.1%
Compound Annual % change	- 2.9%	- 0.69%

The days/1000 rate for general acute hospitals was reduced significantly over the six year time period; a compound annual reduction of almost 3% per year, primarily because of reduction in lengths of stay.

Psychiatric hospitals, however, have not matched this decrease. Days/1000 were only reduced 4% over the entire period, or at a compound annual rate of less than 1% per year. There is no incentive to reduce lengths of stay for psychiatric care because benefits are mandated at 30 day levels.

Conclusion: The more rapid rise in total covered charges for psychiatric hospitals compared to general acutes is due primarily to the patient days/1000 rates for psychiatric not having been reduced to the same extent as those for general acutes. The mandated 30 day benefits provide a negative incentive to reduce days of care.

Case study #2: Clinical Social Worker (Psych)

Legislature mandated make available LCSW coverage effective 7/1/79

Supposition: LCSW charges for 1 hour o/p psychotherapy have increased at a greater rate than psychiatrist/psychologist charges for the same services since 7/79. LCSW charges now approximate those of psychiatrists/psychologists.

UCK is based on charges of all providers in a given specialty for a given type of service. UCK is set to pay at the 90th percentile of all charges submitted for a given service.

UCK level history for LCSW and psychiatrist/psychologists for 1 hour psycho therapy 1978 to present, below:

1 hr psycho	LCSW	Psychiatrist/Psychol.
4/1978	$ 20.00	$ 45.00
4/1979	$ 20.00	$ 49.00
6/1980	$ 45.00	$ 60.00
4/1981	$ 65.00	$ 65.00
4/1982	$ 70.50	$ 70.50
% change 78-82	+252.50%	+56.67%
compared annual % change	+ 37.02%	+11.88%

By 1980, charges submitted from LCSW had reached the same level as those for psychiatrists/psychologists, and therefore, the two UCR's were merged for these 2 disciplines.

Conclusion: The rise in charges & UCR for LCSW psycho therapy was significantly greater than that for psychiatrists/psychologists. By 1980 (April) charges for the 2 disciplines had reached the same level, and thus became indistinguishable from each other. Therefore, the premise that LCSW would/could render services at a more cost effective level over time has not proved to be true.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA

MANDATED BENEFITS

MANDATED COVERAGE	STATUTE	DESCRIPTION	PERTAINS TO:	MONTHLY COST PER CONTRACT
NERVOUS & MENTAL: INPATIENT	38.1-348.7A.	Mandates inpatient nervous and mental benefits on terms no less restrictive than for any other illness, except that benefits may be limited to 30 days in a contract year. Treatment for alcohol and drug abuse may be further limited to $80 per day and 90 days in a lifetime.	All individual and group contracts	Sub. Only .46 Sub. & Fam. 1.58
NEWBORN COVERAGE	38.1-348.6	Mandates benefits for newborns from moment of birth under family coverages; permits subscribers under other types of coverage 31 days within which to enroll the newborn.	All individual and group contracts	Not rated separately
DEPENDENT CHILDREN	38.1-348.1	Mandates continuation of coverage of dependent child who is incapable of self-support because of mental retardation or physical handicap under subscriber's/parent's contract.	All individual and group contracts	Not rated separately
VICTIMS OF RAPE OR INCEST	38.1-348.13	Mandates coverage for pregnancy which results from rape or incest under the accidental injury provisions of the contract.	All individual and group contracts	Sub. Only negligible Sub. & Fam. negligible
PRACTITIONERS OTHER THAN PHYSICIANS:	38.1-824	Mandates payment of benefits for covered services rendered by certain licensed providers.	All individual and group contracts	Sub. Only .38 Sub. & Fam. .92
(PODIATRISTS (CHIROPODISTS (OPTOMETRISTS (OPTICIANS				Sub. Only .04 Sub. & Fam. .10
PSYCHOLOGISTS				Sub. Only .12 Sub. & Fam. .26
CLINICAL SOCIAL WORKERS			Groups and individuals electing coverage	Sub. Only .22 Sub. & Fam. .56
DENTIST	38.1-348.5			Not rated separately

BLUE CROSS AND BLUE SHIELD OF VIRGINIA

MANDATED BENEFITS

MANDATED COVERAGE	STATUTE	DESCRIPTION	PERTAINS TO:	MONTHLY COST PER CONTRACT
DEDUCTIBLE AND COINSURANCE OPTIONS:	38.1-348.12	Mandates offer of one or more of 3 cost-sharing coverages.	All individual and group contracts	
-$100 Deductible;				Sub. Only ($4.04) Sub. & Fam. ($8.62)
-$20% of first $1,000; and				
-$100 Deductible and 20% of next $1,000.				
CONVERSION PRIVILEGES	38.1-348.11	Mandates offer of either non-group coverage or 90-day coverage after termination of individual coverage; group may select which option to offer.	All group contracts	Not rated separately
COORDINATION OF BENEFITS: NON-GROUP CONTRACTS	38.1-348.10	Prohibits coordination of benefits between group contract and non-group contracts.	All group contracts	Not rated separately
MANDATED COVERAGES MADE OPTIONAL	38.1-348.14	Benefits mandated after 7/1/82 shall be optional to group.	All group contracts	No data
NERVOUS & MENTAL: OUTPATIENT	38.1-348.7B.	Mandates benefits for outpatient treatment of nervous or mental disorders including alcohol and drug abuse rehabilitation. Benefit may be limited to $1,000 per calendar year; coinsurance may be limited to 50%.	Groups electing coverage	Sub. Only .38 Sub. & Fam. .96
ALCOHOL AND DRUG DEPENDENCE	38.1-348.8	Mandates 45 days of inpatient care and 45 outpatient sessions per contract year. (Group not required to comply with alcohol and drug abuse mandate in 38.1-348.7, if this option elected).	Groups electing coverage	Rated on individual group experience

BLUE CROSS AND BLUE SHIELD OF VIRGINIA

MANDATED BENEFITS

MANDATED COVERAGE	STATUTE	DESCRIPTION	PERTAINS TO:	MONTHLY COST PER CONTRACT
OBSTETRICAL SERVICES	38.1-348.9	Mandates inpatient obstetrical coverage on terms no less restrictive than any other illness.	Group electing coverage	Sub. Only 1.63 Sub. & Fam. 14.53*

*Rates are for subscriber and spouse of subscriber; add $.84 to family rate for all female dependents under contract.

APPENDIX VII

STATEMENT OF
AMERICAN COUNCIL OF LIFE INSURANCE
AND
HEALTH INSURANCE ASSOCIATION OF AMERICA

JOINT SUBCOMMITTEE MEETING

OCTOBER 18, 1982

The American Council of Life Insurance and the Health Insurance Association of America are the trade associations of the life and health insurance industry. This joint statement is made on behalf of our member companies.

The private health insurance industry through the years has consistently revised and updated the health insurance coverages it offers. It is in favor of improved benefit packages for employees and has worked with employers to improve their health care plans. The health insurance industry believes, however, that mandated benefits will only further contribute to the already burdensome inflationary spiral plaguing the existing health care system.

While mandated benefit laws may have been effective in promoting the services and protecting the financial interests of certain health care providers, they have had the negative effect of limiting the flexibility of employers and unions in choosing the mix of health care coverage to be provided by employee benefit plans. These laws have required employers and unions to purchase unwanted and unneeded coverages, thereby contributing to the increased cost of the health insurance plan and reducing the number of dollars available for other more desired benefits.

The health insurance industry has consistently opposed mandated health insurance laws on economic grounds. Coverage that is required by state law but unwanted by the insurance purchaser unnecessarily and unreasonably increases the cost of insurance to all insureds and increases the likelihood that a purchaser will buy no health insurance at all rather than bear the cost of unwanted coverages. When an employer or union chooses not to purchase health insurance, it is not only the insurance industry that suffers. Employees and union members suffer because uninsured health benefits are inherently less secure, particularly in times of economic recession.

