REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS ON

House Joint Resolution 284: Mandated Health Insurance Coverage for Physical Rehabilitation Services

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 29

COMMONWEALTH OF VIRGINIA
RICHMOND
1992

COMMONWEALTH OF VIRGINIA

CLARENCE A. HOLLAND
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COMMITTEE ASSIGNMENTS
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SENATE

December 30, 1991

To: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to Sections 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits, pursuant to 1991 House Joint Resolution 284, to assess the social and financial impact and the medical efficacy of a proposal by the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities to mandate health insurance coverage for physical rehabilitation services.

Respectfully submitted,

Clarence A. Holland, Chairman
Special Advisory Commission on
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GENERAL ASSEMBLY OF VIRGINIA--1991 SESSION

HOUSE JOINT RESOLUTION NO. 284

Expressing the sense of the General Assembly with regard to health insurance and future funding for services for persons with physical and sensory disabilities.

Agreed to by the House of Delegates, February 22, 1991
Agreed to by the Senate, February 21, 1991

WHEREAS, the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities, hereinafter referred to as the Commission, was established pursuant to House Joint Resolution No. 45 of the 1990 Session of the General Assembly to develop an integrated and accountable service delivery system for persons with physical and sensory disabilities in conjunction with enhanced public and private rehabilitative agencies and programs; and

WHEREAS, the Commission has concluded that current health insurance policies often provide inconsistent or inadequate coverage for certain disabilities due to eligibility criteria, exclusions, waiting periods and gaps in benefits and services; and

WHEREAS, the Commission has received public testimony concerning the needs and priorities of persons with physical and sensory disabilities in the Commonwealth; and

WHEREAS, the Commission is proposing the development of a continuum of community-based services to facilitate the self-sufficiency and independence of persons with physical and sensory disabilities; and

WHEREAS, the Commission has determined that the needs of persons with physical and sensory disabilities should be addressed through a variety of both public and private funding sources, including federal and state-supported programs, private insurance when appropriate, means tested services, and other available resources; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That it is the intent of the General Assembly that recommendations from the Commission regarding proposed changes in health insurance policies be forwarded to the Special Advisory Commission on Mandated Health Insurance Benefits for review in accordance with the provisions of Chapter 34 (§ 9-297 et seq.) of Title 9 of the Code of Virginia and that the Special Advisory Commission forward a report to the Governor and the 1992 Session of the General Assembly, and a copy of such report to the Commission for inclusion in the final report of the Commission to the 1992 Session of the General Assembly; and, be it

RESOLVED FURTHER, That the recommendations forwarded to the 1992 Session of the General Assembly by the Commission be considered in the Executive Branch budgetary review for the 1992-1994 biennial budget and that it is the intent of the General Assembly to consider the recommendations contained in the final report of the Commission to the General Assembly as the basis for consideration of funding for the development of a system of community-based services for persons with physical and sensory disabilities.

INTRODUCTION

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) conducted a review of a proposal made by the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities (Beyer Commission) to mandate health insurance coverage for physical rehabilitation services pursuant to 1991 House Joint Resolution 284.

On May 13, 1991, representatives of the Beyer Commission presented their proposal to mandate coverage for physical rehabilitation services to the Advisory Commission (Appendix A). As part of its review process, the Advisory Commission held a public hearing on June 17, 1991 at 10:30 a.m. in Senate Room B of the General Assembly Building in Richmond to receive comments from all interested parties regarding the Beyer Commission's proposal. Oral comments were heard from representatives of seven organizations. Written comments and additional information were also received.

On July 18, 1991 the Advisory Commission received a revision of the originial Beyer Commission proposal (Appendix B). This revision included technical corrections and changed the proposal from a mandate of coverage to a mandated offering of coverage.

SUMMARY OF PROPOSED LEGISLATION

The Beyer Commission proposal applies to insurers providing accident and sickness policies, corporations issuing accident and sickness subscription contracts, and health maintenance organizations. The mandate applies to both individual and group policies and contracts.

Services to be covered when prescribed by a physician include, but are not limited to:

(1) Physical therapy;
(2) Speech-language services;
(3) Occupational therapy: training for activities of of daily living (dressing, hygiene, mobility, cognitive remediation, homemaking activities or use of assistive technologies);
(4) Cognitive Retraining: services to retrain cognitive functions (orientation, attention and concentration, reasoning, memory, discrimination, behavior and ongoing developmental problems following an injury); and
(5) Neurobehavioral therapies: improvement of behavioral functioning (interpersonal relationships, aggression management, mood management, reality orientation, and anxiety disturbances which are the result of physical damage to the central nervous system).

