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

Section 38.2-3412 of the Code of Virginia, House Bill 1329 (1991) and House Joint Resolution 206 (1992)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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SENATE OF VIRGINIA

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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 and House Joint Resolution 206 (1992 Session).

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of House Bill 1329 (1991 Session) and section 38.2-3412 of the Code of Virginia regarding health insurance coverage for the treatment of mental, emotional and nervous disorders.

Respectfully submitted,

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Introduction

Section 38.2-3412 of the of the Code of Virginia requires that individual and group accident and sickness insurance policies and subscription contracts that provide coverage to a family member contain coverage for a minimum of 30 days of inpatient treatment for mental, emotional, and nervous disorders. The current language requires coverage for treatment in a mental or general hospital. These disorders include drug and alcohol dependency, unless the insured or subscriber has coverage for such treatment pursuant to §38.2-3413.

Section 38.2-3412 (Appendix A) also requires that insurers and health services plans "make available", to group policyholders only, coverage for outpatient treatment for mental, emotional, and nervous disorders. The statute allows the coinsurance factor to be up to 50%. The maximum level of benefits for any given year may be no less than $1,000.

The Advisory Commission's review of §38.2-3412 was initiated as a result of a request by the House Committee on Corporations, Insurance and Banking (CIB) to evaluate 1991 House Bill 1329 (Appendix B), a proposed revision to the current statute. House Bill 1329 was introduced in 1991 by Delegate Robert S. Bloxom (R-Accomack). House Bill 1329 was proposed as a result of an 18-month study of the adequacy of insurance benefits for people receiving treatment or care for all mental disabilities. A task force was established to conduct the study pursuant to 1989 House Joint Resolution 319 and was extended by 1990 House Joint Resolution 42. The task force membership included representatives of health care providers, insurers, the business community, relevant state agencies, and other organizations.

The Advisory Commission held a public hearing to receive comments on House Bill 1329 from all interested parties during a meeting held October 7, 1991. Twelve representatives of various organizations presented oral comments at the hearing. In addition, written comments were received from 10 individuals and organizations.

The Advisory Commission's review of House Bill 1329 was continued into 1992 to allow for a full examination of existing §38.2-3412. In addition to these issues, 1992 House Joint Resolution 206 (Appendix C) requests the Advisory Commission to study the need for insurance coverage parity among mental and physical illness. The Advisory Commission chose to study this issue concurrently with the proposed revision of §38.2-3412.

The Advisory Commission held a two-part public hearing on these mental health issues during its June 1, and July 13, 1992 meetings. Twenty-six speakers were heard and written comments were received from many individuals and organizations. Proposals recommending alternative revisions to §38.2-3412 and House Bill

1329 were submitted by the Virginians for Mental Health Equity (VMHE), Blue Cross and Blue Shield of Virginia (BCBSVA), and Blue Cross and Blue Shield of the National Capital Area (BCBSNCA). Each proposal recommended the addition of partial hospitalization and outpatient treatment benefits in lieu of some portion of the current 30-day inpatient treatment benefit in a largely cost-neutral manner.

Summary of Proposed Legislation

House Bill 1329 amends existing §38.2-3412 subsection A which requires individual and group insurance policies and subscription contracts that provide coverage for a family member to include inpatient coverage for mental, emotional or nervous disorders. The benefits may be limited to 30 days of active treatment in any policy year. The current language requires coverage for treatment in a mental hospital or a general hospital.

Subsection B of §38.2-3412 requires that outpatient coverage be "made available" to group policyholders. Subsection B is not changed in House Bill 1329. The current outpatient benefits may be limited to no less than $1,000. The coinsurance factor can be up to 50%.

House Bill 1329 would allow the currently required 30 days of inpatient care to be converted. The individual covered would be allowed to convert the 30 days of inpatient care to:

- up to 20 days of inpatient care with a 20% copayment and
- $1,000 of outpatient visits with a 50% copayment and
- the 20 days of inpatient care could be converted to up to 40 days of partial hospitalization.

The 30 days of inpatient care or treatment shall include benefits for drug and alcohol rehabilitation and treatment under either option.

Various interested parties suggested that the language in the bill be clarified.

The proposed language has been interpreted by some to reduce the number of inpatient days from 30 to 20 without adding the flexibility of outpatient coverage. Other interested parties have not interpreted the language to offer 40 days of partial hospitalization as a substitute for the days of inpatient care.

