SB

67

file 1

# STATE OF ALASKA
# THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907·465·3800

**LEGISLATIVE AFFAIRS AGENCY**

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May, 1988

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

Mary Van Nimwegen

House Hess:

February 9, 1988

February 16, 1988

February 24, 1988

# STATE OF ALASKA

**DEPARTMENT OF ADMINISTRATION**

*DIVISION OF RETIREMENT & BENEFITS*

*PLEASE REPLY TO:*


☐ *P.O.BOX CR*
*JUNEAU, ALASKA 99811-0203*
*PHONE: (907)465-4460*

☐ *2600 DENALI ST. SUITE 401*
*ANCHORAGE, ALASKA 99503-2740*
*PHONE: (907) 277-7504*


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

*STEVE COWPER, GOVERNOR*

February 24, 1988

The Honorable Niilo Koponen
The Honorable Johnny Ellis
Co-Chairmen, Health, Education,
Social Services Committee
P.O. Box V
Juneau, AK 99811

Dear Representatives Koponen and Ellis:

Re: House CS CSSB 67 (HESS)

This letter is meant to provide our analysis of the fiscal impact if HCS CSSB 67 (HESS) is passed into law. This analysis consists of two separate components. The first addresses the direct increase to health insurance premiums for active state employees for an increased level of coverage. The second addresses the costs to the retirement systems due to the increased levels of coverage for the retiree's health plan.

Premiums for active state employees is estimated to increase $3.70 per month per employee effective July 1, 1989. The costs are assumed to stay level each year thereafter because the state does not have any experience analysis to indicate that costs will increase annually for this additional benfit and it is a small portion of the total health insurance package.

The FY 90 estimated cost for active state employees is calculated as follows:

| | |
|---|---|
| The increase of $3.70 per month<br>times the number of state employees<br>(12,000) x 12 months | $532,800 |

There is also a financial impact to employers participating in the state's retirement plans due to the increased limits of coverage for mental or nervous conditions under the retiree's health plan. In addition to the costs to the state's operating budget shown above, this bill is estimated to result in a .20% increase in the PERS employer contribution rate and a .15% increase in the TRS employer contribution rate and a .15% increase in the TRS State Match contribution rate in FY 90. The estimated FY 90 payrolls are listed below and are assumed to remain level each year thereafter.

The cost to the state of $1,034.6 is calculated as follows:

| | |
|---|---|
| The increase in the PERS contribution rate (.20%) times the estimated FY 90 state PERS payroll ($479,549,872) equals: | $ 959.1 |
| The increase in the TRS contribution rate (.15%) times the estimated FY 90 University of Alaska TRS payroll ($44,753,863) equals: | 67.1 |
| The increase in the TRS contribution rate (.15%) times the estimated FY 90 Department of Education TRS payroll ($5,613,930) equals: | 8.4 |
| | $1,034.6 |

In addition to the state costs described above, there would also be an increase in political subdivisions' FY 90 contribution rate of .20% and in school districts' contribution rate of .15%. This would result in an increase in their annual costs as follows:

| | |
|---|---|
| The increase in the PERS contribution rate (.20%) times the estimated FY 90 political subdivision payroll ($329,744,333) equals: | $ 659.5 |
| The increase in the TRS contribution rate (.15%) times the estimated FY 90 school districts' payroll ($319,882,344) equals: | $ 479.8 |
| | $1,139.3 |

Although there would not be an adverse impact on the actuarial soundness of the PERS and TRS funds if this bill becomes law, the unfunded liability will increase by $3,098,000 and the funding ratio will decrease by .3% in the PERS, and the unfunded liability will increase by $1,826,000 and the funding ratio will decrease by .2% in the TRS.

Sincerely,

Robert F. Stalnaker
Acting Director

RFS/MBC/cam/6

# HOUSE COMMITTEE REPORT

Date referred: 5/9/87

FURTHER REFERRALS: Judiciary
Finance

Health, Education and Social Services

DATE: 2-24-88

The _____ Committee has considered CSSB 67(HESS)
"An Act relating to insurance coverage for the treatment of a mental or nervous condition."

**RECOMMENDS:**

[ x ] replace with HCS SB 67 (HESS) [ ✓ ] the same title
[ ] attached amendment(s) [ ] a new title

- [ ] do pass
- [ ] do not pass
- [ ✓ ] no recommendation
- [ ] individual recommendations
- [ ] additional referral to the _____ Committee

**ADOPTS:** [ ] _____ letter of intent

**ATTACHES NEW FISCAL NOTE(s):**

- [ ] fiscal impact
- [ ] zero fiscal note
- [ ] zero with analysis
- [ ] same as previous fiscal note published _____
- [ ] same as previous zero fiscal note published _____

**SIGNING DO PASS:**

H. Ellis
Otis Kozeny
Mack Rosenberg

**SIGNING OTHER RECOMMENDATIONS:**

Bill Hudson - No Rec.
Donald Dudley No Rec
Bill E. Hess No Rec
Joyce Hawley - No Rec

Otis Kozeny
co-Chairman's signature
H. Ellis

Blue Cross.
of Washington and Alaska

15700 Dayton Avenue North/P O. Box 327
Seattle. Washington 98111-0327
206/361-3000

BLUE CROSS OF WASHINGTON AND ALASKA
PROPOSED 2/16/88 AMENDMENT TO
1988 ALASKA HCS CSSB NO. 67

Section 21.42.365(c)(2) should be amended to read as follows:

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

(a) the actual charge for the treatment received for a mental or nervous condition; or

(b) the usual, customary and reasonable charge for the treatment as determined by the contract of coverage; or

(c) <u>the charge agreed to by contract between the provider and the third party payor</u>;

# STATE OF ALASKA

**DEPARTMENT OF ADMINISTRATION**
*DIVISION OF RETIREMENT & BENEFITS*
*PLEASE REPLY TO:*

Public Employees' Retirement System
Teachers' Retirement System
Judicial Retirement System
Elected Public Officers Retirement System
National Guard Retirement System
Territorial Retirement System
Retirees' Voluntary Dental-Vision-Audio Plan
Supplemental Benefits System
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*PHONE: (907) 277-7504*

*STEVE COWPER, GOVERNOR*

February 12, 1988

The Honorable Niilo Koponen
The Honorable Johnny Ellis
Co-Chairmen, Health, Education,
Social Services Committee
P.O. Box V
Juneau, AK 99811

Dear Representatives Koponen and Ellis:

Re: House CSCSSB 67 (HESS)
(2/9/88 Draft)

In accordance with AS 24.08.036, I am providing an analysis below on House CSSB 67 (HESS). The analysis includes the long-term and short-term costs to the state if the bill is adopted and the impact the bill will have on the actuarial soundness of the Public Employees' (PERS) and Teachers' (TRS) Retirement Systems funds.

The financial impact shown in this letter represents the costs to employers participating in the state's retirement plans due to the increased limits of coverage for mental or nervous conditions under the retiree's health plan. In addition to the costs to the state's operating budget outlined on the fiscal note, this bill is estimated to result in a .20% increase in the PERS employer contribution rate and a .15% increase in the TRS employer contribution rate and a .15% increase in the TRS State Match contribution rate in FY 89. The estimated FY 89 payrolls are listed below and are assumed to remain level each year thereafter.

The cost of $1,034.6 is calculated as follows:

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| The increase in the PERS contribution rate (.20%) times the estimated FY 89 state PERS payroll ($479,549,872) equals: | $ 959.1 |
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| The increase in the TRS contribution rate (.15%) times the estimated FY 89 Department of Education TRS payroll ($5,613,930) equals: | 8.4 |
| | $1,034.6 |



Note: Please Include Your Social Security Number In All Correspondence & Requests Concerning Your Benefits.

In addition to the state costs described above, there would also be an increase in political subdivisions' FY 89 contribution rate of .20% and in school districts' contribution rate of .15%. This would result in an increase in their annual costs as follows:

| | |
|---|---|
| The increase in the PERS contribution rate (.20%) times the estimated FY 89 political subdivision payroll ($329,744,333) equals: | $ 659.5 |
| The increase in the TRS contribution rate (.15%) times the estimated FY 89 school districts' payroll ($319,882,344) equals: | $ 479.8 |
| | $1,139.3 |

Although there would not be an adverse impact on the actuarial soundness of the PERS and TRS funds if this bill becomes law, the unfunded liability will increase by $3,098,000 and the funding ratio will decrease by .3% in the PERS, and the unfunded liability will increase by $1,826,000 and the funding ratio will decrease by .2% in the TRS.

Sincerely,

Robert F. Stalnaker

Robert F. Stalnaker
Acting Director

RFS/bb/7

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Work Draft
Bill Version: HCSCSSB67(HESS)
Publish Date:

# FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental and nervous disorders.
Sponsor: Faiks and Kerttula
Requestor:

Agency Affected: All Agencies
BRU: Retirement and Benefits
Components: Retirement and Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 532.8 | 532.8 | 532.8 | 532.8 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 532.8 | 532.8 | 532.8 | 532.8 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 481.6 | 481.6 | 481.6 | 481.6 |
| FEDERAL FUNDS | 0 | 0 | 24.5 | 24.5 | 24.5 | 24.5 |
| OTHER | 0 | 0 | 26.7 | 26.7 | 26.7 | 26.7 |
| TOTAL | 0 | 0 | 532.8 | 532.8 | 532.8 | 532.8 |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

DRAFT

Prepared By: Robert F. Stalnaker, Acting Director
Division: Retirement and Benefits
Phone: 465-4470
Date: 2-11-88

Approved by Commissioner: John M. Andrews
Agency: Department of Administration
Date:

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

House Committee Substitute for Senate Bill 67
(2/9/88 Draft Version)
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

February 11, 1988

Analysis: This bill would require would require increased limits of coverage for mental or nervous disorders under the state's health plans for active employees of the state and retirees.

This bill is estimated to result in a $3.70 per month increase in Health Insurance costs of an estimated 12,000 state employees effective July 1, 1988. The costs are assumed to remain level each year thereafter because the state does not yet have any experience analysis to indicate that costs will increase annually for this additional benefit, and it is a small portion of the total Health Insurance package.

The FY 89 estimated cost for active state employees is calculated as follows:

| | |
|---|---|
| The increase of $3.70 per month health cost times the number of state employees (12,000) | $532,800 |

Additional costs reflected in increased employer contribution rates in the Public Employees' (PERS) and Teachers' (TRS) Retirement Systems are discussed in a separate letter to Representatives Ellis and Koponen.

DRAFT

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

Committee Substitute
for
Senate Bill 67 (HESS)

"An Act relating to insurance coverage for the treatment of a mental or nervous condition."

This bill expands group health insurance coverage to include an option for 45 days per year of in-patient treatment and 50 hours total per year of out-patient treatment or office visits for each covered individual.

The department supports the progressive approach of this legislation. However, we suggest several amendments which we believe facilitate access to a cost-effective continuum of mental health services by rural and urban Alaskans. The amendments allow mental health services to be provided in the least restrictive environment and help to reduce the per client cost of care. This continuum includes: comprehensive diagnostic and evaluation services; professional services given in the office, home and extended home; case management; day treatment; various levels of residential care (group homes and other residential facilities); and general or psychiatric hospital services.

1) The definition of "inpatient treatment," Sec. 21.42.365(d)(4), should be expanded to include coverage for appropriate treatment received in residential child care facilities which are licensed by the Division of Family and Youth Services under AS 47.35.

Acute psychiatric care facilities are an essential part of a complete continuum of psychiatric services, however, many persons who suffer from a mental or nervous condition may receive appropriate inpatient treatment in the less restrictive and less costly environment of a licensed group home or residential care center. The only private acute psychiatric care hospital in Alaska listed an FY 1986 cost of $551.00 per day. By comparison, per day costs for group homes range from $89.25 to $210.00.

2) The definition of "outpatient treatment," Section 21.42.365 (d)(8), should be expanded to include any mental health care provider who has a master's or doctoral degree in psychology, nursing, or social work and works in conjunction with one or more licensed mental health care providers.

As presently written CSSB 67 allows reimbursement for outpatient treatment only if the provider:

(1) has a master's or doctoral degree in psychology, nursing, or social work, and

(2) is employed by a community mental health care facility which provides the treatment, and

(3) works in conjunction with a licensed provider.

The department believes that expanding the scope of reimbursable providers would allow access to qualified providers by clients in areas without community mental health centers. Some rural areas do not have easy access to a mental health center, but have professional services available through licensed facilities or professionals working in conjunction with licensed professionals.

This may be accomplished by adding "or" to the end of subsection (B) and adding another subsection to read:

> (C) a person who works in conjunction with one or more of the professionals identified in subsection (B)(i), (B)(ii), and (B)(iii) above, and has a master's or doctoral degree in psychology, nursing, or social work.

The legislature has already supported Medicaid reimbursement for inpatient psychiatric facility care, outpatient treatment in a psychiatrist's office, and the services of the various levels of professionals in state supported community mental health centers. (AS 47.07.030). CSSB 67 provides an opportunity for persons not eligible for the Medicaid program to gain similar insurance coverage.

The Department of Health and Social Services endorses the concept of insurance reimbursement for a full continuum of mental health services provided through licensed facilities or when provided by professionals working in conjunction with licensed professionals. The need for increased accessibility is highlighted in many recent reports (e.g. 1986 Resource Committee Report for S.B. 520, 1985 API Children's Facility Study, and 1986 Banergee Study on Child and Adolescent Grants and Contracts).

CSSB 67 is a significant step forward in the delivery of mental health services in Alaska and is supported by the department. The department supports this legislation and urges consideration of these amendments prior to passage.

RECOMMENDED BY:

2/4/88
Dr. Mel Henry, Director
Division of Mental Health and Developmental Disabilities

2-4-88
Kim Busch, Director
Division of Medical Assistance

2/4/88
Yvonne Chase, Director
Division of Family and Youth Services

Date: February 4, 1988

Approved by:
Myra M. Munson, Commissioner

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CS SB 67 (HFSS)
PUBLISH DATE: _____

# FISCAL NOTE

REQUEST:

Revision Date: _____
Title: ...relating to insurance coverage for the treatment of a mental or nervous cond.
Sponsor: _____
Requestor: _____

Agency Affected: Health & Social Services
BRU: Community Mental Health Grants, Institutions and Administration
Components: Community Mental Health Grants, Alaska Psychiatric Institute

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| 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)

see attached sheet

Prepared by: Mel Henry, Director — Phone: 465-3370
Division: Mental Health & Developmental Disabilities — Date: _____

Approved by Commissioner: Myra M. Munson — Date: 2-4-88
Agency: Health & Social Services

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

FISCAL NOTE

More Alaskans would be able to obtain needed mental health services as a result of passage of this bill. These services could be provided by the public or private sector. The Department of Health & Social Services is unable to estimate how much revenue would be generated by the public sector (Alaska Psychiatric Institute and grantee community mental health centers) because consumption patterns might shift if people could access the private sector.

# STATE OF ALASKA

**DEPARTMENT OF ADMINISTRATION**

*DIVISION OF RETIREMENT & BENEFITS*

*PLEASE REPLY TO:*

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*STEVE COWPER, GOVERNOR*


February 12, 1988

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The Honorable Johnny Ellis
Co-Chairmen, Health, Education,
Social Services Committee
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(2/9/88 Draft)

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| | $1,139.3 |

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Sincerely,

Robert F. Stalnaker
Acting Director

RFS/bb/7

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: Work Draft HCSCSSB67(HESS)
Publish Date:

# FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental and nervous disorders.
Sponsor: Faiks and Kerttula
Requestor:

Agency Affected: All Agencies
BRU: Retirement and Benefits
Components: Retirement and Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 532.8 | 532.8 | 532.8 | 532.8 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 532.8 | 532.8 | 532.8 | 532.8 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 481.6 | 481.6 | 481.6 | 481.6 |
| FEDERAL FUNDS | 0 | 0 | 24.5 | 24.5 | 24.5 | 24.5 |
| OTHER | 0 | 0 | 26.7 | 26.7 | 26.7 | 26.7 |
| TOTAL | 0 | 0 | 532.8 | 532.8 | 532.8 | 532.8 |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

DRAFT

Prepared By: Robert F. Stalnaker, Acting Director
Division: Retirement and Benefits
Phone: 465-4470
Date: 2-11-88

Approved by Commissioner: John M. Andrews
Agency: Department of Administration
Date:

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



Rev: 1/11/87

15/6KP/0211-02

House Committee Substitute for Senate Bill 67
(2/9/88 Draft Version)
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

February 11, 1988

Analysis: This bill would require would require increased limits of coverage for mental or nervous disorders under the state's health plans for active employees of the state and retirees.

