SB
295

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: SB295

Sponsor: Faiks

Date referred to committee: 4-24-86

Synopsis completed:

Fiscal note:

Further referrals:

CONTACTS:

✓ Faiks (Steve White) 4523

✓ Pat Clasby (MH) George Rogers / Jerry Schraeder } support mandatory / mandatory

✓ Martin Tirador 586-3141

Gordon Evans, HIAA (Health Insurance Association America)

State Farm

DCED,
✓ Div Insurance 2515 } - John George / didn't testify in S. L&C

DHSS - Norma Lang (3030).

Dr Aaron Wolfe, Langdon Psych Clinic, 561-1361
~~4001~~ Dale, Anch

Alaska State Legislature

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Senate Committee on Health, Education and Social Services

CSSB 295 (HESS) APRIL 30, 1986
RELATING TO INSURANCE COVERAGE FOR THE TREATMENT OF A MENTAL OR NERVOUS CONDITION

The following amendments have been made to the Senate Labor and Commerce Committee Substitute considered by the Committee on April 29, 1986:

page 1, line 19 Includes "office visits" as covered treatment, along with inpatient and outpatient treatment.

page 1, line 21 Clarifies that if an insured declines the coverage that must be offered under this bill, the insurer may offer other coverage for treatment of mental illness.

page 2, line 22 Defines "office visit" as treatment that is not inpatient or outpatient, and is provided by a licensed psychiatrist, psychologist, or psychological associate.

page 3, line 6 Defines "outpatient treatment" as treatment provided in the outpatient department of a licensed hospital (whether in Alaska or Outside) or in a community mental health center established under the State's community mental health center program.

Bannister
4/30/86 ✓

Original sponsor: Faiks

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 295 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance coverage for the treat- [illegible] of a mental or nervous condition."

BE IT ENACTED BY THE LEG[illegible]URE OF THE STATE OF ALASKA:

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.365. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS CONDITION. (a) An insurer that issues for delivery, delivers, or renews a health insurance policy in the state after January 1, 1987, shall offer the insured an option to receive the following coverage for treatment of a mental or nervous condition of the insured or other person covered by the insured's health insurance policy:

(1) 45 days a year of inpatient treatment for each covered individual;

(2) a total of 50 hours a year of outpatient treatment or office visits for each covered individual, accumulated in any increments of time.

(b) The health insurance policy may impose reasonable contract limitations, but may not require that the insured pay a higher deductible or co-payment for a cost for treatment of a mental or nervous condition than for a cost for treatment of another condition or illness.

(c) If an insured declines the coverage offered by an insurer under this section, the insurer may offer the insured other coverage for treatment of a mental or nervous condition.

(d) In this section

1 (1) "co-payment" means the portion of the cost to be paid
2 by the insured;
3 (2) "cost" means the lesser of the following:
4 (A) the actual charge for the treatment received for a
5 mental or nervous condition; or
6 (B) the usual, customary and reasonable charge for the
7 treatment;
8 (3) "health insurance policy" means a hospital or medical
9 expense policy, or a nonprofit health care corporation plan;
10 (4) "inpatient treatment" means continuous treatment during
11 a 24-hour period in the psychiatric unit of a general hospital li-
12 censed under AS 18.20, a psychiatric hospital that is licensed under
13 AS 18.20, or a hospital in the state that is specifically exempt under
14 AS 18.20.020 from the licensing requirements of the state;
15 (5) "mental or nervous condition" means a mental disorder
16 identified in
17 (A) the Diagnostic and Statistical Manual of Mental
18 Disorders (Third Edition) published by the American Psychiatric
19 Association; or
20 (B) the ICD-9-CM (First Edition) published by the
21 Commission on Professional and Hospital Activities;
22 (6) "office visit" means treatment that is not inpatient
23 treatment or outpatient treatment and that is provided by
24 (A) a psychiatrist who is licensed as a physician in
25 the state and certified, or eligible for certification, in psy-
26 chiatry by the American Board of Psychiatry and Neurology;
27 (B) a physician who is employed by the federal govern-
28 ment in the state and certified or eligible for certification in
29 psychiatry by the American Board of Psychiatry and Neurology; or

1 (C) a psychologist or psychological associate licensed
2 under AS 08.86;
3 (7) "outpatient treatment" means treatment that is not
4 inpatient treatment and that is provided
5 (A) in the outpatient department of
6 (i) a hospital that is licensed under AS 18.20 or
7 that is specifically exempt under AS 18.20.020 from the
8 licensing requirements of the state;
9 (ii) a hospital that is located in another state
10 and that is either licensed or specifically exempt from
11 the licensing requirements of that state; or
12 (iii) an entity that is designated by the Depart-
13 ment of Health and Social Services as the organizational
14 unit in a geographical area to receive funds under AS 47.-
15 30.520 - 47.30.620; and
16 (B) by one or more of the following, or by a person
17 who is under the direct supervision of one or more of the follow-
18 ing, has a master's or doctorate degree in psychology, nursing,
19 or social work, and is employed by the same health care facility
20 as the person or persons providing the direct supervision,
21 (i) a psychiatrist who is licensed as a physician
22 in the state and certified, or eligible for certification,
23 in psychiatry by the American Board of Psychiatry and Neu-
24 rology;
25 (ii) a physician who is employed by the federal
26 government in the state and certified or eligible for certi-
27 fication in psychiatry by the American Board of Psychiatry
28 and Neurology; or
29 (iii) a psychologist licensed under AS 08.86.

1 * Sec. 2. AS 21.36.090(d) is amended to read:
2 (d) Except to the extent necessary to comply with AS 21.42.365,
3 a [A] person may not practice or permit unfair discrimination against
4 a person who provides a service covered under a group disability
5 policy that extends coverage on an expense incurred basis, or under a
6 group service or indemnity type contract issued by a nonprofit corpo-
7 ration, if the service is within the scope of the provider's occupa-
8 tional license. In this subsection, "provider" means a state licensed
9 physician, dentist, osteopath, optometrist, chiropractor, or nurse
10 midwife.
11 * Sec. 3. AS 21.87.340 is amended to read:
12 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
13 provisions contained or referred to previously in this chapter, the
14 following chapters and provisions of this title also apply with re-
15 spect to service corporations to the extent applicable and not in
16 conflict with the express provisions of this chapter and the reason-
17 able implications of the express provisions, and for the purposes of
18 the application the corporations shall be considered to be mutual
19 "insurers":
20 (1) AS 21.03
21 (2) AS 21.06
22 (3) AS 21.09, except AS 21.09.090
23 (4) AS 21.18.010
24 (5) AS 21.18.030
25 (6) AS 21.18.040
26 (7) AS 21.18.120
27 (8) AS 21.21.321
28 (9) AS 21.36
29 (10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) AS 21.42.345 - 21.42.365 [AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

FOR DISCUSSION ADOPTED

By Fahrenkamp
April 29, 1986

A M E N D M E N T

CSSB 295 (L&C) An Act requiring insurers to offer certain coverage for the treatment of a mental or nervous condition in certain health insurance policies.

page 3, line 4 -- amend to read:

(C) a psychologist or psychological associate licensed under AS 08.86.

Rationale:
As currently written, CSSB 295 (L&C) limits the required offering of mental health coverage to services provided in a licensed hospital or provided on an outpatient basis by a licensed psychiatrist, a physician employed by the federal government and eligible for certifiction in psychiatry, a licensed psychologist, or persons who hold masters or doctorate degrees in psychology, nursing, or social work and are supervised by a psychiatrist or psychologist. The bill specifies that the supervisor must be employed by the same health care facility as the person being supervised.

This raises two concerns. Under current statute, holders of masters degrees in psychology can be licensed as psychological associates. Supervision by a licensed psychologist is required, on a weekly basis for 3 years prior to licensure and on a quarterly basis thereafter. There is not a requirement that the supervisor and the psychological associate be employed by the same facility. Currently, individual insurance companies decide what services they will cover, and some do cover the services of psychological associates. The concern is that excluding them from SB 295 may result in insurance companies refusing to cover their services, instead limiting their coverage to that required by law.

Secondly, SB 251, which was approved by the full Senate on April 2 and is currently under consideration by the House HESS Committee, would amend the psychology licensing statute to allow psychological associates to practice without supervision if, upon satisfaction of certain criteria, the licensing board certifies them to do so. Through contacts made in regard to SB 251, some insurance companies have indicated a willingness to cover the services of psychological associates practicing without supervision should SB 251 be signed into law. Again the concern is that by excluding psychological associates from the mandatory category in SB 295, coverage of their services may be unattainable.

THE PROPOSED AMENDMENT WOULD REQUIRE THAT SERVICES OF PSYCHOLOGICAL ASSOCIATES MEETING STATUTORY SUPERVISORY REQUIREMENTS OR CERTIFIED TO PRACTICE WITHOUT SUPERVISION BE COVERED BY THE MENTAL HEALTH OPTION.

Similar arguments could be made on the behalf of social workers who are seeking licensure through SB 227.

MEMORANDUM State of Alaska

TO: John George
Director

Thru: Paul Troeh
Deputy Director

FROM: Jim Jordan
Insurance Market Analyst

DATE: April 21, 1986

FILE NO:

TELEPHONE NO:

SUBJECT: Analysis/Comments HB 313

General

HB 313 requires that all subscriber contracts and all expense incurred, disability insurance contracts contain coverage for treatment of a mental or nervous conditions It would appear the intent of this Act is to require coverage for mental or nervous conditions in the same manner as for any other condition, illness, or injury. This proposal would allow the coverage to be "capped" by the prescribed number of treatments outlined in A.S. 21.42.365(a). However, the existing construction is not entirely clear as A.S. 21.42.365(b) would appear to require the benefits for a mental or nervous condition be provided on a "usual, customary, or reasonable" basis even though a contract may provide for analogous benefits on a "scheduled" basis.

It should be noted that HB 313 would be equally applicable to group, as well as individual, contracts. Therefore, a person shopping for an individual contract could not purchase a policy without this coverage, even if it was their desire to do so. The proposal would also impact collectively bargained group health benefits.

The proposed act, by omission, may be constitutionally defective. A literal reading would suggest the requirements would apply to contracts already in force which provides for "impairment of contract", constitutional problems. This can be corrected by adding a provision that the requirements are for only new group and individual contracts issued after the effective date of the act and that all in-force, group contracts must contain the requirements on the first policy anniversary following the effective date of the act. Additionally, these requirements may not be able to be imposed on group contracts issued in other states, even though some Alaska residents are covered under that contract. Also, self-insurers and any of the federal health benefit programs would not be affected by this act.

Recommendations For Technical Amendments

If it is the intent to provide coverage for treatment of a mental or nervous condition on the same basis as for any other covered condition, injury, or illness, it is suggested that A.S. 21.42.365(a) be amended to read as follows:

> "(a) An expense incurred, disability insurance policy that provides for hospital and medical benefits issued by an insurer, or a subscriber contract that provides for hospital and medical benefits issued by a hospital or medical service corporation; must provide coverage for treatment of a mental or nervous condition on the same basis as for any other covered condition, injury, or illness which may not be limited for each covered person to less than:

(3)

(1) 60 days a year for inpatient treatment;
(2) 90 days a year for partial hospitalization;
(3) 30 days a year for outpatient treatment; and
(4) the option of each covered person to exchange a maximum of 45 days of inpatient treatment for additional days of partial hospitalization; for the purpose of computing the exchange, two days of partial hospitalization equal one day of inpatient care."

If the above change is made, then A.S. 21.42.365(b) and A.S. 21.42.365(c)(1), (2), (3), (5) are not needed and can be deleted.

A.S. 21.42.365(c)(7)(A) may be in conflict with A.S. 21.36.090(d) as this section would allow payment of outpatient treatment to be limited only to a psychiatrist licensed as a physician and certified in psychiatry. The reason for this statement is that a licensed physician, without the certification in psychiatry, may be able to legal provide outpatient mental or nervous care under their Alaska license. Division of Occupational Licensing staff have indicated the physician's licensing law is silent on this point. It may be this section needs to be amended to reference only a licensed physician.

A.S. 21.42.365(a)(2) and (4), and A.S. 21.42.365(c)(8) may also need to be amended. It is my understanding that the "partial hospitalization" provision would be intended for those patients that leave the inpatient facility to go to work, but return to spend the night as an inpatient. On a work-release basis, it would appear that the typical patient would probably be out of the facility for, at most, 10 hours in a 24 hour period. (This assumes one hour before and after work, and eight hours on the job.) If this is the typical case, then the "partial hospitalization" provision may be of no effect.

Recommended Position

It is my recommendation the division oppose HB 313 in its current form. I could only recommend support if the various, above amendments were made and the concept was changed from a mandatory benefit inclusion to a mandatory offer of the benefit.

SB 295

psychologist examination may be issued a temporary license by making a written request to

statement by the psychological associate and the supervisor must be registered with the board for review and approval. (Eff. 1/14/82, Reg. 81; am 4)

Authority: AS 08.86.070(a)(1)
AS 08.86.080
AS 08.86.130

HB 313 Page 2 of 2

IV Analysis: This bill would require increased limits of coverage for mental, emotional, or nervous disorders under the State's health plans for active employees of the state and all retirees. The estimated cost to the state shown on the attached fiscal note is in addition to the estimated cost of $900,500 to other employers participating in the state's retirement and group health plans.

This bill is estimated to result in a $2.65 per month increase in Health Insurance costs of an estimated 13,200 state employees. It is also estimated to result in a .12% increase in the PERS employer contribution rate and a .075% increase in the TRS employer-contribution rate and a .075% increase in the TRS State Match contribution rate. The PERS state salaries for FY 87 are estimated to be $590,176,728 and the TRS state salaries for FY 87 are estimated to be $456,833,417. Costs are estimated to increase at a rate of 8% each year.

The FY 87 estimated state cost of $1,440,000 is calculated as follows:

The increase of $2.65 per month health cost times the number of state employees (13,200) times 12 months equals	$419,760
The change in the PERS employer contribution rate (.12%) times the estimated FY 87 State PERS salaries ($590,176,728) equals	$708,212
The change in the TRS employer contribution rate (.075%) times the estimated FY 87 State TRS salaries ($68,569,578) equals	$ 51,427
The change in the TRS State Match contribution rate (.075%) times the estimated FY 87 TRS system salaries ($456,833,417) equals	$342,625
TOTAL	$1,522,024

The present value of the cost of this bill in PERS is $7,411,000 resulting in a .6% decrease in the funding ratio. The present value of the cost of this bill in TRS is $3,916,000 resulting in a .4% decrease in the funding ratio.

-2-

30. APPLICATION FOR LICEN- REDENTIALS. An applicant for redentials as a psychologist will ised thout examination if the applicant

es with 12 AAC 60.010(a); and

s verification of his or her valid ertificate, license, or other evidence n issued by another licensing jur- provides evidence to the board that e, license, or other evidence of was issued based upon examination tions substantially similar to the 's at the time of application for an ; or

s verification that he or she is a good standing of the American aminers in Professional Psychology. 12/ 78, Reg. 68; am 1/14/82, Reg. 81)

Authority: AS 08.86.070(a)(1)
AS 08.86.080
AS 08.86.150

0.040. APPLICATIONS REVIEWED OARD. (a) An application received rtment will be reviewed by the board meeting before the applicant will be o sit for the examination, approved orary license, or approved for licen- dorsement. No application will be re- til all the submissions required by 0.010 or 12 AAC 60.020 have been y the department. It is the responsi- he applicant to assure that all submis- eceived by the department.

pplication and supporting documents received at least 45 days before a examination for the applicant to be to sit for that exam. If an application orting documents are received less than efore the next scheduled examination, icant will be considered for the

the psychological associate ...

