SB
457

# American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900
Melvin Sabshin, M.D., Medical Director

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Alaska Psychiatric Association
4001 Dale Street, Suite 101
Anchorage, Alaska 99508

February 28, 1984

Senator Josephson
Pouch V
Juneau, Alaska 99801

Dear Senator Josephson:

The Legislative Committee of the Alaska Psychiatric Association has reviewed Senate Bill 457. We are in support of the concept of this bill but we recommend some tightening of its provisions to be sure that the coverage relates directly to health services.

We recommend the following changes:

> Page 1, Line 28: Add "in an accredited hospital or licensed program."
>
> Page 2, Line 12: The entire definition should be "person suffering from a mental or nervous condition" means a person whose psychobiological processes are impaired severely enough to be diagnosed under the DSM-III, the Diagnostic and Statistical Manual of the American Psychiatric Assocation.
>
> Page 2, Line 21: Should read in its entirety "Provider means a licensed physician or psycholoigst; a mental health professional under the supervision of alicensed provider (1.); a mental health clinic funded under AS47.30: (the Community Mental Health Act) with consultation by a licensed provider (1.); or an accredited public hospital or licensed general hospital or psychiatric hospital."

We believe these changes should be repeated in he second portion of the Act pertaining to Section 21-54.025, Page 3, Line 25 - Page 4, Line 9 - Page 4, Line 18 to maintain consistency throughout the bill.

Sincerely,

Jerry L. Schrader, M.D.
Legislative Representative
Alaska Psychiatric Association

JLS/saw Enc.

# Benefit law in Hawaii overruled

SAN FRANCISCO—Hawaii doesn't have the right to impose benefit requirements on employers, the U.S. Court of Appeals here has ruled.

In a major victory for the business community, the appeals court said the Employee Retirement Income Security Act pre-empts Hawaii's comprehensive health care law.

"ERISA shall supersede any and all state laws relating to employee benefit plans," the court ruled in Standard Oil Co. of California vs. Agsalud.

In 1974, shortly before ERISA was passed, Hawaii enacted a comprehensive health care law. That law requires:

- Employers to pay at least half of the group health insurance premium.
- Group plans to provide at least 120 days of hospital coverage.
- Employers to offer inpatient benefits for detoxification.

Standard Oil's plan, however, did not provide all the alcoholism benefits the state's regulations mandated. When Hawaii sought to enforce its law against the oil giant, Standard Oil took the case to federal court.

Hawaii argued that the states, not Congress, have the right to regulate private health care plans. It has been trying to get Congress to accept this position.

The appeals court noted Congress could have chosen to exempt all governmentally required insurance programs from ERISA coverage, but it didn't.

The ERISA Industry Committee, which represents the nation's 100 largest corporations on benefit issues, said the Standard Oil decision is a major victory for employers.

"This is a very significant case which should help to forestall future litigation in the pre-emption area," said George Pantos, ERIC counsel.

Employers with multistate operations say a hodgepodge of state requirements for benefits is costly to administer because businesses continually have to revamp their benefit plans to meet changing regulations.

But Rep. Cecil Heftel (D-Hawaii) says guaranteeing a certain level of employee benefits through state law overshadows the administrative burden state regulations may impose on corporations that have operations in many states. ■

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

Senate Bill 457

"An Act relating to mental health insurance."

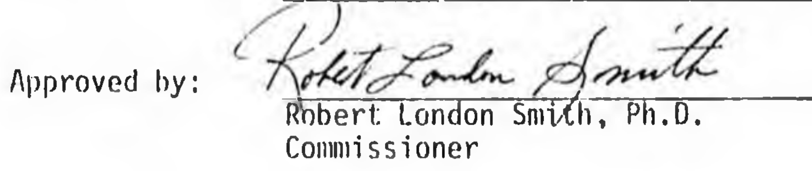
This bill would require insurance carriers to provide mental health coverage for all individual and group health insurance policies written in Alaska.

The Division of Mental Health and Developmental Disabilities supports the passage of Senate Bill 457 as it will provide additional sources of revenue for public and private mental health providers in Alaska. This is especially important for Alaska's community mental health centers who must contribute local match to be eligible to receive state grant funding. In order to generate this match, these centers must produce revenue. By requiring coverage, it will increase the resources upon which the centers may bill for their services.

From a technical standpoint, beginning on line 2, page 3, it should be pointed out that the Division of Mental Health and Developmental Disabilities does not have the authority to license community agencies.

Recommended by: ______________________
Philip Shapiro, Director
Division of Mental Health and
Developmental Disabilities

Date: 3/1/84



Approved by: ______________________
Robert London Smith, Ph.D.
Commissioner

Date: 3/1/84

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

**REQUEST**
Bill/Resolution No.: SB 457
Title: An Act Relating to Mental Health Insurance
Sponsor: Faiks
Requestor:
Date of Request:

