REPORT OF THE
INSURANCE TASK FORCE OF THE
DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES AND THE
BUREAU OF INSURANCE ON

Insurance Coverage For Persons With Mental Disabilities

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 47

COMMONWEALTH OF VIRGINIA
RICHMOND
1990

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INTERIM REPORT
House Joint Resolution 319
Insurance Task Force

November 29, 1989

Executive Summary

In May 1989, as requested by House Joint Resolution 319, Howard M. Cullum, Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, and Steven T. Foster, Commissioner, Bureau of Insurance, State Corporation Commission, convened a task force composed of service providers, the insurance industry, advocates for individuals with mental disabilities, and university teaching hospital representatives. Jointly they appointed Isabel Brenner, a member of the State Mental Health, Mental Retardation and Substance Abuse Services Board, as Chairman of the newly-formed Insurance Task Force. The task force held its first meeting in June and has met monthly since then.

To approach its charge, Task Force members divided into four groups to define the issues and develop recommendations for consideration by the larger group. As part of HJR 319, the task force was charged with coordinating its study with the SJR 169 Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs. For the past two years, the Joint Subcommittee has been working with a Substance Abuse Insurance Task Force comprising agency and industry representatives. This Task Force has been studying ways to provide adequate insurance coverage for substance abuse services. In addition SJR 191, 1989, established a Joint Subcommittee to study certain practices among psychiatric professionals and institutions. All of these study committees are reviewing similar issues. Two Insurance Task Force members sit on these legislative study groups and have apprised the task force of their activities and status.

Deborah Haller, Ph.D., Chairman of the Substance Abuse Insurance Task Force, presented the task force with the status of her group's progress and preliminary recommendations. She discussed the issues which had been obstacles to the group's progress and methods used to resolve differences. It was clear that many of the issues were the same or similar to those discussed by the Insurance Task Force and that it would be important, if possible, to dovetail activities with those of the Substance Abuse Insurance Task Force. The Substance Abuse Insurance Task Force has set a late November deadline for submitting its report.

The HJR 319 Task Force would like the opportunity to review the report of the Substance Abuse Insurance Task Force and have sufficient time to formulate findings and prepare its own report. Further, the Bureau of Insurance has planned to undertake a January benefits survey which will yield valuable data for the task force about Virginia's present coverage status.

Therefore, the Insurance Task Force is recommending the extension of its study for another year to allow sufficient time to review the report of the Substance Abuse Insurance Task Force and to analyze the information to be collected in the benefits survey to be conducted by the Bureau of Insurance. Study of these documents will be necessary for the task force to complete its work.

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Background

There is concern that high costs of health care and demands on the health insurance industry have resulted in efforts to reduce benefits and use of other means to curtail benefits to Virginians. Persons with mental disabilities are particularly vulnerable to benefit reductions and encounter difficulties in accessing covered care and services because benefits for the treatment of mental and physical diseases and disorders are handled differently in a number of ways. Some alcohol and other drug treatment services are excluded from coverage in benefit programs and health maintenance plans. Code mandates have caused insurance benefits for mental health treatment to be provided in the most restrictive and, often, expensive, treatment environment. Not infrequently, families and individuals are not aware of reduced or absent benefits until those treatment services are needed.

The Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs (SJR 169) has been working for two years to develop legislative proposals to respond to unavailable or reduced benefits for alcohol and drug abuse treatment as well as to achieve greater flexibility in the offering of treatment settings to allow the use of more appropriate treatment environments.

Purpose and Scope of Study

Through House Joint Resolution 319, the study of adequate insurance benefits was extended to include persons receiving treatment or care for all mental disabilities. The Task Force was encouraged by HJR 319 to develop a productive relationship with the Substance Abuse Insurance Task Force. Further, the resolution charged the insurance industry to work with the public sector to investigate methods of financing appropriate treatment that will prove to be cost-effective.

House Joint Resolution 319 directed the Department of Mental Health, Mental Retardation and Substance Abuse Services to join with the Bureau of Insurance to establish a task force to study insurance coverage for persons with mental disabilities. The joint resolution specifically identified the membership of the task force that was convened by Howard M. Cullum, DMHMRSAS Commissioner, and Steven T. Foster, Commissioner, Bureau of Insurance, State Corporation Commission in May 1989. Task Force membership is listed in Appendix A.

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At the task force's initial meeting June 21, 1989, Commissioner Howard M. Cullum stressed the challenge and difficulty of accomplishing "...the study of continued availability of adequate insurance coverage for persons with mental disabilities." He stressed the need to develop strategies to strengthen the coordination and cooperation between the public and private sectors and the insurance industry to achieve maximum utilization of appropriate mental health treatment in the most cost-effective manner. This charge was to be accomplished in coordination with the work of the SJR 169 group which is studying mandated substance abuse treatment and prevention programs.