Offered: 4/24/86
Referred: Health, Education and
Social Services

Original sponsor: Faiks

1 IN THE SENATE — BY THE LABOR AND COMMERCE COMMITTEE

2 CS FOR SENATE BILL NO. 295 (L&C)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act requiring insurers to offer certain coverage
7 for the treatment of a mental or nervous condition in
8 certain health insurance policies."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. AS 21.42 is amended by adding a new section to read:

11 Sec. 21.42.365. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS
12 CONDITION. (a) An insurer that issues for delivery, delivers, or
13 renews a health insurance policy in the state after January 1, 1987,
14 shall offer the insured an option to receive the following minimum
15 coverage for treatment of a mental or nervous condition of the insured
16 or other person who would otherwise be covered by the insured's health
17 insurance policy:

18 (1) 45 days a year of inpatient treatment for each covered
19 individual;

20 (2) a total of 50 hours a year of outpatient treatment for
21 each covered individual, accumulated in any increments of time.

22 (b) The health insurance policy may impose reasonable contract
23 limitations, but may not require that the insured pay a higher deduct-
24 ible or co-payment for a cost for treatment of a mental or nervous
25 condition than for a cost for treatment of another condition or ill-
26 ness.

27 (c) In this section

28 (1) "co-payment" means the portion of the cost to be paid
29 by the insured;

1 (2) "cost" means the lesser of the following:

2 (A) the actual charge for the treatment received for a

3 mental or nervous condition; or

4 (B) the usual, customary and reasonable charge for the

5 treatment; [in the judicial district of this state]

6 (3) "health insurance policy" means a hospital or medical

7 expense policy, or a nonprofit health care corporation plan;

8 (4) "inpatient treatment" means continuous treatment during

9 a 24-hour period in the psychiatric unit of a general hospital li-

10 censed under AS 18.20, a psychiatric hospital that is licensed under

11 AS 18.20, or a hospital in the state that is specifically exempt under

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15 (A) the Diagnostic and Statistical Manual of Mental

16 Disorders (Third Edition) published by the American Psychiatric

17 Association; or

18 (B) the ICD-9-CM (First Edition) published by the

19 Commission on Professional and Hospital Activities;

20 (6) "outpatient treatment" means treatment that is not

21 inpatient treatment and that is provided by one or more of the follow-

22 ing, or by a person who is under the direct supervision of one or more

23 of the following, has a master's or doctorate degree in psychology,

24 nursing, or social work, and is employed by the same health care

25 facility as the person or persons providing the direct supervision,

26 (A) a psychiatrist who is licensed as a physician in

27 the state and certified, or eligible for certification, in psych-

28 iatry by the American Board of Psychiatry and Neurology;

29 (B) a physician who is employed by the federal

who determines? Insurance co. do.

of more than 12 hrs

what? (Original spelled out.) Insurers bill according to these codes

Legal concern was that if raised, we're delegating authority.

Concern: once social workers licensed, won't be able to get coverage. Now is left to discretion of insurance company!

Recommended by legal; 'cause were saying only psychiatric MDs can get paid through this bill - so is a form of discrimination

1 government in the state and certified or eligible for certi-
2 fication in psychiatry by the American Board of Psychiatry and
3 Neurology; or

4 (C) a psychologist licensed under AS 08.86.

5 * Sec. 2. AS 21.36.090(d) is amended to read:

6 (d) Except to the extent necessary to comply with AS 21.42.365,
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9 policy that extends coverage on an expense incurred basis, or under a
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11 ration, if the service is within the scope of the provider's occupa-
12 tional license. In this subsection, "provider" means a state licensed
13 physician, dentist, osteopath, optometrist, chiropractor, or nurse
14 midwife.

15 * Sec. 3. AS 21.87.340 is amended to read:

16 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
17 provisions contained or referred to previously in this chapter, the
18 following chapters and provisions of this title also apply with re-
19 spect to service corporations to the extent applicable and not in
20 conflict with the express provisions of this chapter and the reason-
21 able implications of the express provisions, and for the purposes of
22 the application the corporations shall be considered to be mutual
23 "insurers":

24 (1) AS 21.03
25 (2) AS 21.06
26 (3) AS 21.09, except AS 21.09.090
27 (4) AS 21.18.010
28 (5) AS 21.18.030
29 (6) AS 21.18.040

original had psych. assoc. now would apply only if supervised by psychologist

or psych assoc. ~~who has been granted the ability to practice without supervision~~ under AS 08.86.164(e)

certified

Can't discriminate among providers.

new insurance section

But per definition of "outpatient" in SB 295, must discriminate ~~this allows~~.

Put in by legal.

hospital & medical services corp.

?

?

Terry Bannister

Must provide these services.
Group may contract w/ them
to provide range of medical services -
must now include m.h. services.

1 (7) AS 21.18.120

2 (8) AS 21.21.321

3 (9) AS 21.36

4 (10) AS 21.69.400

5 (11) AS 21.69.520

6 (12) AS 21.69.600, 21.69.620, and 21.69.630

7 (13) AS 21.78

8 (14) AS 21.90

9 (15) AS 21.42.345 - 21.42.365 [AND 21.42.355]

10 (16) AS 21.89.040

11 (17) AS 21.89.060.

No effective date.

SB 295

Liability of hospital for negligence of nurse assisting operating surgeon. 29 ALR3d 1065.

Hospital's liability for injury or death to patient resulting from or connected with administration of anesthetic. 31 ALR3d 1114.

Liability of hospital for refusal to admit or treat patient. 35 ALR3d 841.

Attending physician's liability for injury caused by equipment furnished by hospital. 35 ALR3d 1068.

Hospital's liability to patient injured going to or using bathroom or toilet facilities. 36 ALR3d 1235.

Liability for negligence in diagnosing or treating aspirin poisoning. 36 ALR3d 1358.

Liability of one releasing institutionalized mental patient for harm he causes. 38 ALR3d 699.

Medical malpractice in connection with diagnosis, care, or treatment of diabetes. 42 ALR3d 482.

Hospital's liability for injury allegedly caused by improper diet or feeding of patient. 42 ALR3d 736.

Liability for injury allegedly resulting from negligence in making hypodermic injection. 45 ALR3d 731.

Liability for injury or death from blood transfusion. 45 ALR3d 1364.

Liability of hospital for injury caused through assault by a patient. 48 ALR3d 1288.

Hospital's liability to patient for injury allegedly sustained from absence of particular equipment used in diagnosis or treatment of patient. 50 ALR3d 1141.

Hospital's liability for negligence in selection or appointment of staff physician or surgeon. 51 ALR3d 981.

Liability for injuries or death resulting from physical therapy. 53 ALR3d 1250.

Liability of hospital, or medical practitioner, under doctrine of strict liability in tort, or breach of warranty, for harm caused by drug, medical instrument, or similar device used in treating patients. 54 ALR3d 258.

Liability of physician or hospital in the performance of cosmetic surgery upon the face. 54 ALR3d 1255.

Liability of hospital, other than mental institution, for suicide of patient. 60 ALR3d 880.

Validity and construction of contract between hospital and physician providing for exclusive medical services. 74 ALR3d 1268.

Tort liability of physician or hospital in connection with organ or tissue transplant procedures. 76 ALR3d 890.

Recovery for mental or emotional distress resulting from injury to, or death of, member of plaintiff's family arising from physician's or hospital's wrongful conduct. 77 ALR3d 447.

Malpractice in connection with diagnosis of cancer. 79 ALR3d 915.

Patient tort liability of rest, convalescent, or nursing homes. 83 ALR3d 871.

Arbitration of medical malpractice claim. 84 ALR3d 375.

Malpractice in connection with electroshock treatment. 94 ALR3d 317.

Application of rule of strict liability in tort to person or entity rendering medical services. 100 ALR3d 1205.

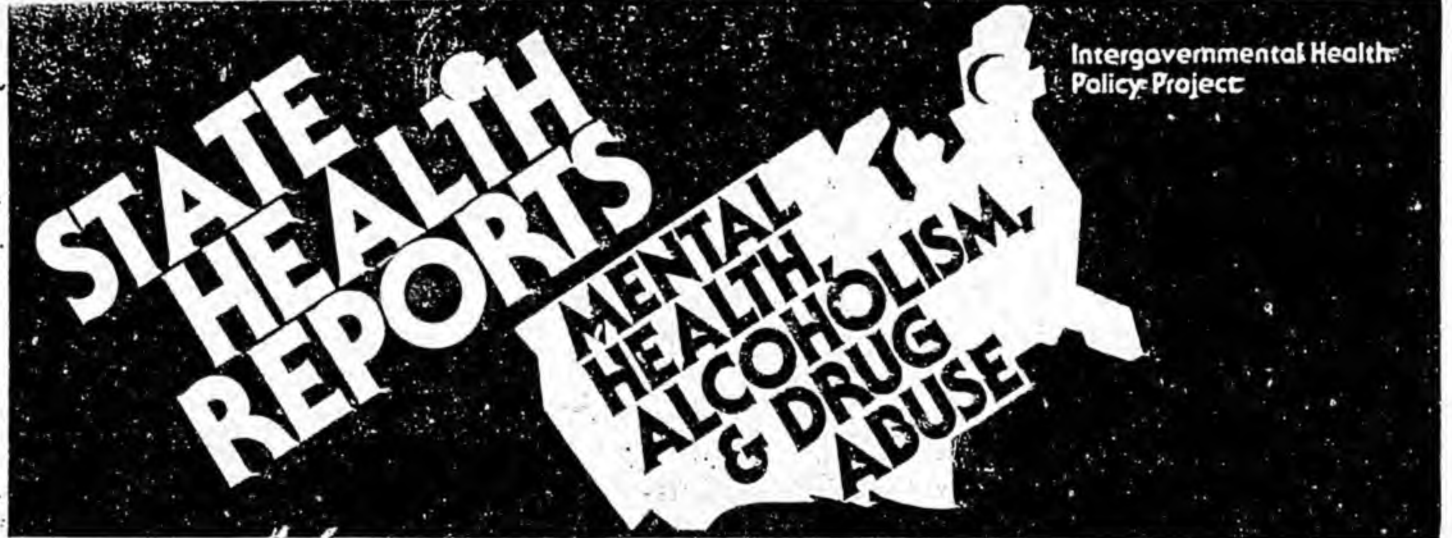
Sec. 18.20.020. License required. No person or government unit, except the federal government, acting severally or jointly with another person or governmental unit may establish, conduct or maintain a hospital in the state without a license. (§ 40-6-3 ACLA 1949; am § 3 ch 112 SLA 1957)

Cross references. — As to requirement for certificate of need to construct or alter a health care facility, see AS 18.07.011 — 18.07.111.

Opinions of attorney general. — A nursing home is considered a hospital for the purpose of the licensing provisions. 1963 Op. Att'y Gen., No. 7.

If a person establishes a hospital which gives general and medical treatment and in addition provides nursing service, both aspects of hospital operation are nonetheless within the same hospital, and there is no justification for breaking up the operations of one hospital into separable units for licensing purposes; therefore, one license should be required for the entire hospital operation. 1963 Op. Att'y Gen., No. 7.

Collateral references. — Licensing and regulation of nursing or rest homes. 97 ALR2d 1187.



No. 20 (Special Feature) *January 1986*

State Laws Mandating Private Health Insurance Benefits for Mental Health, Alcoholism, and Drug Abuse

Editors Note: This special feature of STATE HEALTH REPORTS ON MENTAL HEALTH, ALCOHOLISM, & DRUG ABUSE *examines the current status of state laws mandating private health insurance benefits for mental health, alcoholism, and drug abuse, and the policy context from which they have evolved.*

This REPORT *was written by Adrienne Lang, Assistant Director for Government Relations at the American Psychiatric Association, from information provided by the Intergovernmental Health Policy Project. Special thanks are also due to Bill Butynski, Executive Director for the National Association of State Alcohol & Drug Abuse Directors, for providing an update on the status of the laws related to alcohol and drug abuse insurance benefits.*

This REPORT *represents an update of* Private Health Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness, *a monograph published by IHPP in 1979.*

A regular issue of STATE HEALTH REPORTS *will be mailed to you very shortly.*

I. INTRODUCTION

Traditionally, alcoholism, drug abuse and mental health were viewed as "different" from physical disorders. Causes were mysterious, cures rare and a social stigma was attached to victims. Frequently, the medical establishment treated only the physical problems related to these diseases, while neglecting the less tangible underlying problems.

Recent years have witnessed tremendous growth in public expenditures for alcoholism, drug abuse and mental illness as well as a lessening of the stigma associated with them, and an increase in practical treatment alternatives. Nonetheless, many private health insurers have not expanded their coverage to pay for comprehensive treatment of these diseases. Most private health insurance reimbursement for alcoholism, drug abuse and mental health is limited to medically-oriented inpatient settings, and few companies pay for comparable benefits in outpatient settings or those staffed by non-medical personnel.

Because of the limited coverage available in the private marketplace, state governments have exercised their regulatory authority over the insurance industry to require expansion of such benefits.

Despite the opposition of health insurers, a number of state legislatures enacted laws in the 1970s requiring them to provide benefits for alcoholism, drug abuse and mental health. Other legislatures enacted less stringent versions of these same statutes, requiring only that health insurers "offer" such benefits to the policyholders at their option. The state laws were enacted for a variety of reasons: to encourage recogni-

tion and treatment of these diseases to the same degree as physical illnesses; to lessen the burden on public programs; to reduce utilization of other medical services because of pseudo-diagnoses or related physical diseases; and to improve the structure of treatment benefits.

This special feature of State Health Reports highlights some of the problems leading to state legislation in this area, analyzes specific provisions of a variety of state laws on the subject, and provides additional detail on costs (where available) and other issues surrounding this public policy question.

II. BACKGROUND

A. Prevalence and Costs

When discussing health insurance benefits for alcoholism, drug abuse and mental illness, it is helpful to consider the extent of these problems in the United States and the resources already devoted to them. According to a recent report prepared for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) by the Research Triangle Institute[1], the economic burden of alcohol abuse, drug abuse, and mental illness in 1980 was an estimated $190.7 billion. Alcohol abuse contributed to the major portion of these costs, estimated at $89.5 billion. The costs of mental illness were estimated at $54.2 billion and drug abuse at $46.9 million.

For 1983, total costs to society for ADM of that total, disorders were estimated at $249.2 billion; alcohol abuse contributed $116.6 billion, drug abuse accounted for $59.7 billion and the costs associated with mental illness were $72.7 billion.

The study also indicated that employees with ADM problems are likely to be less productive than otherwise comparable workers. The reduced productivity impact due to alcohol and drug abuse was estimated to be $50.6 billion and $25.7 billion, respectively, or 56 and 55 percent of the total alcohol and drug abuse cost. The study said that reduced productivity due to mental illness was $3.1 billion; that figure, however, represents only people reporting partial work disability due to severe emotional or chronic disorders, and does not reflect the costs of the true prevalence of mental illness.

