FINAL REPORT OF THE
INSURANCE TASK FORCE

Studying Insurance Coverage for Persons with Mental Disabilities

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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FINAL REPORT
House Joint Resolution 42
Insurance Task Force

November 1, 1990

Preface

In May 1989, as requested by House Joint Resolution (HJR) 319, Howard M. Cullum, then 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. Isabel Brenner, a member of the State Mental Health, Mental Retardation and Substance Abuse Services Board, was appointed Chairman and Rubyjean Gould provided staff support to the Insurance Task Force. By action of the 1990 General Assembly, HJR 42 extended the Insurance Task Force study for another year.

Foremost in the group's discussion was the concept of a conversion method that would allow the trade off of the mandated 30 day inpatient hospitalization for alternative and more appropriate partial hospitalization or outpatient care. Interested in greater flexibility and cost neutrality, the Task Force looked at ratios for substituting inpatient treatment with partial hospitalization and outpatient services.

Task Force members recommended that an independent, third party provide objective assistance with examining the "conversion" concept and recommending alternative methods or formulae for providing flexibility with cost neutrality. The Task Force received the findings of the study conducted by economists from the Johns Hopkins University School of Hygiene and Public Health and Boston University and selected two options for additional examination and financial analysis.

Acting to achieve more flexible treatment choices within the constraint of maintaining premium cost neutrality, the Task Force recommended by vote that the 30 day inpatient mandate be converted to allow up to 20 days inpatient with a 20% co-payment, $1,000 of outpatient visits with a 50% co-payment, and a 2 for 1 substitution of inpatient days for partial hospitalization.

Further the Task Force recommended that the General Assembly work toward the ideal by considering the issues of parity coverage for mental health and substance abuse treatment, adequacy of funding to support treatment, and increasing the insurance mandates to include partial hospitalization and outpatient treatment.

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Executive Summary

In May 1989, as requested by House Joint Resolution (HJR) 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 1989 and met monthly since then.

As part of HJR 319, the Task Force was charged with coordinating its study with Senate Joint Resolution (SJR) 169 Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs. The Joint Subcommittee worked with a Substance Abuse Insurance Task Force comprising agency and industry representatives. This task force studied 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. These study committees reviewed similar issues. Two Task Force members sat on these other legislative study groups and 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. 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 coordinate activities of this Task Force with those of the Substance Abuse Insurance Task Force. The Substance Abuse Insurance Task Force submitted a report in November 1989, continued to meet, and submitted a final report recommending a three tier system with conversion ratios of 1:6 inpatient days[1] to outpatient visits[2] and 1:3 inpatient days to day support/intensive outpa-

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[1] Inpatient means 24 hour hospitalization in a hospital setting.

[2] Outpatient visit means hourly sessions of mental health treatment either individual or group conducted by a therapist, counselor, psychiatrist, social worker, psychologist, or other mental health professional.

tient[3], and outpatient visits. To test its recommendation, the SJR 23 subcommittee recommended that a pilot project be designed using community services board sites and the medicaid charging system.

By action of the 1990 General Assembly, HJR 42 extended the Insurance Task Force 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.

After reviewing the SJR 191 recommendations, the Task Force proceeded to develop recommendations. Foremost in the group's discussion was the concept of a conversion method that would allow the trade off of the mandated 30 day inpatient hospitalization for alternative and more appropriate partial hospitalization or outpatient care. Interested in greater flexibility and cost neutrality, the Task Force looked at ratios for substituting inpatient treatment with partial hospitalization and outpatient services and came to an impasse.

Several studies were cited about the relative value of trading inpatient care for less costly and sometimes more effective alternative psychiatric treatment. Clinical studies claim cost savings for early intervention which reduced the duration of the more costly inpatient treatment. Insurance industry studies claim that when outpatient benefits are offered, rather than having improved flexibility, a new market is tapped with large numbers of new consumers seeking services so that overall cost is far greater.

Task Force members recommended that an independent, third party provide objective assistance with examining the "conversion" concept and recommending alternative methods or formulae for providing flexibility with cost neutrality. The Task Force received the study findings and selected two options for additional examination and financial analysis. Members were concerned that the legislative recommendations be efficacious and withstand the close scrutiny of General Assembly members.

Because Virginia has been cited as a national leader in mental health and the Task Force is representative of all the forces interested in this issue, the National Institute of Mental Health provided grant monies to partially underwrite the cost of a study by health care economists. A select committee of the Task Force interviewed health care economists and recommended the selection of

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[3] Partial or intensive residential treatment means psychiatric or mental health treatment in a less restrictive setting than a hospital and may range from 4 hours to 24 hours in duration.

a team of researchers from the Johns Hopkins University School of Hygiene and Public Health and Boston University. The Task Force awarded them the contract to examine the conversion concept and alternatives by providing econometric analyses of variations of the conversion as well as alternative formulae.

Stephen Ayres, M.D., Dean of the Medical College of Virginia offered to assist the Task Force by reacting to the Johns Hopkins' report and assured that its findings and recommendations were within the context of Virginia's health delivery system. He expressed an interest in having a small group explore the provider side of the mental health care equation with a view toward the development of standards and provider incentives.

The Task Force discussed the findings, formulated positions, and prepared recommendations for consideration by the Governor and the General Assembly. Acting to achieve more flexible treatment choices within the constraint of maintaining premium cost neutrality, the Task Force recommended by vote that the 30 day inpatient mandate be converted to allow up to 20 days inpatient with a 20% co-payment, $1,000 of outpatient visits with a 50% co-payment, and a 2 for 1 substitution of inpatient days for partial hospitalization. Five Task Force members supported a conversion option of 20 days inpatient and a 2 for 1 conversion of inpatient days to partial hospitalization which would allow up to 40 days of partial hospitalization.

Further the Task Force recommended that the General Assembly work toward the ideal by considering the issues of parity coverage for mental health and substance abuse treatment, adequacy of funding to support treatment, and increasing the insurance mandates to include outpatient treatment.

Task Force Recommendations

The General Assembly specified the composition of the Task Force's membership to be service providers, the insurance industry, advocates for individuals with mental disabilities, and university teaching hospital representatives. This diversity of interests proved to be a strength in providing the full articulation of the various aspects of issues. However, when it came to forging recommendations, the diversity of perspectives frequently made it difficult to achieve consensus and necessitated that decisions be made by actual vote of the membership.

The Task Force formulated recommendations that delineated broad policy for an ideal system which addressed issues of parity, adequacy and therefore, mandates. These goals were established as clinically beneficial and morally appropriate. Understanding that these policy objectives could not be achieved in the current political and economic climate, the Task Force explored incremental initiatives to provide improved service flexibility without increasing the insurance premium.

1. Options for Conversion of Mandate

Within the reality of fiscal constraint warranted by Virginia's economy, Task Force members developed a feasible method to engender service flexibility using the Commonwealth's mandate of 30 days inpatient hospital care and requiring insurance premium cost neutrality. This narrow approach should not be viewed as the ideal response, but rather a tough answer to a difficult problem and a possible first step. The conversion options follow:

Four options were presented to the Task Force by Drs. Richard Frank, David Salkever, and Thomas McGuire. These options were cost neutral for the employer purchasing the benefit plan and provided greater treatment flexibility beyond Virginia's 30 day inpatient hospitalization. It was made clear that the cost neutrality of the options was **purely for the employer or company purchasing the benefit package and not for the public sector or tax payer, the provider, or the consumer.** This cost neutrality was achieved at the price of cost shifting to the provider, the public sector, and the client or consumer of mental health services.

Inpatient treatment utilization data show that the greatest resources are used initially in the early days of treatment, followed by a rapid decline, and then utilization levels off over time. Based on this pattern, the first few days of inpatient treatment, which account for the most significant use of resources, must be used to pay for alternative outpatient or partial day treatment to meet the cost neutrality constraint. The conversion of the 30 day mandate would apply to employees with insurance benefits purchased by employers. Because of the mandate provision in the Insurance Code, its major impact would be for small groups and employees enrolled in group benefit plans. It would not apply to those receiving benefits through a self-insurance program or policies written outside of Virginia.

Conservative assumptions were made by the researchers and in three of the four options co-payments were used as the mechanism to finance alternative treatment either for partial hospitalization or outpatient visits.

Most members reviewed the options and expressed dismay that Virginia's current 30 day inpatient mandate offers such a meager basis for supporting treatment alternatives. It was clear that given the cost neutrality constraint that parity could not be achieved through the options offered. Concern was expressed that with conversion, optional outpatient coverage, now included in many insurance packages, might no longer be offered or that the mandate and its conversion might become the ceiling rather than the threshold for coverage.

Many expressed support for expanding Virginia's mandate to include outpatient or partial hospitalization treatment. Typical of many provider observations were "None of the options offered, in our opinion, provide adequate mental health coverage for citizens of the Commonwealth" and "...none are close to offering adequate mental health benefits," or "...well placed people may be adequately served by their insurance protection but the financially disadvantaged may not be, consequently mandates are established to protect those in need of specialized services."

Given the researchers' choices, members registered their preferences as follows:

Option # 1:
Up to 20 days inpatient and 2 for 1 conversion to partial hospitalization up to 40 days. There is no change to the copayment arrangement. Outpatient care costs remain unin-

sured. The inclusion of partial care coverage would reduce current uncovered outpatient costs by approximately 10%.

The savings obtained from limiting inpatient coverage to 20 days is reflected by the reduction in inpatient plan costs which then are used to fund the partial hospital benefit.

The uninsured inpatient costs would increase to $1.1 million or 91% and would most likely be absorbed by transfers to the public sector (shifts to taxpayers) or through charge increases to "other payers" by hospitals due to increased bad debt.

Favoring:

Martin V. Cornetta, representing the Virginia Alliance for the Mentally Ill: "The Task Force has been given four options to consider. Three of these options contain co-payment which is a travesty. Consequently I vote for ... option 1."

Sally Duran, representing the Virginia Association of Health Maintenance Organizations.

John F. Troy, representing the insurance industry.

As a first choice: Alan J. Wood, representing HMO Virginia Blue Cross/Blue Shield: "...offer as an alternative to the current mandate."

Dennis Wright, representing the Virginia Chamber of Commerce: "...this option represents the best overall result in taking into consideration the administrative costs, additional co-insurance burdens placed on employees as required by the other options and the essential need for a straight forward method of enhancing flexibility of mandated inpatient benefits."

Option # 2:
Up to 30 days inpatient with 20% co-payment and a 2 for 1 conversion to partial hospitalization up to 40 days. Outpatient care costs remain uninsured.

The savings on inpatient care from introducing a copayment are larger than in Option 1.

The uninsured inpatient costs would increase to $1.7 million generated by increased copayments and would most likely be

absorbed by patients and their families and other payers due to rises in hospital bad debt.

Favoring:

Could also support: Alan J. Wood, representing HMO Virginia Blue Cross/Blue Shield: "...although the 20% coinsurance on mental health/substance abuse inpatient services than for other inpatient services could potentially be too costly for those enrollees who already have a higher coinsurance."

Option # 3:
Up to 20 days inpatient with 20% co-payment, $1,000 outpatient with a 50% co-payment, and a 2 for 1 trade to partial hospitalization.

The inpatient savings to the plan from imposing a 20 day limit and a 20% copayment reduces the uninsured portion of outpatient costs. Under the assumption of no substitution, Option 3 results in no increase in premium Allowing for some substitution, there would be a small savings to the plan.

