SB

67

file 2

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 8, 1988

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

Dear Messrs. Koponen and Ellis:

Re: CSSB 67 (HESS)

The purpose of this letter is to provide you an analysis of the fiscal impact of CSSB 67 (HESS). The present version of the bill would have no fiscal impact on the cost of health insurance for the state. Our analysis indicates that insurers would be required to offer the option to receive the minimum level of coverage for treatment of a mental or nervous condition.

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

The State of Alaska now provides mental health coverage for all eligible employees. The level of this coverage is somewhat less than that provided for in the bill in an effort for cost containment in the plan. Health insurance benefits are determined at the bargaining table and may not be changed as a result of this bill.

Please let me know if you have any questions regarding this matter or should you require further information.

Sincerely,

Robert F. Stalnaker
Acting Director

RFS/MBC/cam/III

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Please let me know if you have any questions regarding this matter or should you require further information.

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Robert F. Stalnaker
Acting Director

RFS/MBC/cam/III

5-0356T
Ford
2/18/88

Original sponsors: Faiks and Kerttula

IN THE SENATE

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

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; and providing for an effective date."

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, shall offer 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 21.42.365(a) is repealed and reenacted to read:

(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.

* Sec. 3. 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 licens physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

* Sec. 4. 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) <u>AS 21.42.345 - 21.42.365</u> [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 5. AS 21.42.365, as 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.

* Sec. 6. AS 21.42.365, as amended by sec. 2 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, 1990.

* Sec. 7. Section 2 of this Act takes effect January 1, 1990.

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>;

743.540 Application and certificates not required, blanket health insurance policies. An individual application need not be required from a person insured under a blanket health insurance policy, nor shall it be necessary for the insurer to furnish each person a certificate. [1967 c.359 §467]

743.543 Facility of payment, blanket health insurance policies. All benefits under a blanket health insurance policy shall be payable to the person insured, or to the designated beneficiary or beneficiaries of the person, or to the estate of the person, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to the parent, guardian or other person actually supporting the person. However, the policy may provide that all or a portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid. [1967 c.359 §468]

743.546 Policy form approval, blanket health insurance. The commissioner may exempt from the policy form filing and approval requirements of ORS 743.006, for so long as the commissioner deems proper, any blanket health insurance policy to which in the opinion of the commissioner such requirements may not practicably be applied, or may dispense with such filing and approval whenever, in the opinion of the commissioner, it is not desirable or necessary for the protection of the public. [1967 c.359 §469]

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses. [1973 c.143 §2]

743.552 Guidelines for application of ORS 743.549. The commissioner shall by rule establish guidelines for the application of ORS 743.549, including:

(1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision. [1973 c.143 §3]

743.555 Application of ORS 743.549 and 743.552. ORS 743.549 and 743.552 shall apply to any group or blanket health insurance policy containing a provision described in ORS 743.549 which is issued more than 90 days after June 26, 1973. Policies which are in existence 90 days after June 26, 1973, shall be brought into compliance on the next anniversary date, renewal date or the expiration date of the applicable collectively bargained contract, if any, whichever date is latest. [1973 c.143 §4]

743.557 Group health insurance coverage for treatment for chemical dependency including alcoholism; limitation on deductibles and coinsurance; eligible treatments and programs; allowable limits on payments; cost containment. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430.010, within the limits specified in this section. Notwithstanding the limits for particular types of

services specified in subsections (6) to (8) of this section, a policy may limit the total of payments for all treatment of any kind under this section for chemical dependency including alcoholism, together with payments for all treatment of any kind under ORS 743.558 for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in ORS 743.558. For persons requesting, in any 24-consecutive month period, payments for treatment of any kind for chemical dependency including alcoholism, but not requesting payments for treatment of any kind of mental or nervous conditions, a policy may limit the total of payments for all treatment to $6,000 in that 24-consecutive month period.

(3) Subject to the provisions of ORS 743.123, 743.128 and 743.135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, shall be eligible to receive payments for treatment. In addition, an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures through which Mental Health Division approved programs with alternative arrangements for supervision or for review of treatment plans may become qualified to receive payments for treatment.

(4) Chemical dependency, for purposes of this section, refers to the addictive relationship an individual may have with any drug or alcohol agent. This dependency may be characterized by either a physical or psychological relationship, or both, to the extent that it interferes with the individual's social, psychological or physical adjustment to common problems on a daily basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(5) Payments shall not be made under this section for educational programs to which drinking drivers are referred by the judicial system, nor for volunteer mutual support groups.

(6) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for chemical dependency including alcoholism to an amount less than $4,500 in any 24-consecutive month period.

(7) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for care and treatment in residential facilities for chemical dependency including alcoholism, the policy shall not limit payments to an amount less than $3,000 in any 24-consecutive month period. Within this dollar limit, payments shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week. Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments.

(8) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient services, the policy shall not limit payments to an amount less than $1,500 in any 24-consecutive month period. If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services. The policy may limit coverage for such service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(9) Under ORS 430.315, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10) A group health insurance policy may provide, with respect to treatment for chemical

dependency including alcoholism, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment. This review shall be made according to criteria made available to providers in advance. Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only; or to review, on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes, on each case, in a timely fashion, to the insurer.

(11) For purposes of paragraph (b) of subsection (10) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(12) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment, as defined in ORS 430.010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation; or

(c) An alternative residential facility.

(13) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430.010 and under subsection (7) of this section, shall require demonstration that outpatient services, as defined in ORS 430.010 and under subsection (7) of this section, if appropriate and less costly than residential facility services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(14) For purposes of paragraph (b) of subsection (10) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430.010 and under subsections (7) and (8) of this section, shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis. [1975 c.689 §2; 1977 c.632 §3; 1981 c.319 §2; 1983 c.601 §5]

Note: See note under 743.558.

743.558 Group health insurance coverage for mental or nervous conditions; limitation on deductibles and coinsurance; eligible treatments and programs; allowable limits on payments; cost containment. Every insurer offering group health insurance

benefits shall provide benefits for expense arising from mental or nervous conditions that meet the following requirements:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430.010 within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (4) to (6) of this section, a policy may limit the total of payments for all treatment of any kind under ORS 743.557 for chemical dependency including alcoholism, together with payments for all treatment of any kind under this section for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in this section. However, for person requesting, in any 24-consecutive month period, payments for treatment of any kind for mental or nervous conditions, but not requesting payments for treatment of any kind for chemical dependency including alcoholism, a policy may not limit the total of payments for all treatment to less than $9,000 in that 24-consecutive month period.

(3) Subject to the provisions of ORS 743.123, 743.128 and 743.135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, shall be eligible to receive payments for treatment.

(4) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for mental or nervous conditions to an amount less than $7,500 in any 24-consecutive month period, subject to the provisions of subsection (5) of this section.

(5) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for treatment in residential facilities, the policy shall not limit payments to an amount less than $3,000 in any 24-consecutive month period. A policy may specify that any payments made under this subsection shall directly reduce, dollar for dollar, amounts available for payments under subsection (4) of this section. Within the dollar limit in this subsection, payments shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week. Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments.

(6) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient treatment, the policy shall not limit payments to an amount less than $2,000 in any 24-consecutive month period. If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services. The policy may limit coverage for in-home service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(7) Under ORS 430.021, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(8) A group health insurance policy may provide, with respect to treatment for mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment. This review shall be made according to criteria made available to providers in advance. Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only; or to review, on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes, on each case, in a timely fashion, to the insurer.

(9) For purposes of paragraph (b) of subsection (8) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(10) For purposes of paragraph (b) of subsection (8) of this section, when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment as defined in ORS 430.010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation; or

(c) An alternative residential facility.

(11) For purposes of paragraph (b) of subsection (8) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430.010 and under subsection (5) of this section, shall require demonstration that outpatient services, as defined in ORS 430.010 and under subsection (5) of this section if appropriate, and less costly than residential facility services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situation; risks to self or others; and readiness to participate consistently in treatment.

(12) For purposes of paragraph (b) of subsection (8) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430.010 and under subsections (5) and (6) of this section, shall require demonstration that treatment is justified, considering the individual's history and the current medical, occupational, social and psychological situation, and the overall prognosis. [1973 c.613 §2; 1983 c.601 §6]

Note: Section 10, chapter 601, Oregon Laws 1983, provides:

Sec. 10. Sections 7, 8 and 11, chapter 601, Oregon Laws 1983, and ORS 743.557, 743.558 and 750.055 as amended by sections 5, 6 and 9, chapter 601, Oregon Laws

B-Engrossed
Senate Bill 31

Ordered by the House June 10
Including Senate Amendments dated April 28
and House Amendments dated June 10

PRINTED PURSUANT TO ORS 171.130 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of State Health Planning and Development Agency)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Revises health insurance reimbursement requirements for mental or nervous conditions and chemical dependency. Requires that State Health Planning and Development Agency draft model set of review criteria for use in certain health care facilities and residential programs and facilities.

Directs Insurance Division to adopt criteria for determining when health maintenance organization meets specified requirements for provision of chemical dependency benefits and when certain contracts for discounted health care services meet specified requirements. **Allows health maintenance organizations to charge co-payments for mental health care until June 30, 1991. Directs Insurance Commissioner to adopt rules necessary to interpret Act.**

Declares emergency, effective June 30, 1987.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 430.010, 748.555, 750.055 and section 10, chapter 601, Oregon Laws 1983; repealing ORS 743.557, 743.558 and section 2, chapter 601, Oregon Laws 1983; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this Act is added to and made a part of ORS chapter 743.

SECTION 2. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism and for mental or nervous conditions. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment provided in health care facilities, residential programs or facilities, day or partial hospitalization programs or outpatient services shall be considered eligible for reimbursement if it is provided by:

(a) Programs or providers described in ORS 430.010 or approved by the office of Alcohol and Drug Abuse Programs or by the Mental Health Division under subsection (3) of this section.

(b) Programs accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation

NOTE: Matter in bold face in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted.

of Rehabilitation Facilities.

(c) Inpatient programs provided by health care facilities as defined in ORS 442.015 (16). Residential, outpatient, or day or partial hospitalization programs offered by or through a health care facility must meet the requirements of either paragraph (a) or (b) of this subsection in order to be eligible for reimbursement.

(d) Residential programs or facilities described in subsection (3) of this section if the patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week.

(e) Programs in which staff are directly supervised or in which individual client treatment plans are approved by a person described in ORS 430.010 (4)(d) and which meet the standards established under subsection (3) of this section.

(3) The office of Alcohol and Drug Abuse Programs shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the division or any county mental health program. The Mental Health Division shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that not related to the division or any county mental health program. Standards proposed by the American Association of Partial Hospitalization should be considered as one possible source for such rules. In addition, an insurer or insurers and the office of Alcohol and Drug Abuse Programs, or an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures for programs that are approved by the office or the division and that provide alternative arrangements for supervision or for review of treatment plans to become qualified to receive payments for treatment.

(4) A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Mental Health Division and the office of Alcohol and Drug Abuse Programs jointly shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the office or the division and any county mental health program.

(5) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Child or adolescent" means a person who is 17 years of age or younger.

(c) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than $10,500 for adults and $12,500 for children or adolescents. For persons requesting

payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all treatment to less than $6,500 for adults and $10,500 for children and adolescents.

(7) The limits for mental or nervous conditions specified in this section shall apply to persons with diagnoses of both chemical dependency and mental or nervous conditions, who are being treated for both types of diagnosis, as well as persons with only a diagnosis of a mental or nervous condition.

(8) The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents.

(9) Payments shall not be made under this section for educational programs to which drivers are referred by the judicial system, nor for volunteer mutual support groups.

(10) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for inpatient treatment in hospitals and other health care facilities thereunder:

(a) For chemical dependency to an amount less than $4,500 for adults and $4,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $4,000 for adults and $6,000 for children or adolescents.

(11) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for treatment in residential programs or facilities or day or partial hospitalization programs:

(a) For chemical dependency to an amount less than $3,500 for adults and $3,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $1,000 for adults and $2,500 for children or adolescents.

(12) Notwithstanding the minimum benefits for particular types of services specified in subsections (10) and (11) of this section, and except as permitted by subsection (1) of this section, the policy shall not limit total payments for inpatient, residential and day or partial hospitalization program care or treatment:

(a) For chemical dependency to an amount less than $8,500 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $8,500 for adults and $10,500 for children or adolescents.

(13) Except as permitted by subsections (1) and (6) of this section, in the case of benefits for outpatient services, the policy shall not limit payments:

(a) For chemical dependency to an amount less than $1,500 for adults and $2,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $2,000.

(14) If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health care facility, residential, day or partial hospitalization or outpatient services. The policy may limit coverage for in-home service to persons who have completed their initial health care facility, residential, day or partial hospitalization or outpatient treatment and did not termin. te that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(15) Under ORS 430.021 and 430.315, the Legislative Assembly has found that health care cost

containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(16) A group health insurance policy may provide, with respect to treatment for chemical dependency or mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential programs or facilities, day or partial hospitalization programs or outpatient services less than the proportion of coinsurance required for treatment in health care facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either insurer staff or personnel under contract to the insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment:

(A) This review shall be made according to criteria made available to providers in advance upon request.

(B) To facilitate implementation of utilization review programs by insurers, the State Health Planning and Development Agency shall draft an advisory or model set of criteria for appropriate utilization of inpatient, residential, day or partial hospitalization, and outpatient facilities, programs and services by adults, children and adolescents, and persons with both a chemical dependency diagnosis and a mental or nervous condition. These criteria shall be consistent with this section and shall not be binding on any insurer or other party. However, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, any insurer may adopt the criteria or similar criteria with or without modification. The agency shall revise these criteria at least every two years. In developing and revising these criteria, the agency shall organize a technical advisory panel including representatives of the Insurance Division, the office of Alcohol and Drug Abuse Programs, the Mental Health Division, the Health Division, the insurance industry, the business community and providers of each level of care. The agency shall place substantial weight on the advice of this panel.

(C) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon; a psychologist licensed by the State Board of Psychologist Examiners; a nurse practitioner registered by the Oregon State Board of Nursing; or a clinical social worker registered by the State Board of Clinical Social Workers, with physician consultation readily available. The reviewer shall have expertise in the evaluation of mental or nervous condition services or chemical dependency services.

(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, insurers shall permit treatment providers, policy holders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Insurers shall provide a timely response to such inquiries.

Approval of a particular admission does not represent a guarantee of future payment.

(E) An appeals process shall be provided.

(F) An insurer may choose to review all providers on a sampling or audit basis only; or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case in a timely fashion to the insurer.

(17) For purposes of paragraph (b) of subsection (16) of this section, a utilization review contractor is a professional review organization or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(18) For purposes of paragraph (b) of subsection (16) of this section, when implemented through an insurance contract, reimbursability of inpatient treatment requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation;

(c) An alternative residential program or facility; or

(d) A day or partial hospitalization program.

(19) For purposes of paragraph (b) of subsection (16) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential, day or partial hospitalization level of treatment shall require demonstration that outpatient services, if appropriate and less costly than residential, day or partial hospitalization services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(20) For purposes of paragraph (b) of subsection (16) of this section, reimbursability of treatment at the level for outpatient facility, service or program shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis.

(21) Discrete medical or neurologic diagnostic or treatment services including any professional component of that service, costing in excess of $300, occurring concurrently with but not directly related to treatment of mental or nervous conditions shall not be charged against the inpatient benefit level.

(22) The benefits described in this section shall renew in full either on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.

(23) Health maintenance organizations, as defined in ORS 750.005 (3), shall be subject to the following conditions and requirements in their provision of benefits for chemical dependency or mental or nervous conditions to enrollees:

(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the

enrollee is required to pay does not exceed the amount of coinsurance and deductible customarily required by other insurance policies which are subject to the provisions of ORS chapter 743 for that type and level of service.

(b) Nothing in this section prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this section.

(c) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers associated with the health maintenance organization.

(d) The Insurance Division shall make rules establishing objective and quantifiable criteria for determining when a health maintenance organization meets the conditions and requirements of this subsection.

(24) Nothing in this section shall prevent an insurer or health care service contractor other than a health maintenance organization, except as provided in subsection (23) of this section, from contracting with providers of health care services to furnish services to policy holders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) An insurer or health care service contractor may establish limits for contracted services which are actuarially equivalent to the benefits required by this section, so long as the same range of treatment settings is made available.

(b) An insurer or health care service contractor, other than a health maintenance organization, may negotiate with contracting providers as to the cost of actuarially equivalent benefits, and such actuarially equivalent benefits for services of contracting providers shall be deemed to equal the minimum benefit levels specified in this section.

(c) An insurer or health care service contractor is not required to contract with all eligible providers, and payment for covered services of contracting providers may be in alternative methods or amounts rather than as specified in this section.

(d) Insurers and health care service contractors other than health maintenance organizations shall pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract. The insured shall have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions. Policies described in this subsection shall be subject to the provisions of subsection (1) of this section, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(e) The Insurance Division shall make rules establishing objective and quantifiable criteria for determining that a contract meets the conditions and requirements of this subsection and that actuarially equivalent services of contracting providers equal or exceed services obtainable with the minimum benefits specified in this section.

(25) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to assure continuing access to levels of care most appropriate for the insured's condition and progress.

(26) The Insurance Commissioner, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions.

SECTION 3. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.150, 731.162, 731.204 to 731.362, 731.382, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.320, 732.325 and 732.505 to 732.595.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780, apply to not for-profit health care service contractors.

(B) ORS chapter 733 applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.011, 743.012, 743.018 to 743.030, 743.037 to 743.108, 743.114, 743.116, 743.119 to 743.128, 743.350 to 743.370, 743.402, 743.412, 743.492, 743.495, 743.498, 743.527, 743.529, 743.549 to 743.555, 743.800 to 743.833 and 743.850 to 743.890.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528 (2).