The proposal contains an exemption from §38.2-3419 which requires that mandates added on or after July 1, 1982 be offered to any new or existing group policyholder. This provision appears to be unnecessary because the revised proposal is consistent with the requirements of §38.2-3419.

The proposal does not limit coverage to head and spinal cord injured insureds.

Language customarily included in mandated benefit sections of the Code of Virginia to exclude short-term travel, accident only, limited or specific disease, or individual conversion policies or contracts, or policies sold to Medicare eligible persons was not part of the orginal proposal. The standard language was added upon revision. In order for the language of the proposal to be consistent throughout, the reference to Medicare supplement policies should be removed from subsection A of proposed §38.2-3418.2.

Limited mandated benefit policies authorized by §§38.2-3425 through 38.2-3430 are not exempt from the requirements of this proposal.

INSURANCE COVERAGE FOR REHABILITATION SERVICES

Current Insurance Coverage for Physical Rehabilitation in Virginia.

Virginia law does not require that rehabilitation benefits be included in policies issued in Virginia. Individual policies must contain definitions of "sickness" or "accidental injury" that meet the minimum required by Insurance Regulation No. 19, Rules Governing the Implementation of the Individual Accident and Sickness Minimum Standards Act. The regulation includes the following:

> "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.
>
> The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.
>
> Such definition may provide that injuries shall not include:

(1) injuries for which benefits are provided under any workmen's compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law: or

(2) injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

"Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability or similar law.

This regulation applies to individual policies only. There are no similar requirements for group contracts.

A review of contracts filed for approval in Virginia indicates that some, though not all, policies include some coverage for occupational therapy, speech therapy and convalescent and skilled nursing care. Many policies do not contain any provisions for rehabilitative care.

Typically health insurers provide coverage for acute care and some skilled nursing and acute rehabilitation. However, when a patient is no longer making progress or does not need the level of care provided in the facility where the insured is located, insurers typically will not extend coverage for lower level services or for inpatient services in facilities not covered under the insured's policy or contract.

The Code of Virginia does include the mandate of coverage for dependent children (§38.2-3409). It requires that an insurer continue to cover a child incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on the policyowner for support and maintenance, without regard to the child's biological age.

Mandates for Rehabilitation Services in Other States

Connecticut, Louisiana, and West Virginia require that health insurers make coverage available for a wide array of comprehensive rehabilitative services administered by licensed health care professionals acting within the scope of their licenses in qualified medical facilities.

Under a 1982 law enacted in Connecticut (§38-174p of the Connecticut Insurance Laws), the optional benefit must include coverage for physician services, physical and occupational therapy, nursing care, psychological and audiological services and speech therapy, social services, respiratory therapy and the administration of prescription drugs and medicines. Coverage must also extend to costs associated with prosthetic and orthotic devices and other supplies and services necessary for rehabilitation. Services must be rendered at a comprehensive rehabilitative facility as defined by the statute.

Louisiana enacted a statute in 1990 (§22:230.1 of the Louisiana Insurance Laws) which requires insurers to make available coverage for speech and language therapy, physical therapy rehabilitative services and occupational therapy. Services must be rendered by licensed speech pathologists, audiologists, physical therapists, physicians or occupational therapists acting within the scope of their licenses.

West Virginia's 1990 law (§33-15-4d of the West Virginia Insurance Laws) defines rehabilitation services as "those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status." These services include "diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in combination: (1) Stroke; (2) Spinal cord injury; (3) Congenital deformity; (4) Amputation; (5) Major multiple trauma; (6) Fracture of femur; (7) Brain Injury; (8) Polyarthritis...; (9) Neurological disorders...; (10) Cardiac disorders...; (11) Burns."

The statute requires that the specified coverage be made available and specifically excludes services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance and custodial services from the definition of rehabilitation services. Services must be rendered in a facility meeting requirements set forth in the statute. Deductibles, coinsurance and other limitations as apply to other covered services are specifically allowed with respect to rehabilitation services.

The Advisory Commission's staff contacted each of the above states. According to the responses received, studies were not done on the cost of implementing these mandates prior to or since their enactment. The Advisory Commission was also unable to obtain any information about the impact of the mandate on facilities and providers.