Issue statements have been solicited from the groups, associations, universities, hospitals, insurance industry, and other affiliations represented on the task force. Statements have been received from the following groups and associations: The Virginia Association of Clinical Counselors, The Virginia Association of Community Services Boards, The Virginia Chamber of Commerce, and The Travelers. Points of consensus and agreement have been reached by the task force's small groups. Recommendations and solutions to the issues will be more difficult to mutually forge, however there is a sense of confidence that the task force will be able to complete its charge by late spring.

Calendar

The Task Force met on June 21, July 19, August 16, September 27, October 18, and November 29, 1989. Meetings are scheduled for January 31, February 21, March 21, and April 18, 1990.

Process and Study Participants

After defining issues and information needs, the task force membership decided to meet in small groups to accomplish its legislative charge. Four groups were formed at the first meeting.

Recommendations

The Insurance Task Force recommends that the study be continued for another year to allow sufficient time to review the report of the Substance Abuse Insurance Task Force and to analyze the information to be collected in the benefits survey to be conducted by the Bureau of Insurance. Study of these documents will be necessary for the task force to complete its work.

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1. **What Is: Definitions** - Chairman: Joel Silverman, M.D.

Members: Phyllis McCafferty, LCSW, Chris Rowe, and Robert Wright.

Task:

Review definitions of mental disabilities: those on insurance policies as well as medical/legal definitions. Rely on diagnostic and statistical manual for specific definition of diseases. Review samples of existing HMO Indemnity policy definitions.

Determine percent and profile of consumers of services and those covered by benefits also those excluded, i.e. self-insured, federal and state workers; mandated services; treatments and modalities. Look at percentages of Virginians that fall into different categories: regular insurance; no insurance; affiliated with HMO.

Preliminary Findings:

Insurance policies of all major carriers and HMOs in Virginia were reviewed for their definition of "mental disability" and the coverages provided for "mental disabilities". Approximately 60 insurance policies were reviewed for the definition of mental illness. Among the groups findings were:

- Most of the policies reviewed were consistent with language in the Code of Virginia. Descriptions of benefits provided under the different insurance policies were varied, especially wide variations occur in mental health and substance abuse treatment out-patient services.

- It is difficult to discern what is covered and, more importantly, what is **not** covered under the provisions of the policies.

- There are many more limitations on treatment for mental health care than for other coverages.

- There is concern on the part of providers that Utilization Review can be used by insurers to prevent or reduce the delivery of benefits. Standards used by insurers to determine when treatment is no longer needed are not made available to policy holders or to health professionals. Often, nurses or other staff who have not seen the patient or physician make the determination based on a report or records review. Similarly, there is concern on the part of insurers that providers may abuse treat-

ment benefits by tailoring services to the patient's benefit package rather than care needs.

- HMOs do not cover Long Term Care. Benefit coverage is limited to acute care or short-term treatment when the patient will get better within a short time period. Maintenance of individuals at their current functional level is not viewed as an acceptable outcome for reimbursement for treatment.

- There is differential treatment toward chronic mental health patients as opposed to acute care treatment. Example: Diabetes is a chronic condition with treatment and medications provided as benefits; whereas treatment for chronic mental illness is routinely not covered as a benefit in insurance policies.

- There is differential handling of mental health treatment in coverage provided by HMOs and insurers for inpatient and out-patient treatment in contrast to coverage provided for non-mental health treatment.

Data and Information Needs:

The group identified the need for information about the percentage of Virginians covered under various programs and plans. The Bureau of Insurance is contracting to have a study undertaken in January 1990 to collect the required data.

Discussion:

Definitions: The group discussed the different definitions for mental illness and the addition of the words "acute and chronic" in the Code of Virginia, § 37.1-1 or in the insurance sections. Other points raised were tying the mental health definition to the Diagnostic Standards Manual 3R Edition as a reference and use of the words "mental health disorder" or "mental health disability" in lieu of "mental health disease." The group also discussed developing its own definition.

Services: There was discussion about mandated services and a plan of conversions; the inflexibility between outpatient and inpatient treatment benefits as obstacles to providing the appropriate clinical treatment setting for the client; and the cost savings that could by achieved by greater access to outpatient settings as an alternative to inpatient psychiatric hospitalization.

HMO History: The group reviewed the philosophy and history of the federal legislation establishing Health Maintenance Organizations in 1973. The federal statute requires that HMOs shall provide treatment or care for disorders that are "...subject to improvement." The purpose of HMOs is to provide an alternative to traditional health insurance programs. HMOs were established with a different benefit design which included preventive measures, i.e. well baby clinics. They were not designed to provide treatment and care for individuals with chronic conditions. HMOs were developed to be responsive to employers who purchase the plans as a low cost alternative to traditional insurance programs. HMOs do not screen clients and the rating structure is not based on conventional experience rating.