**FISCAL DETAIL**
Agency Affected: Department of Health and Social Services
Program Category Affected: Division of Mental Health and Developmental Disabilities
BRU, Program or Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 84 | FY 85 | FY 86 | FY 87 | FY [illegible] | FY 89 |
|---|---|---|---|---|---|---|
| 100 PERSONAL SERVICES | | | | | | |
| 200 TRAVEL | | | | | | |
| 300 CONTRACTUAL | | | | | | |
| 400 SUPPLIES | | | | | | |
| 500 EQUIPMENT | | | | | | |
| 600 LAND & STRUCTURES | | | | | | |
| 700 GRANTS, CLAIMS | | | | | | |
| 800 MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | | | | | | |
| REVENUE | | | | | | |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | | 0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | | | | | | |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: James L. Scoles Phone: 465-3370
Division: Mental Health and Developmental Disabilities Date: 2/27/84
Approved by Commissioner: Robert Landon Smith, M.D. Date: 3/1/84
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

12/1/83

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:



REQUEST
Bill/Resolution No.: SB 457
Title: "An Act relating to Mental Health Insurance"
Sponsor: Faiks
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: All State Agencies
Program Category Affected: Health Insurance
BRU, Program or Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

| Operating | FY 84 | 85 | FY 86 | FY 87 | FY 88 | FY 89 |
|---|---|---|---|---|---|---|
| 100 Personal Svcs | | | | | | |
| 100 Rtmnt & Bnfts | -0- | 531.4 | 584.6 | 643.0 | 707.3 | 778.0 |
| 200 Travel | | | | | | |
| 300 Contractual | | | | | | |
| 400 Supplies | | | | | | |
| 500 Equipment | | | | | | |
| 600 Land & Struct | | | | | | |
| 700 Grants, Claims | | | | | | |
| 700 TRS Match | | | | | | |
| TOTAL OPERATING | -0- | 531.4 | 584.6 | 643.0 | 707.3 | 778.0 |
| CAPITAL | | | | | | |
| REVENUE | | | | | | |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| General Fund | | 480.4 | 528.4 | 581.3 | 639.4 | 703.3 |
| Federal Funds | | 24.4 | 26.9 | 29.5 | 32.5 | 35.7 |
| Other | | 26.6 | 29.3 | 32.2 | 35.4 | 39.0 |
| Total | -0- | 531.4 | 584.6 | 643.0 | 707.3 | 778.0 |

POSITIONS: None

| | | | | | | |
|---|---|---|---|---|---|---|
| Full-Time | | | | | | |
| Part-Time | | | | | | |
| Temporary | | | | | | |

SOURCE OF FUNDS TO OFFSET IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: J.K. Humphreys J.K. Humphreys Phone: 465-4460
Division: Retirement & Benefits Date: 2-23-84

Approved by Commissioner: Lisa Rudd [signature] for Date: 3-1-84
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Senate Bill 457
Fiscal Note Analysis
Prepared by the Division of Retirement & Benefits
Department of Administration

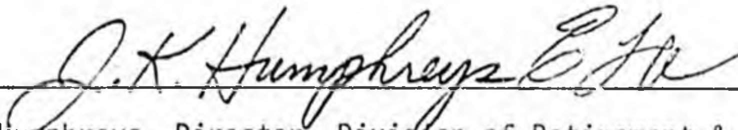
February 23, 1984

IV Analysis: This bill would require increased limits of coverage for mental, emotional, or nervous disorders under the State's group health plans for active employees of the State and for all retirees. The estimated cost to the State shown on the attached fiscal note is in addition to the estimated cost of $63,000 to other employers participating in the State's group health plans.

Position Paper

SB 457

The Department of Administration opposes this bill. No apparent public purpose is served by requiring employers to include this coverage in their group policies. Such a requirement undercuts efforts to contain costs of health care and restricts freedom to bargain and design coherent benefit plans.



2/27/84

J.K. Humphreys, Director, Division of Retirement & Benefits — Date

3-1-84

Lisa Rudd, Commissioner, Department of Administration — Date

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 457
Title: Mental Health Insurance
Sponsor: Senator Faiks
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: Commerce & Economic Development
Program Category Affected: Public Protection
BRU, Program or Subprogram(s) Affected: Division of Insurance

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 84 | FY 85 | FY 86 | FY 87 | FY 88 | FY 89 |
|---|---|---|---|---|---|---|
| 100 PERSONAL SERVICES | | | | | | |
| 200 TRAVEL | | | | | | |
| 300 CONTRACTUAL | | | | | | |
| 400 SUPPLIES | | | | | | |
| 500 EQUIPMENT | | | | | | |
| 600 LAND & STRUCTURES | | | | | | |
| 700 GRANTS, CLAIMS | | | | | | |
| 800 MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | -0- | -0- | -0- | -0- | -0- | -0- |
| CAPITAL | | | | | | |
| REVENUE | | | | | | |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | | | | | | |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | | | | | | |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Kenneth C. Moore, Director — Phone: 465-2515
Division: Division of Insurance — Date:

Approved by Commissioner: Richard A Lyon — Date:
Agency: Commerce and Economic Development

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 457
Title: Mental Health Insurance

Sponsor: Senator Faiks
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: Commerce & Economic Development
Program Category Affected:
Public Protection
BRU, Program or Subprogram(s) Affected:
Division of Insurance