Comparison of Beyer Commission Proposal with the Existing Mandates in Connecticut, Louisiana and West Virginia

The Louisiana statute is limited to physical, speech and occupational therapies.

In Connecticut, coverage is broadened further to include physician services, nursing care, psychological and audiological services, social services, respiratory therapy, the administration of prescription drugs and medicines, the cost of prosthetic and orthotic devices and other necessary supplies and services.

The West Virginia statute appears to require coverage for the broadest range of services of the three states, but specifically excludes services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance and custodial services.

The three existing statutes include coverage for physical, speech and occupational services, as does the Beyer Commission proposal. The original Beyer Commission proposal, however, required this coverage to be included in all health insurance policies, rather than requiring the "offer" or availability of coverage as in the other three states. The revised proposal is a mandated offering of coverage. In addition, the Beyer Commission proposal addresses Medicare supplement policies unlike the others.

Coverage for cognitive retraining and neurobehavioral therapies is not mentioned in the other statutes as covered services, although services necessary for treating victims of spinal cord injuries and brain injuries are specifically included in the West Virginia statute. Therefore, coverage may be available for such treatment in West Virginia to those policyholders who select rehabilitation therapy benefits.

The relatively broad coverage made available in West Virginia is significantly limited by specific exclusions, unlike the Beyer Commission proposal.

INCIDENCE OF HEAD INJURIES IN VIRGINIA

According to an article written by members of the Department of Rehabilitation Medicine of the Medical College of Virginia and Virginia Commonwealth University, approximately 400,000 to 500,000 people sustain traumatic brain injuries each year in the United States (West, p.127). Of those, approximately 70,000 to 90,000 individuals suffer moderate to severe chronic disabilities (West, p.127). Using a national population figure of 250 million, the annual incidence rate for traumatic brain injury is 160-200 per 100,000 and for moderate to severe disability is 28-36 per 100,000.

When these national rates are applied to the Virginia population figure of 6.2 million, an estimated 9,920 to 12,400 individuals would be expected to suffer traumatic brain injuries annually in Virginia. Of those, approximately 1,736 to 2,232 would be expected to suffer moderate to severe chronic disabilities resulting from head injuries.

According to testimony provided by to the Advisory Commission by Dr. Gregory O'Shanick of the Medical College of Virginia, a survey conducted by the Virginia Head Injury Foundation (VHIF) in 1983 indicated that approximately 14,000 individuals sustain traumatic brain injuries in Virginia annually.

In 1984, the General Assembly of Virginia enacted §51.5-11 requiring the Department of Rehabilitative Services (DRS) to establish and maintain a central registry of individuals who sustain head injury in Virginia. Currently, information obtained by DRS regarding head injury victims is forwarded to VHIF. VHIF conducts outreach to make information about programs and services available to individuals and their families. Information provided by VHIF indicates that between July 1984 and December 1990 information on approximately 36,000 persons was compiled by the registry. Figures obtained from DRS show the number of head injury victims added to the registry over the last three calendar years to be as follows:

1988	5499
1989	8097
1990	6471

These figures differ significantly from the number of head injuries estimated using national incidence rates and the results of the VHIF survey. The discrepancy may be attributed to underreporting by hospitals and physicians and the fact that injuries not requiring inpatient admission to a hospital are usually not reported. VHIF is currently attempting to address underreporting by hospitals.

Case Study on Incidence and Cost Associated with the Medical Treatment of Head Injuries

A study conducted at the Hartford Hospital in Hartford, Connecticut revealed that over the three year study period from 1984 to 1987, 1214 patients diagnosed as having suffered traumatic brain injuries were admitted on an inpatient basis (Bennett, p. 558). Seventy-two percent of the study group were male and 28% were female. Table 1 illustrates that the 16 to 25 year old age group had the strongest representation in the study population. This finding is consistent with the majority of other studies.

Table 1: Age Breakdown of Study Population

Age	Percentage
0-15	22.9
16-25	**30.6**
26-40	21.4
41-55	8.7
56-64	5.8
65-99	10.6
	100.0

(Bennett, p. 558)

For the purpose of the study, patients were categorized by type of injury. Table 2 outlines these categories which reflect increases in severity from Group I-IV.