2. **Benefits** - Chairman: Frank Singleton

Members: Randy Canterbury, M.D., Marilyn Penrod, Samuel Rubin, Ph.D., Alan Wood, and Dennis Wright.

Task:

Determine current and optimal. Look at cost-effectiveness. Comparisons with the Canadian health care system.

Information needs: healthcare coverage; current legislation; carriers subject to requirements; percentage of Virginians covered; percentage on self-insured plans; options by carriers and benefit levels.

Preliminary Findings:

- The group agreed to explore conversion of inpatient benefits to partial hospitalization and other alternative settings to increase treatment flexibility.

- There should be parallel benefits mandated regardless of the source of funding. Similar mandates should apply, notably psychiatric care for children and substance abuse treatment which currently are not provided for by the State Medical Assistance Plan.

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3. **Access and Monitoring** - Chairman: Charles M. Davis, M.D.

Members: Sally Duran, Dwight McCall, and John Troy

Task:

Service accessibility vis a vis trade-offs. Private and public sector service availability. Protections and safeguards to assure quality and efficient delivery of services based on outcome data. Cost control monitoring and management. Methods to preclude system abuse by clients, providers, or insurers.

Preliminary Findings:

- Early appropriate treatment saves dollars in the long run.

- Federal substance abuse statutes on confidentiality are a stumbling block to the appropriate provision of treatment and interfere with continuity of treatment. Citing the repeated performance of initial evaluations as costly in time and funds, a method should be offered to provide professionals with access to client records. Professionals instead of institutions might be the point of access.

- The mandated benefits as currently structured are too rigid.

Discussion:

Monitoring: It is not clear who should monitor treatment. An independent third-party should monitor Utilization Review and in-take. The regulatory agency was offered as one possible alternative. Another means to lessen the difficulty of monitoring service provision might be to have clearly established and followed standards.

4. **Public Sector - Chairman: H. O. Smith**

Membership: Martin Cornetta, Cary Suter, MD, and Glenn Yank, M.D.

Task:

Impact of changes on the public sector. What is the appropriate role of the public sector as financier of solutions.

Preliminary Findings:

- Intensive outpatient and partial hospitalization services should be offered in conjunction with necessary inpatient services based on appropriate level of care. A formula could be developed for trade offs or conversion of services.
- A characteristic of adequate coverage as "That level of services that would not increase the demand on public sector services" was offered to the task force for consideration.
- Alternative treatment programs must have built in incentives if they are to be used.
- Methods of regulation and scrupulous utilization review would have to be part of the alternative treatment program.
- Care should be exercised in mandating services to avoid significantly reducing the number of insured persons because uninsured persons will seek services from the public sector.

Discussion:

Equity: The issues of what is equitable, and independent evaluations of appropriateness of services or utilization reviews were discussed by the group.

Affordability: Affordability of mandated services and the consequences of high costs of insurance benefits forcing small businesses to drop out of programs must be weighed.

Adequacy: A statistical model for determining "adequacy" and the determination of standard deviations or "outliers" as the basis for exclusion was suggested. How the outliers are defined becomes the basis for the mandates.

References and Resources

The following presentations were made to the task force:

Canadian Health Insurance Program as it relates to services and treatment for individuals with mental disabilities by Frank MacHovec, Ph.D., Director, Office of Quality Assurance, DMHMRSAS, former mental health practitioner in Winnipeg, Manitoba.

Innovative Programs - Managed Mental Health Services by James Martinez, Assistant Director, Mental Health Services

SJR 169: Substance Abuse Insurance Task Force created by the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs - Progress Report by Deborah Haller, Ph.D., Chairman of the Joint Subcommittee.

Written Materials

The following articles and materials were distributed to assist the task force in its work:

"Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums," Barbara Browne, Raymond Browne, Susan T. McLaughlin, Cynthia Wagner, Journal of the American Society of CLU and CHFC, Vol. 41, June 1987.

"Financing and Demand for Mental Health Services," Thomas McGuire, Journal of Human Resources, XVI, 4, 1981.

"Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature," Kenneth R. Jones and Thomas R. Vischi, Medical Care, 1979; 17 (Supplement): 1-82.

"A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment," Emily Mumford, Herbert Schlesigner, Gene Glass, Cathleen Patrick, and Timothy Cuerdon, American Journal of Psychiatry, 141:10, October 1984.

"Are Psychiatric Benefits Worth the Cost?" Donald J. Scherl, M.D., Journal of the American Medical Association, June 14, 1985; Vol 253, No. 22.