In comparison, mental illness costs $18.5 billion due to lost employment (complete disability) of its victims, involving incapacitation either at home or in hospitals. Alcohol and drug abuse have lower costs for lost employment at $4.1 billion and $312 million respectively.

The ADAMHA study results also indicated that the combined costs for ADM treatment services in 1980 were $31.6 billion, divided among mental illness ($21.0 billion), alcohol abuse ($9.5 billion), and drug abuse ($1.2 billion). This represents direct health services provided to victims of ADM, including long and short hospitalizations, services from physicians and other sources.

Although the ADAMHA study did not address the issue of public versus private expenditures, other groups have made estimates in this regard. According to the American Psychiatric Association,[2] in 1980 total mental health care dollars were divided as follows:

- o 25 percent federal,
- o 28 percent state and local,
- o 12 percent insurance,
- o 35 percent private.

An interesting comparison is that in the same year for total medical care, insurance paid 26 percent, while state and local governments paid only 9 percent. Further, the insurance slice of the pie for mental health showed a decrease from 14 percent in 1971 to 12 percent in 1980.

According to a report prepared by the National Association of State Alcohol and Drug Abuse Directors, for FY 84, states contributed 49.5 percent ($666.9 million) of total funds for alcohol and drug abuse treatment and prevention services, while federal programs contributed 20.7 percent ($278.5 million), county or local sources 9.7 percent ($130.1 million) and other sources such as private health insurance and client fees 20.1 percent or $271.2 million.[3]

B. Impact of the Federal Em(yee Retirement Income Security Act of 1974 on Mandated Benefit Statutes

A central question to state mandates of any type has been a legal one: do states have the power to require insurance companies to provide a minimum level of coverage, or would the federal Employee Retirement Income Security Act of 1974 (ERISA) pre-empt state laws?

Following enactment of the landmark mandated mental health benefits law in Massachusetts in (1974), the Metropolitan Life Insurance and Travelers Insurance Companies sued the Commonwealth of Massachusetts, contending that the statute violated Section 514(a) of ERISA, which provides that the federal law shall "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."

However, the Massachusetts Supreme Court held that the governing section of ERISA is 514(b), which states that ERISA shall not "be construed to exempt or relieve any person from any law of any state which regulates insurance." In June 1985 the U.S. Supreme Court upheld the lower court, finding that the Massachusetts mandated benefit law is a "law which regulates insurance" -- and that therefore there is no pre-emption.[4]

C. Support for Mandated Benefits

An anticipated benefit accruing from improved insurance coverage of alcoholism, drug abuse and mental illness is decreased utilization of medical services for other illnesses and avoidance of more costly levels of care. Patients with chronic illnesses or those recovering from certain surgeries benefit from psychiatric intervention, often with a decline in inpatient days and readmission rates. Admission costs for patients with alcoholismrelated complications also improve with psychiatric care. But these outgrowths, called "offset costs," are plausible, but difficult to quantify with any precision.

The difficulty of measuring offsetting costs is evidenced by the widely ranging figures found by Jones and Vischi,[5] that is, a 5 to 80 percent reduction in medical utilization in cases with psychiatric intervention. Mumford and Schlesinger[6] have devoted several s(ies to the measurement of offset costs. One research study of the effect of mental health treatment as part of post-operative/hospital care among heart attack and surgical patients found lower long-term costs of care for such patients (fewer complications, earlier discharges, fewer readmissions). A new Mumford and Schlesinger report[7] on 58 studies of effects of outpatient psychotherapy on subsequent medical services showed 85 percent reporting a decrease in such services.

While findings such as these do provide some percentages and measurements, there are other offsetting factors not as easily calculated. McGuire and Montgomery[8] say that "each of us has a financial stake in the treatment of mental illness." Their point is that the taxpayer and the fellow-employee are indeed paying for the mentally ill, the alcoholic or drug abuser through the criminal justice system, state institutions, absenteeism from the workplace, and unemployment. These very concerns, and the associated state and local pricetags, have been forceful in motivating state legislators to support mandated benefits as a way to shift some of these costs to the private sector.

State laws mandating health insurance coverage for alcoholism, drug abuse and mental illness could alter not only benefits structure but treatment patterns. A classic example is the "revolving door" syndrome of alcoholics who go through detoxification time after time, but receives no follow-up treatment because their insurance covers only the acute inpatient detoxification. Proponents of mandated benefits offer this example to illustrate that coverage of alcoholism treatment episodes not only provides needed therapeutic treatment, but also prevents more costly multiple detoxifications and chronic absenteeism.

D. Opposition to Mandated Benefits

The major opponents of mandated benefit laws are insurers and business/employer groups. Interestingly, unions also tend to oppose mandated benefits. Insurers maintain that mandates stifle competition and innovation; lead to a fragmented health care system; do not guarantee the provision of

necessary and appropriate care; and deny flexibility to employers.

Furthermore, the extent to which such mandates drive up employers' labor costs is concerning a number of state policy makers, who feel many companies may become discouraged from locating or remaining in a state with mandated mental health benefits For example, New York's commissioner of insurance recently observed that "mandated benefits and increased provider coverage raise the cost of conducting business in New York, thus creating an additional incentive for an employer to abandon New York State. The insurance department recognizes this forces cost increases on employers and opposes all such legislation..." In addition, statutory mandates obstruct flexible benefit plans such as "cafeteria plans," that have become increasingly popular among employees and are designed to permit consumer choice of health care services.

It should be noted, however, that many employers have chosen to self-insure to avoid compliance with mandated benefits laws. Their reason, at least in part, is that ERISA preempts them from state laws regulating health insurance. It has been estimated that as much as 30 percent of the market is self-insuring and they are certainly doing so to avoid increases in their health insurance costs.

In sum, insurers and employers offer a multitude of philosophical and practical reasons for opposing comprehensive health insurance benefits for alcoholism, drug abuse and mental illness. Often, alcoholism and drug abuse are thought of as social problems requiring nonmedical care while mental illness is often perceived of as a disease without clear definition, diagnosis or treatment. Insurers claim it is actuarially difficult to measure risks without a predictable course of illness. The reason underlying all of these perceptions is costs, because health care follows the dollar.

III. PRIVATE HEALTH INSURANCE COVERAGE FOR MENTAL HEALTH CARE SERVICES

A. Overview

Private insurers and employers historically have not covered mental illness. The growth and development of the insurance industry during the 1930's and 1940's did not encompass either interest in nor coverage of mental illness. Traditional views held that mental illness and its treatment were different from physical illness. The stigma attached to mentally ill patients and their families combined with insurers' and employers' fears of unpredictable (presumed runaway) utilization and costs to make coverage scant. Some growth in benefits occurred following advances in treatment of the mentally ill, including the move away from long-term hospitalization, psychopharmacologic interventions, and new programs of outpatient therapies. Private health insurance was growing tremendously, and by the 1970s, the private sector was called on to share a portion of the financial burden of treating mental illness. At this time a number of state legislatures passed laws mandating mental health benefits in private insurance.

Fearing expensive costs for psychiatric care and regarding mental illness as a subjective disease, health insurers place special limitations on benefits, particularly on outpatient treatment. For example, the coinsurance rate for outpatient psychiatric care is generally 50 percent compared to the usual 20 percent for other illnesses. Several sources attribute the high coinsurance rates to earlier cost experience. When insurance companies initially offered outpatient major medical benefits, they made no distinction between mental and physical illness. As experience accumulated, they found that outpatient psychiatric services constituted a large portion of all ambulatory care costs.[9]

B. Existing Coverage

Coverage today has improved, in part due to state laws mandating benefits for the treatment of mental illness. The Health Insurance Association of America (HIAA), surveyed 36 of its companies and reported virtually all employees in the study (99 percent) had coverage for inpatient treatment of mental illness; of those with coverage, nearly 85 percent had inpatient benefits the same as for other covered conditions.[10]

An American Psychiatric Association (APA) survey of 300 private plans found that 100 percent of them provided some level of inpatient and/or outpatient coverage. The breakdown of this coverage shows:

- o 6 percent provided that same inpatient and outpatient coverage as for other conditions;
- o 59 percent provided the same inpatient coverage as for other conditions; reduced coverage for outpatient;
- o 3 percent provided the same outpatient coverage as for other conditions; reduced coverage for inpatient;
- o 31 percent provided reduced coverage for both inpatient and outpatient care.[11]

The Bureau of Labor Statistics Level of Benefit Studies, which cover a far more comprehensive pool of employees, produced the following data:[12]

- o 99 percent had some level of inpatient coverage;
- o 94 percent had some level of outpatient;
- o 53 percent (a decrease of 5 percent since 1981) cover inpatient care on the same basis as other illness;
- o 7 percent cover outpatient coverage the same as for other illnesses.

The differences in coverage between mental and physical illness are usually explained by deductibles, coinsurance, and day/visit and/or dollar limitations. The APA survey found reduced inpatient benefits were most likely to be associated with small employee groups and Blue Cross-Blue Shield plans. On the outpatient side, while 98 percent of the surveyed plans provided coverage for outpatient mental illness care, only 10 percent provided benefits on the same basis as other illnesses and 90 percent on a reduced benefit basis. The reduced level outpatient benefits are explained by:

- o 69 percent with a higher coinsurance;
- o 35 percent impose maximum changes per visit;
- o 29 percent impose visit limits.

The majority of plans provided coverage at a 50 percent coinsurance rate; the most common "generous aggregate level of benefit coverage, greater than $1,500 at the 20 percent coinsurance rate, was generally distributed equally," except for Blue Cross Blue Shield plans.[13]

The BLS studies found that the 94 percent covered for outpatient services: 20 percent have a limit on days or visits, 67 percent put a ceiling on dollars, and 53 percent impose major medical coinsurance limited to 50 percent.

C. Model Benefits

Model benefits for mental illness are more difficult to design than for alcoholism or drug abuse, because the latter illnesses have spawned more universal treatment regiments and protocols. The imprecise nature of mental illness, a key factor causing insurers not to cover its treatment, makes any model package elusive. Writers and researchers tend to propose descriptive models, rather than precise packages.

The National Institute of Mental Health contracted with GLS Associates, Inc., to develop model benefit packages as part of a comprehensive analysis of laws that mandate benefits. The GLS report describes three model benefit packages.[14] Because the first, the "ideal" package of nondiscriminatory coverage (i.e., the same as for other illness), is not viewed as viable, it also offers two alternatives.

Alternative one places emphasis on outpatient coverage, restricting coverage of inpatient care to a set number of days, e.g., 30 days. Extended coverage would be provided for services rendered in both private offices and organized settings of care. Diagnoses to be covered under this plan would be generously defined, with limits placed on the number of psychotherapy visits to be covered per year. Those providers considered reimbursable would be the same as in the ideal benefit package, i.e., physicians and licensed psychologists in private offices, all certified/licensed providers in organized settings of care. Copayments and deductibles would be imposed at customary limits, e.g., 50 percent copayments; ceilings would be imposed upon

determination of reasonable c( ).[15]

The advantages of this model cited in the report increased delivery sites/providers, utilization of outpatient rather than more costly inpatient treatment, and emphasis of the community mental health model. Disadvantages may include lack of coordination of a spectrum of mental health services, and lack of quality control and/or utilization review.

Alternative two, viewed by GLS as having support from providers and insurers, emphasizes inpatient care and catastrophic coverage. Details of this plan include "generous coverage on inpatient days, e.g., 60 days, with outpatient coverage limited to (1) services rendered in organized settings of care, and (2) services rendered in the private offices of psychiatrists or licensed psychologists when referred by a physician. Treatment for disabilities to be reimbursed under this plan would be limited to diagnoses listed in the ICDA code that are amenable to short-term treatment. The providers to be reimbursed in organized settings would be the same as in the other suggested plans, but would be restricted in office settings to physicians or psychologists via referral from other physicians. All providers would be subject to quality of care review by a multi-disciplinary team. Copayments and deductibles would be kept to a minimum level, e.g., 80/20 percent copayments, due to the presence of utilization and cost review mechanisms."[16]

D. Costs and Utilization

Both proponents of nondiscriminatory coverage of mental illness and of mandated benefits provide economic arguments supporting their views. Insurers generally agree that claims for mental illness are about 5 percent, of what total claims which is less than expected with the prevalence of mental illness.[17] The GLS study summarizes national utilization patterns under group contracts:

- o There are between 3 and 8 inpatient psychiatric admissions per 1,000 covered persons per year.
- o The average length of stay for a psychiatric inpatient admission is between 10 and 22 days.
- o There are between 30 and 90 inpatient days per 1,000 covered persons per year.
- o There are between 4 and 20 persons per 1,000 eligibles utilizing outpatient services per year.[18]

These numbers are a reflection of availability of services and the stigma still attached to mental illness. The utilization of benefits cannot occur absent the benefit or under limitations.

Blue Cross and Blue Shield of Massachusetts studied the impact of that state's statute and found a sharp increase in payments for outpatient mental health claims in 1976, when the mandate was implemented. During the period 1977 through 1982, payments generally peaked in the second quarter, indicating greater utilization prior to meeting the maximum benefit allowance. Psychotherapy services accounted for the major category of payments (about 75%) for group and non-group plans.

The number of psychiatrists reimbursed under Blue Cross/Blue Shield plans has also grown steadily from 1974-1983. In addition, the number of psychologists and social workers practicing in the state has increased even more dramatically due to inclusion of their services under the mandate, so that by 1983, psychologists and social workers providing services under Blue Cross Blue Shield plans in Massachusetts outnumbered psychiatrists.[19]

The Center for Health Policy Studies reports the following primary findings regarding 1984 mandated benefit costs for Maryland Blue Cross and Blue Shield:

- o Mandated benefits per member month cost \$5.35, or 11.2 percent of total benefit costs of \$47.96 (for a statistically typical family contract of 3.3 persons annual mandated benefit cost is \$212 out of total benefit cost of \$1,899).
- o Mandated mental and alcohol rehabilitation benefits are \$4.12 per member month, or 8.6 percent of total benefit costs.
- o Mandated outpatient mental benefits are \$2.09 per member month, or 4.4 percent of total benefit costs and 27.2 percent

·of total major medical benefit cost.

- The major components of mandated benefit costs are outpatient mental, inpatient mental, podiatrist and psychologist services.[20]

Blue Cross-Blue Shield, in testimony :fore the Maine legislature, said premium ›r mandated mental illness coverage in- eased by $5/month. to the average family ›ntract in Kansas, $2 to $3/month in Mary- nd, and $6/month in Massachusetts.[21]

Offset costs discussed in the intro- ıction are an important component to consider hen discussing the costs and utilization of ental illness benefits as are related costs, so discussed earlier. The National Institute Occupational Safety and Health cites a onservative" estimate of the costs of ecutive stress at more than $19 billion; en its "ultraconservative" figure is more an $11 billion.[22]

In a future book on occupational stress, e corporate view of the need for a continuum mental health care offers the following ottom line": "The designing of health nefits is the most critical component of rporate mental health policy. It is through availability of these benefits that rkers and their families gain access mental health services in the community."[23]

Current Status of State Laws Mandating vate Health Insurance Benefits for Mental alth Services

Of the twenty-six states regulating ntal health benefits in private health urance policies, fourteen have "mandatory erage" statutes, which require insurers pay for mental health care in certain es of insurance policies. "Mandatory erage" laws exist in Arkansas, Colorado, nnecticut, Maryland, Maine, Massachusetts, nnesota, Montana, New Hampshire, North kota, Ohio, Oregon, Virginia, and Wis- sin. The remaining thirteen states (Cali- nia, Florida, Georgia, Illinois, Kansas, isiana, Massachusetts, Missouri, New York, nessee, Vermont, Washington, and West ginia) require only that insurance policies er" such coverage at the policyholder's option. Connecticut, Maryland, and Virginia, have laws with both mandatory and optional provisions.

