REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

PARITY IN THE COVERAGE OF MENTAL HEALTH TREATMENT AND COVERAGE FOR OUTPATIENT TREATMENT IN INDIVIDUAL POLICIES AND CONTRACTS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
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COMMONWEALTH OF VIRGINIA

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SENATE

December 27, 1995

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 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 to assess the social and financial impact and the medical efficacy of Senate Bill 368 (1994), parity in the coverage of mental health treatment and House Bill 1223 (1994), coverage for outpatient mental health treatment in policies issued on an individual basis.

Respectfully submitted,

Clarence A. Holland
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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TABLE OF CONTENTS

Introduction

Section 38.2-3412 of the Insurance Code of Virginia required, in 1991, that individual and group accident and sickness insurance policies and subscription contracts delivered, issued for delivery, reissued, extended, or when any term of the policy or contract is changed or any premium adjustment is made that provide coverage on an expense incurred basis for a family member provide coverage for a mental, emotional and nervous disorder. The limits of the benefit were to be no more restrictive than for any other illness except that benefits could be limited to a minimum of 30 days of inpatient treatment for mental, emotional and nervous disorders in a mental or general hospital. The required coverage included treatment for drug and alcohol rehabilitation and treatment. The levels of coverage could be different from the coverage that is payable for the treatment of other mental, emotional and nervous disorders if the benefits covered the reasonable cost of necessary services or provided an $80 per day indemnity benefit. Benefits could also be limited to 90 days of active inpatient treatment in the covered person's lifetime.

The mandate required that insurers and health services plans "make available," to group policyholders only, coverage for outpatient treatment for mental, emotional and nervous disorders. These outpatient benefits consisted of durational limits, dollar limits, deductibles, and coinsurance factors that were no less favorable than for physical illness. The statute allowed the coinsurance factor to be up to 50% or the coinsurance factor applicable for physical health, whichever is less. The maximum level of benefits for any given year could be no less than $1,000. Section 38.2-3413 required coverage be made available under group contracts for treatment of alcohol and drug dependence.

House Bill 1329 was introduced during the 1991 Session of the General Assembly, based on the recommendations of an 18-month task force, to revise § 38.2-3412. The task force, composed of representatives of health care providers, insurers, the business community, relevant state agencies, and other organizations, was created to study the adequacy of insurance benefits for people receiving treatment or care for all mental disabilities. HB 1329 was referred to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) for review.

House Bill 1329 allowed the existing required 30 days of inpatient care to be converted to include partial hospitalization and outpatient treatment benefits. The insured or subscriber was allowed to convert the 30 days of inpatient care to up to 20 days of inpatient care with a 20% copayment, $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 insured had the option of choosing the existing 30 days of inpatient coverage or the option mentioned above. Insurers recommended that the bill be revised, and the addition of partial hosptialization and outpatient treatment benefits be offered in lieu of some portion of the then current 30-day inpatient treatment benefit in a largely cost-neutral manner.

The Advisory Commission also reviewed House Joint Resolution 206, which requested the Advisory Commission to study the need for parity in coverage for mental and physical illnesses. The Advisory Commission chose to study the parity issue concurrently with HB 1329.

The Advisory Commission voted to recommend that § 38.2-3412 be revised to include benefits for partial hospitalization and outpatient treatment in 1992. The Advisory Commission supported the addition of partial hospitalization and outpatient benefits in lieu of some portion of the 30 days of inpatient treatment in an effort to develop a cost-neutral recommendation.

Current Mental Health Mandate

Section 38.2-3412 of the Code of Virginia, as revised in 1992, requires each individual and group accident and sickness insurance policy or individual and group subscription contract to provide coverage for inpatient and partial hospitalization mental health and substance abuse services as described below:

Individual and Group Coverage:

- inpatient treatment for an adult for a minimum of twenty days per policy or contract year at a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility;
- inpatient treatment for a child or adolescent for a minimum of twenty-five days per policy or contract year at a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility; and
- up to ten days of inpatient benefits may be converted, when medically necessary, to partial hospitalization coverage at a rate of 1.5 days per 1 day of inpatient coverage for adults, children, or adolescents.

Group Coverage Only:

- each group accident and sickness insurance policy or group subscription contract must provide coverage for outpatient mental health and substance abuse services for a minimum of twenty outpatient visits for an adult, child or adolescent per policy or contract year;
- benefit limits are to be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five visits shall be at least 50%;
- medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of benefit; and
- if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum.

1994 Senate Bill 368 - Parity in the Coverage of Mental Health Treatment

During the 1994 Session of the General Assembly, the Senate Committee on Commerce and Labor referred Senate Bill 368 to the Advisory Commission for review. Senator R. Edward Houck was the bill's chief patron. Senate Bill 368 amends § 38.2-3412.1 to require that individual and group policies and subscription contracts providing coverage on an expense-incurred basis for a family member of the insured or the subscriber provide benefits for "inpatient and outpatient treatment of a mental disorder that are not less favorable than benefits for any other illness, condition or disorder that are covered by such policy or contract." The bill also requires that deductibles, benefit or lifetime limits, lifetime episodes of treatment limits, copayments and coinsurance factors, and benefit year maximums for deductibles shall not be different or separate from coverage for any other illness.

Senate Bill 368 also requires individual accident and sickness policies to provide coverage for outpatient substance abuse services consistent with the existing requirement for group policies and contracts for outpatient mental health and substance abuse services.

The bill adds a definition of "mental disorder" as meaning "all medically recognized mental illnesses, as defined by the Diagnostic and Statistical Manual, Third Edition, Revised (DSM III-R) as updated from time to time except substance abuse disorders." In addition, Senate Bill 368 would have provided that the section does not preclude the usual and customary procedures to determine the appropriateness and medical necessity for treatment of mental disorders, or drug or alcohol dependence provided that the medical necessity and appropriateness determinations are in the same manner as for the treatment of any other illness, condition or disorder covered by the policy.

1994 House Bill 1223 - Coverage for Outpatient Mental Health Treatment in Individual Policies

House Bill 1223 was introduced during the 1994 Session of the General Assembly and referred to the Advisory Commission by the House Committee on Corporations, Insurance and Banking. The bill was patroned by Delegate Gladys B. Keating and amends § 38.2-3412.1 of the Code of Virginia relating to the mandate of coverage for mental health and substance abuse services. House Bill 1223 requires individual policies and subscription contracts and individual conversion policies and contracts to meet the same requirements as group policies and group contracts for outpatient mental health and substance abuse services. The bill requires coverage to include at least 20 outpatient visits each policy or contract year. The benefit limits are to be no more restrictive than for physical illness except the coinsurance after five outpatient visits in any year must be at least 50%.

At the suggestion of Senator Houck, the Advisory Commission supported the creation of a second task force (Parity Task Force) composed of members of the mental health consumer community, mental health care providers, business leaders, insurers, governmental representatives, and other organizations. The task force was charged with reviewing both Senate Bill 368 and House Bill 1223 and reporting its findings and recommendations to the Advisory Commission for its consideration.

1995 Senate Joint Resolution 285 - Task Force Studying Parity in Mental Health Coverage

The Advisory Commission supported the creation of a task force in 1994 to review 1994 Senate Bill 368 and 1994 House Bill 1223. During the 1995 Session, Senate Joint Resolution 285 was passed to continue the task force studying parity in mental health coverage for one year. The chief patron of the resolution was Senator Clarence A. Holland. The Parity Task Force is composed of mental health consumers and providers, members of the business community, governmental representatives, and representatives of the insurance industry. The Parity Task Force was charged with reviewing the adequacy of mental health coverage to achieve consensus on what constitutes adequate mental health and substance abuse health insurance benefits. The Parity Task Force began its work in December of 1994.

The Parity Task Force completed its work in the Fall of 1995 and presented its findings and recommendations to the Advisory Commission at the November 20, 1995 meeting in Richmond. A public hearing was held and five members of the Parity Task Force spoke in favor of the findings and recommendations. No one spoke in opposition to the findings and recommendations of the Parity Task Force. The full report of the Parity Task Force is Appendix D of this document.

The Parity Task Force reported that it identified the following areas of agreement:

- Mental illness and substance abuse can be reliably and effectively diagnosed and treated;
- Parity does not exist across the board. Current benefits often do not provide coverage for an adequate range of mental health treatment options;
- When appropriate mental health services are not available, there are costs to individuals, families, and society, including a negative monetary impact to both the public and private sectors due to medical cost offsets and reduced worker productivity;
- Failure of primary care physicians to recognize mental health problems results in inappropriate care, over-utilization of services, and unnecessary costs. Thus, there is a need for improvement in mental health instruction and training in medical schools and in continuing education;
- Businesses, insurance companies, and consumers need assurance that mental health providers are properly trained and credentialed;

- In a price-sensitive market, any increase in benefit costs may cause a decrease in benefits offered and in the number of people covered;
- Managed health care can be a viable and successful approach to mental health care delivery and a way of protecting against unlimited expenditures; and
- Outpatient mental health treatment is an important component of a mental health services delivery system. Cost savings may be achieved through availability of outpatient care as an alternative to hospitalization.

Based on these areas of agreement and other findings, the Parity Task Force recommended that § 38.2-3412.1 of the Code of Virginia be amended to require outpatient mental health coverage that includes at least 20 outpatient visits each policy or contract year in individual policies, subscription contracts, and individual conversion policies. The benefit limits are to be no more restrictive than for physical illness except that coinsurance after five outpatient visits in any year must be at least 50%. In addition, if all covered expenses for an outpatient visit apply toward any deductible required by a policy or contract, the visit shall not count toward the visit benefit maximum set forth in the policy or contract.

The Parity Task Force also recommended the establishment of a standing subcommittee of the mental health committee of the Medical Society of Virginia, with representatives from the primary care/family medical societies of Virginia, the Psychiatric Society of Virginia, the Old Dominion Medical Society and Virginia's medical schools. The tasks of this committee would be to encourage interdisciplinary collaboration and conduct an ongoing evaluation of the medical school psychiatry curriculum for primary care in order to recommend constructive change.

The Parity Task Force recommended that a state budget item of $75,000 per school per year for five years be included in the Commonwealth's annual budget to cover one base salary and fringes and be appropriated to each of the three teaching medical schools to develop, improve, and expand the mental health education of medical students and primary care residents. The Parity Task Force also recommended that the State Board of Medicine, the Old Dominion Medical Society and the Medical Society of Virginia encourage and/or require that primary care and family physicians document at least one hour of continuing medical education relevant to mental health and substance abuse problems annually.

Social Impact

Mental health treatment, whether inpatient or outpatient, is an integral part of the delivery of health care. According to information provided by the Parity Task Force, most people who are treated for mental illnesses and/or disorders rarely anticipate a need for such insurance coverage, although 25% of all Americans have a mental illness or disorder. Information obtained from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) indicates that an estimated 226,017 Virginians over the age of 18 suffered from a serious mental

disorder in 1990, representing 4.8% of the total population. DMHMRSAS estimates that 177,000 (11.8%) children and adolescents ages 0-17 have or are at-risk of having mental health problems.

Many individuals choose not to seek mental health treatment for fear of being stigmatized or ostrasized by society. In fact, according to *Consumer Reports* magazine (November 1995), fewer than one-third of American adults suffering from a mental or addictive disorder obtain professional help. Two reasons given for not seeking treatment are a lack of coverage or a lack of comprehensive coverage, and the negative social stigma attached to mental illness. While more difficult to measure and quantify, the societal costs of untreated mental illnesses include an increase in absenteeism from work or school, over-utilization of public assistance and entitlement programs, disintegration of the family, and crime. The report of the Parity Task Force indicates that these social costs are borne by all taxpayers, both individual and business. The report further indicates that investment in appropriate, quality mental health and substance abuse treatment may result in reductions in these social costs that would translate to reduced requirements for tax dollars.