"State Mandates for Mental Health Insurance: What Is Their Cost?" Runck Hospital and Community Psychiatry, March 1983; Vol. 34, No. 3.

"Mandated Mental Health Benefits in Private Health Insurance," Thomas McGuire and John Montgomery, Journal of Health, Politics, Policy and Law, Vol. 7, No. 2, Summer 1982.

"Payers Want Cost-Effective Mental Health Treatment Programs," Constituency Currents.

Canadian Federal Health Programs Brochures.

Excerpts from The Coverage Catalog, 2nd Edition, American Psychiatric Office of Economic Affairs
- Medicare and Medicaid
- Trends in Inpatient and Outpatient Benefits 1979- 1986 by percent of participants
- Mandated Minimum Benefit Package/Mandated Availability, 1975
- State Mandate Summary
  - Kaiser-Permanente
  - Glossary
  - DMHMRSAS - Community Services Boards Fees and Expenses

"Core Services Taxonomy III," Department of Mental Health, Mental Retardation and Substance Abuse Services, December 20, 1988

"Freedom of Choice in Health Insurance," a position paper from the National Center for Policy Analysis;

"The Price of State Mandated Benefits," by Jon R. Gabel, Health Insurance Association of America and Gail Jensen, University of Illinois at Chicago;

"The Erosion of Purchased Health Insurance," by Gail A. Jensen and Jon R. Gabel;

"State-Mandated Group Health Insurance Coverages," by Mark Power and August Ralston from Benefits Quarterly.

"Mandated Mental Health Insurance: A Complex Case of Pros and Cons, Andrea Patterson, State Legislative Report, September, 1988.

"A Client-Centered Comprehensive Mental Health System," Toward a Model Plan for a Comprehensive, Community-Based Mental Health System, National Institute of Mental Health, October 1987.

"Comparative Costs and Impacts of Canadian and American Payment Systems for Mental Health Services," Douglas Bigelow and Bentson

McFarland, Hospital and Community Psychiatry, August 1989, Vol. 40, No. 8.

"Health Care Rationing through Inconvenience: The Third Party's Secret Weapon," Gerald Grumet, M.D., The New England Journal of Medicine, August 31, 1989.

"Canadian Health System Eroding, Private Tier May Evolve, MD Warns," Bill Trent, American Medical News, September 8, 1989.

"Preliminary Report: Substance Abuse Insurance Task Force of the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs," prepared by Cecil Camlin for the Virginia Association of Community Services Boards.

"Insider Interview: Dr. Lewis Judd, Director, National Institute of Mental Health," Tony Leberto, Healthweek, August 14, 1989.

"Editorial," Thomas Higgins, Healthweek, August 28, 1989.

"The Impact of HMO Development on Mental Health and Chemical Dependency Services," Maureen Shadle and Jon B. Christianson, Hospital and Community Psychiatry, November 1989, Vol. 40, No. 11.

"Litigating Insurance Coverage for Mental Disorders," Paul Appelbaum, M.D., Hospital and Community Psychiatry, October 1989, Vol. 40 No. 10.

"California Mandates Parity for Some Mental Disorders," American Psychiatric Association News, October 20, 1989.

Task Force Recommendations for Revision of SJR-169, distributed to Joint Subcommittee Studying Mandated Substance Abuse Programs, November 28, 1989.

Senate Joint Resolution 196, Medicaid Coverage for Substance Abuse Treatment in Virginia, Department of Mental Health, Mental Retardation and Substance Abuse Services, November 21, 1989.

Assembly Bill No. 360, California Legislature - 1989-1990 Regular Session, Amended in Assembly May 25, 1989.

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Code Citations:

Insurance Code Sections Requiring Provision of Mandated Benefits

§ 38.2-3408 Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.

§ 38.2-3409 Coverage of dependent children.

§ 38.2-3410 Construction of policy generally; words "physician" and "doctor" to include dentist.

§ 38.2-3411 Coverage of newborn children required.

§ 38.2-3412.A. Coverages for mental, emotional or nervous disorders. (Inpatient).

§ 38.2-3415 Exclusion or reduction of benefits for certain causes prohibited.

§ 38.2-3416 Conversion on termination of eligibility; insurer required to offer conversion policy or group coverage.

§ 38.2-3418 Coverage for victims of rape or incest.

Insurance Code Sections Requiring Offering of Mandated Benefits

§ 38.2-3412.B Coverages for mental, emotional or nervous disorders. (Outpatient).

§ 38.2-3413 Coverage for alcohol and drug dependency.

§ 38.2-3414 Optional coverage for obstetrical services.

§ 38.2-3417 Deductible and coinsurance options required.

§ 38.2-3418.1 Coverage for mammograms. (Effective 1/1/90)

§ 38.2-3419 Additional mandated coverage made optional to group policy or contract holder.