(g) ORS 744.005 to 744.265.

(h) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(i) ORS 743.135, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(j) ORS 743.557 and 743.558 except that group practice or staff health maintenance organizations which are federally qualified pursuant to Title XIII of the Public Health Service Act shall be deemed to comply with the requirements of ORS 743.557 and 743.558.

(k) Section 2 of this 1987 Act.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The commissioner may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 752.045 that are deemed necessary for the proper administration of these provisions.

SECTION 4. ORS 430.010 is amended to read:

430.010. As used in ORS 430.010 to 430.050, 430.100 to 430.170, 430.260 to 430.270 and 430.610 to 430.700, unless the context requires otherwise:

(1) "Division" means the Mental Health Division.

(2) "Health facility" means a facility licensed as required by ORS 441.015 or a facility accredited by the Joint Commission on Accreditation of Hospitals, either of which provides full-day or part-day acute treatment for alcoholism, drug addiction or mental or emotional disturbance, and is licensed to admit persons requiring 24-hour nursing care.

(3) "Residential facility" or "day or partial hospitalization program" means a program or facility providing an organized full-day or part-day program of treatment, but not licensed to admit persons requiring 24-hour nursing care. Such a program or facility shall be:

(a) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380 and 430.610 to 430.880 for alcoholism;

(b) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction; or

(c) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041 and 430.610 to 430.880 for mental or emotional disturbance.

(4) "Outpatient service" means a program or service providing treatment by appointment. Such a program or service shall be:

(a) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380 and 430.610 to 430.880 for alcoholism;

(b) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction;

(c) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041 and 430.610 to 430.880 for mental or emotional disturbance; or

(d) Provided by medical or osteopathic physicians licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; psychologists licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; nurse practitioners registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or clinical social workers registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610.

SECTION 5. Section 2, chapter 601, Oregon Laws 1983, is repealed.

SECTION 6. Section 10, chapter 601, Oregon Laws 1983, as amended by section 1, chapter 124, Oregon Laws 1985, and section 179, chapter 158, Oregon Laws 1987 (Enrolled House Bill 2409), is further amended to read:

Sec. 10. [*(1)*] Sections 7, 8 and 11, chapter 601, Oregon Laws 1983, are repealed on July 1, 1987.

[*(2) The amendments to ORS 743.557, 743.558 and 750.055 by sections 5, 6 and 9, chapter 601, Oregon Laws 1983, are repealed on july 1, 1987.*]

SECTION 7. ORS 743.145 does not apply to section 2 of this Act because section 2 of this Act constitutes a reenactment of ORS 743.557 and 743.558 or to ORS 750.055 because of its amendment by this Act.

SECTION 8. Section 2 of this Act and the amendments to ORS 750.055 (1)(k) of this Act apply to contracts entered into, renewed or extended on or after July 1, 1988.

SECTION 9. ORS 743.557 and 743.558 are repealed June 30, 1988.

SECTION 10. Paragraph (a) of subsection (23) of section 2 of this Act is not operative after June 30, 1991.

SECTION 11. ORS 748.555 is amended to read:

748.555. (1) The following provisions of the Insurance Code shall apply to fraternal benefit so-

cieties to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.026, 731.032 to 731.154, 731.162, 731.166, 731.170, 731.204 to 731.356, 731.378 to 731.434, 731.446, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640, 731.644 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.245, 732.250, 732.320 and 732.325.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.570, 733.590 to 733.680 and 733.710 to 733.780.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.012, 743.018 to 743.030, 743.039 to 743.054, 743.060, 743.069, 743.078, 743.084 to 743.108, 743.114, 743.116, 743.123, 743.350 to 743.370 and 743.558 (1985 Replacement Part) **mental or nervous conditions covered under section 2 of this 1987 Act.**

(f) ORS 744.005 to 744.265.

(g) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(2) For the purposes of this section, fraternal benefit societies shall be deemed insurers and benefit certificates issued by such societies shall be deemed policies.

SECTION 12. If House Bill 3081 becomes law, on January 1, 1988, section 11 of this Act is repealed.

SECTION 13. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect June 30, 1987.

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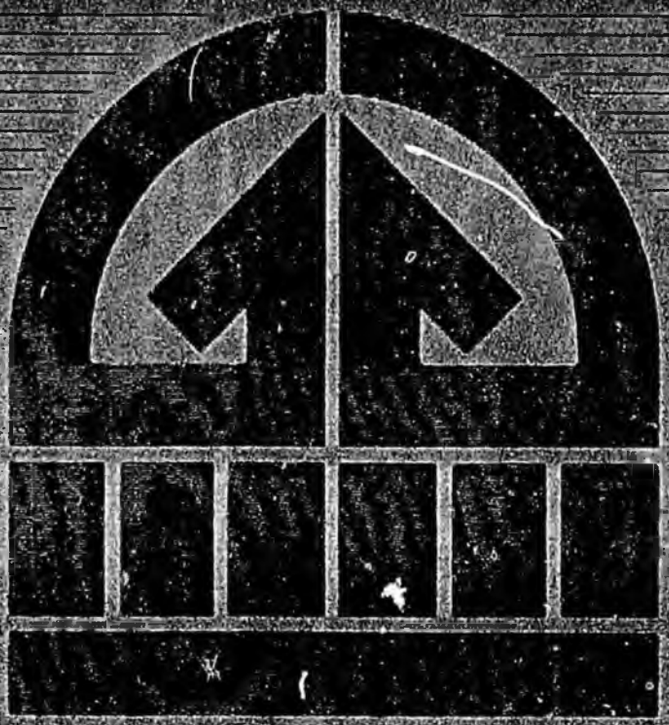

MENTAL HEALTH PROJECT

Human Resources Series

MANDATED MENTAL HEALTH INSURANCE: A COMPLEX CASE OF PROS AND CONS

by

Andrea Paterson

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MANDATED MENTAL HEALTH INSURANCE: A COMPLEX CASE OF PROS AND CONS

INTRODUCTION

On June 1, 1985, state legislatures across the country were still anxiously awaiting word from the U.S. Supreme Court on the legality of state laws requiring insurance companies to offer or provide minimum mental health benefits. Twenty-six states already had such laws; nearly all other states had considered them. Fifteen years of legislative action in this area was on hold.

The Court had yet to hand down its decision in the jointly heard case of Metropolitan Life Insurance Company v. Massachusetts and Travelers Insurance Co. v. Massachusetts. Specifically at issue was the legality of a Massachusetts law mandating certain minimum inpatient and outpatient mental health benefits in any group or individual insurance plan.

Metropolitan Life Insurance Company had charged that the state's mandated benefits law was in conflict with the federal Employee Retirement Income Security Act of 1974 (ERISA), which broadly preempts any and all state laws that regulate employee benefit plans. Massachusetts maintained that its mandated benefits law was protected by a key exception to ERISA's broad preemptive power: an exception that upheld the power of state laws regulating the business of insurance (1, p. 11).

In a different vein, the Travelers Insurance Company maintained that Massachusetts minimum benefits law was preempted by the federal National Labor Relations Act (NLRA) because it applied to benefit plans negotiated under collective bargaining agreements (1, p. 7). The state law, in effect, mandated certain terms of collective bargaining agreements by requiring the purchase of certain benefits, regardless of whether or not the parties involved wanted such benefits (2, p. 22). Massachusetts held that its law was not preempted by the NLRA because mandating minimum benefits did not upset the balance of power between the negotiating parties (2, p. 18).

On June 3rd, 1985, the Supreme Court upheld the Massachusetts law on both counts. Regarding the law's possible preemption by ERISA, the Court held that "if a state law regulates insurance, as mandated-benefits laws do, it is not preempted" (1, p. 21). Congress intended to preserve such state regulatory rights in exempting state laws governing the insurance industry from ERISA's preemptive power (1, p. 18). Regarding the law's possible preemption by the NLRA, the Court, citing the "purpose of Congress [as] the ultimate touchstone" (1, p. 22), held that Congress' intent in passing the NLRA was to establish "an equitable process for determining the terms and conditions of employment" (1, p. 28). The Court found no incompatibility "between federal rules designed to restore the equality of bargaining power and state. . .legislation that imposes minimal substantive requirements on contract terms negotiated between parties" (1, p. 29).

Across the country, legislative, professional and consumer advocates of mandated mental health insurance breathed a sigh of relief. Yet the Supreme Court decision stayed only the legal controversy surrounding these laws. Advocates and opponents alike maintain the fight is far from over. And while the Supreme Court decision has placed responsibility for mandating mental health benefits solidly back into the hands of the states, few state lawmakers would dispute the

fact that mandatory mental health benefits can be a hot political and economic issue to handle.

OVERVIEW: THE LONG-STANDING ARGUMENT BETWEEN THE INSURANCE INDUSTRY AND THE MENTAL HEALTH ESTABLISHMENT

In many state legislatures, controversy over mandated mental health insurance has largely reflected the traditional stand-off between the insurance industry and the mental health community over the necessity and appropriateness of minimum benefits laws. Points of contention between the two groups generally center on consumer choice in the free market system, potential increases in mental health services utilization and costs following a mandate, and the appropriateness of the legislative arena for deciding such an issue.

Consumer Choice in the Free-Market System. Opponents argue that mandates interfere with the market for mental health insurance and are unfair to consumers and industry alike. They maintain that mandates do the following:

- Deny employers and employees the right to choose the benefits they want. As such, the issue is not the ultimate desirability of mental health insurance, but the appropriateness of mandating such insurance when consumers have limited funds with which to buy all types of insurance coverage. The result is less consumer choice and higher premiums;

- Act as a regressive tax. As most employees pay for at least some portion of their health insurance, either through direct premiums or through decreased wages, a law that forces every employee--regardless of income--to purchase the same minimum benefits necessarily imposes a greater hardship on individuals with a lower income;

- Give an unfair advantage to insurance carriers not required to provide minimum benefits. One of the industry's toughest new competitors--Health Maintenance Organizations--are generally not covered by state mandates. In addition, individual insurance plans often are not covered;

- Encourage the trend toward self-insurance. As more companies find themselves required to purchase insurance packages containing unwanted mandated benefits, they will be more likely to self insure, thus side-stepping all federal and state regulation of employee insurance plans;

- Discourage industry from staying or locating in a state. As employers spend an average of 38 percent of their employee labor costs on benefits, a mandate that increases employee benefit costs will detract from that state's ability to attract or retain businesses (3, p. 9);

- Increase the number of uninsured employees. Small businesses may choose to drop their employee health insurance altogether if mandates increase the price of that insurance beyond an affordable point.

Proponents argue that a mandate can restore to proper functioning the otherwise improperly functioning market in mental health insurance, as well as ensure minimum coverage for individuals who need, but are unable to afford mental health insurance. To this end, proponents maintain that two key problems keep the market in mental health insurance from functioning properly.

- The average mental health consumer is not well-informed about the need for and value of mental health insurance. It is estimated that the stigma associated with mental illness helps keep four-fifths of the individuals suffering from a mental disorder from seeking treatment (4, p. 3). Many individuals also have "unrealistic feelings of immunity to mental illness" (5, p. 34), stemming in part from a general "lack of understanding of mental illness, especially when compared to physical illness" (4, p. 3). Furthermore, many employees without mental health coverage are reluctant to ask their employers for such coverage, and employees with such coverage are reluctant to use it because they fear that they will jeopardize their jobs (5, p. 34). Finally, an individual's employer and family may undervalue mental health insurance because they benefit indirectly and in ways that cannot be readily quantified.

- The market in mental health insurance is kept from functioning properly by a phenomenon known as "adverse selection." Adverse selection refers to "the tendency of high-risk policyholders to choose insurance plans with coverage they are likely to use," and for low-risk policyholders not to choose these same plans (6, p. 208); thus it changes the nature of the "risk pool" created by insurance coverage of an illness. When only those high-risk individuals, who know they will use mental health insurance, select plans offering mental health coverage, there is no real risk pool created. As most of the individuals in the pool will take advantage of the mental health services, the costs of that care are not spread evenly over a larger, randomly-selected group reflective of the true risk of mental illness among the general population. As the costs of the mental health coverage climb toward the out-of-pocket care costs, the insurance plans offering mental health coverage often have to drop or decrease that coverage to remain competitive.

Proponents of mandated insurance also maintain that it improves shallow insurance coverage for those low-income employees who would not normally have the out-of-pocket resources for mental health care, but who might need it at some point in their lives to retain their jobs and well-being. Such individuals could use their insurance to defray the costs of mental health care following, for example, the unexpected death of a child or spouse or a traumatic divorce.

Potential Increases in Mental Health Services Costs and Utilization. On the issue of the effect of mandates on mental health care costs and utilization, each side charges the other with misinterpretation of research data and flawed research designs. Moreover, both sides cite studies and statistics that refute the other's "inaccurate" findings.

Opponents argue that mandates greatly increase the costs and utilization of mental health care, without a comparable increase in benefits to individuals and society.

- Blue Cross/Blue Shield of Massachusetts reported a 24-fold increase in outpatient mental health care costs following the implementation of that state's minimum benefits law. In addition, the number of individual therapy sessions almost tripled, making it the single most common procedure covered by Blue Cross/Blue Shield (7, p. 8).

- Minnesota Blue Cross/Blue Shield, between 1976 and 1980, reported a 115 percent increase in inpatient costs for psychiatric care and chemical dependency following the implementation of that state's mandate. Overall hospital charges in the state increased by only 58.2 percent during the same period (7, p. 8).

- In Kansas, Blue Cross/Blue Shield found that the state mental health mandate added "nearly five dollars per month to the average family contract"; in Maryland, Blue Cross/Blue Shield found the increase to be "between two and three dollars per month per family contract" (3, p. 5).

Opponents maintain that mandates produce this dramatic increase in costs and utilization for several reasons. First of all, without providing adequate provider incentives to control costs, they greatly expand provider markets.

- Minimum mental health benefit laws have been associated with average statewide increases of 7 percent in the number of psychiatrists and 32 percent in the number of psychologists (8, p. 207).

- In Wisconsin, the number of state-approved outpatient clinics, for the treatment of drug and alcohol abuse and mental illness, soared from under 40 to over 900 following the implementation of that state's minimum benefits law (9, p. 2)

Secondly, opponents maintain that the amount of mental health care that a consumer will use depends largely on the price of those services, so utilization can and often does skyrocket in situations of greatly increased access to mental health services.

- Between 1974 and 1981, under the liberal mental health coverage provided by the Blue Cross/Blue Shield federal employee benefits plan (FEB), the number of visits to a psychiatrist per 1000 individuals increased 34.1 percent. Yet the number of visits to psychologists, social workers and other nonmedical therapists rose over 300 percent. In 1981, the combined total for FEB subscribers was 922.5 visits per 1000 individuals (7, p. 7).

- A group of Philadelphia area employers, who reviewed hospital utilization by their employees, found that "intensity of hospitalization increases dramatically with availability of benefits. . . .[and] the patients with the more generous benefits have much longer lengths of stay" (7, p. 9).

Proponents argue that mental health costs and utilization stabilize over time, that direct savings will result if an individual in need receives appropriate mental health care, and that mandates can be implemented in such a way as to control unnecessary use of mental health services. Regarding the stable costs and utilization of mental health care over time, proponents cite such examples as the following:

- A 1982 study indicated that the percentage of federal employees receiving psychiatric benefits under both the Blue Cross/Blue Shield and Aetna federal employee benefit plans is relatively stable at around 1.5 percent of the total number of enrollees (6, p. 8).

Proponents insist that the insurance industry's claim of greatly increased costs is reflective of the fact that mandates force "insurers [to] pick up the tab that was once paid by the government and the users themselves (8, p. 207).

States presently pay 50 percent of the costs associated with mental health care, while the insurance industry pays only 12 percent. In contrast, states pay only 15 percent and private insurance dollars pay 28 percent of the costs of general medical care. The net increase in costs of a mental health mandate is estimated to be $1 to $2 per person for the general population (8, p. 208).

Proponents also claim that appropriate mental health care results in direct financial benefits to individuals, employers and society. They maintain that "attempting to establish a false dichotomy between mental and physical illness leads to a false economy in insurance coverage" (6, p. 8).

- Individuals suffering from mental disorders "will use their medical-surgical benefits to cover but not treat their diseases if they do not have access to mental health services" (4, p. 12).

- Mental health care can decrease the use of other--and often more costly--medical services. A Blue Cross/Blue Shield study of individuals diagnosed as having one of four chronic diseases, including certain types of heart disease, hypertension and diabetes found that "the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it" (10, p. 428). In general, reductions in other medical costs resulting from the provision of appropriate mental health treatment range from 5 to 80 percent (8, p. 208).

- Sixty-six percent of the $237.6 billion that drug abuse, alcoholism and mental illness cost society in 1984 was paid out in indirect costs such as decreased job productivity and loss of employment (11, p. 16). An increase in direct expenditures for mental health care could thus produce a significant decrease in indirect costs; even minimal psychotherapy has often been attributed with creating "lessening absenteeism, increasing productivity and decreasing the number of on-the-job accidents (4, p. 7).

Finally, co-payments and co-insurance provisions as well as peer review of psychiatric claims can be effective in controlling excessive and unnecessary use of psychiatric services.

- A 1985 study found "employee insulation from cost" to be the greatest factor contributing to excessive health care costs (4, p. 9).

- More than 400 psychiatrists review mental health benefit claims, based on peer review guidelines developed by the American Psychiatric Association, for 24 national and local insurers across the country. Aetna Life and Casualty spent $20,000 on such peer review in 1981, and saved an estimated $2.4 million. Mutual of Omaha's estimated savings totaled $300,000 during its first year of formal peer review procedures (6, pp. 10-11).

Appropriateness of Legislative Arena for Deciding Insurance Questions. Opponents argue that the state legislature is simply not an appropriate place for questions of insurance coverage to be decided. They maintain that the insurance industry is in the best position to judge the most cost-effective and appropriate mental health benefits on a plan-by-plan basis.