Premium Impact

House Document No. 3 (1995), "The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 1993 Reporting Period" (House Document 3), indicates that coverage for inpatient hospitalization for mental, emotional and nervous disorders treatment accounts for 3.17% of the total policy premium in single coverage individual contracts. House Document 3 also reports that coverage for inpatient hospitalization for mental, emotional and nervous disorders treatment accounts for 2.68% of the total policy premium in family coverage individual contracts.

House Document 3 also indicates that mental, emotional and nervous disorders (inpatient and outpatient) and alcohol and substance abuse (inpatient and outpatient) accounts for 6.65% of the total policy premium in single coverage group contracts. Mental, emotional and nervous disorders (inpatient and outpatient) and alcohol and substance abuse (inpatient and outpatient) accounts for 6.29% of the total policy premium in family coverage group contracts.

Coverage for Mental Health Treatment in Other States

According to information obtained from the National Association of Insurance Commissioners (NAIC), thirty-two states currently have some type of mandate of coverage for mental illness. The state requirements vary greatly. Twenty-four states require insurers to provide or make available coverage for mental illness in group policies only. Six states require coverage for mental illness in both individual and

group policies and contracts. One state, Idaho, mandates coverage for mental illness in workers' compensation policies only.

Several states have laws regarding equity in mental illness coverage. However, no state has a mental health mandate or offer of coverage that establishes complete equity between physical and mental health. Many of those states with mental health mandates or mandated offerings also include inside limits to the coverage. A chart summarizing other states' mandates is contained in Appendix E.

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 Parity Task Force, most people who are treated for mental illnesses and/or disorders rarely anticipate a need for such insurance coverage, although 25% of all Americans have a mental illness or disorder. The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) reports that an estimated 226,017 Virginians over the age of 18 suffered from a serious mental disorder in 1990, representing 4.8% of the total population. DMHMRSAS estimates that 177,000 (11.8%) children and adolescents ages 0-17 have or are at-risk of having mental health problems. DMHMRSAS reports that in 1995, Community Services Boards that are part of the Virginia public mental health system served approximately 106,000 Virginians with mental illnesses. This figure does not include the need met by the private sector or those needs that go unmet.

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

Mental health coverage is currently mandated in § 38.2-3412.1 of the Code of Virginia. However, coverage for outpatient treatment is not mandated in individual policies and contracts. The Parity Task Force reported that outpatient mental health benefits are generally very limited or not available at all in the individual insurance market. According to information obtained by the Parity Task Force, Trigon Blue Cross Blue Shield, the largest health insurer in Virginia, does not include coverage for outpatient mental health care in any of its traditional indemnity policies. Other insurers do, but with limitations of annual or lifetime maximums, and no consistency in plan designs. The Parity Task Force also reported that managed care HMO companies in Virginia offer a balance of inpatient and outpatient mental health coverage.

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.*

The Parity Task Force Report states that persons with inadequate coverage or the inability to self-pay may choose not to seek care. Mental health care providers and consumers make the argument that the lack of coverage for outpatient treatment in individual policies results in unnecessary and costly over-utilization of inpatient treatment. Proponents also noted the unfavorable effects untreated mental illnesses can have on the individual, family, society, and the workplace.

According to *Consumer Reports* magazine (November 1995), fewer than one-third of American adults suffering from a mental or addictive disorder obtain professional help. Two reasons given for not seeking treatment are a lack of coverage or a lack of comprehensive coverage, and the negative social stigma attached to mental illness.

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.*

In a brief survey of a few cental Virginia area psychotherapists, it was reported that the average cost for an hour of outpatient psychotherapy is $75-$80. Area psychotherapists indicated that, on average, one day of inpatient mental health treatment is over $500. It was also reported that, on average, one day of partial hospitalization for mental health treatment is $280. Psychotherapists in the central Virginia area reported that most patients seeking treatment for mental illnesses and disorders visit an average of eight times. Area psychotherapists estimated that the cost of prescription drugs used in mental health drug therapy ranges from $75-$100 per month.

Proponents argue that without adequate coverage, individuals forgo treatment completely or stop receiving treatment when benefits cease because paying-out-of pocket would leave some individuals medically indigent. The Parity Task Force found significant research shows that without mental health treatment, the individual's condition may deteriorate, and medical costs for physical illnesses are higher for persons with untreated mental health problems.

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

Information received from DMHMRSAS indicates that an estimated 226,017 Virginians over the age of 18 suffered from a serious mental disorder in 1990, representing 4.8% of the total population. DMHMRSAS estimates that 177,000 (11.8%) children and adolescents ages 0-17 have or are at-risk of having mental health

problems. Information provided by the Parity Task Force indicates that 25% of all Americans have a mental illness or disorder

106,000 Virginians received mental health services through the Community Services Boards (CSBs) during 1995. CSBs treated 65,010 individuals on an outpatient basis in 1994. Approximately, 47,362 received emergency intervention in 1994.

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

Members of the task force representing mental health providers and consumers reached consensus with the other task force members in recommending outpatient coverage in indivdual policies. It was acknowledged by the Parity Task Force that parity does not exist across the board. Mental health coverage is often available at significantly lesser coverage amounts than those for physical health, or not available at all. Providers on the Parity Task Force noted that individuals covered by individual policies that do not provide coverage for outpatient mental health treatment often forgo or decrease treatment if there is not adequate coverage.

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

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

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.

DMHMRSAS was represented on the Parity Task Force. No separate information or findings of the state health planning agency or the appropriate health system agency regarding the social impact of the mandated benefit was presented during this review.

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 National Psychiatric Health Systems 1993 Annual Survey reports that the shift from inpatient to alternative treatment programs, such as the proposed insurance

coverage, is resulting in significant reduction in costs per hospital admission. Proponents argue that by offering only inpatient mental health benefits in individual policies, insurers actually encourage the over-utilization of costly inpatient services.

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

The Parity Task Force noted that mental health treatment is less well understood than treatment for physical illnesses and, as a result, is perceived as being susceptible to abuse. Insurers expressed concern that mandating parity in mental health care coverage would result in over-utilization and abuse of mental health treatment. Providers and consumers stated that currently some individuals needing outpatient treatment are forced to seek costly inpatient care or forgo treatment. Proponents contend that the proposed mandate would allow individuals covered under an individual policy to obtain outpatient treatment, which is less expensive and just as effective.

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

Outpatient treatment is reported to be less costly than inpatient care that may be unnecessary. Proponents argue that by offering only inpatient mental health benefits in individual policies, insurers actually encourage the over-utiltization of costly inpatient services. The National Psychiatric Health Systems 1993 Annual Survey reports that the shift from inpatient to alternative treatment programs, such as the proposed insurance coverage, is resulting in significant reduction in costs per hospital admission.

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.*

The recommended insurance mandate should not greatly affect the number of providers. However, the other recommendations made by the task force may affect the coursework and training of primary care physicians. Mental health care consumers and providers stressed the importance and effectiveness of early and accurate diagnosis of mental illnesses by primary care physicians and family practitioners. The Parity Task Force found that failure of primary care physicians to recognize mental health problems results in inappropriate care, over-utilization of services, and unnecessary costs. Thus, there is a need for improvement in mental health instruction and training in medical schools and in continuing education.

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.*

There is an anticipated administrative expense associated with changing coverage to comply with the proposed coverage. Trigon estimates an increase of premium costs to an individual policyholder to be 1.5% to 3% and a claims increase of 1.35% to 2.7%.

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

The total cost of health care is not expected to be significantly affected.

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.*

Providers and consumers of mental health care contend that research, both empirical and anecdotal, demonstrates the medical efficacy of outpatient treatment of mental disorders. The efficacy of many treatments for mental disorders is comparable to that in other branches of medicine. Insurers and other opponents questioned whether providers could set standards of treatment for mental illnesses and disorders, as well as determine the average length of treatment. Providers and consumers on the Parity Task Force argued that most mental illnesses can be coded and given a schedule of treatment.

The NPC Report states that the treatment success rate for mental illness ranges from 60% to 80%. *The NPC Report* indicates that such illnesses as manic-depressive illness can be effectively treated through outpatient drug therapy. Before this form of treatment was used, individuals suffering from this illness usually required hospitalization. In a survey conducted by *Consumer Reports*, results indicated that overall, almost everyone who sought help through outpatient therapy experienced some relief or improvement that made them less troubled and their lives more pleasant.

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.*

It is recognized that the benefit addresses a medical need and is consistent with the role of health insurance. The Parity Task Force acknowledged the medical efficacy of early and accurate diagnosis and proper treatment of mental illnesses. The Parity Task Force concluded that outpatient mental health treatment is an important component of a mental health care plans. The Parity Task Force concluded that to eliminate outpatient treatment as a component of treatment is to effectively remove care, while simultaneously risking the more serious costs and problems of inpatient care or increased medical costs. *The NPC Report* states that the treatment success rate for mental illness ranges from 60% to 80%.

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

Some individuals on the Parity Task Force initially felt that a new mandate was inconsistent with the current national trend to decrease the number of mandates. Insurers and other opponents expressed concern that adding another mandate would increase the overall premium cost to individual policyholders and small businesses. They stressed the importance of more flexibility in health care coverage, not less. Insurers questioned whether the proposed benefit would prove to be too expensive for individual policyholders.

The potential premium costs to consumers that may result from a mandated benefit were of great concern to the members of the Parity Task Force. Information obtained in a Parity Task Force survey stated that Trigon estimated a claims cost increase of 1.5% to 3% and resulting premium impact of an estimated 1.35% to 2.7% addition to its individual policies which did not currently offer outpatient mental health benefits. However, providers, consumers, and insurers acknowledged that the use of medical services decreased when appropriate mental health services are provided. The Parity Task Forces stated that numerous studies show a decrease from 5% to 80% in medical service use following mental health treatment. It was determined that an incremental cost differential and resulting minimal impact on consumers is acceptable in light of the offsetting benefits to the consumer.

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

It is expected that the cost of a mandated offer of coverage would be higher because the cost would rest on only those who select the coverage. In the case of group policies and contracts, coverage for both inpatient and outpatient treatment is currently mandated.

Conclusion

The Advisory Commission received the recommendations of the Parity Task Force and will refer these findings and recommendations directly to the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor of the General Assembly for consideration during the 1996 Session.

LD2905685

SENATE BILL NO. 368

Offered January 25, 1994

A BILL to amend and reenact § 38.2-3412.1 of the Code of Virginia, relating to accident and sickness insurance; mental health coverage.

Patrons—Houck; Delegate: Davies

Referred to the Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412.1 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3412.1. Coverage for mental health and substance abuse services.

A. As used in this section:

"Adult" means any person who is nineteen years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health, Mental Retardation and Substance Abuse Services Board pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of nineteen years.

"Inpatient treatment" means mental health or substance abuse services delivered on a twenty-four-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental disorder" means all medically recognized mental illnesses, as defined by the Diagnostic and Statistical Manual, Third Edition, Revised (DSM III-R) as updated from time to time, except substance abuse disorders.

"Mental health services" means treatment for mental, emotional or nervous disorders.

"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, clinical psychologist, 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.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive

outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" means treatment for alcohol or other drug dependence.

"Treatment" means services including diagnostic evaluation, medical psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor employed by a facility or program licensed to provide such treatment.

B. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide benefits for inpatient and outpatient treatment of a mental disorder that are not less favorable than benefits for any other illness, condition or disorder that are covered by such policy or contract.

C. Coverage for mental disorders shall neither be different than nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes of treatment limits, copayment and coinsurance factors, and benefit year maximums for deductibles and copayment and coinsurance factors.