For these reasons the industry contends that prospective purchasers of employee benefit plans should not be forced to choose between submitting to state mandated benefit laws and leaving the desired benefits uninsured.

OVERVIEW

Traditionally, insurers have determined the level of coverage they would offer to the public. This determination was based on what the market demanded and what could be soundly underwritten. Over the past several years legislatures have been injecting themselves into this decision-making process by mandating various forms of additional health insurance coverage. These requirements fall into three categories: first, those which mandate additional benefits or expansion of existing coverage; second, those which mandate the types of practitioners to be reimbursed and third, those which mandate the conditions of sale of the policy. This legislative activity has been accelerating rapidly.

It is instructive to review some of the causes for the escalation of these legislative initiatives. First, private health insurance coverage contains some unacceptable gaps. Second, society's concept of health has been expanding. Third, society has altered its opinion of its responsibility concerning individual risks that should be minimized through public or private insurance. Fourth, mandating expanded insurance coverage in the private sector has proved to be a useful means of shifting the service and cost for certain health related problems away from public programs. Finally, the continually expanding number of both licensed practitioners and type of licenses has contributed significantly to the increase in legislative initiatives.

Health insurers' opposition to enactment of mandated benefits is based on sound business reasoning. Mandated benefits tend to increase cost. They result in higher rates of utilization, contribute to the use of more expensive services rather than the substitution of less expensive and equally effective ones, and lead to a greater use of expensive technology. These demand pressures lead to higher prices, which in turn lead to the need for more protection--and thus to higher premiums and out-of-pocket expenses.

Non-physician professionals argue that their contribution cannot be maximized until insurers pay them directly without their services' being ordered or supervised by a physician. They contend this will improve the distribution of health manpower and reduce costs. Research and experience have shown

that these desirable effects are not always realized. Insurers are presently reluctant to reimburse new types of health care providers directly because there are no clearly defined standards of review for either the impairment classifications or the treatment modes selected for various diagnoses.

ERISA PREEMPTION

Section 514 of the Employee Retirement Income Security Act preempts state laws which relate to an employee benefit plan, but it does not preempt state laws which regulate insurance.

Courts have consistently interpreted ERISA as prohibiting state regulation of self-funded or self-insured plans. Dawson v. Whaland, 529 F.Supp. 626 (D.N.H.) 1982); General Split Corporation v. Mitchell,523 F. Supp. 427 (E.D. Wisc. 1981); St. Paul Electrical Workers Welfare Fund v. Markman, 490 F.Supp. 931 (D. Minn. 1980); Hewlett-Packard Company v. Barnes, 425 F.Supp. 1294 (N.D.Cal. 1977).

One of the ironies of enacting mandated benefit laws is that they encourage employers to reject insurance and to provide self-funded plans to their employees, thereby freeing themselves from such laws by means of the ERISA preemption. In this way, rather than creating more protection for employees, mandated health benefit laws may actually cause less.

COST IMPACT OF MANDATED BENEFITS

The impact of mandated benefits on premium costs and overall health care expenditures seems to have had no real effect on the decision-making process thus far. The reason may be that the addition to the monthly premium expense appears to be small. These

additional expenses become more significant when multiplied by the number of insureds and compounded by the number of new mandated benefits.

In Maryland the Economic Matters Committee of the State Legislature studied the cost impact of eighteen health insurance benefits mandated over the past ten years. After reviewing the data, the Committee concluded:

> "It appears from the data in the Blue Cross-Blue Shield Report that the mandated coverages passed by the Legislature in the last decade may have increased the cost of health care to the health insurance policyholder without necessarily improving the quality of where a health service is added as a benefit paid by insurance, the incidence of the unnecessary utilization of that service may increase. The Committee questions the ability of the average policyholder to afford these mandated coverages when one considers that there is doubt as to whether his health has been improved."

The Maryland Blue Cross Plan calculated that the eighteen benefits increased subscribers' premium costs by approximately $23.3 million per year. When the premium cost for the purchase of mandated optional benefits is added, the additional cost to subscribers is approximately $39 million per year. The actual impact on Maryland citizens is even greater when the cost to those covered by commercial insurers is factored into the total cost of providing these benefits. Despite the study the Maryland Legislature has disregarded the findings and has continued to enact mandated benefits.

Most of the cost of the predominant form of health insurance, group, is borne by employers. The net effect of mandating increased coverage is to increase the employers' cost of doing business in the Commonwealth.

The summary of key findings and conclusions contained in Dr. Larson's 1979 Report to the Bureau of Insurance indicated that the direct results of mandated benefits are increases in the price and in the level of utilization of covered health care services. He expressed concern that legislative intervention will start "a pernicious cycle which in the long run penalizes the disadvantaged groups which proponents purport to be helping." He notes that just because mandated benefits result in increased use and may lead to an enriched product or service, it does not necessarily mean people will receive better care or gain improved access to needed health care services. Dr. Larson observed that the dramatic impact on consumer spending is not apparent because the cost impact of each piece of mandated benefit legislation to each insured is quite small.

Consumers expect the cost of protection, the premium, to be at a reasonable level. Health care costs become unreasonable when they reach a level where the consumer must sacrifice the consumption of other goods and services. As the amount of insurance protection approaches absolute financial security, the cost of protection becomes exhorbitant.

CONSUMER AWARENESS

Proponents of mandated benefits maintain that consumers are not aware of the coverages afforded them. Nor, they say, are consumers aware of services which are not covered. These contentions are unfounded.

Consumers covered by individual insurance receive a readable policy clearly explaining what is and what isn't covered. Each participant in a group insurance program is provided a certificate or benefits booklet which describes the coverage provided and exclusions. In many instances the employer has a benefits person in the personnel department who advises and answers employee inquiries daily. The group insurance policy is available for inspection during regular business hours. Employees who are covered by employer plans subject to ERISA are also provided with summary plan descriptions.

ACTIVITY IN VIRGINIA

The subject of mandated benefits is not a novel one to the Commonwealth. The topic has been the subject of extensive debate over the last several years and these deliberations have consistently resulted in the conclusion that mandated benefits are costly and lead to overutilization.

In its 1982 report to the Governor and General Assembly (Senate Document No. 25), the Commission to Study the Containment of Health Care Costs recommended "that the Commonwealth repeal the state mandated insurance provisions." This recommendation was made after a careful study of the issues. The Commission considered comments and testimony from a number of witnesses. Dr. Karen Davis, a nationally known health care economist and professor of Health Services Administration at Johns Hopkins University, recommended changing the laws to enable the employer to choose the insurance plan that is most appropriate for his employees rather than

requiring the employer to purchase costly options. The Commission also considered the trend to self-insurance and to avoid state-mandated benefits and premium tax.

While Commissioner Thompson dissented in part from the recommendation of the majority, his dissent was based on the wording being "too inclusive since it relates to policy provisions other than specific benefits...." He suggested that the recommendation be reworded. In their dissent in part to the report, several legislators specifically acknowledged that "undoubtedly" state-mandated benefits have served to increase the costs and use of services.

In addition to the cost containment Commission's report, the Bureau has its own report, mentioned earlier, which was prepared by Professor John Larson. In his report, Professor Larson noted that mandated benefits result in "an increase in price and the level of utilization of covered health care services." One of his conclusions was that "The General Assembly of Virginia should temporarily, if not permanently, place a moratorium on mandating additional benefits or coverage in health insurance policies."

In 1982 the General Assembly enacted Section 38.1-348.14 which requires that coverages mandated (sic) after July 1, 1982 be optional. It is the legislature's prerogative to change its mind, but some might view any action promoting mandating benefits inconsistent with past legislative policy.

MAKE AVAILABLE AS AN OPTION

As Dr. Larson indicated in his report many states are altering their approach to mandated benefits by requiring that the insurer make available a particular benefit as an option. Opponents of that alternative suggest that this approach is the same as not enacting a requirement or repealing existing requirements. Evidently they believe the offer or notice of availability is never made by the insurer. Failure to make an offer or give notice of availability is subject to penalty as is violation of any other requirement of the insurance code. They may argue that this requires policing and is too great a burden to place on the Bureau of Insurance.