Inclusion of outpatient coverage in the mandate will reduce the out of pocket liabilities of individuals who use outpatient mental health services and are covered by insurance plans that currently do not cover those services. Expanded outpatient coverage may allow public providers of mental health care to obtain third party payments for individuals who formerly did not have insurance coverage for outpatient mental health care.

The uninsured inpatient costs would be about $2.1 million and would most likely be absorbed by transfers to the public sector (shifts to taxpayers) or through charge increases to "other payers" by hospitals due to increased bad debt. Inpatient costs due to increased copayments would most likely be absorbed by patients and their families and other payers due to rises in hospital bad debt.

Favoring:

Randolph Canterbury, M.D., representing the University of Virginia.

John B. Davies, M.D., representing the Psychiatric Society of Virginia.

Charles M. Davis, M.D., representing the Medical Society of Virginia.

Phyllis T. McCafferty, L.C.S.W., Licensed Social Worker, representing the National Association of Social Workers, Virginia Chapter and Virginia Society of Clinical Social Workers, Inc.

Dwight McCall, Ph.D., L.P.C., C.C.M.H.C., representing Virginia Association of Clinical Counselors.

Clarissa Rowe, representing the Virginia Association of Retarded Citizens.

Reluctantly, Samuel Rubin, Ph.D., Licensed Clinical Psychologist, representing the Virginia Academy of Clinical Psychologists.

S. James Sikkema, representing the Mental Health Association in Virginia, "Strength: to assure the availability of partial hospitalization and outpatient services. Weakness: Option #3 may establish a lower standard and less availability of mental health care than is presently available through the combined existing mandate and currently available outpatient coverage in most insurance policies written Virginia."

With great misgivings, Joel Silverman, M.D., representing the Medical College of Virginia.

H. O. Smith, representing the Virginia Association of Community Services Boards.

Option # 4:
$10,000 overall limit, 20% co-payment for all treatment, and $1,000 coverage limit on outpatient.

This option implies identical savings from inpatient use. The consequence of the 20% copay for all services is to increase the portion of outpatient costs that are insured and reduce plan costs from partial care.

Inclusion of outpatient coverage in the mandate will reduce the out of pocket liabilities of individuals who use outpatient mental health services and are covered by insurance plans that currently do not cover those services. Expanded

outpatient coverage may allow public providers of mental health care to obtain third party payments for individuals who formerly did not have insurance coverage for outpatient mental health care.

The increase in outpatient costs to the plan will cause a modest increase in plan total cost relative to the base plan. The uninsured inpatient costs would be about $2.1 million would most likely be absorbed by transfers to the public sector (shifts to taxpayers) or through charge increases to "other payers" by hospitals due to increased bad debt. Inpatient costs due to increased copayments would most likely be absorbed by patients and their families and other payers due to rises in hospital bad debt.

Favoring: None

This section reflects the Task Force's recommendations for policy directions and broad goals for Virginia's ideal system of benefits and services for the mentally disabled.

These formal recommendations were voted by Insurance Task Force members at their September 18, 1990 meeting and written responses received subsequently from members who were absent on that date. All Task Force members were polled. When there were non-supporting votes, members holding the minority position are identified and their position and comments. If members are not identified, then there was complete concurrence with the recommendation.

1. Adequacy

   A. Current private sector coverage and benefits are not adequate for all consumers.

      Not Supporting: Sally Duran, representing Virginia Association of Health Maintenance Organizations; Alan Wood, representing HMO-Virginia, Blue Cross and Blue Shield of Virginia, and Dennis Wright, representing the Virginia Chamber of Commerce.
      Dennis Wright stated that companies believe that they are providing adequate benefit coverage to meet the needs of their employees and their dependents.

   B. Current private sector coverage and benefits are not adequate for special cases.

      Abstaining: Alan Wood.

   C. When resources are limited, client groupings should receive treatment or care concomitant to the severity of their illness or disorder. Resources and benefits should be provided when appropriate and necessary.

      Abstaining: Alan Wood.

   D. Current public sector coverage and benefits are not adequate. Most severely impaired clients should be provided with treatment. If an individual can afford treatment costs, efforts should be made to have the individual contribute toward payment of the cost of care.

2. Parity

In the global context, mental disorders and mental illnesses should be addressed and provided for in the same manner as are other physical disorders and illnesses. Limitations on benefits should be based on the severity of the debilitating condition rather than it being a "mental illness or mental disorder" as opposed to a "medical illness or medical disorder." Treatment of mental or substance abuse disorders or illnesses should not be addressed or managed in a discriminatory manner.

Not Supporting: Sally Duran, Alan Wood, Dennis Wright, and John F. Troy, the Travelers Insurance Companies, representing the insurance industry.
John F. Troy accepted the statement in concept, but felt that limitations toward some illnesses and disorders, i.e. back injuries, is necessary, but should be limited to mental illness or mental disorders.

3. Public or Private Care Providers

A. Care and treatment of certain mental health or substance abuse diagnoses should not be provided exclusively in the public sector or the private sector.

B. Care and treatment of particular mental health or substance abuse diagnoses should not be excluded from provision in the public sector or the private sector.

Not Supporting: Alan Wood.

C. Clients should have a choice of treatment settings as clinically indicated with a range of treatment options made available.

D. The public should pay for care or treatment when it is in the public good and when an individual citizen can not afford to pay their own way for treatment or care.

The determination of public support should be based on the individual's ability to pay and on treatment setting.

4. Quality and Cost Control Mechanisms

A. There is concern about run away costs and the following mechanisms should be instituted to control cost. Co-insurance payments, utilization review standards, deductibles, managed care, network providers, and other reasonable and appropriate cost control means. Risk should be spread broadly to minimize costs, benefit packages should be designed to control costs, and scientific advancements should be supported to identify lower cost or more effective treatment methods. Early access to services should be provided for prevention and incentives should be established to encourage utilization of more cost-effective treatment.

B. There is concern about poor or inappropriate quality of care or treatment and the following means should be instituted to assure quality. Through statute, professional societies should be granted immunity from prosecution for quality assurance activities and the self-policing of professionals within their ranks who provide inappropriate treatment. Objective factors should be used by network providers and hospitals to maintain the quality of treatment by excluding providers who do not provide appropriate treatment.

C. Limitations on coverage for treatment should be a function of the diagnosis and the severity of the illness or the disorder. Coverage should be based on the diagnosis and utilization review should be employed to assure the efficacy of the treatment.

D. Managed Care and Utilization Review

1) There should be regulations requiring the development of criteria for the conduct of managed care panel participants and utilization reviewers which include qualifications requisite for their participation.

Not supporting: Sally Duran, Alan Wood, and Dennis Wright.
Sally Duran: There are national organizations studying utilization review and it is premature to develop criteria for the conduct of utilization review.

Alan Wood: Let the free market shape the demand for managed care and utilization review panels.
Dennis Wright: I am opposed to regulation unless we know that there are problems.

Majority statement in support: Randy Canterbury, M.D., University of Virginia Medical College, representing Virginia's teaching hospitals: Decisions of care managers should reduce or share (spread) tort liability.

2) It is in the best interest for the public to have confidence in these systems, therefore operational standards should be developed for managed care or utilization review that include appeal procedures.

Not supporting: Alan Wood and Dennis Wright.

3) Conditions and clinical procedures would dictate whether reviews would be retrospective or prospective. It would be at the option of the company to delineate whether certain requested treatments be reviewed prospectively.

4) As the situation warrants and at the option of the reviewer, second opinions might be required for mental health and substance abuse treatment. They should not be required nor should they be prohibited.

5) DRGs (diagnostic related groups) developed thus far should not be required to determine reimbursement for mental health and substance abuse treatment and care because there is no scientific evidence to indicate that they are predictive. Their use should be the prerogative of the reviewer or the company.

6) Managed care panels and utilization review panels should include some elements that are independent of insurance companies and providers.

Not supporting: Sally Duran, Dennis Wright, Alan Wood and John F. Troy.
John F. Troy: It is much too early in the development of managed care system to determine that. There is a healthy tension and systems should be allowed to work

their course. Professionals participate and adhere to their professional ethics. It would be a bureaucratic nightmare to manage.

Majority statement in support: Joel Silverman, M.D., Medical College of Virginia, representing Virginia's teaching hospitals: Volunteers should provide the independent elements of managed care provider panels or utilization review panels.

G. Preferred Provider Organizations should not be able to limit mental health provider membership because it limits freedom of choice of the consumer.

Not Supporting: Sally Duran, John F. Troy, Alan Wood, and Dennis Wright.
Alan Wood: "We believe that the current PPO statutes do not allow insurers to negotiate the best arrangements possible in terms of costs and patient volume, a circumstance which has led to higher health insurance premiums in Virginia."

5. Mandates

A. Mandatory benefits should not be based on prevalence or incidence of illnesses or disorders.

B. Outpatient substance abuse and mental health services or treatment should not be made mandatory to make available[4] on individual policies.

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[4] Virginia has two types of insurance mandates. One is a "mandate to make available" which requires the insurance company to offer the buyer or insurance purchaser a particular benefit. The buyer may decline to purchase the benefit. The other mandate is a requirement that the benefit must be included in any insurance package or benefit plan sold to a group.

C. Substance abuse and mental health out patient services or treatment should be made mandatory[5] to spread the cost and avoid adverse selection.

Not supporting: Sally Duran, Alan Wood, Dennis Wright, and John F. Troy.
Objections based on concerns of not maintaining cost neutrality.

[5] Mandatory in all group insurance policies written in Virginia.

The Ideal System

I. Services
  A. Available and accessible for all who require services
    1. Full range of cost-effective professional services
    2. Range of settings -
      a. Most appropriate
      b. Least restrictive
      c. Allows continuity of care
      d. Nearby
      e. Treatment setting choices for clients
    3. Records available to providers for effective delivery

  B. Adequately funded by a variety of sources
    1. Public - government
    2. Private - benefit programs
    3. Personal - individual contribution or payment

  C. Managed Care System
    1. Treatment evaluation for effectiveness
    2. Assurance of appropriateness of care
    3. Resolution of treatment disputes
    4. Appropriate sharing of decision criteria
    5. Unbiased appeals process

II. Providers
  A. Education
    1. Formal education and training
    2. Ample continuing education and training opportunities

  B. Include many professional disciplines

  C. Reimbursement for services rendered
    1. Fair payment
    2. Proper and timely payment
    3. Service invoicing process manageable

III. Service Delivery in a patient-oriented environment
  A. Screening - Gatekeepers
    1. Timely access to appropriate care
    2. Treatment setting choices
    3. Appropriate sharing of decision criteria
    4. Unbiased appeals process

B. Providers
    1. Competent and proficient
    2. Effective delivery
    3. Appropriate modality and setting
    4. Continuity of care
    5. Treatment setting choices

C. Reimbursement Mechanisms
    1. Adequate, timely financial support for services
    2. Control costs to reflect reasonable charges

D. Case Managers/Managed Care System
    1. Properly trained and experienced
    2. Assure treatment follow through
    3. Review efficacy of treatment rendered
    4. Perform quality assurance function

IV. Cost and Quality Control
    A. Assure cost effective treatment
    B. Provide quality assurance and risk management programs
    C. Maintain credentialing protocols
    D. Provide reporting loops to improve service delivery
    E. Maintain ongoing economic analysis of outcome data.

Background

There is concern that high costs of health care and demands on the health insurance industry have resulted the reduction of mental health insurance benefits to Virginians. Persons with mental disabilities are particularly vulnerable to benefit reductions and encounter difficulty in accessing covered care and services because benefits for the treatment of mental and physical diseases and disorders are handled differently from treatment for other health conditions 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 services are needed.