~~B.~~ *D.* Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization ~~mental health and~~ substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty-five days per policy or contract year.

3. Up to ten days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein which provides inpatient benefits in excess of twenty days per policy or contract year for adults or twenty-five days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

~~5. This subsection shall not apply to short-term travel, accident only, limited or specified disease 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.~~

~~C.~~ *E.* Each *individual and* group accident and sickness insurance policy or group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient ~~mental health and~~ substance abuse services as follows:

1. A minimum of twenty visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least fifty percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

~~4. This subsection 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. 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 made.~~

F. Nothing contained in this section shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of mental disorders or drug or alcohol dependence, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

G. This section shall not apply to short-term travel, accident only, limited or specified disease 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.

H. 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 term of the policy or contract is changed or any premium adjustment made.

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

1994 SESSION

LD1230320

HOUSE BILL NO. 1223

Offered January 25, 1994

A BILL to amend and reenact § 38.2-3412.1 of the Code of Virginia, relating to accident and sickness insurance coverage for mental health and substance abuse services.

Patrons—Keating, Copeland, Plum and Scott

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412.1 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3412.1. Coverage for mental health and substance abuse services.

A. As used in this section:

"Adult" means any person who is nineteen years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health, Mental Retardation and Substance Abuse Services Board pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of nineteen years.

"Inpatient treatment" means mental health or substance abuse services delivered on a twenty-four-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" means treatment for mental, emotional or nervous disorders.

"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, clinical psychologist, 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.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" means treatment for alcohol or other drug dependence.

"Treatment" means services including diagnostic evaluation, medical psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor employed by a facility or program licensed to provide such treatment.

B. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty-five days per policy or contract year.

3. Up to ten days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein which provides inpatient benefits in excess of twenty days per policy or contract year for adults or twenty-five days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to short-term travel, accident only, limited or specified disease 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.

C. Each *individual and* group accident and sickness insurance policy or *individual and* group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of twenty visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least fifty percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. This subsection shall not apply to short-term travel, accident only, *or* 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. 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 made.

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: _____
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Clerk of the House of Delegates	Clerk of the Senate

SENATE JOINT RESOLUTION NO. 285

Continuing the Parity Task Force established by the Special Advisory Commission on Mandated Health Insurance Benefits.

Agreed to by the Senate, February 23, 1995
Agreed to by the House of Delegates, February 22, 1995

WHEREAS, the Senate Committee on Commerce and Labor considered legislation introduced in the 1994 Session that was intended to provide parity of mental health insurance benefits with physical health benefits and referred it to the Special Advisory Commission on Mandated Health Insurance Benefits; and

WHEREAS, that commission has sought the cooperation of mental health consumers and providers, the business community and the insurance industry to review the adequacy of such benefits and the feasibility of achieving the intent of such legislation; and

WHEREAS, the aforesaid parties have selected representatives to meet with two members of the General Assembly designated by the chairman of the Mandated Benefits Commission and two members of the executive branch appointed by the Secretaries of Administration and Health and Human Resources to form a task force to make recommendations to the commission on such issues; and

WHEREAS, the interested parties have pledged approximately $6,500 to support the work of the task force and such task force began its work with meetings in December, 1994; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Parity Task Force established by the Special Advisory Commission on Mandated Health Insurance Benefits shall be continued to try to achieve consensus on what constitutes adequate mental health and substance abuse health insurance benefits.

The direct costs of this study shall not exceed $3,000.

The current members of the task force shall continue to serve subject to the confirmation by the Senate Committee on Privileges and Elections regarding the service of the Senate member and the confirmation by the Speaker of the House of Delegates regarding the service of the House member. Staff for the study shall be provided by the Center for Environmental Negotiation at the University of Virginia and the Virginia Supreme Court Alternative Dispute Resolution section.

The task force shall be continued for one year only and shall complete its work and submit its findings to the Special Advisory Commission on Mandated Health Insurance Benefits. The Special Advisory Commission shall report the task force findings to the Governor and the 1996 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Virginia
Mental Health Insurance Parity
Task Force

FINAL REPORT

November 7, 1995

TABLE OF CONTENTS

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Virginia Mental Health Insurance Parity Task Force
FINAL REPORT
Nov. 7, 1995

Executive Summary

At its June, 1994 meeting, the Special Advisory Commission on Mandated Health Insurance Benefits authorized the creation of a task force to address mental health and substance abuse mandated benefits. The task force was invited "to address mental health and physical health insurance coverage distinctions, and to what extent parity should be and can be achieved between the two, balancing the social impact, financial impact and medical efficacy."

This consideration was prompted by the introduction of Senate Bill No. 368 and House Bill No. 1223 during the 1994 General Assembly, which sought to amend the mental health mandate to achieve parity with other benefits. At its first meeting, the Task Force agreed to state its purpose as follows:

1. To study the adequacy of mental health coverage and delivery as required under law, including the distinctions from physical health coverage.
2. To develop public policy recommendations, if appropriate, for any changes to current mental health coverage and delivery, including consideration of the cost, funding, and concept of parity.

The Task Force membership consisted of three business representatives, three representatives of the insurance and HMO industry, four representatives of consumers, family members and providers, two representatives from the Executive branch, and one member each from the Senate and House of Delegates (see roster). Given the controversial nature of the issues under consideration, members agreed to use consensus as the basis for decision making. Two facilitators experienced in consensus-based processes assisted the Task Force.

The Task Force met eight times from Dec. 5, 1994, to Oct. 3, 1995. Members heard presentations from Task Force members as well as other individuals about a variety of topics related to mental health diagnosis, treatment, and insurance coverage. In addition, three member working groups developed recommendations for the Task Force.

The Task Force reached consensus on three major themes as presented in this report. These are:

1. Eight statements of general agreement
2. A recommendation to change the individual mental health benefit mandate to provide for out-patient insurance coverage
3. Recommendations concerning mental health education and primary care physicians

TASK FORCE RECOMMENDATIONS

I. Statements of Agreement and Endorsement

A. Background

The Parity Task Force was convened in response to Senate Bill 368, to study the issue of "parity" between mental health/substance abuse care and physical health care. The participants consisted of members of the business and insurance industries, representatives of the Executive and Legislative branches of Virginia State government, as well as mental health provider and consumer groups. The Task Force agreed to attempt to reach consensus with regard to any agreements and set as its charge:

1. to study the adequacy of mental health coverage and delivery as required under state law, including the distinctions from physical health coverage;

2. to develop the public policy recommendations, if appropriate, for any changes to current mental health coverage and delivery, including consideration of the concept of parity.

B. Introductory Statement of Agreement

The Parity Task Force agrees that the goals of physical and mental health care are the same, and include:

a) the promotion of good health, both physical and mental

b) the integration of physical and mental health care

c) access to effective care

d) timely, accurate diagnosis and appropriate treatment

e) optimal treatment outcomes, a restoration of lost functionality and a return to health and productivity.

C. Specific Areas of Agreement

The Parity Task Force agrees, further, that:

1. Mental illness and substance abuse can be reliably and effectively diagnosed and treated.

Mental health treatment is less well understood than treatment for physical illnesses and, as a result, is perceived as being susceptible to abuse. In fact, the treatment of mental illness and substance abuse through modern protocols is quite similar in its effectiveness to the treatment of physical disorders. While there is a need

for improvement in the early diagnosis and appropriate treatment of mental health problems, just as there is in physical health care, prevention and early intervention efforts yield significant reduction in later problems and their costs.

2. **Parity does not exist across the board. Current benefits often do not provide coverage for an adequate range of mental health treatment options.**

It is acknowledged that parity is a complex issue and that there is no easy way to determine equality of coverage in health care plans. Physical health care has limited coverage, including benefit limits and separate coverage amounts. Nonetheless, mental health coverage is often available at significantly lesser coverage amounts, or is not available at all.

3. **When appropriate mental health services are not available, there are costs to individuals, to families, and to society, including a negative monetary impact to both the public and private sectors due to medical cost offsets and reduced worker productivity.**

When people do not have access to timely and appropriate mental health services, not only do affected individuals suffer, but there are costs to society. Without mental health services, the individual's condition may deteriorate, and there is significant research to show that medical costs are higher for persons with untreated mental health problems. Families suffer as they struggle to deal with the effects of untreated or inappropriately treated mental illness. Communities suffer as untreated substance abuse leads to crime and violence. In addition, businesses suffer as costs increase in the form of absenteeism, turnover, and reduced worker productivity.

4. **Failure of primary care physicians to recognize mental health problems results in inappropriate care, over-utilization of services, and unnecessary costs. Thus, there is a need for improvement in mental health instruction and training in medical schools and in continuing education.**

Because most mental health problems are brought to the primary care setting and are often unrecognized, there are opportunities in this setting to improve mental health care. There clearly is a need for improvement in mental health training/education for physicians in both primary (medical school) and continuing education. Because the provision of physical health care and mental health care has not been effectively coordinated, there is not adequate connection between primary care and mental health care. Often, physicians treat physical health problems that are masked mental health problems. If the underlying mental health condition could be appropriately diagnosed and referred, costs would be reduced and the patient's total health needs would be better served. Under prepaid health plans, the financial incentives will necessitate better coordination between primary care and mental health care providers. The lack of coordination between physical health care and mental health care has led the Task Force to make a set of recommendations regarding the training and continuing education of primary care physicians.

5. **Businesses, insurance companies, and consumers need assurance that mental health providers are properly trained and credentialed.**

As a part of providing quality care, there is a need to ensure proper training and credentialing of the full range of private and public mental health providers. There is also a need for the various professional groups to address disconnections between and among mental health care providers.

6. **In a price-sensitive market, any increase in benefit costs may cause a decrease in benefits offered and in the number of persons covered.**

The achievement of parity in the marketplace is difficult and complicated. With regard to insurance, the Task Force is aware that in a price-sensitive market, benefit costs may have a negative impact on the number of people covered. Systems must be in place such that businesses, through their health benefit plans, do not assume unlimited risks.

7. **Managed health care can be a viable and successful approach to mental health care delivery and a way of protecting against unlimited expenditures.**

In the absence of a managed mental health care system, it is reasonable to have some form of limitation on mental health benefits. Nonetheless, the Parity Task Force believes that mental health benefits are an essential component of health care plans. In addition, it agrees that mental health benefits should be constructed to achieve levels of quality and outcomes that are consistent with the levels of quality and outcomes generally achievable through physical health care benefits.

8. **Outpatient mental health treatment is an important component of a mental health services delivery system. Cost savings may be achieved through availability of outpatient care as an alternative to hospitalization.**

To eliminate outpatient treatment as a component of treatment is to effectively remove care, while simultaneously risking the more serious costs and problems of inpatient care or increased medical costs. Outpatient benefits are not currently mandated as a part of individual insurance packages. The Parity Task Force is reluctant to recommend mandating any new benefits. It is our view, however, that outpatient benefits in individual policies should be consistent with outpatient benefits in group policies. While we recognize that individual policies constitute a small portion of the insured marketplace and an even smaller portion of the citizens of the Commonwealth (6%), we believe this to be a small but significant step toward consistency in good health care.

II. Recommendations for an Individual Outpatient Benefit Mandate

It is the recommendation of the Mental Health Parity Task Force that Section 38.2-3412.1 of the Code of Virginia be amended to require outpatient mental health coverage that includes at least 20 outpatient visits each policy or contract year in individual policies, subscription contracts, and individual conversion policies. The benefit limits are to be no more restrictive than for physical illness except that coinsurance after five outpatient visits in any year must be at least 50 percent. In addition, if all covered expenses for an outpatient visit apply toward any deductible required by a policy or contract, the visit shall not count toward the visit benefit maximum set forth in the policy or contract.