Table 2: Breakdown of Study Population by Group

Group	Description	Percentage
I	Concussion	28.2
II	Fracture	3.5
III	Intracranial injury with fracture	28.1
IV	Intracranial injury without fracture	40.2
		100.0

(Bennett, p. 557)

The breakdown for mean length of stay (LOS), mean Intensive Care Unit LOS (ICU/LOS), and the mean age per group is presented in Table 3. This information is helpful in understanding the average amount of acute care needed for an individual who sustains a traumatic brain injury.

Table 3: Length of Stay and Age by Group

	Group			
	I	II	III	IV
Mean LOS (days)	5.5	6.1	14.5	20.5
Mean ICU/LOS (days)	0.5	0.5	4.4	6.2
Mean Age (years)	26.1	21.3	30.0	34.5

(Bennett, p. 560)

The following table illustrates the final disposition of the study population by group. This information indicates that as the severity of the injury increased, a greater number of patients entered rehabilitation facilities upon discharge from the study hospital.

Table 4: Final Disposition by Group (Percentage)

Outcome	Group I	II	III	IV	Total
Home	92.7	95.4	67.0	58.6	72.0
Short-term Rehab	2.9	0.0	9.4	16.6	10.0
Skilled Nursing Fac.	1.8	2.3	3.7	7.6	4.7
Left AMA*	1.8	0.0	1.8	1.0	1.4
Expired	0.8	2.3	18.1	16.2	11.9
	100.0	100.0	100.0	100.0	100.0

*Left hospital against medical advice
(Bennett, p. 558)

Researchers found that the mean charge for emergency and acute care per head injury patient over the study period was $11,645. This figure represents charges for medical services administered in the hospital, and does not include charges for rehabilitation services administered at rehabilitation facilities or in the home following discharge. This study did not address the cost of rehabilitation services, but provides useful information on the characteristics of head injured persons and their initial medical treatment.

Virginia Head Injury Study

In 1983, VHIF conducted a survey of the hospitals in Virginia to identify and document the incidence, characteristics, and cause of traumatic brain injury in the Commonwealth. The findings of that survey were included in The Report of the Head Injury Task Force to Secretary of Human Resources Joseph Fisher issued June 28, 1985. These findings largely support the figures presented in the case study above regarding incidence by age and sex. The report indicates that 44% of head injuries are caused by automotive and road accidents, 38% by falls and other accidents and 15% by homicide, assault and child battering (Task Force, 1985).

Spinal Cord Injuries in Virginia

According to the VHIF, the Spinal Cord Injury Registry receives and provides outreach to approximately 230 new injuries each year (VHIF, 1991). Most individuals with spinal cord injuries need physical and occupational therapy.

AVAILABLILITY OF REHABILITATION SERVICES IN VIRGINIA

In September 1990 VHIF published the Directory of Head Injury Resources in Virginia which lists most of the facilities in Virginia that offer rehabilitation programs and summarizes the services and level of care provided at each. The following table is based on the VHIF directory and lists the types of programs available in each region of Virginia.

Program Type	Region 1 Southwest	Region 2 Northern	Region 3 Central	Region 4 Tidewater
Support	X	X	X	X
Sub-Acute Care		X	X	X
Acute Rehab	X	X	X	X
Post-Acute Rehab	X	X	X	X
Day Treatment		X	X	X
Outpatient Services	X	X	X	
Long-Term Living	X		X	
Vocational	X	X	X	X
Community Re-entry		X	X	
Case Management	X	X	X	X
Recreation/Social	X	X	X	X

Facilities that chose not to be included in the VHIF directory are not reflected in the information presented in the above table.

Support programs and recreational and social programs are conducted in each region by VHIF through its local chapters. DRS provides vocational, supported employment, independent living, case management, Social Security disability determination and other related services, and maintains four regional offices and 36 field offices throughout Virginia. Private facilities provide the majority of the other available programs.

Only Region 3 has facilities offering programs in all of the categories outlined here. The absence of certain programs in various regions indicates that necessary services are not available throughout the state. Additional information obtained during the course of research indicates that waiting lists exist for some programs and that travel to other areas of the state to obtain services is not uncommon.

REVIEW CRITERIA

Social Impact

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

Based on national figures it can be estimated that between 9,920 and 12,400 individuals (approximately 0.2% of Virginia's population) sustain traumatic brain injuries annually in Virginia. The Central Head Injury Registry maintained by DRS recorded information regarding 6,471 individuals who sustained head injuries in 1990. This figure, however, does not include brain injuries that are treated in emergency rooms or in settings other than on an inpatient basis.