Purpose and Scope of Study

Through House Joint Resolution (HJR) 319 and subsequently, House Joint Resolution (HJR) 42, 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, then DMHMRSAS Commissioner, and Steven T. Foster, Commissioner, Bureau of Insurance, State Corporation Commission in May 1989. The complete Task Force membership over its 18 month life is listed in Appendix A.

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 was studying mandated substance abuse treatment and prevention programs.

Issue statements and support positions were solicited from the groups, associations, universities, hospitals, insurance industry, and other affiliations represented on the Task Force. Statements were received from most of the represented groups and affiliations. Recommendations and solutions to the issues were more difficult to mutually forge. Subsequently, larger groups were formed to develop positions for consideration by the entire Task Force membership.

In response to Task Force members' concerns about benefit coverage for employees in self-insurance programs, the Virginia Chamber of Commerce undertook a survey of the benefit programs of large and medium sized self-insured companies. (See Page vi.) The survey showed that many self-insured companies in the private sector are providing both inpatient and outpatient mental health care. Most surveyed exceeded Virginia's mandates.

Process and Study Participants

After defining issues and information needs, small groups were formed to develop recommendations that were considered and discussed by the larger membership. There was agreement that greater treatment flexibility would provide more appropriate and effective treatment. It was also agreed that achieving flexibility through a broader range of treatment options to be achieved realistically had to be within a cost neutral setting. The cost neutral constraint was applied to the cost of the insurance premium and not the other segments of the health care picture. It was understood that cost neutrality for the insurance purchaser would likely have cost shifting consequences for the consumer and the provider, especially the public sector provider. The Task Force decided to engage independent health care economists for the econometric analyses of recommended inpatient mandate conversion alternatives. Ultimately, the Task Force discussed its recommendations and voted to reflect supporting as well as non-supporting positions.

The Issues

1. Definitions - Legal Documents

Discussion and findings:

The definition in the *Code of Virginia*, § 38.2-3412 was reviewed by the Task Force for its content and in comparison with definitions found in other state codes.

- Many other state codes did not have mental health definitions at all. Other state codes had definitions that were similar to Virginia's definitions.

The group discussed the different definitions contained in insurance policies and compared them with the legal definition for mental illness found in the *Code*. Members suggested the addition of the words "acute and chronic" in the Code of Virginia, § 37.1-1 or in the insurance sections. Other points proposed were tieing 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" as a substitute for "mental health disease." The group also discussed starting from scratch and developing its own definition.

★[6] The group agreed that coverage has not been adversely affected by the Code's current definition. There was discussion about the purpose of changing the definition and it was pointed out that there are risks to changing it. The strengths and weaknesses of the proposed change were discussed. **It was the unanimous decision of the group to leave the definition as it stands.**

[6] ★ Task Force decision.

2. Parity

Discussion and findings:

Insurance policies of many major insurers and HMOs in Virginia were reviewed for their definition of "mental disability" and the coverage provided for "mental disabilities". Approximately 60 insurance policies were reviewed for the definition of mental illness. Based on this review of benefits in insurance policies, the Task Force explored the issue of non-discrimination in the offering of mental health and substance abuse treatment provisions in benefit packages. It was noted that there is a consistent disparity of benefits for the treatment of mental disabilities. Most felt that it is scientifically and morally in the best interests of the Commonwealth.

- 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 outpatient services in policies written outside Virginia.

- 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 statutory limitations on treatment for mental health care than for other coverage.

- 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 to the same extent as a benefit in insurance policies.

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

- Some individuals with mental illnesses or mental disorders have received **inappropriate treatment due to the stigma** associated with treatment for mental illness, limited benefit programs, restricted access or availability of mental health treatment, or misdiagnosis of their condition.

Based on scientific evidence of the biologic origins of many mental disorders, it is becoming increasingly clear that many mental illnesses and disorders are of physical (biological) origin and therefore, their treatment should not be classified differently than other physical illnesses or disorders. Several recent court cases outside of Virginia have required the inclusion of treatment of behaviors due to disfunction of the central nervous system with other physical illnesses on this basis.

★[7] Therefore, in the global context, mental disorders and mental illnesses should be addressed and provided for in the same manner as are other physical disorders and illnesses. Limitations on benefits should be based on the severity of the debilitating condition rather than it being a "mental illness or mental disorder" as opposed to a "medical illness or medical disorder." Treatment for all chronic diseases should be handled in a consistent manner.

Most members of the Task Force concurred that philosophically there should be parity; however, some felt that in practice, coverage must be different. One member said that a great number of so-called physical illnesses and disorders also have specific coverage limitations. Insurance coverage is meant to offer protection to individuals from unexpected healthcare costs to protect their assets and therefore, certain limitations are necessary to offer the protection at an affordable cost.

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[7]★ Indicates a consensus position of the Task Force.

3. **Treatment Services:**

Discussion and findings:

There were extensive discussions about adequacy of services, efficacy of the mandated services, and methods to improve treatment flexibility through a plan of conversions. There is much overlap among these issues. For purposes of this report's organization, the following issue clusters will be presented:

A. Benefits and Service Delivery

B. Adequacy of Services

C. Mandated Services

D. Methods for Improving Flexibility: Conversion Formulae

The inflexibility between access to outpatient and inpatient treatment benefits is an obstacle to providing appropriate and cost effective clinical treatment for the client. Benefits provided are the most intensive, most expensive and not necessarily the most effective treatment. Cost savings may be achieved by greater access to outpatient settings as an alternative to inpatient psychiatric hospitalization.

A. Benefits and Services:

There was discussion about the current mental health care and substance abuse treatment delivery system. The issues and points of agreement are noted.

- It is widely believed that there is value to early appropriate treatment. Early intervention may be cost-effective by treating some mental health disorders on a less costly outpatient basis before more costly inpatient care is required.

- Intensive outpatient and partial hospitalization services should be offered in conjunction with necessary inpatient services based on **appropriate level of care.** Required by the condition being treated.

- 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.

- There must be **separate substance abuse and mentally ill treatment programs for the dually diagnosed.**

- **Alternative treatment programs must have built in incentives** if they are to be used.

- When resources are limited, client groupings should receive treatment or care concomitant to the severity of their illness or disorder. Resources and benefits should be provided when appropriate and necessary. Ideally, the outcome of treatment should be considered.

Preferred Provider Organizations:
Concern was expressed by representatives of the insurance industry, HMOs, and the Chamber of Commerce that Virginia's current Insurance Code prohibits the establishment of exclusive networks of providers. They said that if allowed, closed networks would lower costs for consumers by providing the insurance company leverage to assure the provider a sizable amount of the market. The representative from Blue Cross/Blue Shield stated, "...the current PPO statutes do not allow insurers to negotiate the best arrangements possible in terms of costs and patient volume, a circumstance which has led to higher health insurance premiums in Virginia."

After Task Force members discussed the implications of allowing closed preferred provider networks similar to the health maintenance closed network, the group recommended:

- ◘[8] Preferred Provider Organizations should not be able to limit mental health provider membership. This would discourage freedom of choice for those needing care by placing additional charges or sanctions on consumers who seek care outside of the network without lowering costs of care.

Public or private care providers:
The Task Force membership included providers from both the private and public sectors of mental health and substance abuse treatment. There were discussions about the effect on demands for public services due to funding or benefit changes in the private sector. The group explored the issue of who

[8] ◘ Indicates a decision by vote of the Task Force.

should pay for care and the funding mechanisms to support it. Members could not reach consensus on preferable mechanisms, i.e. increased premiums, increased taxes, teaching hospital indigent funds, non-collectibles and write offs. However, there was general consensus on the following points.

- Care and treatment of mental health or substance abuse diagnoses should not be provided exclusively in the public sector or the private sector.
- Care and treatment of particular mental health or substance abuse diagnoses should not be excluded from provision in the public sector or the private sector.
- Clients should have a choice of treatment settings as clinically indicated with a range of treatment options made available.
- The public should pay for care or treatment when it is in the public good and when an individual citizen can not afford to pay for treatment or care.
- The determination of public support should be based on the individual's ability to pay and on treatment setting.
- As costs increase, there is a greater shift to the public sector for services due to limits of insurance benefits, demographic changes in population distribution, and increased drug dependence.
- The private sector should not pay for public sector services.

B. Adequacy of Services:

The Task Force had general consensus on the following items about the adequacy of the current delivery system based on their observations and experience.

- A characteristic of adequate coverage could be considered to be **that level of private sector services that would not increase the demand on public sector services.**
- Current private sector coverage and benefits are not adequate for all consumers.

Some members of the Task Force felt that benefit coverage is determined by the employer based on an assessment of work force needs. Considering choices which employers

and employees are required to make in selecting benefit plan designs, it is believed that current levels of coverage provide an excellent balance of benefits which serve to prevent families from facing financial ruin in the event of severe medical and mental difficulties.

- Current private sector coverage and benefits are not adequate for special cases.

- Current public sector coverage and benefits are not adequate to provide severely impaired clients with adequate treatment.

- Public funds for treatment of mental health and substance abuse will not grow concomitantly to support increasing service demands.

Business and Demand for Services

Many employers recognize the need for health benefit programs and typically bear the majority of the cost of providing medical benefits for their employees and their dependents.

- Business stands substantial risk associated with increasing benefit costs and catastrophic cases. Employers and their employees should be acknowledged as the ultimate payers of the fees and charges of providers. Business is seeking greater flexibility and new ways to address the escalating costs of health care because it can not afford them.

- Business employers decide the market basket of benefit packages to the extent allowed by law.

- When employee health care costs become prohibitive, employers decrease or cease providing employee health care coverage which results in either the individual employee or the public paying for the employee's care and treatment services; or go self-insured and continue to provide health care services to employees which may or may not exceed mandated service requirements. In some cases, employers cease providing health insurance altogether.

- Increasing public education and knowledge will reduce the stigma associated with mental illnesses and disorders and, thus increase the demand for services.

- The objective of treatment is to reduce the duration of inpatient care and to return the client to productivity.

C. **Mandates:**

The Task Force studied the *Code of Virginia*, § 38.2-3412, § 38.2-3413, and § 38.2-4300 containing the insurance benefit mandates pertaining to treatment for mental, emotional or nervous disorders and benefits for drug and alcohol rehabilitation and treatment. It learned the history of the development of these Code sections and the contextual background for their enactment. The distinction between benefits that have a *mandate* and those that have a *mandate to make available* was considered.

Task Force members received a rough estimate of the proportion of Virginians actually covered by the mandates in contrast to those covered by their employer's self-insurance programs, out of state carriers, or those without any coverage.

Members from the insurance industry and business pondered whether mandates inhibit the development of innovative and pilot programs. A segment of the group wanted to remove all mandates. There were questions about the actual cost of mandates that could not be answered. Some quoted articles saying that mandates save money, while others quoted different articles stating that mandates increased costs and did not provide improved access.

- The mandated benefits as currently structured are too restrictive. Virginia's mandated mental health services should have greater flexibility to allow more appropriate treatment, while maintaining cost neutrality for insurance purchasers. Mandates should allow a means to provide an appropriate range of treatment options and continuity of care to reduce the revolving door phenomenon.

- Extreme care and caution 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.

- Mandatory benefits should not be based on prevalence or incidence of illnesses or disorders.

- ◘[9] Outpatient substance abuse and mental health services or treatment should not be made mandatory to make available on individual policies.

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[9] ◘ Indicates a decision by vote of the Task Force.