This concern may be alleviated by requiring a written rejection of the offer to provide a mandated benefit. A written rejection by the group policyholder is evidence that the offer to make available a benefit was made. While this suggestion seems logical, it does increase the administrative burden on the insurer and, in view of the existing penalty provisions in the insurance code, it is not necessary to encourage compliance by insurers.

The requirement to make available coverages instead of mandating them is consistent with a judicious review of the issue by the legislature and places the decision for coverage where it belongs, squarely before the employer-purchaser.

THE NEED TO MANDATE

The minutes of the Subcommittee's meeting held on August 25, 1982 reflect testimony that "consumers tend to be apathetic

regarding the mandated benefits issue...." In this day of the enlightened consumer and his many champions, it is unlikely that apathy would be evidenced if there were an interest in a given issue. The fact is that coverage is available on a voluntary basis.

Often the focus of this debate is misdirected to the nature of the illness or treatment instead of identifying the true purchaser, the employer, and its costs. Granted the employer is not the purchaser when individual coverage is provided, but it is the employer who bears the brunt of the cost of mandated benefits. Most health insurance is experience rated, so the cost of any new benefit is, quite obviously, passed through to the employer. To the extent funds are needed to pay for these increased costs they are diverted from other employer-sponsored benefits. The collective bargaining process is similarly hampered.

The resulting frustration and costs lead to employer movement to self-insurance. While other factors may contribute to a decision to self-insure, avoidance of the cost of mandated benefits is not an insignificant one. By self-insuring, the employer circumvents the mandated benefits requirements. Unfortunately, employees lose more than mandated benefits. They lose the benefits which arise from a fully insured plan, one which is adequately reserved, one which is regulated by the Commonwealth, and one backed by the quaranty association created by the Legislature.

CONCLUSION

Providers, insurers, and government have an obligation to review the evidence that is available concerning health care and its cost. It is incumbent on providers, insurers and legislators to assess the economic and social impact of their decisions.

Mandated benefits do not provide an efficient contribution to the health care delivery system, and do contribute to a needed cost escalation. Benefits desired by consumers are readily available in a competitive market. If employers seek to avoid mandating benefits through self-funding, protection for employees can be reduced.

APPENDIX VIII

MINUTES

Joint Subcommittee Studying the
Crippled Children's Program and
Mandated Health Insurance Benefits
October 18, 1982
House Room 4 - State Capitol
2:00 p.m.

Present	Absent
William T. Wilson	Willard J. Moody
Linda J. Pasternak	Frederick C. Boucher
Alson H. Smith, Jr.	James M. Thomson
Walter H. Emroch	Stephen S. Perry, Jr.
Gladys B. Keating	
Vincent F. Callahan, Jr.	
Frank D. Hargrove	
Virgil H. Goode, Jr.	
Nathan H. Miller	
James C. Roberts	
George I. Dobbs	

Staff: Hugh P. Fisher, III

The meeting was called to order at 2:00 p.m. by the Chairman, Delegate Wilson. The Chairman stated that the subcommittee's first order of business was to hear presentations relating to the operation of the Crippled Children's Program. He then recognized the meeting's first speaker, Dr. Bedford H. Berrey, Assistant Commissioner of the Office of Health Care Programs for the State Department of Health.

Dr. Berrey read a prepared statement, a copy of which is enclosed.

After Dr. Berrey had finished his presentation, Delegate Wilson asked if the exclusionary clauses referred to in his statement are a major problem now. Willard R. Ferguson,M.D., Director of the Bureau of Crippled Children in the Health Department,responded that the exclusionary clauses are not a big problem now, but could be in the future. He stated that health insurance companies do put the clauses in their policies and contracts; and if the companies were to begin denying coverage to crippled children, the impact on Health Department funds would be significant.

Delegate Wilson asked Dr. Ferguson if he had discussed this matter with Blue Cross and Blue Shield. Dr. Ferguson responded by stating that th Health Department has talked with Blue Cross and Blue Shield regarding the exclusionary clause issue.

In response to another question by Delegate Wilson, Dr. Ferguson stated that if all health insurance companies enforced the exclusionary clauses in their contracts and policies, the Health Department estimates that it would have to pay another $500,000 a year to provide services under the

Crippled Children's Program. Dr. Berrey then stated that his organization would furnish the subcommittee with an analysis of the costs involved in the exclusionary clause issue.

The next speaker was Mr. Robert Treibley, Acting Deputy Director of the Virginia Medical Assistance Program. Mr. Treibley stated that approximately $7.8 million is paid annually by private insurers to Medicaid recipients. Therefore, he said, if exclusionary clauses are enforced, the Commonwealth would have to provide another $7.8 million per year for Medicaid recipients.

The next speaker was Mr. Frank Sutherland, General Counsel for Life of Virginia Co. Mr. Sutherland stated that the key question the subcommittee needs to address is whether the taxpayers of the Commonwealth or the policyholders should pay for the coverage which is subject to exclusionary clauses. He added that his company does not have any cost figures regarding this issue, but he said he could talk to some of the other insurance carriers in an effort to obtain such figures.

The next speaker was Mr. Edwin Soeffing, Counsel for the Health Insurance Association of America. Mr. Soeffing reiterated Mr. Sutherland's contention that what is involved is the basic policy issue of whether the taxpayers or the policyholders should pay for the coverage subject to exclusionary clauses. Delegate Hargrove asked Mr. Soeffing if any state has prohibited the use of exclusionary clauses. Mr. Soeffing replied that he is not aware of any states which have done that.

Delegate Wilson stated that he is bothered by the fact that the clauses are in policies, yet are not enforced. Delegate Wilson continued by stating that if the insurance industry is opposed to a ban on the use of exclusionary clauses, it should send the subcommittee some information. He asked the companies in the industry to send the subcommittee members the information prior to the next meeting.

The next person to testify before the subcommittee was John A. Russell, M.D., Chairman of the Insurance and Peer Review Committee of the Neuropsychiatric Society of Virginia. Dr. Russell summarized an information sheet, a copy of which is attached.

Delegate Wilson asked Dr. Russell if he knows why the exclusionary clauses are not enforced by insurance companies. Dr. Russell replied that he is not sure why, but he suspects they have not been enforced because they have not yet been a financial burden to the companies. R. Dale Hunsaker, M.D., Director of the Health Department's Division of Family Health Services, then stated that the Health Department believes that exclusionary clauses are not being enforced because the insurance companies cannot identify which children are in the Crippled Children's Program. He said he believes that the clauses will be enforced if the companies can find a way to identify which children are in the program.

Mr. Sutherland commented that while the insurance industry has not enforced exclusionary clauses for participants in the Crippled Children's Program, in general the industry has enforced the clauses. He added that use of an exclusionary clause is similar to a coordination of benefits clause, and he further stated that the clause simply provides that benefits will not be provided a person if the person is eligible to receive the same benefits through another organization (such as a governmental body). He stated that, of course, benefits are provided in those cases in which the affected parties do not have coverage through another organization.

Delegate Wilson then commented that next the subcommittee would hear testimony regarding the issue of mandated health insurance benefits, and he urged those parties speaking on that issue to be brief in their remarks.

The first speaker to address the mandated benefits issue was Joe W. King, M.D., representing the Virginia Committee of the National Association of Private Psychiatric Hospitals. Dr. King read a prepared statement, a copy of which is enclosed.

The next person to address the study group was Robert A. Hanson, Vice-President of the Mental Health Association of Virginia. Mr. Hanson read a prepared statement, a copy of which is attached.

The next speaker was Mr. Stephen Capo of the Virginia Association of Community Services Boards. Mr. Capo stated that in the past he has heard the comment that if all the mandated benefits were repealed, employers could make rational decisions regarding the provisions in their health insurance policies. He said that employers cannot make such rational decisions, and he said that as an employer it is very difficult for him to decide what coverages he wants in his policies.