This bill is estimated to result in a $3.70 per month increase in Health Insurance costs of an estimated 12,00 state employees effective July 1, 1988. The costs are assumed to remain level each year thereafter because the state does not yet have any experience analysis to indicate that costs will increase annually for this additional benefit, and it is a small portion of the total Health Insurance package.

The FY 89 estimated cost for active state employees is calculated as follows:

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|---|---|
| The increase of $3.70 per month health cost times the number of state employees (12,000) | $532,800 |

Additional costs reflected in increased employer contribution rates in the Public Employees' (PERS) and Teachers' (TRS) Retirement Systems are discussed in a separate letter to Representatives Ellis and Koponen.

DRAFT

SPRING 1986

# PERSPECTIVE

THE BLUE CROSS AND BLUE SHIELD MAGAZINE

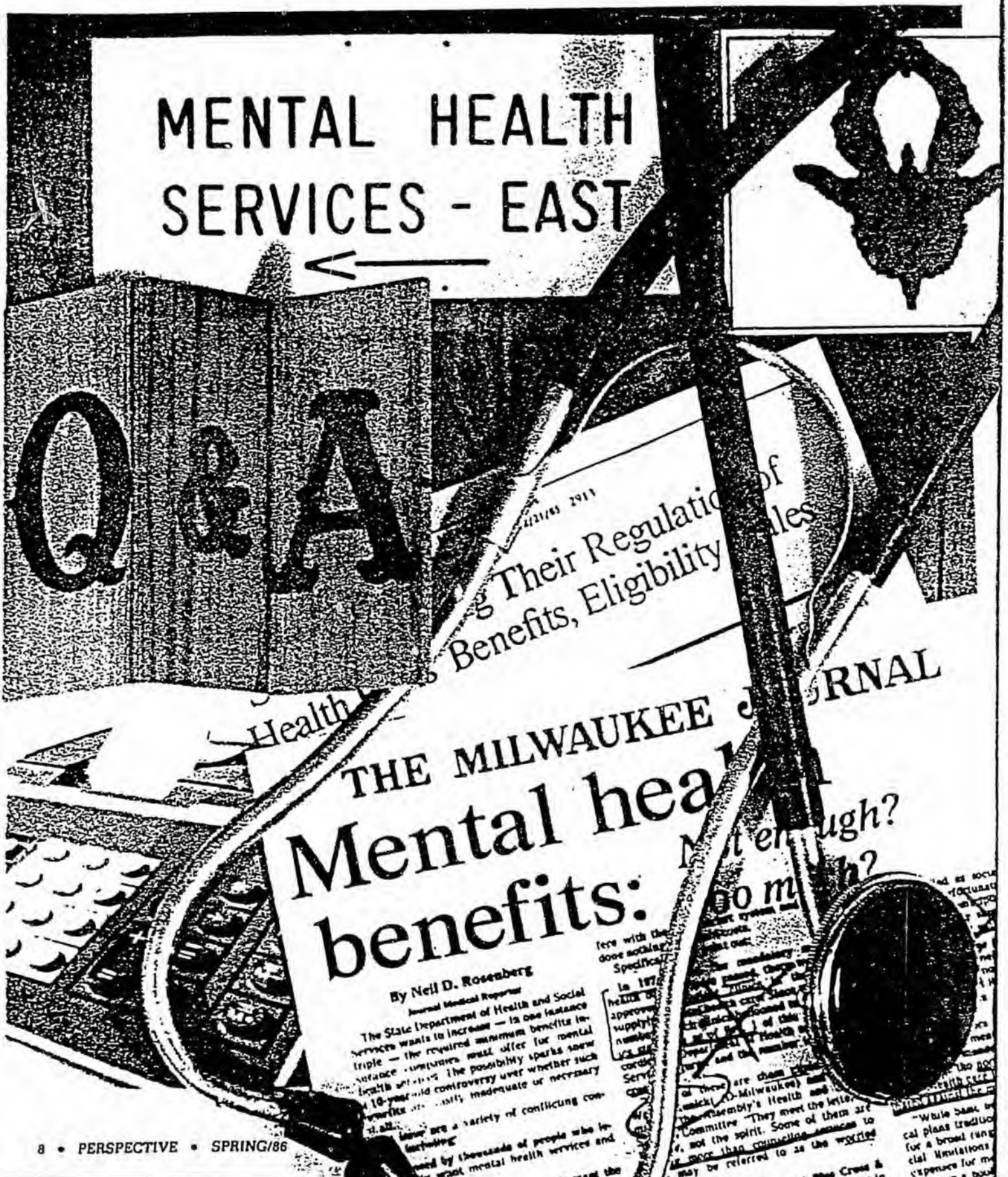


## SEVEN QUESTIONS READERS ASK ...

*including the cost of high-tech baby care*

QUESTION #2:

# Why Are Mental Health Benefits So Troublesome For Health Insurers?



Greg Scandlen speaks as an analyst for the Blue Cross & Blue Shield Association. He says "insurers are nervous about *any* kind of benefit that they can't get an actuarial handle on," that is, be able to project usage patterns, fees charged and total payout.

Studies of mandated mental health benefits indicate that, even where cost barriers have been removed, a very small segment of the population uses the benefits, predominantly the more affluent. In the Federal Employee Health Benefit Program, only 2% used the mental health benefit but spent 8% of the available monies.

Linda Frisman, of the economics department at Boston University, offers this insight: the Massachusetts mental health mandate doesn't affect two million residents (the self-insured), those on Medicare, those on Medicaid.

Wisconsin State Rep. John Merkt questions "when is enough, enough?" in mandated mental health coverage, citing usage of the benefit by the 4,200 students on the Madison campus of the University of Wisconsin, one-third of whom used the benefit last year, enough to more than double the student health insurance premium. Of the claims for psychiatric, alcoholism and drug abuse services, 90% were psychiatric, a pattern that he labels "abuse." He explains: "This benefit is subject to overuse and abuse by both users of the service *and providers* of the service." Merkt launched a study that found students using the full benefit in the first semester, then using the full benefit again in the second semester. This was corrected by changing the student health policy from a calendar-year basis to a policy-year basis.

Rep. Merkt

Moreover, state legislators voted to double the first-dollar coverage (from $500 to $1,000), but added a 10% copayment. Then they expanded outpatient treatment locations to include the offices of psychiatrists and nationally registered psychologists. Unsatisfied, they voted an inpatient-benefit minimum (30 days or $7,000 minus a 10% copayment, whichever is less).

## CONGRESS FEARFUL

Insurers argue that Congress, unlike the states, has been fearful of abuse and excessive cost for mental health benefits, hence legislating a 50% copayment and even a $250 annual limit for psychiatric coverage under Medicare.

Earl Thayer, secretary of the State Medical Society of Wisconsin, sees mandates as "a self-generating mechanism to increase care when it's not really needed." He explains: "It's damned expensive when you take optional things and make them mandatory. It sounds like you're treating people equally, but mandates are creating a demand that was never there before."

On the matter of abuse, Wisconsin State Rep. Walter Kunicki says that, "in many cases, mental health centers are staffed with persons of limited training who hold themselves out as mental health practitioners in order to bill for services which are more properly classified as social services." He calls these understaffed centers "psychotherapy mills."

The Wisconsin Department of Health & Social Services contends that mandating outpatient coverage reduces the demand for bed care.

But insurers find it nearly impossible to identify displaced costs.

New Hampshire Blue Cross & Blue Shield found these disturbing results of a mandated mental health benefit:

## When Mental Health* Was Mandated ... In 29 States

| | |
|---|---|
| 1973 | California<br>Maryland (enriched 1975)<br>Massachusetts (enriched 1982)<br>Oregon |
| 1974 | Illinois (enriched 1977) |
| 1975 | Connecticut (enriched 1982)<br>Louisiana<br>Minnesota<br>New Hampshire (enriched 1983)<br>North Dakota |
| 1976 | Colorado<br>Florida (enriched 1983)<br>Vermont<br>Virginia (enriched 1977)<br>Wisconsin |
| 1977 | New York<br>West Virginia |
| 1978 | Kansas |
| 1979 | Arizona<br>Arkansas (enriched 1983)<br>Maine (enriched 1983)<br>Tennessee (enriched 1980) |

*That's 22 states in the 1970's.*

| | |
|---|---|
| 1980 | Missouri<br>Ohio |
| 1981 | Georgia (enriched 1984)<br>Michigan<br>Texas |
| 1982 | (none; but see 1973 and 1975) |
| 1983 | Washington |
| 1984 | Hawaii |

*That's another 7 states already in the 1980s.*

---

*not counting alcoholism (38 states) and drug abuse (15 states), benefits which involve mental health services, these often mandated ahead of the mental health benefit itself

Meanwhile, 34 states mandate paying for psychologists, 6 for psychiatric nurses and 10 for social workers.

**not counting mentally handicapped (32 states)*


- Psychiatric inpatient claims have not declined.
- Hospital length of stay for such disorders has increased.
- A 54% increase in costs the second year, a 245 increase in four years.
- Community mental health center rates have gone up 30% faster than the fees charged by private psychiatrists.

Similarly, a study of CHAMPUS (health program for dependents of those in military service) shows that, in claim-heavy Hawaii, social workers charged *more* than psychiatrists, and more than half of their claims were disallowed because of price.

Massachusetts was one of four states to feel the initial impact of state-mandated mental health coverage. The year was 1973.

California, Maryland and Oregon were in that maiden group.

But it is Massachusetts which sums up the results of those 12 years. Says John Thompson, president of Blue Shield of Massachusetts (with Blue Cross-Blue Shield the biggest health insurers in the state and nominal targets of the 1973 legislation):

> "Prior to the mandated $500 mental health benefit, the Plan paid $1.9 million for outpatient mental health benefits. Payments have increased by 2,400% ... exceeding $48 million in 1985.
>
> "Moreover, there are now more than 6,600 psychiatrists, and licensed clinical independent social workers participating in the benefit ... a ratio of one mental health provider for every 666 citizens ... the

highest of any state in the country. Mandating reimbursement policies for third-party payors increases the proliferation of providers."

## WISCONSIN CARE BOOMING

Wisconsin's experience matches Massachusetts':

- In 1974 when mental health benefits were mandated, there were 39 approved outpatient clinics in the state.
- By 1984, clinics ballooned to 939 and are "still increasing."

Similarly, says Blue Cross & Blue Shield United of Wisconsin:

- In 1974, mental health claims amounted to 25¢ a month per subscriber.
- By 1984, that figure had jumped to $1.56, "flying in the face of reasonable cost-containment efforts."

Other Blue Cross & Blue Shield Plans have looked at mental-health mandates on the basis of added fees to the subscriber:

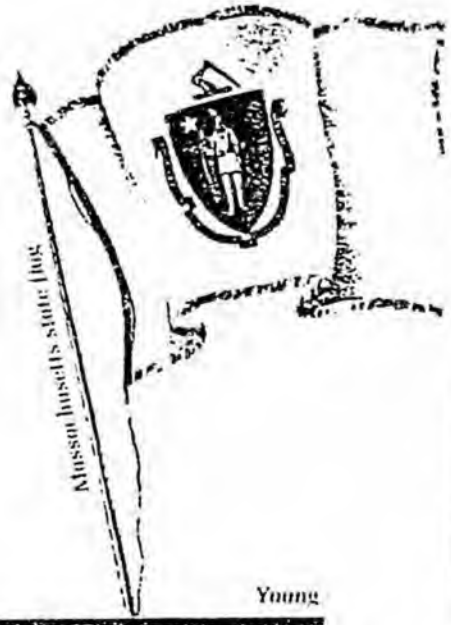
- $6 extra family fees per month in Massachusetts,
- "nearly $5" in Kansas, and
- "between $2 and $3" in Maryland.

No sooner did the Supreme Court hand down its ruling that states had a right to mandate benefits than a bill was introduced asking Massachusetts legislators to increase the mental health mandated psychotherapy benefit from $500 to $1,000. But that was one of only dozens of such legislative thrusts provoked by the decision.

States are accused of "dumping," getting rid of their social responsibility. James Young, MD, vice president of Blue Shield of Massachusetts, explains how pressures develop: The state moved to de-institutionalize mental patients; at the same time, the legislature "passed mandated-benefits legislation to facilitate it."

Kevin Dwyer in the BUSINESS JOURNAL says that "mandates have been a boon to outpatient treatment and counseling centers, the home health care industry, chiropractors, optometrists, even government-run health services agencies."

A business regulation committee in Maine was told that the proposed mental health bill (1983) "is without cost-restraint ... no regulatory restraints on the cost or growth of mental health (services) ... not subject to rate review, certificate of need, or even health planning (except for inpatient beds) ... and precluded the selective contracting, fee negotiations, preferred provider arrangements or capitated reimbursement mechanisms which hold so much promise in the area of cost containment." The law passed anyway.




Young

NON-DISCR.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

April 2, 1987

Honorable William H. Gray, III
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, DC

Dear Mr. Chairman:

This letter responds to a request by the Committee Staff for an estimate of H.R. 1067, the "Medicare Mental Illness Non-Discrimination Act" introduced by Representative Downey. Technical problems with the legislative language in the bill prevented us from estimating the bill as introduced. However, discussions with your and Representative Downey's staffs permitted the following general estimates to be developed.

The intent of the bill is to remove the current limitations on Medicare coverage of mental health and inpatient psychiatric hospital services. Current law limits the maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for the treatment of mental, psychoneurotic, or personality disorder to $250 per calendar year for each Medicare beneficiary. Medicare only recognizes a maximum of 62.5 percent of $500 of such charges, or $312.50, and will reimburse 80 percent of this amount or $250. Consequently, the effective coinsurance rate is 50 percent for the first $500, and 100 percent thereafter. The reimbursement limit applies to all mental health services whether or not they are supplied by a physician or psychiatrist. However, the limit does not include diagnostic services supplied by a physician. Current law also limits inpatient psychiatric hospital care to 190 days during a beneficiary's lifetime.

Our estimate of the cost of removing the current limitations on mental health and inpatient psychiatric hospital care is contained in the following table. Per your staffs' request, we also have included an alternative approach where the mental health benefit limit is raised from $250 to $2000 per calendar year. The unrounded increase in the Part B monthly premium for each option is also shown as requested. All estimates are in millions of dollars for fiscal years.

| Option | Fiscal Years 1988 | 1989 | 1990 | 1991 | 1992 | 5-Year Total |
|---|---|---|---|---|---|---|
| 1. Eliminate Mental Health Limit of $250 per year | | | | | | |
| Outlay Increase (millions of $) | 150 | 230 | 300 | 450 | 520 | 1690 |
| Premium Increase ($ per month) | .11 | .12 | .13 | .13 | .13 | |
| 2. Increase Mental Health Limit from $250 per year to $2000 per year | | | | | | |
| Outlay Increase (millions of $) | 140 | 210 | 300 | 400 | 460 | 1510 |
| Premium Increase ($ per month) | .10 | .10 | .11 | .11 | .12 | |
| 3. Eliminate Inpatient Psychiatric Hospital Lifetime Limit | | | | | | |
| Outlay Increase (millions of $) | 270 | 410 | 460 | 510 | 560 | 2210 |
| Premium Increase ($ per month) | .20 | .21 | .21 | .22 | .23 | |

Development of this estimate involved using data from the Medicare and the Medicaid Statistical Systems. The estimate also benefited from the recently completed Medicare Mental Health Demonstration conducted by the Department of Health and Human Services. This demonstration was a multi-year, multi-million dollar examination of the expansion of Medicare's mental health benefit. Several of the experimental variations examined by the demonstration were very similar to the modifications of current Medicare law proposed in the bill.

Mental Health Estimates

The Medicare statistical system data showed that approximately 465,000 Medicare beneficiaries used $47 million in mental health services in 1985. Hence, the average user of mental health services used $101 in 1985. In addition, approximately 10 percent of the beneficiaries who had mental health services had claims that totaled very near or at the $250 limit. More importantly, this 10 percent of users consumed approximately 29 percent of all Medicare mental health outlays.