Additionally, both the Virginia Association of Clinical Counselors and the Virginia Academy of Clinical Psychologists have requested that the provider categories of clinical psychologist and professional counselor be specifically added to the language in §38.2-3412 subsection B. Both groups have stated that it is their understanding that the omission of these

categories is not intentional.

The category of clinical nurse specialist is also not included. Subsection D was not revised in House Bill 1329.

The task force established to conduct the study pursuant to House Joint Resolution 319 included representatives from the following organizations:

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 of Social Workers
Psychiatric Society of 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 those with mental disabilities and providers:

Virginia Association of Clinical Counselors
Virginia Association of Retarded Citizens

An excerpt from the final report containing their recommendations follows:

> 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.

The Task Force concentrated its work on the concept of a conversion method that would allow the trade-off of the 30-day inpatient coverage for alternative and sometimes more appropriate partial hospitalization or outpatient care. The Task Force had the dual goals of increased flexibility and cost neutrality. The Task Force was unable to develop the conversion method without additional assistance. It was decided to seek an independent third party to provide objective assistance to examine the conversion concept and to recommend alternative methods that would provide flexibility and still be cost neutral.

A team of researchers from the John Hopkins University School of Hygiene and Public Health and Boston University was selected to assist the Task Force by providing econometric analyses of various conversion formulas.

Drs. Richard Frank, David SalKever and Thomas McGuire presented four options to the Task Force. These options were cost neutral for the purchaser of the benefit plans and provided greater flexibility. The cost neutrality of the options did not extend to the public sector or taxpayer, provider or consumer. It was acknowledged that there would be a shifting of cost to the provider, public sector and consumer of the services.

According to the report of the Task Force, utilization data on inpatient treatment has shown that the largest use of resources occurs in the early days of treatment. There is then a rapid decline and utilization then levels off over time.

The researchers made what they believe to be conservative assumptions in their work. Co-payments were used in three of the four options as the mechanism to finance alternative treatment either for partial hospitalization or outpatient visits.

The Task Force voted on the four options and selected the option which provided the basis for the stautory revision now contained in House Bill 1329. The vote was not unanimous and among those voting for this option some dissatisfaction with all of the alternatives was voiced. Representatives of the following organizations voted in favor of this option:

University of Virginia
Psychiatric Society of Virginia
Medical Society of Virginia
National Association of Social Workers, VA Chapter
and Virginia Society of Clinical Social Workers, Inc.
Virginia Association of Clinical Counselors
Virginia Association of Retarded Citizens
Virginia Academy of Clinical Psychologists
Mental Health Association in Virginia
Medical College of Virginia
Virginia Association of Community Services Boards.

The option selected by the Task Force (Option #3) was summarized in this manner in the final report:

Option #3:

Up to 20 days inpatient with 20% copayment, $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 reduced 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 co-payments would most likely be absorbed by patients and their families and other payers due to rises in hospital bad debt.

Coverage for Treatment of Mental Disabilities in Other States

Twenty-nine states, including Virginia, have some type of mandate for coverage of mental disabilities. Fourteen of those states require that coverage be offered or "made available" to the policyholder. There is significant variation in the requirements that states impose for this coverage. Twenty states require coverage for outpatient treatment. The requirements vary from New Hampshire's requirement for group policies (15 full hours of treatment in any consecutive 12-month period) to Connecticut's requirement for group policies (50% copayment, maximum of $2,000; additional benefits may be provided at the option of the group policyholder). A number of the states that have requirements of coverage for outpatient treatments limit that requirement to group contracts.

At least seven states have requirements of coverage for inpatient and outpatient treatment for mental, emotional or nervous disorders. (Kansas, Kentucky, Maryland, Massachusetts, Missouri, Tennessee and West Virginia). Kansas, Maryland and Massachusetts require the coverage to be included. The other states have "must offer" requirements.

Kansas requires 30 days of inpatient coverage, and for outpatient treatment a scale with 100% of the first $100, 80% of the second $100, 50% of the next $1,640 and $7,500 lifetime maximum.

Maryland requires 30 days of inpatient coverage. For outpatient coverage the requirement is 65% for the first 20 visits per calender year or benefit period and not less than 50% for subsequent visits. Half-way house benefits must include a minimum of 120 days at 75% (up to $30 per day).

Massachusetts requires 60 days of inpatient coverage and $500 per 12-month period for outpatient treatment.