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 84 | FY 85 | FY 86 | FY 87 | FY 88 | FY 89 |
|---|---|---|---|---|---|---|
| 100 PERSONAL SERVICES | | | | | | |
| 200 TRAVEL | | | | | | |
| 300 CONTRACTUAL | | | | | | |
| 400 SUPPLIES | | | | | | |
| 500 EQUIPMENT | | | | | | |
| 600 LAND & STRUCTURES | | | | | | |
| 700 GRANTS, CLAIMS | | | | | | |
| 800 MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | -0- | -0- | -0- | -0- | -0- | -0- |
| CAPITAL | | | | | | |
| REVENUE | | | | | | |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | | | | | | |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | | | | | | |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Kenneth C. Moore, Director Phone: 465-2515
Division: Division of Insurance Date:

Approved by Commissioner: Richard A. Lyon Date:
Agency: Commerce and Economic Development

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

Division of Insurance

Testimony on SB 457

SB 457 will mandate specific levels of mental health insurance that must be included in every health insurance policy issued or delivered in Alaska. The proposed benefit is fairly substantial. The mandate does not extend to self insurers or to contracts issued by hospital service corporations such as Blue Cross. Presently there are no coverage mandates for health insurance in the insurance code.

The Division of Insurance is not in favor of this legislation and has expressed the same sentiment on other bills mandating specific insurance coverage. The reasons for this view are:

1. This bill conflicts with Federal Law, specifically ERISA and NLRA. These Acts contain preemptions relating to plans which are established pursuant to a collective bargaining agreement. In a recent case, the U. S. District Court for the Eastern District of Michigan decided that a mandate in Michigan state law was preempted, virtually equally, by the two laws. The case is Michigan United Food & Commercial Workers Unions and Food Employers Health & Welfare Fund v. Baerwaldt (Civil Action No. 82-73821);

2. This bill would require coverage on unrelated policies such as individual disability policies, accidental death & dismemberment insurance policies and dread disease insurance policies. These kinds of policies are usually sought by individual purchasers seeking specific areas or kinds of coverage. These coverages are voluntary choices which should be preserved. The mandate of a base line of coverage which will often bear no relation to the voluntarily purchased coverage will likely destroy that market;

3. If a mental health benefit is an economically insurable hazard, and there is sufficient demand for it, a sufficient number of companies will make it available. In short, if it is economic and the demand is there, competition will assure that the coverage is there;

4. Insurance companies have varying economic abilities and underwriting skills or expertise. Some benefits and coverages are beyond the ability of an insurer to handle on an economic basis. Some require expertise not present in all insurers. This is particularly true of the small to medium size insurer. These companies would either be forced out of the market or have to go to the expense of developing expertise not now existent. This is all unnecessary since that to the degree that public demand exists, the public will gravitate to those markets offering the coverage desired, but leave a role for the smaller insurer;

5. Each element of coverage in both individual and group policies has a cost impact. The purchaser has limitations on the dollars he has available for health insurance coverage. This is particularly true of the individual who is unemployed or economically disadvantaged. A mandate of a particular coverage has the effect of reducing other coverages on a policy where the mandated coverage is not already provided or is provided in a more limited form. If the mandated coverage is not economic, it could end up being the only coverage in a policy, in which case it would probably not be purchased;

6. Mandated coverage generally has a favorable impact on particular interests but at the expense of other health care provision and providers. The absence of

a coverage mandate tends to allow the public to establish and maintain the kind of balance it desires in that field; and,

7. The definition of provider in the bill includes persons not licensed by the state. This creates a situation that impacts the insurers ability to control costs.

The Division of Insurance has in the past supported legislation addressing health insurance from the anti-discrimination viewpoint. We review mandate legislation to see if there is a form of discrimination to be addressed. In the bill at hand we have not identified a discrimination issue. Our position is that it is appropriate for the insured and the insurer to establish the kind and level of insurance coverage. Once that choice has been made, it is appropriate for the legislature and the state to prohibit discrimination within that framework. This approach was used as recently as last year with passage of SCSHB 403 (HESS). That bill added AS 21.36.090(d) which basically provides that once the benefit is established, any provider who can perform the particular service within the scope of his or her license, can do so under the policy.

There are three other sections of the Alaska Insurance Code that have been added in the same vein. AS 21.42.345, adopted in 1975, provides that if coverage is provided for family members, the new born child is covered to the same extent from the moment of birth. AS 21.42.355, adopted in 1981, provides that if coverage is provided for pregnancy, childbirth and the period after childbirth, then the advanced nurse practitioner nurse midwife is able to bill and receive payment for services covered under the policy. AS 21.89.040, adopted in 1976, provides that a policy providing coverages for services within the scope of practice of an optometrist shall provide them if the service is performed by an optometrist.

We urge that this bill be held without action.

STATE HEALTH REPORTS
MENTAL HEALTH, ALCOHOLISM, & DRUG ABUSE
Intergovernmental Health Policy Project
*In This Issue: Mandated Insurance Benefits • Drunk Driving • Reports and Publications • Highlights • No. 7, March 1984*

# Mandated Insurance Benefits

During the current legislative sessions, at least 14 states have introduced legislation affecting private health insurance coverage of mental illness, alcoholism, and drug abuse.