This recommendation has been made in order to:

1. Correct the disparity between mental health coverage mandates in the group and individual market.

2. Ensure the availability of outpatient mental health benefits in all segments of the population in Virginia.

3. Reflect the growing industry trend toward the provision of outpatient mental health benefits in the individual market.

4. Allow individuals access to appropriate treatment early in the disease process.

5. Conform with existing professional protocols that recommend treatment in the least restrictive setting.

6. Realize the medical cost offset of appropriate mental health treatment.

A. Disparity Between Group and Individual Policies

During the 1992 General Assembly session, the legislature modified mandated mental health and substance abuse health insurance benefits. Prior to this change, individual and group health insurance policies were required to include coverage for 30 days of inpatient treatment. Insurers were required to offer group policy holders the option of purchasing a minimum of $1,000 of benefits for outpatient therapy.

The modifications to group insurance mandated benefits provided coverage for inpatient, partial hospitalization, outpatient therapy and medication management visits. To achieve coverage for this array of services without significant increases in the cost, the required inpatient benefits were reduced from 30 days to 25 days for children and adolescents and from 30 days to 20 days for adults. The "tradeoff" for these inpatient day reductions was the addition of partial hospitalization coverage and the modification that the first 5 visits of outpatient care be covered as any other illness and the next 15 visits must be covered by at least 50 percent. These "tradeoffs" and adjustments were to achieve the stated objective of maintaining cost neutrality of premiums.

Individual health polices were able to reduce inpatient coverage by the same five or ten days, but were not required to include benefits for outpatient therapy. Therefore, no "tradeoff" took place and consumers effectively lost inpatient benefits with no counterbalancing outpatient coverage. The 1995 Mental Health Insurance Parity Task Force believes this disparity between the group policy mandate of outpatient mental health benefits and the individual non-mandate should be corrected. We recommend correcting this disparity by requiring individual insurance contracts to offer the same benefits as currently mandated for groups.

Another practical reason for the coordination of the group and individual mandates is the avoidance of consumer confusion. As it is becoming increasingly more consumer friendly to switch back and forth between group and individual policies with no penalty of pre-existing condition waiting periods or portability penalties, consumers expect reasonable continuity of coverage. Many longtime group policy holders are unpleasantly surprised to discover no outpatient behavioral benefits are available in many individual policies.

B. The Current Availability of Outpatient Behavioral Health Care Benefits in the Individual Marketplace

Outpatient mental health benefits are generally very limited or not available at all in the individual insurance market. Trigon Blue Cross Blue Shield, the largest insurer in the Commonwealth, does not include coverage for outpatient mental heath care in any of its traditional indemnity policies. Other insurers do, but with limitations to annual or lifetime maximums and no consistency in plan design.

Managed care HMO companies in Virginia do offer a balance of inpatient and outpatient mental health coverage. Three of four HMOs reviewed offered outpatient mental health benefits the same as or exceeding the existing group mandate (Trigon, Southern Health, and MAMSI). All of these included limits on the number of visits covered annually. The fourth HMO (Sentara) had not filed its individual HMO product with the Bureau as of our review date.

The availability of these HMO products offering outpatient mental health benefits to the total Virginia population does pose a problem. The HMOs are generally available only in Northern Virginia, Richmond, Tidewater, and only recently, Roanoke. However, according to Trigon, 81% of the individual policies they write are in rural areas, small towns (less than 20,000) or towns and suburbs (20,000 - 100,000). In order to reach this population, traditional indemnity policies are written and outpatient mental health is limited or not offered at all.

Another issue with availability to consumers is the underwriting practices of insurance companies. Carriers can deny coverage or subject policyholders to pre-existing condition limitations if no prior coverage was ever in place. Trigon's open enrollment policy, available to those policyholders unable to purchase other policies, does not include outpatient mental health benefits.

When debating the mandates, the Task Force also considered the distinction between benefits that have a mandate and those that have a mandate to make available. Insurance company representatives were reticent of the mandate to make available option because adverse selection issues would make pricing difficult, possibly prohibitive. The consensus was to have a mandate to level the playing field for all insurers.

C. Adjusting an Ineffective Benefit Structure

The trend in the insurance and managed care arena is to design plans to encourage the more cost effective outpatient care. Decreasing lengths of stay at inpatient facilities are being experienced in both physical and mental admissions. The shift from inpatient to alternative treatment programs is resulting in significant reductions in costs per hospital admissions. (Source: National Association of Psychiatric Health Systems 1993 Annual Survey: Final Report, *Employee Benefits Plan Review,* December 1994)

Ironically, by only offering inpatient mental health benefits, an individual policy insurer could actually be encouraging the utilization of costly inpatient services. This is completely contradictory to all the trends in the marketplace and creates an ineffective benefit structure.

Mental health treatment, be it inpatient or outpatient, is an integral part of the delivery of health care. The Task Force recognizes the efficiencies and necessities of outpatient mental health benefits and supports the inclusion of these benefits in policies available in the Commonwealth.

D. Access to Treatment

Why should Virginians who do not have access to group policies be subjected to less than adequate mental health care? Most people who are treated for mental illnesses and/or disorders would never have anticipated a need for such insurance coverage, even though statistics indicate that 25% of all Americans have a mental illness or disorder. Most people find the social impact of seeking mental health care very traumatic due to the immense barrier created by the stigma attached to mental illness. When this barrier is finally scaled and the initial shock of being in therapy subsides, the horror of little or no insurance coverage is often the final blow. There is ample anecdotal information to indicate many people choose not to seek care, even though they may be very ill, because of their inadequate insurance coverage or inability to self-pay. This attitude would not be tolerated in cardiac or cancer patients.

Virginians covered by individual policies needing out-patient therapy must be prepared to pay the costs or look to the local Community Services Board mental health center. Although the public community services board system in Virginia provides a high proportion of indigent care, Community Services Boards also charge for services based on the client's ability to pay. Therefore, persons with inadequate coverage or the

inability to self-pay may also choose not to seek care from the public system. In some localities, CSB resources may be inadequate to meet the demand for services that exists. This puts citizens needing mental health services in the unenviable position of making a health related decision based on everything except their health.

A Continuum of Care Study is currently being conducted by the Department of Mental Health, Mental Retardation and Substance Abuse Services. This study is intended to examine the capacities and needs of the current system so that Virginia can address these by adding new resources or deploying current resources as needed.

E. Efficacy of Treatment

Mental illnesses are both real and definable. Research on mental health and substance abuse treatment interventions has allowed many people to recover quickly and return to productive lives. More and more people are able to receive effective treatment in a less expensive and intensive outpatient basis.

Over the past two decades, treatment options for mental illnesses have become more numerous, more specific and more effective. Research in clinically controlled trials has verified the effectiveness of these interventions, and provided a scientific basis for clinical decision making.

The efficacy of many treatments for mental disorders is comparable to that in other branches of medicine. For example, controlled studies have demonstrated that treatment intervention for schizophrenia, panic disorder, bipolar disorder, obsessive-compulsive disorder and major depression result in significant improvement for 60% to 80% of all patients. In contrast, the improvement rate for angioplasty and atherectomy, two commonly performed surgical procedures, are less than 60%.

Research continues on treatment of mental illness and substance abuse disorders, and new treatments are expected to increase effectiveness rates in the near future.

During 1993, the National Institute of Mental Health commissioned a review of the research on efficacy of various interventions for treatment of the most serious and disabling of mental illnesses. A summary of these results is presented below.[1]

Schizophrenia: Schizophrenia is an illness that develops in late adolescent or early adulthood, and is characterized by psychotic features such as hallucinations and delusions, as well as loss of will. Standard antipsychotic medications have been used over the past thirty years, and they are effective in reducing symptoms in 60% of the most seriously ill people with schizophrenia. Nonetheless, medication fails to prevent relapse in up to 60% of those patients with whom it is initially effective.

The addition of specific psychosocial treatments to the medication regimen can decrease the re-hospitalization rate to as low as 25% in a two-year period.

During the 1990's, new medications (e.g. clozapine, risperidone) have provided relief for one-third of the previously treatment-resistant patients with schizophrenia.

Bipolar Disorder (Manic-Depressive Illness): Bipolar disorder is characterized by a cycling between extreme highs (mania) and extreme lows (depression). Lithium is a highly effective drug that enables people with bipolar disorder to lead essentially normal lives. Approximately 80% of patients respond to lithium within five to ten days. People on lithium are 28 times less likely to relapse in any given month than those without this standard drug therapy. The addition of other anti-psychotic or anti-convulsive medications, electro-convulsive therapy, and psychosocial interventions increase the effectiveness of lithium therapy. Concomitant individual, family and group therapy increase patient compliance with the treatment plan, reducing relapse rates.

Major Depression: Major depression is characterized by loss of interest and pleasure, feelings of worthlessness, fatigue, suicidal ideation, and disturbances in bodily functioning. In its severe form, medication is an essential component of treatment. Three classes of anti-depressant medications are currently available. Between 80% to 85% of all people with major depression respond to one or a combination of drugs. Electro-convulsive therapy is equally effective for patients who cannot tolerate the medication or for whom a faster response is required.

In less severe cases, a variety of psychotherapies have been shown to be effective. Psychotherapy alone has been proven to be effective in patients who prefer not to take medication, or who exhibit prominent psychosocial difficulties or show evidence of a personality disorder. Additionally, psychotherapy in conjunction with medication appears to decrease the incidence of recurrence in people with more severe depressions.

Panic Disorder: People with panic disorder experience discrete periods of intense fear or discomfort accompanied by shortness of breath, dizziness, palpitations, sweating, choking, and chest pain. Response rates to medications, including anti-depressants and anti-anxiety agents, range from 70% to 90%. Most studies have also reported that individual therapy focusing on cognitive and behavioral approaches have success rates comparable to medication. Studies are underway to determine if the combination of cognitive or behavioral therapy in conjunction with medication achieves even greater results.

Obsessive-Compulsive Disorder: OCD is characterized by crippling ritualistic behaviors and obsessive thinking patterns. Fully 80% of all OCD patients demonstrate some response to medications, with more than 60% achieving at least a moderate improvement. The addition of behavioral therapy increases response rates.

F. The Importance of Early Diagnosis and Intervention in Increasing Effectiveness

For almost all disorders, the effectiveness of treatment is increased when the disorder is diagnosed early in the disease process and appropriate treatment is administered.[2] This, of course, reduces costs in several important ways:

1. It minimizes costs of inappropriate pre-diagnosis treatment;

2. It minimizes intensiveness of treatment required; and

3. It minimizes ongoing costs of treatment.

For example, recurrent episodes of mania in bipolar disorder have a cumulative negative effect on functioning and response rate. Therefore, the sooner patients are diagnosed and treated, the greater their chances for recovery. Since at least 80% of patients who have an episode of mania will have another without treatment, the opportunity for reducing overall costs associated with bipolar disorder is significant.

In depression, early treatment is important to speed complete recovery. One study determined that a long history of symptoms prior to intervention was the only variable that correctly predicted a chronic outcome. A history of recurrence also affects the ability of the patient to remain well following initial treatment. Patients with three or more pre-treatment episodes of depression had a significantly shorter time to relapse and a relapse rate 50% higher than patients who had two or fewer prior episodes.[3]

Panic disorder typifies the problem with lack of early diagnosis and treatment. Since the disorder manifests itself with symptoms that appear to be physical rather than psychological, undiagnosed patients can incur thousands of dollars in unnecessary tests and inappropriate treatment for heart disease, stroke, and related illnesses. Allowed to progress untreated, panic disorder can progress to agoraphobia in which the patient in unable to leave a small, confined area such as his home as a result of anticipatory anxiety. Agoraphobia has immense occupational and social costs.[4]

"The existence of effective treatments is only relevant to those who can obtain them. Far too many Americans with...mental illness and their families find that appropriate treatment is inaccessible because they lack any insurance coverage or the coverage they have for mental disorders in inequitable and inadequate...These inequities...can and should be overcome."[5]

G. Existing Research Concerning Medical Cost Offset Attributable to Mental Health Treatment and its Ultimate Utility in Actuarial Formulations

A body of evidence is being developed that demonstrates that there are significant costs of untreated or under-treated mental illness. These costs accrue to the individual with the mental illness, his family, his employer, and society as a whole.