A study conducted by VHIF with a grant from DRS in 1983 found that approximately 14,000 individuals suffer head injuries in Virginia annually. Head injuries are most prevalent among males and those between the ages of 16 and 25. The Spinal Cord Injury Registry receives approximately 230 new injuries per year.

b. The extent to which insurance coverage for the treatment or service is already available.

Coverage for physical therapy, speech and language therapy, and occupational therapy is available under some health insurance contracts in Virginia, although in many instances the coverage is limited. Cognitive retraining and neurobehavioral therapies, however are not routinely covered. Such services are often administered months or years after the accident and determination of causality is sometimes difficult.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

Treatment for a period of 36 to 60 months is often required before significant progress is achieved with respect to cognitive and neurobehavioral abilities. The expense of the necessary treatment programs is prohibitive for most citizens. Some individuals may receive the required services through public funding.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

Necessary treatment is normally very expensive and often places an enormous financial burden on families. Caregiving by family members is time consuming and can result in a loss of earnings in addition to the cost of treatment.

e. The level of public demand for the treatment or service.

The level of public demand for physical rehabilitation services is relatively low because relatively few individuals (an estimated 2,000 Virginians) suffer moderate to severe chronic disabilities resulting from head injuries annually.

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

Demand exists among those currently suffering from brain and spinal cord injuries and their families. Public awareness of this problem is low and so is the demand for this type of insurance coverage.

Providers widely support this proposed insurance coverage. Facilities and resources that have room for expansion and demand for services would likely grow if coverage were available. Such a growth in demand would likely be a result of those persons who currently need treatment gaining access to those services.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

The Advisory Commission received no information regarding the interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

No such findings were presented to the Advisory Commission during the course of its review of this proposal.

Financial Impact

a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.

The number of facilities that are equipped to provide the types of services that would be utilized as a result of the proposed mandate would not be expected to be greatly affected in the short term (five years). This is due to the expense involved in the physical construction of the facilities and staffing needs. However, as opponents of the proposal have pointed out, some expansion of services and staff could be expected to occur

within the first few years. Such expansion would result in an increase in the cost of treatment which would likely be reflected in increased charges to patients. A mandated offer of coverage would be expected to have a smaller effect in this area.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service is unknown. Opponents, however, have voiced concern that psychiatric diagnoses may be deliberately reported to insurers as traumatic brain injury related, possibly resulting in an increase in the prescription of cognitive retraining and/or neurobehavioral therapy.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

The proposal would require coverage for a broad range of services which should allow the most appropriate service to be provided. Currently, insurance policies generally cover the higher levels of acute care, some subacute rehabilitation and skilled nursing care. The care for which insurers reimburse generally ends at the point where the patient should be receiving a lower level of care. In theory, this proposal would then result in lower levels of care being provided when appropriate. However, it is unlikely that a considerable amount of care at a level higher than required is reimbursed by insurers at the present time.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

In the short-term, the number and types of providers will not be affected greatly. In the long-term, the number of individuals trained in the therapies covered by this proposal would be expected to increase (physical, occupational, speech, cognitive retraining, and neurobehavioral therapies).

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

Based on information collected by the State Corporation Commission's Bureau of Insurance during its 1989 study of mandated benefits and providers pursuant to 1991 SJR 215, the

average reported cost of administering a new mandate is $71,000. One insurer has estimated that the cost of the proposed mandate if enacted could be $7.79 per contract per month ($93.48 annually).

Information on the cost of rehabilitation that the Advisory Commission obtained from randomly selected Virginia facilities is included as Appendix A. It is difficult to generate a typical patient or average cost of care across the board because of the variance in individual treatment needs of patients.

f. The impact of coverage on the total cost of health care.

The total cost of health care may increase by an undetermined amount. However, a number of individuals currently receiving care that is reimbursed by state funding would be able to pay for their care using their insurance coverage.

Medical Efficacy

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

The quality of patient care and the health status of Virginians could be improved by increased access to the type of care included in the proposed mandate. Medical research supports early intervention and often lengthy therapy for brain and spinal cord injuries. However, although traditional rehabilitation treatment is well defined and established, cognitive retraining and neurobehavioral therapies are viewed by some as wide ranging, ill-defined, and controversial with respect to outcome assessment.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.

This criterion is not applicable to the current proposal.

2) The methods of the appropriate professional organization that assure clinical proficiency.

This criterion is not applicable to the current proposal.