Of the fourteen states with "mandatory" laws, Arkansas, Connecticut, Maryland, Massachusetts, and Virginia make the "mandatory coverage" applicable to individual as well as group contracts. The other nine laws affect group policies only.

Provisions in "mandatory coverage" laws pertaining to treatment setting are quite significant because this is an area where insurers typically have provided less coverage of mental illness, especially for outpatient care. Of the fourteen laws with mandatory coverage, the majority require treatment benefits for mental disorders be provided in both inpatient and outpatient settings.

Three states (Arkansas, Ohio, Tennessee) mandate coverage only for outpatient care. With regard to inpatient care, most states with mandatory benefits statutes require a minimum of 30 days in a general hospital or another approved facility such as a public-private mental hospital or community mental health center. Four states (Maryland, Montana, Virginia and Wisconsin) require at least 30 days of full hospitalization, while others such as Maine and Massachusetts require a minimum 60 days, and North Dakota, 70 days. Ohio's statute does not specify any inpatient benefit limits, while four states (New Hampshire, Minnesota, Georgia and Louisiana) mandate that mental health coverage be on a par (of equivalent value) with coverage for physical illness generally.

Partial hospitalization benefits are included under the provisions of 10 state statutes. In general, the number of days covered is usually twice the number of inpatient days allowed. Some states, such as Connecticut, have an exchange provision: if a partial hospitalization session costs less than 50 percent of one patient visit, then two sessions of partial hospitalization may be exchanged for one inpatient day; if the cost is greater than 50 percent, then one session of partial hospitalization may be exchanged for one inpatient day. North Dakota and Colorado have similar exchange provisions. Partial hospitalization is only

available as an option in Maryland, and partial hospitalization is included under outpatient benefits in Wisconsin.

Benefits for outpatient care also vary significantly from state to state. Fearing excessive costs associated with coverage for outpatient psychiatric care, most states have included specific limitations on such coverage, resulting in benefits that are far below those provided for physical illness. Thirteen states place a maximum dollar limit on outpatient benefits. For example, the Massachusetts law sets a maximum benefit at $500 per year, while in New York it is $700 per year. In 1985, Wisconsin increased its $500 to $1000 per year minus a copayment of up to ten percent. Other state laws mandate coverage for reasonable charges with copayments of up to 50 percent (Montana, Colorado) and a maximum dollar limit of not less than $1000 per benefit period. Maryland's law mandates copayments of up to 50 percent of the benefits provided for other types of illnesses.

Meanwhile, coverage in New Hampshire (for major medical policies only) must contain deductibles and copayments on a par with those for other illnesses, with limits of not less than $3,000 per person in any consecutive 12-month period, up to a lifetime maximum of $10,000. Oregon's new statute provides an overall benefit that applies to both inpatient and outpatient mental health care of up to $9,000 in any consecutive 24-month period, with different benefit limits for other services such as chemical dependency.

In terms of provider eligibility, more states across the nation have passed laws defining the terms for mental health provider reimbursement than have approved mandatory mental health benefits[24]. A total of forty states have enacted laws defining under what circumstances, certain health providers (e.g., physician, psychiatrist, psychologist, clinical social worker, psychiatric nurse) are eligible for payment for services provided within the scope of their license, training and experience. Of the twenty-six states mandating mental health benefits, twenty-four have such reimbursement provisions. Wisconsin and North Dakota do not have this type of statute. The majority of states limit private practice coverage to licensed or certified physicians, psychiatrists, and/or psychologists. All of the states include physicians and psychiatrists, while all but two with mandated benefit laws include reimbursement provisions for psychologists.

Furthermore, non-discrimination in reimbursement has also been extended to a variety of other mental health professionals. For example, eleven states reimburse certified clinical social workers, while Maine covers licensed/accredited psychiatric nurses, and Massachusetts and West Virginia include licensed psychotherapists. New Hampshire's law includes payment for licensed pastoral counselors, and Oregon extends payment to nurse practitioners.[25]

IV. PRIVATE HEALTH INSURANCE BENEFITS FOR ALCOHOLISM AND DRUG ABUSE TREATMENT

A. Overview

Alcoholism is a widespread disease affecting millions of Americans. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), roughly two-thirds of the adult population uses alcohol, with just one-third of that group accounting for 95 percent of consumption. More than 10 million Americans are serious problem drinkers or full-blown alcoholics and three million children, 13 to 17 years old, have significant alcohol-related problems. An additional 30 to 40 million people are affected because of a family relationship with an alcoholic or others injured by alcoholics.[26] Finally, estimates suggest that each year some 2,400 babies born in the U.S. suffer from the fetal alcohol syndrome (FAS), a condition now clearly associated with maternal drinking during pregnancy. FAS is characterized by a variety of severe physical abnormalities and is a significant cause of mental retardation. Maternal alcohol consumption affects an additional 36,000 pregnancies annually, though to a degree less devastating than the fully-developed fetal alcohol syndrome.[27]

Drug abuse is also costly to both health care and business. Data from the National

APR 25 1986

Alaska State Legislature

CO-CHAIRMAN
FINANCE COMMITTEE

907-465-3740

JAN FAIKS
POUCH V
CAPITOL BUILDING
JUNEAU, ALASKA 99811

Senate

April 24, 1986

MEMORANDUM

TO: Senator Fahrenkamp
Senate Health, Education, and Social Services Committee

FROM: Senator Jan Faiks

SUBJECT: Committee Hearings on Senate Bill 295

I would appreciate your scheduling hearings before your committee on Senate Bill 295, an Act requiring insurers to offer coverage for the treatment of a mental or nervous condition in certain health insurance policies.

I am enclosing two memos and several publications which give background information on this bill. Should you or the committee members need additional information, please let me know.

Thank you.

OUT OF SESSION
1024 WEST SIXTH AVENUE, SUITE 302 ANCHORAGE, ALASKA 99501 907-274-6611

Alaska State Legislature

BETTYE FAHRENKAMP, Chairman
ARLISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
PAUL FISCHER
EDNA ARMSTRONG-DE VRIES

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Senate Committee on Health, Education and Social Services

M E M O R A N D U M

TO: Members, Senate Committee on Health, Education and Social Services

FROM: Committee Staff

RE: Committee Meeting, April 29, 1986

DATE: April 28, 1986

On Tuesday, April 29, 1986 from 1:30-3:30 p.m. in the Beltz Room, the Senate Committee on Health, Education and Social Services will hear the following bills:

SB 295 Requiring insurers to offer coverage for the treatment of a mental or nervous condition in certain health insurance policies.

CSSB 295 (L&C) will require insurers to offer their customers the opportunity to purchase mental health coverage on all health insurance policies sold in Alaska. The bill establishes a minimum level of coverage which must be offered and requires that the deductible for mental health coverage be no higher than that for other medical coverage. Eligible treatment is limited to 1) that provided in a hospital licensed by the state or specifically exempt from licensure, or 2) provided in an outpatient setting by a licensed psychiatrist or psychologist, or under the supervision of a psychiatrist or psychologist. A definition of "mental or nervous condition" is provided.

SB 295 is intended to enhance the accessibility and affordability of mental health services in the state. Legislation (HB 313) is under consideration by the House Labor and Commerce Committee that would require that all health insurance policies include mental health benefits.

CSHB 255 (HESS) Authorizing the Department of Health and Social Services to enter into agreements concerning the care and custody of Native children.

Under the federal Indian Child Welfare Act (ICWA), the state is authorized to enter into agreements with "Indian tribes," which is defined in ICWA to include "Alaska Native villages." (As background, it should be noted that ICWA is one of the few federal statutes which authorizes Native entities to exercise tribal powers whether or not they exist on reservations). According to the Department of Health and Social Services, HB 255 does not add to the Department's authority as it exists under federal law, and the Department is in fact currently involved in agreements with Native organizations.

The House Letter of Intent clarifies that the bill would not empower the Department to recognize the jurisdiction of tribal courts whose authority has not been established by the legislature.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ______

REQUEST
Bill/Resolution No.: SB 295
Title: An Act Requiring Insurers to offer coverage for the treatment of ...
Sponsor: Faiks
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: All State Agencies
BRU: Retirement and Benefits

Components: Retirement and Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
RTMNT & BNFTS						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
TRS MATCH						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:	-0-	-0-	-0-	-0-	-0-	-0-
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared By: J.K. Humphreys, Director
Phone: 465-4470
Division: Retirement & Benefits
Date: 2/21/86

Approved by Commissioner: Eleanor Andrews
Date: 3/4/86
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 295
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration
February 21, 1986

Analysis:

Passage of this bill would require insurers to offer an option to receive certain minimum coverage for treatment of a mental or nervous condition.

It is our understanding that an employer, as policy holder of a group plan, could elect this option for covered employees. Employees in a group plan could not make this election on an individual basis.

The State of Alaska now provides mental health coverage for all eligible employees. The level of this coverage is somewhat less than that provided for in the bill in an effort of cost containment in the Plan. Health insurance benefits are determined at the bargaining table. This bill would not affect our present level of coverage or cost.

Should the higher level of coverage described in the bill be incorporated into the state's health plans, FY 87 costs to the state are estimated to increase by $1,522,024.

This cost is calculated as follows:

The increase of $2.65 per month health cost times the number of state employees (13,200) times 12 months equals	$419,760
The change in the PERS employer contribution rate (.12%) times the estimated FY 87 state PERS salaries ($590,176,728) equals	$708,212
The change in the TRS employer contribution rate (.075%) times the estimated FY 87 state TRS salaries ($68,569,578) equals	$ 51,427
The changes in the TRS state match contribution rate (.075%) times the estimated FY 87 TRS system salaries ($456,833,417) equals	$342,625
Total	$1,522,024

COMMITTEE REPORT

SENATE

FURTHER:

4/24/86

Date 5-1-86

Mr. President

The Committee on HESS considered SB 295

requiring insurers to offer coverage for the treatment of a mental or nervous condition in certain health insurance policies.

and (a majority of the committee) (the committee) reports it back with the following recommendations:

[X] do pass

[ ] do pass with attached amendment(s)

[X] replace with/or adopt CS for SB 295
[X] new title
[ ] same title and recommends

[ ] and attached a "LETTER OF INTENT" [ ] NEW FISCAL NOTE

[ ] reports it back without recommendation

[ ] recommends referral to ______ Committee

MEMBERS SIGNING DO PASS

[signature]
[signature]
[signature]

MEMBERS HAVING OTHER RECOMMENDATIONS

[signature] Do Pass
Chairman

Chairman recommendation

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST	FISCAL DETAIL
Bill/Resolution No.: SB 295	Agency Affected: Commerce & Econ. Dev.
Title: Treatment of a mental or nervous condition in certain policies	Program Category Affected: Consumer Protection
Sponsor: Faiks	BRU, Program or Subprogram(s) Affected:
Requestor:	Insurance
Date of Request:	

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
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	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared By: John George, Director Phone: 465-2515
Division: Insurance Date: 4/25/85

Approved by Commissioner: /r Loren H. Lounsbury Date: 4/26/85
Agency: Commerce and Economic Development

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

7/1/84

2227WA42585a

'Mental 1'
'YT'

April 24, 1986

MEMORANDUM

TO: Senator Fahrenkamp, Chairman
Senate Health, Education, and Social Services Committee

FROM: Senator Jan Faiks

SUBJECT: Background on Senate Bill 295

This bill will require insurers to offer their customers the opportunity to purchase minimum mental health coverage in all health insurance policies sold in Alaska.

Currently, twelve states have passed similar laws which require that policy holders be given the opportunity to purchase mental health insurance. Fourteen other states take a stronger position; they do not give the policy holders an option, but rather require that minimum mental health coverage be included in every health insurance policy.

This bill adopts the "mandatory option" approach because it allows subscribers to decide whether the benefits of mental health coverage are worth the added premium costs, and it preserves this option for the collective bargaining process.

Most states that require mental health coverage also define the minimum coverage that must be offered. Senate Bill 295 requires a minimum of 45 days of inpatient treatment and 50 equivalent hours of outpatient treatment per year.

These requirements are consistent with the requirements of other states. For inpatient services, four states require a minimum of 30 days, while two other states require 45 days. For outpatient services, minimum requirements are expressed in either visits (one other state calls for thirty per year) or dollar limits (six state have minimums ranging from $500 to $1000 per year). The remaining states require only that mental health benefits be on par with those offered for other illnesses.

When mental health coverage is offered, usually the benefits are much less than those available for other treatment. Insurers will often require that their customers pay a higher deductible or a greater portion of the cost of mental health services.

In a 1980 survey of health insurance plans in Alaska, 87% offered inpatient coverage and 74% offered outpatient coverage for mental illness. If these plans follow a national pattern which was identified in a 1983 study, only half of our plans will offer inpatient and less than 10% will offer outpatient benefits that are equal to coverage that is offered for other illnesses.

In order that mental health coverage be given parity with other coverages, then, this bill requires that the former be offered under the same terms as the latter.

There are several myths that have impeded the requiring of mental health coverage in health insurance policies. According to one belief, the costs of psychiatric treatment are unpredictable and uncontrollable.

This belief stems in part from the common perception of mental illness in terms of only its more serious forms, like schizophrenia. However, only 15% of persons who are treated in private mental hospitals suffer from this acute disease. For most forms of mental illness, only one hospital stay with several follow-up visits are all that is needed for successful treatment.

From seven to ten percent of subscribers use mental health benefits when these are available in their policies. This is approximately the same rate that subscribers use extra care from other medical specialists.

There is no evidence that mental health benefits are abused at a rate that differs from other health benefits. If insurers are concerned about accountability, they can subscribe to peer review services that will review the validity of individual claims. These services have shown a costs-to-savings ratio of 1:100.

It is true that mental health coverage will mean higher premium cost to subscribers. However, this cost is not substantial. A national survey of 79 major corporate plans revealed that the average annual premium increase for each subscriber was $29.47.

On the other hand, psychotherapy produces savings in the form of increased employee productivity and reduced absenteeism. The Equitable Life Assurance Society has verified that every dollar invested in mental health treatment results in a three dollar increase in productivity.

Medical science has long recognized the correlation between physical disease and mental health. Many dollars that are now paid for other medical services are actually paid for the indirect treatment of mental impairments. In addition, studies have proven that direct treatment of mental problems results in lower costs for other medical care.

In a 1983 study, a moderate amount of psychotherapy was shown to significantly reduce hospital costs for persons suffering from four different types of chronic disease. Another study that same year showed that patients who received outpatient psychotherapy treatment used 56% fewer medical services than those who had not been treated.