Moreover, they maintain that mental health mandates often have proven to be more costly than mandates for other types of health care. In 1984, Maryland Blue Cross/Blue Shield reported that inpatient and outpatient mental health care

accounted for 60 percent of its expenditures per member month for mandated benefits. In addition to mental health, Maryland law requires coverage of prosthetic devices, alcohol rehabilitation, home health care, as well as services rendered by podiatrists, chiropractors and optometrists, to name a few (12, p. 14).

Opponents also charge that mandating one set of benefits that expands the market for one group of care providers sets a dangerous precedent for the next special interest group that hopes to increase the currency and utilization of its services through mandates. Finally, opponents maintain that legislative efforts to provide coverage for mental health care on a par with that provided for physical illnesses are misguided. The insurance industry generally defends its track record on mental coverage by insisting that mental illness is different from physical illness: "diagnoses are subjective, protocols of treatment are unclear, providers of services are more numerous and less well-trained than is true of medical conditions" (7, p. 1).

Proponents argue that state mandates are an appropriate way to restore competition to a mental health insurance market otherwise riddled by the forces of adverse selection. They cite a long tradition of government intervention in improperly functioning markets--a tradition evidenced, for example, by the extensive body of federal and state anti-trust laws.

Proponents also argue that the insurance industry's power over mental health coverage has led to a history of employee health benefits in which "the human mind has been treated as a second class citizen" (4, apx. a). Employers often do not regard mental health benefits as essential in part because insurance companies generally refrain from promoting them.

In addition, insurance plans heavily favor inpatient care for mental health disorders, while rarely providing it at a level on a par with the coverage provided for physical illnesses. Moreover, proponents claim that the insurance industry's reliance on inpatient care for mental illness reflects a resistance to incorporating new methods of treatment for mental disorders, many of which rely on less-restrictive treatment settings.

- In 1983, the American Psychiatric Association found that, out of 300 insurance plans covering 33 million employees and their dependents, all provided coverage for inpatient care, but only 49 percent of the plans provided coverage on a par with other physical illnesses (6, p. 7). A 1985 update of that study indicated that the number of plans offering such comprehensive coverage had dropped to 48 percent (4, p. 5). Moreover, while 98 percent of the plans provided coverage for outpatient treatment, only 10 percent provided such treatment on the same basis as other medical conditions (6, p. 7).

Proponents maintain that mandated benefits requiring a mix of inpatient and outpatient services could help combat discrimination against the mentally ill in insurance coverage and provide individuals with an appropriate mix of inpatient, outpatient and partial-hospitalization services. Outpatient and partial hospitalization services have been proven to be a more cost-effective and therapeutic type of treatment for many mentally ill individuals, which can avert the potential harm of unnecessary inpatient hospitalization (5, p 38).

GENERAL LEGISLATIVE GUIDELINES: SPECIFIC STATE ISSUES IN MANDATING OR EXPANDING MENTAL HEALTH INSURANCE COVERAGE

Lawmakers must consider carefully the arguments both in favor of and against mandated mental health insurance in deciding to introduce such legislation or to support or oppose it. Specifically, state legislators should pay close attention to the key questions relative to mandating minimum mental health coverage.

What is the nature of the law? Are minimum benefits required or is the availability of such benefits mandatory? Minimum benefits packages can increase the costs of consumers' premiums and of insurance dollars paid for mental health care, so they generally incite fierce opposition from the insurance industry. Yet mandatory availability of mental health insurance coverage--often considered as a political compromise--can allow the forces of adverse selection to continue to operate, thus perpetuating the improper functioning of the mental health insurance market.

Who is covered? Insurance policies usually differentiate between those individuals who wish to improve their overall mental health and those who are ill as a result of a mental disorder; in general, insurance policies only cover treatment provided to the latter. In addition, most insurance policies limit the mental health services they cover so as to preclude any long-term treatment for mental illness. Costs of mental health care can go up considerably when more long-term treatment is brought under a mandate. Many argue, however, that those who do not receive appropriate mental health care, whatever the duration, will simply continue to use inappropriate medical services, drain the public mental health system and drive up the indirect costs of mental illness to society.

What types of treatment are covered? Minimum coverage generally applies to inpatient and outpatient services, while other laws may also require coverage of such services as partial-hospitalization. Inpatient care can often be necessary for mental disorders of an acute and intensive nature. It can be harmful, however, if treatment in such a restrictive setting is not clinically necessary. In addition, many state commitment laws restrict involuntary hospitalization to those cases in which the patient presents a clear and present danger to himself or to others. If clinically feasible, partial hospitalization and outpatient care are generally preferred treatment alternatives because they minimize the patient's dislocation and allow him or her to retain the use of natural support systems. In some localities, however, treatment settings and programs that offer accountable, commmunity-based outpatient and partial-hospitalization services are less readily available.

What coverage is provided? The problem with legislative determination of minimum levels of mental health coverage is that they tend to become maximum levels. Thus, those mentally ill who require more extensive treatment may not receive it. Still, select mandatory coverage in this area tends toward a norm.

- Most state laws mandate minimum inpatient care coverage of at least 30 days per year in a general or psychiatric hospital or some type of authorized mental health care facility; at least four states require inpatient care for psychiatric disorders to be of equal value with that provided for physical illnesses (13, p. 1.6). Many states that require coverage for partial hospitalization allow twice the number of partial hospitalization days as inpatient days (13, p. 1.7).

- State laws requiring or offering mental health benefits vary greatly with respect to outpatient treatment. Statutes can require coverage for a certain number of outpatient visits, for treatment provided up to a dollar limit or for some combination thereof. For example, Tennessee covers 30 outpatient visits per year; Georgia covers 48-50 visits per year, depending on the type of policy. Florida covers outpatient treatment up to $1,000; Massachusetts covers $500 per year. Minnesota provides for coverage of at least 80 percent of the first $750 of outpatient treatment; Vermont provides full coverage for the first five outpatient visits, and 80 percent of the treatment costs up to $500 after the first five visits.

What types of treatment settings are covered? Most state laws cover inpatient and outpatient care provided in traditional settings such as general or psychiatric hospitals or community mental health centers (CMHCs). Other laws cover additional community care providers such as free standing clinics. An increase in the number of treatment settings covered can increase utilization, but it can also help ensure appropriate treatment as well as use of the least restrictive--and least expensive--treatment setting.

Which mental health professionals are authorized to provide services? Many state laws cover only physicians and licensed psychologists. Others include such providers as clinical social workers and psychiatric nurses. Increasing the number of service providers can improve access and decrease the per unit cost of mental health care through increased competition among providers. Yet increasing the number of service providers can increase the total costs of mental health care as a result of increased utilization.

What cost containment mechanisms does the law contain? As with insurance coverage of physical illness, copayments and monetary caps can effectively limit unnecessary use of mental health services, but they can also discourage appropriate use of mental health services if they are too restrictive. Where copayments are specified, they are often 50 percent of the treatment costs once the appropriate deductible has been subtracted (13, p. 1.7). (The standard deductible for physical illness is 20 percent.) Provisions for peer review prior to reimbursement for services can effectively limit unnecessary provision of services by providers.

What types of policies are required to provide the minimum level of services? All mandated benefits laws cover group insurance policies; many cover individual policies as well. Requiring individual insurance policies to provide the minimum benefits necessarily ensures that such benefits are available. But it can also discriminate against and raise premium costs for a well-informed consumer who knows with a much greater certainty than a large corporation buying on behalf of its employees whether or not such benefits are necessary. Moreover, including both group and individual insurance plans can increase the trend towards self-insurance among employers and individuals.

THE STATES' RESPONSE IN RECENT YEARS

The following chart delineates the existing 26 state minimum benefits laws with respect to the type of mandate, the year passed and the services, policies and providers covered. In 1987, at least twenty-seven states are considering legislation that will mandate minimum mental health benefits, expand benefits level, service providers or insurance providers, or study various aspects of mental health insurance.

At present, 12 states require minimum benefits, 12 states require the availability of such benefits and two states require coverage for certain services and the availability of coverage for others. Connecticut was the first state to pass such a law in 1971; Georgia and Oregon were the most recent states to pass such legislation in 1984. The majority of the states passed their laws in the mid-to-late 1970s. The statutes in 23 states cover inpatient care, 24 cover outpatient care and nine cover partial hospitalization. (Wisconsin's law does not specify the types of services covered: it merely stipulates that coverage is provided for treatment of mental illness at usual and customary rates.) All 26 states cover group policies; nine cover individual policies as well. All cover services provided by a physician, 24 cover services provided by a licensed psychologist, 12 cover services provided by a licensed or clinical social worker and six provide coverage for additional service providers including psychiatric nurses, marriage and family counselors, licensed psychotherapists and pastoral counselors (see chart of state laws, p. 11).

FUTURE IMPLICATIONS AND DIRECTIONS

The track record of recent legislative attempts to pass mandated mental health legislation may or may not indicate that a plateau has been reached among the states that plan to adopt such measures. Many state lawmakers suspended their efforts in this area pending the Supreme Court's decision in Metropolitan Life v. Massachusetts. According to the National Mental Health Association, legislative interest in mental health mandates has risen considerably since the Supreme Court upheld the Massachusetts law.

Efforts among those states that already have mandates are largely focused on updating or expanding their laws. A number of states have considered legislation to expand the number of service providers covered by the mandate. In 1986, Maryland, Minnesota, and New Hampshire are all considering legislation to put Health Maintenance Organizations (HMOs) under their mandates. Massachusetts is considering legislation to include specialists in psychiatric and mental health nursing, Minnesota to include certified psychologists, and New Hampshire to include clinical social workers. In 1985, California, New York, and West Virginia considered, but did not pass, legislation that would have made mandatory the mental health coverage that is presently optional in all insurance policies. In 1986, Maryland decreased from 50 to 40 percent the copayment on outpatient mental health care (1986 Md. Laws, chap. 843).

States are also beginning to act on quality assurance and utilization review. In 1985, the Oregon State Health Planning and Development Agency issued the first of two required reports evaluating the effectiveness of that state's 1984 benefits law, which mandated coverage for outpatient and partial hospitalization services and significantly reduced inpatient care coverage.

The statute allowed insurers two cost containment options, one of which was adopted by Blue Cross/Blue Shield of Oregon and seems likely to be adopted by other Oregon insurers: professional peer review of reimbursement claims, evaluated for both the level of care and length of treatment. While the report acknowledges certain problems with the existing statute, it does state that in Oregon "more people are currently receiving services for less money" than were previously. It notes that nominal increases in outpatient care costs have been offset by marked decreases in inpatient care costs for both Blue Cross/Blue Shield and SelectCare (14, p. 10).

States must remember, however, that much of the research relative to the impact of state minimum benefits has yielded conflicting evidence. Both the insurance industry and the mental health community dispute each other's statistics, citing flaws in research design and biased interpretation of data. Moreover, in 1984-85, the Baltimore, Maryland-based Center for Health Policy Studies undertook a major review of the literature relevant to mandated mental health insurance and made recommendations regarding further research. The report cited methodological inconsistencies in the research that had been done, such as differences in provider settings and the use of health insurance claims as research data, as cause for this conflicting evidence (13, pp. 1.12, 3.58). Thus state legislators must remember to evaluate the effectiveness of a minimum benefits law in light of the mental health system and resources within their own state.

Finally, the private sector also has begun to address more aggressively the issue of mental health care for employees. In deciding to support or oppose mandated mental health insurance, state legislators would want to weigh carefully any changes in the corporate world's overall approach to combating mental illness. For example, a 1984 survey of 64, mostly Fortune 500, companies with over 19 million employees indicated substantive changes in approach to mental health care:

- 19 percent had recently increased their lifetime or annual maximums for mental health coverage;
- 22 percent had recently enhanced their coverage for outpatient services, with an additional eight percent planning to increase outpatient coverage in the near future;
- 73 percent had developed Employee Assistance Programs (EAPs) to combat the problems associated with emotional problems and alcohol and drug abuse. While 30 percent of the EAPs still focused on alcohol and drug abuse intervention and treatment, 68 percent had broadened their scope to include short-term mental health treatment;
- 41 percent had implemented stress management programs (15, pp 15-16).

STATE MANDATORY MENTAL HEALTH INSURANCE LAWS

STATE	MANDATE TYPE: MANDATED BENEFITS PACKAGE	MANDATED AVAILABILITY	YEAR	SERVICES COVERED: INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION	POLICIES COVERED: GROUP	INDIVIDUAL	ADDITIONAL PROVIDERS COVERED: PSYCHOLOGISTS	SOCIAL WORKERS	OTHER
AR	X		1979	X	X		X	X	X		
CA		X	1973	X	X		X		X	X	(1)
CO	X		1976	X	X	X	X		X		
CT	X		1971	X	X	X	X	X	X	X	
FL		X	1976/83	X	X	X	X		X		
GA		X	1984	X	X		X	X	X		
IL		X	1975	X	X		X	X	X		
KS		X	1978	X	X		X		X	X	
LA		X	1975	X	X		X		X	X	
ME	X		1983	X	X	X	X		X	X	(2)
MD	X		1974	X	X		X	X	X	X	
		X				X	X				
MA	X		1973	X	X		X	X	X	X	(2) (3)
MN	X		1975	X	X		X				
MO		X	1980	X	X		X	X			
MT	X		1983	X	X		X		X	X	
NH	X		1975	X	X	X	X		X		(4)
NY		X	1977	X	X		X		X	X	
ND	X		1975	X		X	X				
OH	X		1978		X		X		X		
OR	X		1984	X	X	X	X		X	X	(5)
TN		X	1974		X		X		X		
VT		X	1975	X	X	X	X		X		
VA	X		1975	X			X	X	X	X	
		X	1975		X		X		X	X	
WA		X	1983	--see note #6--			X		X		
WV		X	1977	X	X		X	X	X		(7)
WI	X		1975/85	X	X		X				

1) psychiatric nurses and licensed marriage, family and child counselors

2) psychiatric nurses

3) licensed psychotherapists

4) licensed pastoral counselors

5) nurse practitioners

6) Coverage provided for treatment at usual and customary rates, subject to reasonable deductibles and copayments, for services provided by a licensed physician, a licensed psychologist or a licensed community mental health agency.

7) licensed psychotherapists

NEW HAMPSHIRE CASE STUDY: THE PROS AND CONS OF EXPANDING EXISTING MENTAL HEALTH BENEFITS

New Hampshire's current mental health benefits law, passed in 1975 and implemented in 1977, requires certain minimum mental health coverage in all group insurance policies. The law differs from many state mandated benefits laws in that it differentiates between major medical and non-major medical insurance policies and contracts. Major medical policies must provide inpatient, partial hospitalization and outpatient services for mental illness on a par with other illnesses, with an annual limit of $3,000 and a lifetime limit of $10,000. Non-major medical policies must cover 15 hours of outpatient care, with the patient assuming the cost of the first two visits.

As a result of the law, the New Hampshire state hospital and the CMHCs have reaped substantial benefits from shifting costs.

- The state bills about $450,000 per year to private insurers for care provided in the New Hampshire State Hospital. This return on care provided to insured individuals helps defray the costs of that care and ensure that state funds are only used for truly catastrophic mental health problems that require long-term care and treatment of an acute nature (16).

- In 1986, New Hampshire's CMHCs will receive an estimated $4.5 million from private insurers for care provided in local settings and covered by the state mandate (16). These savings to the CMHCs are critical to ensure the availability of many community-based counseling and mental health care services that cannot be, by state law, paid for by state dollars. Without reimbursement from private insurers, these services might not exist. New Hampshire state law stipulates that state funds can be used only for the severely and chronically mentally ill, and for mentally ill elderly or children (16).

Blue Cross/Blue Shield of New Hampshire opposed the original law and opposes the currently proposed amendments to it. As reason for its past and present opposition, the insurer cites dramatic increases in its own costs for mental health care as well as the questionable effectiveness of the law's cost containment measures.

- Between 1977 and 1981, Blue Cross/Blue Shield increased by 245.4 percent the amount that it paid to the state's CMHCs for mental health care. During the same period, rates charged by the CMHCs increased 30 percent more than the rates charged by private psychiatrists (17).

- Inpatient claims have remained constant and the average length of stay in an inpatient psychiatric facility has gone up from 19 to 22 days (17).

- Eighty-two billing units of psychologists and pastoral counselors now qualify for reimbursement, as opposed to the 13 psychologists who qualified for reimbursement prior to the mandate, indicating a rapid growth in service providers following the mandate (17).

A number of legislative proposals are currently being considered in New Hampshire related to the state's mandated mental health law. These proposals include:

- Increasing the minimum outpatient coverage from 17 outpatient visits to 25 visits, with no more than a 50 percent copayment and an annual cap of $2500;

- Expanding the number of eligible service providers to include clinical social workers;

- Extending the mandate to include Health Maintenance Organizations (HMOs).

The state is also studying the possible implementation of some type of quality assurance or utilization review procedure to ensure that the mental health services provided under the mandate are necessary and of high quality.

The NCSL Mental Health Project conducted a technical assistance program for New Hampshire in January 1986 to help educate legislators and staff about the possible consequences of and alternatives to the proposed changes in the state's minimum benefits laws. Participating in the program was Dr. Richard Frank, mental health economist, Johns Hopkins University, Baltimore, Maryland. The suggestions provided to New Hampshire do not necessarily reflect those of NCSL or the National Institute of Mental Health.

ARGUMENTS FOR AND AGAINST THE PROPOSED CHANGES IN NEW HAMPSHIRE'S LAW

Increasing the mandate. Increasing the mental health benefits required can increase utilization and costs as well as the amount of the regressive tax that mandates impose on working individuals. Yet an increase in benefit levels will mitigate further the forces of adverse selection in the market for mental health insurance and transfer more of the costs for mental health care from individuals and the public sector to the private sector.