Mr. Capo made available to the subcommittee a paper from the Virginia Association of Mental Health Directors, a copy of which is attached.

The next person to testify was Mr. H. Rick Sampson, Director of Mental Health Services for the Rappahannock Area Community Services Board. Mr. Sampson read a prepared statement, a copy of which is enclosed.

The next speaker was Mrs. Mary A. Marshall, a member of the House of Delegates from Arlington. Mrs. Marshall presented the subcommittee with a proposed amendment to Virginia Code §§ 38.1 - 348.7 and 38.1 - 348.8. A copy of Mrs. Marshall's proposed amendment is enclosed.

Mrs. Marshall explained that presently the law mandates benefits only for inpatient care in cases of mental, emotional, and nervous disorders, including alcoholism and drug dependence. She stated that inpatient treatment for these disorders is much more expensive than outpatient treatment would be. Therefore, she said, her proposal provides for outpatient benefits for those disorders of up to $1,000 per patient in any calendar or policy year.

In response to a question from Delegate Wilson, Delegate Marshall stated that she does not know which organizations are opposed to her proposal. Ms. Pasternak asked Delegate Marshall what was the basis for limiting benefits in cases of alcoholism and drug dependence to $80.00 per day and limiting outpatient treatment benefits to $1,000 per year. Delegate Marshall replied that those figures are in the statutes of many other states. Also, she said that she has been told that many alcoholism treatment centers operate at a charge of $80.00 per day.

The next individual to address the subcommittee was Stuart Ashman, M.D., Medical Director of the Tidewater Psychiatric Institute. Dr. Ashman read excerpts of a prepared statement, and attached to these minutes is a copy of his statement.

The next speaker was Ms. Susan Leone, a licensed professional counselor. Ms. Leone read excerpts of a prepared statement, a copy of which is enclosed.

The next person to address the subcommittee was Mr. Timothy McCarthy of the Virginia Chapter of the National Association of Social Workers. Mr. McCarthy stated that his organization opposes the establishment of a benefit ceiling for inpatient treatment of mental disorders, alcoholism, and drug dependency. However, he said, his organization would not oppose the $1,000 benefit ceiling on outpatient treatment suggested by Delegate Marshall. Mr. McCarthy concluded by stating that the Virginia Chapter of the National Association of Social Workers believes that insurance coverages relating to mental health should not be optional.

Delegate Wilson stated that any person who wishes to furnish material to the subcommittee should both distribute that material to the members prior to the next meeting and bring additional copies to that meeting.

The subcommittee then decided that its next meeting will be held at 10:00 a.m. on December 1 in House Room 4 of the State Capitol.

There being no further business, the meeting was adjourned.

#

APPENDIX IX

COMMONWEALTH of VIRGINIA

Department of Health
Richmond, Va. 23219

JAMES B. KENLEY, M.D.
COMMISSIONER

December 1, 1982

The Honorable William T. Wilson
Chairman, HJR 90 Study Committee
General Assembly of Virginia
Richmond, Virginia 23219

Dear Mr. Wilson:

Enclosed is a copy of a letter from representatives of HIAA and Blue Cross/Blue Shield of Virginia agreeing to the maintenance of a status quo position regarding the administration of exclusionary provisions in hospitalization policies as they pertain to the Health Department's Crippled Children's Program, and the initiation of a further study between those two groups and representatives of this Department to reach a mutually agreeable long-term solution to this problem.

Inasmuch as our situation is not critical at this time and this represents a good faith effort to solve the problem without legislation, we have accepted this agreement and now request that our portion of the HJR 90 study be discontinued.

Sincerely,

James B. Kenley, M. D.
State Health Commissioner

Enclosure

LIFE OF VIRGINIA

LAW DEPARTMENT

November 30, 1982

Dr. James B. Kenley
State Health Commissioner
Department of Health
109 Governor Street
Richmond, VA 23219

Re: HJR 90 - As it relates to Crippled Children's Program

Dear Dr. Kenley:

On behalf of the HIAA Companies and the Blue Cross and Blue Shield plans doing business in Virginia, we are writing to confirm the arrangement we discussed previously with Miss Rebecca Monroe, Staff Assistant of your office.

Specifically, we have agreed to maintain the status quo regarding the administration of the exclusionary provision in our policies pending a mutually agreeable long-term solution, which we will work to develop in the meantime.

In exchange for this undertaking by us, it is our understanding that the Health Department will withdraw its measure to eliminate the exclusionary provision of our policies.

Sincerely,

Francis A. Sutherland, Jr.
State Vice President for the HIAA
(Health Insurance Assoc. of America)

Langhorne H. Smith
Vice President
Corporate Services
Blue Cross - Blue Shield of Virginia

FASjr/crn

LD1175131

APPENDIX X

HOUSE BILL NO. 272

Offered January 25, 1982

A BILL to amend and reenact §§ 38.1-98.1 and 38.1-328 of the Code of Virginia, which regulate the delivery of certain group insurance certificates in Virginia; enforcement of such provisions.

Patron—Wilson

Referred to the Committee on Corporations, Insurance and Banking

---

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.1-98.1 and 38.1-328 of the Code of Virginia are amended and reenacted as follows:

§ 38.1-98.1. Enjoining unlicensed foreign or alien companies from transacting business in State.—Whenever a foreign or alien insurance company not licensed to do an insurance business in this ~~State~~ *Commonwealth* shall engage in any insurance transaction or do any insurance business in this ~~State~~ *Commonwealth* , the Commission shall have jurisdiction and the powers of a court of equity to issue, on its own motion or on motion of any party in interest, temporary or permanent injunctions restraining such insurance company from engaging in any such insurance transaction or business.

For the purposes of this section, the following acts, effected by mail or otherwise, shall constitute the transacting of an insurance business in this ~~State~~ *Commonwealth* : (1) the issuance or delivery of contracts of insurance to residents of this ~~State~~ *Commonwealth* or to corporations authorized to do business therein; (2) the solicitation of applications for such contracts; (3) the collection of premiums, membership fees, assessments or other considerations for such contracts; or (4) the transactions of any other insurance business in connection with such contracts.

Process may be served in accordance with § 13.1-119 ~~of this Code~~ or any other manner prescribed by law.

This section shall not apply to any life insurance or annuity company organized and operated, without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual by issuing insurance and annuity contracts only to or for the benefit of such institutions and individuals engaged in the service of such institutions ; ~~provided~~ . Such company shall be deemed, as to all Virginia policyholders and contract holders, to have appointed the clerk of the Commission its attorney for service of process in Virginia, such appointment to be irrevocable and to bind the company and any successors in interest and to remain in effect as long as there is in force in this ~~State~~ *Commonwealth* any contract made by that company or any obligation arising therefrom ; ~~nor shall~~ . *The provision of* this section *shall not* apply to any insurance or annuity contracts issued by any such life insurance or annuity company ; ~~nor shall it apply~~ *or* to the following acts or transactions: (1) the procuring of a policy of insurance upon a risk within this ~~State~~ *Commonwealth* where the applicant is unable to procure coverage in the open market with a company or companies licensed to do business in this ~~State~~

Commonwealth and is otherwise in compliance with ~~article~~ ~~3.1~~ *Article 5* (§ ~~38.1-314.1~~ *38.1-327.46* et seq.), ~~chapter~~ ~~7~~ *Chapter 7.1* , Title 38.1; (2) contracts of reinsurance; (3) transactions in this ~~State~~ *Commonwealth* involving a policy lawfully solicited, written and delivered outside of this ~~State~~ *Commonwealth* covering only subjects of insurance not resident, located, or to be performed in this ~~State~~ *Commonwealth* at the time of issuance of such policy; (4) transactions in this ~~State~~ *Commonwealth* involving group or blanket insurance and group annuities where the group or blanket policy of such insurance or annuities was lawfully issued and delivered in a state where the company was authorized to transact business *, if the certificates of insurance provided under such group or blanket insurance meet the requirements of § 38.1-328* ; (5) the procuring of contracts of insurance issued to an "industrial insured" as hereinafter defined. For the purposes of this section an "industrial insured" is an insured (a) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer, (b) whose aggregate annual premiums for insurance on all risks total at least ~~twenty-five thousand dollars~~ *$25,000* , and (c) who has at least twenty-five full-time employees

Nothing in this section shall apply to nonprofit Railroad Brotherhood or other similar fraternal organizations.