Effects of Balancing the Social, Financial and Medical Efficacy Considerations

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

Proponents have argued that the proposed mandate or mandated option of coverage for physical rehabilitation services addresses both medical and social needs. From a medical perspective, rehabilitative services are often required after the need for acute care has passed. From a social perspective it is in the public interest to rehabilitate an injured party to his or her fullest potential, improving the value or quality of the person's life as much as possible.

Opponents, however, argue that a mandate or mandated option of coverage for physical rehabilitative services will not address the needs of individuals who have health insurance coverage through self-funded plans, policies issued in other states, and federally sponsored programs such as Medicare and Medicaid or individuals who are uninsured. In comparing statistics on traumatic brain injury with the findings of a recent United States General Accounting Office report on the uninsured (GAO, p.39), the age group most susceptible to head injury (16-25 years of age) is also the age group where the likelihood of being uninsured is greatest. Therefore, the current proposal would probably directly affect fewer citizens of Virginia than most mandated benefit statutes.

Opponents also contend that head-injured persons often have a wide range of educational, vocational and social needs which fall outside the scope of health insurance. Opponents also contend that cognitive retraining and neurobehavioral therapies have not been proven to be medically efficacious.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

The need for the services mandated under this proposal are recognized by both proponents and opponents. Opponents argue that this mandate does not address the need for coverage because a mandate will not affect workers covered by self-insured plans, working for out-of-state employers, those covered by federal programs or those without insurance.

It is difficult to estimate the cost of this mandate because the cost of therapy and length of treatment vary widely depending on individual circumstances. However, one insurer has estimated that the cost of the proposed mandate if enacted could be $7.79 per contract per month ($93.48 annually). Opponents have argued that such an increase in premium would make health insurance coverage considerably more difficult for individuals and small businesses to afford.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

The need for coverage of physical rehabilitation services would not likely be met by a mandated option of coverage. Under such circumatances, group policyholders would not be required to provide such coverage to group members. The option to elect coverage would not be available to the group members individually. This is significant because the majority of Virginians who have health insurance are covered by group plans available through employment. A 1986 survey conducted for the State Corporation Commission found that 83% of families that were insured for health care obtained that coverage through employment. A mandated option of coverage would directly affect fewer citizens of Virginia and therefore be less effective in addressing the identified need.

Opponents of mandates make the argument that administrative expenses will not be reduced by "offering" coverage and that insurers are more susceptible to adverse selection with a mandated offering.

RECOMMENDATION

As a result of the evaluation conducted pursuant to House Joint Resolution 284 and documented in this report, the Special Advisory Commission on Mandated Health Insurance Benefits recommends to the General Assembly of Virginia that the Beyer Commission's proposal to mandate coverage or the option of coverage for physical rehabilitation services <u>not</u> be enacted.

CONCLUSION

Although the Advisory Commission recognizes the needs of persons with physical and sensory disabilities, it has found that the mandate of insurance coverage or the option of insurance coverage for physical rehabilitation services proposed by the Beyer Commission will likely have a significant impact on insurance premiums and will not adequately address the identified social issue. The revised proposal does not include specific exclusions, such as those adopted in other states, which could limit the required coverage in order to limit costs and ensure that the minimum level of benefits is adequately defined. The Advisory Commission believes that alternatives other than insurance based approaches should be examined by the proponents of the current proposal to address the needs of Virginia citizens with physical and sensory disabilites who do not have health care coverage for certain physical rehabilitation services.

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D R A F T

38.2-3418.1. Coverage for physical rehabilitation services. A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, each health maintenance organization providing a health care plan for health care services and each insurer proposing to issue individual or group Medicare supplement policies shall provide coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth for physical rehabilitation services.

B. The physical rehabilitation services covered by this section shall be prescribed by a physician and shall include, but not be limited to, physical therapy, occupational therapy, speech-language services, cognitive retraining and neurobehavioral therapies.

"Cognitive retraining" means those services provided to retrain cognitive functions, including, but not limited to, orientation, attention and concentration, reasoning, memory, discrimination, behavior, and ongoing developmental problems following an injury.

"Neurobehavioral therapies" means those therapies provided to improve behavioral functioning including, but not limited to, interpersonal relationships, aggression management, mood management, reality orientation, and anxiety disturbances which are a consequence of physical damage to the central nervous system.