Increasing the number of eligible service providers to include social workers. Increasing the number of eligible service providers can increase the utilization and costs of mental health services and shift a greater percentage of the costs of mental health care to the private insurance industry. Yet an increase in the number of service providers can increase consumer access. In addition, including social workers could encourage more competition among existing service providers, thus decreasing the per unit cost of mental health care and increasing the quality of care since providers will need to ensure high quality care in order to retain their clients.

Including HMOs under the mandate. Including HMOs under the mandate would decrease their competitive edge against traditional insurance carriers already covered by the mandate and would spread the risk of mental health care costs over a greater number of individuals. Yet including HMOs could accelerate the trend toward self-insurance among those businesses and individuals striving to hold down their health care costs.

SOLUTIONS THAT COULD BRING PROS AND CONS INTO AN APPROPRIATE BALANCE

Increase the minimum coverage and the number of service providers in conjunction with other cost containment mechanisms. New Hampshire could move ahead with legislation designed to increase the minimum coverage required under the mandate and to expand the number of service providers if it made use of other cost containment measures that would offset the increased use of mental health services that such a dual increase in coverage and eligible service providers

would probably bring about. Examples of such containment measures that could be employed include:

- Increasing deductibles or copayment rates;

- Limiting increases in outpatient coverage to roughly 25 visits, after which the offset effects of mental health care on use of medical care tend to decrease.

Implement some type of vigorous utilization review and quality assurance programs. The state could also work to control upward pressure on utilization if it implemented some type of quality assurance or utilization review procedure. New Hampshire may wish to consult the American Psychiatric Association's guidelines for peer review of psychiatric claims and the American Psychological Association's guidelines for peer review of psychological claims. Such peer review programs have already been credited with saving millions of dollars nationwide.

Along this line, New Hampshire may want to consider bringing HMOs under the mandate, as they have both the administrative ability to control costs and the incentives to control utilization.

CONCLUSION

Since New Hampshire's experience with its present mental health mandate has been generally positive, the state would want to weigh carefully any possible amendments to the law before proceeding. Yet if the state decides to move ahead with proposed changes, it can move ahead with the knowledge that the present law will provide a solid foundation for further actions in this area.

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16) Remarks by Donald Shumway, Director, Division of Mental Health and Developmental Services, New Hampshire Department of Health and Human Services, at the New Hampshire Technical Assistance Program. January 1986.

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TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are edited tapes of the actual technical assistance program presented for New Hampshire in January 1986, as well as the background materials distributed at the New Hampshire program.

The tapes of New Hampshire's technical assistance program, entitled "Mandating and Expanding Mental Health Insurance Benefits: The Pros and Cons" feature keynote addresses by Dr. Richard Frank, Assistant Professor, Department of Health Policy and Management, Johns Hopkins University and Alexander Taft, Vice President of Public Relations and Legislative Liaison, Blue Cross/Blue Shield of New Hampshire.

Background materials relating to "Mandating and Expanding Mental Health Insurance Benefits: The Pros and Cons" include a summary of select state legislation, a bibliography and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive loan copies of these tapes, or the background information distributed at the technical assistance program, please copy, complete and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, Colorado 80265.

Name: _____

Title: _____

Address: _____

_____

Requesting New Hampshire background materials_____ tapes _____

MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In June 1986, the National Institute of Mental Health (NIMH), U.S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues from 1986 through 1989.

The goal of NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information regarding mental health issues.

During this three-year program, the Mental Health Project will respond to specific issue and format needs of legislators. Under the guidance of the Mental Health Advisory Committee, which is composed of legislators and other persons with mental health experience, Project staff will obtain assistance from expert consultants and state policymakers to provide a variety of services to states, including testimony, special workshops and seminars, and individualized assistance.

Based upon input from the state legislatures, five states will be chosen each year to receive technical assistance on state-specific mental health issues. Along with the programs, the Mental Health Project will develop background materials, audio tapes, and various publications for each issue area. These materials are available free of charge to requesting parties.

The mental health technical assistance programs offered during 1987-88 are:

Arkansas	Maximize federal funds at the state hospital and consolidate hospital facilities
Delaware	Determine the role of the psychiatric hospital in a youth mental health system
North Carolina	Develop coordination of care between the community and state hospital
North Dakota	Determine the role and function of the state hospital as community-based services are expanded
Utah	Determine the future role of the state hospital

The Mental Health Project Manager is Rebecca I. Craig, who may be contacted at NCSL's Denver office (303/623-7800). The acting federal project officer is Jacque Rosenberg, Policy and Planning Branch, National Institute of Mental Health (301/443-3657).

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GOVERNOR

Department of Human Resources
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3886 BEVERLY AVENUE NE, SUITE 19, SALEM, OREGON 97305-1389 PHONE 378-4684

Memorandum

July 30, 1987

TO: Interested Persons

FROM: Wayne J. Wolfe, Acting Assistant Director
Office of Health Policy
Department of Human Resources

SUBJECT: Publications of the Former State Health Planning and Development Agency

The 1987 Legislature eliminated the State Health Planning and Development Agency through Senate Bill 343 and placed its responsibilities with the Director's Office of the Department of Human Resources. It is now known as the Office of Health Policy and will continue with its former duties of health planning and policy development, program and facility review, certificate of need and Office of Rural Health.

The Office of Health Policy will continue to make copies available of the policy papers and reports developed by the former State Health Planning and Development Agency.

Questions regarding these publications should be referred to the Office of Health Policy, 3886 Beverly Avenue, N.E., Suite 19; Salem, Oregon 97305; telephone 378-4684.

WJW:ah

SCOTT MANCHESTER, MSW

Certificate of Need Coordinator

Office of Health Policy

Department of Human Resources
3886 Beverly Avenue NE. Suite 19 Salem 97305 Phone 378-2959
1-800-255-7007

Second Report on

OREGON'S EXPERIENCE WITH REMODELING INSURANCE BENEFITS FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY

Report to the 64th Oregon Legislative Assembly
on Implementation of Chapter 601,
Oregon Laws 1985

December 15, 1986

Oregon State Health Planning
and Development Agency
3886 Beverly Avenue, N.E., Suite 19
Salem, Oregon 97305-1389

VICTOR ATIYEH
GOVERNOR

State Health Planning and Development Agency

3886 BEVERLY AVENUE NE, SUITE 19, SALEM, OR 97305-1389 PHONE 378-4684

December 15, 1986

The Honorable Victor Atiyeh
Governor

The Honorable John Kitzhaber
President of the Senate

The Honorable Vera Katz
Speaker of the House

Mental illness and drug abuse are serious problems in the state of Oregon, directly affecting hundreds of thousands of Oregonians and indirectly affecting all of us. In recognition of these problems, the 1983 Oregon Legislature passed legislation aimed at assuring that Oregonians have access to cost effective mental health and chemical dependency treatment, by requiring that insurance policies cover such treatment.

The attached report fulfills the obligation of the State Health Planning and Development Agency (SHPDA) under Section 8 of Chapter 601, Oregon Laws 1983 (Senate Bill 522), by providing an analysis of Oregon's experience with mandated insurance benefits for mental health and chemical dependency which were created by that statute.

Chapter 601 provided insurance benefits for the first time for residential and outpatient mental health and chemical dependency services. Previously, coverage was mandated for only the most expensive setting for care--inpatient services. By providing coverage for less expensive services, and allowing insurance companies to screen claims to determine whether a less intensive setting would have been appropriate, it was hoped that Chapter 601 would result in more people receiving mental health and chemical dependency services, while at the same time containing costs.

This report finds that the statute seems to have achieved its intended effects. The service delivery system has undergone a restructuring that involves less emphasis on inpatient care and greater emphasis on outpatient and residential settings. The benefit levels created by the statute have resulted in many more people receiving treatment, while increasing costs to insurers by only about one percent.

There have been some problems associated with the implementation of Chapter 601. Over the past 15 months, the SHPDA has sponsored a series of meetings which have involved over one hundred persons representing all groups with an interest in this statute. These work groups have identified issues associated with Chapter 601, and in many cases have reached agreement on solutions. The SHPDA is grateful to all of the work group participants for the many hours that they have contributed to this evaluation process and for their efforts to provide us with data on the impact of Chapter 601. As a result of this process, the SHPDA is making a number of recommendations for changes in the statute. Our recommendations are detailed in this report and are incorporated into three bills which have been pre-session filed for consideration by the 1987 Legislature: SB 30 , SB 31, and SB 32.

The most significant of our recommendations are that the sunset on Chapter 601 be removed; that minimum benefit levels for children and adolescents be improved; and that the statute no longer allow lower benefit levels for persons with both a mental illness and a chemical dependency problem than it provides for persons with a mental illness alone.

This agency believes that this report represents a balanced presentation of all the issues related to mental health and chemical dependency insurance benefits in Oregon. We believe that Oregon's experiment with achieving cost containment in mental health and chemical dependency services through reimbursement incentives has proven successful.

We hope that Oregon's Legislative Assembly will continue this program, but at the same time consider adjustments to some existing provisions as proposed in this report's recommendations.

Sincerely,

Richard H. Grant

Richard H. Grant
Director

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INTRODUCTION

This is the second report developed by the State Health Planning and Development Agency (SHPDA) to comply with Section 8 of Chapter 601, Oregon Laws 1983. A report was also prepared for the 1985 legislative session. The current report represents an update of the 1985 report. The statute was created by the 1983 legislative session through enactment of Senate Bill 522 of that session. It is still generally referred to as "SB 522"; however, in order to avoid confusion with the current session's bill numbers, the 1983 statute will be referred to in this report as "Chapter 601." Section 8 of this statute reads:

> "SECTION 8. The State Health Planning and Development Agency shall consult with the Insurance Commissioner and with all insurers, public and private providers and state agencies which implement policies under the authority of this Act, in order to prepare reports to the 1985 and 1987 sessions of the Legislative Assembly. The purpose of the reports shall be to:
>
> "(1) Describe the extent to which the options under this Act have been exercised.
> "(2) Identify savings and expenses attributable to the exercise of the options.
> "(3) Identify problems which interfere with, or arise from, exercises of the options, and evaluate alternative solutions to such problems.
> "(4) Recommend whether or not the approaches to cost containment, authorized as options under this Act, should be eliminated, continued or made mandatory; and whether or not they should be extended, on an optional or a mandatory basis, to other coverages under insurance policies written in Oregon.
> "(5) Recommend and describe desirable characteristics of other approaches to cost containment which may be appropriate for legislative action."

This report is also intended to fulfill the requirements of ORS 171.875 and 171.880, which require that any legislative measure proposing mandated health insurance coverage be accompanied by a report assessing the social and financial effects of that coverage.

Provisions of Chapter 601

Chapter 601 took effect on July 1, 1984. This statute made major changes in the requirements for coverage of mental illness and chemical dependency treatment by insurance companies.

The purpose of the law is to provide reimbursement incentives so that, "to the greatest extent possible, the least costly settings for treatment, outpatient services and residential facilities, shall be widely available and utilized except when contraindicated because of individual health care needs" (Chapter 601, Sections 3 and 4).

The provisions of the bill were expected to result in more people receiving treatment for mental illness and chemical dependency, while containing costs to insurers.

The entire text of the statute is included as Appendix A of this report.

The statute for the first time mandated that insurance companies cover residential and outpatient settings for mental health and chemical dependency. For mental health, policies are required to provide at least $2,000 in coverage for outpatient services over a 24-month period; and $3,000 for care in "residential" settings (which can include services such as intensive outpatient and day hospitalization, which are not strictly "residential"). Section 6 of Chapter 601 (which revised ORS 743.558) specifies the mental health coverages.

For chemical dependency, policies must include at least $1,500 in outpatient coverage and $3,000 in residential coverage over a 24-month period. The statute also for the first time mandated coverage of treatment for drug addiction, as well as alcoholism. Such coverage is specified in Section 5 of the statute (which amends ORS 743.557).

At the same time, coverage for inpatient mental health services was slashed from around $24,000 for 24 months (actually, 30 days treatment every 12 months) to only $7,500. Chemical dependency inpatient coverage remained the same (except that drug treatment was now included)--$4,500 in any 24-month period.

Maximums for overall reimbursement for all settings in a 24-month period were set at $9,000 for mental health and $6,000 for chemical dependency and combined mental health/chemical dependency problems.

The statute also allowed, but did not require, insurance companies to implement either of two "cost containment methods" (outlined in ORS 743.557(10) and 743.558(8), Sections 5 and 6 of the statute). One option, through which insurers could provide for a lower copayment for residential and outpatient services than for inpatient care, has not been widely implemented.

The other option, however, has been implemented by several insurers, including Blue Cross/Blue Shield. It involves review of claims for payment, by the insurer or a contractor, of the appropriateness of both the level of care provided and the length of treatment. An insurer who finds that treatment could have been provided in a residential setting, for example, rather than on an inpatient basis, may reimburse at the rate that applies to the lower cost setting.

The benefit levels and cost containing options established under Chapter 601 are summarized in Table 1, and contrasted with the situation prior to this statute's enactment.

Background

In developing this report, the SHPDA has relied on several reports that it issued in previous years.

Table 1

MANDATED HEALTH INSURANCE BENEFITS IN OREGON FOR CHEMICAL DEPENDENCY, INCLUDING ALCOHOLISM, AND FOR MENTAL OR NERVOUS CONDITIONS, BEFORE AND AFTER CHAPTER 601, OREGON LAWS 1983

Features	BEFORE		AFTER	
	Chemical Dependency Including Alcoholism	Mental or Nervous Conditions	Chemical Dependency Including Alcoholism	Mental or Nervous Conditions
1. Scope?	Alcoholism only	Diagnosed mental or nervous conditions	Other drug dependency as well as alcoholism	Diagnosed mental or nervous conditions
2. Statutory authority for reduced co-payments as a cost-containing incentive for use of outpatient, day, or residential treatment, rather than inpatient?	No	No	Optional in negotiated insurance contracts	Optional in negotiated insurance contracts
3. Statutory authority for more costly treatment to be subject to review against detailed criteria justifying need, as a cost-containing incentive?	No	No	Optional in negotiated insurance contracts	Optional in negotiated insurance contracts
4. Requirement for coverage in group policies?	Shall provide	Shall offer	Shall provide	Shall provide
5. Requirement for coverage in individual policies?	Shall offer	None	Shall offer *(alcohol only; and $4,500, as at present)*	~~Shall offer~~ *None*
6. Minimum overall benefit every 24 months?	$4,500	$25,000 (approximate)	$6,000	$9,000 (unless payments are asked for both chemical dependency and mental or nervous conditions, in which case an overall cap of $6,000 may be applied)
7. Minimum outpatient benefit every 24 months?	None	$1,000 (actually $500 every 12 months, with 50% co-payment)	$1,500, with the same co-payment as for any medical outpatient treatment; usually 20%	$2,000 (sunset after 2 yrs.) with the same co-payment as for any medical outpatient treatment; usually 20%
8. Minimum benefit for intensive part-day treatment or for round-the-clock non-medical residential treatment, every 24 months?	None	None	$3,000, with the same co-payment as for inpatient treatment	Up to $3,000, from the $7,500 for inpatient (see below), with the same co-payment as for inpatient treatment
9. Minimum benefit for round-the-clock inpatient treatment in which needs for nursing care and physician treatment may be met, every 24 months?	$4,500	$24,000 (approximate; actually, 30 days of hospitalization every 12 months; present rates around $400 per day)	$4,500, with the same co-payment as for any medical inpatient treatment	$7,500, with the same co-payment as for any medical inpatient treatment

7/6/83

In May 1982, the SHPDA issued a report called "The Growth of Hospital-Based Alcohol Treatment Programs: Overview and Implications." This report found that, at the time of its writing, "The treatment of alcoholism in general hospitals and specialized alcoholism treatment programs is sharply increasing in Oregon in particular, and the United States in general. At the same time, providers have shown little interest in non-hospital treatment, such as day treatment, outpatient care and residential care."

The report also found that clinical research has not indicated that inpatient care is any more effective, for most patients, than less restrictive and less expensive settings. "It is clear that some treatment is superior to no treatment, and differences in treatment methods apparently do not significantly affect long-term outcome. The implications for allocating our scarce human and financial resources should be to emphasize simpler and less expensive alcohol treatment programs that de-emphasize hospital care."

The report concluded with the following recommendations: "Oregon's mandated insurance law should be rewritten to require the use of less costly treatment modes such as outpatient and day treatment, except where inpatient care is clearly medically necessary... Health care professionals, problem drinkers, alcoholics and the public at large must be made aware that treatment in a residential setting and outpatient care is much less expensive than traditional hospital inpatient treatment, and just as effective."

Through the enactment of Chapter 601, the 1983 legislature in effect adopted these recommendations.

In March 1983, the SHPDA issued a report called "Mandated Health Insurance Benefits in Oregon," which analyzed the 14 health delivery mandates in Oregon statute in an attempt to determine the costs and savings to insurers and health care consumers.

The report concluded: "The results of this analysis indicate that the mandated health insurance benefits that have the largest fiscal impact are those related to coverage of four large-scale services: obstetrical care, newborn care, mental and nervous disorders, and the treatment of alcoholism" (emphasis added).

The report noted that research studies indicate that coverage of mental illness can create an offsetting of other medical expenditures. Recent studies have indicated that this is true of coverage for alcoholism treatment as well. Alcoholics and persons with mental illness who receive treatment for these problems use fewer medical services overall than those who do not.

The report also found that much of the costs related to alcohol treatment resulted because only coverage of inpatient care--the most expensive setting--was mandated. "A full continuum of care is optimal to meet the needs for alcoholism treatment in Oregon. The current system of reimbursement has not supported the development and maintenance of a wide range of effective treatment settings."