§ 38.1-328. Scope of chapter.–The provisions of this chapter shall apply to all kinds or classes of insurance except annuities and ocean marine insurance; but such provisions shall not apply to *individual* life insurance policies and *individual* accident and sickness insurance policies, not issued for delivery nor delivered in this ~~State~~ *Commonwealth* , nor to contracts of reinsurance. *Notwithstanding any provisions of this title, certificates of insurance provided to residents of this Commonwealth through group contracts delivered or issued for delivery outside of this Commonwealth shall provide benefits which are reasonable in relation to the premiums charged and shall provide benefits as required by the laws of this Commonwealth unless the Commission determines that certain benefits are not appropriate for the coverage provided. The Commission shall have authority to enforce the provisions of this section under the enforcement provisions of Chapter 1 (§ 38.1-1 et seq.) of this title.*

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

APPENDIX XI

MINUTES

Joint Subcommittee Studying the
Crippled Children's Program and
Mandated Health Insurance Benefits

December 1, 1982

House Room 4 - General Assembly Building

10:00 a.m.

Present	Absent
William T. Wilson	Walter H. Emroch
Linda J. Pasternak	Vincent F. Callahan, Jr.
Alson H. Smith, Jr.	Willard J. Moody
Gladys B. Keating	Frederick C. Boucher
Frank D. Hargrove	Virgil H. Goode, Jr.
James C. Roberts	Nathan H. Miller
Stephen S. Perry, Jr.	James M. Thomson
George I. Dobbs	

Staff: Hugh P. Fisher, III

The meeting was called to order at 10:00 a.m. by the Chairman, Delegate Wilson. The Chairman stated that it appears an agreement has been worked out by the health insurance industry and the State Department of Health regarding the application of exclusionary clauses against participants in the Crippled Children's Program.

The Chairman then read out loud correspondence relating to the agreement. He noted that the agreement provides that

Blue Cross and Blue Shield of Virginia and the Virginia members of the Health Insurance Association of America will not enforce the exclusionary clauses in their policies against participants in the Crippled Children's Program, while the Health Department will not take any action to eliminate exclusionary clauses. The Chairman further stated that the agreement also provides that the interested parties will work to develop a long-term solution to the issue. He indicated that the agreement seems reasonable to him, and he added that the interested parties could report to the subcommittee at a later date concerning their suggested long-term solution.

The Chairman then stated the agreement in the form of a motion, and there was a second to the motion. By a unanimous vote the subcommittee then agreed to support the compromise worked out by the health insurance industry and the Health Department. Enclosed with these minutes is a copy of the correspondence relating to the compromise.

The Chairman then stated that the next item on the subcommittee's agenda involved presentations relating to the issue of mandated health insurance benefits. He stated that Mr. Sumpter Priddy, Executive Director of the Virginia Retail Merchants Association, had approached him prior to the meeting and asked Delegate Wilson to announce that the Virginia Retail Merchants Association is opposed to all mandated benefits.

The Chairman said that the first person to speak before the subcommittee would be Mr. Lee Tait, Vice-President of

the C&P Telephone Company. Mr. Tait read a prepared statement, a copy of which is enclosed.

After Mr. Tait had completed his presentation, Delegate Wilson announced that he had another engagement and would therefore have to leave the meeting. He asked Delegate Smith to serve as Acting Chairman during his absence.

The first speaker recognized by Delegate Smith was John Russell, M.D., a psychiatrist in private practice in Richmond. Dr. Russell stated that he is a consultant for Blue Cross and serves on the Blue Shield Advisory Committee. Dr. Russell made available to the subcommittee members an information sheet, and he summarized that sheet. Attached to these minutes is a copy of Dr. Russell's information sheet.

In reponse to a question by Delegate Smith, Dr. Russell said that there is enough money available for health care, as long as that money is properly used.

Delegate Hargrove asked Dr. Russell if the medical community can police its members so as to prevent the overcharging for services mentioned by Dr. Russell. Dr. Russell replied that presently there is no mechanism by which the medical community can police its members. Delegate Hargrove stated that he does not feel that the Legislature should be put in the position of having to prevent abuses within the medical community. He urged that community to study the problem mentioned by Dr. Russell. In response to a question from Ms. Pasternak, Dr. Russell stated that he is in favor of making treatment for

psychiatric problems mandatory both on a inpatient and outpatient basis.

The next individual to address the subcommittee was Ms. Carol Simms, a licensed professional counselor. Ms. Simms summarized the material she had made available to the subcommittee at its October 18 meeting.

The next speaker was Mr. Craig L. Nuckles, a representative of the Substance Abuse Program Directors of Virginia. Mr. Nuckles read a prepared statement, a copy of which is attached.

The next speaker was Mr. John D. T. Hartman, Jr., a representative of the Mental Health Committee of the Virginia Hospital Association. Mr. Hartman read a prepared statement, a copy of which is attached.

The next individual to address the study group was Joe W. King, M.D., a representative of the Virginia Committee of the National Association of Private Psychiatric Hospitals. Dr. King stated that his organization opposes the repeal of the present mandated benefits statutes. He also said that his organization favors the establishment of some type of study group which would continuously study health care costs. Dr. King added that such a study group could be appointed either by the Legislature or the Governor, and he said it should have representatives of providers, the insurance industry and the public.

The next speaker was Mr. Allen C. Goolsby, III, Council for the Medical Society of Virginia. Mr. Goolsby said that from the standpoint of political philosophy, the Medical

Society is opposed to mandated benefits. He added that his organization believes that each consumer should have the flexibility to purchase the coverages he desires. However, he said, there are two areas in which coverages should be mandated: (1) new born infants, and (2) mental illnesses. Mr. Goolsby continued by stating that if the statutes providing for mandated benefits in the area of mental illness are repealed, most mentally ill persons will be without coverage. He expressed his organization's viewpoint that it is important to provide minimal coverages for mental illness.

The next speaker was Mr. Mark Pinsker, a representative of the Behavioral Sciences Consortium. Mr. Pinsker read a prepared statement, a copy of which is attached.

The next individual to address the subcommittee was Mr. Gene Camp, President of the Virginia Chapter of the Association of Labor-Management Administrators and Consultants on Alcoholism, Inc. Mr. Camp summarized a prepared statement, a copy of which is enclosed.

The next speaker was Ms. Sue Gift, a member of the Greater Richmond Council on Alcoholism and Drug Abuse. Ms. Gift stated that she favors retaining the present mandated benefits in the areas of alcoholism and drug abuse.

The next speaker was Mr. Steve Capo, a representative of the Virginia Association of Community Services Boards. Mr. Capo said that alcoholism is the nation's biggest health problem, and he stated his organization's support for the continuation of mandated coverages in the areas of

alcoholism and drug addiction. Mr. Capo added that if coverage for alcoholism and drug addiction is not mandated, then many alcoholics and drug addicts will not have coverage for those diseases. He concluded by stating that rather than repealing mandated benefits, a better approach would be to establish a study group to conduct a thorough review of the health care system.

The next person to address the study group was Mr. Jonathan M. Murdoch-Kitt, an attorney representing the Virginia Psychological Association and the Virginia Academy of Clinical Psychologists. Mr. Murdoch-Kitt expressed his organizations' support for mandated benefits. He further stated that many provider groups are telling the subcommittee that they favor a freeze on such benefits for the time being, because those groups feel that politically it is not possible now to mandate additional benefits. However, he said, despite their stated support for a freeze, many provider groups actually would encourage an expansion of mandated benefits if they felt that such an expansion was politically possible.