"Occupational therapy" includes, but is not limited to, activities which relate to training for the activitites of daily living such as dressing, hygiene, mobility cognitive remediation, homemaking

activities, or use of assistive technology.

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D R A F T

38.2-3418.2. Optional coverage for physical rehabilitation services. A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, each health maintenance organization providing a health care plan for health care services and each insurer proposing to issue individual or group Medicare supplement policies shall offer and make available coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth for physical rehabilitation services.

B. The physical rehabilitation services covered by this section shall be prescribed by a physician and shall include, but not be limited to, physical therapy, occupational therapy, speech-language services, cognitive retraining and neurobehavioral therapies.

"Cognitive retraining" means those services provided to retrain cognitive functions, including, but not limited to, orientation, attention and concentration, reasoning, memory, discrimination, behavior, and ongoing developmental problems following an injury.

"Neurobehavorial therapies" means those therapies provided to improve behavorial functioning including, but not limited to, interpersonal relationships, aggression management, mood management, reality orientation, and anxiety disturbances which are a consequence of physical damage to the central nervous system.

"Occupational therapy" includes, but is not limited to, activities which relate to training for the activities of daily living

such as dressing, hygiene, mobility, cognitive remediation, homemaking activities, or use of assistive technology.

C. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

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Information Obtained by Staff
Random Sampling of Virginia Facilities
June, 1991

Facility 1

Average Inpatient Bill	$650-700 per day (not including physician charge)
Average Day Program Bill	$350-400 per day
Outpatient	Depends on Service

Facility 2 (Long-Term Living)

Monthly Fee	$1340

Facility 3(Long-Term Living)
(No longer Operating Due to Cost of Program

Monthly Fee	$1500
Average Length of Stay	2 years

Facility 4 (Acute Rehabilitation)

Average Inpatient Bill	$650-700 per day
Average Length of Stay	
-Head	45 days
-Spinal Cord	28 days

Facility 5 (Full Range of Services)

A great variation in cost depending on severity of injury and vocational training selected. Individual fees shown below:

Residential Fees (Per Day)

Dormitory	$ 48
Transitional Living Unit	100
Hospital Inpatient	390
Day Student	22
Vocational Evaluation	69
Vocation Training	32

Speech/Language/Hearing Evaluation/Therapy

Direct Supervision/Contact per 15 minutes	22.50
Indirect Supervision/Contact per 30 minutes	22.50

Occupational Therapy

Treatment per 15 minutes	22

Physical Therapy

Evaluation per 15 minutes	25
Direct Supervision /Contact per 15 minutes	22
Indirect Supervision/Contact per 15 minutes	14

Public Comments on House Joint Resolution 284 Proposal

June 17, 1991 Public Hearing Speakers

1. Robert Demichelis
   Virginia Head Injury Foundation

2. Linda Meyer, Ph.D.
   Speech-language-Hearing Assoc. of Virginia

3. Raymond C. Graesser
   Director, Long Term Rehabilitation
   Case Management Program
   Virginia Department of Rehabilitative Services

4. Joan Gardner
   Government Affairs Counsel
   Blue Cross and Blue Shield of Virginia

5. Reginia Palmer
   Counsel, Health Insurance Association
   of America

6. Dr. A. Gregory Toler
   Virginia Optometric Association

7. Judy Divers
   Special Assistant
   Office of the Secretary of Health and
   Human Resources

Written Comments

Nathan D. Zasler, M.D., Director of Brain Injury Rehabilitation Services at the Medical College of Virginia dated August 23, 1991.

Dennis Kade, Ph.D., Director of Psychological Services at Cumberland Hospital for Children and Adolescents dated July 16, 1991.

Blue Cross and Blue Shield of Virginia dated July 17, 1991.

Janice L. Cockrell, M.D., FAAP, FAAPMR, Director of Physical Medicine and Rehabilitation of Children's Hospital dated July 22, 1991.

Humana Hospital - Richmond's RehabCare Program dated June 10, 1991.

Jeffery S. Kreutzer, Ph.D., Associate Professor and Director, Rehabilitation Psychology at the Medical College of Virginia dated July 10, 1991.

Peter D. Patrick, Ph.D. and Harry Weinstock, President and Executive Director of the Virginia Head Injury Foundation respectively, dated July 15, 1991.

Articles submitted by the Beyer Commission regarding the medical efficacy of cognitive retraining and neurobehavioral therapies received July 15, 1991.

Jane S. Brittingham, a concerned citizen, dated July 12, 1991.