STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES
AND HEALTH CARE ADMINISTRATION

Regulation H-2000-03

HEALTH INSURANCE COVERAGE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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Section 1. **General Provisions.**

Purpose. The five largest health insurance companies doing business in Vermont, as measured by covered lives, are required to file with the Commissioner (1) an annual report card on the health insurance plan's performance in relation to quality measures for the care, treatment, and treatment options of mental health and substance abuse conditions covered under the plan, and (2) the health insurance plan's revenue loss and expense ratio relating to the care and treatment of mental health conditions covered under the health insurance plan. This regulation sets out the minimum reporting requirements.

Section 2. **Authority.**

This regulation is issued pursuant to the authority of the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration to promulgate regulations. 8 V.S.A. § 4089b(f) and (g) and 8 V.S.A. § 75.

Section 3 **Scope.**

This rule applies to the five largest health insurance companies licensed in Vermont, as measured by covered Vermont lives, which shall be measured annually by the Vermont Department of Banking, Insurance, Securities and Health Care Administration as of December 31 of the year immediately preceding the report.

Section 4. **Definitions.**

(A) "Commissioner" means the commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration.
(B) "Discharge rate" means the number of insureds who were discharged from an inpatient facility divided by the number of covered lives in the calendar year ending December 31 immediately preceding the report.
(C) "Division" means the Division of Health Care Administration of the Department of Banking, Insurance, Securities and Health Care Administration.
(D) "Insured" means the certificate holder and any dependents.
(E) "Insurer" means each of the five largest health insurance companies doing business in Vermont as measured by covered Vermont lives, as determined annually by the Division.

Section 5. **Responsibilities of Insurers.**

A. Report Cards. On or before March 1 of each year or at such other time as specified in 8 V.S.A. § 4089b, insurers must file with the Division a report card on the health plan's performance in relation to quality measures for the care, treatment, and treatment options of mental health and substance abuse conditions covered under the plan. The measures presented in the report card will be based on data from the previous calendar year, unless otherwise indicated by the Division.

The measures that must be filed include:

(1) the discharge rates from inpatient mental health and substance abuse care and treatment of insureds;
(2) the average length of stay for insureds receiving inpatient mental health and substance abuse care and treatment;
(3) the average number of treatment sessions for insureds receiving outpatient mental health and substance abuse care and treatment;
(4) the percentage of insureds receiving inpatient mental health and substance abuse care and treatment;
(5) the percentage of insureds receiving outpatient mental health and substance abuse care and treatment;
(6) the number of insureds denied authorization (prior and concurrent) for mental health and substance abuse services, per 1000 members using average membership;
(7) number of insureds denied authorization (prior and concurrent) for mental health and substance abuse services with X denials in a calendar year per 1000 members using average membership (where X is defined in the Act 129 Reporting Manual);

(8) the number of denials appealed internally by insureds reported separately from the number of denials appealed internally by providers;
(9) the rates of readmission to inpatient mental health and substance abuse care facilities;
(10) the level of patient satisfaction with the quality of the mental health and substance abuse care and treatment provided to insureds under the health insurance plan. The Commissioner shall approve the form content of the survey or mechanism used to determine patient satisfaction; and
(11) any other quality measure established by the commissioner.

B. Loss Ratios. On or before March 1 of each year or at such other time as specified in 8 V.S.A. § 4089b, insurers must file with the Division the health insurance plan's revenue loss and expense ratio relating to the care and treatment of mental health conditions covered under the health insurance plan. The expense ratio report shall list amounts paid in claims for services and administrative costs separately.

Section 6. **Responsibilities of the Department.**

Reporting Specifications. The Division will produce an annual reporting manual with specifications for submitting each of the required report card and loss ratio elements. Where applicable, these specifications will be based on nationally accepted reporting standards such as the Health Plan Employers Data and Information Set (HEDIS).

Coordination with Rule 10. The Division will ensure that compliance with this regulation does not duplicate a reporting requirement for those insurers that are also subject to reporting requirements under the Division's Rule 10.000, Quality Assurance Standards and Consumer Protections for Managed Care. In cases where a reporting measure is required under this regulation and under Rule 10, the reporting manual specification will be the same as in the most recent edition of the Rule 10 Implementation Manual.

Section 7. **Severability.**

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provisions to other persons or circumstances shall not be affected thereby.

Section 8. **Effective Date.**

This regulation shall be effective on April 2, 2001. However, the requirements of section 5(B) above shall sunset July 1, 2003.