Current Coverage for Mental Disabilities Provided Under Accident and Sickness Insurance Policies in Virginia

In 1989, the State Corporation Commission's Bureau of Insurance surveyed the top writers of accident and sickness (health) insurance to obtain information for another study. Two questions were added to the survey to obtain information about coverage for mental, emotional and nervous disorders. Thirty-one companies responded to the survey. Of these companies responding 8 or 26% provide only those coverages that are required by Virginia law (mandates) in their standard policy. Seventy-four percent of the companies offer or provide coverage above the limits required.

In general, most additional coverage is in the form of increased maximums and longer lengths of stay. A sample of the types of options companies offer appears below:

- No 30-day maximum if policy covers 200 or more employees
- 120 partial and full hospital day coverage if policy covers 200 or more employees
- Unlimited coverage for all categories at the policyholder's request
- Treated the same as any other illness for inpatient
- Outpatient: 50% of charges up to a maximum benefit of $500 per year; $1,000 lifetime maximum
- A number of companies do not offer any coverage in a residential setting or full or partial hospital day
- $1,000,000 maximum for inpatient, and partial and full hospital day
- Negotiate with group client
- 60 days inpatient (mental disabilities)
- $5,000 lifetime limit for residential
- Unlimited inpatient days in a general hospital
- Outpatient same as any other illness up to $4,000 per calendar year
- All inpatient up to $50,000 lifetime maximum for mental disabilities other than alcohol and chemical dependency
- Coverage for partial hospital day in licensed rehabilitation facility
- $2,500 year outpatient; $25,000 lifetime maximum
- Total $25,000 lifetime maximum for inpatient and outpatient
- 60 days residential setting
- $1,000 calendar year limit under major medical for alcohol or drug abuse

In general, the majority of companies provide more than the mandated levels of coverage for the treatment of mental disabilities. However, the types and amounts of coverage vary considerably from one company to another.

Evaluation of §38.2-3412, HB 1329 (1991) and HJR 206 (1992) Based on Review Criteria

Social Impact

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

According to information provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the national prevalence rate is 15.4% for the population over 18 years of age having at least one alcohol, drug abuse, or other mental disorder. National statistics indicate that 11.8% of children and adolescents are either at risk for mental health problems or currently exhibit some mental health problems.

Based on Virginia's 1990 population of 6.2 million and an above average rate of mental illness and substance abuse, 178,000 children and adolescents are at risk of developing a mental

health problem. It is estimated that one million Virginians will have a mental illness or substance abuse disorder requiring treatment in a given year.

In 1990 the 40 Community Services Boards that are a part of the Virginia public mental health system, served over 161,000 adults with mental illnesses. Average length of stay is 28 days. These figures do not include the need met by the private sector or those needs that go unmet.

According to BCBSVA claims experience, approximately 10% of their policyholders use mental health services.

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

Some level of insurance coverage for mental health treatment is generally available. Insurance coverage for treatment on an inpatient basis is available because of the mandate of coverage of at least 30 days of active inpatient treatment in any policy year.

Outpatient coverage is a "must offer" mandate for group contracts. Responses of insurers to a 1989 State Corporation Commission survey indicated that the majority of insurers responding (89%) provided outpatient benefits prior to the mandate.

Information provided by Blue Cross and Blue Shield of Virginia (BCBSVA) indicates that over 95% of all BCBSVA group policyholders chose to include outpatient mental health benefits in their total health insurance package. BCBSVA does not include outpatient coverage for mental health services in its standard individual contracts. BCBSVA has stated that the coverage is not included in the standard individual contracts because of cost consequences.

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.

Proponents make the argument that the lack of coverage for outpatient treatment can result in the inappropriate or unnecessary use of inpatient treatment. Proponents also point to the effects that untreated mental illnesses have on the individual, their family and society.

Proponents also make the point that those without insurance coverage end up in the already crowded public mental health system. Proponents say a reduction in the current mandate will make treatment unavailable for many. DMHMRSAS projects that under current conditions there will be waiting lists for outpatient treatment of close to 1,500 people in the years 1996-2000.

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.

Proponents make the argument that without insurance coverage out-of-pocket payments may leave some individuals medically indigent. Proponents who had used mental health services, or who had family members needing such care, described going without prescribed therapy and medications because coverage was not available or had been exhausted. Proponents also discussed paying for bills for hospitalizations years after the care was needed because the amount of the bill was so high.