A 1993 Massachusetts Institute of Technology study found that the total costs of untreated depression amount to $43.7 billion annually on a national basis. The indirect (non-treatment) costs of severe mental illnesses were conservatively estimated at $48 billion in 1990. The non-treatment costs of all mental illnesses and substance abuse disorders is probably exponentially higher.

Cost offset is the term used to describe the savings that can be realized through an investment in appropriate, quality mental health care. Cost offsets are generally categorized as medical cost offset, employer cost offset, and social cost offset.

1. Medical Cost Offset

The savings that can be achieved in medical costs through the provision of mental health and substance abuse treatment are the most measurable and best documented. It is widely accepted that there is a direct connection between improved mental health and improved physical health. The greater the offset, the more likely it is that mental health services will pay for themselves.

Researchers have estimated that as much as 50% to 70% of a doctor's normal caseload consists of patients whose medical illnesses are significantly related to psychological factors. Fully 25% of these patients are estimated to have disabling psychiatric illnesses. One research study reported that patients with diagnosable mental illnesses average twice as many visits to their primary care physicians as do patients without mental illness.[6]

The use of medical services decreases when appropriate mental health services are provided. Numerous studies show a decrease from 5% to 80% in medical service use following mental health treatment. A comprehensive analysis of 60 investigations of psychotherapy effects on medical utilization found that 85% demonstrated medical utilization decreases following psychotherapy. The average decrease for inpatient utilization was 73.4%; for outpatient medical services, the average decrease was 22.6%.[7]

In Hawaii, Medicaid recipients with mental illness had medical costs 200% - 250% higher than higher than others. Mental health intervention reduced medical costs by $623 per person annually. This represents a 22% reduction.[8]

Medicaid patients hospitalized for physical illnesses and provided mental health interventions realized average cumulative savings of $1,500 over a subsequent 2-1/2 year period. The cost of these mental health interventions was entirely paid for by these savings.[9]

The McDonnell-Douglas Corporation saw a $7,370 reduction in the use of medical care over four years for each employee who accessed quality, appropriate mental health and/or substance abuse treatment.[10]

Three hundred veterans who received abbreviated mental health treatment following a history of excessive medical care utilization were able to reduce outpatient medical visits by 36%. Control group members who received no psychotherapy actually increased medical utilization.[11]

A three year study of 10,000 Aetna beneficiaries showed that after initiation of

mental health treatment, client medical costs dropped continuously over 36 months. The health costs of one treatment group fell from $242 the year prior to treatment to $162 two years post-treatment. Other subject groups demonstrated similarly dramatic cost offsets, leading the researchers to conclude that a decrease in total health care costs can be expected following mental health interventions even when the cost of intervention is included.[12]

There is convincing, consistent evidence that drug and alcohol treatment reduces medical and related mental health treatment costs. In California, 15 months after treatment, a random sample of 3,000 clients reported a 36% decrease in hospitalizations for medical problems; a 58% decrease in hospitalizations for drug overdose; a 38% decrease in emergency room visits; and a 25% decrease in the total number of hospital days.[13]

In Minnesota, of the 17,000 - 19,000 clients in the Consolidated Chemical Dependency Treatment Fund, 64% are abstinent six months after treatment. An estimated $22 million was saved annually in health care costs following treatment for alcohol and other drug abuse.[14]

Similar results were found in Ohio. One year after 668 citizens were treated for drug and alcohol abuse, a 66% decrease in hospital admissions was reported, along with a 41% decrease in emergency room utilization. In Washington state, clients who received private or public substance abuse treatment incurred half the in-hospital costs of the untreated population.[15]

2. Workplace Cost Offset

When an employer pays health insurance premium costs or claims costs for employees, the medical cost offset will be a consideration in determining judicious use of resources. Evidence also demonstrates that employers experience more direct costs of untreated mental illness and substance abuse disorders, however.

During 1985, the total cost of untreated mental illnesses, excluding substance abuse disorders, was estimated at $129.3 billion annually. Approximately half of these costs were attributable to lost productivity in the work place.[16]

In any one month period during 1990, almost 8 million people experienced depression at an estimated annual cost of $16 billion. Fully $10 billion of this cost was attributable to absenteeism from the workplace.[17]

Stress causes American workers to miss an average of 16 days on the job each year, and nearly three-fourths of the corporate medical directors and human resources managers surveyed call stress "very pervasive" or "fairly pervasive." Managers surveyed reported that 13% of their employees suffer from symptoms of depression including difficulty concentrating (36%), sleep problems (35%), loss of energy (27%), and

loss of interest in work (18%).[18]

McDonnell Douglas reported that employees with mental illnesses and substance abuse disorders have excess days of absenteeism. Over the course of four years, the employee with a substance abuse disorder will incur 88 excess days; the employee with a mental illness will incur 50 excess days. Those employees who were treated for chemical dependency lost 44% fewer days than those who did not receive treatment. Employees who were treated for mental illness had a 34% reduction in missed days.

Similar improvements were seen in turnover statistics. Fully 40% of those employees identified with a chemical dependency were no longer employed by McDonnell Douglas three years later. For employees with mental illness, the three-year turnover rate was 16%. Four years post-treatment, only 7.5% of those employees with a chemical dependency had been terminated or quit. For people with mental illness, a 60% reduction in turnover was seen four years after initiation of treatment. Turnover is inherently costly to employers through recruitment and retraining costs as well as the cost of Unemployment Compensation Insurance.

Untreated mental illnesses and substance abuse disorders are also believed to increase work place accidents, raising Workers' Compensation insurance costs.

3. Societal Cost Offset

The societal costs of untreated mental illnesses and substance abuse disorders is less concrete and more difficult to measure. Nonetheless, general knowledge about these disorders, anecdotal information and generally accepted statistics allow attribution of some costs to these disorders when they are untreated.

The total economic cost of drug abuse was reported to be $67 billion in 1990. More than two-thirds of these costs resulted from losses from crime and incarceration, and related law enforcement expenses. For alcohol abuse, the total cost was estimated to be $99 billion in 1990. Productivity losses resulting from death and illness resulted in 70% of the total costs, while 16% of the total costs related to accidents resulting from alcohol abuse. This report concluded that "it costs every man, woman and child in this country nearly $1,000 annually to pay for unnecessary health care, extra law enforcement, auto accidents, crime, and lost productivity resulting from substance abuse."[19]

Mental illness, including depression, can be as functionally disabling as a serious heart condition and more disabling than other chronic physical illnesses such as lung or gastrointestinal problems, angina, hypertension and diabetes.[20]

Untreated mental illnesses and substance abuse disorders are also believed to lead to increased educational costs resulting from school failure, suspension and expulsion, and drop out prevention programs. Some of these costs are the result of children with these conditions; others result from children who live in a dysfunctional family with one or more members who have these conditions.

Other social costs of untreated mental illnesses and substance abuse disorders result from family dysfunction that leads to family disintegration and physical abuse. These costs are reflected primarily in court costs and public assistance and entitlement program costs.

These social costs are borne by all taxpayers, both individual and business. It appears that an investment in appropriate, quality mental health and substance abuse treatment may result in reductions in these social costs that would translate to reduced requirements for tax dollars.

4. Use of Offset Information in Actuarial Formulations

The most comprehensive United States mental health survey in a decade found that 48% of those surveyed experienced mental illness at some point during their lifetimes. Fully 29.5% had been affected during the previous 12 months. Provision of appropriate mental health services to these people suggests there may be potentially enormous savings based on the cost offset research and theories.

For health insurance pricing determinations, medical cost offset information will be most applicable. Nonetheless, a Trigon actuary reported to the Mental Health Insurance Parity Task Force that Trigon does not consider medical cost savings that may result from inclusion of mental health and substance abuse treatment coverage.

Inclusion of cost offset results by insurance company actuaries requires two pieces of information:

a. Evidence that mental health and substance abuse insurance benefits increase access to these kinds of care, resulting in a lower incidence of untreated mental illness and substance abuse disorders.

b. Evidence of the degree to which this increased access will reduce medical care costs.

Members of the Task Force believe that this evidence exists. Admittedly, it does not exist in specific numbers that are applicable by the lay person to health insurance pricing decisions. Nonetheless, it is readily verifiable and confirmed by numerous empirical studies. Since actuarial decisions are based on assumptions and past experience, it is feasible to believe that some medical cost offset adjustments can be made as mental health and substance abuse coverage pricing determinations are made.

Members of the Task Force also acknowledge that availability and accessibility of appropriate mental health and substance abuse treatment to reduce workplace and societal costs is more than an insurance concern. Therefore, claim and premium costs should not be the sole determinant of good public policy with regard to mental health and substance abuse health insurance.

H. Premium Cost to the Consumer

The potential premium cost to consumers that may result out of any mandated benefit was of paramount concern to the members of the Mental Health Insurance Parity Task Force.

In recommending that individual accident and sickness policies be required to provide coverage for outpatient mental health and substance abuse services consistent with the existing requirement for group policies, the Task Force does not believe that this mandate change will be completely cost neutral. With the offering of new benefits, it is anticipated utilization will increase. However, we believe that the incremental cost increase is outweighed by the resulting overall societal benefits.

The Mental Health Task Force requested comments from a variety of insurers on the premium and cost differentials expected in individual policies if an outpatient mandate was required. As of the writing of this report four companies responded -- Trigon, Blue Cross Blue Shield of the National Capital Area, Time, and Health Plus. Responses are attached and addressed in the Public Comments section of this report.

Trigon estimated a claims cost increase of 1.5% to 3% and resulting premium impact of an estimated 1.35% to 2.7% to its individual policies which did not currently offer outpatient behavioral benefits.

Of the market place offerings, the HMOs are currently offering these benefits and would not see a premium impact as result of a mandate. Other individual insurance writers like Golden Rule and Time currently offer some variation of outpatient benefits so their resulting premium impact theoretically should be less than Trigon's prediction. All the carriers could potentially see an offsetting reduction in claims cost because of reduced costly inpatient days of treatment, early intervention and diagnosis, and medical offsets attributable to mental health treatment.

It is the consensus of the Task Force that an incremental cost differential and resulting minimal impact to consumers is acceptable in light of the offsetting benefits to the consumer, to the public, and to the Commonwealth.

III. Mental Health Education and Primary Care Physicians

A. Introduction

The Parity Task Force has studied the interrelationships of primary care medicine and psychiatry and the role of this collaboration in clinical and economic health care outcome.

The Committee received important testimony from Dr. Anthony Kuzel, family physician and faculty member in Family Medicine at the Medical College of Virginia. Dr. Kuzel "emphasized that there is increasing recognition in the importance of training and education about mental health and behavioral "medicine" in primary care and family medicine. "There needs to be better training within family medicine for mental illnesses, and physicians should be able to recognize the signs of problems such as family violence or substance abuse. Mental health should be emphasized in the curriculum of residency programs." (Minutes of June 22, 1995)

In additional discussions within the Task Force, we learned that 20% to 30% of the problems presenting to the primary care practitioners are primarily mental health in nature. Many other problems have major mental health components. There is abundant literature documenting that primary care physicians need better training to adequately diagnose and treat these patients. Proper diagnosis and treatment enhances the quality of the patients' mental and physical health, reduces significant losses to business from decreased attendance and poor work productivity, and produces savings by reducing needless, expensive medical tests and services.