Chapter 601 creates reimbursement for a full continuum of care for both chemical dependency and mental illness. In addition to allowing people to receive treatment in the most appropriate setting for their own problem, this reimbursement system saves money over the old model, in which only the most expensive settings had to be reimbursed.

The SHPDA also issued two previous reports on Chapter 601. The first was entitled "Oregon Senate Bill 522, 1983, Implementation: Quarterly Progress Report #1." This report was published on October 1, 1983, and reissued June 28, 1984. Its primary purpose was to fulfill the requirements of Section 7 of the statute by presenting "an advisory or model set of criteria" for possible use by insurance companies in screening claims for appropriateness of setting and length of stay under the major cost containment option of the statute.

The SHPDA also issued a report to the 1985 legislature on "Oregon's Experience with Remodeling Insurance Benefits for Mental Health and Chemical Dependency," which was the first report required by Section 8 of Chapter 601. The current report is the second report required by Section 8. The 1985 report found that the statute appeared to be having its intended effects. Costs to insurers resulting from mental health and chemical dependency claims had gone down. More programs for residential and outpatient treatment had opened, and there was some evidence that more people were receiving treatment.

The report made several recommendations for changes to the legislation, however, in order to clarify the statute's intent and to correct inequities. These changes were incorporated into SB 10 and HB 2051 in the 1985 session.

HB 2051 simply extended the sunset date on outpatient mental health coverage from July 1, 1985, to July 1, 1987, so as to conform to the sunset date for the rest of the statute. This bill passed by wide margins in both the House and the Senate, and is included as Appendix B of this report.

SB 10 proposed some changes to statutory language and adjustments to the minimum benefit levels. It passed in the Senate by a vote of 22 to 6, but did not reach the House until the last week of the session and was still in committee upon adjournment.

The current report updates our previous report to the 1985 legislature, and makes a number of recommendations for changes to the statute. These recommendations have been incorporated into three bills: SB 30 , SB 31, and SB 32. The most important of our recommendations is that ORS 743.557 and 743.558 should be continued, and that the current sunset date of July 1, 1987, should be repealed.

The development of this report

Section 8 of Chapter 601 requires the SHPDA to "consult with the Insurance Commissioner and with all insurers, public and private providers and state agencies which implement policies under the authority of this Act," in order to develop this report to the legislature.

In order to meet this requirement, the SHPDA developed work groups on child and adolescent and general issues; and on chemical dependency and mental health treatment. All parties with a known interest in the legislation were invited to participate, and as the work groups progressed, a number of other organizations and individuals expressed an interest and became involved. The mailing list for these work groups now includes 107 persons and groups, representing a number of insurance companies, mental health and chemical dependency treatment providers, professional associations, state agencies, and the business community.

The work groups began meeting in October, 1985, and met nine times through December, 1986. The groups were intended to:

1. Help the SHPDA collect data on Chapter 601, in terms of its cost and its impact on providers, insurers, and patients.

2. Help the SHPDA to search the professional literature for data on optimum program design, staffing levels, and costs.

3. Identify problems or concerns related to the implementation of Chapter 601.

4. Discuss these problems and, to the extent possible, develop a consensus on solutions.

The work groups accomplished all of these tasks. Of particular importance is the fact that the work groups acted as a forum for discussion between providers of care and insurers. Both sides gained an understanding of the other's perspective, and as a result consensus was reached on most issues.

It should be emphasized that the recommendations in this report are SHPDA's recommendations--not the work groups'. When the work groups were able to reach a consensus, the SHPDA adopted that position. But when a consensus was not reached, the SHPDA is responsible for the recommendations which are incorporated in this report. We attempted to make a recommendation that balanced the different viewpoints represented in the work groups. Individual work group members may disagree with some individual recommendations; but all work group members support most of the recommendations, and all support the idea that mental health and chemical dependency benefits should not be allowed to sunset.

IMPACT OF CHAPTER 601

When Chapter 601 was enacted, it was expected to have these principal results:

1. The development of a continuum of care for the treatment of mental health and chemical dependency services. By mandating insurance coverage for all settings, rather than just the more expensive inpatient setting, it was anticipated that patients would have more access to less restrictive settings; that more residential, day treatment and outpatient programs would be created; and that some inpatient programs might close.

2. Shifting of patients (where appropriate) from inpatient to outpatient or residential levels. In addition to the development of a full spectrum of services, it was expected that Chapter 601 would cause a shift in the service system, so that proportionately less services were provided at the inpatient level and more services were provided in less expensive residential and outpatient settings.

3. As a result of this shift in the service system, it was anticipated that an overall reduction in the costs of mental health and chemical dependency treatment would be achieved, enabling more people to obtain services. During the 1983 legislative session, the SHPDA estimated that this statute would save $371,520 per biennium in state employee health care costs alone.

In our 1985 report, we stated that it appeared that these results were being achieved, but that the statute had been in effect for too short a time to enable any firm conclusions. The statute has now been in effect for 2 1/2 years, and our data now largely confirm the conclusion of our earlier report. The statute has had its intended effects of enabling more people to receive care and of increasing the availability of alternatives to inpatient care. The costs to insurers of inpatient care have gone down, although costs of mental health outpatient services have increased somewhat, as a result of many more people receiving treatment. The data to support these findings are outlined below.

Impact on the service system

Since Chapter 601 took effect, a number of new outpatient and residential programs have opened. Nine new outpatient mental health programs (including two hospital-based programs) have opened or have received approval from the Mental Health Division. One new hospital-based mental health day treatment program has opened. Thirty-five new outpatient chemical dependency programs have been approved by the Office of Alcohol and Drug Abuse Programs (including eight hospital-based programs). Ten residential chemical dependency programs (including five in hospitals) have opened. It should be noted that not all of these programs represent new providers; some are already existing programs which simply received approval for a new type of service, or received approval in order to qualify for insurance reimbursement. When a provider received approval for more than one type of service, they have been counted twice in the statistics above.

Utilization of inpatient mental health and chemical dependency programs has not changed greatly since Chapter 601 took effect. Table 2 indicates that use rates (patient days per 1,000 population) for psychiatric inpatient units has declined slightly since the statute took effect, but that inpatient chemical dependency unit use rates have continued to increase. It appears that inpatient chemical dependency use has not increased as quickly since Chapter 601 passed as it did in previous years, however.

Use rates for inpatient chemical dependency units increased by 32 percent from 1980-81 to 1982-83 (when the new statute was passed). Use rates for inpatient mental health units increased by four percent during this time period. In the two years following enactment of the new statutory provisions, however, the inpatient chemical dependency use rate increased by only 12 percent; and the inpatient mental health use rate declined by seven percent. Please note that these statistics represent only the use of dedicated inpatient mental health and chemical dependency units. Some people will have received inpatient treatment for mental health and chemical dependency problems outside of established specialty programs.

This agency has data only on the utilization of inpatient and hospital-based services. We have no statistics on the use of outpatient and residential programs. However, it is reasonable to assume that the substantial growth that has occurred in the number of approved programs has also meant growth in the number of people receiving treatment. Data from the Bankers Life Company support this assumption. In the year and a half before Chapter 601 took effect, 7.7 percent of Bankers Life's total claims were for mental health treatment and 1.6 percent were for chemical dependency. In the year and a half after Chapter 601 took effect, these figures rose to 9.0 percent and 1.9 percent, respectively. Claims for outpatient treatment increased substantially more than claims for inpatient treatment. On a proportionate basis, claims for outpatient mental health treatment increased by 23 percent and claims for outpatient chemical dependency treatment increased by 100 percent.

Obviously, utilization patterns for mental health and chemical dependency services are influenced by more than just the insurance reimbursement mandates. Some hospitals have been anxious to get into such services because they see an unmet need; because such services are not yet subject to DRG-based payment by Medicare; and because "unbundling" and diversifying services is a currently popular marketing strategy. Some of the new outpatient and residential programs were started because of county RFP's or for other reasons. Some of these new programs are targeted at the indigent and not at those with insurance coverage. Nevertheless, this agency believes that the growth in outpatient and residential programs is motivated, at least in part, by the increased availability of insurance reimbursement for these services.

The available data therefore indicate that Chapter 601 achieved its intended effects in terms of increasing the availability of less expensive alternatives to inpatient care; and of bringing more people into treatment.

Table 2

Use of Dedicated Inpatient Mental Health and Chemical Dependency Units in Oregon, 1981 - 1985

	1984-85	% Change	1983-84	% Change	1982-83	% Change	1981-82	% Change	1980-81
Oregon population	2,675,800	0.6	2,660,000	0.9	2,635,000	(0.8)	2,656,185	(0.2)	2,660,735
Mental health units:									
Beds	412	1.2	407	(0.2)	408	0.0	408	(0.7)	411
Patient days	86,219	(4.1)	89,880	(1.7)	91,426	0.8	90,723	2.4	88,601
Patient days/1,000 pop.	32.2	(4.7)	33.8	(2.6)	34.7	1.5	34.2	2.7	33.3
Chemical dependency units:									
Beds	352	13.2	311	5.8	294	37.4	214	13.8	188
Patient days	66,776	9.2	61,152	4.3	58,641	19.9	48,914	8.9	44,904
Patient days/1,000 pop.	25.0	8.7	23.0	3.1	22.3	21.2	18.4	8.9	16.9

SOURCE: SHPDA, Annual Reports for Oregon Hopitals and Special Inpatient Care Facilities. Most data are reported for years starting October 1 and ending September 30, although some facilities report statistics for a different time period. Population estimates from Center for Population Research and Census, Portland State University.

Impact on costs

As noted in the "Introduction" section of this report, Chapter 601 established two "cost containment methods" which could be used by any insurer. These were first, establishment of a lower percentage copayment for residential or outpatient services than for inpatient services; and second, review of claims for payment to determine whether the level of care and length of treatment were appropriate. Based on the agency's survey of insurers two years ago and SHPDA's contacts with insurers over recent months as part of our work groups on this issue, it appears that few (if any) insurers have set copayments lower for residential or outpatient care than for inpatient treatment. However, most of the major health insurers in the state are now conducting utilization review on mental health and chemical dependency claims, as allowed by Chapter 601.

Insurers have achieved substantial savings as a result of this utilization review. Blue Cross/Blue Shield of Oregon (BCBSO) has carefully tracked its costs under Chapter 601. In calendar year 1985, BCBSO reduced payments for 26 percent of the claims it received for mental health and chemical dependency treatment, because utilization review indicated that the level of care received was inappropriate. In nearly all of these cases, payment was reduced from the inpatient level to the residential level. BCBSO reports that it saved $246,430 as a result of these level of care reductions, or about $ .48 per group policy member ($ .04 per member per month).

BCBSO is the only insurance carrier which has provided data which can be used to compare insurance company costs per member per month for mental health and chemical dependency treatment before and after Chapter 601 took effect. In this agency's survey of insurers two years ago, BCBSO reported that before Chapter 601, it paid an average of $1.34 per member per month for mental health and chemical dependency treatment. Of this total, $1.18, or 88 percent, was for inpatient treatment. Mental health treatment accounted for $ .89 per member per month and chemical dependency treatment accounted for the remaining $ .45.

BCBSO now reports that from July 1984 through June 1985 (the first year of implementation of Chapter 601), its total costs for mental health and chemical dependency payments for group policies was $1.85 per member per month. This is a 38 percent increase over the amount reported prior to Chapter 601 taking effect. This compares to a 3.8 percent increase in overall medical care costs during this time period. Only $ .94 out of the $1.85 total (51 percent) was for inpatient treatment. This represents a 20 percent decline in the cost of inpatient treatment per member per month to BCBSO, since Chapter 601 took effect. Payment for outpatient and residential treatment, which was only $ .16 per member per month before Chapter 601 took effect, has risen to $ .91 per member per month.

Mental health treatment accounted for $1.37 per member per month; while chemical dependency treatment accounted for the remaining $ .48 per member per month. The chemical dependency figure is only a slight increase over the $ .45 per member per month reported prior to Chapter 601 taking effect.

Thus, BCBSO's costs for mental health and chemical dependency benefits increased by $ .51 per member per month in the year after Chapter 601 took effect. Because the average monthly payment to BCBSO group policy members was about $42 in 1984-85, this time, this amounts to about a one percent increase in total costs. BCBSO appears to be purchasing substantially more services for its money, however, because its costs of inpatient treatment have gone down. A slight increase in overall costs appears to have allowed many more people to receive treatment in outpatient and residential settings which are substantially less expensive than the inpatient care which had previously been covered. BCBSO says that it has not had to raise its premiums as a result of Chapter 601.

To summarize, the "cost saving" effects of Chapter 601 appear to be mixed. Overall, BCBSO costs for mental health and chemical dependency services increased by $ .51 per member per month after Chapter 601 took effect. Nearly all of this increase appears to be attributable to mental health outpatient coverage. Costs of inpatient treatment for BCBSO have decreased under Chapter 601, and costs of chemical dependency treatment have remained about the same.

Although comprehensive data from before and after Chapter 601 took effect are not available from any other insurer, we have no reason to believe that the BCBSO data are atypical, and according to the Insurance Division, BCBSO accounts for 37 percent of all health insurance premiums statewide.

Summary

It is the SHPDA's conclusion that in general, Chapter 601 did what is was supposed to do: get more people into treatment in a more cost effective manner. Costs to insurers appear to have increased, but not dramatically. The increase appears to be largely attributable to increased payments for outpatient mental health services. The costs of other types of services has remained stable or declined. The number of people receiving insurance reimbursement for mental health and chemical dependency services appears to have increased; and a shift in the service system has occurred so that more outpatient and residential services have become available. The rate of growth in the use of inpatient services has declined.

ISSUES AND PROBLEMS RELATED TO IMPLEMENTATION

Although Chapter 601 is generally accomplishing what it was intended to do, there have been problems and controversy associated with certain aspects of its implementation. In some cases, fine tuning of the statute appears to be necessary to correct problems.

Areas of concern that have been discussed in meetings of SHPDA's work groups include:

Sunset of the legislation

Section 10 of Chapter 601 sunsetted the legislation as of July 1, 1987. It is our understanding that this was done because the legislature wanted to evaluate how the legislation had worked and what impact it had. As noted earlier, it is our conclusion that the legislation has had its intended effects of making mental health and chemical dependency services more accessible, while at the same time containing costs. Those attending our work groups meetings, including insurance company representatives, providers of care, other state agencies, and representatives of the business community, unanimously agree that this legislation should be continued. It is therefore SHPDA's recommendation that this sunset date be removed.

Coverage of children and adolescents

When Chapter 601 was enacted in 1983, the required minimum benefit levels for mental health and chemical dependency were set at what was considered to be the minimum necessary level for adult care. The people involved in drafting the bill did not consider the needs of children and adolescents. Members of the SHPDA study groups agree that children and adolescents have significantly different needs from adults. They need longer lengths of stay, and higher ratios of staff to patients.

A search of the scientific literature revealed few studies on appropriate program design for child and adolescent treatment. Studies that were available, however, seemed to indicate that effective programs could have as low as 28 to 35 day lengths of stay for both mental health and chemical dependency. Some studies reported far longer lengths of stay, but none reported shorter stays.

In Oregon, however, lengths of stay for all types of hospital care are lower than the national average. Our overall average length of stay for all inpatient psychiatric services was only 10 days in 1985, compared to the 59 day national average reported by the National Association of Private Psychiatric Hospitals for 1984.

According to the Oregon Psychiatric Association, the average length of stay currently in Oregon for children and adolescents is 22 days for inpatient psychiatric care, compared to 10 days for adults (based on a survey of six hospitals in January and April, 1986). BCBSO reports that claims it received for inpatient mental health care from July 1984 through June 1985 had average lengths of stay of 13 days for adolescents, compared to only eight days for adults. Aetna reported 21 days for

adolescents, versus nine for adults, based on its 1985 inpatient mental health claims. Thus, lengths of stay for children and adolescents appear to be over twice as long as for adults for inpatient mental health services.

Charges reported by insurance companies for inpatient mental health services are also substantially higher for children and adolescents than for adults. BCBSO reports an average charge for inpatient and residential or day mental health treatment of $4,800 for adolescents from July 1984 through June 1985, 63 percent higher than the $2,949 reported for adults. Bankers Life reported an average charge of $18,672 for inpatient mental health treatment of adolescents in 1985 (including physician fees), compared to $7,379 for adults (or a 153 percent difference). Aetna reported inpatient mental health treatment charges of $10,775 for adolescents, compared to $3,962 for adults in 1985, a difference of 172 percent.

For inpatient chemical dependency treatment, a difference also exists between adolescents and adults, although it is not as great as for mental health care.

On SHPDA's "Annual Reports for Oregon Hospitals and Special Inpatient Care Facilities" for October 1984 through September 1985, three facilities reporting inpatient chemical dependency services for children and adolescents had an average length of stay of 27 days for such services. This was 50 percent higher than the 18-day overall average for all inpatient chemical dependency units in the state. Insurance companies reported similar length of stay differences for inpatient chemical dependency based on their claims data. BCBSO reported average stays of 17 days for adolescents versus 13 days for adults from July 1984 through June 1985. Aetna reported 26-day average stays for adolescents and 15 days for adults in 1985.

CareUnit Hospital of Portland, which does over one-fourth of all inpatient chemical dependency treatment in the state, has reported that in May 1986, its adolescent program had over two clinical and nursing staff for each patient, compared to a one-to-one staffing ratio in its adult program.

CareUnit reported costs per stay of $5,314 for its adolescent inpatient program in May, 1986; 50 percent higher than the $3,543 reported for adults. BCBSO reported average inpatient and residential program claims from hospitals of $3,213 for adolescents and $2,537 from adults from July 1984 through June 1985, a 27 percent difference. Bankers Life reported average charges in 1985 of $5,689 for adolescents versus $4,759 for adults for inpatient chemical dependency services. Adolescent charges were 20 percent higher than adult charges. Aetna reported average inpatient chemical dependency charges of $6,318 for adolescents and $3,460 for adults in 1985--an 83 percent difference.