The Medicare mental health demonstration had a number of demonstration sites where Medicare beneficiaries were allowed unlimited mental health benefits. The average weighted cost per Medicare user in these sites was over $510 per year. However, the demonstration did focus on providing services through carefully selected provider groups and outreach activities. A more general expansion of the mental health benefits might therefore not be expected to produce increases of this magnitude. Hence, we reduced this estimate of per capita spending in an unlimited setting by 25 percent to approximately $384 per year. One approach to the estimate would have been to assume that provision of an unlimited mental health benefit would have raised the average outlay per user from $101 to $384 per year. However, such an approach would omit several important considerations.

First, many observers believe that some elderly who currently need mental health services are receiving them through providers billing mental health services through other billing codes not subject to the mental health limit, thus avoiding $250 limitation. We were unable to locate any reliable data regarding the frequency of this occurrence. However, we did reduce the overall increase in cost per user by 5 percent to account for this factor based on widespread agreement that at least some care is being provided in this manner. A second consideration in the estimate is the increase in the number of users of mental health services that removing the limit would produce. The Medicare Mental Health Demonstration found that the number of users of services doubled during the demonstration. Since the 465,000 current users represent 1.52 percent of Medicare enrollees, that would mean that approximately 3 percent of all Medicare enrollees could become users. Given the estimates of the prevalence of mental health problems among the elderly which range as high as 18 percent, an increase from 1.52 percent to 3 percent users seems reasonable. However, although we believe that this level of use would eventually be reached, it would take several years to reach these levels due to such constraints as the available supply of providers. Hence, we have assumed that the use rate would be 1.8 percent in 1988, 2.1 percent in 1989, 2.6 percent in 1990 and 3 percent in 1991 and 1992. Finally, although the Medicaid statistical system could not produce exact estimates, it appears that eleven states offer some additional mental health coverage to medicare beneficiaries who are also medicaid eligible. Based on conversations with Medicaid staff in these states, we reduced the estimate by 5 percent to account for this factor.

Our estimate of eliminating the Mental Health Limit (option 1) involved combining the foregoing assumptions with our baseline assumptions concerning increases in program prices and overall Medicare program growth. The estimate of placing a $2000 per calendar year limit on mental health reimbursement (option 2) built on the estimate of option 1. Specifically, the Medicare Mental Health Demonstration found that 6.2 percent of the users exceeded $2000 per year in costs.

The 6.2 percent of users consumed 12 percent of total mental health services, and we have reflected this in our estimate.

It should be noted that an argument can be made that other Medicare savings will accrue because of the improved health status of those receiving these expanded services. However, the demonstration evaluators found no such effects. Based on their findings and a lack of other evidence on whether such offsets exist, we made no adjustment in our estimates.

Inpatient Psychiatric Benefit Estimate

Medicare spent approximately $550 million on providing 103,400 beneficiaries inpatient psychiatric hospital care in 1985. Unfortunately, the Medicare Statistical system could not identify the exact number of persons that reached their limit during the year. However, the Medicaid Statistical system identified approximately 31,000 Medicare enrollees that received $813 million in inpatient psychiatric hospital services through the Medicaid program. If the current 190 day lifetime Medicare reimbursement limit were eliminated, Medicare would pay for many of the services currently being reimbursed through Medicaid, and federal costs would increase by the state share of Medicaid. In addition, some additional utilization would occur from beneficiaries or their families who are financing care not currently being paid for by either Medicare or Medicaid. After examining the current distribution of stays in such hospitals, it appears that a 12 percent increase could be expected based on the number of stays at the current limit. As was the case with the mental health estimate, the combination of the foregoing assumptions and our baseline assumptions yielded our estimate of eliminating the Medicare inpatient psychiatric hospital limit.

Please note that all estimates are preliminary pending final legislative language. If you have any further questions, please call me or have your staff contact Don Muse (226-2820).

With best wishes,

Sincerely,

Edward M. Gramlich
Acting Director

cc: Honorable Thomas J. Downey

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# Changes in Health Care Costs and Utilization Associated With Mental Health Treatment

Harold D. Holder, Ph.D.
James O. Blose, M.P.P.

*Health insurance claims of families covered by Aetna's Federal Employees Health Benefit Program from 1980 through 1983 were analyzed to determine if any changes in total health care utilization and costs were associated with the initiation of mental health treatment. A total of 26,915 families in which at least one member received mental health treatment were compared with a randomly selected group of 16,468 families in which no member had received mental health treatment. Total health care costs for those receiving mental health treatment were significantly higher than costs for the comparison group. However, those costs dropped significantly after initiation of mental health treatment and continued to decline over the study period. The biggest declines occurred among persons age 45 and older, a finding that may have important policy considerations.*

While mental health care could be seen as adding to the overall cost of general health care, there is growing evidence that mental health care actually results in lower total heath care utilization and costs for treated persons. This can be the result even when the cost of mental health care itself is included. Follette and Cummings (1), in

one of the first major American studies of this question, found that the use of nonpsychiatric medical services dropped following the initiation of psychotherapy. Jones and Vischi (2) reviewed 13 studies and found that 12 showed reductions in medical care utilization ranging from 5 to 85 percent following mental health intervention.

Mumford, Schlesinger, and Glass (3), in a meta-analysis of 15 controlled cost-offset studies published before 1978, estimated the cost-reduction effect for mental health treatment at between 0 and 14 percent.

Mumford, Schlesinger, and Glass (4), following a review of research on the impact of psychological intervention on recovery from surgery and heart attacks, found that on the average psychological intervention reduced hospitalization by approximately two days below the control group's average of 9.92 days.

Another study by Mumford and associates (5), which utilized a meta-analysis of published cost-offset research, found that the range in outcomes varied from a 72.4 percent increase in the use of medical services following psychotherapy to a 181.6 percent decrease. The study found that the offset effect is likely to be greater for inpatient medical care utilization than for outpatient utilization. It also found that older people had greater offset effects following mental health treatment than did younger people.

Dr. Holder is director of the Prevention Research Center in Berkeley, California, and lecturer in the School of Public Health at the University of California. Mr. Blose is a senior analyst at the Human Ecology Institute in Chapel Hill, North Carolina. Dr. Holder's address is 2532 Durant Avenue, Berkeley, California 94704. This research was conducted under contract no. ADM 281–83–0011 with the National Institute of Mental Health.

The same research team has also conducted a five-year longitudinal analysis of medical care utilized by persons enrolled with the Blue Cross/Blue Shield Federal Employees Benefit Program from 1974 through 1978. They found that persons with from seven to 20 mental health outpatient visits had medical care charges that were $309 lower than those of the comparison group, and those with more than 21 visits had charges $284 lower than the comparison group (6).

Two studies have been conducted involving patients from the Columbia Medical Plan. Kessler and associates (7) found a 7.6 percent reduction in medical visits for adults in the year following the beginning of the psychiatric episode compared with the year before, and a 9.3 percent reduction for children. Hankin and associates (8) found that the receipt of specialty mental health care was followed by a short-term reduction in nonpsychiatric utilization.

Emotional problems could be associated with either underutilization or overutilization of medical care (3). Underutilization as a result of self-abuse or neglect can contribute to excess morbidity and untreated physical disability or disease. Thus higher medical care costs could follow mental health treatment as a consequence of an improved emotional state and increased self-awareness (9,10).

On the other hand, overutilization prior to initiation of mental health treatment could result in substantially higher general medical care costs. The above studies suggest that overutilization of health care prior to initiation of mental health treatment is more likely than underutilization, on the average.

## Research design

This paper describes the results of a research project to further investigate the question of over- or underutilization of health care and to document the nature of changes in health care costs and utilization following initiation of mental health care. The findings described are from a study of federal employees and their family members enrolled with the Aetna Life and Casualty Company under the Federal Employees Health Benefit Program (FEHBP) during the calendar years 1980 through 1983. To document changes in total health care utilization and costs, the study analyzed all health insurance claims filed by covered individuals who began mental health treatment.

During the years covered by this study, Aetna FEHBP was the second largest of more than 100 health plans available to federal employees. Two benefit options were available under the plan: the high-option plan, which set limits of $20,000 annually for inpatient mental health care and $1,000 annually for outpatient mental health care; and the low-option plan, which had limits of $15,000 and $750, respectively.

Both options included coverage for treatment services rendered by a wide range of practitioners and facilities, as long as overall care of the patient was evaluated and controlled by a physician. There were no changes in mental health coverage during the study period.

In this study, persons receiving mental health treatment were defined as those who had received medical treatment under a primary diagnosis of mental illness. All health care claims were reviewed to locate all families with one or more members who had filed at least one claim for mental health treatment and who were continuously enrolled with Aetna during the study period. The number of such families totaled 26,915, and 33,009 individuals in these families received mental health treatment.

In addition, a random sample from the total continuously enrolled population of families who did not file claims for mental health treatment was selected as a comparison group. This random sample was composed of 16,468 families and included 41,829 indi-

viduals who were stratified by age to match the age distribution of the mental health study group. Families with any member receiving treatment for alcoholism or drug abuse were excluded from both the comparison group and the mental health study group.

The ideal research design for determining statistically significant changes in total health care patterns would use experimental treatment and no-treatment control groups randomly assigned from the same population. However, the identification of a diagnosed but untreated group is impossible in a large field study utilizing health insurance claims as a means to identify the treatment population.

An alternative is a quasi-experimental design that utilizes a nonequivalent comparison group as well as multiple pretests and posttests (11,12). A pre-post design was used to compare pre-mental-health-treatment averages over various time periods with averages after initiation of treatment.

Since the comparison group is a nonequivalent one, it can be used only for baseline comparisons with the mental health treatment group.

In addition, a longitudinal analysis that pooled available data from all individuals was used to describe long-term patterns. The pre-post analysis permits reliable testing for statistically significant changes in cost and utilization. The longitudinal analysis permits use of all the available data to document long-term trends and tendencies.

## Comparison of the groups

The mental health study group and the comparison group were quite similar in average family age, family size, and type of health insurance plan option. The average family size for those with at least one member receiving mental health care was 2.57 persons, compared with 2.54 persons in families in the random sample. The average family age (as of January 1984) was 48.8 years for the mental health treatment group and 49.2 years for the comparison group. The same percentage of both groups (79 percent) were enrolled under high-option coverage.

The monthly per-person costs (in January 1980 dollars) for all health care for families with at least one member receiving mental health treatment were $158.82, compared with $91.85 for the random sample. Most of this difference was the result of inpatient treatment costs ($104.85 a month for the mental health treatment group versus $60.12 a month for the random sample). However, there were also differences between the two groups in ambulatory care and other costs over the four-year study period.

The families with at least one member receiving mental health treatment averaged .39 inpatient days per person per month compared with .18 days for the random sample. Mental health treatment costs amounted to $22 per month, or 14 percent of the $159 average monthly costs for all health care for persons in the mental health study group, thus indicating that these cost differences are not due primarily to the cost of mental health treatment. All of these comparisons were statistically significant at $p<.001$. In point of fact, given the relatively large treatment group and comparison group sizes utilized in this study, most differences were statistically significant.

## Mental health treatment costs and utilization

During the 1980–83 period, those in the continuously enrolled population who filed mental health treatment claims were largely female (60.6 percent). The mean age was 45.3 years but varied widely. More than 16 percent of the group were under 21 years old and 23 percent were 65 and over. Forty-five percent of the group were enrollees (federal employees or annuitants), 33 percent were spouses, and 22 percent were dependent children. Less than 1 percent were other dependents.

The cost of mental health care per person receiving care during the study period was $2,079 (January 1980 dollars), of which 63.4 percent was paid by Aetna as health insurance benefits. Inpatient care, though utilized by only 20 percent of the mental health patients, accounted for 60 percent of mental health treatment costs. The average length of inpatient mental health treatment was 32.2 days. More than half of the inpatient stays were 21 days or less, and almost a fourth were seven days or less. The average cost per admission was $3,887 (January 1980 dollars), and the average number of admissions per person utilizing inpatient care was 1.57. No data were available on whether the inpatient stays were in specialty facilities or general hospitals.

Ambulatory care was used by 83.7 percent of those receiving mental health treatment, and they had an estimated 22 mental health ambulatory visits per person during the study period. The number of estimated visits is based on claims data from institutional providers only; whether a similar number of visits were made to private practitioners is unknown. The primary providers of ambulatory mental health care were physicians, who accounted for 71 percent of total visits (Aetna's codes did not distinguish between types of physicians); psychologists, who accounted for 20 percent; and psychiatric social workers, who accounted for slightly more than 3 percent.

## Pre-post patterns of medical care

Total medical care costs and utilization for individuals receiving mental health treatment were analyzed using the first such treatment event as a reference point. Individuals began treatment during each month of the study period, and there were varying amounts of data available for analysis before and after initiation of treatment. For example, persons beginning treatment in early 1980 would have only a few months of pretreatment data but more than three years of posttreatment data. For those whose initial treatment was in mid-1983, the opposite situation applied.

The primary research question

was whether there was a reduction in total health care utilization and cost following initiation of mental health treatment. Thus the study tested for statistically significant changes in medical care costs and utilization using three groups composed of individuals having similar pre- and posttreatment periods. The first group contained persons for whom 12 months of pretreatment data and 12 months of posttreatment data were available (N=12,699). Analysis found a statistically significant decrease in total monthly health care costs per person ($t=6.44$, $df=25,396$, $p<.001$). The costs dropped from $263.28 before treatment to $208.79 after initiation of treatment (January 1980 dollars).

Longer and more meaningful periods of comparison were provided by group 2, persons for whom a full 24 months of pretreatment data and 12 months of posttreatment data were available (N=5,213). In general, cost and utilization levels in group 2 increased from the 13- to 24-month pretreatment period to the 12 months preceding initial mental health treatment; they then declined during the first 12 months after initiation of treatment. Total health care costs per month per person increased from $121 to $278 and then fell to $202 after initiation of treatment ($F=102.14$, $df=15,638$, $p<.001$). This pattern is primarily due to changes in inpatient costs, which went from $74.91 during the 13- to 24-month pretreatment period to $201.33 after initiation of treatment. Inpatient costs in the 12-month period after initiation of mental health treatment dropped to $127.70. The differences were statistically significant ($F=82.02$, $df=15,638$, $p<.001$). Ambulatory costs and utilization remained essentially the same during the first year after initiation of treatment.

These results are confirmed in the analysis of group 3, those with at least 12 months pre- and 24 months posttreatment data. This group provides clear evidence that the decline in cost and utilization continues in the second year following the initiation of mental health treatment. Total health care costs per month per person fell from $242 in the year before treatment to $214 in the first year after treatment began to $162 in the following year. These differences were statistically significant ($F=21.88$, $df=17,642$, $p<.001$). As with group 2, this drop was primarily the result of decreases in inpatient days per month per person from .63 to .52 to .39 days ($F=19.02$, $df=17,642$, $p<.001$) and inpatient costs per month per person from $167 to $133 and $106 ($F=13.95$, $df=17,642$, $p<.001$). Ambulatory care costs actually increased in the year following initiation of treatment (from $59.15 in the year before to $64.15 in the year after) due to the use of ambulatory mental health services, but they fell below the pretreatment level in the second posttreatment year ($42.29). These differences were also statistically significant ($F=60.59$, $df=17,642$, $p<.001$).

**These results provide considerable evidence that total health care costs and utilization gradually increased before mental health treatment was initiated and decreased afterward.**

These results provide considerable evidence that the total health care cost and utilization for treated persons gradually increased prior to the initiation of mental health treatment and then decreased afterward. This is true even when all mental health treatment costs and utilization are included in the analysis. Ambulatory care often did not follow this pattern, likely due to extensive use of ambulatory mental health care during the period after initiation of treatment.

The health care patterns of the family members of persons receiving mental health treatment were also analyzed. Total monthly health care costs for the family members of mental health patients showed a downward trend, beginning before the point of initiation of mental health treatment of the family member or members. For example, untreated individuals with data for at least 24 months before and after initiation of treatment for a member of their family (N=3,074 families) had total health care costs per month per person of $101.71 in the 13- to 24-month pretreatment period, $93.13 in the 12-month pretreatment period, and $74.03 in the 12-month period after initiation of treatment ($F=5.05$, $df=9,221$, $p<.01$).