The negative financial impact of inadequate psychiatric care effects the insurance industry, business, the Commonwealth of Virginia (Medicaid, Medicare, indigent care) to a major degree.

The formal mental health education of primary care practitioners takes place in three settings:

1. Medical school education (4 years)

2. Family medicine and primary care residency education, which follows medical school (3-4 years)

3. Continuing education for practitioners (lifelong)

The Committee reviewed a number of recommendations for improving the integration of mental health and primary care and for improving the diagnostic and treatment skills in mental health issues for primary care physicians.

B. Recommendations

1) Establish a standing subcommittee of the mental health committee of the Medical

Society of Virginia, with representatives from the primary care/family medicine societies of Virginia, the Psychiatric Society of Virginia, the Old Dominion Medical Society and our state's medical schools. This committee would encourage interdisciplinary collaboration and would conduct an ongoing evaluation of the medical school psychiatry curriculum for primary care in order to recommend constructive change.

2) A state budget item of $75,000 per year for five years to cover one base salary and fringes would be appropriated to each medical school to develop, improve and expand the mental health education of medical students and primary care residents. A psychiatric faculty member in each school would be in charge of expanding the psychiatric teaching of medical students and designing specific clinical supervision and classroom education in relevant topics including depression, anxiety disorders, ADHD in children, substance abuse, marital malady, teen problems, sexual concerns. Diagnostic, counseling, treatment and referral skills would be emphasized. There are 1,643 medical students and 700 primary care residents in Virginia. This then amounts to $96 per trainee per year. Funding is required because of the current unavailability of appropriate medical school resources to meet these needs.

3) We recommend that the State Board of Medicine, the Old Dominion Medical Society and the Medical Society of Virginia should encourage and/or require that primary care and family physicians document at least one hour of continuing medical education relevant to mental health and substance abuse problems annually.

APPENDICES

A. Public Comments

In order to fully review the fiscal impact of its recommendations, the Mental Health Parity Task Force solicited public comment from a cross-section of the insurance industry on two issues related to coverage for mental health services:

1. The claims and premium cost differentials experienced as a result of the 1992 change in mandated mental health benefits in the group market.

2. The anticipated claims and premium cost differentials expected as a result of mandated outpatient mental health benefits in the individual market.

Public comments were requested from the following organizations:

Marianne Randazzo	Metra Health
Legal Department	The Guardian
Joe Burns	Aetna Health Plans
Robin Macco	Lincoln National
Legal Department	Principal Mutual
Roderick Mathews	Trigon Blue Cross Blue Shield
Gail Thompson	Blue Cross and Blue Shield of the National Capital Area
Legal Department	Nationwide
Legal Department	Celtic Life
Legal Department	Golden Rule Insurance
Legal Department	Time Insurance
Legal Department	Mutual of Omaha
Tom Barbera	MAMSI
Larry Berman	George Washington
Julie Blauvelt	Southern Health
Kim Chope	Optima Health
Elizabeth Gee	Partners National Health
Tom Goddard	Health Plus
Michael Lanza	CIGNA Healthcare
Tamara Smith	Kaiser Foundation
Meredith Yancy	Humana Group Health

Although few public comments were received, the following conclusions can be abstracted from the respondents:

1. Valid cost data concerning the 1992 change in mandated mental health benefits in the group market cannot be derived due to:

The relatively recent change in the mandate does not allow for the collection of sufficient utilization experience necessary for an actuarially credible determination.

Numerous other factors, including other benefit changes, have influenced the utilization of services in the period before and after the effective date of the change.

2. The addition of outpatient mental health benefits in individual insurance products would increase premiums costs for the subscriber by an estimated 1.3 to 3.0 percent.

B. Proposed Legislative Language

§ 38.2-3412.1. **Coverage for mental health and substance abuse services.** - A. As used in this section:

"Adult" means any person who is nineteen years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health, Mental Retardation and Substance Abuse Services Board pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of nineteen years.

"Inpatient treatment" means mental health or substance abuse services delivered on a twenty-four-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" means treatment for mental, emotional or nervous disorders.

"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, clinical psychologist, 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.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as

an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" means treatment for alcohol or other drug dependence.

"Treatment" means services including diagnostic evaluation, medical psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug or substance abuse counselor employed by a facility or program licensed to provide such treatment.

B. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or

intermediate care facility for a minimum period of twenty-five days per policy or contract year.

3. Up to ten days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein which provides inpatient benefits in excess of twenty days per policy or contract year for adults or twenty-five days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to short-term travel, accident only, limited or specified disease 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.

C. Each individual and group accident and sickness insurance policy or group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of twenty visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least fifty percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible

required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection 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. 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 made. (1993, c. 132; 1995, c. 279.)

C. Footnotes

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D. Senate Joint Resolution No. 285

WHEREAS, the Senate Committee on Commerce and Labor considered legislation introduced in the 1994 Session that was intended to provide parity of mental health insurance benefits with physical health benefits and referred it to the Special Advisory Commission on Mandated Health Insurance Benefits; and

WHEREAS, that Commission has sought the cooperation of mental health consumers and providers, the business community and the insurance industry to review the adequacy of such benefits and the feasibility of achieving the intent of such legislation; and

WHEREAS, the aforesaid parties have selected representatives to meet with two members of the General Assembly appointed by the chairman of the Mandated Benefits Commission and two members of the Executive branch appointed by the Secretaries of Administration and Health and Human Resources to form a task force to make recommendations to the Commission on such issues; and

WHEREAS, the interested parties have pledged approximately $6,500 to support the work of the task force and such task force began its work with meetings in December, 1994; now, therefore be it

RESOLVED by the Senate, the House of Delegates concurring, That the task force appointed by the Special Advisory Commission on Mandated Health Insurance Benefits shall be continued to try to achieve consensus on what constitutes adequate mental health and substance abuse health insurance benefits.

The current members of the task force shall continue to serve. Staff for the study shall be provided by the Center for Environmental Negotiation at the University of Virginia and the Virginia Supreme Court Alternative Dispute Resolution section.

The task force shall complete its work and submit its findings to the Special Advisory Commission on Mandated Health Insurance Benefits. The Special Advisory Commission shall report the task force findings to the Governor and the 1996 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for processing legislative documents.

August 7, 1995

Dear:

During the 1994 Session of the Virginia General Assembly, House Bill 1223: Coverage for Outpatient Mental Health Treatment in Policies Issued on an Individual Basis and Senate Bill 368: Coverage for Mental Health Treatment (Parity) were referred by their respective committees to the Advisory Commission on Mandated Benefits for review. The Advisory Commission supported the creation of a task force composed of members of the mental health consumer community, mental health care providers, business leaders, insurers, governmental representatives, and others. The task force, known as the Virginia Mental Health Parity Task Force, has reviewed both House Bill 1223 and Senate Bill 368 and is preparing to report its findings and recommendations to the Advisory Commission for its consideration.

As a member of that task force, I am respectfully requesting your organization's comments on the following issues concerning mandated coverage for mental health and substance abuse services:

1) The premium and claims cost differentials expected in individual policies, subscription contracts, and individual conversion policies for required outpatient mental health coverage that includes at least 20 outpatient visits each policy or contract year. The benefit limits are to be no more restrictive than for physical illness except that coinsurance after five outpatient visits in any year must be at least 50 percent. In addition, if all covered expenses for an outpatient visit apply toward any deductible required by a policy or contract, the visit shall not count toward the visit benefit maximum set for in the policy or contract.

2) Section 38.2-3412.1 of the Code of Virginia relating to the mandate of coverage for mental health and substance abuse services for group policies and subscription contracts was amended in 1993 to provide a mental health benefit conversion option that provided flexibility in mandated mental health service coverage by providing a range of services in varied treatment settings. Assess the financial impact, if any, of this mandate.

Thank you for your attention to this most important policy issue. Please return your comments by **August 31, 1995** and direct them to my attention at P.O. Box 6800, Lynchburg, VA 24505. If you have any additional questions related to this request for comment, please contact Ms. Kim Barnes, Executive Director of the Richmond Area Business Group on Health at (804) 282-5931.

Sincerely,

Elliot S. Schewel

TRIGON
Trigon BlueCross BlueShield

Roderick B. Mathews
Senior Vice President, Corporate
Legal and Government Affairs Officer

August 31, 1995

Richmond Area Business Group on Healthcare
7275 Glen Forest Drive
Suite 301
Richmond, Virginia 23226

Re: Senator Schewel's August 7, 1995, Letter

Gentlemen:

Trigon Blue Cross Blue Shield responds to Senator Schewel's August 7, 1995, inquiry as follows:

The addition of outpatient mental health coverage described in Senator Schewel's letter to individual health insurance products would increase the claims cost by an estimated 1.5% to 3%. The resulting impact on the premium would be an estimated 1.35% to 2.7%. Our estimate on a percentage basis is the same for our underwritten and open enrollment products, although the absolute dollar amounts would be higher for the open enrollment products due to their higher claims costs and premiums.

It is difficult to measure the specific impact of the change to Section 38.2-3412.1 which allowed for the substitution of 1.5 days of partial hospitalization coverage for each day of inpatient coverage for mental health and substance abuse services. This is due to there being numerous other factors which have influenced the utilization of these services in the period before and after the effective date of this change. The information we have for our individual insurance products does indicate an overall decrease in the utilization of mental health services as compared to the period before this change.

	July 1992 - June 1993	July 1993 - June 1994	July 1994 - June 1995
Payments per Participant			
Inpatient	$ 32.17	$ 32.06	$ 26.48
Partial Day	$ .74	$ 1.57	$ 1.57
Days per 1000			
Inpatient	55.1	48.7	40.9
Partial Day	2.8	5.2	5.6

It is important to note that you cannot conclude from this information that the addition of outpatient mental health services might not have financial impact. The 1993 change to 38.2-3412.1 provided for a substitution of benefits already provided under the contract; whereas, requiring coverage of outpatient mental health services would provide additional benefits.

We trust the foregoing is responsive to the inquiry and with best wishes, we remain

Yours very truly,

Rod Mathews

Roderick B. Mathews

RBM/pac
rabgoh.901

BlueCross BlueShield
of the National Capital Area

A Member of the Blue Cross and Blue Shield Association
An Association of Independent Blue Cross and Blue Shield Plans

650 12th Street, S.W. Washington, D.C. 20065
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Chartered by the Congress of the United States

September 1, 1995

BY FACSIMILE

The Honorable Elliot S. Schewel
RABGOH
7275 Glen Forest Drive
Suite 301
Richmond, Virginia 23226

Dear Senator Schewel:

This is in response to your request for information on the impact on claims and premium costs of specific mental health and substance abuse benefits for group and individual health benefit plans.

BCBSNCA implemented the revised mental health and substance abuse mandate for group policies issued on or after July 1, 1994. The benefit became available to existing groups on the contract renewal date. For example, the benefit became available two months ago for contracts renewed in June 1995. A full year of experience for all group and individual contracts in Virginia is not yet available.

For a number of years, BCBSNCA has provided outpatient mental health and substance abuse benefits in its individual health benefit products. In 1994 when the mental health and substance abuse benefit for group policies was revised to comply with the mandate, BCBSNCA also revised its individual product benefit to be consistent with the group mandated benefit.

Actuarially credible data requires a minimum of 2 years of utilization (claims) experience. The mental health and substance abuse benefit revisions in group and individual health care products were implemented in 1994. Sufficient data is not yet available to determine what impact, if any, the revised mental health and substance abuse outpatient benefit will have on the claims and premium costs.