Because there are no specific minimum coverage levels for children and adolescents in state statute, and no insurers (to our knowledge) provide higher benefits for children and adolescents than for adults, it may be that the cost and length of stay differences cited above are artificially

low. Some child and adolescent patients may be discharged earlier than they otherwise would have been because of the lack of a payment source, and some may not receive treatment at all.

We conclude that there is a substantial amount of documentation that the costs of providing mental health and chemical dependency treatment to children and adolescents are substantially greater than the costs of adult treatment. Costs for treating children and adolescents appear to be 63 to 172 percent greater for mental health and 20 to 83 percent higher for chemical dependency. This difference was not considered when the benefit levels in Chapter 601 were set originally. These levels were set so as to be minimally adequate for adults. They are wholly inadequate for children and adolescents.

The SHPDA recommends that separate minimum benefit levels for children and adolescents be provided for in the statute. Based on discussions at our study group meetings, we recommend that benefit levels for children and adolescents for mental health treatment be as follows:

Inpatient and day or partial hospitalization	$10,500 of which only $3,000 could be used for day or partial hospitalization
Outpatient	$ 2,000
Overall	$12,500

The total available coverage of at least $12,500 in coverage for children and adolescents, compares to $9,000 for adults. The $10,500 in inpatient and day treatment coverage would allow for a 20 to 25-day inpatient stay, if it were all used for inpatient care. As noted above, this is about the current average length of stay for inpatient mental health care of children and adolescents in Oregon. Many providers think this average should be considerably higher; and of course there will be children and adolescents who need longer-than-average stays. This inpatient coverage level is therefore considered to be barely adequate, even as a minimum, but it represents a substantial improvement over what is available now.

The proposed benefit level also allows for up to $3,000 of the $10,500 inpatient benefit to be used for day or partial hospitalization. It is hoped that this will provide an incentive for providers to move children and adolescents into this lower level of care, whenever this is feasible.

The minimum outpatient mental health benefit for children and adolescents is set at $2,000, the same as for adults. The difference, however, is that all of this $2,000 would be available for outpatient treatment of children and adolescents, no matter how much inpatient or day treatment is provided. For adults, this benefit is subject to the $9,000 overall cap. If the $9,000 is exhausted by adult inpatient and day treatment, the $2,000 outpatient benefit would not be available.

The proposed $10,500 inpatient level for mental health treatment of children and adolescents is 40 percent higher than the current $7,500 level for adults.

For chemical dependency treatment of children and adolescents, the SHPDA recommends the following benefit levels:

Inpatient	$ 6,000
Residential/day or partial hospitalization	4,500
Combined total for inpatient, residential, and day or partial hospitalization	$ 9,000
Outpatient	1,500
Overall	$10,500

The inpatient level is a third higher than the current adult level of $4,500. The residential/day treatment level is 50 percent higher than the current adult level. The outpatient benefit level is the same as the current adult level, but, as with the benefits for mental health, this outpatient benefit will be reserved for children and adolescents, and could not be reduced on the basis of the amount of inpatient or residential care delivered. The recommended minimum overall benefit level of $10,500 compares to $6,000 overall currently for adults.

Using data from BCBSO, the SHPDA has estimated the overall cost impact of these benefit level changes. BCBSO reports that adolescents represented 35 percent of all group payments for hospital inpatient or residential care for mental health; and 19 percent of all hospital inpatient and residential chemical dependency treatment. Statistics for outpatient and freestanding residential treatment were not available, but we will assume that the percentage is the same. (Actually, the percentage is likely to be less, because there is likely to be less difference between adults and adolescents for length of time in treatment for outpatient care.)

Under SHPDA's proposal, the total exposure of insurance companies for child and adolescent coverage would increase by 39 percent for mental health care (from $9,000 to $12,500) and by 75 percent for chemical dependency (from $6,000 to $10,500). The inpatient benefit levels would increase by 40 percent for mental health care (from $7,500 to $10,500); and by 33 percent for chemical dependency (from $4,500 to $6,000).

From July 1984 through June 1985, BCBSO paid $8,535,221 in group coverage for mental health care and $2,965,576 in group coverage for chemical dependency. According to the state Insurance Division, BCBSO accounted for $466 million out of a statewide total of $1,256 million in insurance premiums in 1985, or 37 percent of the total. Because BCBSO had 517,235 group plan members in 1984-85, we estimate that there are about 1.4

million people statewide with group health insurance coverage (assuming that BCBSO represents 37 percent of the total).

From these statistics, we estimate that about $8.1 million annually is currently being spent in Oregon on mental health care for children and adolescents, and $1.5 million for chemical dependency.

We have no way of predicting what the mix of treatment settings would be under the new coverage levels; i.e., the percent that would go for inpatient care as opposed to residential or outpatient treatment. If the increased benefit levels for children and adolescents were to result in increased payments by insurance companies in proportion to the increases in the overall benefit caps, then total statewide payments for child and adolescent mental health services could increase by as much as $3.2 million, or $ .19 per group policy member per month. Chemical dependency payments could increase by as much as $1.1 million, or $ .07 per member per month. As noted earlier, total reimbursement by BCBSO for mental health and chemical dependency services was $1.85 per member per month from July 1984 through June 1985. This would therefore represent a 14 percent increase in mental health and chemical dependency payments.

Costs may not increase in proportion to the increases in the overall benefit caps, however. We believe they are likely to increase at least as much as the increases in the inpatient portion of the benefit levels. As noted above, this would be a 40 percent increase for mental health and a 33 percent increase for chemical dependency. Under this scenario, payments for child and adolescent mental health services would increase by $3.2 million, or $ .19 per member per month--the same as in the above calculations. Chemical dependency reimbursement, however, would increase by only about $500,000, or $ .03 per group policy member per month. Overall, this would represent an increase of 12 percent in insurance company payments for mental health and chemical dependency services.

In summary, it is well documented that the cost of treating children and adolescents for mental health and chemical dependency is considerably higher than the cost of treating adults. This was not considered when Chapter 601 was originally drafted. Therefore, the SHPDA is recommending separate, higher minimum benefit levels be set in the statute for children and adolescents. We estimate that this will increase the cost to insurers for mental health and chemical dependency benefits by 12 to 14 percent, or about $ .22 to $ .26 per group policy member per month. The purpose of these increased benefit levels is that more treatment be delivered to children and adolescents than to adults. Providers should not use the higher benefit levels merely as a basis for charging higher per diem rates. This principle should be included in the statute as a policy statement.

Dual diagnosis

Current provisions of ORS 743.557(2) and 743.558(2) (Chapter 601, Sections 6 and 7) allow insurance companies to limit benefits for all settings to $6,000 over 24 months for persons who need both mental health and chemical dependency treatment (so-called "dual diagnosis" patients).

People with only mental health needs can be reimbursed up to $9,000. The $6,000 level for multiproblem patients seems overly restrictive and gives providers an incentive for "gaming" the patient's diagnosis. However, insurers have pointed out that most chemical dependency patients can be said to have an associated psychiatric diagnosis; and that therefore deleting this requirement might merely result in raising the overall benefit level to $9,000 for both mental health and chemical dependency.

Rationally, dual diagnosis patients have needs which are at least as great as those of mental health patients. The SHPDA therefore recommends that the dual diagnosis benefit levels be increased so that they conform to the mental health benefit levels. This would mean an overall cap of $9,000 instead of $6,000 for adult dual diagnosis treatment; and an overall cap of $12,500 instead of the current $6,000 for children and adolescents with dual diagnoses.

The SHPDA shares the concerns of insurers that an increase in the dual diagnosis levels may cause some chemical dependency treatment programs to find dual diagnoses in increasing numbers of patients. For this reason, the SHPDA also recommends that dual diagnosis treatment be recognized in the statute as a separate type of treatment from either chemical dependency or mental health treatment, with separate utilization review and program approval criteria and standards.

It is difficult to estimate the cost impact of increased benefit levels for dual diagnosis treatment, because we do not have good statistics on the proportion of all mental health and chemical dependency patients who are dual diagnosis patients. A reasonable guess would be that 20 percent of all chemical dependency patients could have dual diagnoses. We also assume that all persons in mental health programs will be billed on the basis of mental health benefit levels, even though some of these people may also have dual diagnoses. Last, we will assume that payments for dual diagnosis patients will increase in proportion to the increase in the overall benefit levels; that is, a 50 percent increase for adults ($9,000 ÷ $6,000) and a 108 percent increase for children and adolescents ($12,500 ÷ $6,000). Because 16 percent of BCBSO's group coverage claims for chemical dependency were for adolescent treatment, we can weight the above the above figures and estimate that payments for dual diagnosis treatment will increase by 59 percent overall.

BCBSO spent $2,965,576 on chemical dependency payments to group policy members from July 1984 through June 1985. As noted earlier, BCBSO represented 37 percent of all group insurance business in the state. It can therefore be estimated that about $8 million is spent annually by insurers for chemical dependency treatment for group policy holders. If 20 percent of these payments are for dual diagnosis patients, then approximately $1.6 million is currently spent by insurers annually on dual diagnosis patients with group policy coverage.

With the above statistics, we can estimate that the proposed increase in dual diagnosis benefit levels will cost insurers statewide about $900,000, or $ .05 per member per month. This represents a three percent increase in insurance company payments for mental health and chemical dependency, based on BCBSO statistics.

Other benefit level issues

The SHPDA is proposing major changes in the mandated benefit levels only in the two areas described above--coverage for children and adolescents; and coverage for dual diagnosis patients. Other issues related to benefit levels have been raised at our work group meetings, however.

Some mental health service providers have advocated an increase in the benefit level for inpatient mental health services. Benefits for this setting were cut substantially by Chapter 601, on the assumption that the new $7,500 benefit for a 24-month period would be adequate for most patients. At current hospital and physician charges, this amounts to payment for about a 15-day stay. Data collected by the Oregon Psychiatric Association from six hospitals in January and April, 1986, indicate that patient lengths of stay exceeded the inpatient benefit levels in 24 percent of the cases. Because the existing benefit level is adequate for 76 percent of patients, we do not consider this to be as high a priority as changing the child/adolescent and dual diagnosis benefits. The fact that 24 percent of all patients need more inpatient mental health services than the benefit levels cover is significant, however, and will eventually need to be addressed by the legislature.

The SHPDA is proposing a slight change in the residential chemical dependency level for adults. Data provided by residential treatment programs indicates that costs are generally somewhat higher than the $3,000 minimum benefit currently provided for in the statute. Laurelhurst Manor, a residential program in Portland, estimated its costs for adults at $3,750 per case. The Addiction Treatment Association recommended that the residential benefit level be increased to $3,500. The SHPDA concurs with the ATA recommendation, because it is supported by data on actual program costs and because it will increase the incentive for residential as opposed to inpatient care. It's also a relatively minor change in the benefit levels. The SHPDA estimates that even if all adult patients in residential chemical dependency programs were to be reimbursed for the full $500 increase in the benefit level, this would add only $ .04 per member per month to insurance company costs. Of course, not all patients will receive the maximum reimbursement level. Many will have lesser treatment needs, or will leave treatment before completion of the program, or will have their reimbursement reduced as a result of utilization review. The actual cost impact of this change is therefore likely to be considerably less than $ .04 per member per month.

Utilization review

One of the "cost containment methods" established by ORS 743.557 (10) and 743.558(8) (Sections 5 and 6 of Chapter 601) is utilization review by insurers to determine whether or not the level of care provided was appropriate. The statute does not mandate that such utilization review be done, but gives insurers explicit authorization to do such reviews if they wish. As noted earlier, most of the larger health insurers in the state now conduct such reviews. BCBSO has stated that its mental health and chemical dependency utilization review program resulted in

direct savings of $246,430 due to level of care reductions in calendar year 1985.

Section 7 of Chapter 601 required the SHPDA to prepare an advisory, non-binding set of criteria for use by insurance companies for screening claims in terms of level of care and length of treatment. The SHPDA issued these model criteria on October 1, 1983; and also presented a detailed, specific example of these criteria for alcohol problems. In the fall of 1984, SHPDA participated, with BCBSO and a number of treatment providers, in two utilization review work groups organized by the Oregon Medical Association and the Oregon Association of Hospitals. These groups developed a simpler and less restrictive set of utilization review criteria, which were endorsed by SHPDA and BCBSO. The SHPDA is currently working with groups of providers and insurers to develop utilization review criteria for children and adolescents, and we plan to begin development soon of criteria for dual diagnosis patients.

Since Chapter 601 was enacted, providers have had a number of concerns regarding the utilization review process. Currently, the primary concern is that the statute requires that "Review shall be on a post-admission basis rather than by mandatory prior approval..." Although not all providers favor mandatory prior approval, they would like to be able to find out in advance whether an insurer would consider a particular admission to be appropriate.

SHPDA's work groups reached a consensus on recommendations regarding the utilization review process, which would address the above issue and several other concerns, and would give insurers more freedom of choice in the method of utilization review. Our recommendations are as follows:

1. Continue to allow insurers to do utilization review if they wish.

2. Continue the requirement that SHPDA issue model utilization review criteria, but require that SHPDA revise these criteria every two years, and strengthen existing language in the statute requiring that SHPDA consult with all affected parties.

3. Require that reviewers have experience and expertise in the particular area that they are reviewing (i.e., mental health or chemical dependency treatment).

4. Allow providers or patients to request prior approval or concurrent review for particular cases, and state that they are entitled to a timely response to such requests.

5. Give insurers the option of which type of review they wish to provide, so long as the review criteria are defined and made available to providers. Insurers who elect to require prior approval should make allowances for the admission of emergency cases.

Licensure and approval of programs

When Chapter 601 went into effect, coverage was mandated for certain settings of care that were not previously licensable in the state of

Oregon: residential and outpatient mental health and chemical dependency services; and inpatient drug abuse services. The statute requires that inpatient facilities, in order to be eligible for reimbursement, must be licensed by the Health Division, but individual programs within hospitals, such as mental health or substance abuse programs, need no special approval or certification beyond the hospital license. Outpatient and residential services must be "licensed, approved, established, maintained, contracted with or operated by the Mental Health Division" in order to be eligible for reimbursement (ORS 430.010(3) and (4); Chapter 601, Section 1).

Thus, there is an apparent inequity, in that freestanding outpatient and residential programs require the approval of the Mental Health Division or Office of Alcohol and Drug Abuse Programs in order to be reimbursed while hospital-based outpatient and residential programs do not.

Section 2 of Chapter 601 mentions Joint Commission on Accreditation of Hospitals (JCAH) accreditation as an alternative to licensure or approval for hospital-based programs, but does not require JCAH accreditation. Work group members have pointed out that other nationally-recognized standards are available, in addition to JCAH standards. These include the standards of the America Association of Partial Hospitalization (AAPH) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

The SHPDA is therefore recommending that all outpatient, residential, and day or partial hospitalization programs, whether or not they are hospital-based, be required to have approval from either the appropriate state agency (Mental Health Division or Office of Alcohol and Drug Abuse Programs) or from one of the nationally-recognized accreditation bodies (JCAH, AAPH, or CARF) in order to be eligible for insurance reimbursement. For inpatient programs, health facility licensure by the Health Division would continue to be the only program certification required, as it is now.

The definitions of the various treatment settings in ORS 430.010 (Chapter 601, Section 1) currently define which programs are eligible for insurance reimbursement. These definitions were primarily intended to apply to state supported mental health and chemical dependency programs, however (county mental health programs and subcontractors). The multiple purposes of ORS 430.010 has caused some problems. Because the statute related to county mental health programs is referenced, in ORS 430.010, the Mental Health Division (MHD) has taken the position that outpatient programs must be recognized by the local county mental health program before they can receive approval for insurance reimbursement purposes. It is our understanding that this was not the intent of Chapter 601, and the SHPDA therefore recommends that the statute give the Mental Health Division and the Office of Alcohol and Drug Abuse Programs the authority to approve treatment programs for insurance reimbursement purposes, without requiring that they be a part of a county mental health program.

Two issues have also arisen in regards to inpatient health facility license requirements. First, the definitions of various types of health facilities in ORS 442.015(16) establish what the licensure categories will be. ORS 442.015(16)(a) defines the licensure category "hospital." ORS 442.015(16)(d) defines another licensure category called "special inpatient care facility," which includes facilities for the treatment of alcoholism. Medicare will reimburse only for a facility that is licensed as a "hospital." Therefore, facilities for the treatment of alcoholism are not eligible for Medicare reimbursement, because of the way that health facilities are defined in Oregon statute. It doesn't seem fair that a hospital-based alcoholism unit should be eligible for Medicare reimbursement while a freestanding "facility for the treatment of alcoholism" performing the same service should not. Therefore, the SHPDA is recommending that ORS 442.015(16) be revised so that "special inpatient care facility" becomes a subcategory of "hospital."

The second licensure issue relates to drug treatment facilities. As noted earlier, Chapter 601 for the first time mandated reimbursement for drug abuse services. For inpatient drug abuse services to be reimburseable, Chapter 601 requires that they be licensed by the Health Division. However, ORS 441.017 states that, "For purposes of licensing health care facilities, 'health care facility,' as defined in ORS 442.015, does not include...facilities established for treatment of drug abuse." Thus, the Health Division is prohibited by statute from licensing inpatient drug facilities. Alcohol treatment facilities are subject to licensure, and most such facilities also treat drug abuse. Technically, however, they are not <u>licensed</u> to treat drug abuse. ORS 441.017(3), which establishes the licensure exemption for drug abuse, should be repealed. There is no reason why inpatient alcohol treatment facilities should be subject to licensure, while drug facilities are not. Also, by allowing the Health Division to license drug facilities, the reimbursability of such facilities would be clarified.