Three states (**ALASKA, INDIANA,** and **MISSOURI**) are currently considering legislation that would mandate, for the first time, coverage for mental illness treatment. All three bills outline packages of minimum mental health benefits under certain health insurance contracts. **ALASKA's** S 457 requires disability insurance policies to provide the following minimum benefits: 1) 60 days of inpatient care per policy year; 2) 120 days per policy year of day treatment services (60 days of which may be traded on a 2-for-1 basis for 30 days of inpatient benefits); and 3) 40 visits per policy year of outpatient services. **INDIANA's** H 1307/S 172 require all accident and sickness insurance policies providing hospitalization or medical benefits to provide coverage for mental or nervous conditions that is equivalent to coverage provided in the policy for any other illness. The legislation establishes the following minimum benefits: 1) 60 days of inpatient care per policy year; 2) 24 visits of outpatient care per policy year (subject to certain conditions; 3) 120 days of partial hospital services per policy year; and 4) 120 days of benefits for residential treatment per policy year. A similar measure in **MISSOURI** (H 1479) would mandate coverage for mental illness in all individual and group insurance plans, and all prepaid health maintenance plans. The proposal would mandate that coverage must be equivalent to coverage for any other illness, and sets minimum requirements similar to those in **ALASKA** and **INDIANA**—60 days of inpatient care, 120 days of day program services, and 40 visits of outpatient services per policy year.

**WEST VIRGINIA's** H 1829 modifies existing mental health legislation by mandating equitable mental health benefits standards for individual and group health expense policies. The bill further provides that employers shall ensure that group health expense insurance policies comply with these mental health benefits standards.

Legislators in **GEORGIA** are considering a measure (SB 259) which would limit coverage under individual policies to a maximum of 30 days per policy year for inpatient care, and 8 visits per policy year for outpatient care. Coverage under group policies would be limited to a maximum of 60 days per policy year for inpatient care, and 50 visits per policy year for outpatient treatment.

Other proposals that are being discussed include **CALIFORNIA's** A 3748, which would require group policies that cover hospital, medical, or surgical expenses to offer coverage of community residential treatment services for persons with psychiatric disabilities. **OKLAHOMA** is considering legislation (SB 484) that would mandate, for the first time, health insurance benefits for the treatment of mental illness. **NEW YORK's** A 6648 would require group policies that cover inpatient hospital care to also provide coverage for the diagnosis, evaluation, and crisis intervention of mental and emo-

tional disorders on an outpatient basis. **CALIFORNIA's** S 2160 would extend insurance coverage for the costs of mental illness to include treatment provided in a psychiatric health facility.

Three states (**IOWA, OKLAHOMA** and **PENNSYLVANIA**) are considering legislation that would mandate, for the first time, private health insurance coverage for the treatment of alcoholism and drug dependency. **IOWA's** SF 2013 requires that individual and group policies of accident and health insurance provide coverage on substantially the same basis as other health care coverages. However, the policies may include specified limitations on total and annual outpatient, residential, and inpatient coverages.

**OKLAHOMA's** SB 484 also requires that coverage for alcoholism and drug dependency be on the same basis as other coverage when rendered in the following facilities: hospital, detoxification, residential, and outpatient programs that are licensed, certified and approved by the state.

**PENNSYLVANIA's** H 1901 requires all health or sickness or accident insurance policies, and all subscriber contracts or certificates providing hospital or medical/surgical coverage on a cost-incurred basis, to include those benefits for alcohol abuse and dependency on a cost-incurred basis. Coverage includes inpatient detoxification, nonhospital residential services for a minimum of 30 days a year, and outpatient alcohol services for at least 30 full session visits or equivalent partial visits a year.

**NEBRASKA's** LB 842 would require that alcoholism coverage consist of primary and outpatient treatment and outpatient programs for at least 90 days per benefit period, with at least two of these periods available during the lifetime of the policy.

**MARYLAND** is considering a proposal that would expand insurance coverage for the costs of alcoholism to include partial hospitalization facilities approved by the Joint Commission on Accreditation of Hospitals. Another measure (H 1218) being discussed in the **MARYLAND** legislature would extend minimum benefits levels for the treatment of alcoholism to 60 outpatient visits and to $2,000 during any calendar year. Current law sets minimum benefits at 30 outpatient visits and $1,000 during any calendar year.

**MISSISSIPPI** is considering a proposal (S 2647) that would modify existing drug services requirements. S 2647 would eliminate the maximum coverage limit imposed by previous law, and require benefits for the care and treatment of drug abuse to be provided on the same basis as other benefits.

A bill in **MASSACHUSETTS** (H 4761) would extend outpatient alcoholism benefits to $3,000 over a 12-month period.

Legislation which mandates direct insurance reimbursement to mental health professionals, the so-called "freedom-of-choice" concept, is being discussed in several states. A measure (H 1786) in **MASSACHUSETTS** would provide direct reimbursement for services performed by certified clinical specialists in psychiatric and mental health nursing. **ALABAMA's** H 153 would require all insurance policies that include mental health services to provide reimbursement for services rendered by a duly qualified counselor of the state.

## Drunk Driving

Thirty-five states have drunk driving legislation pending but it is expected that fewer laws will be enacted this year than in the recent past. Most of the current proposals are aimed at fine-tuning specific aspects of the existing laws. This is an apparent reflection of the legislators' views that major 1981-83 revisions should be allowed an opportunity to demonstrate their effectiveness.