★[10] There should be parallel benefits mandated regardless of the source of funding treatment, i.e. children's services covered by Medicaid. Similar mandates should apply, notably psychiatric care for children and substance abuse treatment which currently are not provided for by Medicaid/Medicare under the State Medical Assistance Plan.

Some group members recommended that:

■[11] Substance abuse and mental health out patient services or treatment should be made mandatory to spread the cost and avoid adverse selection.

D. **Conversion for Access and Treatment Flexibility:**

There was discussion about mandated services and the advisability of a plan to access outpatient care through conversion of inpatient treatment benefits. The current mandate and many insurance programs only provide for inpatient hospitalization which prevents covered access to what may be a more appropriate clinical treatment setting for the client and precludes the cost savings associated with lower cost outpatient care as an alternative to inpatient psychiatric hospitalization.

It was accepted that in the current political and economic climate, the acceptability by the General Assembly of a mandate conversion would be predicated on cost neutrality of the insurance premium. This proved a dilemma for some members because the increased flexibility allowing outpatient or partial hospitalization would be achieved at the cost of reduced needed inpatient services and an increased demand on the already heavily burdened public sector. The reality of political conditions could lead to a conversion option that would be clinically inadvisable.

★ To succeed in today's environment, any conversion methodology must contain the following features:

1. It must be cost effective and provide appropriate continuity of care.

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[10] ★ Indicates consensus of the Task Force membership.

[11] ■ Indicates a decision by vote of the Task Force.

2. It must be cost neutral to insurance purchasers and include both inpatient and outpatient services.[12]

3. It must have built in economic incentives if it is to be used.

4. It must have properties that control induced demand.

5. It must be flexible for changing treatment modalities and be able to accommodate the state of the art and evolution in treatment.

6. It must have the capacity to respond to inflation.

★[13] Any conversion methodology must have control mechanisms to regulate the conversion process, to report its usage, and evaluate its efficacy.

4. Monitoring:
Gatekeepers, Utilization Review, and Managed Care Issues

Discussion and findings:

Task Force members recognized and agreed that health care costs need to be contained and that managed care is one mechanism to accomplish that end. The Task Force members reviewed various health care management mechanisms. They heard reports of managed care, utilization review, and other gatekeeper operations acting either prospectively to approve treatment or reviewing treatment for reimbursement retrospectively. Task Force members were not clear who should monitor treatment. One suggestion was that an independent third-party should monitor services, reimbursement, and treatment in-take.

The Task Force received mixed reviews on managed care, utilization review, and other health care management systems. Some articles claimed that managed care allows for greater treatment flexibility. Others stated that managed care leads to limiting benefits.

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[12] Some members urged that appropriate clinical choices and not cost neutrality be the uppermost concern in deciding upon a conversion option.

[13] ★ indicates consensus of the Task Force.

Providers were concerned that utilization reviews and other managed care systems are used by insurers to prevent or reduce the delivery of benefits. They said that standards used by some 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 make the determination based on a report or records review.

Concomitantly, there is concern on the part of insurers that providers may abuse insurance benefits by tailoring services to the patient's benefit package rather than care needs. They felt that further regulation should not be considered without a justifiable basis because the marketplace has already produced the development and sufficient self-regulation of the utilization review process.

- Another means to lessen the difficulty of monitoring service provision could be to have clearly established and followed standards.

- Oversight of utilization review would have to be part of the alternative treatment conversion program.

- Limitation on coverage for treatment should be a function of the diagnosis and the severity of the illness or the disorder. Coverage should be based on the diagnosis and utilization review should be employed to assure the efficacy of the treatment.

- Managed care systems may ultimately lead to parity of benefits and conditions covered, thereby, lessening the focus on the issues of the level of mandated benefits and mandating plans of service.

The Task Force agreed and made the following recommendations:

■[14] Managed care, including utilization review, is a reality of health care that will be used increasingly to control costs and quality of care. It should be well-structured and have a neutral appeals system.

★[15] There is concern about run away costs and the following mechanisms are recommended to control cost:

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[14] ■ Indicates a decision by majority vote of the Task Force.

[15] ★ Indicates a consensus position of the Task Force.

- ★ Co-insurance payments, deductibles, utilization review standards, managed care, network providers, and other reasonable and appropriate cost control means.

- ★ Risk should be spread broadly to minimize costs, benefit packages should be designed to control costs, and scientific advancements should be supported to identify lower cost or more effective treatment methods. Early access to services should be provided for prevention and incentives should be established to encourage utilization of more cost-effective treatment.

★[16] There is concern about poor or inappropriate quality of care or treatment and the following means are recommended to assure quality.

- ★ Through statute, professional societies should be granted immunity from prosecution for quality assurance activities and the self-policing of professionals within their ranks who provide inappropriate treatment. Objective factors should be used by network providers and hospitals to maintain the quality of treatment by excluding providers who do not provide appropriate treatment.

◘[17] It is in the best interest for the public to have confidence in these systems, therefore operational standards should be developed for managed care or utilization review that include appeal procedures.

- ★ There was concern that access to care might be governed by cost rather than treatment need. To safeguard against this perception or actuality, it was suggested that there should be regulations requiring the development of criteria for the conduct of managed care panel participants and utilization reviewers which include qualifications required for their participation.

  A. Gatekeepers providing access to care or reimbursement of treatment must be experienced,

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[16] ★ Indicates consensus of the Task Force.

[17] ◘ Indicates a decision by vote of the Task Force.

knowledgeable professionals using objective standards.

B. Gatekeepers must be liable for the consequences of their decisions.

★ Conditions and clinical procedures would dictate whether reviews would be retrospective or prospective. It would be at the option of the utilization review program to delineate whether certain requested treatments be reviewed prospectively.

★[18] As the situation warrants and at the option of the reviewer, second opinions might be required for mental health and substance abuse treatment. Many said that second opinions are useless because many providers do not wish to take issue with the recommendations of their colleagues, thus, they do not serve the interests of the consumer nor assist in lowering health care costs. They should not be required nor should they be prohibited by law.

■[19] DRGs (diagnostic related groups) developed so far should not be used to determine reimbursement for mental health and substance abuse treatment and care because current evidence indicates that they are not predictive. With advancements in mental health treatment and improved technology, DRGs might be considered to be reliable and useful. Use of appropriate methodology should be the prerogative of the reviewer.

■[20] Gatekeepers and utilization review panels should include some elements that are independent of insurance companies and providers, who are clearly perceived as being be disinterested and objective.

Some members felt that managed care operators should have no financial interest in the outcome of their decisions.

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[18] ★ Indicates consensus of the Task Force.

[19] ■ Indicates a decision by vote of the Task Force.

[20] ■ Indicates a decision by vote of the Task Force.

It was suggested that:

A. Volunteers might provide the independent elements of managed care provider panels or utilization review panels.

B. The Bureau of Insurance might be an appropriate site for overseeing monitoring operations.

C. Community services boards might be an appropriate agent for the monitoring operations.

D. A competitive process might be used to develop a better monitoring mechanism.

E. The market has sufficient checks and balances.

Some Task Force members took exception to the above suggestions and stated that it is much too early in the development of managed care systems to determine that they are not working. It was asserted that there is a healthy tension and systems should be allowed to work their course. Professionals participate and adhere to their professional ethics. Regulation of review organizations could be a bureaucratic nightmare to manage.

Report of Mandates Conversion Options

CENTER ON ORGANIZATION
AND FINANCING
OF CARE FOR THE
SEVERELY MENTALLY ILL

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Development Center
Department of Health Policy
and Management
School of Hygiene and Public Health
The Johns Hopkins University

Mental Health Policy Studies Program
Department of Psychiatry
School of Medicine
University of Maryland

Department of Mental Hygiene
School of Hygiene and Public Health
The Johns Hopkins University

OTHER COLLABORATING
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REPORT TO THE

COMMONWEALTH OF VIRGINIA TASK FORCE

ON

MENTAL DISABILITIES

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I. Background and Task Definition

The Commonwealth of Virginia currently has a mandated benefit statute that requires private insurers to provide a minimum of 30 days of inpatient psychiatric care under both individual and group policies sold in the state. Thirty states have some statute regarding the provision of mental health coverage by private insurance. The majority of these statutes only specify that coverage be made available as an option.[1] Mandated minimum benefit packages have been specified and adopted by 14 state legislatures. The mandated benefit package specified in the Virginia statute is among the most restrictive of the 14 states with similar laws.

During the 1989 session of the Virginia General Assembly a joint resolution was passed that directed the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Bureau of Insurance to establish a task force to study insurance coverage for individuals with mental disabilities. Among the concerns of the task force was the structure of the mental health mandate. The task force had particular interest in increasing the flexibility of the existing statute. This was, in part, motivated by the recognition that the existing mandate would not necessarily extend coverage to a variety of treatment approaches that have been found to be cost-effective in clinical research. The desire for flexibility was accompanied by concerns over increases in premium costs to purchasers of insurance.

The need to explore possible changes in the mandated benefit statute led the task force to enter into a contract with the Johns Hopkins University's School of Hygiene and Public Health. The charge to the research team from Johns Hopkins was to examine options for making mandated minimum

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[1] See Levin, B.L., "State Mandated Mental Health Benefits United States 1987" Florida Mental Health Institute, University of South Florida mimeo.

benefits more flexible in a manner that would not result in insurance premium increases. This report summarizes the results of that investigation.

II. Development of Options

The practical goal of our research effort was to develop a new minimum benefit package that includes coverage of partial hospitalization and outpatient treatments for mental health problems. Adding new coverages to an insurance benefit consisting of 30 days of inpatient coverage while maintaining existing premium levels requires that all new coverage be paid for by savings derived from reductions in currently covered services. This means that any benefit design options to be considered (those meeting the "no premium increase" criterion) would have to significantly reduce coverage for inpatient mental health care. This fact led us, in consultation with the task force, to consider two main classes of options for increasing flexibility of the existing mandate.

1) Use of a conversion factor to transform inpatient days into partial hospital days and outpatient visits. The conversion rates would depend on specification of cost sharing provisions and other benefit design features that would maintain a constant premium level.

2) Use of a total dollar allowance for mental health care under specified cost sharing provisions and other benefit design features that would maintain a constant premium level.

III. Overview of Method

The approach to developing the new mandated benefit package relied on construction of a simulation model that would allow for a quantitative

assessment of costs and utilization patterns associated with a number of concrete benefit design options. The model was structured so as to make use of data on utilization of mental health services in the Commonwealth of Virginia.

This method consisted of two steps.[2] The first step used data from the state employees health plan in Virginia to develop a description of mental health care utilization. Those data were combined with information on patterns of services use from the research literature to characterize the demand for mental health services by a Virginia population.[3]

The second step was to simulate the baseline plan and then the impact of an insurance benefit change on the level and patterns of costs for mental health care. The model of demand developed in the first step was applied to the state employees data to predict what utilization and costs would be in the baseline plan that provided for 30 days of inpatient mental health coverage, no cost sharing and no ambulatory mental health coverage. After developing the baseline prediction, the model was used to forecast the consequences of the insurance benefit changes. This together with assumptions about the demand response to insurance plan changes underlie our predictions. The component pieces that made up the simulation model are presented schematically in Figure 1.

A key set of assumptions, the subject of a great deal of discussion with the task force, involved the degree of substitutability between inpatient mental health care and partial hospital care. It was our recommendation that

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[2] A detailed description of the model of mental health benefits used in the analysis is presented in an Appendix to this report.