While in general the health care patterns of the family members of mental health patients follows that of the treated group, that is, costs are higher before treatment and lower after initiation of treatment, the peak in costs occurred in the second year prior to treatment and declined after that point. This could suggest that family members anticipated the start of mental health treatment, or that they put more personal energy into support and less into utilization of health care as the family member with mental health problems became increasingly disabled just prior to treatment. It is also possible that the increasing disability of the family member with emotional problems in some ways deterred other members from utilizing health care.

## Longitudinal analysis of total health care costs

The pre-post analysis confirms that statistically significant changes in health care patterns are associated with the initiation of mental health treatment. However, the patterns of average monthly total health care costs can also be examined longitudinally by pooling the data for all mental health patients (more than 33,000). This yields a distribution of average cost per individual over a six-year period—36 months before and 36 months after the initiation of mental health treatment. The pretreatment val-

ues were $108 (31 to 36 months), $128 (25 to 30 months), $124 (19 to 24 months), $126 (13 to 18 months), $147 (seven to 12 months), and $493 (one to six months). Posttreatment initiation values were $239 (one to six months), $183 (seven to 12 months), $167 (13 to 18 months), $158 (19 to 24 months), $144 (25 to 30 months), and $137 (31 to 36 months).

These data illustrate the gradual rise in total health care costs over the 36-month period before the start of mental health care and a sharp climb in such costs in the six-month period immediately prior to treatment. After treatment began, total costs dropped continuously over the following 36 months.

The longitudinal patterns of age and gender subgroups were similar to that of the overall study population. However, important differences between subgroups did exist. One way of examining these differences is to evaluate the extent to which the health care costs of persons receiving mental health treatment converge with the cost levels of individuals of similar age or sex from the random sample of families in which no members received mental health treatment.

For each six-month interval defined above, monthly total health care costs of treated individuals were transformed into a proportion of the average monthly per-person health care costs of the corresponding age or sex cohort from the random sample. The age and sex cohort provides a baseline for the expected level of cost on the average. For each month of the study period, average total health care costs for the mental health patients (defined by age group or gender) were divided by the monthly average for the corresponding age or sex cohort to develop an index or ratio. Thus a value of 1 indicates that the monthly average for any interval was equal to the monthly four-year average of the baseline group. A value less than 1 means the mental health treatment group experienced costs less than the baseline, and a value greater than 1 indicated costs higher than baseline.

All of the three youngest treatment subgroups (under 14, 14 to 19, and 20 to 24) incurred initial costs (in the 31- to 36-month pretreatment period) that were higher than their age cohorts, with values of 1.47, 1.19, and 1.61, respectively. By the end of the follow-up period (31 to 36 months after initiation of treatment), health care costs for all groups remained considerably higher than for their age cohorts (2.49 for those under age 14, 3.17 for ages 14 through 19, and 2.44 for ages 20 through 24). The 14 to 19 age group had the highest costs relative to their nontreatment age cohort at the time of initiation of treatment. Their costs peaked at a level 23 times higher than their general age cohort.

Compared with their younger counterparts, mental health patients in the three older subgroups (25 to 44, 45 to 64, and 65 and older) incurred costs that converged more closely with those of their age cohort by the final posttreatment interval (31 to 36 months). This is illustrated by the values of 2.12 for those between age 25 and 44, 1.73 for those between age 45 and 64, and 1.37 for those age 65 and older.

Cost ratios for males and females were also analyzed. Females in the treatment group initially (31 to 36 months prior to treatment) had total health care costs per month that were significantly higher than costs for females in the random sample (a proportional value of 1.77). Males receiving mental health treatment, however, had costs comparable to males from the random sample baseline at this point (1.01). By the final posttreatment period, males were closer to the levels of the random sample (1.66) than were females (1.99), although the costs for treated females were closer to their actual pretreatment costs.

## Conclusions

The results of this study provide confirmation of the findings of previous studies as well as provide new findings, previously unreported, concerning the question of the potential for mental health treatment to reduce other health care costs.

In this study, the total health care utilization and costs of Aetna FEHBP-enrolled families receiving mental health treatment were higher than those of a demographically similar comparison group of enrolled families not receiving mental health treatment.

The longitudinal pattern of total health care costs illustrates that a marked increase in such costs among individuals with mental health problems can be expected over the 36-month period prior to initiation of treatment. A decrease in total health care costs can be expected following the start of mental health treatment—even when the costs of this treatment are included. This is in contrast to Borus and associates' finding (13) that offset savings in general ambulatory medical care were overshadowed by charges for the specialty mental health care itself.

Our analysis of specific age subgroups indicates that subpopulations are differentially contributing most to the overall drop in total health care utilization. The best convergence with the baseline level of their general age group cohorts occurred for patients who were age 65 and older, followed by those in the 45 to 64 age group. The two youngest groups, ages 14 to 19 and under age 14, had the least convergence with their general age group cohorts. It is possible that these differential cost patterns are due in part to age-related variations in specific diagnoses or in severity of mental illness. This issue could not be addressed with the data available for this study but merits further investigation.

It is not possible to estimate exactly how much of the decline in health care utilization after initiation of treatment is due to treatment per se versus other factors such as self-selection and motivation, regression toward the mean, and so forth. The relatively long periods before and after initiation of treatment used in our analyzes, however, provide a valuable perspective for evaluating this issue.

Some previous studies that have utilized relatively short pretreatment periods (usually 12 months) have been open to the criticism that the reductions in health care costs immediately following treatment initiation might be explained by "regression to the mean" (3,5).

Following an extraordinary level of stress and discomfort (one expression of which is increased health care utilization), a subsequent drop in health care utilization could be expected (at least temporarily) simply because of the termination of the crisis at hand.

Some of the observed decreases in costs and utilization in this study are likely related to this natural adjustment. However, we found that the health care costs of treated individuals continued to drop in relation to their prior costs as well as in relation to the costs of untreated persons of similar age and sex for up to three years after initiation of treatment. We believe it is rather unlikely that this decline is totally explained by an ending of a personal crisis (and the resulting statistical regression).

This study, like the others cited earlier, supports a conclusion that the initiation of mental health treatment by self-motivated patients can yield positive reductions in health care utilization and costs for a large insured population even when there is no direct control over the variety and quality of care. Such a finding has important policy implications for prepaid medical groups as well as insurance companies.

No study of the health care costs and utilization of treated persons based on a single enrolled health insurance population is readily generalizable beyond that population. Given the heterogeneity of enrolled populations, the variety of health insurance benefit plans across the country, and the mix of available general health care and mental health treatment services, no single study is likely to be nationally representative.

This study is not as subject to biases due to regional variations in general health or mental health care as is much other research, since the population of persons filing mental health treatment claims with Aetna is a national one, drawing on all 50 states. However, it is not necessarily geographically representative of either the U.S. population or the population of federal employees, since many factors influence the choice of health plans by government workers.

Roughly 60 percent of Aetna claimants receiving mental health treatment are age 45 and older. The study finding that older age groups have greater opportunity for cost reductions than younger groups is an important policy consideration. Older people tend to use more medical care services than those in younger age groups, specifically more expensive hospital care. As the Aetna-enrolled population is older than many enrolled populations, studies of a noticeably younger enrolled population may find smaller treatment effects.

This study makes an important contribution to an ever-enlarging research base concerning the patterns of health care before and after mental health treatment. The study documents the potential of reductions in total health care costs following initiation of mental health treatment. The longitudinal pooled data show that total health care costs at the end of the 36-month period following initiation of treatment are higher than the costs at the equivalent point 36 months before treatment. However, given the six-year span represented and the general tendency of health care costs to increase as a population ages, this result is not surprising.

Since the cost trend following treatment initiation is downward, it may not be unrealistic to expect even lower total health care costs over a longer follow-up period.

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Official Business

**COMMITTEE:** HOUSE HESS

**DATE:** 2-9-88

# SIGN-IN

**Subject of meeting:**
CSSB 330 Approp: DOE for K-12
HB 372 Suspended Imposition of Sentence
CSSB 67 Health Insurance for Mental Conditions

| NAME | ADDRESS | PHONE | REPRESENTING | DO YOU WANT TO TESTIFY?. if yes, which one? |
|---|---|---|---|---|
| BOB STALNAKER | BOF CR | 465-4470 | RETIREMENT + BENEFITS | CSSB 67 |
| Sharron Fothergill | 3340 Fritz Cove Juneau | 586-4950 | Mental Health Trust | 67 4 |
| Jerald Mikesell | Pouch F | 465-2865 | DOE | no |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |

Official Business

**COMMITTEE:** HOUSE HESS

**DATE:** 2-9-88

# SIGN-IN

**Subject of meeting:**
CSSB 330 - Approp: DOE for K-12
HB 372 - Suspended Imposition of Sentence
CSSB 67 - Health ins. for Mental Conditions

| NAME | ADDRESS | PHONE | REPRESENTING | DO YOU WANT TO TESTIFY? if yes, which one? |
|---|---|---|---|---|
| Sharon Young | 3110 W 11th St | 6-1083 | AASB | No |
| Greg Gilly | " | " | " | " |
| BB Manners | 705 Munsing Way #302 | 586-3090 | NEA- | Yes 330 |
| Joanne Clark | Div. of Mental Health + D.D. | 465-3370 | Div. of Mental Health + D.D | yes |
| DAVE Williams | Div. of Budget & Finance | 465-3015 | PHS | No |
| Nina Keeler Kinney | Dept of Public Safety PO Box N, 99811 | 465-4356 | Council on Domestic Violence & Sexual Assault | HB 372 |
| Gordon Evans | 318 4th St. | 586-3210 | HIAA | CSSB67 yes 1 |
| Mike Miller | | | | CSSB 67 yes 2 |
| Clark Gruening | 328 Coleman St | 586-3110 | APIT | CSSB 67 yes 3 |
| Karen Rehfeld | | 3795 | Leg Finance | NO |
| Stephanie Joannides | P.O Box KC Juneau 99811 | 5-3428 | Dept of Law | only if there are questions - HB372 |

# Alaska State Legislature

PRESIDENT
907-465-3755

JAN FAIKS
POST OFFICE BOX V
JUNEAU, ALASKA 99811

Senate

May 11, 1987

MEMORANDUM

TO: Representatives Johnny Ellis and Niilo Koponen, Co-Chairmen,
House Health, Education and Social Services Committee

FROM: Senator Jan Faiks
President of the Senate

SUBJECT: Background on Senate Bill 67
An Act relating to insurance coverage for the treatment of a mental or nervous condition

The Senate HESS Committee Substitute to Senate Bill 67 has been referred to your committee for consideration. 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, and will eliminate the discrimination which currently exists between mental health and other medical insurance benefits.

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.

The Senate HESS Committee Substitute adopts the "mandatory/option" approach because it allows subscribers to decide whether the benefits of mental health coverage are worth the added premium costs. I would like the committee to consider the adoption of the "mandatory benefit" approach, thus requiring the inclusion of mental health care in group insurance policies.

OUT OF SESSION
6060 YUKON DRIVE ANCHORAGE, ALASKA 99516 907-274-6611

Most states that require mental health coverage also define the minimum coverage that must be offered. Senate Bill 67 requires a minimum of 45 days of inpatient treatment and 50 equivalent hours of outpatient treatment per year.

The Senate HESS Committee Substitute has changed this requirement from 50 hours to 50 visits. I would like to maintain the original language of 50 hours, as it would provide greater benefits to the patients and would not create administrative problems for the insurers, since the medical profession already keeps detailed time records of patient visits.

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 states 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 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.

About one-fifth of our population suffers some degree of mental impairment, 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 <u>suicide</u>.

In 1984, mental illness was estimated to have cost our nation 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).

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

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. As 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. The Equitable Life Assurance Society has verified that every dollar invested in mental health treatment results in a three dollar increase in productivity. Mental health treatment also reduces drug and alcohol-related crime.

Medical science has long recognized the correlation between physical disease and mental health. Physicians have estimated that up to one-half of all ailments which they treat have symptoms of mental or emotional disorder. 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.

Senate Bill 67 may indirectly reduce the dependency of the community mental health centers in Alaska on State funds. These facilities currently receive matching grants from the State and charge their patients a sliding fee base upon their ability to pay. After the grant is matched, all additional fees are devoted to enhance the programs and expand their facilities. Division of Mental Health personnel report that because of a lack of funds, these centers can only provide 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.

Specifically, this bill proposes the following:

Section 1. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS CONDITION. AS 21.42 is amended to add a new section (21.42.365) which will require coverage for treatment of a mental or nervous condition.

(a) All insurers who are authorized under AS 21.09 to provide major medical coverage in Alaska must offer the insured or subscriber or other person covered by the policy minimum benefits of 45 days a year of inpatient treatment for each covered individual, and a total of 50 hours a year of outpatient treatment or patient visits of mental or nervous conditions.

The committee substitute from the Senate HESS Committee changed this coverage from 50 hours to 50 visits, as the insurers felt that it would be too difficult to record office visits which last fractions of an hour.

I request that the House HESS Committee change this back to the original language specifying hours, rather than visits, as it is to the greater benefit of the patient. The record-keeping of these visits would not place a burden on the insurers, as doctors already keep detailed time accounts of patients' visits.

(b) The insurer or service corporation cannot charge more for this coverage than for the cost of treating any other condition or illness. Contract limitations must be reasonable.

(c) The Senate HESS CS to this bill provides that if an insured or a subscriber does not opt for the coverage under this section, the insurer or service corporation may offer other coverage for treating a mental or nervous condition.

I ask that the committee consider changing this language to adopt the mandatory benefit approach, whereby mental health care benefits must be included in group insurance policies.

(d) This portion contains a definition of terms used in this section.

I would request that the committee consider changing the definition of "office visit" in section (7) to reflect that treatment which is provided through the professional offices of the listed classes of mental health care providers.

Section 2. AS 21.36.090(d) is amended to prohibit unfair discrimination against a person who provides a state-licensed medical service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if that service is within the scope of the provider's occupational license.

Section 3. AS 21.87.340 is amended to add additional chapters and provisions which apply to service corporations.

Section 4. Provides an effective date for this act for policies entered into on or after January 1, 1988.

A similar bill was introduced last year. It passed the Senate, and made it through the House, but died in the Rules Committee during the final hours of last year's session.

Passage of this legislation is vital to provide Alaskans access to mental health coverage on the same basis as other medical benefits, which, in turn, will shift more of this burden from the State to the private sector.

I am enclosing an amendment and a marked-up copy of SB 67 which reflect the requested changes to this bill. I would appreciate the committee's consideration of the legislation at its earliest convenience. Should you need any additional information, please let me know.

Thank you.

# *Sitka Mental Health Clinic*

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*Michael Boyd, Ph.D.*
*Psychologist*

12-9-87

Honorable Nilo Koponen
Co-Chairman House, Health Ed. and Soc. Svcs. Comm.
Rm. 106
Capital Building
P.O. Box V
Juneau, Alaska 99811

Dear Representative Koponen:

I am writing concerning CSSB 67 which is scheduled to come before your committee during the upcoming session of the legisalture. CSSB provides for insurance coverage for treatment of mental or nervous conditions. I would like to encourage you to speedily act on CSSB 67 and refer it on with a recommendation of approval by the house.

State funded mental health programs depend on insurance payments for much of their revenue. At this time, many insurance companys will not pay for treatment provided by someone who is not a psychiatrist or licensed psychologist. While many clinics are directed by psychologists or psychistrists, few can afford to have professionals of that level as primary care givers. CSSB 67 provides that state funded mental health clinics would be eligible for insurance payments as long as a therapist is supervised by a physician or a psychologist. With the provisions of CSSB 67, state funded mental health clinics would be more able to collect needed revenue from third party payors.

Respectfully,

Michael J. Boyd, Ph.D.
Psychologist

MB/imr

cc: Albert P. Adams
John Sund
Albert Adams

Memo: Rep. Niilo Koponen - House RESS
Attn: Lisa McClaren

RE: SB 67-
Clinical Social Workers as providers

Date: 2/8/88

From: Marsha Schneider, MSW, ACSW
Executive Director
Alaska Chapter
National Assoc. of Social Workers

NASW recommends that clinical social workers be included as qualified providers of mental health services without regard to place of employment. Specifically, Sec. AS 21.42. [page 4, line ~~##~~ 14] include a new section to read . . .