Finally, there is a cost savings that will be enjoyed by the State of Alaska. Nationwide, the state governments pay about 50% of the total cost of our mental health bill. When subscribers are given access to mental health coverage on the same basis as other medical benefits, more of this burden will be shifted from the State to the private sector.

Thank you.

NOTE: Documents referenced herein are available from committee staff.

'Zhar'

April 24, 1986

MEMORANDUM

TO: Senator Fahrenkamp, Chairman
Senate Health, Education, and Social Services Committee

FROM: Senator Jan Faiks

SUBJECT: Additional Background Materials on SB 295

In order to assist your committee with its deliberations on Senate Bill 295, I am enclosing two publications. One is a special feature article of "State Health Reports on Mental Health, Alcoholism, and Drug Abuse" and the other is a booklet entitled Mental Health Services: The Case for Insurance Coverage.

I know that your Committee has many important issues before it, and that your members may have difficulty finding time to review these materials. Therefore, I would like to offer the following brief summary of them. My comments deal with the issues which I believe are most important when considering this bill.

1. Prevalence of Mental Illness in Our Society

About one-fifth of our population suffers some degree of mental imparity, ranging from mild anxiety to chronic schizophrenia. For our young people, aged thirteen to twenty four, the leading cause of death is not injury, disease, or accident, but is suicide.

In the year of 1984, mental illness is estimated to have cost our society 67.6 billion dollars. This figure includes not only the direct cost of treating mental illness ($12 billion), but also the greater cost of lost

productivity and employment ($44.6 billion) and of mental health related crimes, vehicle accidents, and other social burdens ($11 billion).

Physicians have estimated that up to one-half of all ailments which they treat have symptoms of mental or emotional disorder.

2. Effectiveness of Mental Health Treatment

Studies show that treatment is effective for 80% of all patients who have mental disorders.

3. Control of Overuse and Misuse of Mental Health Benefits

Studies show that mental health benefits are not used any more than are other medical benefits. In one plan which required no deductible or co-payment by the patient, about 9% of the persons who had this coverage used it.

Where there is fear of abuse, this can be controlled through rigorous utilization management and peer review of the health providers.

4. Social Benefits of Mental Health Care

When mental health treatment becomes more affordable and available to employees, employers report a significant increase in job attendance and productivity and a significant reduction in on-the-job accidents.

Mental health treatment also reduces drug and alcohol-related crime.

3. Cost Savings through Reduced Utilization of Other Health Coverage

Researchers studied thirteen health plans to determine the effect of mental health coverage on the utilization of other medical benefits. Because of the many variable factors - the types of plans, the populations covered, etc. - the results varied widely.

In twelve of the thirteen, however, the availability of mental health coverage caused a reduction in use of other health treatment. This ranged between 5% and 80%, with a median reduction of 20%.

Apparently, the health insurers do not identify this reduction in terms of dollars saved. It is clear, however, that there are fewer claims filed for general medical treatment when subscribers have mental health coverage. According to Montana authorities, after the passage of a 1983 law that mandated mental health coverage in all policies, most insurers did not even need to adjust their premium rates.

5. Saving Public Funds by Shifting Costs to Third-party Payers.

Currently, public funds pay a proportionately higher burden of mental health treatment costs than do insurance plans.

Public funds pay more, by a factor of 10%, for mental health costs than they do for other health care (52% of total MH treatment v. 42% of treatment costs for other health care). Insurers pay less, by a factor of 10%, for mental health care than they do for other illness treatment (12%-15% of total MH treatment cost v. 25% of total costs for all other care).

By increasing the availability of mental health coverage, treatment costs will be shifted from the public sector to the private one. The lesson in New Hampshire illustrates this point. This state mandated MH coverage in 1977. By 1980, the private fees collected by state mental health facilities had risen by 100%.

I have asked our Division of Mental Health to provide me with information concerning how the bill will impact the state's funding of the Alaska Psychiatric Institute and the community mental health centers.

For the centers, SB 295 may indirectly reduce their dependency on state funds. These facilities receive matching grants from the state and charge their patients a sliding fee based upon their ability to pay. After the grant is matched, all additional fees are devoted to enhance the programs and expand their facilities.

Division personnel say that because of a lack of dollars, these centers can provide only 25-30% of the communities' mental health needs. They predict that the passage of a mental health insurance bill will allow them to serve up to one-half of this need.

6. <u>Discrimination against Mental Health Benefits</u>

The main purpose of SB 295 is to outlaw discrimination between mental health and other medical insurance benefits.

I have conducted an informal survey of the five major health insurers in the state. What I discovered is that the co-payment required of patients for outpatient mental health services is uniformly higher than that required for treatment of other conditions - 50% for mental conditions versus 20% for other illnesses.

In most cases, the insurers place a low total cap on the amount of benefits which can be paid. For example, Aetna places a $1000 cap on payments for outpatient services.

Unfortunately, this is characteristic of health insurance plans across the nation. A recent study reveals that only 51% of these plans give inpatient mental health coverage parity with other inpatient coverage. For outpatient coverage, only 10% of the plans show parity.

In today's world, one must accept the fact that mental impairments are prevalent in our society and that they are as real, as identifiable, and as treatable as are any other illnesses. If one accepts the proof that, with institutional internal monitoring of claims and services, mental health coverage is no more misused or abused than is other coverage, then this discrimination is not justified.

Discrimination makes mental health treatment less affordable and less accessible, and for this, we all pay.

Thank you.

Blue Cross
of Washington and Alaska

/ SB 295

MAR 12 1986

sp. Martin

3111 C Street, Suite 100
P.O. Box 10-2480
Anchorage, Alaska 99510-2480
(907) 561-5065

March 11, 1986

The Honorable Senator Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, AK 99811

Dear Senator Fahrenkamp:

I am writing and asking your support for SB 295, a bill requiring writers of disability insurance to offer benefits for nervous and mental conditions as a part of any health care coverage package.

SB 295 will keep the decisions as to the coverage needs in the hands of those that pay for the coverage and those that will use it. It is important to recognize there is a difference between the mandated offering and the mandated benefit. The offering is a requirement that we, as a carrier, must offer certain levels of a specific benefit to a purchaser of our product. The mandated benefit will require a group to purchase a product regardless of need or the ability to pay. Mandated benefits inclusion in any health care contract may well reduce the capacity of a group to purchase even basic segments of a health care program.

So, I ask that you give consideration to SB 295 in that it does provide for a mandated offering of benefits for nervous and mental conditions to purchasers of health care coverage in the State of Alaska.

Sincerely,

Martin

Martin E. Tirador,
Senior Representative
Corporate Relations

SB 295 INSURANCE COVERAGE FOR MENTAL HEALTH. (FAIKS)

MOVE THE H.E.S.S. COMMITTEE SUBSTITUTE WITH A TITLE CHANGE.

1. REQUIRES INSURERS TO OFFER THEIR CUSTOMERS THE OPPORTUNITY TO PURCHASE MENTAL HEALTH COVERAGE ON ALL HEALTH INSURANCE POLICIES SOLD IN ALASKA; ESTABLISHES A MINIMUM LEVEL OF COVERAGE WHICH MUST BE OFFERED.

2. IF THE INSURED DECLINES THE OFFERING, THE INSURER MAY OFFER OTHER MENTAL HEALTH COVERAGE. (i.e. THAT PROVIDED BY BLUE CROSS AS PART OF THEIR GENERAL MEDICAL POLICY)

3. THE MANDATORY OFFERING WOULD COVER:

OUTPATIENT VISITS (LICENSED HOSPITAL IN ALASKA OR OUTSIDE, COMMUNITY MENTAL HEALTH CENTER)

INPATIENT VISITS (LICENSED HOSPITAL IN ALASKA)

OFFICE VISITS (LICENSED PSYCHIATRIST, PSYCHOLOGIST, PSYCH. ASSOC , OR A NURSE OR SOCIAL WORKER SUPERVISED BY A PSYCHIATRIST OF PSYCHOLOGIST).

SEE ATTACHED FOR ACTUAL CHANGES MADE IN H.E.S.S. CS.

DIDN'T

SOMEONE (FAIKS?) MAY PROPOSE AN AMENDMENT FOR J.P. TANGEN THAT WOULD DEFINE "INSURER" (SEE ATTACHED).

J.P. Tangen
SB 295

Offered: 4/23/86
Referred: Finance

Original sponsors: Sund, M.M.Miller,
Hurley, et al

1 IN THE HOUSE BY THE JUDICIARY COMMITTEE

2 CS FOR HOUSE BILL NO. 589 (Judiciary)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to disability insurance; and provid-
7 ing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 21 is amended by adding a new chapter to read:

10 CHAPTER 55. STATE DISABILITY INSURANCE.

11 ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

12 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a
13 nonprofit incorporated legal entity to be known as the Comprehensive
14 Disability Insurance Association. Membership consists of all licensed
15 hospital or medical service corporations in the state that offer
16 subscriber contracts for major medical coverage and all insurers
17 licensed to transact disability insurance in the state that offer
18 policies for major medical coverage on an expense incurred basis. All
19 members shall maintain membership in the association as a condition of
20 doing disability insurance business, or being able to offer subscriber
21 contracts, in the state.

22 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of
23 directors of the association shall be made up of seven individuals
24 selected by participating members, subject to approval by the director
25 of the division of insurance. The director or the director's designee
26 shall serve as a nonvoting ex officio member of the board. In deter-
27 mining voting rights at members' meetings, a member is entitled to
28 vote in person or proxy. The vote shall be a weighted vote based upon
29 the member's premiums for disability insurance for major medical

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May, 1986

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS date base CM 14. In order to save space copies of minutes have not been left in the files.

Jeanie Henry

Senate Health Education & Social Services Committee 4/29/86, 1:43pm
" " " " " " " 5/1/86, 2:10pm

Mental Health Services:
The Case for Insurance Coverage

Samuel A. Mitchell

Charter North Hospital
2530 DeBarr Road
P.O. Box 143929
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Second Printing January 1986

Mental Health Services:
The Case for Insurance Coverage

by Samuel A. Mitchell
Director of Research
Federation of American Hospitals

Samuel A. Mitchell is Director of Research for the Federation of American Hospitals. Mr. Mitchell earned his BA from Harvard and his MBA from Harvard Business School. He was an analyst with Smith Barney, Harris Upham and has directed research activities at the Pharmaceutical Manufacturers Association and the Health Industry Manufacturers Association.

Acknowledgements

The purpose of this booklet is to present, in layman's language, some highlights of what is known about mental illness and mental health services.

In preparing it, I benefitted greatly from the generosity of several scholars.

Specifically, I would like to thank Emily Mumford, Ph.D., of the New York State Psychiatric Institute; Thomas G. McGuire, Ph.D., of Boston University; Morris B. Parloff, Ph.D., of Bethesda, Maryland; Paul Widem of the National Institute of Mental Health; and Brian T. Yates, Ph.D., of American University. I am also grateful to the members of the Psychiatric Committee of the Federation of American Hospitals (see page 47) for their guidance and support. I greatly appreciate their taking the time to give me their comments and suggestions. Thomas G. Goodwin assisted with the editing and format; the booklet design and typography are the work of Raymond Branton, Jr., and Ruth E. Smith did the typing and organized the exhibits.

All errors and omissions of analysis and fact are, of course, mine alone.

S.A.M.

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1

Executive Summary

Unlike many other health services, mental health care has been studied extensively. In general, it has been found to be not only safe but also effective. Few question the need for intensive care of people with acute or chronic medical problems — even if the prospects for improvement are dim.

Yet, because the evidence of the effects of intervention is not widely recognized, the ability of mental health service providers to generate improvements is sometimes suspect. There also seems to be lack of recognition of the burden to society of alcoholism, drug abuse, and mental illness. In some quarters, in fact, there remains an unwillingness to acknowledge the reality of these disorders.

Review of the existing scientific literature reveals a reality very much at odds with prevailing myths.

Myth #1:

The problems of behavior-related illnesses are not serious.

Reality

- At any given time, about 29 million Americans (19% of the population over age 18) suffer from psychiatric disorders.
- Suicide is the leading cause of death for people age 13 to 24.
- The estimated total economic cost to society of alcohol

and drug abuse and mental illness in 1984 alone was $237.6 billion.

The public tends to underestimate the costs of mental illness because direct treatment costs are low (only 18.6% of the total). The remaining costs are indirect, e.g., reduced productivity, lost employment, costs of crime, etc.

The potential payoff from more mental health care is large. Increasing such services should, of course, result in higher direct expenditures, but these costs will be more than offset by the disproportionate reduction in indirect costs as well as in the costs of other kinds of medical care.

Myth #2:

Mental health services have not generally been shown to be effective.

Reality

There have been literally hundreds of studies into the efficacy of a wide variety of psychiatric services, and several in-depth reviews of the literature. Scholars consistently have found that:

- patients receiving mental health care show significant improvement in mood, personality, and behavior.
- in experimental studies, the average therapy recipient tends to be better off than 80% of those who do not receive treatment. There also have been numerous studies comparing different types of treatment to determine which produce the desired outcome at least cost. Alternatives to traditional inpatient settings, such as partial hospitalization combined with outpatient care, are cost-effective alternatives to inpatient care for *some* patients. To be effective, however, community-based programs must include intensive institutional support. There is unanimity among mental health professionals that for a significant percentage of patients, outpatient care can never replace inpatient care.

Myth #3:

The costs of mental health care usually exceed the benefits.

Reality

The mental health cost-benefit literature is still in an early stage of development. As such, findings to date are necessarily tentative. Because of the difficulties in defining costs and benefits and in measuring them, no methodology will be immune from criticism.

Nonetheless, the cumulative weight of evidence that the benefits of mental health services exceed the costs is sufficiently impressive to shift the burden of proof to skeptics. Specifically:

- the major studies of substance abuse programs uniformly show a benefit to cost ratio greater than one;
- in experimental studies, people receiving psychotherapy show a significant reduction in the use of other medical services;
- according to an analysis of Blue Cross/Blue Shield claims files, total charges increased at a slower rate for beneficiaries receiving outpatient psychotherapy than for a comparable group with no outpatient visits. Furthermore, inpatient medical/surgical charges for people 55 and over with at least seven outpatient psychotherapy visits were actually less than charges for the comparison group.
- in hospital settings, surgical or medical patients provided with modest, psychologically informed support had shorter stays and recovered more comfortably from surgery than those who did not receive such care.

Myth #4:

Mental health services are substantially overused and misused.

Reality

- The proportion of people with a particular mental affliction who are treated is as follows: schizophrenia, 53%; alcohol and drug abuse, 18%; depression, 32%; and anxiety, 23%.
- According to the comprehensive Rand Health Insurance Study, people with the greatest need spend over three times as much per year for mental health services as people in good mental health. They are more likely to receive care and their care is more intensive.

Summary

In sum, psychiatric disorders are a major social and financial problem; mental health care works; the initial evidence is that benefits are greater than costs; and rather than overuse and misuse of mental health services in our society, there is underuse.

Indeed, were insurers to base coverage decisions on the unmet need for a service, its therapeutic effectiveness, and its ability to deter use of other medical expenditures, mental health services should be near the top of the list.