[3] The data for the state employees were provided to us by Robert L. Wright from the Bureau of Insurance. We are grateful for his help and advice in the use of those data.

in the absence of strong evidence supporting a high degree of substitution with respect to partial care that conservative assumptions be made. We assumed that making partial hospital care a covered service would lead some users of outpatient care to use that form of treatment. Next, we considered two alternative assumptions: 1) that no substitution occurred between inpatient and partial hospital care and 2) that 10% of inpatient cases substituted partial care for inpatient care.

Several benefit plan options were compared to a base plan that was assumed to consist of 30 days of inpatient mental health treatment with no deductible and no copayment. Since there are many possible variations in the type of coverage offered in the state, we adopted one rather common form of inpatient coverage for use as a base plan. Benefit plan options which maintain a constant premium level are made relative to this base coverage. Thus, while the results do not literally apply to all benefit designs, the general parameters outlined by the options will apply to wide a variety of existing plans. Finally, demand for outpatient mental health care is assumed to respond to insurance coverage. Our assumption about demand response is based on national research on the demand for ambulatory mental health care.[4] Extending coverage to include outpatient mental health services is assumed to result in significant increases in service use in addition to new payments for existing use being incurred by insurance.

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[4] See the Appendix for a description of the demand response assumptions. McGuire T.G. "Financing and Reimbursement for Mental Health Services" in Taube C. and Mechanic D (Eds) The Future of Mental Health Services REsearch Washington: USGPO 1989.

IV. Results

Table 1 presents the set of specific benefit design options that are consistent with the general options outlined in Section II above. Each of these plans is roughly consistent with the goal of not increasing premiums. The base plan represents our characterization of the existing mandate.

Options 1 and 2 specify conversion rates from inpatient care to partial hospital care and offer no outpatient coverage. Options 1 and 2 differ in their methods of obtaining the savings from inpatient coverage necessary for funding the new partial hospital benefit. Option 1 reduces maximum coverage of inpatient care from 30 to 20 days, while not making any changes in the copayment arrangements (zero copayment). Option 2, in contrast, maintains the 30 days of coverage but imposes a 20% copayment. Option 1 therefore funds partial care by shifting financial responsibility onto parties who will absorb the costs for days 21 to 30. Option 2 funds the partial care benefit by imposing costs on all users of inpatient mental health care.

Option 3 represents a benefit package that covers both outpatient care and partial hospitalization. Because there is substantial use of outpatient mental health services when no outpatient coverage exists, and because outpatient use is responsive to insurance coverage, new savings must be extracted from the inpatient benefit to fund outpatient coverage. Option 3 therefore reduces inpatient coverage by 1) placing a twenty day limit on coverage and 2) imposing a 20% copayment on inpatient benefits. (Recall we assume that the base plan offers 30 days of coverage with no cost sharing provisions). Even with these significant reductions in inpatient coverage, only a very limited outpatient benefit is consistent with constant premium. The result is a 50% copayment and a $1,000 limit on coverage for outpatient

treatment.

Option 4 creates an overall expenditure limit with specific cost sharing features for partial hospital and outpatient services. No specific conversion rates are identified. Twenty percent copayments are imposed on all services (partial care previously had no copayment) including inpatient care. Thus, the new benefits are funded by constraining total expenditures per person to an amount that would purchase roughly 20 inpatient days and by imposing cost sharing on all mental health services.

Table 2 presents the quantitative results of our analysis for each of the options and the base plan. The results show the total costs of care and the amount of treatment costs by treatment setting. These costs are disaggregated by those: 1) borne by the affected health insurance plan and 2) not covered by insurance. Note that for the base plan total insurance plan costs are roughly $7 million. The entire plan cost is accounted for by inpatient coverage since this is the only service that is insured. The uninsured amount of inpatient care is $565,000 which represents the costs of care for individuals who exceed the 30 days of mandated coverage. Since no insurance for outpatient mental health care is assumed to exist, the full costs of outpatient use, $2.3 million, for a population similar to the state employees, is "uninsured". Finally, no partial hospital care is used when the service is not covered by insurance. Thus total mental health costs for the population are approximately $9.8 million.

In considering each of the optional plans we develop our forecast under two assumptions regarding substitution. These assumptions are referred to as upgrades and downgrades on Table 2. Upgrades consist of individuals who used outpatient services under the base plan who would make use of partial hospital

services when they become covered. Upgrades were assumed to be 10% of the original number of outpatient users. These individuals would upgrade to use 25 days of partial hospital care at a cost of $200 per day. When there is outpatient care the plan only pays the difference between the upgraded partial use ($5000) and the average level of outpatient use. Downgrades are assumed to be 10% of the inpatient users. They stop using the average inpatient use and begin using 25 days of partial hospital care at $200 per day.

Options 1 and 2 extend coverage only to partial care. Thus outpatient care costs remain uninsured. However, because of the upgrades from inclusion of partial care coverage, outpatient costs are reduced by approximately 10%. The savings obtained from limiting inpatient coverage to 20 days (Option 1) is reflected by the reduction in inpatient plan costs from $6,999,000 to between $5,759,000 and $5,183,000 depending on the substitution assumption made. These savings are then used to fund the partial hospital benefit, which has a plan cost of between $1.5 and $1.9 million. The impact on premiums can be seen by examining that Total/Plan category at the bottom of Table 2. Option 1, assuming no substitution, leads to a roughly 4% increase in plan costs. When a small amount of substitution is permitted (downgrades) total plan cost increase by about 1%. The savings on inpatient care from introducing a copayment (Option 2) are larger than in Option 1. Thus, the benefit change results in small declines in Total/Plan costs (from $7.0 to between $6.8 and $6.7 million).

Option 3 introduces outpatient coverage with a $1,000 limit and a 50% copayment. The inpatient savings to the plan from imposing a 20 day limit and a 20% copayment amount to between $2.5 and $3.0 million depending on the substitution assumptions. This clearly reduces the uninsured portion of

outpatient costs. Under the assumption of no substitution Option 3 result in almost no increase in premium (less than 1%). Allowing for some substitution results in small savings to the plan (see bottom section of Table 2 under Total Plan). Option 4 implies identical savings from inpatient use. The consequence of the 20% copay for all services is to increase the portion of outpatient costs that are insured and reduce plan costs from partial care. The increase in outpatient costs to the plan will cause a modest increase in plan total cost relative to the base plan (5.6% to 7.4% depending on substitution assumptions).

V. Cost Shifting, Premiums and Budget Neutrality

Inspection of the uninsured costs for inpatient care displayed along the top of Table 2 makes it clear that flexibility in benefit design requires substantial amounts of cost shifting. The uninsured inpatient costs under the base plan amount to $565,000. Assuming some substitution choosing Option 1 increases the uninsured inpatient costs to about $1.1 million or a 91% increase. Option 2 further increases the uninsured inpatient costs to $1.7 million. Options 3 and 4 imply uninsured inpatient levels of about $2.1 million. The expansion of outpatient coverage permits cost shifting from uninsured cost to plan paid costs. The main implication of cost shifting is that while insurance premiums will not rise noticeably under Options 1,2 or 3, the plans are not budget neutral in an overall sense. Responsibility for paying for uninsured inpatient costs will fall on either 1) the public sector, 2) other payers or 3) patients and their families.

Uninsured inpatient costs generated by limits on covered days (Options 1, 3 and 4) are those most likely to be absorbed by transfers to the public

sector (shifts to taxpayers) or through charge increases to "other payers" by hospitals due to increased bad debt. Uninsured inpatient costs generated by increased copayments (Options 2, 3 and 4) are most likely to be absorbed by patients and their families and other payers due to rises in hospital bad debt.

Shifts to the public sector, due to rises in uninsured hospital costs, may in part be offset by shifts from the public sector to private payers due to increased outpatient coverage. Expanded outpatient coverage may allow public providers of mental health care to obtain third party payments for individuals who formerly did not have insurance coverage for outpatient mental health care. A case study of mandated mental health benefits in Massachusetts suggests that this cost shift might be sizeable.[5]

VI. Conclusions and Recommendations

The simulation results presented above illustrate clearly that adding new mental health benefits to an insurance package in a manner that does not result in premium increases requires significant reductions in existing coverage for mental health care. The strict limitation of Virginia's existing mental health mandate coupled with the desire not to increase premiums dramatically reduces the opportunities to introduce flexibility into the Virginia mandated mental health benefit.

Table 1 above presents a set of four options which all closely adhere to the "no premium increase" criterion. The goal of any changes in the mandate appears to be to increase the range of mental health treatments that are

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[5] Frisman L.K., McGuire T.G. and Rosenbach M.L., "Costs of Mandates for Outpatient Mental Health Coverage in Private Health Insurance" Archives of General Psychiatry, June 1985 538-561.

covered by insurance while allowing premiums to remain constant. We believe that Option 3 best meets that goal. Option 3 allows for rather generous partial hospital coverage and a modest outpatient benefit, thus expanding coverage to each of the major mental health care treatment modalities. Option 3 does not lead to any meaningful change in premiums. Options 1 and 2 do not offer any outpatient mental health coverage. Moreover, depending on the substitution assumptions made Option 1 may result in small premium increases. Option 2 results in some small declines in insured costs. Option 4 we anticipate would be difficult to implement in practice and leads to premium increases of between 5.6% and 7.4%.

Under all Options the reductions in inpatient coverage necessary to finance the new benefits will result in increased financial burdens to other parties. Most prominent among those are taxpayers and users of inpatient pstychiatric care and their families. Extending coverage for outpatient care allows for the possibility that some of the costs to the taxpayers will be reduced from reduced amounts of uninsured care provided by public community mental health providers. Inclusion of outpatient coverage in the mandate will also reduce the out of pocket liabilities of individuals who use outpatient mental health services and are covered by insurance plans that currently do not cover those services. We therefore believe the potential gains from changing the existing mental health mandate would be greatest under Option 3.

TABLE 1

Summary of Base Plan and Options Analyzed

	Inpatient	Outpatient	Partial
Base Plan	30 days	none	none
Option #1	20 days	none	2/1
Option #2	30 days 20% copay	none	2/1 (to 40)
Option #3	20 days 20% copay	$1000 50% copay	2/1
Option #4	$10,000 overall limit, 20% copay for all, $1,000 covered limit on outpatient		