Necessary treatment can be relatively expensive. A 1989 BCBSVA study on the costs of mandates estimated an average cost of approximately $75 per physician or other provider visit for inpatient treatment and $41 per visit for outpatient coverage. For individuals needing prolonged care the cost can be substantial.

In 1992 testimony, BCBSVA provided information on the cost of care. One-hour sessions of outpatient psychotherapy could range from $40 to $120 or more. BCBSVA claims experience indicates an average inpatient treatment stay of approximately 15 days. But, treatments range from one day to 28 or 30 day programs. Other insureds have spent from several months to several years in extensive residential programs. Per diem expenses can range from $300 to $1,000 or more.

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

Proponents cited information from the National Institute of Mental Health estimating that in any given month, 653,014 Virginians or 12.6% of the adult population, will have a diagnosable mental illness. Over a six-month period the rate increases to 14.8% of the adult population. In a lifetime, 22.1% of adult Virginians will suffer from a mental illness.

During the 1990 fiscal year, 152,287 Virginians received mental health services through the Community Services Boards. More than 70,000 people received outpatient care and 1,500 received inpatient treatment. Over 41,000 received emergency intervention. More than 4,000 people are on waiting lists including 1,330 needing outpatient care.

Because of a variety of factors including negative connotations of seeking treatment, DMHMRSAS estimates that only 20% of those who need care actually seek it.

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

Providers and individual consumers have indicated support for the concept of mental health parity. Proponents cite the

need for flexibility in covered treatment in the absence of parity with treatment for physical illnesses.

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

Group policyholders are offered outpatient coverage by mandate. A survey done for the Task Force on Insurance Coverage for Mental Disabilities revealed that of 10 large Virginia companies and 10 mid-sized companies, nearly all offered coverage for outpatient treatment.

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.

The Department of Mental Health, Mental Retardation and Substance Abuse Services supports flexibility in the coverage for treatment of mental disabilities. DMHMRSAS believes, although not specifically addressed in a study of this mandate, that the mandate of treatment of mental illness has a positive social impact by legitimating and allowing focus on the direct and immediate treatment for mental diseases and mental disorders. Without the mandate it is believed individuals would possibly present themselves to general practitioners with vague or clouded symptoms to mask their mental disorder. There would be expensive tests and delays while physical disorders were ruled out. Early intervention and timely treatment of mental illness reduces the disruption to employment and family. Early treatment also reduces the cost to public programs that often support those with mental illness.

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.

Opponents make the argument that expanding insurance coverage to include a specific conversion formula in the mandate may increase the cost of services. BCBSVA points to the expansion of the recent outpatient treatment program and per diem increases from $100 - $200 three or four years ago to $300 - $500 today. BCBSVA also expressed concern with residential programs that would not be licensed or certified.

Proponents make the argument that outpatient treatment is less expensive than inpatient care and that the decrease in costs from inappropriate inpatient usage will not result in any increase in the cost of outpatient care.

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

Opponents of the mandate point to the "induced demand" that may result from the flexibility to use outpatient care. Opponents point to the impact that the utilization of managed care has had on reducing the cost of inpatient mental health care. Insurers say that potential exists for outpatient treatment to be over utilized and managed care as it currently exists cannot be effectively administered in the outpatient setting.

Proponents make the point that often when preferable outpatient treatment is not covered inappropriate and more costly inpatient care is delivered. Proponents believe that there will be a savings from the increased use of less expensive outpatient care and a resulting decrease in inpatient care.

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

Proponents make the point that the current inpatient mandate deters people from accessing treatment early and encourages people to wait until a crisis. At that point more costly inpatient services are utilized. The VHME proposal is seen as a balance that allows flexibility and a continuum of benefits.

Opponents take the position that the conversion proposal in the House Bill 1329 would be a more expensive alternative because the copayment for services would have to be 36% and not 20% to result in cost neutrality.

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.

Proponents believe that the need for mental health services will increase as the population increases. Proponents acknowledge that the mix of providers and treatment settings may change as the type of insurance coverage changes. Proponents believe that the number of outpatient providers may increase as more outpatient coverage is available. They also believe, however, that the increase would be offset because of fewer inpatient benefits and inpatient providers because people would be more likely to seek treatment earlier in their illness if they would not have to be hospitalized.

Proponents make the point that neither insurance benefits nor advertising by facilities or providers can create demand for mental health treatment. They believe benefits and advertising may affect where a person decides to access treatment.