(v)(a) a clinical social worker licensed or certified as a clinical social worker by the state or;

(b) ~~certified~~ certification by a national professional organization offering certification of clinical social ~~workers~~.

These organizations currently include:

(1) NASW ~~Clinical~~ Register of ~~Clinical~~ Social Workers;
(2) National Registry of Health Care Providers;
(3) American Board of Examiners in Clincal Social Work.

At the present time our estimate is that there is approximately 15-20 clinical social workers currently on the NASW Register that are in private practice that would be included as additional providers under this bill (1)

The next Register will be open in September of 1988. To be eligible ~~as~~ a for certification under ~~The~~ the NASW Register of Clinical Social Workers a social worker must meet the following requirements:

(1) Masters or doctoral degree in social work in a program accredited by the Council on Social Work Education;

(2) 2 years of f-t experience or 3000 hours accumulated over a period of not less than 24 months, of post-masters clinical social work practice that was supervised by a social worker holding at least a Master's degree.

(3) Has at least 2 years of f-t exper. or 3000 hours of direct practice within the last 10 years.

(4) Is a current member of the Academy of Certified Social Workers, or is licensed or certified in a state at the appropriate level.

Requirements for the Nat. Registry of H.C. providers are similar. Requirements for the ABECSW (referred to as the diplomate in clinical social work) are 5 years of direct practice

(3) Please be aware that this standard is very stringent (see Vendorship Report, page 4). Without licensing of social workers by the State of Alaska, this high standard must be ~~###~~ maintained because there is no mechanism to assure that qualifications are met by practitioners. Additionally, there is the problem of consumer protection and accountability. Because certification currently requires membership either in NASW or the Society of Clincal Social Work Practice (SCP) in Alaska, there are internal grievance committees that can handle ethics complaints.

We can not recommend that ACSW be used as an alternative ~~to~~ to clinical social work certification because not all ACSW's (approx. 125 in Alaska) are engaged in clinical social work practice.

Thanks for your assistance.

(3)

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*EXPER:* 83- Asst Prof University of Alabama Birmingham; 80-83 Bryce Hospital Social Work Supervisor; 74-77 Brewer-Porch Childrens Center Social Worker

Tuskegee Institute

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*EXPER:* 84- Executive Director Ctr for Chdn & Parents; 82- Clinical Social Worker Private Practice

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*EXPER:* 85- Social Worker Div of Fam & Youth Svc; 83-85 Psych Providence Hospital; 78-82 Psych Malcolm Bliss Mtl Hlth Ctr

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*REGNO:* 020429
*PRAC:* I; CP; GR; FAM
*EDUC:* PhD 76 U Pittsburgh, Pittsburgh PA; MPH 73 U Pittsburgh, Pittsburgh PA; MSW 71 U Pittsburgh, Pittsburgh PA
*SPEC:* A; AD; Chd/ Sex Ab; Dth Dyg; Gen Prac
*EXPER:* 86- Director Good News Counseling of Alaska; 84-86 Director Samaritan Counseling of Alaska; 75-84 Director Alaska Childrens Services Executive

**GIN, ROBERT G.*** ACSW
Alaska State Sch for the Deaf
Alaska State Prgm for Deaf, 1729 Sunrise Dr, Anchorage AK 99508
*PH:* (907) 277-9810
*REGNO:* 001006
*PRAC:* I; GR; FAM
*EDUC:* MSW 62 U Michigan, Ann Arbor MI
*SPEC:* C; A; AD; Gen Prac; Med Con
*EXPER:* 73- Soc Svc Spec Alaska State Sch for the Deaf; 70-73 Soc Wkr Alaska Chdns Svc Ctr for Chdn & Parents; 66-70 Dir Therapeutic Svc Jesse Lee Home



1988 Registry — Sept. 1988

(4)

### Eagle River

**JONES, DOROTHY M., DR*** LCSW/CA* ACSW
Private Practice
Star Rt Box 5203, Eagle River AK 99577 *PH:* (907) 694-2055H
Private Practice
2221 E Northern Lights Blvd, #204, Anchorage AK 99508
*PH:* (907) 277-0201
*REGNO:* 018302
*PRAC:* I; FAM
*EDUC:* DSW 69 U California, Berkeley CA; MSW 61 UCLA, Los Angeles CA
*SPEC:* A
*EXPER:* 83- Private Practice; 80-83 The Collective A Feminist Therapy Center; 77-80 Alaska Womens Resource Center Therapy Prgm

**LEMERY, EUGENE F.** ACSW
Dept of Army
Box 5020, Loveland Circle, Eagle River AK 99577
*PH:* (907) 862-9190
*REGNO:* 009371
*PRAC:* FAM
*EDUC:* MSW 63 U Utah, Salt Lake City UT
*SPEC:* C; AD
*EXPER:* 82- ADCO CPC Fort Richardson AK; 75-82 Soc Wkr VA Center Hot Springs SD; 67-75 Psych Soc Wkr MO Div Mtl Hlth

**PUGH, RICHARD G.*** CCSW/UT*
USAF
3366 Kantishna Dr, Eagle River AK 99577 *PH:* (907) 552-4732
*REGNO:* 023821
*PRAC:* I; CP; FAM
*EDUC:* MSW 76 Castleton St Col, Castleton VT
*SPEC:* AD; A; Mar/Dvc; Fam Vio; Chd/ Sex Ab
*EXPER:* 85- Elmendorf USAF Regional Hospital

### Fairbanks

**LUNDQUIST, BEVERLY A.*** ACSW
Private Practice
1510 Jennifer Drive, Fairbanks AK 99709 *PH:* (907) 455-6302
*REGNO:* 019799
*PRAC:* I; FAM; GR; CP
*EDUC:* MSW 80 Smith Col, Northampton MA
*SPEC:* AD; A; C; Gen Prac; Chd/ Sex Ab
*EXPER:* 85- Supervisor Resource Ctr for Parents & Children; 84- Private Practice; 81-84 Clinician Fairbanks Comm Mtl Hlth Ctr

**MATTAINI, MARK A.*** ACSW
Private Practice
1737 University Ave G43, Fairbanks AK 99709
*PH:* (907) 479-4168B
*REGNO:* 021753
*PRAC:* GR; I; FAM; CP
*EDUC:* MSW 78 U Utah, Salt Lake City UT
*SPEC:* MIN; A; AD; Gen Prac; Sub Ab
*EXPER:* 84- Consultant Applied Behavioral Ecology; 83-85 Director Mental Health Tanana Chiefs; 80-82 Director Autism Teaching Center

**PATRICK-RILEY, COLLEEN C.*** ACSW
Fairbanks Counseling & Adop, PO Box 1544 222 Front St, Fairbanks AK 99707 *PH:* (907) 456-4729B
*REGNO:* 019153
*PRAC:* FAM; I; CP; GR
*EDUC:* MSW 79 U Washington, Seattle WA
*SPEC:* C; AD; Chd/ Sex Ab; Mar/Dvc; Gen Prac
*EXPER:* 83- Director Fairbanks Counseling & Adoption; 79-83 Social Worker Jesse Lee Home AK Chdns Svcs

**SCOLLAN, ELIZABETH L.*** ACSW
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PO Box 82326, Fairbanks AK 99708 *PH:* (907) 452-1575B
*REGNO:* 022393
*PRAC:* I; FAM; CP; GR
*EDUC:* MSW 80 Tulane U, New Orleans LA
*SPEC:* C; AD; A; Chd/ Sex Ab; Gen Prac
*EXPER:* 86- Private Practice; 84 Child Sexual Abuse Specialist Fairbanks CMHC; 81-84 Director Treatment Hospitality House

**STORTZ, LIBBY FINESMITH*** CSW/NY ACSW
Private Practice
PO Box 83003 College, Fairbanks AK 99708 *PH:* (907) 455-6675B
*REGNO:* 019399
*PRAC:* I; CP; FAM; GR
*EDUC:* MSW 77 Columbia U, New York NY
*SPEC:* A; C; Mar/Dvc; Gen Prac; Chd/ Sex Ab
*EXPER:* 84- Clinical Social Worker Private Practice; 80-84 Counselor Resource Ctr Parents & Children; 77-80 Organizer NYC Commission Human Rights

**WOODS, PAMELA W.** ACSW
Fairbanks Counseling & Adop
PO Box 73411, Fairbanks AK 99707 *PH:* (907) 488-3948B
*REGNO:* 027859
*PRAC:* FAM; I; CP; GR
*EDUC:* MSW 82 U Washington, Seattle WA
*SPEC:* AD; A; Chd/ Sex Ab; Mar/Dvc; Gen Prac
*EXPER:* 86- Clinician Fairbanks Counseling & Adoption; 82-85 Clinician Fairbanks Community Mental Health; 82-82 Lecturer Dept of Psych Univ of Alaska

### Kodiak

**FIELDS, DONALD K.*** ACSW
Kodiak Is Mental Health Ctr
PO Box 2693, Kodiak AK 99615 *PH:* (907) 486-5742B
*REGNO:* 022566
*PRAC:* I; CP; FAM; GR
*EDUC:* MSSW 75 U Missouri, Columbia MO
*SPEC:* AD; A; Gen Prac; Mar/Dvc; Dth/Dyg
*EXPER:* 75- Clinician III Kodiak Is Mental Health Ctr

**SAPP, CAROLYN D.*** ACSW
Kodiak Island MHC
1515 Lynden, Kodiak AK 99615 *PH:* (907) 486-3386H
316 Mission Rd #119, Kodiak AK 99615 *PH:* (907) 486-5742B
*REGNO:* 022251
*PRAC:* I; FAM; GR; CP
*EDUC:* MSW 70 VA Commonwealth U, Richmond VA
*SPEC:* C; A; AD; MIN; Sub Ab
*EXPER:* 83- Psych Soc Wkr Kodiak Island MHC; 78-83 Forensic Soc Wkr St Elizabeth Hospital

### Nome

**BRONSTON, SHIRLEY N.*** LSCSW/KS* ACSW
Private Practice
490 Front Street, Nome AK 99762 *PH:* (907) 443-2133
*REGNO:* 002734
*PRAC:* I; FAM; GR
*EDUC:* MSW 64 U Kansas, Lawrence KS
*EXPER:* 81- Clinician Norton Sound Family Svcs; 75- Private Practice with Psychiatric Clnic; 72-76 Private Practice Shawnee Mission KS

**MCMILLAN, PAMELA A.** ACSW
Private Practice
Box 1165, Nome AK 99762 *PH:* (907) 443-2855B
*REGNO:* 017001
*PRAC:* I; GR
*EDUC:* MSW 69 U Utah, Salt Lake City UT
*SPEC:* AD; Alc Ab
*EXPER:* 79- Private Practice; 76-78 Director Wrangell Office Gateway Mtl Hlth; 72-78 Therapist Alaska Psychiatric Institute

**POYOUROW, MARVIN S.*** ACSW
352 E Third St Box 699, Nome AK 99762 *PH:* (907) 443-5266
*REGNO:* 024538
*PRAC:* FAM; GR; CP; I
*EDUC:* MSSW 57 Columbia U, New York NY
*SPEC:* A; AD; Gen Prac; Mar/Dvc; Sub Ab
*EXPER:* 83- Clinician III Norton Sound CMHC Nome AK; 82- Private Practice Oceanview Clinic Nome AK; 62-83 Director Extended Care SE CO Fam/MHC

# PROFESSIONAL SOCIAL WORK RECOGNITION

## Vendorship Report

### June 1987

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.
7981 EASTERN AVENUE, SILVER SPRING, MARYLAND 20910
(301) 565-0333

# TABLE OF CONTENTS

# I. INTRODUCTION

This is the latest in a series of reports from the National Association of Social Workers (NASW) on our continuing efforts to achieve recognition of the professional social worker as an independent health-care provider whose charges for treatment services are reimbursable by all private and public health-care insurers. This 1987 Vendorship Report seeks to provide a picture of the current status of these efforts and an overview of the complexities of third-party payment as it pertains to social workers.

Reducing costs while enhancing quality of care is a major issue now affecting every component of the health/mental health delivery system, including social work services. Social workers must be more conscious of and knowledgeable about the actual service delivery costs of their interventions as well as more alert to the cost-benefit implications of the provision of social work services in the larger context of overall expenses for health/mental health care.

As more health insurance policies include mental health benefits, and as budgets for agencies decrease, clinical social workers in all settings are steadily exploring with clients the use of health insurance to help defray the cost of clinical social work services. The use of insurance payments (also called "third-party payments") is thus of vital interest to all clinical social workers.

A further issue is societal recognition of social workers as fully qualified professionals who provide the bulk of mental health services in the United States, but who too frequently are devalued or are seen as legitimately practicing only when under a physician's supervision. This misapprehension is fostered by other professionals who perceive clinical social workers as competitors for clients and dollars. Thus, the struggle for professional recognition is tied to the struggle for independent mental health provider status.

The information contained in this report will be useful to social work practitioners, agency administrators, social work students, and NASW members currently working to achieve full recognition of professional social workers. Efforts are being rewarded through successful legislation and regulation at the federal and state levels, through more knowledgeable consumers, and through successful negotiations with representatives of the insurance industry to recognize social workers.

# II. GENERAL PERSPECTIVES

## A. On Third-Party Reimbursement

Charging fees for service is common practice in social work agencies. The contract for payment, whether verbal or written, is usually between the agency and the client recipient of the service. With the advent of major medical insurance protection in the 1950s and the emergence of federal health-care programs such as Medicare in the 1960s, many persons receiving treatment for emotional and mental illnesses became eligible for reimbursement of all or part of the cost of treatment received from approved health-care providers. Some states have recently enacted legislation requiring health insurance contracts to include coverage for mental health. This is usually for a specific amount and is called "mandated" mental health coverage (see section D below). Some employers, consumers, and unions also insist on coverage for emotional and mental illness and substance abuse in insurance contracts. In spite of this progress, by 1987 most health insurance contracts and many federal health-care programs do not provide benefits for the treatment of emotional or mental illnesses or substance abuse. Moreover, few of the contracts and programs that do provide such benefits recognize clinical social workers as qualified providers of treatment whose fees for service can be reimbursed.

When a client has insurance coverage for mental illness, the policy usually requires that the client pay a certain amount before the insurance is activated. This is called a "deductible" and may vary from $50 to $500, depending upon the policy. After the deductible has been met, the insurance policy will reimburse the client for a proportion of the fees charged. This proportion varies from policy to policy but usually is 50 percent to 80 percent of the fees charged. Sometimes there is a maximum allowable amount for a particular service. For example, if the policy pays 50 percent of an allowable fee of $40 per visit after the deductible has been met, then the company will reimburse the client $20 for each visit. If the charge is $50 per hour, the client must pay $30 per hour to make up the total of $50. The amount the client pays is referred to as a "copayment."

Insurance companies issue policies which specify the services and service providers they will cover. They may also specify an upper limit to the total amount they will pay, and restrict the number of therapist visits for which they will pay per week or per year. It is therefore important to encourage the client to scrutinize the insurance policy in order to clearly understand entitlements and limitations. It is also important to remember that the insurance reimbursement is to the client, and only if benefits can be and are assigned, will reimbursement checks go directly to the social worker or agency.

Three factors need to be considered in attempting to determine if a client is eligible for reimbursement. They are: (1) Is the client insured for the treatment of the diagnosed illness? (2) Are social workers recognized as qualified providers under the state's insurance laws, the specific insurance contract, or the regulations pertaining to the federal program? (3) Does the provider meet the criteria established by the state, or social work professional association, or insurance contract for recognition as a clinical social worker? The answer to all three questions must be affirmative for the insured person to qualify for reimbursement in accordance with the conditions of the contract or program.

## B. On Securing Recognition

There are four basic methods for securing recognition of clinical social workers as approved providers for reimbursement under health insurance contracts. They are: (1) mandated recognition of the profession by state or federal legislation; (2) voluntary recognition by the insurer; (3) demand for inclusion by the purchaser of the contract; and (4) a negotiated demand by consumer representatives (such as labor unions).