2

Insurer Concerns

Major private sector employers have long accepted the need to provide some health insurance coverage for mental illness. According to a 1983 survey by the American Psychiatric Association of 300 plans covering 33 million workers and dependents, all of the plans provided inpatient coverage for mental illness. Virtually all (98%) also provided coverage for outpatient treatment for mental illness.[1]

Only 51% of the 300 plans surveyed, however, provided inpatient coverage for mental illness on the same basis as for any other illness. And, only 10% of the plans provided outpatient mental health coverage on the same terms as for outpatient coverage of other medical conditions.

Paralleling the rise in coverage for mental health benefits has been a rising concern among some employers and insurers about the value of mental health services relative to the dollars spent. Third-party payers have questioned whether generous coverage of mental health benefits is worth the extra premium cost. Many insured workers also have doubts that the risk of alcoholism, drug abuse, and mental illness is high enough or serious enough in either medical or economic terms to warrant the cost of obtaining protection.

Insurers are taking more of a "show me" attitude toward such issues as the effectiveness of psychotherapy; the relative cost of different treatment settings in obtaining a desired outcome; and the benefits of psychiatric care relative to cost.

Finally, insurers are concerned that there is vast misuse

---

1. S. Muszynsky, J. Brady, S. Sharfstein, *Coverage for Mental and Nervous Disorders: Summaries of 300 Private Sector Health Plans*, (Washington, D.C., American Psychiatric Press, Inc. 1983).

and overuse of mental health services by those who are psychiatrically oriented but who do not really need treatment in order to remain productive members of society.

This report presents an overview of data and analysis pertinent to these issues.

3

Prevalence and Cost of Mental Illness

According to a major study sponsored by the National Institute of Mental Health (NIMH), at any given time about 29 million Americans — 19% of the population over age 18 — suffer from psychiatric disorders. These disorders range from anxiety to schizophrenia. Anxiety disorders such as phobias, panic disorders, and obsessive-compulsive behavior afflict 13.1 million Americans; alcohol and drug abuse, 10.1 million; depression, 9.4 million; and schizophrenia, 1.5 million (Exhibit 1).

Treatment rates are low. According to this NIMH survey of 10,000 people, slightly over half of those with schizophrenia are treated; and only about 1 in 5 of those suffering from substance abuse or anxiety receive treatment (Exhibit 1). Mood disorders such as major depression and manic depression affect 6 percent of the population over 18, but only about a third of these seek care (Exhibit 1).

Mental disorders are about twice as prevalent among the under-45 population. Alcohol and drug abuse drop sharply after age 44. Antisocial behavior also seems to be primarily a problem of the young.

The NIMH survey criteria for establishing diagnoses were derived from the American Psychiatric Association's latest diagnostic and statistical manual of mental disorders. The criteria were translated into a detailed questionnaire that could be conducted by a lay interviewer.

★ ★ ★ ★

Mental illness is extremely costly to society. The estimated total economic cost to society of alcohol abuse, drug abuse, and

mental illness (ADM) in 1984[2] was $237.6 billion (Exhibit 2). Alcohol abuse accounted for 47 percent of the total ($111.5 billion); drug abuse, 25 percent ($58.5 billion); and mental illness, 28 percent ($67.6 billion).

Direct treatment costs are a relatively small portion of the total — slightly more than 18%. Indirect costs, e.g., reduced productivity and lost employment resulting from premature death and avoidable illness, account for the majority of economic costs to society of these afflictions (66%). Other related costs such as ADM-related crime and motor vehicle crashes comprise the remaining 16%.

EXHIBIT ONE
PREVALENCE OF MENTAL ILLNESS WITHIN A SIX-MONTH PERIOD

Disease	*Number Affected*	*% of U.S. Adults Affected*	*% Who Are Treated**
Anxiety	13.1 million	8.3%	23%
Alcohol and Drug Abuse	10.1 million	6.4%	18%
Depression	9.4 million	6.0%	32%
Schizophrenia	1.5 million	1.0%	53%

*highest rate of treatment

Source: National Institute of Mental Health

2. The estimated 1984 total economic cost of ADM was obtained by multiplying the percent change in the consumer price index (CPI-U) 1980 through 1984 by the 1980 estimates developed for ADAMHA (Alcohol, Drug Abuse, and Mental Health Administration) by the Research Triangle Institute.

Hospitals account for about 53% of the direct treatment costs by setting ($20.6 billion, Exhibit 3). Facilities established specifically to care for people suffering from alcoholism, drug abuse, and mental illness account for 37% of the total.

Since direct treatment costs are a small proportion of the total economic cost of ADM, the potential payoff from higher direct costs is high. An increase in direct costs resulting from wider application of treatments proven to be effective should result in a far greater associated reduction in the indirect cost of illness.

The key is to improve the rate at which those who need help seek it — a major problem since awareness of need in many cases may be inversely related to intensity of need.

Besides reducing unnecessary suffering, greater awareness among the public and employers of the surprisingly widespread prevalence of mental illness and the huge economic burden of ADM is in everyone's economic interest. Greater awareness of the magnitude of the problem should stimulate greater demand for coverage of treatment, provided it can be shown that ADM treatment works.

EXHIBIT TWO

COSTS TO SOCIETY OF ALCOHOL ABUSE, DRUG ABUSE, AND MENTAL ILLNESS, (ADM), 1984* ($ MILLION)

	Alcohol Abuse	*Drug Abuse*	*Mental Illness*	*Total*
Core Costs	$99,172	$36,689	$65,301	$201,161
Direct				
Treatment	11,819	1,495	26,113	39,425
Support	1,226	303	3,235	4,793
Indirect				
Mortality[a]	18,009	2,467	8,965	29,440
Morbidity[b]	68,118	32,425	26,988	127,532
Reduced Productivity	(63,005)[c]	(32,036)[c]	(3,889)[c]	(98,930)
Lost employment	(5,114)	(389)	(23,099)	(28,602)
Other Related Costs	12,357	21,782	2,265	36,404
Direct				
Motor vehicle crashes (Property loss)	2,722	[d]	—	2,722
Crime[b]	2,924	7,362	1,084	11,370
Public	(2,569)	(5,549)	(791)	(8,908)
Private	(325)	(1,676)	(293)	(2,293)
Property loss/damage	(30)	(138)	(—)	(168)
Social welfare program	47	2	250	300
Other	3,628	669	821	5,118
Indirect				
Victims of Crime	214	1,053	—	1,267
Crime careers	—	10,869	—	10,869
Incarceration	2,244	1,826	110	4,181
Motor vehicle crashes (time loss)	578	[d]	—	578
Total	$111,528 [c]	$58,471 [c]	$67,565 [c]	$237,565

Totals may not add due to rounding.

a. At 6 percent discount rate. As suggested by the PHS *Guidelines* document, the present value of lost future productivity due to premature mortality was also calculated using discount rates of 10 and 4 percent. The use of a 10 percent rate decreases indirect costs by the following amounts: alcohol abuse — $4,881 million; drug abuse — $704 million; and mental illness — $2,444 million. The use of a 4 percent rate increases indirect costs by the following amounts: alcohol abuse — $4,455 million; drug abuse — $638 million; and mental illness — $2,177 million.

b. Components are indicated in parentheses.

c. The total costs to society for each of the three ADM disorders are not comparable, since the completeness of data available for each cost category varied significantly. For example, the estimate of reduced productivity is relatively complete for alcohol abuse, only partially complete for drug abuse, and incomplete for mental illness.

d. Although costs are hypothesized to occur in this category, sufficient data are not available to develop a reliable estimate.

Source: Research Triangle Institute (RTI), "Economic Costs to Society of Alcohol and Drug Abuse: 1980," June, 1984, RTI/2734/00-01FR.

*The data developed by the Research Triangle Institute were for 1980. Estimates for 1984 ADM costs were obtained by increasing the RTI 1980 data by the percent increase in the CPI-U, 1980-84 (October to October).

EXHIBIT THREE
DIRECT ADM COSTS BY SETTING, 1984*
($ MILLION)

SETTINGS	ALCOHOL ABUSE	DRUG ABUSE	MENTAL ILLNESS	ALL ADM
ADM Facilities	$1,318	$563	$12,483	$14,365
Hospital-based	425	106	7,057	7,587
State and county psychiatric hospitals	270	67	4,491	4,829
Private psychiatric hospitals	54	14	888	956
VA neuropsychiatric hospitals	41	10	676	728
Non-Federal general hospitals with separate psychiatric units	60	15	1,002	1,076
Other ADM facilities and services	893	457	5,428	6,777
Federally funded	275	62	1,242	1,530
Residential treatment centers for children	0	0	603	603
Freestanding facilities	472	330	704	1,505
Other facilities	61	41	223	325
ADM units in correctional facilities	2	10	—[a]	12
Private practice psychiatrists	72	7	1,433	1,511
Private practice psychologists	61	6	1,223	1,291
General health facilities	$9,630	931	13,629	24,189
Hospital-based	5,980	657	6,338	12,975
Non-Federal community hospitals (Excluding psychiatric units)	4,957	524	4,900	10,380
VA general hospitals and other facilities	678	57	1,073	1,808
Other Federal facilities[b]	346	75	366	786
Other general health facilities and services	3,650	275	7,290	11,214
Nursing homes	208	—[a]	3,467	3,676
Private practice physicians	904	35	1,084	2,023
Dentists	774	74	835	1,682
Other health professionals	213	20	229	462
Drug and drug sundries	934	88	1,009	2,032
Other health services	447	42	483	973
Volunteer services	169	16	182	368
Total	$10,947	$1,495	$26,113	$38,553

Totals may not add due to rounding.

a. Less than $.5 million.
b. A small portion of these were in non-hospital-based facilities.

Source: Research Triangle Institute (RTI), "Economic Costs to Society of Alcohol and Drug Abuse: 1980," June, 1984, RTI/2734/00-01FR.

*The data developed by the Research Triangle Institute were for 1980. Estimates for 1984 ADM costs were obtained by increasing the RTI 1980 data by the percent increase in the CPI-U, 1980-84 (October to October).

4

What is Mental Health Care?

According to a study done by the Office of Technology Assessment (OTA)[3], mental health care (which OTA refers to as "psychotherapy") is a mansion with many rooms. There are at least forty definitions in the literature. Here we use the term "psychotherapy" interchangeably with mental health services or psychiatric care. No attempt will be made to present a detailed taxonomy. Suffice it to say that when scholars interested in assessing effectiveness analyze mental health care or psychotherapy, they usually limit their scope of inquiry to techniques which:

- have an established conceptual/scientific base;
- are applied by trained and experienced professionals in a purposeful manner; and,
- are intended to help individuals change various personal characteristics (feelings, behavior, attitude) that cause unnecessary, avoidable distress.

The techniques meeting these broad criteria vary widely in terms of theoretic underpinnings, setting, type of counseling, training, etc. Insurers and other observers have been puzzled by the finding of effectiveness for a wide variety of treatments. There seems to be a lingering suspicion that if studies show that many psychiatric treatments apparently work, then perhaps the reality is that none of them work and the measurements are flawed.

There are two main responses to this concern. First, liter-

3. Office of Technology Assessment, *The Implications of Cost-Effectiveness Analysis of Medical Technology, Background Paper No. 3: The Efficacy and Cost Effectiveness of Psychotherapy* (Washington, D.C., U.S. Government Printing Office, Stock No. 052-003-00783-5, October 1980).

ally hundreds of measures of effectiveness have been subjected to tests of statistical validity, and the great majority of them have passed. The odds of this happening if mental health services were not effective are vanishingly small. Second, as the OTA report noted, there are indeed common threads running through the bewildering variety of different approaches:

> "... A number of important similarities exist across different theoretical persuasions. Some theorists . . . in fact, argue that psychotherapeutic change is predominately a function of factors common to all therapeutic approaches. The primary ingredients of such common, nonspecific factors are the therapist's understanding, respect, interest, encouragement, and acceptance. Thus, while the contents and procedures of psychotherapy may differ . . . all forms of psychotherapy share common 'healing' functions. All therapists combat the patient's demoralization and sense of hopelessness by the relationship they establish with the patient and by providing an explanation for previously inexplicable feeling and behavior. According to those who maintain that such nonspecific factors are responsible for psychotherapy's effects, one reason for the success of therapy is because it removes the mystery from the patient's suffering and supplants it with hope."[4]

4. OTA, p. 13.

5

Is Mental Health Care Effective?

According to the Office of Technology Assessment, the literature reviews all report that under certain conditions mental health services are effective. The more recent the literature surveyed, the stronger the evidence of effectiveness. In fact, there is little evidence that mental health care does not work. A variety of treatments are effective for a variety of diagnoses.

Just like aspirin, however, there is a lack of understanding of the way psychotherapy works, i.e., the conditions required for it to be effective. Accordingly, no one research design and no one set of measures will provide a definitive conclusion. Rather, it is necessary to look at the weight of evidence.

It is impossible to separate the therapist from the therapy and to control entirely for variations among patients. Outcome measures can be quantified but often they are based on subjective evaluations. If, however, a large number and variety of evaluative studies have produced the same general finding, it is fair and reasonable to infer that such a finding is valid.

Fortunately, there have been literally hundreds of studies on the effectiveness of psychotherapy and a number of exhaustive scholarly reviews of the literature. Perhaps the two most comprehensive literature searches are the NIMH synthesis and Smith, Glass, and Miller's meta-analysis.

The NIMH synthesis was conducted by Parloff et al. for the Institute of Medicine[5] as part of IOM's work for the President's Commission on Mental Health. The OTA report sums up Parloff's finding as follows:

5. Parloff, M.B., et al., "Assessment of Psychosocial Treatment of Mental Health Disorders: Current Status and Prospects," (Washington, D.C., Report to the National Academy of Sciences, Institute of Medicine, 1978).

"Parloff et al.'s . . . general finding . . . was that 'patients treated by psychosocial therapies show significantly more improvement in thought, mood, personality, and behavior than do comparable samples of untreated patients.' These reviewers found that spontaneous remission rates developed from separate samples provide evidence that psychosocial treatment seems to result in greater improvement than would be expected without psychotherapeutic treatment. Their finding is supported most clearly for disorders such as anxiety states, fears and phobias.

"The central aspect of Parloff et al.'s . . . review was a summary, by each psychopathological condition, of the available treatment research evidence. To appreciate the complexity of this task, consider their discussion of severe mental disorders such as schizophrenia . . . Parloff . . . found that individual and group psychotherapies provide an ambiguous amount of improvement for institutionalized patients; however, in conjuction with drug therapies and other psychological treatments, they appear to have important effects . . . For such hospitalized populations . . . Parloff et al. found considerable evidence that a specific type of therapy (behavior-based) improved social adjustment . . . They also found that the return of the severely disturbed patients to their community had positive effects on treatment outcomes, although this finding was limited to patients with certain interaction skills, and under the condition that the patient returns to a 'good' family situation."[6]

Smith, Glass and Miller's magisterial review[7] covered 475 controlled studies of psychotherapy. A controlled study was defined as one where one group received psychotherapy and another comparable group did not. A controlled study was included for review if it covered treatments that:

- were psychological or behavioral
- were conducted by professionals
- were for patients identified as having a behavioral or emotional problem.

The technique Smith, Glass, and Miller used to review and

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6. OTA, p. 44.