TABLE 2

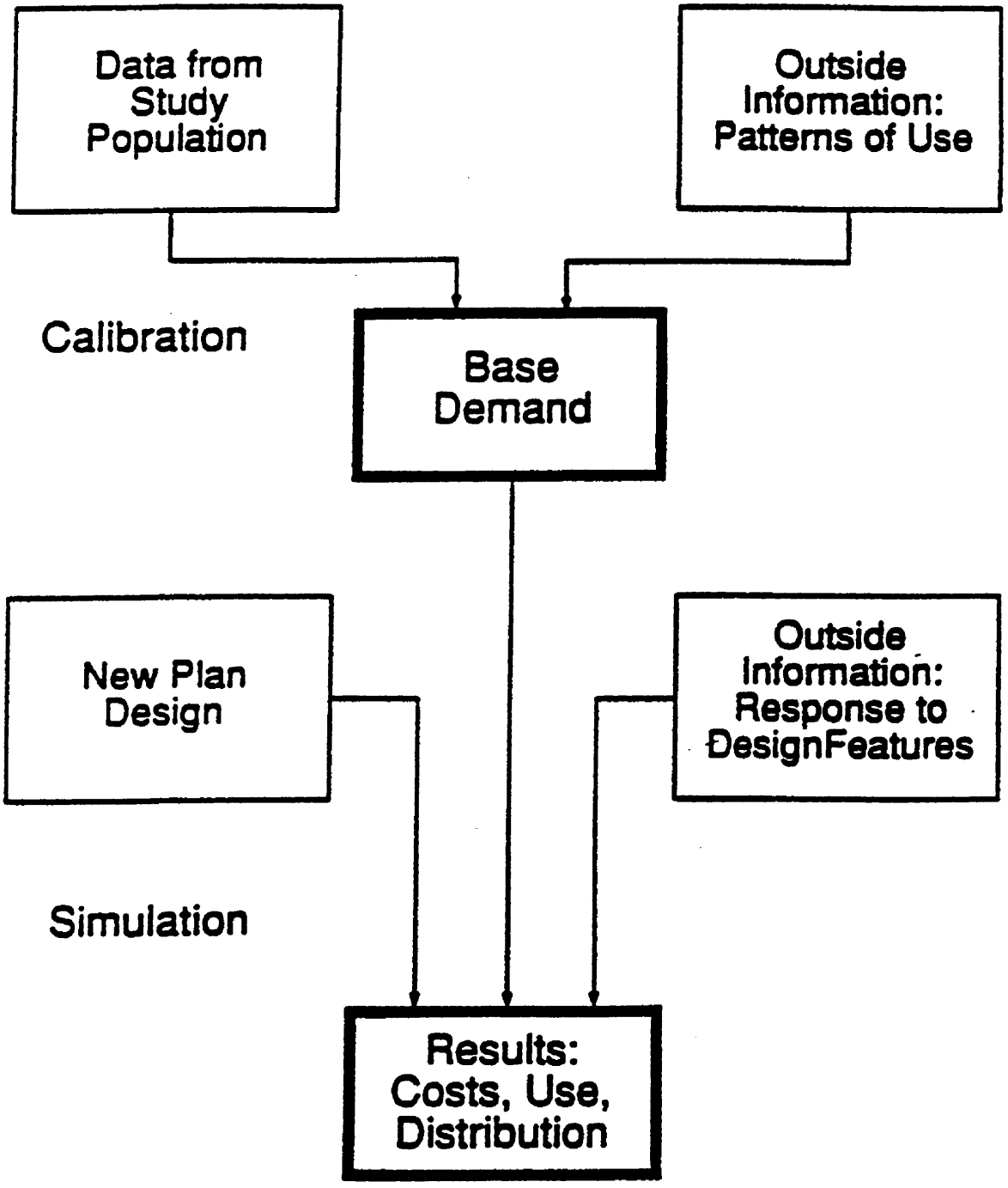
Simulation Results Cost Patterns

($000s)

		OPTION #1		OPTION #2		OPTION #3		OPTION #4	
	Base Plan	Upgrades Only	Up and Downgrades	Upgrades Only	Up and Downgrades	Upgrades Only	Up and Downgrades	Upgrades Only	Up and Downgrades
Inpatient									
Plan	6,999	5,759	5,183	5,315	4,784	4,479	4,031	4,479	4,031
Uninsured	565	1,200	1,080	1,879	1,691	2,301	2,071	2,301	2,071
Total	7,565	6,959	6,263	7,194	6,475	6,780	6,102	6,780	6,102
Outpatient									
Plan	0	0	0	0	0	1,000	1,000	1,662	1,662
Uninsured	2,319	2,087	2,087	2,087	2,087	1,636	1,636	1,107	1,107
Total	2,319	2.087	2,087	2,087	2,087	2,636	2,636	2,770	2,770
Partial									
Plan	0	1,534	1,889	1,534	1,889	1,534	1,889	1,381	1,700
Uninsured	0	0	0	0	0	0	0	153	189
Total	0	1,534	1,889	1,534	1,889	1,534	1,889	1,534	1,889
Total									
Plan	6,999	7,293	7,072	6,849	6,673	7,013	6.920	7,522	7,393
Uninsured	2,885	3,287	3,167	3,966	3,778	3,937	3,707	3,561	3,367
Total	9,884	10,580	10,239	10,815	10,451	10,950	10,627	11,084	10,761

Figure 1

Structure of Forecasting Model



TECHNICAL APPENDIX

A Model of Mental Health Benefits

This appendix describes the model of mental health care utilization used to generate predictions in the report. Section A.1 contains a summary of the approach. Development of the base case utilization is described in Section A.2. Demand response assumptions are discussed in Section A.3.

A.1 Summary of Approach

The method consists essentially of two steps. The first step is calibration of a model of demand for services. In this step, information about the study population is combined with information about patterns of service use from research studies to make up a description of demand for services by the study population. Information about a study sample is always limited, and is always less than the researcher would need to make fully accurate forecasts. The calibration step takes advantage of whatever information is available for the study population, supplementing study population data where necessary with information from outside research. For example, it might be known that in an existing plan for state employees, with 20 percent copayment up to 50 visits, and 50 percent copayment from visits 51-70, average annual outpatient expenditures per user is $750. Interest is in the cost of a benefit of $2,000 per year. To estimate the cost impact of this new coverage requires information about the distribution of users around the mean of $750. This distributional information would be drawn from research studies. In this example, the calibration step combines data from the study population about the mean use with data from research

about the distribution to develop a more complete picture of demand. The calibration step is taken once for each study population. In this project, Virginia-specific information is used to the extent possible; this is supplemented with information from other studies where necessary.

The second step in the method is simulation of the effect of a plan change. Simulation uses the model of demand calibrated in the first step to forecast the effects. The base level of demand is determined in the first step. This together with assumptions about demand response underlay predictions about the effects of plan changes. To continue the example, information about the mean use (from the study population) and the distribution of users around the mean (from research studies) gives information about how many users are to be affected by an increase in the limit. An assumption about demand response then leads to a prediction of how much the affected users change their behavior. Assumptions about demand response are made based on research on mental health services use. The simulation step can be taken many times for each study population, once for each plan change of interest. Multiple changes in a plan can be examined at once.

The simulation model is capable of forecasting the effects of demand-side coverage policies, supply-side payment policies, and administrative practices. Assumptions about the effects of a plan change is necessary to forecast the effects on the study population. It is recognized that while the information about some behavior responses is reasonably good (such as the response of demand for ambulatory services to changes in coverage), the information about many important responses is weak. To choose one among

many possible examples, there is little basis for a confident estimate of the effect of a change in coverage for ambulatory services on demand for inpatient services. This should be kept in mind when interpreting the model's results.

A.2 Development of a Base Case

In order to forecast the effect of changes in coverage, it is necessary to begin with initial patterns of utilization, what we refer to here as a base-case utilization. Our base case is developed based on information provided to this project about utilization of state employees in the Blue Cross Basic Plan (BCBP). These data are used to calibrate a complete model of mental health care utilization.

It is recognized that the experience of state employees in the BCBP may not be representative of many employee groups in Virginia. We choose this group for two reasons. First, more extensive information was available to us about this group than any other. In particular, detailed information about the distribution of LOS for psychiatric and substance abuse treatments were available. Given the nature of this project, this information was critical. Second, state employees in the BCBP represent a likely high use group, and therefore is unlikely to understate costs for the population as a whole. To further address the generality issue, we model a lower use group, with patterns similar to state employees (but with lower levels of use). We hope that this additional base case with help in providing a balanced picture.

Utilization data for enrollees in the BCBP was made available to this project from several sources. These data, along with information from health services research, were used to develop a base-case model.

Enrollment

There were 26,134 single contracts and 16,224 family contracts enrolled in the BCBP as of July 12, 1990. Assuming 3.5 individuals per family contract, there were 82,918 individuals enrolled in BCBP as of July, 1990. This represents 45 percent of all contracts among active employees. (The other plans are KeyCare and Cost Awareness, with lower benefits than the BCBP.)

Benefits

Inpatient psychiatric hospital care and professional services are covered at 100 percent with providers contracting with Virginia BC. Outpatient care is covered at 80 percent of the UCR for visits 1-50, and at 50 percent for visits 51-70. There is a deductible of $100 per hospital confinement, and a $200 major medical deductible ($400 per family) per year. (Cost sharing for outpatient mental health care does not count towards the stoploss.)

Inpatient Utilization

Material supplied to the project lists hospital admissions, days, and covered charges for BCBP admissions for the period 6/1/89 to 5/31/90. Admissions are separated into those above and below thirty days, and those for substance abuse and other psychiatric conditions. For our purposes, we combine these into one psychiatric category, since substance abuse and psychiatric admissions are treated identically in the benefit plan.

Total covered charges for hospital care over this period were:

Psychiatric (Non-SA) LE 30 days:	$3,485,300
Psychiatric (Non-SA) GT 30 days:	2,569,389
Substance Abuse LE 30 days:	1,517,932
Substance Abuse GT 30 days:	227,838
Total	$7,800,459

In addition, since BCBP utilization accounts for 57.2 percent of all psychiatric inpatient charges for Virginia BCBS, we attributed this percentage of the inpatient major medical charges from type of service Hospital Psychiatric, Psychiatric, Psychologist, and Social Worker to the BCBP account. These data are available for the period 7/1/88 through 6/30/89. The BCBP charges for these services are $508,958.

The benefit plan is structured around days per person per year, while the data are reported on use (LOS) per admission. An algorithm is used to go from a distribution of days per admission to a distribution of days per individual. The algorithm consists of three steps. At the end of the three steps, we have a distribution of days per person, consistent with the known information about utilization. Three alternative values are analyzed for the readmission rate.

1. Data: LOS/Admission

	LT 30 days		MT 30 days	
	admiss.	days	admiss.	days
Psych.	462	6705	100	4566
SA	213	3336	13	499
Total	675	10041	113	5065

2. Imputed Data: LOS/Admission

	1-10	11-20	21-30	31-45	46+
Psych.	154	154	154	63	37
SA	71	71	71	13	
Total	225	225	225	76	37

Rationale: Both psychiatric and SA admissions have a mean of approximately 15 days for LOS<30. No SA has LOS>45. Division of psychiatric admissions is by facility-level inspection, and includes some estimates.

3. Transforming per admission to per person per year.

Per person distribution

readm rate	1-10	11-20	21-30	31-45	46+	max LOS
5%	202.5	213.75	213.75	79.65	38.95	67.06
10%	180	202.5	202.5	83.3	40.9	83.49
15%	157.5	191.25	191.25	86.95	42.85	98.43

Note: Assumes readmission rate is constant across admission LOS categories, and there can only be one readmission per year. Effect of readmission is to move person to the higher category. The maximum LOS is calculated to generate correct total days.

Outpatient Utilization

Little data are available at present on the outpatient utilization of psychiatric care in the BCBP. The major medical report for 7/1/88 through 6/30/89 contains a summary of all major medical charges for all Virginia BCBS enrollees. It does not separate use by plan, nor does it report the number of users, so it is impossible to directly calculate average charges per user.

For all plans, we have "covered charges" for the following Type of Service codes attributable to outpatient psychiatric care:

Hospital Psychiatric	$ 67,772
Psychiatric	4,704,104
Psychologist	174,104
Social Worker	83,407
Total	$5,029,387

At least 57.2 percent of these charges should be attributed to BCBP. The percentage may be higher because of the much more favorable coverage for outpatient psychotherapy in the BCBP, and resulting demand response, and adverse selection effects. Based on these considerations, we assume that 70 percent of these charges are BCBP, a total of $3,520,570. "Covered charges" as it is used in the reports available to us means plan payments, and does not include deductibles or cost sharing.

Based on the Rand Health Insurance Experiment, a randomly assigned population with the BCBP coverage would have about 3.4 percent of the population in treatment for outpatient care each year. Considering the potential for selection, we will assume 5.0 percent of the BCBP enrollees use outpatient mental health care per year.