The next speaker was Mr. Charles W. Gunn of the State Department of Mental Health and Mental Retardation. Mr. Gunn stated that mental illness is a very widespread problem in this country and there is a 25% chance that a person will need treatment for mental illness sometime during his lifetime. Mr. Gunn further stated that early intervention often prevents cases of mental illness from becoming more pronounced. He added that his agency favors the

continuation of the present mandated benefits, plus a new mandate providing benefits for outpatient treatment of mental illness. He also stated that his agency would support reasonable caps on mandated benefits. Further, he said, the Department of Mental Health and Mental Retardation believes that such benefits are cost effective.

The next person to address the subcommittee was Mr. Z. C. Dameron of the Virginia Manufacturers Association. Mr. Dameron stated that compared to other states, Virginia has a significant number of mandated benefits. He added that whereas his organization has no problems with mandating coverage for new born infants, it does have some problems with mandating coverage for alcoholism and drug addiction. Mr. Dameron further stated that although his organization does not necessarily want to see the present mandates repealed, it does favor a freeze with regards to additional mandates.

The next person to testify was Mr. Edwin Soeffing, Counsel of the Health Insurance Association of America. Mr. Soeffing noted that his organization submitted a statement during the subcommittee meeting held on October 18, and he said he did not want to repeat what is in that statement. Mr. Soeffing said that the Health Insurance Association of America basically opposes the enactment of mandated benefits, because such benefits increase premium costs and lead many employers to self-insure under the Employee Retirement Income Security Act (ERISA). He further stated that employers are very concerned about spiralling health

care costs, and he said that health care costs must be brought under control. More and more employers, he said, are self-insuring.

Mr. Soeffing then summarized some information he had received from two insurance companies regarding the costs of mandated benefits to those companies. He stated that Mutual of Omaha Insurance Company had furnished him some information regarding the costs to the company of implementing three of Virginia's mandated benefit laws. He said that information was received concerning the cost of implementing mandated coverages for new borns, for mental illness, and for alcoholism and drug abuse. He noted that Mutual of Omaha said it had sent out approximately 15,000 renewal notices or riders concerning mandated coverage for new borns, at a cost of $5,800. For mental illness coverage the company sent out approximately 14,000 renewal notices or riders, at a cost of $5,460. For alcoholism and drug abuse coverage the company sent out about 8,000 renewal notices or riders, at a cost of $4,044. Therefore, he said, the company incurred $15,304 in administrative costs only due to implementing three of Virginia's mandated benefits statutes.

Mr. Soeffing continued by stating that the Aetna Life and Casualty Co. had furnished him information concerning the total extra cost which Virginia's mandated benefit statutes had added to that company's health insurance policies. He said that the total additional cost of Aetna's policies attributable to the Virginia mandates is 6.3% for an employee and 12.7% for an employee's dependents. He

added that the average increase in premium costs attributable to the mandates is 9.5%. Mr. Soeffing concluded by stating that he believes the Aetna figures are conservative, and he added that in actuality the mandates may have resulted in a greater increase in premium costs than the figures reflect.

Attached to these minutes is a copy of correspondence sent to the subcommittee by Mr. Soeffing.

In response to a question from Mr. Dobbs, Mr. Soeffing said that premiums would not necessarily be lowered if the mandated benefits are repealed, because such action would require the companies to send out forms announcing that the mandates have been repealed. In response to a question by Delegate Hargrove, Mr. Soeffing said that the Health Insurance Association of America favors the repeal of all mandated benefits, including those mandated on an optional basis. He added that those coverages mandated on an optional basis are responsible for significantly increasing each company's administrative costs.

The next speaker was Mr. John Boritas of the Metropolitan Life Insurance Co. Mr. Boritas stated that if Virginia was the only state in the country, then his organization would prefer that coverages be mandated on an optional basis. However, he said, Metropolitan's contracts are designed on a national basis. Therefore, he said, even if Virginia should repeal its mandated benefits, his company would still offer the mandates; because other states require them.

In response to a question from Delegate Smith, Mr. Boritas said that Metropolitan has learned to live with Virginia's mandates. However, he said, there is a definite trend among employers to self-insure. He added that each additional mandate creates a greater incentive for a large, national company to self-insure.

In response to a question from Delegate Keating, Mr. Boritas stated that he would guess that compared to other states, Virginia ranks in the middle in terms of the number of mandated benefits.

The next individual to address the subcommittee was Mr. J. Maurice Miller of the Richmond law firm of Mays, Valentine, Davenport and Moore. Mr. Miller stated that although his client, the Aetna Life Insurance Company, would prefer not to have any mandates, the insurance industry has, for the most part, learned to live with them. He added that there has been an increasing trend to self-insure as more mandates have been added.

Mr. Miller continued by stating that his company in particular, and the insurance industry in general, are opposed to House Bill No. 272 of 1982, which is another issue the subcommittee has been charged with studying. Mr. Miller then made available to the subcommittee members and summarized a statement regarding Aetna's position on House Bill No. 272. A copy of that statement is attached to these minutes.

The next person to address the subcommittee was Mr. Philip S. Marstiller, an attorney for the Richmond firm of

Thomas & Fiske. Mr. Marstiller explained that he was representing Blue Cross and Blue Shield of Virginia. Mr. Marstiller began by referring to the position paper dated October 15, 1982, which he had submitted during the subcommittee meeting of October 18. He expressed his client's oppostion to House Bill No. 272, and he stated the arguments against that legislation which are listed in the October 15 position paper.

Mr. Marstiller also stated that mandated benefits unnecessarily increase health care costs, and he cited some examples which he said proved that point.

Mr. Marstiller cited several examples which are discussed in the paper distributed by Blue Cross and Blue Shield during the October 18 subcommittee meeting. Those examples deal with the number of licensed and certified substance abuse treatment beds in Virginia, the fees charged by licensed clinical social workers, and alleged abuses in the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS).

Mr. Marstiller also stated that in 1975 in Massachusetts, Blue Cross and Blue Shield paid $15 million for inpatient psychiatric care and $2 millon for outpatient care. In 1976, he said, benefits for psychiatric care were mandated. In 1981 in Massachusetts, he said, Blue Cross and Blue Shield paid over $46 million for inpatient psychiatric care and $38 million for outpatient care.

Mr. Marstiller further stated that in 1979 the Virginia General Assembly mandated coverage for alcoholism treatment.

During that year, he said, the average length of stay in a psychiatric hospital for alcoholism treatment was 12.8 days for Blue Cross and Blue Shield subscribers. For 1980 the average length of stay was 20.5 days, which represented approximately a 60% increase over the previous year's figure. Mr. Marstiller said that the availability of mandated coverage, not the medical needs of patients, accounted for that increase.

Mr. Marstiller continued by stating that in 1978 the average charge per day by alcoholism treatment facilities in Virginia was $60. In 1979, the year in which coverage for alcoholism treatment was mandated, the average charge per day rose to $115. And, Mr. Marstiller said, in 1980 the average charge per day was $170.

He also stated that in 1979 Blue Cross and Blue Shield of Virginia developed psychiatric payment guidelines in which the company said it would cover the condition of potential suicide. He said that after the guidelines were published, there was an increase of several hundred percent in the number of persons diagnosed as potential suicides.

The next speaker was Mr. Francis A. Sutherland, Jr., General Counsel of Life of Virginia Co. Mr. Sutherland stated that since his company sells insurance in all states, different mandated benefits in each state make the design and sale of policies very confusing. He also stated that although his company is opposed to all mandated benefits, it would prefer that any mandates in the State Code be in the form of options.

The next individual to address the study group was Mr. Stephen J. Kaufmann, Deputy Commissioner for Regulatory Policy for the State Bureau of Insurance. Mr. Kaufmann stated that in regards to House Bill No. 272, the Bureau of Insurance believes that if the subcommittee recommends the retention of mandated benefits, then it should consider whether all Virginia residents should be entitled to the mandated coverages. He further said that it is the view of the Bureau of Insurance that all Virginians should be treated equally with respect to mandated coverages.