One issue that has seen increased activity is drinking age and other youthful offender legislation. **NEBRASKA** and **SOUTH DAKOTA** are the first states to raise their drinking age in 1984. **NEBRASKA's** LB 56, sponsored by the speaker, passed with relative ease. It raises the drinking age from 20 to 21 effective January 1, 1985. The **SOUTH DAKOTA** law raises the age for purchase of low-powered beer from 18 to 19; purchase of all other alcohol in the state is pegged at 21 years. A tougher bill, raising the age from 18 to 21, failed in the Senate Judiciary Committee. Fifteen other states (**ALABAMA, COLORADO, CONNECTICUT, FLORIDA, GEORGIA, HAWAII, IOWA, KANSAS, MAINE, MISSISSIPPI, RHODE ISLAND, TENNESSEE, VERMONT, VIRGINIA,** and **WEST VIRGINIA**) also have drinking age bills pending, but many are expected to face tough fights. The governors of **IOWA** and **VERMONT** are

on record as opposed to such measures. **VERMONT's** Governor Snelling, serving his last term, has vetoed such bills in the past. In contrast, prospects are much brighter in **MAINE, WEST VIRGINIA** and **RHODE ISLAND,** where all three governors have publicly indicated their support. **NEW YORK's** Governor Cuomo has also indicated strong support for raising the drinking age to 21, and legislation is expected to follow.

Thirteen states have proposed other types of youth offender legislation. These bills mandate either lower blood alcohol content levels as proof of intoxication in minors, stiffer license suspension penalties for violations of existing alcohol-related offenses, or some combination of the two. Related legislation, which would allow alcohol vendors to require signed affidavits if the age of the purchaser is in doubt, has been introduced in **NEW YORK.** In **RHODE ISLAND,** stiffer penalties for underage possession are being considered.

Other issues that are moving include open container restrictions and prohibitions against drinking while driving. Bills on these topics have passed one or more houses in four states (**COLORADO, NEW MEXICO, SOUTH CAROLINA,** and **WASHINGTON**). Several states have proposed additional assessments against the DWI violators to fund counter-measures programs; **CALIFORNIA, OKLAHOMA,** and **NEW JERSEY** report progress in this area.

Six states report passage, in at least one house, of bills strengthening existing penalties. In **VIRGINIA** a senate-passed .10 per se bill and a house-passed, governor-supported .15 per se bill are due to be decided soon. A major overhaul of **KENTUCKY's** drunk driving laws has passed one house. The **KENTUCKY** legislature meets biannually, which partially accounts for the delayed revision of the current law. The **NEW MEXICO** legislature has sent a bill to Governor Anaya that would, among other provisions, make **NEW MEXICO** the 42nd state to adopt an illegal per se statute.

Progress certainly has been made since 1980. As of March, 13 states had been notified of their eligibility to receive Section 408 incentive funds from last year's Howard-Barnes drunk driving law. **ARIZONA** and **NEW JERSEY** received their notifications in March. According to the newly-formed National Commission Against Drunk Driving, 23 states now authorize use of preliminary roadside testing, whereas only 13 did in 1981. Nineteen states now have administrative per se license suspension laws. A year ago only six states did. Seventeen states, including **SOUTH DAKOTA** and **NEBRASKA** have raised their drinking age since 1980. In six of those states, the age was raised to 21.

[This article appeared in the National Safety Council's March 5, 1984, *POLICY UPDATE*, "Drunk Driving Legislation," and is reprinted here with their permission. Copies of the full report, with a state-by-state analysis, are available from the National Safety Council, Office of Federal Affairs, 1705 DeSales Street, N.W., Washington, DC 20036, (202) 293-2270.]

# Reports and Publications

## Patients' Rights

According to the results of a recent study funded by the Ohio Department of Mental Health, Office of Program Evaluation, 44 states and the District of Columbia recognize a "qualified right to refuse medication." Of those states, 25 extend this right to all adult psychiatric patients being treated in state mental institutions. A patient has the "qualified right" only if it is established that he or she does not present a special condition such as incompetency or dangerousness. However, the hospital staff may override the refusal and force the patient to take medication if the patient manifests a special condition. The report indicates that an "emergency" serves as justifiable grounds for overriding medication refusals. In fact, 45 states have established procedures to override a patient's refusal of medication in emergency situations. However, only 30 states have procedures to override refusals in nonemergency situations.

According to the survey results, six states (**ALABAMA, ALASKA, OHIO, PENNSYLVANIA, SOUTH CAROLINA,** and **WYOMING**) do not recognize the patient's right to refuse medication. The 25 states where all patients may refuse medication are **FLORIDA, HAWAII, ILLINOIS, IOWA, KENTUCKY, MAINE, MARYLAND, MASSACHUSETTS, MINNESOTA, MONTANA, NEBRASKA, NEW HAMPSHIRE, NEW JERSEY, NEW MEX-**

**ICO, NEW YORK, NORTH CAROLINA, OKLAHOMA, OREGON, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, VERMONT, VIRGINIA,** and **WISCONSIN.**

Nine states (**ARKANSAS, CALIFORNIA, CONNECTICUT, KANSAS, LOUISIANA, MICHIGAN, MISSOURI, UTAH,** and **WEST VIRGINIA**) recognize refusal rights for voluntary/competent patients, while voluntary/involuntary competent patients may refuse medication in ten states and the **DISTRICT OF COLUMBIA (ARIZONA, COLORADO, DELAWARE, GEORGIA, IDAHO, MISSISSIPPI, NEVADA, NORTH DAKOTA, SOUTH DAKOTA,** and **WASHINGTON**). The only state to recognize the rights of voluntary/competent/incompetent patients to refuse medication is **INDIANA.**

Data for this survey were collected from all 50 states and the District of Columbia. Results of the survey appear in "Psychiatric Patients' Right to Refuse Psychotropic Medication: A National Survey," published in the *Mental Disability Law Reporter,* Volume 7, Number 6, November-December 1983.