SJR 215 Requesting the Bureau of Insurance of the State Corporation Commission with the assistance of the Department of Health to study mandated benefits and providers and recommending a one-year moratorium on the adoption of any additional mandated health insurance benefits and providers. February 23, 1989.

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Statistical Information and Data

Survey of Psychiatric Benefits at 10 large and 10 mid-sized Virginia companies, Virginia Chamber of Commerce.

Psychiatric Treatment Charge Data - 7/1/88 - 6/30/89 Includes Substance Abuse Data.

State Employee Insurance Coverage and Enrollments - 1989/1990, Department of Personnel and Training, Commonwealth of Virginia.

Data Regarding HMO and Other Coverages - 1987 and 1988, Virginia-Pilot Ledger Star from Virginia Insurance Commission filings 1987.

Identification of mandated insurance coverage for mental disability services and programs

Current recipients of benefits for service

Groups excluded from mandated services

"Comparative Charges - Psychiatric Hospitals," Virginia Health Care Costs Council, February 1, 1989.

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Appendices and Exhibits

A. HJR 319

B. Time line for Insurance Task Force - Flow Chart

C. Membership

D. Staff Support

E. Survey of Psychiatric Benefits at 10 large and 10 mid-sized Virginia companies, Virginia Chamber of Commerce.

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Appendix A.

1989 SESSION

LD6716424

HOUSE JOINT RESOLUTION NO. 319

Offered January 23, 1989

Requesting that the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Bureau of Insurance establish a task force to study insurance coverage for persons with mental disabilities.

Patron--Bloxom

Referred to the Committee on Rules

WHEREAS, in Virginia and nationally, the high costs of health care and demands on the health insurance industry are resulting in efforts to reduce or eliminate the minimum levels of mandated insurance coverage for persons with mental disabilities; and

WHEREAS, the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs has recognized the problem of unavailable or reduced benefits for alcohol and drug abuse treatment; and

WHEREAS, the insurance industry has expressed interest to the Joint Subcommitee Studying Mandated Substance Abuse Treatment and Prevention Programs in cooperating with the public sector to investigate methods of financing appropriate treatment for substance abuse; and

WHEREAS, national studies have shown that early and appropriate treatment of psychiatric illnesses can frequently prevent more costly inpatient care or institutionalization; and

WHEREAS, it is imperative that the Commonwealth develop strategies to strengthen the coordination and cooperation between the public and private sectors and the insuran industry to achieve maximum utilization of appropriate mental health treatment in the mo cost-effective manner; and

WHEREAS, the continuing availability of adequate and appropriate private insurance coverage for persons with mental disabilities has a direct impact on Virginia's public mental health system and the costs to Virginia taxpayers; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Bureau of Insurance are requested to establish a task force to study the continued availability of adequate insurance coverage for persons with mental disabilities. The task force shall coordinate its study with the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs.

The task force shall be composed of members jointly selected by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services and the Commissioner of Insurance from among the following organizations, and agencies: the State Mental Health, Mental Retardation and Substance Abuse Services Board; the Community Services Boards; the Bureau of Insurance; the State Chamber of Commerce; the Virginia Neurological Society; the Virginia Academy of Clinical Psychologists; the Coalition for Mentally Disabled Citizens of Virginia; the Mental Health Association of Virginia; the Virginia Association of Social Workers; the Virginia Alliance for the Mentally Ill; Blue Cross and Blue Shield; a health maintenance organization; the commerical insurance industry; the Medical Society of Virginia and Virginia's teaching hospitals.

The task force shall complete its work in time to submit its findings and policy proposals to the Governor and 1990 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