<u>Definition of "residential mental health"</u>

Chapter 601 states that, "'Residential facility' means a program or facility providing an organized full-day or part-day program of treatment, but not licensed to admit persons requiring 24-hour nursing care" (ORS 430.010(3); Chapter 601, Section 1). The statute goes on to state that payment at the "residential" benefit level "...shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week" (ORS 743.558(5); Chapter 501, Section 6).

The term "residential facility" implies a freestanding, halfway house sort of program. In fact, this sort of residential facility is an accepted model for chemical dependency service delivery. However, no such facilities exist for mental health services. Providers believe that the most appropriate model for delivery of mental health services that are more than outpatient and less than inpatient is probably a day or partial hospitalization program. In such programs, patients do not stay overnight; and programs are likely to be associated with hospitals or other providers, rather than being freestanding.

Many providers and insurers have not realized that under Chapter 601, "residential" also means "day treatment." The standard meaning of the word "residential" implies to many people that it does not include day treatment. It is therefore advisable for the statute to clarify that the "residential" benefit level really applies to more types of services that just residential facilities. In order to clarify that this setting can involve more models of treatment than simply residential facilities, the SHPDA recommends that references to "residential facilities" in the statute be changed to "residential facilities and day or partial hospitalization programs."

Members of SHPDA's work groups have also advised us that the requirement that "residential" programs provide treatment at least four hours per day, four days per week, may be too restrictive. Apparently, day treatment programs sometimes provide fewer hours of care, or concentrate services over less than four days a week. It is therefore recommended that day or partial hospitalization be defined so that program approval or accreditation is required, but no specific hour-based standard is applied. Providers appear to agree, however, that genuinely residential programs should be defined as those in which patients stay overnight and participate in a structured program at least eight hours per day.

Services and providers covered

Providers have frequently raised questions about whether particular diagnoses or types of programs are covered under Chapter 601. Oregon statute does not define or mandate any particular policy on these issues. Insurance companies therefore have discretion. The SHPDA understands that insurance companies have generally refused to reimburse for Diagnostic and Statistical Manual (DSM-III) V code diagnoses, and it appears that they are allowed to do this under Chapter 601. It was the intent of the statute, however, that insurers should still cover the diagnoses they covered prior to Chapter 601 taking effect.

An issue raised in SHPDA's work groups is whether medical treatment should be charged toward the benefit levels in Chapter 601. It is our opinion that because reimbursement for mental health and chemical dependency is limited, treatment or diagnostic procedures primarily related to medical problems should not be charged to these benefits, even when the patient's primary diagnosis is mental illness or chemical dependency.

Detoxification services should continue to be covered under the substance abuse inpatient benefit levels. However, the statute should be revised to state that for both mental health and substance abuse services, ancillary medical or neurological diagnostic or treatment services that are concurrent with, but not directly related to a mental health problem or normal detox protocol will not be charged to the mental health or substance abuse benefit levels.

There have also been questions raised as to whether conditions which apply to private practitioners also apply to treatment programs approved under Chapter 601. Specifically, ORS 743.135 requires reimbursement for registered clinical social worker (RCSW) services, but only when the patient has been referred by a physician. It is our understanding

that this restriction was not intended to apply to organized programs which had been approved by the Mental Health Division or Office of Alcohol and Drug Abuse Problems. In such cases, it is the program which is being reimbursed, not the individual practitioner; and the program has had to meet various requirements in order to receive certification.

However, ORS 743.557(3) and 743.558(3) (Sections 5 and 6 of Chapter 601) start out by saying "Subject to the provisions of ORS 743.123, 743.128 and 743.135...," before going on to say that programs are eligible to receive payment for treatment. This could be interpreted as meaning that physician referral is required for RCSW services per ORS 743.135, even in an approved program. Although the SHPDA believes that this was not the intent, the issue should be clarified. We therefore recommend that these cross-references be deleted from ORS 743.557(3) and 743.558(3).

Groups covered under the mandates

Currently, Chapter 601 applies only to group health insurance policies written in the state of Oregon. Thus, many people have insurance coverage that is not subject to these mandates. Types of coverage which are not subject to Chapter 601 include self-insured groups, individual policies, blanket policies, policies written out of state, group or staff model health maintenance organizations (HMOs), Medicare and Medicaid.

As a general principal, the SHPDA believes that insurance mandates should apply as broadly as possible, so that everyone is playing by the same rules, and no one is put at a competitive disadvantage as a result of having to comply with the mandates. There are a number of practical and legal problems that prevent this, however.

The largest group which is currently not subject to insurance mandates is the self-insured. Businesses have increasingly been setting up their own insurance plans in order to gain better control over costs and utilization. A federal statute, the Employee Retirement Income Security Act of 1974 (ERISA), has been interpreted as preempting state regulation of self-insured groups. Unless future federal court decisions change this interpretation, or Congress amends ERISA, it does not appear that states can apply insurance mandates to self-insured groups.

Likewise, federal requirements govern what is covered under Medicare and Medicaid.

In some areas, however, it appears that action can be taken to make Chapter 601 more broadly applicable. ORS 750.055(1)(j) (Section 9, Chapter 601) states that "group practice or staff health maintenance organizations which are federally qualified pursuant to Title XIII of the Public Health Service Act shall be deemed to comply with the requirements of ORS 743.557 and 743.558." Thus, the Kaiser and Eugene Clinic HMOs are exempted from the Chapter 601 mandates, although all other HMOs are not. Although Kaiser does provide treatment to its members for mental illness and chemical dependency, its coverage of mental health and chemical dependency services does not fully conform to the provisions of Chapter 601, particularly in regard to residential and inpatient

care. The SHPDA recommends that all HMOs be brought under Chapter 601's requirements.

The SHPDA is not recommending at this time that any other groups be brought under the Chapter 601 mandates. It may be advisable at some future time to include individual policies, blanket policies, or policies written out of state, but the SHPDA believes that more study is needed before any of these types of policies are made subject to Chapter 601.

Blanket policies are often of a limited or short term nature, although some groups such as university students are also sometimes covered under blanket policies. Research would have to be done on whether Chapter 601 should apply to all blanket policies or only certain types of blanket policies.

Practical problems would have to be resolved in order to bring out-of-state policies covering Oregon residents under the requirements of Chapter 601. Fundamental changes to the insurance code would be required to attempt covering all state residents regardless of group policy status. The insurance code currently covers policies--that is the group contracts issued to employers--issued in Oregon. it is not a straightforward matter to claim Oregon jurisdiction over a contract issued to a multi-state employer headquartered in another state, possibly even issued by a company not licensed to do business in Oregon; and potential conflicts would occur if the state in which the group policy was issued had laws which applied to all coverage under the policy (as most states do) regardless of residence of the employees. In addition to the legal problems, practical difficulties and resulting costs of compliance would be introduced for multi-state employers and their insurers from the necessity of varying benefit plans by state. These difficulties would provide an added incentive for such employers to self-insure the health benefits, which would remove them from any state jurisdiction.

STATUTORILY REQUIRED REPORT

ORS 171.875 requires that: "Every proposed legislative measure that mandates a health insurance coverage, whether by requiring payment for certain providers or by requiring an offering of a health insurance coverage by an insurer or health care service contractor as a component of individual or group health insurance policies, shall be accompanied by a report that assesses both the social and financial effects of the coverage in the manner provided in ORS 171.880, including the efficacy of the treatment or service proposed. The report may be prepared either by the chief sponsor or by any other proponent of the proposed measure. The report shall be submitted with the proposed measure when the proposed measure is submitted for filing, and shall be in writing and be a public record."

ORS 171.880 lists a number of questions which must be addressed as a part of this report. We will attempt to answer these questions here, as they relate to the continuation of Chapter 601 and SHPDA's proposed revisions to that statute. ORS 171.880(1) asks five questions related to the social effect of the proposed measure, including:

To what extent is the treatment or service used by the general population of Oregon?

Statistics on the utilization of mental health and chemical dependency services were presented and discussed earlier in this report. It is impossible to estimate the total number of Oregonians who use mental health and chemical dependency services, because statistics are not reported for private practitioners and for many outpatient and residential programs. In 1985, 12,328 people were discharged from inpatient mental health and chemical dependency programs in Oregon, not including state or VA hospitals. Inpatient care represents only a small fraction of the total care delivered. BCBSO reported that from July 1984 through June 1985, it processed 18,398 claims for mental health and chemical dependency services. If BCBSO represents 37 percent of the private health insurance business in the state, then this would imply approximately 50,000 insurance claims statewide.

The President's Commission on Mental Health estimated in 1978 that approximately 15 percent of the United States population could benefit from mental health services. This would mean that in 1985, over 400,000 Oregonians were in need of mental health services. SHPDA's need determination rules, which are based on national studies of the prevalence of chemical dependency, estimate that 7 percent of the adult population and 19 percent of the adolescent population are problem drinkers. This would mean that in Oregon in 1985, about 135,000 adults and 53,000 adolescents were problem drinkers. The Governor's Council on Alcohol and Drug Abuse Programs has estimated that 12,000 adolescents in Oregon suffer from drug abuse.

In other words, mental illness and chemical dependency are serious problems in Oregon, affecting hundreds of thousands of Oregonians. Tens of thousands of Oregonians use treatment services each year.

To what extent is the insurance coverage already generally available in Oregon?

Chapter 601 has been in effect since July 1, 1984. This report seeks to justify the continuation and revision of already-existing coverage mandates. As noted earlier, prior to the enactment of Chapter 601, insurance coverage was generally available only for inpatient mental health and alcoholism services. Currently, coverage for children and adolescent and for dual diagnosis patients, although generally available, is believed to be inadequate. Most group policies cover mental health and chemical dependency services only up to the minimum levels required by Chapter 601.

What proportion of the population already has such coverage?

All individuals covered under group policies issued in Oregon are currently covered under Chapter 601. See answer above.

To what extent does the lack of coverage result in financial hardship in Oregon?

Because this report seeks to revise, rather than create, an existing insurance mandate, this question is not entirely relevant. However, children and adolescents and dual diagnosis patients are believed to currently have inadequate coverage for mental health and chemical dependency services. Some members of these groups may in fact experience financial hardship resulting from the inadequacy of their coverage. The Oregon Psychiatric Association estimated, based on a survey of six hospitals in January and April, 1986 that 43 percent of all children and adolescents receiving inpatient mental health services required more treatment than is covered under the existing benefit levels in Chapter 601. (As mentioned earlier, this is the case for only 24 percent of adult patients.)

In addition, if Chapter 601 were allowed to sunset, many Oregonians would either experience financial hardship in order to obtain needed mental health and chemical dependency services, or would forego such services. It is impossible to estimate how many persons would be affected, because we have no data on the financial status of mental health and chemical dependency patients, and we don't know what sort of insurance coverage would continue to be provided, if the mandates were no longer in effect. Outpatient, residential, and day or partial hospitalization services would be the most likely targets for reductions in coverage, so patients needing these services would be most affected.

What evidence exists to document the medical need in Oregon for the proposed treatment or services?

As detailed in the answer to the first question, above, it appears that hundreds of thousands of Oregonians are in need of mental health and chemical dependency services. This estimate is based on a number of authoritative studies on the incidence of mental illness and chemical dependency. Chapter 601 allows insurers to review claims to determine whether the level of care delivered was medically necessary. BCBSO has

been reviewing all claims for reimbursement since Chapter 601 took effect, and determined that some reimbursement was justified in all claims reviewed in 1985, although the amount of reimbursement was reduced in some instances.

ORS 171.880(2) asks five questions concerning the financial effect of the proposed measure, including:

To what extent is the coverage expected to increase or decrease the cost of treatment or services?

Changes in the minimum required benefit levels for mental health and chemical dependency services are proposed in only three areas: services to children and adolescents; services to dual diagnosis patients; and residential chemical dependency services. The costs of increasing these benefits was fully discussed earlier in this report. Overall, the increased benefit levels are expected to cost insurers no more than $ .35 per member per month. This is equivalent to a 19 percent increase in insurance company payments for mental health and chemical dependency services; and a 0.8 percent increase in insurance company costs for all health services.

To what extent is the coverage expected to increase the use of the treatment or services?

The proposed revisions to Chapter 601 are expected to have little if any effect on the utilization of services. The groups effected by the proposed benefit level changes already have coverage for mental health and chemical dependency services--the proposal is simply to increase the coverage to more adequate levels. The creation of insurance coverage for a particular type of service might be expected to result in the increased use of that service. As noted earlier in this report, the use of outpatient and residential programs for mental health and chemical dependency appears to have increased dramatically since Chapter 601 took effect. We do not expect any similar effect to result from the improvement of an existing benefit, however.

To what extent is the mandated treatment or service expected to be a substitute for more expensive treatment or services?

As detailed earlier in this report, Chapter 601 was originally enacted in order to provide coverage for lower-cost alternatives to inpatient mental health and chemical dependency services (i.e., outpatient and residential care). Costs to insurers of inpatient care appear to have in fact decreased since Chapter 601 took effect. The revisions to Chapter 601 which are currently being proposed do not change this situation, and do not create coverage for any new less costly alternative.

To what extent is the coverage expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?

There are no new areas of coverage being created by the proposed revisions to Chapter 601, so administrative expenses resulting from the proposed

revisions should not be substantial. However, all group policies issued in Oregon will need to be amended if the proposed changes are made. Insurance company claim personnel must also become familiar with the changes. Changes in levels of treatment for adolescents, eligible program definitions, and maximum benefit cap provisions will raise many technical questions that must be analyzed. The associated costs of insurers will no doubt be passed on directly or indirectly to policyholders, but we have no way of estimating the magnitude of these expenses.

As noted earlier, the proposed improvement in the benefit levels for services to children and adolescents, dual diagnosis patients, and residential chemical dependency programs is expected to have an overall impact on insurance company costs of less than $ .35 per member per month. Insurance companies would need to increase premiums to policyholders by less than one percent, if at all, in order to cover these increased costs.

What will be the effect of this coverage on the total cost of health care?

The SHPDA believes that Chapter 601 has had the effect of reducing the total cost of health care to Oregonians. There is a substantial amount of documentation in the scientific literature of the fact that people who receive mental health and chemical dependency services subsequently experience large reductions in their overall medical care expenditures. Chapter 601 has allowed more people to gain access to such treatment.

In addition, Chapter 601, when it was originally enacted, incorporated several provisions aimed at reducing or controlling the cost of mental health and chemical dependency services. As discussed earlier, the utilization review provisions of Chapter 601 have resulted in direct cost savings to insurers. The fact that outpatient and residential services are now covered, instead of just inpatient services, has resulted in some extra costs to insurers for outpatient and residential services; but has also helped to ensure that services are delivered in the lowest cost setting appropriate to the patient. Costs have gone up only marginally, while many more people have been reimbursed for services they received. Costs to insurers for inpatient care have decreased as a result of Chapter 601; and costs of chemical dependency services have remained stable.

As mentioned earlier, the proposed increases in benefit levels for children and adolescents, dual diagnosis patients, and residential chemical dependency are expected to add slightly to insurance company expenses. In many cases, however, treatment is currently being received, but the patient is paying the portion of the bill which is not covered by insurance. In such cases, the proposed revisions will simply cause a shift in the payment source, from the patient to the insurer, rather than adding to the overall costs of health care.

In summary, Chapter 601 is designed to ensure that Oregonians have at least the minimum necessary insurance coverage for mental health and chemical dependency problems. While ensuring access to such services, it is also designed to ensure that such services are delivered only when medically necessary, and in the lowest cost setting which is appropriate.

SUMMARY OF RECOMMENDATIONS

As a result of its analysis and the advice of its work groups, the SHPDA is recommending a number of revisions to Chapter 601. These revisions have been explained and analyzed in detail in the section of this report titled "Issues and Problems Related to Implementation."

These recommendations have been incorporated into three bills: SB 30, SB 31 and SB 32. The first bill simply eliminates the current July 1, 1987, sunset date on Chapter 601. The second bill incorporates most of the substantive revisions to Chapter 601. The third bill incorporates our two recommendations relating to inpatient health facility licensure (recommendations number 9 and 10, below).

The SHPDA's recommendations concerning revisions to Chapter 601 are as follows:

1. The sunset on Chapter 601, currently July 1, 1987, should be repealed.

2. Because children and adolescents need longer lengths of stay and higher staffing ratios, they should have higher minimum benefit levels than adults. Minimum required benefit levels for mental health treatment of children and adolescents should be:

Inpatient and day or partial hospitalization	$10,500 of which only $3,000 could be used for day or partial hospitalization
Outpatient	$ 2,000
Overall	$12,500

3. For chemical dependency, the minimum benefit levels for children and adolescents should be:

Inpatient	$ 6,000
Residential/day or partial hospitalization	$ 4,500
Combined total for inpatient, residential, and day or partial hospitalization	$ 9,000
Outpatient	$ 1,500
Overall	$10,500

4. The overall cap for dual diagnosis patients should be $9,000 for adults and $12,500 for children and adolescents, rather than $6,000 as it is now. It should be clarified, for utilization review and program approval purposes, that dual diagnosis is a separate type

of mental health service from either chemical dependency treatment or mental illness treatment.

5. The minimum required coverage level for adult residential chemical dependency services should be increased from $3,000 to $3,500.

6. Recommendations related to utilization review by insurers are to:

   a. Continue to allow insurers to do utilization review if they wish.

   b. Continue the requirement that SHPDA issue model utilization review criteria, but require that SHPDA revise these criteria every two years, and strengthen existing language in the statute requiring that SHPDA consult with all affected parties.

   c. Require that reviewers have experience and expertise in the particular area that they are reviewing (i.e., mental health or chemical dependency treatment).

   d. Allow providers or patients to request prior approval or concurrent review for particular cases, and state that they are entitled to a timely response to such requests.

   e. Give insurers the option of which type of review they wish to provide, so long as the review criteria are defined and made available to providers. Insurers who elect to require prior approval should make allowances for the admission of emergency cases.