Opponents believe that increased utilization may result from flexibility in this mandate. They believe that there would be a resultant increase in the number of providers. BCBSVA points to the increases in the numbers of mental health providers as they have been mandated as providers.

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.

Opponents make the argument that the operational adjustments an insurer will have to make to offer flexibility could triple the $71,000 estimates cost for a new mandate (Based on information provided to the SCC in a survey of insurers in 1989). BCBSVA estimates that the conversion in House Bill 1329 would add up to 2% of claims expenditures and therefore premiums.

Proponents take the position that although some administrative costs may be incurred the overall affect of the House Bill 1329 proposal is cost neutral. The Virginians for Mental Health Equity take the position that their proposal would add $1.13 per month per individual covered to insurance premiums.

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

Proponents of the mandate cite research that demonstrates that appropriate mental health care reduces overall health care costs. Proponents cited the McDonnell Douglas Corporation employer assistance program as an example. The company projected that the company would save $5.1 million in three years by providing appropriate mental health care when first needed. This projection was based on a reduction in employee and dependent claims from $7,500 and $11,000 for dependents to $2,400 and $6,800 for dependents.

Proponents also cited information developed by the Hawaii Medicaid Project. The project determined that Medicaid patients receiving therapeutic interventions had a total reduction in medical claims costs of $623 per person, an overall decrease of 22%. Similar intervention for federal employees was found to save $274 per person for an overall reduction of 34%.

Opponents argue that because the proposals are not cost neutral the overall cost of health care will be increased.

<u>Medical Efficacy</u>

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.

Proponents made the argument that the medical efficacy of biologic treatments has been demonstrated in well performed controlled studies. Proponents also stated that medications are effective in the treatment of mood disorders, anxiety disorders and primary thought disorders as well as personality disorders, somatoform disorders and substance abuse. Proponents also stated that although it is more difficult to evaluate psychosocial

treatment there are studies demonstrating the efficacy of cognitive psychotherapy in the treatment of major depression, social phobia, panic disorder and substance abuse disorders.

Opponents agreed with the research that compares inpatient treatment to less restrictive outpatient therapy and partial hospitalization that shows retaining ties with families, jobs and schools results in better outcomes. The medical efficacy of the mental health services and outpatient treatment was not questioned. It was the conversion rate and treatment terms that were questioned by opponents.

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.

Not applicable.

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

Not applicable.

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.

The proposed conversion options address medical and social needs. Proponents made the argument that mental health coverage is in the public's best interest because the effect that people needing treatment have on everyone. Insureds expect to have coverage when needed. The current mandate for inpatient coverage is not consistent with current clinical practice which has changed considerably from the time the mental health mandate was enacted.

Opponents made the point that the restrictions in House Bill 1329 are inconsistent with the role of health insurance because flexibility is not given to the policyholders to make decisions based on their medical needs and financial capabilities. Opponents also stated that with regard to House Joint Resolution 206, it is the role of insurance to determine which conditions apply to certain services based on market demand.

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

Opponents made the argument that alternative coverage is

available from insurers if requested by policyholders. (Staff assumes this references group policyholders). They also argue that there would be costs for all policyholders (2% from BCBSVA) if House Bill 1329 were enacted. The costs would be greater if parity were required. BCBSNCA projected a premium increase for the mental health benefit of 43.9%.

Proponents take the position that some inpatient care combined with the option of outpatient care reduces the overall costs to society. Because those in need of mental health care interact with all of us, and statistically from time to time many more individuals need care than is often contemplated.

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

Proponents take the position that because of adverse selection a mandated option will disproportionately cover only those most likely to need care. To spread the risk effectively the mandate must require the inclusion of conversion to outpatient coverage in all policies.

Opponents suggested that an optional mandate could address the need for outpatient coverage and/or conversion.

Recommendations

The Advisory Commission voted to recommend that §38.2-3412 be revised to include flexibility for conversion to partial hospitalization and outpatient treatment. The action was taken at the November 9, 1992 meeting of the Advisory Commission. Eight members voted in favor of the recommendation, two members were opposed and one member abstained. The proposal recommended by the Advisory Commission combines elements of the revised proposals submitted by the VMHE and insurers. The recommended proposal is:

1. That for individual and group policies and contracts there must be at least 20 days of inpatient treatment for adults and 25 days of inpatient treatment for children and adolescents under the age of 19 in a policy year. This coverage must be on the same terms as medical/surgical treatment with regard to copayments, deductibles, and benefits.