7. Smith, M.L., and Glass, G.V., *The Benefits of Psychotherapy*, (Baltimore: Johns Hopkins University Press, 1980).

assess the literature is called meta-analysis — a quantitative procedure for integrating and summarizing research findings across studies. Once those studies to be reviewed have been selected and classified according to various criteria for methodological rigor, they are then coded on a set of variables thought to be associated with outcomes. These measures, e.g., patient characteristics, therapist experience, study design quality, treatment setting, etc., are then correlated with outcomes.

Smith et al. developed a standardized measure for the size of the effect of psychotherapy for each of the 475 studies selected for review. By standardizing the measure of effect, Smith et al. were able to compare results across studies. The findings of Smith, Glass and Miller offer impressive scientific support that, unlike many medical treatments, psychotherapy does make people better:

> "Smith et al.'s . . . principal finding was that, on the average, the difference between average scores in groups receiving psychotherapy and untreated control groups was 0.85 standard deviation units (i.e., the effect size difference was 0.85). According to Smith et al., this average effect size can be translated to indicate that the average person who receives therapy is better off than 80% of the persons who do not. They found little evidence for the existence of harmful effect of psychotherapy (i.e., very few cases where the mean of the control group was higher than the treatment group). Smith et al. found some significant differences across the types of therapies whose effects were studied (the range was 0.14 to 2.38) but these effects are confounded by variables such as patient and therapist characteristics which were distributed unequally among the therapies. Finally, their methodological categories proved not to correlate with effect sizes; thus, for example, the better designed studies did not yield less positive findings."[8]

When is mental health care effective?

According to at least four independent literature reviews, all the mental health services tested proved effective for the following kinds of disorders: "ambulatory nonpsychotic de-

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8. OTA, p. 46.

pressions; mild to moderate anxieties, fears, and simple phobias; compulsions; sexual dysfunctions; reactions to developmental crises of adolescence, mid-life, and aging; and problems of everyday life such as vocational and marital adjustments . . ."[9]

A review of the literature on the effectiveness of psychiatric care also shows that, in combination with drug therapy, it is useful in the treatment of such disorders as "the schizophrenias, manic-depressive disorders, psychosomatic disorders, antisocial disorders, alcoholism, drug abuse, and childhood hyperactivity and severe learning disabilities."[10] Luborsky and his associates, for example, reported that "a combination of treatments may represent more than an added effect of two treatments; there may also be some mutually facilitative interactive benefits for combined treatments."[11]

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9. Morris B. Parloff, Ph.D., in National Institute of Mental Health Series EN No. 2, *Cost Considerations in Mental Health Treatment: Settings, Modalities, and Providers*, Taintor, Z., Widem, P., and Barrett, S.A., Editors, DHHS Publication (ADM)84-1295 (Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1984) p. 42.

10. Parloff, p. 43.

11. Luborsky, L.; Singer, B.; and Luborsky, L.; "Comparative Studies of Psychotherapies," *Archives of General Psychiatry* 32 (8): 995-1008 1975, p. 1004.

6

Comparison of the Costs and Outcomes of Different Treatment Settings

Mental health care works. But, which treatment settings show better clinical outcomes; and, for a given outcome, which setting is less costly?

A. Ancona Berk, Ph.D., reviewing 33 studies using controls (comparison groups) summarized her findings in tables four through seven.

The main finding of Berk's literature review was that alternatives to traditional inpatient settings, such as partial hospitalization combined with intensive community-based care, appear more cost-effective for certain patients.

Perhaps the most highly regarded study comparing treatment settings published to date is by Weisbrod, Test and Stein. It is special in that it used a far more comprehensive set of cost and benefit measurements than anything done previously. Also, it comes closest to meeting the requirement of a rigorous controlled clinical trial.

The aim of the Weisbrod et al. study was to compare the traditional methods of treating the chronically mentally ill with a community-based treatment program called "Training in Community Living" (TCL). The essential difference was that an interdisciplinary staff was moved from the Wisconsin State Hospital into the community. The focus, then, was on working with patients not in the hospital but in the community itself.

Key findings from the 28-month study period were:

1. the cost per patient in the TCL program were slightly higher, *but*

2. the benefits, mainly in the form of patient earnings, also were higher;

3. the net result was that benefits valued in monetary terms for the TCL program were still less than valued costs, but the

shortfall was less than for the traditional program (Exhibit 8).

Although treatment programs which place greater emphasis on outpatient care can be more cost-effective for some patients, inpatient treatment nonetheless remains the only realistic option for a significant percentage of mentally ill patients. Weisbrod, for example, did not in any way argue that all disorders could be treated in an outpatient setting. For those patients who can be harmful to themselves or others, who cannot respond to treatment while remaining in their homes or work environments, or who require resocialization, stabilization or a highly controlled course of medication, there exists no alternative to hospitalization. Examples of these kinds of patients, taken from the case records of an adolescent care facility, are presented in Exhibit 9.

There is, however, no escaping the fact that there is a "gray area" problem with psychiatric hospitalization. How much inpatient care is enough to assure a favorable outcome but no more than enough?

The state of the art of diagnosis is not sufficiently developed to support widely accepted objective criteria for measuring quality and cost-effectiveness of care. The appropriate action under these circumstances is not to curtail inpatient coverage but rather to redesign coverage so that providers have an incentive to choose that mix of care that produces the best possible medical outcome per available dollar. When paired with careful utilization management, this approach should go a long way toward improving the cost-effectiveness of care while still making sure it is not denied to those who really need it.

EXHIBIT FOUR

CLINICAL OUTCOMES OF REVIEWED STUDIES WHERE CONTROLS WERE NOT RANDOMLY SELECTED[a]

Setting		*Setting results*			
Experimental	Control	Experimental Better	Control Better	No Difference	Number of Studies
Partial Hospitalization	Traditional Inpatient	3	2	2	7
Community	Traditional Inpatient	2	1	4	7
Brief Inpatient Stay	Traditional Inpatient	1		1	2
Brief Inpatient Stay and Partial Hospitalization	Traditional Inpatient	1			1

a A. Ancona Berk, Ph.D., in National Institute of Mental Health, Series EN No. 2, *Cost Considerations in Mental Health Treatment: Settings, Modalities, and Providers*, Taintor, Z.; Widem, P.; and Barrett, S.A., eds. DHHS Pub. No. (ADM) 84-1295, Washington, D.C.; Supt. of Documents, U.S. Government Printing Office, 1984, p. 20.

EXHIBIT FIVE
CLINICAL OUTCOMES OF REVIEWED RANDOMIZED CONTROL TRIALS[a]

Setting		*Setting results*			
Experimental	Control	Experimental Better	Control Better	Not Determinate	Number of Studies
Partial Hospital-ization	Traditional Inpatient	3		1	4
Community	Traditional Inpatient	2		4	6
Brief Inpatient Stay	Traditional Inpatient	2	1	1	4
Brief Inpatient Stay and Partial Hospital-ization	Traditional Inpatient	1			1
Home care — With Drugs or With Placebos	Traditional Inpatient	1			1

a. Berk, p. 21.

EXHIBIT SIX

ECONOMIC OUTCOMES OF REVIEWED SIMULTANEOUS CONTROL STUDIES[a]

Setting		*Setting results*				
Experimental	Control	Experimental Cheaper	Control Better	No Difference	No Economic Outcome Discussed	Number of Studies
Partial Hospitalization	Traditional Inpatient	2			5	7
Community	Traditional Inpatient	5	1		1	7
Brief Inpatient Stay	Traditional Inpatient				2	2
Brief Inpatient Stay and Partial Hospitalization	Traditional Inpatient				1	1

a. Berk, p. 22.

EXHIBIT SEVEN

ECONOMIC OUTCOMES OF REVIEWED RANDOMIZED CONTROL STUDIES[a]

Setting		*Setting results*				
Experimental	Control	Experimental Cheaper	Control Better	No Difference	No Economic Outcome Discussed	Number of Studies
Partial Hospitalization	Traditional Inpatient	2			2	4
Community	Traditional Inpatient	3			3	6
Brief Inpatient Stay	Traditional Inpatient	1		2	1	4
Brief Inpatient Stay and Partial Hospitalization	Traditional Inpatient	1				1
Home care — With Drugs or With Placebo	Traditional Inpatient				1	1

a. Berk, p. 23.

EXHIBIT EIGHT
COSTS AND BENEFITS PER PATIENT, CONTROL (C) AND EXPERIMENTAL (E) GROUPS, FOR TWELVE MONTHS FOLLOWING ADMISS ON TO EXPERIMENT

	C	E	E - C
COSTS			
Costs for which monetary estimates have been made			
1. Direct treatment costs			
Mendota Mental Health Institute (MMHI)			
Inpatient	$3096	$ 94	$-3002**
Outpatient	42	0	-42**
Experimental center program	0	4704	4704†
Total	$3138	$4798	$ 1660†
2. Indirect treatment costs			
Social service agencies			
Other hospitals (non-MMHI)	$1744	$ 646	$-1098**
Sheltered workshops'	91	870	779**
Other community agencies:			
Dane County Mental Health Center	55	50	-5
Dane County Social Services	41	25	-16**
State Dept. of Voc. Rehab.	185	209	24[h]
Visiting Nurse Service	0	23	23**
State Employment Service	4	3	-1*
Private medical providers[c]	22	12	-10[e]
Total	$2142	$1838	$ -304†
3. Law enforcement costs			
Overnights in jail	$ 159	$ 152	$ -7[e]
Court contacts	17	12	-5[e]
Probation and parole	189	143	-46
Police contacts	44	43	-1[e]
Total	$ 409	$ 350	$ -59†
4. Maintenance costs	$1487	$1035	$ -452
5. Family burden costs:			
Lost earnings due to the patient	$ 120	$ 72	$ -48[e,f]
Total costs for which monetary estimates have been made	$7296	$8093	$ 797†
Other costs			
6. Other family burden costs			
Percentage of families reporting physical illness due to the patient	25%	14%	-11%[e]
Percentage of family members experiencing emotional strain due to the patient	48%	25%	-23%[e,f]
7. Burden on other people (e.g., neighbors, co-workers)	?	?	?

	C	E	E - C
8. Illegal activity costs: Total	1.0	0.8	-0.2[a]
No. of arrests for felony	0.2	0.2	0.0[a]
9. Patient mortality costs (percentage dying during the year)			
Suicide	1.5%	1.5%	0%
Natural causes	0%	4.6%	4.6%
BENEFITS			
Benefits for which monetary estimates have been made			
1. Earnings[h]			
From competitive employment	$1136	$2169	$ 1033**d
From sheltered workshops	32	195	163**d
Total	$1168	$2364	$1196†
Other benefits			
2. Labor market behavior			
Days of competitive employment per year	77	127	50[d]
Days of sheltered employment per year	10	89	79[d]
Percentage of days missed from job	3%	7%	4%[d]
No. beneficial job changes	2	3	1[g]
No. detrimental job changes	2	2	0[g]
3. Improved consumer decision-making			
Insurance expenditures	$ 33	$ 56	$ 23[d]
Percentage of group having savings accounts	27%	34%	7%
SUMMARY			
Valued benefits	$1168	$2364	$ 1196
Valued costs	7296	8093	797
Net (Benefits - Costs)	$-6128	$-5729	$ 399†

*Significant at the .10 level.
**Significant at the .05 level.
†Signifcance not tested, as the number is a sum of means.

[a]These data were derived from ager. / or patient reports on the number c contacts, patient reports being used only when it was not possible (or was excessively costly) to obtain the relevant information from the agency. Estimates of the costs per contact were obtained from the agency.

[b]Data from the Department of Vocational Rehabilitation (DVR) were available only for the 28-month study period as a whole, which included the follow-up period after the experiment. The per patient costs presented in Exhibit Eight are 12/28, or 43 percent of the 28-month data, reflecting average cost for one year. The figures reflect double counting because much of the DVR expenditures go for payments to other agencies that are included in cost section 2 of the exhibit. We have been able to account for, and to exclude, DVR payments to the sheltered workshops but not, for example, to hospitals. The $24 difference is biased upward by the omission of counselling expenses

attributable only to C-group members.

[c]These figures include fees for physicians, psychologists, and nurses but exclude any associated laboratory fees.

[d]These data were derived from patient reports and as such subject to misreporting. Patient reports were used only when it was not possible (or was excessively costly) to obtain the relevant information from an independent source. In some cases, when an interviewer suspected faulty reporting, individual spot-checks were made with the agency in question; agencies that were not able to provide us with information on all patients were sometimes able to provide it on this spot-check basis.

[e]These figures are derived from interviews conducted four months after admission with 22 families of E group patients and 18 families of C group patients (34% of the E group, 27% of the C group). The other families were not interviewed because: (1) they lived outside of Dane County (23% of each group); (2) the subject or the family refused to cooperate (12% of the E group, 22% of the C group); or (3) the relative could not be contacted (31% of the E group, 28% of the C group). The questionnaire examined the families' experience in the two weeks preceding the interview only, and, with some trepidation, these figures have been inflated to an annual average. The reduced sample size and the single interview yielded data which must be interpreted with caution.

[f]These figures were derived by multiplying the number of days of work the family members missed because of the patient by a daily wage of $24 ($3 an hour).

[g]Our judgments, based on examination of patient reports.

[h]Earnings do not include value of fringe benefits, if there were any.

[i]Interviewers' assessments.

[j]Includes Madison Opportunity Center, Inc., and Goodwill Industries.

Source: Weisbrod, Burton A., Ph.D., "A Guide to Benefit-Cost Analysis as seen through a Controlled Experiment in Treating the Mentally Ill," *Journal of Health Politics, Policy, and Law*, Vol. 7, No. 4, Winter 1983, pp. 808-845.

EXHIBIT NINE

EXAMPLES OF PATIENTS FOR WHOM PSYCHIATRIC HOSPITALIZATION IS ESSENTIAL (ADOLESCENTS)

N.N. — Patient is a 17-year-old male who made a suicidal gesture while under the influence of alcohol. Though the chief complaint at presentation in the Emergency Room was the suicidal gesture, ingestion of sleeping pills, this patient's disorder was alcoholism. In elementary school, learning disability had been diagnosed. He was never successful at school and became a dropout. He began to abuse alcohol. When under the influence he was quick to lose his temper, often getting into physical fights, even with his father. Though the patient had the support of his family, he was unable to find employment. In a fit of alcoholic despair, while intoxicated, he made a suicidal gesture. This 17-year-old male was in need of treatment on an adolescent substance abuse unit.

C.N. — Patient is a 14-year-old male who became depressed during the year-long terminal illness of his mother. During that time, his grades fell and rebellious behavior increased. Following the sudden, unexpected death of one of his good friends, a clinical depression became more and more evident. With the development of suicide ideation, this patient was in need of hospitalization on an early adolescent psychiatric unit where his psychiatric and developmental needs could be appropriately met.

N.D. — Patient is a 14-year-old female who developed bizarre behavior during her second year at a residential facility for mentally retarded children and adolescents. Her behavior included attacking residents, making inappropriate sounds and gestures, e.g., cat noises and gestures with her fingernails. The patient's functioning deteriorated. She was in need of a neuropsychiatric unit for treatment of her psychosis. To treat this severely mentally retarded girl's psychosis on a typical adolescent psychiatric unit is significantly disruptive to the treatment structure of the typical psychiatric unit.