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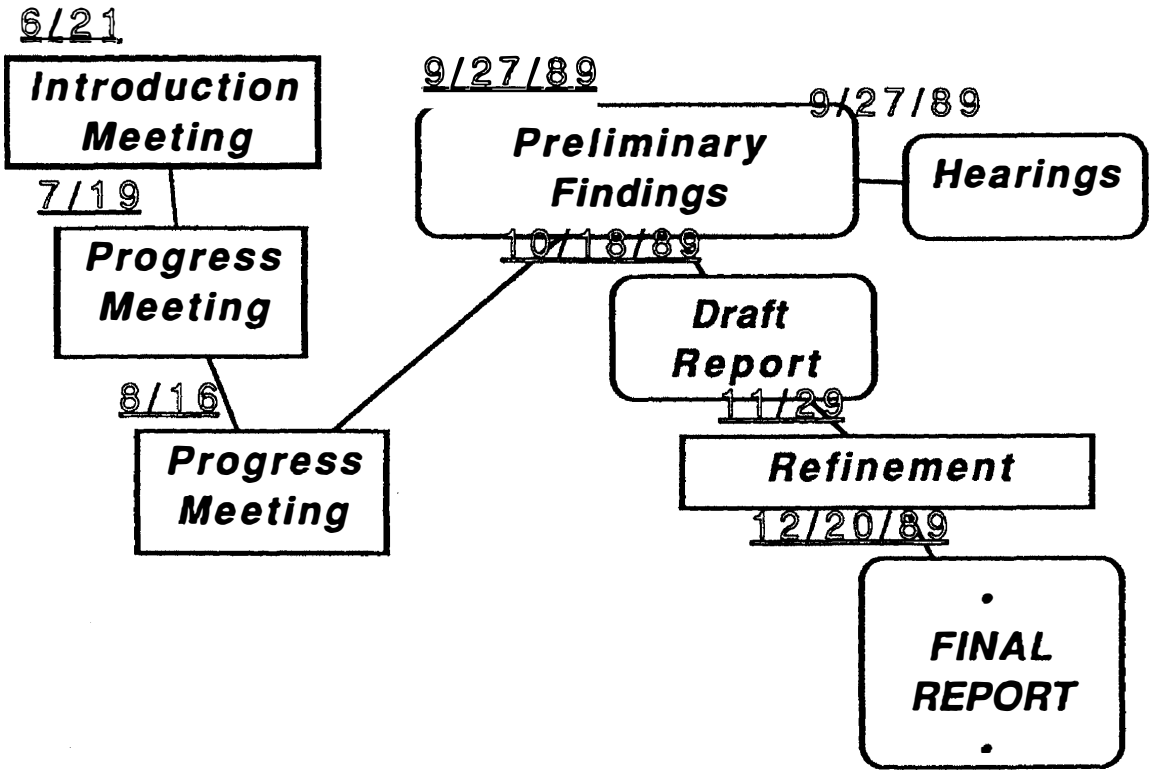
Appendix B.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES... BUREAU OF INSURANCE.....1989

HJR 319: INSURANCE TASK FORCE

A LOOK AT COVERAGE ALTERNATIVES



July 19, 1989 10:00 AM
Richmond, Virginia

Appendix C.

Task Force Representation

Blue Cross and Blue Shield of Virginia
Bureau of Insurance, State Corporation Commission
Coalition for Mentally Disabled Citizens of Virginia
Commercial Insurance Industry: The Travelers
Health Maintenance Organization: Kaiser Permanente
Medical Society of Virginia
Mental Health Association
National Association of Social Workers and the Virginia Society for Clinical Social Work
Virginia Academy of Clinical Psychologists
Virginia Alliance for the Mentally Ill
Virginia Association of Community Services Boards
Virginia Chamber of Commerce
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Virginia Neurological Society
Virginia's teaching hospitals
- Medical College of Hampton Roads
- Medical College of Virginia
- University of Virginia Medical College, UVA Sciences Center.

In subsequent meetings, the task force decided to seek representation from the following two groups to provide the task force with fuller representation of the mental disabilities and providers:

Virginia Association of Clinical Counselors
Virginia Association of Retarded Citizens
Benefit Coverage for Virginians

Task Force Members:

Isabel Brenner, State Mental Health, Mental Retardation and Substance Abuse Services Board Member;
Randolph Canterbury, M.D., University of Virginia Medical College, UVA Sciences Center - Virginia's teaching hospitals;
Martin Cornetta - Virginia Alliance for the Mentally Ill;
Charles M. Davis, M.D., Medical Director, Charter Westbrook - Medical Society of Virginia;
Sally Joyce Duran - Kaiser Permanente, replacing Gary Summers - Kaiser Permanente
Rubyjean Gould - Department of Mental Health, Mental Retardation and Substance Abuse Services;
Phyllis McCafferty, LCSW - National Association of Social Workers and the Virginia Society for Clinical Social Work;
Dwight McCall - Virginia Association of Clinical Counselors;
Betty McManus, Mental Health Association of Northern Virginia, - Coalition for Mentally Disabled Citizens of Virginia;
Marilyn Penrod - Mental Health Association;
Clarissa Rowe - Virginia Association for Retarded Citizens
Samuel Rubin, Ph.D. - Virginia Academy of Clinical Psychologists;
Joel Silverman, M.D., Chairman, Department of Psychiatry, Medical College of Virginia - Virginia's teaching hospitals;
Frank Singleton, Ph.D., Medical College of Hampton Roads - Virginia's teaching hospitals;
H. O. Smith, Western Tidewater Community Services Board - Virginia Association of Community Services Boards;
Gary Summers, Kaiser Permanente - a health maintenance organization;
Cary Suter, M.D., Medical College of Virginia - Virginia Neurological Society;
Richard Tall, HMO-Virginia, Blue Cross and Blue Shield of Virginia - Blue Cross and Blue Shield of Virginia;
John F. Troy, Deputy General Counsel, the Travelers - the commercial insurance industry;
Alan Wood, Blue Cross and Blue Shield of Virginia, substituting for Richard Tall, HMO-Virginia, Blue Cross and Blue Shield of Virginia - Blue Cross and Blue Shield of Virginia;
Dennis Wright, Virginia Power - Virginia Chamber of Commerce
Robert L. Wright - Bureau of Insurance, State Corporation Commission.