Delegate Smith, the Acting Chairman, then stated that the subcommittee has heard sufficient testimony regarding the mandated benefits issue, and there is no need for persons interested in that issue to attend the subcommittee's next meeting. He added that the study group did need to receive additional testimony regarding House Bill No. 272.

The subcommittee then agreed that it should meet again for the purposes of hearing testimony concerning House Bill No. 272 and formulating its recommendations.

There being no further business, the meeting was adjourned.

#

APPENDIX XII

Statement of The Life Insurance Company of Virginia
to the Joint Subcommittee under House Joint Resolution No. 90

House Bill No. 272 which was introduced in the 1982 Session of the General Assembly purports to apply Virginia's mandated benefits to certificateholders insured under group health policies delivered outside of Virginia. As a general rule, group insurance contracts have been written to comply with the laws of the state in which the contract is delivered to the policyholder. When a state attempts to apply its mandated benefits to its residents who are insured under a contract issued to a group policyholder in another state, the effect is extraterritorial extension of mandated benefits.

The Life Insurance Company of Virginia is opposed to extraterritorial application of state mandated health benefits for a number of reasons:

1. If an insurance company must write group insurance plans which comply with the mandates in each state where there are certificateholders, that plan becomes very difficult to administer.
2. The economy of scale and cost savings inherent in group plans is diminished and the premium cost is increased.
3. There is a lack of uniformity when different mandates are applied state by state. An employer wants to provide all employees with consistent uniform benefits regardless of where the employee is located.

4. The Life Insurance Company of Virginia feels that a group policyholder should be able to choose freely whatever benefit plan is appropriate according to its needs and ability to pay the premiums.

When cost of insurance and the administrative problems of complying with conflicting state laws become too burdensome, then employers either terminate the benefit plan or turn to self-insurance. Self-insurance results in a loss of premium tax income and lack of regulatory control over the benefit plan.

We believe and respectfully submit that extraterritorial application of state mandated group health benefits is unwise and unjustified.

The Life Insurance Company of Virginia

Francis A. Sutherland, Jr.
General Counsel

APPENDIX XIII

Minutes
Joint Subcommittee Studying the
Crippled Children's Program and
Mandated Health Insurance Benefits
December 28, 1982
House Room 4 - State Capitol
10:00 a.m.

Present	Absent
William T. Wilson	Walter H. Emroch
Linda J. Pasternak	Willard J. Moody
Alson H. Smith, Jr.	Nathan H. Miller
Gladys B. Keating	Frederick C. Boucher
Vincent F. Callahan, Jr.	George I. Dobbs
Frank D. Hargrove	
Virgil H. Goode, Jr.	
Steven S. Perry, Jr.	
James C. Roberts	
James M. Thomson	

Staff: Hugh P. Fisher, III

The meeting was called to order at 10:00 a.m. by the Chairman, Delegate Wilson. The Chairman stated that this probably would be the subcommittee's final meeting, and he added that the primary purpose of the meeting would be to consider the issues relating to House Bill No. 272 of 1982. He said the legislation provides that certificates of insurance provided to residents of the Commonwealth through group contracts delivered or issued for delivery outside the Commonwealth shall provide any benefits required by Virginia law unless the State Corporation Commission determines that certain benefits are not appropriate for the coverage provided. Attached is a copy of House Bill 272 of 1982.

The Chairman then recognized the meeting's first speaker, Mr. Stephen J. Kaufmann, Deputy Commissioner of Regulatory Policy for the State Bureau of Insurance. Mr. Kaufmann said that the following scenario sometimes occurs under the present law: a person goes to a doctor's office or a hospital to be treated. The physician assumes

the patient is covered under the Virginia mandated benefit statutes. However, when the physician submits a bill to the insurance company or employer (if self insured), he is not reimbursed for his services due to the fact that the employee is covered under a policy issued out-of-state and is thereby not subject to Virginia's mandated benefit laws. Mr. Kaufmann stated that such a situation upsets the physician and frustrates the employee, because it was assumed the employee had coverage. House Bill No. 272, he said, was introduced to help eliminate this problem and to ensure that all Virginia residents are entitled to the mandated benefits.

Mr. Kaufmann continued by stating that the Bureau of Insurance does not have a position concerning the issue of whether the Commonwealth should have mandated benefits. However, he said, it is the position of the Bureau that if the General Assembly decides to retain the present mandates, then all Virginia residents should be covered under them.

The Chairman asked if a similar law is in effect with respect to automobile insurance. Mr. Kaufmann said that no such law is in effect with respect to automobile insurance. However, he said, the vast majority of automobile policies are individual rather than group policies.

Senator Goode commented that he likes the idea behind H.B. 272, but he questioned whether such a law would be legal.

Mr. Roberts said there would be chaos if all fifty states passed a law similar to H.B. 272. Mr. Kaufmann stated that for ten years he

was a compliance officer for an insurance company. He said that with the aid of computer technology a company could cope with the passage of such a law in all fifty states. He said there is no question that the enactment of such a law might result in premium increases. However, he added, the Bureau of Insurance feels that insurers definitely could cope with the laws.

Delegate Smith asked if there are any states without mandated benefits. Mr. Kaufmann replied that four or five states have very few or no mandates, and he stated that Alabama, Rhode Island and Tennessee are three such states. He added that the insurance company he used to work for would try to get as many policies as possible written in those states, because policies issued in them are less expensive.

Mr. Kaufmann continued by stating that his office has rewritten H.B. 272 and condensed it into one paragraph. Enclosed is a copy of the rewritten bill.

Delegate Hargrove commented that in his opinion the insurance industry would not have substantial difficulty responding to a law such as H.B. 272. He further stated that computer technology makes it possible for the industry to deal with such a law with little difficulty.

The Chairman then recognized the next speaker, Mr. J. Maurice Miller, Jr., a Richmond attorney representing the Aetna Life & Casualty Co. Mr. Miller stated that legislation such as H.B. 272 would gum up the process of issuing insurance. He added that group health insurance always has been based on an employer's location and the state where the policy is issued. H.B. 272, he said, would change the entire health

insurance system and make Virginia totally different from the other states. He added that one thing that bothers him is that no statistics showing the extent of the problem have been furnished the subcommittee.

Mr. Miller continued by stating that he used to work for an insurnce company and he saw very few cases in which a Virginia resident was denied coverage because that resident was covered under a policy issued from outside the Commonwealth. He added that he worked in the industry for twenty-five years, and he knew of fewer than five such cases. Mr. Miller further stated that in his opinion there would also be a possible constitutional problem related to legislation such as H.B. 272. He questioned whether it would be constitutional for Virginia to dictate what coverages insurance companies in other states must include in their policies in order to insure Virginia residents.

Senator Goode asked what other states have enacted legislation similar to H.B. 272. Mr. Kaufmann replied that four or five states have enacted such legislation, including New Hampshire, Texas and Florida. In response to another question from Senator Goode, Mr. Kaufmann said that no court cases have resulted yet from the laws in those states.

Delegate Wilson said the subcommittee needs to determine the scope of the problem, and he asked Mr. Kaufmann how many complaints the Bureau of Insurance has received from persons who have been denied coverage due to the fact that they have been covered under a policy issued from outside the State. Mr. Kaufmann replied that the Bureau receives only one or two dozen complaints a year regarding that issue.

However, he said, this is not an issue that will generate a lot of hostility, and he added that most persons would not file a complaint over such a situation.

The next person to address the subcommittee was Mr. Francis A. Sutherland, Jr., General Counsel of the Life Insurance Company of Virginia. Mr. Sutherland made a statement available to the subcommittee, and he summarized that statement. Attached is a copy of his statement.

In response to a question from the Chairman, Mr. Kaufmann stated that many employers are forming multiple employer trusts, which are totally unregulated. He added that the number of these trusts is increasing at a rapid rate in the Commonwealth.

Mr. James M. Thomson, Commissioner of Insurance for the Commonwealth, then stated that the Bureau of Insurance will contact the four or five states with a law similar to H.B. 272 and obtain information regarding the effects of such a law.