Each of these methods requires that supportive information be amassed by the clinical social work advocate(s) and that appropriate decision makers be convinced that recognition of clinical social workers is a decision that will benefit their constituents.

The process will be much the same whichever population is selected as the immediate target. Success will require fact-finding, the designing of an effective presentation, and the building of an appropriate political support base. Recognition via state or federal legislation is most effective since it affects all of the people under that entity's specific jurisdiction. State licensing at the independent clinical practice level is considered a prerequisite for effecting an amendment to the state's insurance code to include social workers as qualified mental health providers (a vendorship law). Social work licensing and vendorship laws at the state level are more effective than individual negotiation with hundreds of insurers, employers, and consumer groups. Successful vendorship efforts depend upon building a broad political support base; that is, developing a coalition of social work and consumer groups.

The NASW national office provides basic background information, data, and resources to assist in the designing of an effective strategy. Ongoing consultation is available to NASW members and state chapters.

## C. On Freedom-of-Choice or Vendorship Legislation

"Freedom-of-choice" legislation requires that if health insurance provides mental health coverage, the beneficiary has the freedom to choose any qualified mental health provider. "Vendorship" refers to the status of a group, in this case clinical social workers, to be eligible for insurance reimbursement as a qualified provider of mental health services. This legislation is usually an amendment to the state's insurance laws and refers to qualified providers as those who are duly certified or licensed for mental health practice in that state. Thus, legal regulation of social workers is almost always a prerequisite to a state vendorship law. Some states do not have freedom-of-choice legislation but rather specifically mandate that beneficiaries be reimbursed for services provided by appropriately licensed or certified social workers. Vendorship efforts are important to ensure that all citizens are free to choose their mental health provider and are not limited to only one profession.

Fifteen states and the District of Columbia currently have some form of such vendorship legislation: California, Florida, Kansas, Louisiana, Maine, Maryland, Massachusetts, Montana, New Hampshire, New York, Oklahoma, Oregon, Tennessee, Utah, and Virginia, as well as the District of Columbia. See Table 1 for further details of state vendorship laws.

A number of NASW chapters are currently working on vendorship or freedom-of-choice legislation in their states, and the NASW 1984 Delegate Assembly voted vendorship activities as one of the top priorities for the Association.

## D. On Mandated Mental Health Benefits

A number of states have passed legislation mandating that all insurance companies that write health coverage in that state must include, as a covered service, reimbursement for mental health claims. Other states have passed legislation that requires insurance companies to offer these mental health benefits but permits the subscriber to reject the benefits. This latter law is called "mandatory availability." Laws mandating benefits for alcohol and drug treatment or requiring mandated availability have also been passed in many states. Mandated mental health benefits laws frequently provide for reimbursement for licensed social workers and thus the law becomes a vendorship law.

Mandated mental health laws do not usually apply to self-insured plans, which now cover a major portion of employees.

| | | | REQUIRE-MENTS | COVERAGE | SURANCE WRITTEN IN ANOTHER STATE | REFERRAL |
|---|---|---|---|---|---|---|
| California | January 1977 Amended 1984 | Licensed Clinical Social worker | None | Policies w/mental health must recognize LCSWs as reimbursable providers | Yes | By treatment physician or program |
| District of Columbia | February 1987 | Licensed Clinical Social Worker | None | Mandated mental health benefits. Must reimburse LCSWs | Not specific | Not required |
| Florida | October 1983 | Licensed Clinical Social Worker | None | Coverage for LCSW must be offered to policy holders; in-patient minimum 30 days, out-patient max. $1500 | Not specifically but may be | Not required |
| Kansas | April 1982 | Specialist Clinical Social Worker | None | SCSW must be reimbursed for services within their scope of practice unless policy holder refuses such coverage in writing | No | Not required |
| Louisiana | July 1981 | Board Certified Social Worker | Must be listed in a National Clinical Social Work Registry | Policies with mental health coverage must reimburse BCSWs | Yes | Referral not required but physician consultation and collaboration required |
| Maine | January 1984 | Certified Social Worker; Clinical Social Worker (after 1/1/85) | None | Policies with mental health coverage must reimburse CSW, | No | Not required unless a condition is diagnosed beyond the scope of CSW licensure |
| Maryland | January 1978 | Licensed Certified Social Worker | Must be on approved vendor list | Policies with mental health coverage must reimburse CSWs | Yes | Physician |
| Massachusetts | March 1982 | Independent Clinical Social Worker | None | Policies with mental health coverage must reimburse ICSWs | Yes | Not required |
| Montana | October 1985 | Licensed Social Worker | None | Coverage for mental health benefits must reimburse LSW with mandatory mental health coverage for group health insurance policies | Not specific | Not required |
| New Hampshire | January 1984 | Certified Clinical Social Worker | None | Coverage for CCSW must be offered to policy holders (who have mental health benefits) for a separate & identifiable premium | Yes | Not required |
| New York | January 1985 | Certified Social Worker | Must have "R" endorsement which attests to 6 yrs of post-master's experience | Policies with mental health coverage must reimburse CSW with "R" endorsement | Yes | Not required |
| Oklahoma | October 1982 | Clinical Social Worker | None | Policies with mental health coverage must reimburse CSWs | Not specifically but may be | Not required |
| Oregon | July 1981 | Registered Clinical Social Worker | None | Benefits to be paid whether service is given by physician, psychologist or clinical social worker | No | Physician or Psychologist |
| Tennessee | July 1985 | Licensed Clinical Social Worker | None | Coverage with mental health benefits. Must cover CSW. | Not specific | Not required |
| Utah | July 1986 | Clinical Social Worker | None | Coverage of mental health benefits must reimburse CSWs | No | Not required |
| Virginia | July 1987 | Licensed Clinical Social Worker | None | Policies with mental health coverage must reimburse LCSWs | No | Not required |

# INSURANCE AND THE GOVERNMENT

Under a variety of health insurance and benefit programs the federal government provides health protection for millions of citizens, including federal employees, military personnel and their families, and dependents and wards of the government. This complex array of services and enabling legislation makes it unlikely that a single piece of federal legislation could order that clinical social workers be approved as reimbursable providers under all of these programs. Therefore, NASW advocates and works for the introduction and enactment of many different pieces of federal health and mental health legislation.

The programs presented below represent the major segments of the federal responsibility for health care, and serve as models for the private health insurance industry.

## A. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) is administered directly by the Secretary of Defense through the Office of the Assistant Secretary for Health Affairs. It is the civilian component of the Military Health Services Systems with approximately 6.2 million eligible beneficiaries. It is charged with the responsibility for providing, through fee-for-service arrangements, medical care for military retirees; dependents of military personnel and retirees; members of the Commissioned Corps of the United States Public Health Service; the CHAMPUS/Veterans Administration Program; handicapped dependents of active military personnel; and employees of the National Oceanographic and Atmospheric Administration.

Benefits covered under CHAMPUS roughly parallel those available under other public and major private health care plans. These include most inpatient and outpatient health services, a portion of physician and hospital charges, medical supplies and mental health services. Determination of benefits is made by the Department of Defense, often in response to Congressional action.

CHAMPUS conducted a demonstration project on the reimbursement of clinical social workers as independent mental health care providers between December 20, 1980 and September 30, 1982. Results indicated that treatment services provided by clinical social workers were cost-effective, and, in 1983, Congress directed the Department of Defense to continue the recognition of clinical social workers as independent mental health treatment providers. Accordingly, regulations to that effect were published as a final rule in the March 1, 1984 Federal Register. The following excerpt appears on p. 7562, section 199.12, "Authorized Providers.":

*Certified Clinical Social Workers. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker meets the following criteria:*

*(1) is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and*

*(2) has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and*

*(3) has had a minimum of two years or three thousand hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.*

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

In order to be reimbursed by CHAMPUS, a qualified clinical social worker must have a provider number. To obtain this, call or write the fiscal intermediary for your state:

### CHAMPUS Fiscal Intermediaries Claims Processing Jurisdictions

**BLUE CROSS OF RHODE ISLAND**

| North Central (E) | Northeast (E) |
|---|---|
| Illinois | Connecticut |
| Indiana | Maine |
| Iowa | Massachusetts |
| Kentucky | Michigan |
| Minnesota | New Hampshire |
| Ohio | New Jersey |
| West Virginia | New York |
| Wisconsin | Rhode Island |
| | Vermont |

Blue Cross of Rhode Island
CHAMPUS Program
1 Weybosset Hill
Providence, RI 02903
(401) 272-8500 X2562

(Continued)



(12)

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**BLUE CROSS OF WASHINGTON/ALASKA**

Northwest (E)

| | |
|---|---|
| Alaska | Oregon |
| Colorado | South Dakota |
| Idaho | Utah |
| Monana | Washington |
| Nebraska | Wyoming |

Blue Cross/Blue Shield of Washington/Alaska
CHAMPUS Program
7001 - 220th Street, S.W.
Mt. Lake Terrace, WA 98043
(206) 771-0203

**BLUE CROSS/BLUE SHIELD OF SOUTH CAROLINA**

| Southeast (E) | Southwest (I) |
|---|---|
| Alabama | Arizona |
| Florida | California |
| Georgia | New Mexico |
| Mississippi | Nevada |
| Tennessee | |

Blue Cross/Blue Shield of South Carolina
CHAMPUS Department
1800 St. Julian Place
Columbia, SC 29204
(803) 799-0777 X4131

**HAWAII MEDICAL SERVICE**

Hawaii (E)

Hawaii Medical Service
CHAMPUS Program
818 Keeaumoku Street
Honolulu, HI 96814
(808) 944-2355

**WISCONSIN PHYSICIAN'S SERVICE**

| South Central (E) | Mid-Atlantic (I) |
|---|---|
| Arkansas | Delaware |
| Kansas | D.C. |
| Louisiana | Maryland |
| Missouri | North Carolina |
| Oklahoma | Pennsylvania |
| Texas | South Carolina |
| | Virginia |

Wisconsin Physicians Service
CHAMPUS Program
1617 Sherman Avenue
Madison, Wisconsin 53707
(608) 221-4711 X654 (833)

## B. Federal Employees Health Benefits Program

The Federal Employees Health Benefits Act (FEHBA) mandates that the U.S. Civil Service Commission negotiate with the private insurance industry for health insurance benefits packages for federal employees, retirees, and their dependents. The Office of Personnel Management (OPM) oversees the program. Many companies who provide insurance for federal employees under FEHBA have for many years voluntarily included social workers as reimbursable providers of mental health services. In February 1986, the President signed into law an amendment to FEHBA which requires that such coverage be included in health plans provided for some 10 million federal employees, retirees, and dependents. It further provides that insurance carriers may not require that social workers be supervised by any other health professional, but may require psychiatric referral. The amendments regarding clinical social workers shall be effective with respect to contracts entered into or renewed for calendar years beginning after December 31, 1986.

## C. Medicaid

Medicaid, authorized by Title XIX of the Social Security Act, is administered by the states, who have the option of authorizing reimbursement of social workers as health-care providers. A number of states will reimburse for clinical social work services if they are provided in an organized medical treatment setting such as a hospital or outpatient clinic. A number of states will also reimburse for clinical social work services if the social worker is an employee of a psychiatrist.

The state Medicaid agency can provide information on each state's policy. Title XIX offers an area in which NASW chapters can advocate for changes in the state law or for regulations to include social workers as eligible for Medicaid reimbursement.

## D. Medicare

Medicare is authorized by Title XVIII of the Social Security Act. At this time, clinical social work services are sometimes reimbursed for home health care, although the reimbursement patterns vary from region to region.

NASW sponsored legislation that directed the Health Care Financing Administration (HCFA) of the Department of Health and Human Services to conduct a clinical social work Medicare demonstration project. HCFA

awarded a contract to SRI International (formerly the Stanford Research Institute) and approved California as the demonstration site. The demonstration project ended December, 1985. Analysis of the data is being completed and a final report will be reviewed by HCFA and given to Congress in April, 1987. Because of complications in the development of an evaluation of this project, it is anticipated that the results will be inconclusive.

## E. Employee Retirement and Income Security Act (ERISA)

In 1974 Congress passed the Employee Retirement Income Security Act (ERISA). Although its primary purpose was pension reform and protection, it also covers employee welfare benefit plans. In a somewhat confusing fashion, ERISA preempts all state laws that "relate to" employee benefit plans, but does not preempt state laws regulating insurance. This general standard thus affects mandated mental health coverage and vendorship laws in a critical fashion.

For example, some large firms such as IBM, ALCOA, J.C. Penney Co., Xerox, and others have taken the position that their self-insured plans are employee benefits and are thus subject to ERISA and exempt from state regulation. Their argument concludes that a state vendorship law requiring reimbursement of clinical social workers does not apply to them.

In a 1982 Maryland case, Metropolitan Life Insurance Company/General Electric vs. Maryland Insurance Commissioner, the Maryland Court of Special Appeals ruled that to impose the Maryland Vendorship Law (which requires reimbursement of clinical social workers) on the GE employee health insurance contract would preempt ERISA, and that the insurance carrier therefore does not have to recognize clinical social workers for this contract.

A number of state legislatures have passed resolutions urging Congress to revise the ERISA law so that it cannot undermine state's rights.

In the meantime, there have been a number of cases challenging this ERISA preemption. The Supreme Court agreed to hear on its 1984/85 docket the latest case of Metropolitan Life Insurance Co. v. Massachusetts. The insurance company claimed that ERISA exempted them from complying with the law mandating mental health coverage (see above). In June, 1985, the Supreme Court upheld the powers of the state to regulate insurance companies. The state's power to require insurance plans to cover mental disorders, said the court, were not preempted by ERISA.

# IV. NONGOVERNMENT INSURANCE COMPANIES

The question is frequently asked: "What insurance companies reimburse for social work services?" To answer this question, clients must be put into two groups: those who work for the federal government and those who do not. Federal employees are covered by private insurance companies that must adhere to federal policies (see Federal Employees Health Benefits Act on page 6). The dependents of military personnel are covered by CHAMPUS (see page 5).

People who are not federal employees have insurance policies written by private companies for individual employers who may be state or county governments, social agencies, industries, or any of a host of others. Each policy is for the benefit of specific employees and will vary according to the agreement negotiated between the employer and the employees and between the employer and the insurance company. Sometimes the health provisions are a part of union-employer negotiations. Even when a large firm with many work sites negotiates a health package that seems to include or at least not to exclude, social workers as qualified mental health providers, the local claims offices may interpret the contract differently. Thus, unless you are talking about federal employees, it is not possible to list insurance companies that "cover clinical social workers" as qualified providers of mental health services. Many insurance companies have done so in specific contracts, but it must be remembered that those same firms have also written health-benefit plans that exclude social work services.

The following is a partial list of companies that either currently issue, or at one time have issued, policies that reimburse for clinical social work.

Aetna Life & Casualty Insurance Co.
Allstate
American General
Bankers Life Casualty Insurance Co.
Blue Cross/Blue Shield (in many localities)
Central National Insurance Company of Omaha
Concordia Welfare Plan
Continental Assurance Co.
Connecticut General
Employers of Wausau
Equitable Insurance & Life Insurance Co.
The Hartford Group
John Hancock Insurance Co.
Liberty Mutual Insurance
Lincoln National Life Insurance Co.
Massachusetts Mutual Insurance Co.
Metropolitan Insurance Co.
Missouri State Medical Plan
Mutual Benefit Life Insurance Co.
Mutual of Omaha
New England Mutual Life Insurance Co.
New York Life Insurance Co.
Northwestern National Life Insurance Co.
Occidental
Pacific Mutual Insurance Co.
Provident Insurance Co.
Prudential Insurance Co.
Republic National Insurance Co.
State Farm
Travelers Insurance Co.
Union Pilot Life Insurance Co.
United of Omaha
Western and Southern Insurance Co.

# V. ROLE OF THE PROFESSIONAL ASSOCIATION

The following describes some of NASW's efforts to define clinical social work and the qualifications of practitioners, to set standards for ethical practice, and to establish quality assurance mechanisms.