Utilization Summary

On the basis of the above analysis, we can summarize the base case utilization in the BCBP:

Total Inpatient Plan Payments:	$8,309,417
Total Outpatient Plan Payments:	3,520,570
Total Plan Payments:	$11,829,987
Plan Payments Per Covered Individual:	$279
Number of Admissions:	788
Number of Inpatient Users:[1]	709
Average LOS:	19.2 days
Average Charges per Admission:	$10,545
Average Charges per User:	$11,720
Number of Outpatient Users:	4,146
Average Charge per User:	$1,415.16
Average Charge per Service:	$75
Average Services per User:	18.9

Distribution of Base Case Demands

The distribution of demand for inpatient care is available from the existing plan, according to the algorithm described above. Within ranges, we will assume that the distribution is uniform.

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[1] This assumes the readmission rate within a year is 10 percent.

For outpatient care, the information on mean use per user must be transformed into a distribution of users based on research and other experience. Although the distribution of users across ranges of visits and costs for the study population is not known, a good deal of experience has accumulated about the distribution of use in research studies and other plans. Use of this experience can help in making more accurate estimates of the effects of changes on the study population. In this appendix, we present data from several plans, showing that the shape of the distribution of demand around the mean use is fairly uniform across studies. Our specific calibration approach here is to take the shaping parameter (a standard deviation from a lognormal) from outside research, and use the study population to position the distribution of users. Based on the review of studies presented here, populations differ mostly on the rate of use and the mean demand. The shape of the distribution around the mean is roughly constant.

The most thoroughly studied users of health care were the 4,000 people who spent up to four years participating in the Rand Health Insurance Experiment (HIE) during the 1970s. Although this is a relatively small group of people to study a low-frequency event such as ambulatory mental health use, this research study has some important compensating advantages. First, the sample population was chosen to be nationally representative, and was followed for three to five years. Second, very detailed information is available about this group, with a minimum of inaccuracy introduced by non-reporting of use. Third, although the Rand population was divided into many insurance plans, all plans were relatively generous in coverage of

ambulatory mental health care. All plans had a family stop-loss feature of no more than $1,000 for all health expenses after which all care was free.

Information about the distribution of users in Year 2 of the HIE to calibrate the model of demand (Wells et al., 1982). During the second year of the HIE, 163 persons used a mental health service. The distribution of users across ranges of visits is shown in Figure A.. About 61 percent of users made between 1-10 visits. How can this be used to help with our problem of forecasting the effect of the benefit change for the study population?

Information from the HIE can be summarized in the form of a functional distribution of users. The shape of the distribution of health care use is generally skewed. There are many users with small amounts of expenditures, visits, or other measure of use, but the distribution has a long tail signifying that there are a few heavy users. A number of families of distributions can fit this general shape. In this model, conditional on being positive, the annual distribution of expenses (or visits) for ambulatory care is lognormal.

Specifically,

$y = \ln(x)$, where y is expenditures for ambulatory care, and

x is normal(μ,σ).

The exact shape of the lognormally distributed y will depend on choice of the two parameters μ and σ (the mean and standard deviation of the normally distributed variable x).

We seek the μ and σ that give the best summary or fit to the Year 2 data from the HIE. Fit is measured by an R-squared statistic, defined as follows:

Letting $i = 1,\ldots,N$ be the number of categories,

f_i = the actual relative frequency in the category,

$\hat{f}_i$ = the fitted relative frequency in the category,

$R^2 = 1 - RSS/TSS$, where

$TSS = f_i(f_i - 1/N)^2$

$RSS = f_i(f_i - \hat{f}_i)^2$.

In Table A.1, the R-squared statistic is high for all combinations of μ and σ shown. This is a reflection of several factors: 1) only combinations close to the best fit are shown in the Table, 2) the original distribution across categories (1–10, 11–20, etc.) was highly unequal, so the TSS is large, and 3) the lognormal describes the data reasonably well. The Table is shown to give an idea of the relative fit of the combinations of μ and σ. Examination of Figure A. gives a better idea of the nature of the fit of the lognormal to the actual distribution, with parameters set at values $\mu = 1.9$ and $\sigma = 1.4$, based on the R-squared statistic from Table A.1.

The best-fitting lognormal is a close fit for some groups and not so close for others. Keep in mind that the observed distribution for the HIE was based only on 163 users — the 4.9 percent of the users between 41 and 50 visits correspond only to 8 people. The shape of the actual data from the HIE would therefore change from year to year as a different group of users appear, even if the underlying process for generating use is unchanged.

Table A.1 contains results of a fit of a lognormal to several other distributions of ambulatory mental health benefits. The National Medical Care Utilization and Expenditure Survey (NMCUES) for 1980 describes a distribution of visits for a national sample. (See Taube et al. (1988) for details.) Data from this study are presented here for background. Because the NMCUES combines information from persons with all ranges of insurance coverage, the distribution of visits cannot be taken as a distribution of demand at a given price.

Three other populations in Table A.1 do fulfill the requirement that the distribution comes from the same insurance plan. These were chosen for inclusion here because they have the additional desirable feature that (after a small deductible in two of three), the cost sharing is constant without limit. The distribution of demand curves can therefore be indexed by the distribution of visit or expenditures, without regard to differences in the point on the demand curves introduced by price differences at different levels of use.

In the case of High-Option Federal employees, and the two proprietary data sources, the μ parameter providing the best fit varies considerably, from 1.4 to 2.3, but the best-fitting σ is relatively constant at 1.3, 1.4, 1.3. Recall that the Rand HIE data was best fit with a lognormal with $\mu = 1.9$, and $\sigma = 1.4$.

Data from these research studies and from the BCBP can now be combined. Based on the research studies, the shape of the distribution is assumed to be described by a lognormal with a variance parameter $\sigma = 1.3$. The curve will be positioned by the BCBP mean. This is done using the simulation

model. For any (μ,σ) and benefit plan (with up to three linear segments), the model generates the relative frequency of users at visits 1-60 and 60+. (This will be described in more detail below). Then given a price and a number of users, it is straightforward to compute plan costs. The process for finding the μ for the BCBP application is to work backwards, knowing that the average charge per user is $2,078. By iterative methods, in the presence of the actual BCBP benefit at a price of $60 per visit, and $\sigma = 1.3$, μ is adjusted until the distribution of demands is such as to just yield an average charge of $1,415.16. The μ that solves this is $\mu = 2.1263$.

At this point, we have an estimated distribution of visits and expenditures, not just a mean and total cost. Specifically, each visit between 1 and 60 is associated with a probability. These initial probabilities are consistent with the calibrated lognormal so that in the presence of the actual benefit, the observed costs are implied. Thus, the distribution gives back the mean we know to be true, and its shape is consistent with the shape of distributions observed from other studies. The model of demand response now allows us to forecast the impacts of changes in the benefit.

The Joint Distribution of Inpatient and Outpatient Care

Twenty percent of the inpatient users are assumed to use no outpatient care. For the other 80 percent, the use of outpatient care is distributed similarly to all users.

A.2 Demand Response

There are several considerations that are important for modeling demand response. A change in cost sharing affects the level of use. A benefit can

be characterized by deductibles, a cost sharing range, and a limit on coverage. A change in cost sharing will generally affect the number of users as well as the level of use. The assumptions made to account for these considerations are described here. We begin with a discussion of demand response for outpatient care.

Outpatient Demand Response

Demand, given use, is linear in cost sharing. Response is a parameter, chose here to be .5. A .5 means that demand with no insurance is 50% of demand with full insurance. This is chosen (in conjunction with the effect of cost sharing on number of users) to be in line with the demand response observed in the HIE. If, for example, for users at a certain point in the distribution of use, the cost sharing rises from 25% to 50%, the number of visits would fall by 12.5% (=(.50-.25)*.5).

Demand-side cost sharing can be specified in the model with up to three linear segments, thereby accommodating deductibles and limits. Segments are set in dollar terms. Quantity demanded is consistent with utility maximization. For users at each part of the distribution quantity is calculated by first finding the quantity demanded at each of the up to the three prices possible. Then, "consumer surplus" is figured for each price. Finally, quantity is determined by the price-demand equality that is associated with the maximum consumer surplus. This multi-stage procedure is necessary because it is not possible to tell in advance which segment of the benefit schedule will be relevant to utility maximization. With declining-block pricing, there may be more than one local maximization, and total conditions must be checked.

The number of users can be affected by cost sharing. Some simple assumptions are made about this impact, for three groups of users, the "high users," the "intermediate users," and the "low users." The rationale for the approach is that there is some fixed non-monetary costs associated with entering treatment that vary across persons. For high users, these fixed costs are small in relation to the total value of treatment, so changes in cost sharing only affect level of use, not the use decision itself. For some low users, the fixed costs are significant, and unless cost sharing is generous, they would not undergo treatment at all. The intermediate users fall in between.

It is assumed first of all that anyone who is willing to demand at least 20 visits at a zero price will be a user no matter what the cost sharing. Some intermediate users who would be at 11-20 with no cost sharing may drop out altogether. This is made dependent on the <u>total cost</u> to the user of 15 visits. The total cost is the relevant measure in the use/no use decision, because it is the total cost of the range of visits contemplated (such as 15) that affects the consumer surplus associated with using. In this formulation, a deductible of $200 would have the same effect on the use/nonuse of the intermediate level users, those around 15 visits, as copayment that led to $200 out-of-pocket cost for the same level of visits. It should be noted that while this makes sense from a theoretical point of view, there is no empirical evidence for how the form of cost sharing affects the use decision.

Specifically, for intermediate users, the effect of a change in OOP costs at 15 visits is assumed to have a linear effect on the number of

users. A value is chosen, here, .25, equal to the fraction of users who would drop use altogether if the benefit plan changed from complete coverage to no coverage. The reduction in users is in proportion to the change in OOP costs for 15 visits.

A similar assumption is made for the low users, those who would make 1-10 visits with no cost sharing. They are more likely to drop out of treatment, so the value of .5 is chosen to say that if cost sharing goes from complete coverage to no coverage, 50% of the low users will stop treatment.

In sum, a change from no to complete cost sharing has three effects: 25% of intermediate users stop using; 50% of low users stop using, and for all users, quantity demanded falls 50%. Each of these three values were chosen to be consistent with research evidence and theory.

Inpatient Demand Response

Inpatient demand response is the simulation model is embedded in a more complex model of utilization determination which takes into account both demand and supply-side cost sharing. Supply-side cost sharing might be introduced, for example, by a prospective payment system. In this project, no supply-side cost sharing was considered, so the model reverts to a more simple form of demand-side response. The demand response is assumed to be linear, and the use at no insurance is 65 percent of the use at full coverage. No users are assumed to drop out altogether when coverage is reduced. The demand response for inpatient care is thus much less than for outpatient care.

Cross-Price Effects

The coverage for outpatient care is assumed not to affect demand for inpatient care. Likewise, the coverage for inpatient care is assumed not to affect demand for outpatient care. These assumptions could be modified in the simulation, but were chosen here in order to not overstate the favorable effects of adding outpatient coverage.

Table 1

Fitting a Lognormal to Distribution of Ambulatory Visits

Note: In each table, μ and σ are parameters of a lognormal distribution for variable y, where $y = \ln(x)$ and x is distributed normally with mean μ and standard deviation σ. The statistic shown is an R-square, where the total variation is sum of the squares of the difference between the actual cell frequency and the average cell frequency, weighted by the actual frequency. The residual sum of squares is the weighted squared difference between the actual and fitted values.