Appendix D.

Staff Support:

Althelia Battle, Bureau of Insurance, State Corporation Commission
Ann Colley, Bureau of Insurance, State Corporation Commission
Martha Mead, Department of Mental Health, Mental Retardation and Substance Abuse Services
Evangeline Tompkins, Bureau of Insurance, State Corporation Commission

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Appendix E.

PSYCHIATRIC CARE BENEFITS SURVEY (LARGE VIRGINIA COMPANIES)

COMPANIES:	BEST PRODUCTS	CSX CORP	CIRCUIT CITY	CRESTAR BANK	ETHYL CORP	JAMES RIVER	REYNOLDS METALS	SOUTHERN STATES	UNIVERSAL LEAF	VIRGINIA POWER
INPATIENT CARE										
DAY LIMITS:										
PSYCHIATRIC	30	45	30	60	30	NO-$6,000 MAX/YR	30	30	120	NO
SUBSTANCE ABUSE	30	45	30	30	30	"	30	45	30	30
PAYMENTS:										
100%	NO	NO	NO	NO	YES	NO	YES	NO	YES	NO
DEDUCTIBLE	$200	$150	$100	$200	NO	$150	NO	$200	$200 HOSP ADM	$200
CO-PAY	80%	80%	80%	80%	NO	80%	NO	80%	NO	80%
STOP/LOSS	NO	NO	$500	$1,500	NO	NO	NO	NO	NO	$600

PSYCHIATRIC CARE BENEFITS SURVEY (LARGE VIRGINIA COMPANIES)

COMPANIES:	BEST PRODUCTS	CSX CORP	CIRCUIT CITY	CRESTAR BANK	ETHYL CORP	JAMES RIVER	REYNOLDS METALS	SOUTHERN STATES	UNIVERSAL LEAF	VIRGINIA POWER
OUTPATIENT CARE										
LIMITS:										
PSYCHIATRIC	$1,000 MAX/YR	$3,500 MAX/YR	$2,000 MAX/YR	$2,500 MAX/YR	$2,500 MAX/YR	$1,000 MAX/YR	20 VISITS	$3,000 MAX/YR	NO	NO
SUBSTANCE ABUSE	"	"	"	"	"	"	90 VISITS	"	NO	NO
PAYMENTS:										
100%	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
DEDUCTIBLE	$200	$150	$100	$200	$200	$150	$100	$200	$200	$200
CO-PAY	50%	80%	80%	80%	50%	80%	80%FOR 20 THEN 50%	80%	80%	50%
STOP/LOSS	NO	NO	$500	NO	NO	NO	NO	NO	NO	NO
SPECIAL PROGRAMS	NO	NO	NO	CASE BY CASE	NO	NO	INTEN O/P PART DAY	NO	NO	NO

PSYCHIATRIC CARE BENEFITS SURVEY (MID-SIZED VIRGINIA COMPANIES)