B.D. — Patient is an 18-year-old female with a history of restricted peer and adult relationships. Following a church retreat, she began to report receiving commands from God. Her affect was quite bizarre. The personnel at the church retreat sent her to the Vanderbilt Emergency Room. She was in need of psychiatric hospitalization on a late adolescent psychiatric unit.

B.M. — Patient is an 11-year-old youngster from the Cumberland Plateau who was admitted with life-threatening obesity. At age 11, she weighed 198 pounds following a 2-year history of compulsive eating. Excessive weight had not only fostered her poor self-image and poor peer relationships, but had disrupted normal family functioning as well. Additionally, her size had interfered with a young girl's natural physical development as well . . . she had never skipped, sat in a school desk, bought a dress in a store.

J.R. — Patient is a nine-year-old boy referred from the Department of Human Services in upper Middle Tennessee. He had been denied educational opportunities because he failed to fit into any educational program in the county. Abandoned at birth by his mother, and passed through a succession of five foster homes, he had internalized an image of despair and worthlessness only to be confirmed by his environment's response to him.

L.A. — Patient is a 15-year-old female from far Western Tennessee whose dramatic weight loss had just been associated with "fad dieting," later thought to be associated with depression and finally diagnosed as anorexia nervosa, a life-threatening psychological disturbance in which youngsters literally starve themselves to death. Prior to admission, her weight had dropped from 138 pounds to a dangerous low of 72 pounds. Associated with this complicated physical concern was her self-imposed isolation from friends and loss of interest in everything typical to that normally expected of a youngster her age.

B.B. — Patient is a five-year-old child from Middle Tennessee who had been raped and continuously sexually abused by her father and uncle. An already confused image of parents was complicated by witnessing her father's suicide for which she assumed immediate responsibility. Guilt, abandonment and

loss created chaos in her life and had interfered with the typical development of a preschool child.

S.K. — Patient is a 12-year-old with seizures who had become isolated and sad over her awareness that she was different from her peers. Her seizures had been out of control over the two months prior to admission, secondary to, or at least concurrent with, the development of deepening depression. During hospitalization, her depression and seizure disorder were treated and brought under control.

J.A. — Patient is a seven-year-old with continuous enuresis in addition to encopresis whose relationships at home had deteriorated due to family reactions to his symptoms. A therapeutic program, necessitating hospitalization, was designed for the patient and the family. Basic improvement occurred during the hospitalization phase of the treatment program. Follow-up treatment was provided on an out-patient basis. The patient is no longer enuretic or encopretic (treatment has been terminated).

R.J. — Patient is an 11-year-old transferred from another part of Vanderbilt University Hospital where he had been admitted for medical treatment. During the work-up, bizarre behavior, including hallucinations, became apparent. Following a neurology work-up, he was transferred to Child Psychiatry for evaluation and treatment of an acute psychotic process.

7

The Benefits of Psychiatric Care Relative to Cost

The literature on mental health care seems settled on three points:

- It works.
- Effective treatments can be provided at very different costs for those patients who are not so severely ill that inpatient care is medically essential. The main factor affecting cost differences seems to be setting (inpatient vs. reduced hospitalization and outpatient services with intensive institutional support).
- For a significant portion of patients, inpatient care is the only therapeutically acceptable alternative.

The literature is much less developed and therefore much more tentative about the issue of benefits relative to costs. To some extent, this tentativeness is the result of limitations inherent in the whole idea of cost-benefit analysis. In many cases, especially in the area of mental health care, the value society puts on certain outcomes depends most fundamentally on widely shared values rather than on the elegance of a baroque new quantitative technique. For example, in strictly monetary terms, the benefits to society of treating people who obviously suffer from severe mental illness through no apparent fault of their own may not exceed the costs. However, since Americans have decided that society exists for the betterment of individuals rather than the other way around, the question of whether to treat such people is assumed to be settled in the affirmative. The only issue is how to treat them.

Unaware of the growing evidence of a strong genetically based susceptibility to substance abuse, some segments of society are not so sympathetic toward people with substance abuse problems. But fortunately for them, the studies of the benefits of substance abuse programs relative to their costs —

though not without research design flaws — suggest that such programs are well worth the money.

Some of the major cost-benefit studies are summarized herein:

(1) **Rufener, B.L., et al.,** *Management Effectiveness Measures for NIDA Drug Abuse Treatment Programs, Vol. 1: Cost-Benefit Analysis*, GPO Stock Number 017-024-00577-1 (Washington, D.C.: National Institute of Drug Abuse, 1977).

Study Description

Rufener et al. performed a cost-benefit analysis of five different therapies for heroin addiction. Benefits were calculated by estimating foregone direct and indirect costs to society resulting from the rehabilitation of a heroin abuser. Costs were based on the accounting records of providing therapy. Benefits were calculated under three different assumptions regarding the size of the heroin abuser population and three different discount rates for determining the present value of costs and benefits.

Results

Regardless of the discount rate and assumptions as to the number of heroin abusers, the ratios of benefits to cost were all greater than one; outpatient drug therapy proved to be the most cost-beneficial.

Comment

The study failed to use random assignment of patients to different treatment techniques.

(2) **Hall, S.M., et al.,** "Contingency Management and Information Feedback in Outpatient Detoxification," *Behavioral Therapy* 10:443, 1979.

Study Description

Hall, Bass, Hargreaves, and Loeb randomly assigned participants in outpatient opiate and barbituate detoxification programs to behavior therapy and no behavior therapy treatments. The group receiving behavior therapy was paid up to $10 per day for drug-free urine specimens.

Results

There was a 20 percent reduction in the use of opiates and barbituates for outpatient detoxification patients. Patients apparently did not use their payments to buy illegal drugs.

(3) **Sirotnik, K.A., and Bailey, R.C.,** "A Cost Benefit Analysis for a Multi-Modality Heroin Treatment Project," *International Journal of Addiction* 10:443, 1975.

Study Description

Sirotnik and Bailey did a cost-benefit analysis of heroin addiction therapies. Their study followed 285 patients over a one and one-half year period.

Results

Benefits exceeded costs by a 2.5 to 1 margin.

Comment

There was no control group limit and the patients were not randomly assigned to therapy.

(4) **Aron, W.S., and Daily, D.,** "Short and Long Term Therapeutic Communities: A Follow-up and Cost-effectiveness Comparison," *International Journal of Addiction* 9:619, 1974.

Study Description

Aron and Daily investigated the comparative cost-effectiveness of the long and short term therapies.

Results

Long term drug abuse therapy proved more cost-effective than short term therapy.

(5) **Goldschmidt, P.G.,** "A Cost-effectiveness Model for Evaluating Health Care Programs: Application to Drug Abuse Treatment," *Inquiry* 13:29, 1976.

Study Description

Goldschmidt sampled 1,640 patients over a 6-month period, finding 1,241 who could be interviewed. The data he obtained were used to compare the cost-effectiveness of drug

substitution (methadone) to the therapeutic community approach.

Results

Drug substitution, i.e., methadone, proved more cost-effective for the period studied.

Comment

The lifetime costs of methadone were not considered; this oversight might change the direction of findings.

(6) **McClellan, A.T.; Luborsky, L.; O'Brien, C.T.; Woody, G.E. and Druxley, K.A.,** "Is Treatment for Substance Abuse Effective?" *Journal of the American Medical Association* 247 (10): 1423-1428, 1982.

Study Description

742 patients in six alcohol and drug abuse treatment programs were studied.

Results

The study found improvements in alcohol and drug use, employment, criminal behavior, and psychological function. The longer the length of treatment and the greater the patient commitment to that treatment, the more positive the findings.

The evidence about the cost of medical treatment following mental health treatment.

How cost beneficial is psychotherapy for people who are:
- not obviously self-destructive?
- not obviously potentially dangerous to others?
- not clearly unable to cope with the usual problems of everyday living without help?

A recent article by Mumford, Schlesinger, Glass, Patrick and Cuerdon addressed this question both by employing a meta-analysis of the cost offset literature and by analyzing the claims files for the Blue Cross and Blue Shield Federal Employees Program, 1974-1978.[12]

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12. Emily Mumford, Ph.D., Herbert J. Schlesinger, Ph.D., Gene V. Glass, Ph.D., Cathleen Patrick, Ph.D., Timothy Cuerdon, B.A., "A New Look at Evidence about Reduced Cost of Medical Utilization Following Mental Health Treatment," *American Journal of Psychiatry* 141:10, October 1984, pp. 1145-1158.

Major findings of the meta-analysis were:

1. "Eighty-five percent of all these studies reported a decrease in medical utilization following psychotherapy "[13]

2. Twenty-six of the 58 studies, comparing medical care utilization before and after psychotherapy, showed an average "effect size" of minus 33.1%. (The effect size is the difference between people receiving treatment and people not receiving treatment as measured by some variable such as cost per year per patient.)

These 26 studies are open to challenge on two grounds. First, the experimental and comparison groups were selected differently. Specifically, the use of medical services by subjects in psychotherapy during the period before and after psychotherapy was compared to the medical use of controls before and after an arbitrary date. Since the use of medical care services may have driven the experimental group to seek mental health services, the observed decline in use after psychotherapeutic treatment may have represented nothing other than the normal tendency for measures of subgroup behavior to converge toward the average for the larger group. (Statisticians call this process "regression to the mean.")

The second problem is self selection. Users of psychotherapy in these 26 experiments might not be typical of the general population.

Although these studies have all the flaws inherent in before-and-after comparisons, they should not be rejected out of hand. The fact that so many studies by different researchers showed a cost-effective outcome suggests (but does not move) that the benefits being observed are not merely statistical artifacts.

3. Of the remaining 32 studies analyzed, 22 (using random assignment of patients to an experimental or control group) showed an average percent reduction of 10.4% in use of medical services. These 22 studies evaluated the effect of psychiatric intervention on people hospitalized for a medical crisis. They were based on a procedure generally accepted as yielding more statistically reliable results; namely, patients were assigned randomly to a control or an experimental group.

4. Mental health services reduced inpatient medical services more than outpatient services.

5. People over 65 received proportionately less mental

13. Mumford et al., p. 1152.

health treatment than the rest of the population, even though psychotherapy for them yields an especially large reduction of inpatient services. For example, as noted by Mumford et al., Levitan and Cornfeld[14] report that length of stay for 24 elderly patients receiving psychiatric consultation was shorter than the mean for the control group. Both the experimental group and the control group had been hospitalized for the same reason and had not received psychiatric care over the same months of the previous year in the same hospital. Also, twice as many of the patients receiving consultation went home rather than being discharged to a nursing home or some other institution.

Analysis of the claim files of Blue Cross and Blue Shield Federal Employees program for the period 1974 through 1978 strongly supports the conclusion that the benefits of providing mental health services to the upper age groups will generate savings significantly greater than the costs:

> "The oldest group among the mental health treatment persons, those over 55, clearly showed the most dramatic decrease in hospital charges; in 1974 they had an average in-patient medical charge more than $160 higher than those of the comparison group. In 1978 they were spending $70 less. This finding cannot be explained by selective dropout, since all persons in the oldest age groups were required to have at least one claim in 1978."[15]

Another key finding from analysis of Blue Cross and Blue Shield Federal Employee program files was that people receiving mental health treatment had a lower rate of increase in total medical charges than people with no mental health claims:

> "Following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year. In contrast, the charges of the comparison group increased faster than the inflation rate."[16]

In sum, the evidence appears compelling that mental health care is effective and often has the incidental effect of being cost-containing, *not* cost-increasing.

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14. Levitan, S.J., Kornfeld, D.S.: "Clinical and Cost Benefits of Liaison Psychiatry," *American Journal of Psychiatry* 139:790-793, 1983.

15. Mumford et al., p. 1156.

16. Mumford et al., p. 1154.

8

Is There Overuse and Misuse of Psychiatric Services and If So, What Should Be Done?

Like anything else, psychiatric services will be overused if the effective cost to the user is minimal. Conversely, however, as the Rand Health Insurance Study has shown, the potential for overuse can be controlled by appropriate cost sharing, rigorous utilization management, and peer review. As Manning and his colleagues at the Rand Corporation reported in the October 1984 issue of *American Psychologist*:

> "Insurance plans with lower co-insurance rates (smaller out-of-pocket payments) significantly increased the use of ambulatory mental health services. For example, participants facing no out-of-pocket cost were twice as likely to seek mental health services as those on a plan in which the participants paid 95% co-insurance until they reached an upper limit on out-of-pocket expenses. The free care group had 73% higher expenditures on ambulatory mental health services than the 95% plan group."[17]

The Rand study is generally considered the most comprehensive, best designed study on the effects of insurance on the use of health care services. It is unique in that it permits analysts to separate the influence of health status from the influence of health insurance on the use of services.

Another important finding from the Rand study is that generous coverage of mental health services over a multi-year period does *not* lead to exorbitant use or expense relative to health care expenditures as a whole:

"A plan with no out-of-pocket cost (i.e., free care) shows

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17. Manning, W.G., Jr., Ph.D.; Wells, K.B., Ph.D.; Duan, N., Ph.D.; Newhouse, J.P., Ph.D.; and Ware, J.E., Ph.D., "Cost Sharing and the Use of Ambulatory Mental Health Services." *American Psychologist* 39: 1077-1089, October 1984.

> limited ambulatory use of mental health care. Only 8.8% of enrollees received annually any mental health care. Only 5% visited annually any formally trained mental health provider. The average ambulatory mental health expense was $24 per enrollee per year.
>
> "Plans with small deductibles followed by free care, such as the $150 person per year individual deductible, do not significantly reduce expenditures below the free care level."[18]

Among some insurers, there is a strongly held conviction that the people who use out-patient mental health services are not "really sick" but rather are young upwardly mobile professional people seeking better living through psychiatry.

The evidence from the Rand Health Study shows that this is a myth. John E. Ware et al. reported in the same issue of *American Psychologist* that spending for mental health services was concentrated on people with the greatest need:

> "Mental health status, as measured by the Rand Health Insurance Study Mental Health Inventory (MHI), is a major predictor of the use of out-patient mental health services. The average person scoring in the lowest tertile of the MHI score distribution spent over three times more per year for mental health care than the average person in the highest tertile; the effect of the MHI on use is substantial whether or not other health status and socio-demographic variables are controlled for . . . Those scoring lower on the MHI are more likely to receive mental health care and their care is more intense."[19]

Ware also reported the disturbing finding that the large majority of those in need of psychotherapy are not treated at all. For example, only one in eight of those in the lowest tertile of the MHI distribution used mental health services in a given year. This low use rate was not the result of poor insurance coverage. Even those with free mental health care have only a one in five chance of receiving out-patient mental health care.

In sum, not only do the data not support the general assumption of widespread overuse and misuse, but rather they provide strong evidence that there exists underuse.

18. Manning et al.

19. Ware, J.E., Jr., Ph.D.; Manning, W.G., Jr., Ph.D.; Duan, N., Ph.D.; Wells, K.B., Ph.D.; and Newhouse, J.P., Ph.D., "Health Status and the Use of Outpatient Mental Health Services," *American Psychologist* 39: 1090-1100, October 1984.

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