As you know, BCBSNCA helped fund the work of the Virginia Mental Health Parity Task Force and has actively participated in the discussions of the group. BCBSNCA understands the Task Force's concern related to recommending any mandated benefit which might increase premium costs in a market that is extremely price sensitive. However, BCBSNCA's actuarial staff does not believe that a credible actuarial analysis can be performed based on BCBSNCA's limited experience with the benefit. I regret that BCBSNCA is not able to provide the requested information.

Sincerely,

Gail M. Thompson

Gail M. Thompson
Administrator
Government Affairs

TRIGON
Trigon BlueCross BlueShield

Roderick B. Mathews
Senior Vice President, Corporate
Legal and Government Affairs Officer

VIA FAX

September 19, 1995

Susan M. Rash, President
Rash & Associates, Inc.
13801 Village Mill Drive, Suite 102
Midlothian, Virginia 23113

Re: Clarification of Letter Responding to Senator Schewel Regarding Mandating Outpatient Mental Health Therapy for Individual Policies

Dear Susan:

I understand the subcommittee of the Mental Health Parity Task Force addressing mandates had two questions regarding my letter of August 31, 1995. Below is clarifying information:

The impact on premium is estimated on the total premium, not just the portion which is payment of claims for mental health benefits. To translate claims costs changes into premium cost changes, one must review the claims costs and expenses which reflect the retention costs. Retention costs consist of fixed costs (such as claims processing and billing) and variable costs (such as commissions and premium tax). Fixed costs usually are stated in terms of dollars per unit and variable costs usually are stated in terms of percent of premium.

The other issue raised related to the chart identifying payments per participant and days per 1000. These are yearly figures.

The group also requested information on the demographics of the individual market. Our market research department has provided information on the individual market in Virginia including age, household income, marital status, employment status and level and geographic location.

Please let me or Wilda Ferguson know if you need additional information.

Sincerely,

Rod Mathews

Roderick B. Mathews

RBM/pac
rash.919
Attachment

RECEIVED
9/21/95

TRIGON
Trigon BlueCross BlueShield

Inter-Office Memo

To: Wilda Ferguson
From: Marty McIntosh
Date: September 11, 1995
Subject: Individual Market Data

Here's what we know about the individual market. The least-firm numbers are urban/rural.

Size: 7% - 9% of individuals are Individually insured.

Age (adults only)*	Total VA Pop 19 - 64	Individually Insured 19 - 64
19-24	14%	16%
25-34	27%	25%
35-44	28%	23%
45-54	19%	20%
55-64	12%	16%
	100%	100%

*Average persons per contract is 1.98 with only 0.57 children.

Household Income

Under $20,000	29%
20,000-40,000	39%
40,000-75,000	22%
Over 75,000	10%
	100%

Marital Status

Married	58%
Single	26%
Divorced/Widowed	16%
	100%

Employment Status

Full Time	59%
Part Time	14%
Retired Early	8%
Student	6%
Temp Unemployed	4%
Homemaker	5%
Disabled	4%
	100%

Employment Level

Self-employed	38%
Manager/Professional	29%
Blue Collar/Clerical/Admin	14%
Service	8%
Technical	7%
Sales	4%
	100%

Geography (Self-reported)

Rural	30%
Small Town (less than 20,000)	19%
Town or its Suburbs (20,000-100,000)	32%
City or its Suburbs (100,000-million)	17%
Large city or its Suburbs (over 1,000,000)	2%
	100%

(No statistical differences from total insured market place)

HEALTHPLUS
A SUBSIDIARY OF SANUS/A NEW YORK LIFE COMPANY

ADMINISTRATIVE OFFICES
7601 Ora Glen Drive
Suite 200
Greenbelt, MD 20770-3641
(301) 441-1600
1-800-635-3121

August 29, 1995

The Honorable Elliott S. Schewell
Commonwealth of Virginia
RABGOH
7275 Glen Forest Drive, Suite 301
Richmond, VA 23226

Dear Senator Schewell:

This letter is written in response to your letter dated August 7, 1995 requesting HealthPlus' comments on mental health and substance abuse services, House Bill 1223 and Senate Bill 368.

1994 House Bill 1223

The premium and cost differentials for subscription contracts and individual conversion policies would not impact HealthPlus. HealthPlus does not offer direct individual policies. The current HealthPlus benefit design offered to employer groups in the Virginia region provide the required coverage, therefore, full implementation would not result in substantial additional cost to HealthPlus.

Senate Bill 368

Senate Bill 368 would not apply to HealthPlus. HealthPlus HMO does not provide contracts on an expense incurred basis.

I hope the above is helpful in this policy issue. If I may be of further assistance please feel free to contact me.

Sincerely,

Karen S Mutchler

Karen S. Mutchler
Analyst
Legislative & Regulatory Affairs

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7275 Glen Forest Drive
Suite 300, Forest Plaza II
Richmond, VA 23226

TIME

TIME INSURANCE COMPANY
501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
Tel: (414) 271-3011

September 6, 1995

Attention: Elliot S. Schewel
RABGOH
7275 Glen Forest Drive
Suite 301
Richmond, VA 23226

Dear Mr. Schewel:

This is in response to your letter dated August 7, 1995, in which you requested the premium and claim cost differentials expected if changes in outpatient psychiatric benefits were to be implemented.

We estimate that these increased benefits would result in an additional annual claim cost of $29.21 per policy. Assuming an expected loss ratio of 75%, we would need an additional $3.25 per policy per month to cover the new outpatient psychiatric benefits.

Attached please find the data which support these calculations.

If you have any questions, please feel free to contact me.

Sincerely,

Beth M. Schmitz

Beth M. Schmitz, ASA
Actuarial Associate
414/299-8659

/bms

Attachments

COST OF PSYCHIATRIC OUTPATIENT ADULT BENEFITS UNDER CURRENT FORM 192

- use a continuance table approach

- outpatient psychiatric daily cost - $124.17 (as of 7/1/95 - per M&R)
  but Form 192 outpatient daily max is $50

- 10 visit average claim factor = 9.47 (from Time outpatient continuance table)
  $500 maximum benefit ($500 = $50 * 10)

- annual frequency = 0.366 (from 7/1/95 M&R - adult outpatient psychiatric, adjusted to reflect Time age distribution)

- must adjust to an occurence frequency - assumed 20 visits in M&R table;
  therefore, divide by 20 visit average claim factor, 17.61

Form 192	
0.0208	Annual occurence frequency
50.00	Psychiatric outpatient daily cost
9.47	Continuance average claim factor (10 visits)
9.84	Annual claim cost (1st 10 visits)

COST OF PSYCHIATRIC OUTPATIENT ADULT BENEFITS UNDER NEW PROPOSAL

- use a continuance table approach

- outpatient psychiatric daily cost - $124.17 (as of 7/1/95 - per M&R)

- first 5 visits are covered at 100%

- additional visits, up to 20, are covered at 50%

- annual frequency = 0.366 (from 7/1/95 M&R - adult outpatient psychiatric, adjusted to reflect Time age distribution)

- must adjust to an occurence frequency - assumed 20 visits in M&R table;
  therefore, divide by 20 visit average claim factor, 17.61

- 16% trend factor, midpoint 7/1/97

	New Proposal
0.0208	Annual occurence frequency
124.17	Psychiatric outpatient daily cost
11.25	Continuance average claim factor (5 visits at 100%, next 15 at 50%)
1.3456	Medical trend for 3 years
39.05	Annual claim cost(1st 20 visits)

COST OF ADDITIONAL OUTPATIENT PSYCHIATRIC BENEFITS

- assumes 75% loss ratio

Current Annual Claim Cost	New Annual Claim Cost	Additional Annual Claim Cost	Additional Monthly Prem. Needed
9.84	39.05	29.21	3.25

M&R Outpatient Psychiatric Table - July, 1995

Male Ee	Annual Frequency	Time Distribution
To 25	0.090	0.171
25-29	0.156	0.125
30-34	0.232	0.161
35-39	0.300	0.168
40-44	0.297	0.136
45-49	0.246	0.097
50-54	0.176	0.062
55-59	0.129	0.048
60+	0.079	0.033
Average Frequency:	0.206	

Female Ee	Annual Frequency	Time Distribution
To 25	0.213	0.171
25-29	0.460	0.125
30-34	0.652	0.161
35-39	0.711	0.168
40-44	0.869	0.136
45-49	0.585	0.097
50-54	0.276	0.062
55-59	0.254	0.048
60+	0.119	0.033
Average Frequency:	0.526	

Total Average Frequency:	0.366

Time Insurance Outpatient Continuance Table

Visits	Continuance Occurence (Est.)	
1	1.000	1.00
2	0.988	1.99
3	0.976	2.96
4	0.964	3.93
5	0.952	4.88
6	0.941	5.82
7	0.929	6.75
8	0.917	7.67
9	0.905	8.57
10	0.893	9.47
11	0.878	10.34
12	0.864	11.21
13	0.849	12.06
14	0.835	12.89
15	0.820	13.71
16	0.806	14.52
17	0.793	15.31
18	0.779	16.09
19	0.766	16.86
20	0.752	17.61

State	Citation	Summary
AR	§ 23-86-113 (group) (1983/1985)	Mandated coverage (unless refused by insured) meeting the following minimum requirements: • Copayment may not differ from other copayments for any other illness, except copayment cannot exceed 20%. • Insurer may not impose limits on benefits with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided such insurer or hospital and medical service corporation may impose an annual maximum benefit payable which shall not be less than $7,500 per calendar year.
CA	§§ 10125 (group) (1983/1990); 11512.5 (nonprofits) (1983/1990)	Mandated offering of coverage meeting the following minimum requirements: • Group policies must include coverage for the treatment of the specifically mentioned biologically based severe mental disorders on the same terms and conditions as treatment of other disorders of the brain. Insurer may reserve the right to confirm diagnoses and review appropriateness of treatment plans. • Coverage for treatment of other mental and nervous disorders are covered under the terms and conditions agreed upon between the group policyholder and insurer and shall be offered to the group policyholder.
CO	§ 10-16-104 (5) (group) (1992/1994)	Mandated coverage in every group contract meeting the following minimum requirements: • Inpatient benefits shall be payable for at least 45 days in any 12 month period. • Partial hospitalization benefits shall be payable for at least 90 days in any 12 month period. • Each two days of partial hospitalization shall reduce by one day the 45 days of inpatient coverage; each day of inpatient hosptalization shall reduce by two days the 90 days of partial hospitalization. • Each day of confinement as an inpatient or two days of partial hospitalization shall reduce by one day the total days available for all other illnesses during one 12 month period. • Each day of inpatient care or two days of partial hospitalization shall reduce by one day coverage available for alcohol treatment. • Outpatient benefits shall be payable for treatment at least once every 90 days in any 12 month period.

(continued...)

CO (continued)	§ 10-16-104 (5) (group) (1992/1994)	• Copayment and deductibles may not differ from that established for other conditions; copayment requirement may not exceed 50%. • Aggregate benefits may be limited to $1,000 in any 12 month benefit period.
CT	§ 38a-514 (group) (1971/1993)	Mandated coverage meeting the following minimum requirements: • Inpatient benefits shall be payable for at least 60 days in any calendar year. • Partial hospitalization benefits shall be payable for at least 120 sessions in any calendar year. If cost per session does not exceed 50% of cost of inpatient session, the session shall equal two partial sessions. If cost exceeds 50%, each session shall equal one inpatient session. • Major medical shall have a rate of 50% for covered expenses (not inpatient) and benefits shall be available up to a maximum of $2,000 per calendar year; additional benefits available upon request up to a maximum of $2,000.
DC	§§ 35-2302 and 35-2304 (1987/1992)	Mandated coverage in every group contract meeting the following minimum requirements: • Inpatient/residential care benefits shall be payable for a minimum of 45 days per year. • Outpatient benefits shall provide coverage with a minimum rate of 75% for the first 40 visits per year and a rate of 60% for any visit thereafter per year. • Lifetime payment shall have a limit of not less than $80,000 or one third of lifetime maximum for physical illness (whichever is greater).
FL	§ 627.668 (group) (1976/1992)	Mandated offering of coverage in every group or prepaid contract meeting the following minimum requirements: • Benefits shall not be less favorable than physical illness; however, if treatment goes beyond specified limit, benefits need not be the same as physical. • Inpatient benefits shall be payable for not less than 30 days/benefit year. • The total partial hospitalization benefits shall not exceed the cost of 30 days of inpatient hospitalization. • The total outpatient benefits paid may be limited to $1,000 for consultation.