The next individual to address the subcommittee was Mr. Jonathan M. Murdoch-Kitt, a Richmond attorney representing the Virginia Psychological Association and the Virginia Academy of Clinical Psychologists. Mr. Murdoch-Kitt stated that his organizations favor both mandated benefits in general and the contents of House Bill 272 in particular. He added that his organizations see nothing wrong in allowing any Virginia resident to be covered under the Commonwealth's mandated benefit statutes.

In response to an inquiry from the subcommittee, Mr. Thomson stated that his office will obtain information regarding the number of multiple employer trusts in the Commonwealth.

The next speaker was Mr. Z. C. Dameron, President of the Virginia Manufacturers Association. Mr. Dameron stated that he is concerned about the effect on premiums of enacting a bill similar to H.B. 272. He added that the insurance industry would need to do more than just change its computer programming in order to respond to such legislation. He added that if legislation similar to H.B. 272 is enacted in numerous states, he is afraid that health insurers will include in their policies all of the mandated benefits of the state with the greatest number of mandates. Since Virginia has fewer mandated benefits than many states, he said, this would result in an increase in premiums for health insurance coverage in the State.

Mr. Roberts then stated that in his opinion House Bill No. 272 is unconstitutional.

The Chairman then asked the subcommittee members what action they wished to take in regards to the contents of H.B. No. 272 and the issue of mandated health insurance benefits. Several members stated that the lack of data regarding the effects of enacting legislation similar to H. B. 272 make it difficult either to support or oppose such legislation. Also, several members stated that although they believe there are too many mandated benefits at the present time, they would support the continuation of the status quo.

The Chairman noted that H.B. 272 was passed by indefinitely during the 1982 General Assembly, because legislation could not be carried over from the 1982 to the 1983 Session. He added that if the Bureau of Insurance wants him to, he will introduce similar legislation during the 1983 Session. However, he said, such legislation would be introduced with the understanding that he is not necessarily in favor of it. The Chairman suggested that Senator Goode contemplate introducing the same legislation in the Senate.

After some additional discussion the subcommittee decided not to continue the study.

A motion was then made that the subcommittee not take a position on House Bill No. 272, due to insufficient data regarding the effects of enacting such legislation. The motion was seconded, and by a unanimous vote the subcommittee passed the motion.

A motion was then made that there be no changes in the Commonwealth's mandated health insurance benefit statutes. The motion was seconded, and by a unanimous vote the subcommittee passed the motion.

There being no further business, the meeting was adjourned.

#

APPENDIX XIV

COMMONWEALTH of VIRGINIA

MES B. KENLEY, M.D.
)MMISSIONER

Department of Health
Richmond, Va. 23219

November 22, 1982

MEMORANDUM

To: Hugh P. Fisher, III, Research Associate
Legislative Services

From: Bedford H. Berrey, M.D., Assistant Commissioner
Office of Health Care Programs

Subject: Requested Information for HJR 90

The following is the data you requested regarding the Crippled Children's Program:

a. Estimated annual number of patients - 19,000.

b. Estimated annual number of patient visits - 36,000.

c. Number of annual hospitalizations - 1,700.

d. Medicaid pays the hospitalization of 25.8% or approximately 440 patients.

e. It is estimated that private insurance carriers will pay $1,113,000 annually for insured children in the Crippled Children's Program.

f. It is estimated that the Medicaid Program will pay $388,000 annually for insured children in the Crippled Children's Program.

g. Total annual projected insurance revenues from Title 19 and private carriers is $1,500,000. This averages out to $883 per hospital admission.

If you have any questions regarding the above data, please call Mr. Paul Mergler at 6-6271.

cc: R. Dale Hunsaker, M.D.

APPENDIX XV

HEALTH INSURANCE ASSOCIATION OF AMERICA

919 Third Avenue, New York, N.Y. 10022-9990, (212) 486-5520

Edwin R. Soeffing
Counsel

December 7, 1982

Mr. Hugh P. Fisher, III
Research Associate
Division of Legislative Services
Post Office Box 3-AG
General Assembly Building
Richmond, Virginia 23208

Re: Joint Subcommittee Studying the Crippled Children's Program and Mandated Health Insurance Benefits

Dear Mr. Fisher:

You asked me by phone to confirm by letter the cost figures I presented on mandated benefits before the Joint Subcommittee at its public hearing of December 1, 1982. I am happy to do so.

As I stated at the hearing, two commercial carriers were able to furnish figures to me. They were Mutual of Omaha and Aetna Life & Casualty.

As for Mutual of Omaha, it was able to provide me estimated implementation costs for three different benefit coverages. For newborn coverage, Mutual of Omaha estimated that approximately 15,000 renewals cost about $5,800. For mental illness coverage, Mutual of Omaha estimated that approximately 14,000 renewals cost about $5,460. And for alcoholism coverage, Mutual of Omaha estimated that approximately 8,000 renewals cost about $4,044. Again, please note it is my understanding that these figures include only the estimated costs of implementation to Mutual of Omaha, and not the cost of providing these benefits by said company.

As for Aetna Life & Casualty, it was able to provide me with the premium rate impact of various health insurance provisions mandated by the State in Chapter 38.1 of the Virginia Insurance Code. Specifically, Aetna considered the effect on premium rates which occurs because statutory provisions relating to dependent children coverage, dental coverage, newborn coverage, mental illness coverage, certain COB language (348.10), conversion coverage, rape coverage, alcoholism/drug abuse coverage, certain deductible/coinsurance language and obstetrical coverage. Based on the inclusion of the aforementioned provisions, Aetna calculated that the total extra cost to the plan would be 6.3% for employees and 12.7% for dependents.

As I further stated, I had one of our HIAA actuaries, Mr. Peter M. Thexton, take a look at the cost figures submitted to me. Mr. Thexton concluded that the actual Aetna premium cost increase (after combining the employee and dependent figures) was 9.5%. He also reported to me that he felt the cost estimates I received from the two companies were representative of those I would obtain if I made a comprehensive survey. A copy of Mr. Thexton's memorandum to me (dated November 24, 1982) is enclosed herewith as verification.

You may wish to talk with the companies about their figures in more specific fashion. In the case of Mutual of Omaha, I suggest you call Mr. Frank Parks, Second Vice President, at (402)341-7600. In the case of Aetna, I suggest you call Mr. J. Maurice Miller, Jr. (of the Richmond law firm of Mays, Valentine, Davenport & Moore) at 644-6011. Mr. Miller represents the Aetna locally.

Once again, I have been happy to furnish in writing the figures HIAA presented orally at the hearing.

With very best wishes.

Sincerely,

Edwin R. Soeffing
Counsel

/br
Enclosure
cc: Mr. John S. Boritas, Metropolitan Life
Mr. Timothy Campbell, Aetna Life & Casualty
Mr. J. Maurice Miller, Jr.
Mr. Frank Parks, Mutual of Omaha

HEALTH
INSURANCE
ASSOCIATION
OF AMERICA

MEMORANDUM

TO Edwin R. Soeffing

DATE 11/24/82

FROM Peter M. Thexton

SUBJECT Virginia Health Insurance Cost Statistics

The memo from the Aetna Life & Casualty, describing the cost of various mandated benefits in Virginia, is quite definitive and could certainly be submitted as testimony. It does not indicate a 20% premium cost for anything, but indicates instead, about an average of 9½% as an increase, primarily for the maternity benefits. This average is of about 6½% of the employee premium and 12½% of the dependent premium. It is generally true that the volume of premium is equal between employees and dependents.

Your indication of implementation costs, as supplied by Mutual of Omaha, has to do with the administrative cost of implementing these benefits. It appears to be in the range of 40¢ to 50¢ per renewal policy, which is about the cost of printing, postage, and incidental clerical expenses. In my opinion, this sounds very efficient.

In my experience, the cost estimates which you received from Aetna and Mutual are representative of those you would receive if you made a comprehensive survey.

PMT/aeg