2. Ten days of inpatient coverage may be converted to partial hospitalization at the option of the certificateholder or family members of the certificateholder. Each day of inpatient coverage must convert to at least one and one-half days of partial hospitalization. Partial hospitalization coverage must include benefits for intensive outpatient programs.

3. Group contracts must include coverage for at least 20 outpatient visits. Coverage for the first five visits must be on the same terms and conditions as medical/surgical visits. The remaining 15 visits can have a copayment no greater than 50%.

4. Medication management outpatient visits must be covered as medical/surgical outpatient visits and must not count against limits on mental health outpatient visits.

5. That the mental, emotional, and nervous disorders treatment mandate should include the coverage of alcohol and drug dependency treatment.

The Advisory Commission believes that the recommended proposal addresses the need for flexibility in the mandate. Concerns about parity that were raised are addressed in the terms required for inpatient coverage and outpatient care for the first five visits.

The Advisory Commission believes that, based on testimony and evidence presented, the recommendation will result in increased flexibility with little or no cost increase.

Conclusion

After studying the mandate of coverage for mental, emotional or nervous disorders, the Advisory Commission voted 8 to 2 with 1 abstention, to recommend a revision of the existing mandate contained in §38.2-3412. The Advisory Commission did not endorse the revision contained in House Bill 1329 or full parity as suggested by House Joint Resolution 206. The recommended proposal incorporates the flexibility that proponents of House Bill 1329 requested as well as some of the parity features that proponents of House Joint Resolution 206 endorsed.

The Advisory Commission believes that its recommended proposal balances the needs for flexibility, parity and affordability.

§ 38.2-3412. Coverages for mental, emotional or nervous disorders. — A. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense incurred basis that provides coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a mental hospital or a general hospital, provide coverage for mental, emotional or nervous disorders. The limits of the benefits shall not be more restrictive than for any other illness except that the benefits may be limited to thirty days of active treatment in any policy year. The thirty days of inpatient care specified in this section for mental, emotional or nervous disorders shall include benefits for drug and alcohol rehabilitation and treatment necessary to restore any covered person to satisfactory emotional and physical health, whether the care is provided in a mental or general hospital or other licensed drug and alcohol rehabilitation facility. However, with respect only to the benefits for alcohol and drug rehabilitation: (i) the level of coverage available may be different from the coverage that is payable for the treatment of other mental, emotional and nervous disorders if the benefits cover the reasonable cost of necessary services, or provide an eighty dollar per day indemnity benefit, and (ii) the benefits may be limited to ninety days of active inpatient treatment in the covered person's lifetime.

The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment is made.

B. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue hospital, medical or major medical subscription contracts shall, in the case of outpatient benefits, make additional benefits available for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for the policy or contract to select any alternative level of benefits that may be offered by the insurer or corporation. The additional outpatient benefits to be made available shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. However, the coinsurance factor need not exceed fifty percent or the coinsurance factor applicable for physical illness generally, whichever is less. The maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to no less than $1,000.

C. Subsection B 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.

D. As used in this section:

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

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician or a psychologist licensed to practice in this Commonwealth. The facility shall be: (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

E. *"Mental, emotional or nervous disorders"* as used in this section shall include physiological and psychological dependence upon alcohol and drugs. However, if the optional coverage made available pursuant to § 38.2-3413 is accepted by or on behalf of the insured or subscriber and included in a policy or contract, "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs. (1976, c. 355, § 38.1-348.7; 1977, cc. 603, 606; 1978, c. 349; 1979, cc. 13, 399; 1986, c. 562.)

Editor's note. — Title XVIII of the Social Security Act, referred to in subsection C, is found in 42 U.S.C. § 1395 et seq.

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

LD5820424

HOUSE BILL NO. 1329

Offered January 14, 1991

A BILL to amend and reenact § 38.2-3412 of the Code of Virginia, relating to health insurance coverage for mental, emotional or nervous disorders.