1.1. RAND HIE Year 2
Source: Wells et al., (1982, p. 59). Several plans, all with stoploss < $1,000.

	Values for μ				
Values for σ	1.7	1.8	1.9	2.0	2.1
1.2	.957	.977	.988	.989	.979
1.3	.969	.984	.991	.989	.978
1.4	.977	.988	.992	.989	.977
1.5	.983	.991	.993	.988	.976
1.6	.987	.992	.992	.986	.974

1.2. National Medical Care Utilization and Expenditure Survey (NMCUES), 1980
Source: Taube et al. (1988). Plans not described, are representative of survey respondents.

	Values for μ				
Values for σ	0.6	0.7	0.8	0.9	1.0
1.9	.986	.995	.995	.987	.970
2.0	.982	.994	.996	.991	.978
2.1	.977	.990	.995	.993	.983
2.2	.971	.985	.992	.993	.986
2.3	.964	.979	.989	.991	.987

1.3. Federal Employees BC/BS High Option, 1981

Source: Sharfstein, Muszynski and Myers (1984, p.196). Plan pays 70% after $150 annual deductible.

	Values for μ				
Values for σ	2.1	2.2	2.3	2.4	2.5
1.1	.966	.986	.976	.940	.880
1.2	.967	.993	.996	.973	.928
1.3	.946	.984	.997	.985	.954
1.4	.921	.965	.984	.981	.957
1.5	.891	.936	.962	.966	.949

1.4. Private Employer, 1985

Source: Proprietary data [HDI2]. Approximately 40,000 covered lives in Mid-Atlantic service company. 50% coverage after $150 annual deductible.

	Values for μ				
Values for σ	2.2	2.3	2.4	2.5	2.6
1.2	.574	.672	.702	.678	.601
1.3	.718	.839	.890	.877	.806
1.4	.747	.877	.940	.933	.863
1.5	.676	.813	.877	.874	.806
1.6	.522	.658	.727	.728	.648

1.5. Private Employer, 1985

Source: Proprietary data [HDI8]. Approximately 24,000 covered lives in Midwestern service company. 50% coverage, no limit.

	Values for μ				
Values for σ	1.2	1.3	1.4	1.5	1.6
1.1	.9782	.9889	.9964	.9998	.9982
1.2	.9880	.9954	.9994	.9995	.9948
1.3	.9943	.9987	.9999	.9973	.9902
1.4	.9978	.9998	.9986	.9938	.9852
1.5	.9994	.9992	.9961	.9895	.9792

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

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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. Coverage 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 Coverage 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.

SB 480 A bill to amend and reenact § 38.2-4214 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 4, consisting of sections numbered 38.2-3425 through 38.2-3430, relating to accident and sickness insurance.

HB 328 A bill to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding Title 38.2 a chapter numbered 53, consisting of sections numbered 38.2-5300 through 38.2-5309, relating to hospital utilization review.

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.

SJR 22 Expressing the General Assembly's support of the development of alternative levels of care for psychiatric and substance abuse treatment and insurance coverage that will reimburse for such care. January 17, 1990.

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.

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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.

Appendices and Exhibits

A. HJR 319

B. HJR 42

C. Task Force Representation

D. Membership

E. Staff Support

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

G. Guidelines for Health Benefits Administration: Concurrent Review, General Administration Procedures

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Appendix A.

HJR 319

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 319

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.

Agreed to by the House of Delegates, February 6, 1989
Agreed to by the Senate, February 23, 1989

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 insurance industry to achieve maximum utilization of appropriate mental health treatment in the most 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.

HJR 42

GENERAL ASSEMBLY OF VIRGINIA--1990 SESSION

HOUSE JOINT RESOLUTION NO. 42

Continuing the task force studying insurance coverage for persons with mental disabilities.

Agreed to by the House of Delegates, February 13, 1990
Agreed to by the Senate, February 27, 1990

WHEREAS, the Task Force to Study Insurance Coverage for Persons with Mental Disabilities was created by the Commissioners of the Department of Mental Health, Mental Retardation and Substance Abuse Services and Insurance pursuant to House Joint Resolution No. 319 passed by the 1989 Session of the General Assembly; and

WHEREAS, the high costs of health care and demands on the health insurance industry are affecting the provision of appropriate care for persons with mental disabilities; 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, the task force was appointed in 1989 and is comprised of service providers, the insurance industry, advocates for individuals with mental disabilities, and university teaching hospital representatives; and

WHEREAS, the task force is currently evaluating four areas of concern: the definitions of mental illnesses to determine the kinds of illnesses covered by insurance and the extent of such coverage; the extent of present benefits and determination of what coverage is needed by persons with mental disabilities; the accessibility and availability of services, including quality assurance, cost control monitoring, and management of costs; and the impact any changes in the current reimbursement system would have on the public sector; and

WHEREAS, the task force is delaying any recommendations until the completion of the work done by its subcommittees and until such time that the recommendations of other relevant studies and surveys are completed; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Task Force Studying the Adequacy of Insurance Coverage for Persons with Mental Disabilities be continued in order to complete the collection of relevant data, evaluate information made available by other studies, and make final recommendations about such insurance coverage. The task force shall complete its work in time to submit its findings and policy proposals to the Governor and 1991 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix C.

Task Force Representation

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 in Virginia
National Association of Social Workers
Psychiatric Society of Virginia
Virginia Academy of Clinical Psychologists
Virginia Alliance for the Mentally Ill
Virginia Association of Community Services Boards
Virginia Association of Health Maintenance Organizations
Virginia Chamber of Commerce
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Virginia Neurological Society
Virginia Society for Clinical Social Work
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

Appendix D.

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;
John Davies, M.D. - Psychiatric Society of Virginia;
Charles M. Davis, M.D. - Medical Society of Virginia;
Sally Joyce Duran, Kaiser Permanente - Virginia Association of Health Maintenance Organizations, replacing Gary Summers
Michael Gooch, Medical College of Hampton Roads - Virginia's teaching hospitals;
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 in Virginia;
Clarissa Rowe - Virginia Association of Retarded Citizens;
Samuel Rubin, Ph.D. - Virginia Academy of Clinical Psychologists;
S. James Sikkema - Mental Health Association in Virginia;
Joel Silverman, M.D., Medical College of Virginia - Virginia's teaching hospitals;
Frank Singleton, 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 - Virginia Association of Health Maintenance Organizations;
Richard Tall, HMO-Virginia, Blue Cross/Blue Shield of Virginia - Blue Cross and Blue Shield of Virginia;
John F. Troy, Deputy General Counsel, the Travelers - the commercial insurance industry;
Alan J. Wood, Blue Cross and Blue Shield of Virginia, substituting for Richard Tall, HMO-Virginia, Blue Cross/Blue Shield of Virginia.
Dennis Wright, Virginia Power - Virginia Chamber of Commerce;
Robert L. Wright - Bureau of Insurance, State Corporation Commission.
Glenn Yank, M.D. - The Galt Scholar, University of Virginia

Appendix E.

Staff Support

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

HJR 42 Insurance Task Force
Final Report November 7, 1990

Appendix F.

Survey of Psychiatric Benefits at 10 Large and 10 Mid-sized Virginia Companies, Virginia Chamber of Commerce.

Psychiatric Care Benefits Survey

(Large Virginia Companies)

Companies	INPT Psych	INPT Subs Abuse	PMTS: 100%	Deduct	Co-pay	Stop/ Loss
Best Products	30	30	NO	$200	80%	NO
CSX Corp	45	45	NO	$150	80%	NO
Circuit City	30	30	NO	$100	80%	$500
Crestar Bank	60	30	NO	$200	80%	$1,500
Ethyl Corp	30	30	YES	NO	NO	NO
James River	NO $6,000 MAX/YR	NO $6,000 MAX/YR	NO	$150	80%	NO
Reynolds Metals	30	30	YES	NO	NO	NO
Southern States	30	45	NO	$200	80%	NO
Universal Leaf	120	30	YES	$200 HOSP	NO	NO
Virginia Power	NO	30	NO	$200	80%	$600

Psychiatric Care Benefits Survey

(Large Virginia Companies)

Companies	OUTPT Psych	OUTPT Subs Abuse	PMTS: 100%	Deduct	Co-pay	Stop/ Loss
Best Products	$1,000 MAX/YR	$1,000 MAX/YR	NO	$200	50%	NO
CSX Corp	$3,500 MAX/YR	$3,500 MAX/YR	NO	$150	80%	NO
Circuit City	$2,000 MAX/YR	$2,000 MAX/YR	NO	$100	80%	$500
Crestar Bank	$2,500 MAX/YR	$2,500 MAX/YR	NO	$200	80%	NO
Ethyl Corp	$2,500 MAX/YR	$2,500 MAX/YR	NO	$200	50%	NO
James River	$1,000 MAX/YR	$1,000 MAX/YR	NO	$150	80%	NO
Reynolds Metals	20 VISITS	90 VISITS	NO	$100	80%/20 THEN 50%	NO
Southern States	$3,000 MAX/YR	$3,000 MAX/YR	NO	$200	80%	NO
Universal Leaf	NO LIMITS	NO LIMITS	NO	$200	80%	NO
Virginia Power	NO LIMITS	NO LIMITS	NO	$200	50%	$600

Psychiatric Care Benefits Survey

(Mid-Sized Virginia Companies)

Companies	INPT Psych	INPT Subs Abuse	PMTS: 100%	Deduct	Co-pay	Stop/ Loss
Amer Safe Razor	120	28	YES HOSP	$50	80% PHY	NO LIMITS
BASF Corp Fibers	NO	NO	YES 1ST $1,600	$100	80%	$2,000
Carter Mach Company	30	30	NO	$100	80%	$2,000
Cooper Inds	45	45	NO	$150+ $100 I/P DED	80%	$1,500
Dom Bank Shenand'h	60	30	NO	$200	80%	$750
Double Envelope	30	30	NO	$200	80%	NO LIMITS
Electrolux Corp	30	30	NO	$200	80%	$1,000
Hercules Inc	30	30:LIFE MAX 60	NO	$300	80%	$2,000
Luck Stone	NO	NO	NO	$200 HOSP	80%	$1,200
Overnite Transport	60	30:LIFE MAX 90	NO:$80 DAY LIMIT D/A	$100	80%	$1,00

Psychiatric Care Benefits Survey

(Mid-Sized Virginia Companies)

Companies	OUTPT Psych	OUTPT Subs Abuse	PMTS: 100%	Deduct	Co-pay	Stop/ Loss
Amer Safe Razor	NO LIMITS	NO LIMITS	NO	$50	80%	NO
BASF Corp Fibers	$1,500 MAX/YR	$1,500 MAX/YR	NO	$150	50%	NO
Carter Mach Co	NO LIMITS	NO LIMITS	NO	$100	50% TO $2,000	$2,000
Cooper Inds	25 VISITS	25 VISITS	NO	$150	50%	$1,500
Dom Bank Shenand'h	$3,000 MAX/YR	$3,000 MAX/YR	NO	$200	80%	NO
Double Envelope	NO LIMITS	NO LIMITS	NO	$200	80% TO $2,000	$2,000
Electrolux Corp	60 VISITS $1,500 MAX/YR VISITS	60 VISITS $1,500 MAX/YR	NO	$200	80%	$1,000
Hercules Inc	40 VISITS	30 VISITS MAX 60	NO	$1,000	50%	$2,000
Luck Stone	$1,500 MAX/YR	$1,500 MAX/YR	NO	$200	80%	$1,200
Overnite Transport	$1,000 MAX/YR	$1,000 MAX/YR	NO	$100	50%	NO