## A. Clinical Social Work Section

The NASW Clinical Social Work Section is the national unit responsible for identifying the programmatic needs of clinical social workers and making appropriate recommendations to the NASW Board of Directors. The Section collaborates with other national units concerned with health and mental health, occupational social work and families and coordinates activities of peer review, and the NASW Register of Clinical Social Workers. In addition to its work in developing the NASW definition of clinical social work, the Section and its predecessor Council has planned three national conferences on clinical social work, NASW publications on clinical social work, and institutes on clinical social work and on private practice at national conferences. A fourth national clinical conference is being planned for the fall of 1988.

In January 1984, the NASW Board of Directors adopted the following definition of clinical social work:

*Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.*

*The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, life support and management issues.*

*Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; ~~client-centered advocacy;~~ consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.*

This definition was incorporated in the Standards for the Practice of Clinical Social Work that were approved by the NASW Board of Directors in June 1984. Single copies are available free of charge from NASW chapters or from the national office.

NASW believes the credentialing of clinical social workers is the responsibility of the social work profession. It is the profession's criteria that provide the basis for definitions enacted by state and federal legislative and regulatory bodies as well as those approved or accepted by insurers. The Association's standards for the independent practice of clinical social work include the following criteria:

1. A degree from a graduate program in social work accredited by the Council on Social Work Education; and

2. A minimum of two years (full-time) or three thousand hours (part-time) of post-MSW clinical social work practice under the supervision of a master's degree-level social worker; and

3. Certification as a clinical social worker by a professional organization offering such accreditation; or

4. Licensure or certification as a clinical social worker by the state in which care is provided, if the state offers such accreditation. Forty-one jurisdictions currently license or certify social workers (see NASW's State Comparison of Laws Regulating Social Work).

## B. The NASW Register of Clinical Social Work

The NASW Register of Clinical Social Workers was initiated in 1976 as a mechanism for identifying qualified clinical social work practitioners. The Register lists clinical practitioners who meet the following criteria for the independent practice of clinical social work:

*Education:*
Has a master's or doctoral degree in social work from a graduate school accredited or recognized by the Council on Social Work Education.

*Supervision:*
Has 2 years of full-time experience, or 3,000 hours accumulated over a period not less than 24 months (for part-time experience), of post-master's clinical social work practice that was supervised by a social worker holding at least a master's degree.

*Currency:*
Has at least 2 years of full-time experience or 3,000 hours accumulated over a period of not less than 24 months (for part-time experience) of direct practice within the last 10 years.

*ACSW:*
Is a current member of the Academy of Certified Social Workers, or is licensed or certified in a state at the appropriate level.

The 1987 edition of the Register will list over 16,500 clinicians across the United States and Trust Territories. The Register is divided into two major sections: an alphabetical listing within city and state, and an alphabetical index of total listings.

Revised editions are planned on a biennial basis. The Register Board decided that the needs of both clients and social workers demanded an approach for reviewing and accepting applications on a continuing basis. Continuing registration was started following the publication of the 1982 Register and will continue following the publication of the 1987 edition.

Some private insurance carriers accept listing in the NASW Register of Clinical Social Workers as evidence that a practitioner meets the minimum requirements for recognition as an independent mental health provider. Copies of new editions of the NASW Register are sent to major insurance companies for their use in identifying qualified clinical social workers. The Register is also used for referral purposes by corporations that have their own self-insured health programs. In addition it is used by Aging Network Services as a referral source and by large corporations with Employee Assistance Programs.

Listing in the NASW Register of Clinical Social Workers was one of the criteria for recognition of social workers who would be eligible to participate in the Department of Defense 1980-82 Experimental Study on the Reimbursement of Clinical Social Workers and the Department of Health and Human Services' Direct Reimbursement of Clinical Social Workers Demonstration Project. Listing in the current NASW Register meets one of the eligibility criteria currently accepted by CHAMPUS for direct reimbursement and for approved peer reviewers.

Listing in the NASW Register of Clinical Social Workers may also be used to qualify for membership in specialized treatment associations such as the Society for Clinical and Experimental Hypnosis, Inc. It is used by some NASW state chapters and practitioners as a referral source, and may be used by state social work regulatory boards to identify qualified clinical social workers.

## C. Diplomate in Clinical Social Work

Established by the Board of Directors in June, 1986, the Diplomate in Clinical Social Work is an advanced specialization certification. To qualify, a social worker must fulfill the requirements for listing in the NASW Register of Clinical Social Workers, and have completed an additional 3 years of clinical social work experience and an advanced clinical social work examination. Until September 30, 1987, those who are otherwise qualified will be admitted without examination.

## D. Peer Review

Peer review is a system whereby clinical social workers assess quality of services and analyze professional clinical social work practice. Quality assurance through peer review provides protection of clients. An important test of the quality of work of a clinical social worker is whether the services are, upon review, found to be clinically necessary and of an acceptable level, i.e., in respect to the results obtained, the amount of time required to achieve acceptable results and the method of intervention employed.

In October 1983, NASW established the National Peer Review Advisory Committee to develop guidelines and criteria for a national social work peer review program to work with the CHAMPUS Professional Peer Review System and to provide peer review of individual cases for private insurance carriers.

As of October 1984, approximately three hundred experienced social workers had been selected, and approximately one hundred fifty have completed the NASW peer review training programs. Full integration of social work reviewers into the CHAMPUS peer review system had occurred by January 1985. Peer review is also available for private insurance companies and NASW currently has contracts to provide peer review for Aetna, Metropolitan Life and Prudential of Florida.

## E. NASW Insurance Program

Since 1967, the NASW Insurance Trust has been offering an expanding array of health, life and disability insurance programs designed exclusively for NASW members. Clinical social workers are recognized as independent mental health treatment providers under the NASW/Principal Financial Group Insurance Plan. The Insurance Trust sponsors a variety of programs at NASW conferences designed to educate members on insurance issues.

Under the NASW-sponsored professional and office liability insurance program, NASW members can receive professional and premises liability coverage for as little as $46.00 annually. The program is also avail-

able to agencies, social work students, and their schools. The importance of liability insurance cannot be overstated. Social workers are increasingly involved in malpractice actions. Even if an employer or agency provides some coverage, it is usually in the social worker's best interest to have additional individual coverage. Rates for liability insurance offered to NASW members are the lowest currently available.

## F. Occupational Social Work

Occupational social work is an excellent opportunity for clinical social workers who wish to be on the leading edge of a new employment trend and who have knowledge and experience in chemical dependency treatment. Many employers are developing employee assistance programs to address problems of dysfunction that affect job performance and lower productivity. Whether internal or external to the worksite, these programs help workers and their families cope with such difficulties as alcoholism, drug abuse, mental dysfunction, AIDS, stress and burnout in addition to concerns about child care and elder care. Employee assistance programs are found in a variety of settings: corporations, unions, hospitals, military, small business, government, family service agencies, universities, and private practice.

Social workers wishing to enter this field will find they need specialized training. In most instances, it will be necessary to take courses in employee assistance programs, addiction counseling, labor-management relations, working with unions or coping with the corporate system. Several schools of social work offer a specialization in occupational social work, while numerous schools offer course work and supervised field practice or continuing education in chemical dependency. Other resources include a myriad of institutes, individual entrepreneurs, workshops and conferences that focus on a wide range of topics such as alcohol and drug abuse in the workplace, work and family stresses, drug testing in the workplace and social worker's role in employee assistance programs and others.

In 1986, NASW established a National Commission on Employment and Economic Support to be responsive to the needs of occupational social workers and to assist the Association in developing programs and policies that meet the challenges of the workplace. We have an Occupational Social Work Information Service and Clearinghouse. Approximately 40 NASW chapters have active programs or interest groups in this practice area. A National Survey of Occupational Social Workers, conducted in 1985, provides a profile of workers, work settings and job tasks. The second National Conference on Occupational Social Work, "Beyond The Leading Edge: The World of Work in the Year 2000," will take place September 9-12, 1987 in New Orleans as part of the NASW Annual Conference.

## G. Academy of Certified Social Workers

The Academy of Certified Social Workers (ACSW) was founded in 1960 by NASW as the first major step toward scientific standard setting for social work practice. The ACSW strives to publicly recognize those social workers who have achieved a level of skill and knowledge beyond that acquired in a graduate program of social work education. Certification is achieved through:

1) membership in NASW and adherence to a strict professional code of ethics,

2) evaluation of a significant amount of work experience by three professional colleagues,

3) an objective written examination.

Academy members have reached a level of practice which qualifies them for independent, self-directed practice.

**OTHER NASW PROFESSIONAL STANDARDS**

Code of Ethics

Standards for Social Work Personnel Practices

Standards for the Classification of Social Work Practice

Standards for the Regulation of Social Work Practice

Standards for Continuing Professional Education

Standards for Social Work in Health Care Settings

Standards for Social Work Services in Schools

Standards for Social Work Practice in Child Protection

Standards for Social Work Services in Long Term Care Facilities

For information on obtaining copies, write
Publication Sales
National Association of Social Workers, Inc.
7981 Eastern Avenue
Silver Spring, MD 20910

# NASW standards for the practice of clinical social work

Prepared by the NASW Provisional Council on Clinical Social Work

*Approved by the NASW Board of Directors*
*June 1984*

National Association of Social Workers, Inc.
7981 Eastern Avenue
Silver Spring, MD 20910
(301) 565-0333

19

## Contents



## Introduction

Historically, the social work profession has focused on both people and their social environment. Clinical social work, whose focus is on individuals, families, and groups, has its roots in social casework, which always has been a primary method for the delivery of social work services. The number of clinical social workers has grown continuously; and clinical social work continues to contribute significantly to the development of knowledge and skills for the profession. In 1978, the National Association of Social Workers (NASW) formally recognized clinical social work as part of a process of organizational differentiation. At that time, NASW established the Task Force on Clinical Social Work, which became the Provisional Council on Clinical Social Work in 1982.

Clinical social workers have practiced in governmental and voluntary agencies and, since the time of pioneer social worker Mary Richmond, in private practice. In 1961, NASW defined private practice as a setting for the delivery of clinical social work services and published its first *Handbook on the Private Practice of Social Work* in 1967.

Clinical practice continues to be an integral part of the services delivered in agency settings. At the same time, an increasing number of clinical practitioners have been moving into independent private practice, which further attests to the commitment of trained and experienced professionals to the direct treatment of individuals, families, and groups. This development, encompassing solo and group practice as well as other arrangements, is in addition to the practice of clinical social work in traditional voluntary and governmental agency settings.

Many states require the legal regulation of social work practice; some states require a special license for practitioners of clinical social work as well as those in independent private practice. Generally, certification for clinical social work requires a master's degree in social work plus at least two years' experience as well as an examination.

Given the variations among the states regarding legal regulation and the needs of clinical social work practitioners, NASW has taken appropriate responsibility for establishing standards of practice for all clinical social workers in all settings. These standards are to be considered desirable for all clinical social workers and are designed to do the following:

- Guide clinical social work practice.
- Guide state regulatory agencies

(20)

which all members are bound. A summary of the Code of Ethics will be found following these standards.

## Definitions

The following definition of clinical social work was accepted by the NASW Board of Directors at its January 1984 meeting:

> Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.
>
> The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues. Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; client centered advocacy, consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.

In May 1961, the NASW Board of Directors endorsed the following definition of private practitioners of social work:

> Private practitioners are social workers who, wholly or in part, practice social work outside a governmental or duly incorporated voluntary agency, who have responsibility for their own practice and set up conditions of exchange with their clients, and identify themselves as social work practitioners in offering services.



The goals of the standards are

- To maintain and improve the quality of services provided by clinical social workers.
- To establish professional expectations so social workers can monitor and evaluate their clinical practice.
- To provide a framework for clinical social workers to assess responsible professional behavior.
- To inform consumers, governmental regulatory bodies, and others, such as insurance carriers, about the profession's standards for clinical social work practice.

Toward the achievement of these goals, the standards

- Define and delineate clinical social work and the private practice of clinical social work.
- Establish specific ethical guidelines for the practice of clinical social work in agency or private practice settings.
- Provide documentation of professional expectations for agencies, peer review committees, state regulatory bodies, insurance carriers, and others.



21

## Standards for the Practice of Clinical Social Work

**Standard 1. Clinical social workers shall function in accordance with the ethics and the stated standards of the profession, including its accountability procedures.**

*Interpretation*

All social workers have a fourfold responsibility: to clients, to the profession, to self, and to society. Social workers shall identify themselves as members of the social work profession. NASW members shall be familiar with and adhere to the NASW Code of Ethics and shall cooperate fully and in a timely fashion with the adjudication procedures of the Committee of Inquiry, peer review, and appropriate state boards. They shall be aware of and adhere to relevant stated professional standards for social work practice.

All clinical social workers shall be willing to have judgments and decisions reviewed by knowledgeable peers in a formal process. When requested by a client, the clinical social worker will provide information about how to file a complaint charging unethical behavior.

**Standard 2. Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions.**

*Interpretation*

Areas of knowledge about individuals, families, and groups required for effective clinical intervention encompass the following:

1. Social, psychological, and health factors and their interplay on psychosocial functioning, such as these:
   - theories of personality and behavior,
   - social-cultural influences,
   - environmental influences,
   - physical health, and
   - impairment and disability, including mental and emotional conditions.
2. Community resources
   - available social resources in the community and their operation and how to use them in the client's behalf and
   - how to identify appropriate services and negotiate a referral.
3. Specific practice skills, including the ability to
   - establish
   - obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis,
   - establish compatible goals of service with the client,
   - bring about changes in behavior (thinking, feeling, or doing) or in the situation in accordance with the goals of service.
4. Knowledge about and skills in using research to evaluate the effectiveness of a service.

The clinical social worker shall have available a variety of appropriate social work therapeutic intervention techniques that he or she uses selectively, depending on the client's needs and capacity for change.

When knowledge and skills are acquired, other than those specific to social work, the practitioner is responsible for obtaining the appropriate training and certification. Clinical social workers shall maintain and enhance their skills through appropriate forms of professional development and continuing education (see *NASW Standards for Continuing Professional Education*) and are personally accountable for all aspects of their professional behavior and decisions.

**Standard 3. Clinical social workers shall respond in a professional manner to all persons who seek their assistance.**

*Interpretation*

Clinical social workers shall respond to each client regardless of the client's lifestyle, origin, race, sex, religion, or sexual orientation.

Clinical social workers shall limit their practice to those clients whom they have the skills and resources to serve. However, they shall be aware of and seek to ameliorate any of their attitudes and practices that may interfere with their ability to offer competent and equitable service. They have a professional responsibility to help a client establish contact with other appropriate resources when they cannot meet the needs for service of a particular client.

If the clinical social worker is unable to schedule a timely appointment for an initial assessment, he or she may screen the client by telephone to determine the urgency of the client's situation. The well-being of the client is the key factor in all decisions. In emergency situations in which the clinical social worker cannot be available to a new client, every effort should be made to find an appropriate source of immediate help.

On occasion, a client may decide to terminate treat-

(12)

premature but the client persists in his or her decision, it is the clinician's responsibility to refer the client to another appropriate treatment resource or, failing that, to help the client terminate treatment as constructively as possible, leaving the door open for the client to reapply for service at another time.

**Standard 4. Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients.**

*Interpretation*

In accordance with the definition of clinical social work (see "Definitions"), the perspective of the person-in-situation is central to clinical practice. Therefore, clinical social workers must be alert to the clients' situations, especially those that affect the clients' behavior and functioning, and must be able to modify the environment, when possible, by referrals to other community services. There will also be occasions when advocacy on behalf of a client will be necessary to obtain needed services.

When a client is being served by other agencies, the clinical social worker shall maintain collaborative contacts as necessary with the other providers to ensure the coordination of services and the client's receipt of optimal benefits from the various services.

When the client is involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility. The clinician shall not share information about a client without the client's informed consent. (See Standard 6 for an elaboration of confidentiality.)

**Standard 5. Clinical social workers shall maintain their accessibility to clients.**

*Interpretation*

In the process of managing a therapeutic relationship, various factors or events may create problems of accessibility. The clinician shall be able to respond to the unanticipated needs of a client by, for example, having telephones answered, either by a person or machine, and messages relayed promptly and accurately. When the clinical social worker is unavailable because of vacation, illness, or any other reason, he or she should make arrangements for coverage by competent peers. These details should be discussed with the client at the beginning of

In establishing an office, the clinical social worker shall be aware that some clients may have or develop physical handicaps. Thus, the clinical social worker shall make every attempt to ensure that offices are free of impediments to mobility and that helping devices are available for sensorially impaired clients. The office's accessibility by public transportation, when it is available, also should be a consideration.