Patron—Bloxom

Referred to the Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3412. Coverages for mental, emotional or nervous disorders.—A. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense incurred basis that provides coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a mental hospital or a general hospital *or in an outpatient or a partial hospitalization or residential treatment setting* , provide coverage for mental, emotional or nervous disorders. The limits of the benefits shall not be more restrictive than for any other illness except that the benefits may be limited to thirty days of active *inpatient* treatment in any policy year. *The thirty days of active inpatient treatment in any policy year may be converted to outpatient or residential care based on the following formula: up to twenty days of inpatient treatment with twenty percent co-payment, $1,000 for outpatient visits with a fifty percent co-payment, and a two for one trade to partial hospitalization.* The thirty days of inpatient care *or treatment converted, based on the formula* specified in this section for mental, emotional or nervous disorders shall include benefits for drug and alcohol rehabilitation and treatment necessary to restore any covered person to satisfactory emotional and physical health, whether the care is provided in a mental or general hospital or other licensed drug and alcohol rehabilitation facility. However, with respect only to the benefits for alcohol and drug rehabilitation: (i) the level of coverage available may be different from the coverage that is payable for the treatment of other mental, emotional and nervous disorders if the benefits cover the reasonable cost of necessary services, or provide an eighty dollar per day indemnity benefit, and (ii) the benefits may be limited to ninety days of active inpatient treatment in the covered person's lifetime.

The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment is made.

B. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue hospital, medical or major medical subscription contracts shall, in the case of outpatient benefits, make additional benefits available for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for the policy or contract to select any alternative level of benefits that may be offered by the insurer or corporation. The additional outpatient benefits to be made available shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. However, the coinsurance factor need not exceed fifty percent or the coinsurance factor applicable for physical illness generally, whichever is less. The maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to no less than $1,000.

C. Subsection B 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.

D. As used in this section:

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

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician or a psychologist licensed to practice in this Commonwealth. The facility shall be: (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

E. "Mental, emotional or nervous disorders" as used in this section shall include physiological and psychological dependence upon alcohol and drugs. However, if the optional coverage made available pursuant to § 38.2-3413 is accepted by or on behalf of the insured or subscriber and included in a policy or contract, "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs.

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

1992 SESSION

LD4120661

HOUSE JOINT RESOLUTION NO. 206

Offered January 21, 1992

Requesting the Special Advisory Commission on Mandated Health Insurance Benefits to study the need for insurance coverage parity among mental disorders and physical illnesses.

Patrons—Mayer, Abbitt, Bloxom, Callahan, Croshaw, DeBoer, Jones, Moore and Robinson; Senators: Gartlan and Lambert

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Referred to the Committee on Corporations, Insurance and Banking

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WHEREAS, one-third of all Americans will experience a mental or substance abuse disorder at some time in their lives, and 19 percent of the population will experience a major mental illness in any given six- month period; and

WHEREAS, nearly one million adult Virginians have one or more mental illnesses; and

WHEREAS, suicide is the second leading cause of death among young people ages 15 to 19, and 15 percent of all school-age children in Virginia are experiencing or are at-risk of mental illness; and

WHEREAS, untreated mental illness and substance abuse disorders result in significantly higher use of other medical services; and

WHEREAS, untreated mental illnesses and substance abuse disorders result in millions of dollars of indirect costs to Virginia businesses in the form of absenteeism, decreased productivity and quality of work, and increased incidence of on-the-job accidents; and

WHEREAS, untreated mental illnesses and substance abuse indirectly cost the Commonwealth millions of dollars in the increased incidence of child abuse, domestic violence, crime, unemployment, homelessness, and automobile accidents; and

WHEREAS, inadequate mental health insurance benefits lead to inadequate care and an increased burden on public and nonprofit mental health care providers; and

WHEREAS, an increasing number of mental illnesses and disorders have been determined to have a biological basis just like diabetes, heart disease, cancer and other physical illnesses; and

WHEREAS, coverage for mental disorders and illnesses frequently include more onerous annual and lifetime dollar and usage limits, and higher coinsurance and copayment requirements and deductibles than coverage for physical illnesses and disorders; and

WHEREAS, the Special Advisory Commission on Mandated Health Insurance Benefits has scheduled a review of existing mandates for mental health providers and benefits during 1992; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Special Advisory Commission on Mandated Health Insurance Benefits be requested to study the social and financial effects on the citizens and businesses of Virginia, and the Commonwealth itself, of prohibiting group health insurers and the Commonwealth as insurer of its employees from discriminating against those citizens of Virginia who seek mental health insurance coverage by establishing dissimilar terms and conditions for mental health services as opposed to physical health services.

The Advisory Commission shall complete its work and submit its findings and recommendations to the Governor and the 1993 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.