## Highlights

• **CALIFORNIA's** legislature is considering several bills that could significantly affect the state's mental health system. AB 2381 replaces the current system of financing and standard-setting for local mental health services with a system of local program grants. The bill would require each county to establish a community mental health service and to meet minimum standards for a state grant made available in the Budget Act. AB 3921 proposes to mandate the transfer of state-funded mental health social services programs to local mental health programs and would also appropriate state funds to local programs for these purposes. SB 1012 specifies an allocation method, based on the mental health need and population size, for funds distributed by the State Department of Mental Health to the local programs. SB 1984 and SB 1985 suggest changes to the disposition of persons found not guilty by reason of insanity.

• **OKLAHOMA** is considering a bill (HB 1760) that would require the Commissioner of Mental Health to establish a program of comprehensive inpatient and outpatient mental health care and treatment for deaf and hearing impared individuals and their families.

• A measure (S 585) being considered in **MASSACHUSETTS** would require all state mental hospitals to establish and maintain outpatient day hospitals for discharged patients for at least six months.

• According to officials at the Social Security Administration (SSA), 12 states have placed moratoriums on disability benefits terminations and nine states are processing benefits determinations using a court-ordered medical improvement standard. **MASSACHUSETTS, ALABAMA, ILLINOIS, OHIO, MICHIGAN, ARKANSAS,** and **IDAHO** are under their governor's executive order to discontinue all benefits terminations; **NEW YORK** and **MASSACHUSETTS** are under orders from their respective state agencies responsible for disability determinations; and **MARYLAND, COLORADO** and **WEST VIRGINIA** have discontinued processing terminations until pending litigation has been resolved. States comprising the 9th Circuit (**WASHINGTON, ALASKA, IDAHO, OREGON, MONTANA, CALIFORNIA, ARIZONA, NEVADA,** and **HAWAII**) are using a court-ordered medical improvement standard to determine whether or not disability benefits should be terminated.


STATE HEALTH REPORTS ON MENTAL HEALTH ALCOHOLISM AND DRUG ABUSE

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SECTIONAL ANALYSIS OF SB 457 - AN ACT RELATING TO MENTAL HEALTH INSURANCE by Senator Faiks.

SECTION 1

Amends AS 21.51 (Disability Insurance Policies). (a) requiring coverage for mental, emotional or nervous disorders the minimum of:

60 days of active inpatient care per year.

120 days of day treatment per year; 60 days of which may be traded for 30 days of inpatient care.

outpatient services of 40 visits per year.

(b) provides for reasonable charges to be reimbursed at a minimum of 80% of usual, customary and reasonable charges.

(c) provides definitions for the sections (a) and (b)

SECTION 2

Amends AS 21.54 (Group and Blanket Disability Insurance.

The provisions of this section are identical to those in Section 1.

SUBSTITUTE HOUSE BILL NO. 1179

State of Washington 48th Legislature 1984 Regular Session

by Committee on Social & Health Services (originally sponsored by Representatives Kreidler, Dellwo, Lewis, Stratton, Ballard, Fiske, B. Williams and West)

Read first time January 12, 1984.

AN ACT Relating to mandated benefits; and adding new sections to chapter 48.42 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1. The legislature takes notice of the increasing number of proposals for the mandating of certain health coverages or offering of health coverages by insurance carriers, health care service contractors, and health maintenance organizations as a component of individual or group policies. Improved access to these health care services to segments of the population which desire them can provide beneficial social and health consequences which may be in the public interest.

However, the cost ramifications of expanding health coverages is resulting in a growing concern. The way that such coverages are structured and the steps taken to create incentives to provide cost-effective services or to take advantage of cost off-setting features of services can significantly influence the cost impact of mandating particular coverages.

The merits of a particular coverage mandate must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage. The legislature hereby finds and declares that a systematic review of proposed mandated or mandatorily offered health coverage, which explores all the ramifications of such proposed legislation, will assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. This chapter provides for a set of guidelines which should be addressed in the consideration of all such mandated coverage proposals coming before the legislature.





NEW SECTION. Sec. 2. Every person or organization which seeks sponsorship of a legislative proposal which would mandate a health coverage or offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit a report to the legislative committees having jurisdiction, assessing both the social and financial impacts of such coverage, including the efficacy of the treatment or service proposed, according to the guidelines enumerated in section 3 of this act.

NEW SECTION. Sec. 3. Guidelines for assessing the impact of proposed mandated or mandatorily offered health coverage to the extent that information is available, shall include, but not be limited to, the following:

(1) The Social impact: (a) To what extent is the treatment or service generally utilized by a significant portion of the population? (b) To what extent is the insurance coverage already generally available? (c) If coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatments? (d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship? (e) What is the level of public demand for the treatment or service? (f) What is the level of public demand for insurance coverage of treatment or service? (g) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?