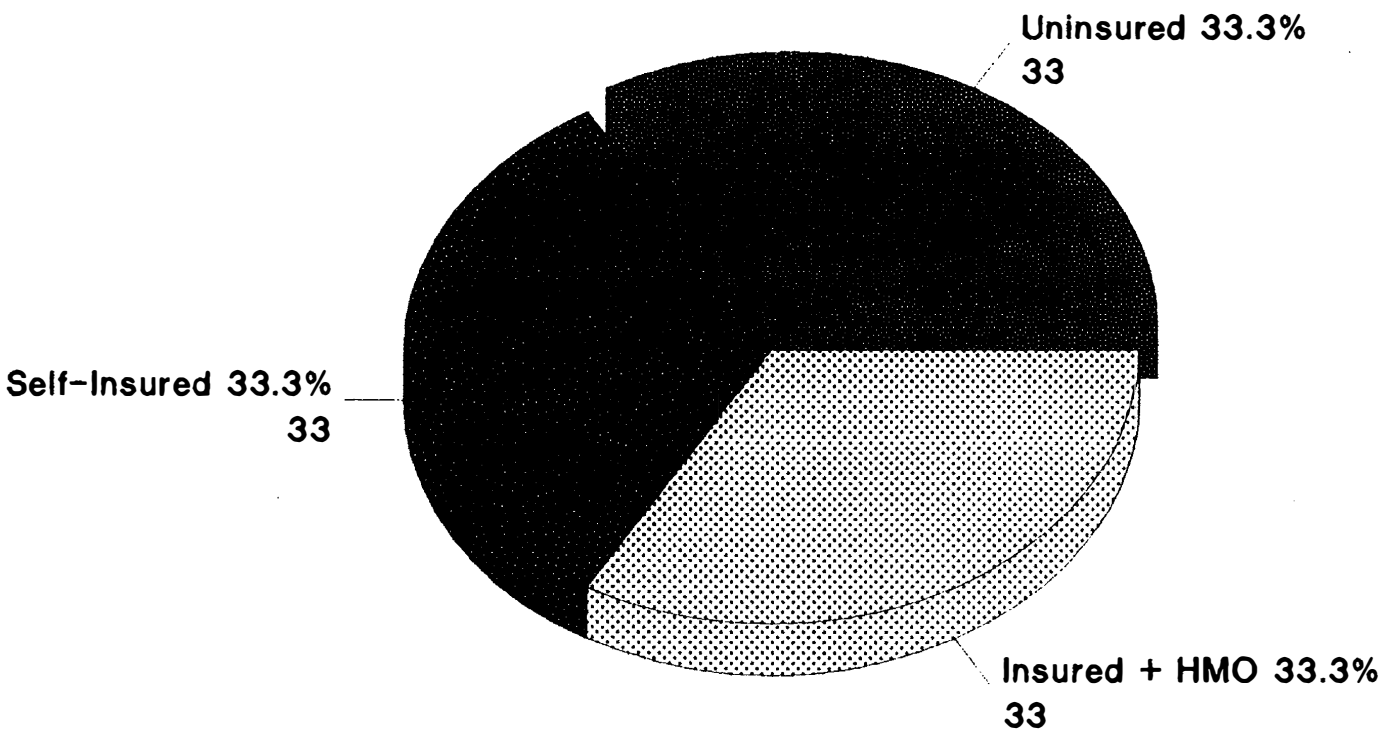
COMPANIES:	AMER SAFE RAZOR	BASF CORP FIBERS	CARTER MACH CO	COOPER INDS	DOM BANK SHENAND'H	DOUBLE ENVELOPE	ELECTRO'X CORP	HERCULES INCORP	LUCK STONE	OVERNITE TRANSPORT
INPATIENT CARE										
DAY LIMITS:										
PSYCHIATRIC	120	NO	30	45	60	30	30	30	NO	60
SUBSTANCE ABUSE	28	NO	30	45	30	30	30	30 -LIFE MAX OF 60	NO	30-LIFE MAX OF 90
PAYMENTS:										
100%	YES-HOSP	YES- 1ST $1,600	NO	NO	NO	NO	NO	NO	NO	NO-$80DAY LIMIT D/A
DEDUCTIBLE	$50	$100	$100	$150+$100 I/P DED	$200	$200	$200	$300	$200	$100
CO-PAY	80%-PHY	80%	80%	80%	80%	80%	80%	80%	80%	80%
STOP/LOSS	NO	$2,000	$500	$1,500	$750	NO	$1,000	$2,000	$1,200	$1,000

PSYCHIATRIC CARE BENEFITS SURVEY (MID-SIZED VIRGINIA COMPANIES)

COMPANIES:	AMER SAFE RAZOR	BASF CORP FIBERS	CARTER MACH CO	COOPER INDS	DOM BANK SHENAND'H	DOUBLE ENVELOPE	ELECTRO'X CORP	HERCULES INCORP	LUCK STONE	OVERNITE TRANSPORT
OUTPATIENT CARE										
LIMITS:										
PSYCHIATRIC	NO	$1,500 MAX/YR	NO	25 VISITS	$3,000 MAX/YR	NO	60 VISITS $1,500 MAX/YR	40 VISITS	$1,500 MAX/YR	$1,000 MAX/YR
SUBSTANCE ABUSE	NO	"	NO	25 VISITS	"	NO	"	30 -LIFE MAX OF 60	"	"
PAYMENTS:										
100%	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
DEDUCTIBLE	$50	$150	$100	$150	$200	$200	$200	$1,000	$200	$100
CO-PAY	80%	50%	50% TO $2,000	50%	80%	80% TO $2,000	80%	50%	80%	50%
STOP/LOSS	NO	NO	$2,000	$1,500	NO	$2,000	$1,000	$2,000	$1,200	NO
SPECIAL PROGRAMS	CASE BY CASE	NO	NO	NO	NO	CASE BY CASE	NO	NO	INTEN O/P PART DAY	PART DAY

ESTIMATED BENEFIT COVERAGE FOR VIRGINIANS

Estimated for 1989



Estimated Coverage by Percentage