**Standard 6. Clinical social workers shall safeguard the confidential nature of the treatment relationship and of the information obtained within that relationship.**

*Interpretation*

Respect for the client as a person and for the client's right to privacy underlies the maintenance of confidentiality in the client-clinician relationship. Although assurance of this confidentiality enhances the therapeutic interaction, the client should be advised that there are circumstances in which confidentiality cannot be maintained. These circumstances would include but not necessarily be limited to the legally mandated requirement to report to appropriate authorities a suspicion of child abuse, including the sexual abuse of children, or a suspicion of bodily harm or violence to some other person.[1] In some circumstances, a clinician may need to advise the parents of a child client's self-destructive behavior to ensure adequate protection for the child. In all such situations, the clinician shall advise the client of the exceptions to confidentiality and privilege, be prepared to share with the client the information that is being reported, and handle the feelings evoked. Except for such explicit, overriding requirements, the clinical social worker shares information only with the written and informed consent of the client.

**Standard 7. Clinical social workers shall maintain access to professional case consultation.**

*Interpretation*

In an agency setting, professional social work supervision or consultation should be available to all social work staff, either in the agency or through a contractual arrangement. If clinical social workers are not available, case con-

[1] Tarasoff v. Regents of the University of California, 551 P

sultation may be obtained from qualified professionals of other disciplines.

The beginning clinical social worker requires regular case-consultation supervision. For the first two years of professional experience, at least one hour of supervision should be provided for every fifteen hours of face-to-face contact with clients. After the first two years, the ratio may be reduced to a minimum of one hour of case-consultation supervision for every thirty hours of face-to-face contact with clients. In some situations, additional consultation will be sought by the clinician, because of complex issues involving a client or suggested by the consultant, because of difficulties the consultant perceives in the clinician's handling of a situation.

Clinicians with five years or more of experience should utilize consultation on an as-needed, self-determined basis. Although clinicians who are in independent practice shall utilize more case consultation when they first begin practicing, they should maintain consultative arrangements throughout the time they are in practice. Clinical social workers shall be knowledgeable about how and when to utilize the expertise of other professional disciplines in the area of medical problems, including pharmacology, and alert to the effects of prescription drugs on a client they can provide feedback to the client's physician.

**Standard 8. Clinical social workers shall establish and maintain professional offices and procedures.**

*Interpretation*

The clinical social worker keeps records of clients that substantiate service in a secure place. He or she maintains the records accurately and in a manner that is free from bias or prejudicial content. The social worker makes these records available to clients at their request.

The clinical social worker should ensure that appropriate insurance is maintained: agency liability, personal professional liability, premises protection, and other pertinent policies.

Clinical social workers shall establish a fee structure when in independent private practice or utilize the fee structure of the agency in which they are working. All terms and procedures for payment shall be discussed with the client at the beginning of treatment; to minimize misunderstanding, it is useful to present these policies in writing as well. This discussion should include the use of insurance reimbursement and how it will be handled; fees for missed [illegible] and collateral contacts; and any other financial issues.

Clinical social workers shall not refuse service to clients solely because the clients are not covered by insurance. They shall not engage in fee splitting: a practice by which a client's payments are divided between the service provider and a non-service provider, such as a referral source.

Billing procedures shall be included in the original discussion and clients' accounts shall be maintained according to acceptable accounting methods, with all bills and receipts provided on a regular and timely schedule. Clinical social workers shall discuss overdue accounts with clients and make every effort to avoid accrual of debt. When it is clear to a client and clinician that, for whatever reason, the client can no longer afford to pay for treatment, a mutually acceptable alternative plan for compensation or an orderly and appropriate termination or referral shall be instituted. Nothing in this standard shall be construed to rule out an individual clinician's decision to provide services on a *pro bono* basis.

When all efforts to collect an overdue account from a client have failed, the client should be informed that unpaid accounts may be turned over to a collection agency or small claims court or that other types of legal action will be taken. If there is a dispute over charges, the clinical social worker should make every effort to resolve it without damaging the therapeutic relationship.

Waiting rooms and offices should be kept clean, and the environment should be properly maintained to ensure a reasonable degree of comfort. Interviewing rooms should ensure privacy and be free of distractions. Steps should be taken to assure the client's and the social worker's personal security.

**Standard 9. Clinical social workers shall represent themselves to the public with accuracy.**

*Interpretation*

The public needs to know how to find help from qualified clinical social workers. Both agencies and independent private practitioners should ensure that their therapeutic services are made known to the public. In this regard, it is important that telephone listings be maintained in both the classified and alphabetical sections of the telephone directory describing the clinical social work services available.

Although advertising in various media was thought to be [illegible]

have made such advertising acceptable. The advertisement must be factual. It should be worded to avoid false promises of cures and should not include testimonials or any other hint of enticement.

The content of the advertisement shall include (1) the private practitioner's or agency's name and professional credentials and (2) the address and telephone number or other contact information. It may also include the type of services provided (e.g., individual, family, or group therapy; alcoholism counseling; divorce mediation; and so forth) and the type of problems that are dealt with (e.g., marital distress, parent-child conflicts, eating disorders).

**Standard 10. Social workers shall engage in the independent private practice of clinical social work only when qualified to do so.**

*Interpretation*

Many states have legal regulations for social workers at a clinical or independent-practice level. If practitioners work in such a state, they must be licensed or certified at this level to engage in independent private practice.

The NASW standards for the independent practice of clinical social work are those required for inclusion in the *NASW Register of Clinical Social Workers:*

1. A graduate degree from a social work program accredited by the Council on Social Work Education.
2. Two years of full-time (or equivalent part-time) clinical social work experience supervised by a clinical social worker.
3. Current membership in the Academy of Certified Social Workers or a license or certification in a state at the appropriate level.

**Standard 11. Clinical social workers shall have the right to establish an independent private practice.**

*Interpretation*

Clinical social workers shall have the right to establish a separate independent practice as a form of secondary employment or after leaving a place of employment. When they establish such a practice, either alone or as part of a group, they are responsible for assuring that the diagnostic and treatment services meet professional standards. If such a practitioner hires clinical social workers or other emplo-

the services provided, for maintaining all these standards, and for upholding all applicable local, state, or federal regulations.

Clinical social workers who are employed by agencies and have an independent private practice should not refer agency clients to themselves unless they have made a specific agreement with the agency and have offered alternative options to the clients. Agencies have the responsibility to establish written, reasonable guidelines or policies about secondary employment (see *NASW Standards for Social Work Personnel Practices*). When an agency does not have clear written policies, the clinical social worker may cite the relevant NASW standards.

When a clinical social worker leaves an agency to establish an independent private practice, he or she must take great care not to coerce or entice agency clients to the private practice. Clients in treatment may be offered various options after consultation with the agency. These options include (1) transferring to another staff member in the agency, (2) continuing with the same clinician in an independent setting, (3) transferring to another agency or to a different private practitioner, or (4) terminating treatment. The overriding principle is the client's right to self-determination and freedom of choice. That is, the client's best interests must always be paramount in these decisions.

## Code of Ethics

### SUMMARY OF MAJOR PRINCIPLES

**I. The Social Worker's Conduct and Comportment as a Social Worker**

A. *Propriety.* The social worker should maintain high standards of personal conduct in the capacity or identity as social worker.

B. *Competence and Professional Development.* The social worker should strive to become and remain proficient in professional practice and the performance of professional functions.

C. *Service.* The social worker should regard as primary the service obligation of the social work profession.

D. *Integrity.* The social worker should act in accordance with the highest standards of professional integrity.

E. *Scholarship and Research.* The social worker engaged in study and research should be guided by the conventions of scholarly inquiry.

**II. The Social Worker's Ethical Responsibility to Clients**

F. *Primacy of Clients' Interests.* The social worker's primary responsibility is to clients.

G. *Rights and Prerogatives of Clients.* The social worker should make every effort to foster maximum self-determination on the part of clients.

H. *Confidentiality and Privacy.* The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

I. *Fees.* When setting fees, the social worker should ensure that they are fair, reasonable, considerate, and commensurate with the service performed and with due regard for the clients' ability to pay.

**III. The Social Worker's Ethical Responsibility to Colleagues**

J. *Respect, Fairness, and Courtesy.* The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

K. *Dealing with Colleagues' Clients.* The social worker has the responsibility to relate to the clients of colleagues with full professional consideration.

**IV. The Social Worker's Ethical Responsibility to Employers and Employing Organizations**

L. *Commitments to Employing Organizations.* The social worker should adhere to commitments made to the employing organizations.

**V. The Social Worker's Ethical Responsibility to the Social Work Profession**

M. *Maintaining the Integrity of the Profession.* The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.

N. *Community Service.* The social worker should assist the profession in making social services available to the general public.

O. *Development of Knowledge.* The social worker should take responsibility for identifying, developing, and fully utilizing knowledge for professional practice.

**VI. The Social Worker's Ethical Responsibility to Society**

P. *Promoting the General Welfare.* The social worker should promote the general welfare of society.

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*This summary is of the NASW Code of Ethics, effective July 1, 1980, as adopted by the 1979 NASW Delegate Assembly. The complete text, including the preamble and expanded definitions of principles, is available on request.*

5-0356X
Ford
2/13/88

Original sponsors: Faiks and Kerttula

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SENATE BILL NO. 67 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance coverage for the treatment of a mental or nervous condition."

BE IT ENACTED BY THE LEGISLATURE 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 authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a group disability insurance policy for major medical coverage on an expense-incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a group contract for major medical coverage in the state, must provide the insured or subscriber the following coverage for treatment of a mental or nervous condition of the insured, subscriber, or other person covered by the policy or contract:

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

(2) a total of 50 hours of outpatient treatment or office visits a year for each covered individual.

(b) The insurer or service corporation providing coverage under this section may impose reasonable contract limitations but may not require that the insured or subscriber pay a higher deductible or co-payment for the cost of treating a mental or nervous condition than for the cost of treating another condition or illness.

(c) In this section

(1) "consulting relationship" means a relationship that

involves review of treatment plans and goals and in-person patient contact on at least a quarterly basis;

(2) "co-payment" means the portion of the cost in excess of the deductible portion to be paid by the insured or subscriber;

(3) "cost" means the lesser of the following:

(A) the actual charge for the treatment received for a mental or nervous condition; or

(B) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage;

(4) "deductible" means the portion of covered costs that must be incurred before benefits become payable;

(5) "inpatient treatment" means treatment of a hospital registered bed patient for whom the hospital makes a daily room charge in

(A) a general hospital that is either licensed under AS 18.20 or located and licensed in another state;

(B) a psychiatric hospital that is either licensed under AS 18.20 or located and licensed in another state; or

(C) a hospital that is located in

(i) the state and specifically exempt under AS 18.20.020 from the licensing requirements of the state; or

(ii) another state and specifically exempt from the licensing requirements of that state;

(6) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits for the insured or subscriber of at least $10,000;

(7) "mental or nervous condition" means a mental disorder

identified in

(A) the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or

(B) the most current edition of the ICD-9-CM published by the Commission on Professional and Hospital Activities;

(8) "national professional organization" means the National Association of Social Workers; the National Registry of Health Care Providers; and the American Board of Examiners in clinical social work;

(9) "office visit" means treatment that is not inpatient treatment or outpatient treatment and that is provided through the professional offices of

(A) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(B) a physician who is employed by the federal government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(C) a psychologist or psychological associate licensed by a state;

(D) a person who works in a consulting relationship with a mental health care provider licensed by a state and has a masters or doctoral degree in psychology, nursing, or social work; or

(E) a clinical social worker who is

(i) licensed or certified as a clinical social worker by a state; or

(ii) certified by a national professional

organization offering certification of clinical social workers;

(10) "outpatient treatment" means treatment that is not inpatient treatment and that is provided

(A) in the outpatient department of

(i) a hospital that is licensed under AS 18.20 or that is specifically exempt under AS 18.20.020 from the licensing requirements of the state;

(ii) a hospital that is located in another state and that is either licensed or specifically exempt from the licensing requirements of that state; or

(iii) an entity that is designated by the Department of Health and Social Services as an organizational unit in a geographical area to receive funds under AS 47.30.520 - 47.30.620; and

(B) by one or more of the following:

(i) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(ii) a physician who is employed by the federal government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(iii) a psychologist licensed by a state;

(iv) a person who works in a consulting relationship with one or more licensed mental health care providers licensed by a state and has a masters or doctoral degree in psychology, nursing, or social work, and is employed by the

same health care facility providing treatment; or

(v) a clinical social worker who is licensed or certified as a clinical social worker by a state or certified by a national professional organization offering certification of clinical social workers.

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

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

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

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(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 [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed on or after January 1, 1989.

5-0356X
Ford
2/9/88

Original sponsors: Faiks and Kerttula

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SENATE BILL NO. 67 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance coverage for the treatment of a mental or nervous condition."

BE IT ENACTED BY THE LEGISLATURE 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 authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a group disability insurance policy for major medical coverage on an expense-incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a group contract for major medical coverage in the state, must provide the insured or subscriber the following coverage for treatment of a mental or nervous condition of the insured, subscriber, or other person covered by the policy or contract:

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

(2) a total of 50 hours of outpatient treatment or office visits a year for each covered individual.

(b) The insurer or service corporation providing coverage under this section may impose reasonable contract limitations but may not require that the insured or subscriber pay a higher deductible or co-payment for the cost of treating a mental or nervous condition than for the cost of treating another condition or illness.

(c) In this section

(1) "co-payment" means the portion of the cost in excess of

the deductible portion to be paid by the insured or subscriber;

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

(A) the actual charge for the treatment received for a mental or nervous condition; or

(B) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage;

(3) "deductible" means the portion of covered costs that must be incurred before benefits become payable;

(4) "inpatient treatment" means treatment of a hospital registered bed patient for whom the hospital makes a daily room charge in

(A) a general hospital that is either licensed under AS 18.20 or located and licensed in another state;

(B) a psychiatric hospital that is either licensed under AS 18.20 or located and licensed in another state; or

(C) a hospital that is located in

(i) the state and specifically exempt under AS 18.20.020 from the licensing requirements of the state; or

(ii) another state and specifically exempt from the licensing requirements of that state;

(5) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits for the insured or subscriber of at least $10,000;

(6) "mental or nervous condition" means a mental disorder identified in

(A) the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American

Psychiatric Association; or

(B) the most current edition of the ICD-9-CM published by the Commission on Professional and Hospital Activities;

(7) "national professional organization" means the National Association of Social Workers; the National Registry of Health Care Providers; and the American Board of Examiners in clinical social work;

(8) "office visit" means treatment that is not inpatient treatment or outpatient treatment and that is provided through the professional offices of

(A) a psychiatrist who is licensed as a physician in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(B) a physician who is employed by the federal government in the state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

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

(D) a person who works under the supervision of a mental health care provider licensed in the state and has a masters or doctoral degree in psychology, nursing, or social work; or

(E) a clinical social worker who is

(i) licensed or certified as a clinical social worker by a state; or

(ii) certified by a national professional organization offering certification of clinical social workers;

(9) "outpatient treatment" means treatment that is not inpatient treatment and that is provided

(A) in the outpatient department of

(i) a hospital that is licensed under AS 18.20 or that is specifically exempt under AS 18.20.020 from the licensing requirements of the state;

(ii) a hospital that is located in another state and that is either licensed or specifically exempt from the licensing requirements of that state; or

(iii) an entity that is designated by the Department of Health and Social Services as an organizational unit in a geographical area to receive funds under AS 47.30.520 - 47.30.620; and

(B) by one or more of the following:

(i) a psychiatrist who is licensed as a physician in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(ii) a physician who is employed by the federal government in the state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(iii) a psychologist licensed under AS 08.86;

(iv) a person who works under the supervision of one or more licensed mental health care providers licensed in the state and has a masters or doctoral degree in psychology, nursing, or social work, and is employed by the same health care facility providing treatment; or

(v) a clinical social worker who is licensed or certified as a clinical social worker by a state or certified by a national professional organization offering

certification of clinical social workers.

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

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

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

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(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 [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed after January 1, 1989.