(2) The Financial impact: (a) To what extent will the coverage increase or decrease the cost of treatment or service? (b) To what extent will the coverage increase the appropriate use of the treatment or service? (c) To what extent will the mandated treatment or service be a substitute for more expensive treatment or service? (d) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders? (e) What will be the impact of this coverage on the total cost of health care?

~~NEW SECTION. Sec. 4. Sections 1 through 4 of this act are each~~

March 2

Vic, Pappy, Joe, Rick

SB 457 - M.H. Insurance

Jan Fuiks
family history of mother in mental illness.
thought insurance would be fair and equitable and bring M.H. issues to front.
upfront ins. costs expensive but decreases after 3 years.

Moss what will this do to cost of premiums to employer?

Div. of Insurance will speak to this. be high initially and may cause problems for small businesses.

Don Koch - Div. of Insurance
testimony in writing — opposes
(1.) pre emption of fed. law - ERISA and Nat'l Labor Rel. Act. - if collective bargaining involved, state may not pre-empt. If exempted, would only cover non-union employees.
Hawaii - Michigan → Fed. court upheld employer.
(2.) affects individual & group policies. find. policies work around narrow limits.

Joe could you allow waiver (written by purchaser) for policies?

Rick require that anyone offering insurance in state, must offer MH insurance

Koch small companies may not be able to do that

In this state, "disability" insurance includes all kinds of health insurance.

Joe — utilization of MH delivery system — effects? more demand on providers?

Koch — feels it would reach alcoholism and drug abuse issues because of broad definitions.

Rice — what do we mandate for health ins?

Koch — no mandates of coverage. Group policies ~~are~~ have options listed. Last yr. chiropractic coverage was an issue. — look at issue to see if there is discrimination.

Mike Coughlin — Ret. & Benefits.
State coverage — inpatient only. (90%)
outpt. in fiscal note — lifetime benefit limited to $2,500. (50%)

~~Koch~~
Joe — mandatory offer of M.H. insurance would be good.

Koch — go for a lesser benefit if that is done.

Martin Tirador — Blue Cross.
damages elements of cost-containment by mandating broad benefits for M.H. coverage.
definitions too vague & general.

- anticipates cost inc between 2-25%.
broad class of people to do counseling —
and what happens if there are no
providers in area? Must transportation
be paid?
Massachusetts stats. prove increased
utilization.
BlueCross has a no. of packages.
No employer has asked for a change
in ins. package. don't move bill.

Joe such a stigmatizing matter - employees
would probably not bring it up.
also, fiscal note does not take into
account cost of not receiving care —
substance abuse, battering, child abuse etc.

Natalie Gottstein - MH Assoc.
material to pass out, including
a draft CS w/ more acceptable changes.
material presented to US Congress, speaks
to cost savings from MH coverage for Fed Emp.
In a 3 yr. period, dramatic decrease
in other health care costs.
Concerned that State consider effects of
MH coverage for Alaskans.
1 in 7 will need MH services; 1 in 3
families will be affected.

Mike Coughlin - Ret Benefits
all inpat. care covered 80%

Steve Silver - Am Ins Assoc.

approval to mandatory coverage. Costly and burdensome — remain Voluntary

concerned w/ small employers → may stop all ins. coverage.

Fed. court decisions prevent application to any coverage affected by collective bargaining

Fed. proposal to tax health care coverage over a certain minimum.

Joe  Study MH Assoc materials / draft CS

Administ. — consider materials

Div of Ins. — see CS — comment

STATE OF ALASKA

**DEPARTMENT OF ADMINISTRATION**

*DIVISION OF RETIREMENT & BENEFITS*
*POUCH CR*
*JUNEAU, ALASKA 99811*

Public Employees' Retirement System
Teachers' Retirement System
Judicial Retirement System
Elected Public Officers Retirement System
National Guard Retirement System
Territorial Retirement System
Retirees' Voluntary Dental-Vision-Audio Plan
Supplemental Benefits System
Group Health/Life Insurance Benefits
Deferred Compensation Plan
Public Employers Social Security Contributions

*Bill Sheffield, Governor*

(907) 465-4460

March 23, 1984

Honorable Joe Josephson
Alaska State Legislature
Pouch V
Juneau, AK 99811

RE: SB 457

Dear Senator Josephson:

In the hearing before the Senate Health, Education & Social Services Committee on SB 457, you asked me to provide comments on materials presented to you by Ms. Natalie Gottstein of the Alaska Mental Health Association during her testimony. The material was reviewed by and discussed with our consultant, William M. Mercer, Inc.

Much of the literature presented by Ms. Gottstein suggests that a large proportion of the population has diagnosable mental disorders and that a significant number of these persons are not receiving adequate medical treatment. It is argued that if these disorders are appropriately treated, then apart from a healthy population, several other benefits can be reaped. It is claimed that these benefits include increases in productivity, reduction in absenteeism, reduction in medical expenses, and avoidance of catastrophic expenses by individuals suffering from mental illness.

While the extent of the benefits from mental health coverage claimed in this literature is not conclusively demonstrated, the evidence does support the contention that appropriate and cost effective care rendered to treatable patients yields dividends on both social and economic fronts. All these factors argue for a need to do something in this area, but we question whether the uniformly high standards that SB 457 would impose on the entire market are appropriate.