GA	§ 33-24-28.1 (1981/1989)	Mandated offering of coverage meeting the following minimum requirements: • Benefits are to be to the same extent as treatment for physical illnesses. Individual policies: • Inpatient: Insurer is not required to cover more than a maximum of 30 days per policy year. • Outpatient: Insurer is not required to cover more than a maximum of 48 visits per policy year. Group: • Inpatient: Insurer is not required to cover more than a maximum of 60 days per policy year. • Outpatient: Insurer is not required to cover more than a maximum of 50 visits per policy year.
ID	§ 72-451 (1994)	Workers' compensation benefits will be paid for psychological injuries incurred as a result of a physical workplace accident.
IL	215 ILCS 5/370c (group) (1979/1990)	Mandated offering of coverage in every group or prepaid contract meeting the following minimum requirements: • Coverage shall be the same as other conditions or disorders. • Insured may be required to pay up to 50% of expenses incurred. • The annual benefit limit may be limited to $10,000 or 25% of the lifetime policy limit, whichever is lesser.
KS	§ 40-2, 105 (1977/1986)	Mandated coverage meeting the following minimum requirements: • Inpatient benefits covering not less than 30 days per year. • Outpatient benefits covering not less than 100% of the first $100, 80% of the next $100, and 50% of the next $1,640 in any year; limited to not less than $7,500 in such person's lifetime.
KY	§ 304.17-318 (1986)	Mandated offering of coverage in any policy or contract for inpatient and outpatient treatment at leaste to the same extent and degree as provided for physical illness.
LA	§ 22:669 (group) (1981/1985)	Mandated offering of coverage in group plans that include option to purchase coverage same as for physical illness (minimum).

ME	24 § 2325-A (nonprofit) (1983/1989) 24-A § 2843 (group) (1983/1992) 24-A § 2749-C (individual) (1996) 24-A § 4234-A (HMO) (1996)	Mandated coverage in every group contract meeting the following minimum requirements: • Parity with physical illness for listed organic based mental illnesses. • Mandated coverage for all group contracts except employers with 20 or fewer employees. • Mandated offer for small groups and individual policies For conditions unlisted, insurers are required to provide: • 30 inpatient days • $1,500 maximum for outpatient treatment per calendar year • $50,000 lifetime maximum
MD	Art. 48A § 477E (group) (1973/1994)	Mandated coverage in every policy meeting the following minimum requirements : • Inpatient coverage for at least 60 days in any calendar or benefit year the same as physical illness (July 1, 1994 - June 30, 1995). On or after July 1, 1995, benefits must be at least equal to the same terms for physical illness. • Partial/residential care coverage provided for at least 60 days under the same policy conditions as phyical illness. • Outpatient benefits providing not letss than 80% for the 1st - 5th visit; 65% for the 6th - 30th visit; and 50% for the 31st and any visit thereafter. • May not separate lifetime maximums, deductibles, coinsurance, copayments, or out-of-pocket limits for physical and mental illnesses.
MA	c.175 § 47B (1973/1991)	Mandated coverage in every policy meeting the following minimum requirements: • Insurer must provide coverage for at least sixty days in any calendar year. • No lifetime maximum monetary limit unless the limit is at least equal to any lifetime maximum monetary limit of treatments of conditions not including mental or nervous conditions.
MN	§ 62A.152 (group) (1975/1993)	Mandated coverage in every group policy meeting the following minimum requirements: • Coverage for at least 90% of first $600 of cost incurred over a 12 month period while insured person is not a bed patient in a hospital.

MS	§ 83-9-39 and § 83-9-41 (1991/1994)	Mandated offering of coverage limited to coverage of treatment of clinically significant mental illness: • Rejection of coverage must be in writing. • Inpatient benefits must cover a minimum of 30 days per year. • Partial hospitalization benefits shall be 60 days per year; rate of payment for inpatient services and partial hospitalization shall be the same as provided for other conditions. • Outpatient benefits cover 25 visits per year; a minimum of 50% of covered expenses which may be limited to a maximum payment of $50 per visit. • Lifetime payments for treatment may be limited, but no less than $50,000.
MO	§ 376.381 (1980/1993)	Mandated offering of coverage meeting the following minimum requirements: • Inpatient benefits for recognized mental illness shall be the same as for any other illness, benefits may be limited. • Outpatient benefits must cover at least 30 days; benefits for outpatients must cover no less than 50% of the reasonable and customary charges and up to the maximum benefit of $1,500 during each policy contract. • Benefits cover not less than 50% of reasonable and customary charges for 20 psychotherapy or professional counseling sessions during any policy contract coverage for at least one session during any 7 consecutive days.
MT	§ 33-22-701 to § 33-22-705 (group) (1979/1991)	Mandated coverage in every group policy meeting the following minimum requirements: • Coverage shall not be less favorable than for physical illness; however, benefits may be limited to not less than 30 calendar days per year. • Benefits consisting of durational limits, dollar limits/deductibles, and coinsurance factors may not be less than for physical illness. • Inpatient benefits may be limited to no less than 30 calendar days per year. If provided beyond 30 calendar days per year, the durational limits; dollar limits/deductibles, and coinsurance factors do not have to be the same as applied to physical illness. • Regarding outpatient coverage, the coinsurance may not exceed 50% or the coinsurance applicable to physical illness (whichever is greater); maximum benefit during the benefit period may be limited to not less than $1,000. • Maximum lifetime benefits shall be no less than those applicable to physical illness.

NH	§§ 415:18-a (group) (1975/1992); 419:5-a, 420:5-a (service corps.) (1975/1994)	Mandated coverage in every group contract meeting the following minimum requirements: • Coverage provided for biologically based mental illnesses. • Group policies must include coverage for mental health benefits that reimburses an equivalent amount as comparable medical-surgical benefits. • Benefits may be limited to $3,000 in any consecutive 12 month period and $10,000 per individual in a lifetime.
NY	§ 3221(1)(5)(A) (group) (1991/1992)	Mandated offering of coverage in every group or prepaid contract meeting the following minimum requirements: • Inpatient benefits may be limited to not less than 30 days in any calendar year. • Outpatient benefits may be limited to not less than $700 in any calendar year.
ND	§ 26.1-36-09 (group) (1985/1993)	Mandated coverage in every group contract meeting the following minimum requirements: • Inpatient benefits cover a minimum of 60 days in any calendar year. • Partial hospitalization benefits cover a minimum of 120 days in any calendar year; each day of inpatient care is equal to two days of partial hospitalization (provided that no more than 46 days of inpatient treatment benefits required may be traded for treatment by partial hospitalization). • Outpatient benefits cover a minimum of 30 hours in any calendar year.
OR	§ 743.556 (group) (1987/1991)	Group policy shall provide coverage the same as for other illnesses. • Regarding inpatient coverage, deductibles and coinsurance for treatment shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness; benefits shall cover no less than $4,000 for adults and $6,000 for children/adolescents. • Partial hospitalization benefits shall cover no less than $1,000 for adults and $2,500 for children/adolescents; for a combination of inpatient and partial treatment, benefits shall cover no less than $8,500 for adults and $10,500 for children/adolescents. • Regarding outpatient coverage, deductibles and coinsurance for treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness; benefits shall cover no less than $2,500.

SC	§ 38-71-737 (1994)	All group policies must offer an optional rider or endorsement to provide benefits for psychiatric conditions as defined. • The offer of coverage may contain provisions prescribing different benefits for psychiatric conditions and physical conditions with respect to coinsurance, deductibles, or contract term affect benefit determinations based upon use or nonuse of preferred providers. • The rider must provide minimum benefits not less than $2,000 for each benefit year with a lifetime maximum benefit of $10,000 • Insurer may provide benefits greater than required by this section
TN	§ 56-7-2601 (group) (1974/1992)	Mandated coverage in all group policies (unless refused by insured) meeting the following minimum requirements: • Benefits shall be provided at the usual and customary rates established by the community mental health center for the services rendered. • Benefits provided shall be subject to deductibles and coinsurance factors that are not less than for physical illness. • Insurers are not required to cover more than 30 outpatient visits per year.
TX	art. 3.51-14 (group) (1991)	Mandated coverage meeting the following minimum requirements: • Insurers must offer benefits at least as favorable as coverage for other services and benefits; policies issued to most state and local public employees must include coverage, durational limits, amount limits, deductibles, and coinsurance factors for treatment of serious mental illness that is at least as favorable as that for other major illnesses. • Coverage may be limited to not more than three separate series of treatments for each covered individual. • Texas Department of Insurance and the Texas Commission on Alcohol and Drug Abuse is to formulate standards for use by insurers for the reasonable control of costs, and benefits that are subject to those standards.
VT	Tit. 8 § 4089 (group) (1975/1989)	Mandated offering of coverage meeting the following minimum requirements: • Inpatient benefits shall provide coverage for 45 days per policy/calendar year. • Partial hospitalization benefits shall provide coverage for 45 days per policy/calendar year. • Outpatient benefits shall be provided at a rate of 100% with respect to the first 5 visits and at a rate of 80% thereafter; benefits may be limited to $500 per policy/calendar year.

VA	§ 38.2-3412.1 (1993)	• Mandated coverage meeting the following minimum requirements: Individual and Group Coverage: • inpatient treatment for an adult for a minimum of twenty days per policy or contract year at a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility; • inpatient treatment for a child or adolescent for a minimum of twenty-five days per policy or contract year at a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility; and • up to ten days of inpatient benefits may be converted, when medically necessary, to partial hospitalization coverage at a rate of 1.5 days per 1 day of inpatient coverage for adults, children, or adolescents. Group Coverage only: • each group accident and sickness insurance policy or group subscription contract must provide coverage for outpatient mental health and substance abuse services for a minimum of twenty outpatient visits for an adult, child or adolescent per policy or contract year; • benefit limits are to be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor apllicable to any outpatient visit beyond the first five visits shall be at least 50%; • medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of benefit; and • if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the ouptatient visit benefit maximum.
WA	§ 48.21.240 (group) (1983/1987)	Mandated offering of coverage in group policies, also offering disability insurance coverage. Treatment shall be covered at the usual and customary rates.
WV	§ 33-16-3a (group) (1977/1993)	Mandated offering of coverage meeting the following minimum requirements: • Inpatient benefits payable for at least 45 days in any calendar year. • Inpatient benefits shall be no less comparable than that offered for physical illness. • Outpatient benefits covering 50% of eligible expenses of up to $500 over a 12 month period.

WI	§ 632.89 (group) (1975/1993)	Mandated coverage in every group contract meeting the following minimum requirements: • Total inpatient and outpatient coverage under the policy need not exceed $7,000. • Inpatient benefits providing coverage for not less than the lesser of the expenses of the first 30 days; the first $7,000 minus a copayment of up to 10% for hospital care or first $6,300 for HMO care. • Outpatient benefits providing coverage for not less than the first $3,000 minus a copayment of up to 10% for hospital care or $2,700 for HMO care.