The current health insurance coverage provided to state employees offers benefits of 50% of eligible physician's expenses up to a maximum of $2,500 each year. If confined to a hospital the benefits are 90% of eligible expenses. Since health coverage is a collectively bargained item, we think it is appropriate that any increases in the coverage come from that arena. This subject has not been discussed at the bargaining table but union representatives apparently have not felt strongly that increased coverage was necessary for their members.



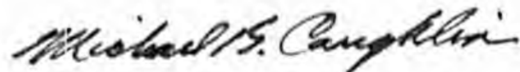
NOTE: Please Include Your Social Security Number In All Correspondence & Requests

The actual cost effectiveness of increased mental health care services for state employees is not clear. SB 457 would mandate a level of benefits and leave few means to the state to control questionable use of mental health services. Also, by raising the cost of our health plan even further, the bill could lead to a reduction in benefits in unregulated non-mental health areas in an attempt to contain overall health care costs. Rather than restricting the delivery of mental health care by high cost professionals and facilities, many employers including the State of Alaska are considering programs such as employee assistance programs which utilize social workers in cases of minor emotional and nervous disorders. This screening approach towards mental health care in conjunction with negotiated contracts involving discount rates with providers could assist in meeting whatever need exists in a cost effective and efficient manner.

In closing, it is our feeling that the current level of mental health coverage for state employees is adequate. If a need for greater access to mental health care does exist, there are other, more flexible means of providing this coverage rather than legislating a level of coverage in the state's group policy. The bill does not focus on those patients most in need--the uninsured and would add to the costs of already burdened purchasers of health insurance.

I hope this information will assist the committee in their discussion of SB 457. Please contact us if we can furnish any other information.

Sincerely,



Michael B. Coughlin
Deputy Director

MBC/mm
cc: Eleanor Andrews
Rebecca Burch
Ken Humphreys

An Act Relating To Equitable
Mental Health Insurance And Benefits Coverage

BE IT ENACTED BY THE STATE OF ALASKA as follows:

(a) All individual and group accident, hospitalization and sickness insurance policies and employee benefit plans for residents of Alaska or delivered, issued for delivery, renewed or used in Alaska providing coverage on an expense incurred basis and individual and group service or indemnity type contracts or plans which provide coverage for a family member of the insured and the subscriber shall provide coverage for treatment for mental, emotional and nervous disorders by a Provider at least equal to the following minimum requirements:

1. Benefits for inpatient care for a person suffering from a mental or nervous condition shall be a minimum no less than 60 days of active care per policy year.

2. Benefits for day treatment or partial hospitalization services for a person suffering from a mental or nervous condition shall be provided for a minimum of 120 days per policy year. Of this amount, 60 days represents a basic coverage and an additional 60 days represents a possible 2 to 1 trade-off for 30 days from inpatient benefits.

3. Benefits for outpatient services for a person suffering from a mental or nervous condition shall be at a minimum:

a. Forty visits per policy year; and

b. The reasonable charges for these services shall be included as covered medical expenses, and benefits shall be payable at a minimum rate of 80% of usual, customary and reasonable charges in Alaska.

(b) 1. Definitions. For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings:

A. "Day treatment services" and "Partial Hospitilization" includes pyschiatric, psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills of clients, provided to individuals and groups by a Provider for periods of more than 2 hours but less than 24 hours per day.

B. "Inpatient services" includes a range of psychiatric, physiological, psychological and other intervention concepts, techinques and processes in:

(i) a designated treatment facility as defined in AS 47.30.915(5), or

(ii)community mental health psychiatric inpatient unit, a general hospital psychiatric unit, a psychiatric hospital, or a public hospital licensed by the State of Alaska or accredited by the Joint Commission on Accreditation of Hospitals (JCAH),

to restore psychosocial functioning sufficient to allow maintenance and support of the patient in a less restrictive setting.

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of pyschiatric, psychoeducation, physiological, psychological and psychosocial evaluative and interventive concepts, techiniques and processes provided to individuals and groups by a Provider.

D. "Persons suffering from a mental or nervous condition" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory which impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being, or both.

E. "Provider" means:

(i) a "mental health professional" or "designated treatment facility", or both, as those terms are defined in AS 47.70.915([illegible]) and AS 47.70.915(4), respectively; or

(ii) a community mental health psychiatric unit, psychiatric hospital, general hospital psychiatric unit or public hospital licensed by the State of Alaska or accredited by the JCAH.

All agency or institutional Providers named in this paragraph shall assure that services are supervised by a psychiatrist or licensed psychologist.

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 437 Mental Health Insurance DATE March 2, 1984

| NAME | REPRESENTING | ADDRESS | PHONE NUMBER |
|---|---|---|---|
| DON KOCH | DIVISION OF INSURANCE | POUCH D JUNEAU | 465-2577 |
| M. TIRADOR | BLUE CROSS | 808 DIXON JNU | 586-3141 |
| Natalie Gottstein | Ak Mental Health Assn | 2611 Fairbanks CT, Anch | 276-1705 |
| Ken Humphreys | Dept. of Admin. | Pouch CR | 5-4460 |
| Michael Coughlin | " | " | " |
| Steve Silver | Am. Ins. Assoc | | |
| | Health Ins. Assoc of America | | |
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