7. Residential, day or partial hospitalization, and outpatient programs should be required to have approval from either the appropriate state agency (Mental Health Division or Office of Alcohol and Drug Abuse Programs) or from one of the nationally-recognized accreditation bodies (JCAH, AAPH, or CARF) in order to be eligible for insurance reimbursement. These requirements would apply whether or not the program is based in a hospital, but for <u>inpatient</u> programs, health facility licensure by the Health Division would continue to be the only program certification required, as it is now.

8. The statute should give the Mental Health Division and the Office of Alcohol and Drug Abuse Programs the authority to approve treatment programs for insurance reimbursement purposes, without requiring that they be a part of a county mental health program.

9. In ORS 442.015(16), "special inpatient care facility" should be a subcategory of "hospital," rather than a separate type of health care facility.

10. Drug abuse facilities should no longer be exempted from licensure requirements. ORS 441.017 should be revised so as to delete this exemption.

11. The definition of day or partial hospitalization should be re-defined to eliminate the current requirement that at least four hours per day, four days per week of care be provided. Program certification standards, rather than any hour-based standard, would be relied upon for such programs. Residential facilities, however, would be required to keep patients overnight and provide at least eight hours of structured programs per day in order to be eligible for reimbursement. Also, it should be clarified that day treatment, partial hospitalization and residential care are all included under the same benefit level. The statute should list each of these three types of care.

12. Detoxification services should continue to be covered under the substance abuse inpatient benefit levels. However, the bill should state that for both mental health and substance abuse services, auxiliary medical or neurological diagnostic or treatment services that are concurrent with, but not directly related to a mental health problem or a normal detox protocol will <u>not</u> be charged to the mental health or substance abuse benefit levels.

13. The cross-reference at the beginning of ORS 743.557(3) and 743.558(3) should be deleted. The intent of this change is to clarify that when reimbursement is paid to an approved program, conditions that would apply to private practitioners (such as physician referral to RCSWs) will <u>not</u> apply to the program.

14. The exemption of group and staff model HMOs in ORS 750.055 should be deleted.

Appendix A

62nd OREGON LEGISLATIVE ASSEMBLY–1983 Regular Session

Enrolled

Senate Bill 522

Sponsored by Senator KITZHABER (at the request of Vernice Paterson)

CHAPTER 601

AN ACT

Relating to health; creating new provisions; amending ORS 430.010, 430.021, 430.315, 743.557, 743.558 and 750.055; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 430.010 is amended to read:

430.010. As used in ORS 430.010 to 430.050, 430.100 to 430.170, 430.260 to 430.270 and 430.610 to 430.700, unless the context requires otherwise: [,]

(1) "Division" means the Mental Health Division.

(2) "Health facility" means a facility licensed as required by ORS 441.015 or a facility accredited by the Joint Commission on Accreditation of Hospitals, either of which provides full-day or part-day acute treatment for alcoholism, drug addiction or mental or emotional disturbance, and is licensed to admit persons requiring 24-hour nursing care.

(3) "Residential facility" means a program or facility providing an organized full-day or part-day program of treatment, but not licensed to admit persons requiring 24-hour nursing care. Such a program or facility shall be:

(a) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041, 430.260 to 430.380 and 430.610 to 430.880 for alcoholism;

(b) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041, 430.260 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction; or

(c) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041 and 430.610 to 430.880 for mental or emotional disturbance.

(4) "Outpatient service" means a program or service providing treatment by appointment. Such a program or service shall be:

(a) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041, 430.260 to 430.380 and 430.610 to 430.880 for alcoholism;

(b) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041, 430.260 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction;

(c) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041 and 430.610 to 430.880 for mental or emotional disturbance; or

(d) Provided by medical or osteopathic physicians licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; psychologists licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; nurse practitioners registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or clinical social workers registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610.

SECTION 2. (1) If a residential program is offered by or through a health facility, it must be either approved by the Mental Health Division or accredited by the Joint Commission on Accreditation of Hospitals.

(2) If an outpatient program is offered by or through a health facility, it must be either approved by the Mental Health Division or accredited by the Joint Commission on Accreditation of Hospitals.

SECTION 3. ORS 430.315 is amended to read:

430.315. The Legislative Assembly finds alcoholism or drug dependence is an illness. The alcoholic or drug-dependent person is ill and should be afforded treatment for [*his*] that illness. **To the greatest extent possible, the least costly settings for treatment, outpatient services and residential facilities shall be widely available and utilized except when contraindicated because of individual health care needs. State agencies that purchase treatment for alcoholism or drug dependence shall develop criteria consistent with this policy in consultation with the Mental Health Division and the State Health Planning and Development Agency. In reviewing applications for certificate of need, the State Health Planning and Development Agency shall take this policy into account.**

SECTION 4. ORS 430.021 is amended to read:

430.021. (1) The Mental Health Division is responsible for the administration of the state mental health programs and the mental health laws of the state.

(2) The division shall direct, promote, correlate and coordinate all the activities, duties and direct services for the mentally or emotionally disturbed, mentally retarded and developmentally disabled, alcoholic and drug-dependent persons; and promote, correlate and coordinate the mental health activities of all governmental organizations throughout the state in which there is any direct contact with mental health programs.

(3) The division shall develop cooperative programs with interested private groups throughout the state to effect better community awareness and action in the field of mental health, and encourage and assist in all necessary ways community general hospitals to establish psychiatric services.

(4) To the greatest extent possible, the least costly settings for treatment, outpatient services and residential facilities shall be widely available and utilized except when contraindicated because of individual health care needs. State agencies that purchase treatment for mental or emotional disturbances shall develop criteria consistent with this policy in consultation with the Mental Health Division and the State Health Planning and Development Agency. In reviewing applications for certificates of need, the State Health Planning and Development Agency shall take this policy into account.

[*(4)*] **(5)** The division shall establish, coordinate, assist and direct a community mental health program in cooperation with local government units and integrate such a program with the total state mental health program.

[*(5)*] **(6)** The division shall promote public education in the state concerning mental health and act as the liaison center for work with all interested public and private groups and agencies in the field of mental health.

[*(6)*] **(7)** The division shall accept the custody of persons committed to its care by the courts of this state.

SECTION 5. ORS 743.557 is amended to read:

743.557. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. **Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.**

(2) [*The policy may limit hospital expense coverage to treatment provided by the following facilities:*] **Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430.010, within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (6) to (8) of this section, a policy may limit the total of payments for all treatment of any kind under this section for chemical dependency including alcoholism, together with payments for all treatment of any kind under ORS 743.558 for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in ORS 743.558. For persons requesting, in any 24-consecutive month period, payments for treatment of any kind for chemical dependency including alcoholism, but not requesting payments**

for treatment of any kind of mental or nervous conditions, a policy may limit the total of payments for all treatment to $6,000 in that 24-consecutive month period.

[*(a) A health care facility licensed as required by ORS 441.015.*]

[*(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.*]

[*(c) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430.260.*]

(3) Subject to the provisions of ORS 743.123, 743.128 and 743.135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, shall be eligible to receive payments for treatment. In addition, an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures through which Mental Health Division approved programs with alternative arrangements for supervision or for review of treatment plans may become qualified to receive payments for treatment.

(4) Chemical dependency, for purposes of this section, refers to the addictive relationship an individual may have with any drug or alcohol agent. This dependency may be characterized by either a physical or psychological relationship, or both, to the extent that it interferes with the individual's social, psychological or physical adjustment to common problems on a daily basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(5) Payments shall not be made under this section for educational programs to which drinking drivers are referred by the judicial system, nor for volunteer mutual support groups.

[*(3)*] (6) Except as permitted by [*subsection (1)*] subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for chemical dependency including alcoholism to an amount less than $4,500 in any 24-consecutive month period [*and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism*].

(7) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for care and treatment in residential facilities for chemical dependency including alcoholism, the policy shall not limit payments to an amount less than $3,000 in any 24-consecutive month period. Within this dollar limit, payments shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week. Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments.

(8) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient services, the policy shall not limit payments to an amount less than $1,500 in any 24-consecutive month period. If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services. The policy may limit coverage for such service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(9) Under ORS 430.315, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10) A group health insurance policy may provide, with respect to treatment for chemical dependency including alcoholism, that any one or more of the following cost containment methods shall be in effect and the

method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment. This review shall be made according to criteria made available to providers in advance. Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only; or to review, on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes, on each case, in a timely fashion, to the insurer.

(11) For purposes of paragraph (b) of subsection (10) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(12) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment, as defined in ORS 430.010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation; or

(c) An alternative residential facility.

(13) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430.010 and under subsection (7) of this section, shall require demonstration that outpatient services, as defined in ORS 430.010 and under subsection (7) of this section, if appropriate and less costly than residential facility services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(14) For purposes of paragraph (b) of subsection (10) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430.010 and under subsections (7) and (8) of this section, shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis.

SECTION 6. ORS 743.558 is amended to read:

743.558. Every insurer offering group health insurance benefits shall [*offer*] provide benefits for expense arising from mental or nervous conditions that meet the following requirements:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of

hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430.010 within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (4) to (6) of this section, a policy may limit the total of payments for all treatment of any kind under ORS 743.557 for chemical dependency including alcoholism, together with payments for all treatment of any kind under this section for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in this section. However, for person requesting, in any 24-consecutive month period, payments for treatment of any kind for mental or nervous conditions, but not requesting payments for treatment of any kind for chemical dependency including alcoholism, a policy may not limit the total of payments for all treatment to less than $9,000 in that 24-consecutive month period.

(3) Subject to the provisions of ORS 743.123, 743.128 and 743.135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, shall be eligible to receive payments for treatment.

(4) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for mental or nervous conditions to an amount less than $7,500 in any 24-consecutive month period, subject to the provisions of subsection (5) of this section.

(5) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for treatment in residential facilities, the policy shall not limit payments to an amount less than $3,000 in any 24-consecutive month period. A policy may specify that any payments made under this subsection shall directly reduce, dollar for dollar, amounts available for payments under subsection (4) of this section. Within the dollar limit in this subsection, payments shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week. Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments.

(6) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient treatment, the policy shall not limit payments to an amount less than $2,000 in any 24-consecutive month period. If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services. The policy may limit coverage for in-home service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(7) Under ORS 430.021, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(8) A group health insurance policy may provide, with respect to treatment for mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment. This review shall be made according to criteria made available to providers in advance. Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only; or to review, on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes, on each case, in a timely fashion, to the insurer.

(9) For purposes of paragraph (b) of subsection (8) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(10) For purposes of paragraph (b) of subsection (8) of this section, when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment as defined in ORS 430.010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation; or

(c) An alternative residential facility.

(11) For purposes of paragraph (b) of subsection (8) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430.010 and under subsection (5) of this section, shall require demonstration that outpatient services, as defined in ORS 430.010 and under subsection (5) of this section if appropriate, and less costly than residential facility services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situation; risks to self or others; and readiness to participate consistently in treatment.

(12) For purposes of paragraph (b) of subsection (8) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430.010 and under subsections (5) and (6) of this section, shall require demonstration that treatment is justified, considering the individual's history and the current medical, occupational, social and psychological situation, and the overall prognosis.

[*(1) In the case of benefits based upon confinement as an inpatient in a hospital, the period of confinement for which benefits are payable shall be at least 30 days in any calendar year.*]

[*(2) In the case of major medical expense coverage, benefits, after the applicable deductible, shall be at a 50 percent rate for covered expenses incurred by the insured while other than an inpatient in a hospital, and benefits shall be available for such expenses during any calendar year up to a maximum of $500.*]

SECTION 7. To facilitate implementation of the amendments to ORS 743.557 and 743.558 by sections 5 and 6 of this Act, the State Health Planning and Development Agency, with technical advice from the Insurance Commissioner, Health Division and the Mental Health Division, and with consultation from affected parties, shall draft, offer for public review, and revise for public distribution, no later than October 1, 1983, an advisory or model set of criteria for appropriate utilization of care in health facilities, residential facilities and outpatient services. These criteria shall be consistent with this Act, and shall not be binding on any insurer or

other party. However, any insurer may, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, adopt the criteria, or similar criteria, with or without modification. In preparing criteria with regard to mental or nervous conditions, appropriate cross-referencing shall be made to the third edition of the Diagnostic and Statistical Manual.

SECTION 8. The State Health Planning and Development Agency shall consult with the Insurance Commissioner and with all insurers, public and private providers and state agencies which implement policies under the authority of this Act, in order to prepare reports to the 1985 and 1987 sessions of the Legislative Assembly. The purpose of the reports shall be to:

(1) Describe the extent to which the options under this Act have been exercised.

(2) Identify savings and expenses attributable to the exercise of the options.

(3) Identify problems which interfere with, or arise from, exercise of the options, and evaluate alternative solutions to such problems.

(4) Recommend whether or not the approaches to cost containment, authorized as options under this Act, should be eliminated, continued or made mandatory; and whether or not they should be extended, on an optional or a mandatory basis, to other coverages under insurance policies written in Oregon.

(5) Recommend and describe desirable characteristics of other approaches to cost containment which may be appropriate for legislative action.

SECTION 9. ORS 750.055, as amended by section 22, chapter 649, Oregon Laws 1981, is further amended to read:

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.150, 731.162, 731.204 to 731.362, 731.382, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.315 to 732.325 and 732.505 to 732.570.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.012, 743.018 to 743.030, 743.037 to 743.108, 743.114, 743.116, 743.119 to 743.128, 743.350 to 743.370, 743.402, 743.412, 743.492, 743.495, 743.498, 743.527, 743.529, 743.549 to [*743.558*] 743.555, 743.800 to 743.833 and 743.850 to 743.890.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528 (2).

(g) ORS 744.005 to 744.265.

(h) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(i) ORS 743.135, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(j) ORS 743.557 and 743.558, except that group practice or staff health maintenance organizations which are federally qualified pursuant to Title XIII of the Public Health Service Act shall be deemed to comply with the requirements of ORS 743.557 and 743.558.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

SECTION 10. Sections 7, 8 and 11 of this Act and ORS 743.557, 743.558 and 750.055 as amended by sections 5, 6 and 9 of this Act are repealed on July 1, 1987, except that the amendment to ORS 743.558 (6) by section 6 of this Act is repealed July 1, 1985.

SECTION 11. This Act does not affect a policy issued before the effective date of this Act. However, this Act applies to a renewal or extension of an existing policy on or after the effective date of this Act as well as to a new policy issued on or after the effective date of this Act.

SECTION 12. Nothing in this Act applies to disability policies.

SECTION 13. This Act takes effect July 1, 1984.

Approved by the Governor July 29, 1983.
Filed in the office of Secretary of State August 1, 1983.

CHAPTER 124
Oregon Laws 1985
AN ACT HB 2051

Relating to health planning; amending section 10, chapter 601, Oregon Laws 1983; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 10, chapter 601, Oregon Laws 1983, is amended to read:

Sec. 10. Sections 7, 8 and 11, **chapter 601, Oregon Laws 1983,** [*of this Act*] and ORS 743.557, 743.558 and 750.055 as amended by sections 5, 6 and 9, **chapter 601, Oregon Laws 1983,** [*of this Act*] are repealed on July 1, 1987[*, except that the amendment to ORS 743.558 (6) by section 6 of this Act is repealed July 1, 1985*].

SECTION 2. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage.

Approved by the Governor May 22, 1985
Filed in the office of Secretary of State May 23, 1985

National Conference of State Legislatures
1050 17th Street • Suite 2100
Denver, Colorado 80265

NCSL MENTAL HEALTH PROJECT

Materials Check List
Mandated Mental Health Insurance

Name:_____ _____

Affiliation:_____Telephone:_____

Address:_____
zip

Please check desired publications/articles/legislation and return form to NCSL.

Articles and Books

___Frank, R.G., and Kamlet, M.S. "Direct Costs and Expenditures for Mental Care in the United States in 1980." Hospital and Community Psychiatry 36:2 (1985): 165-168.

___Goldman, H.H.; Pincus, H.A.; Taube, C.A.; et a;. "Prospective Payment for Psychiatric Hospitalization: Questions and Issues." Hospital and Community Psychiatry 35 (19840: 460-464.

___Lee, F.C., and Schwartz, G. "Paying for Mental Health Care in the Private Sector," Business and Health (October 1984): 12-16.

___Levin, B.L., and Glasser, J.H. "A National Survey of Prepaid Mental Health Services." Hospital and Community Psychiatry 35:4 (1984): 350-355.

___Runck, B. "State Mandates for Mental Health Insurance: What is Their Cost?" Hospital and Community Psychiatry 34:3 (1983): 207-208.

___Scherl, D.J., and English, J.T. "Current Trends in Financing Psychiatric Services: The Initial Response of Psychiatry to Prospective Payment." Psychiatric Annals 14 (1984): 332-339.

___Schlesinger, H.J.; Mumfored, E.; Glass, G.V.; Patrick, C.; and Sharfstein, S. "Mental Health Treatment and Medical Care Utilization in a Fee-for-Service System: Outpatient Mental Health Treatment Following the Onset of a Chronic Disease." American Journal of Public Health 73:4 (1983): 422-429.

___Sharfstein, S.S.; Muszynski, S.; and Arnett, G. "Dispelling Myths About Mental Health Benefits." Business and Health (October 1984): 7-11.

___Sharfstein, S.S.; Muszynski, S.; and Myers, E. Health Insurance and Psychiatric Care: Update and Appraisal. Washington, D.C.: American Psychiatric Press, Inc., 1984.

___Taube, C.; Lee, E.S.; and Forthofer, R.N. "Diagnosis-Related Groups for Mental Disorders, Alcoholism, and Drug Abuse: Evaluation and Alternatives." Hospital and Community Psychiatry 35:5 (10984): 452-455.

Legislation Passed

___California (chap. 295) - Requires insurance policies that include coverage for inpatient care for nervous or mental conditions to provide coverage at general acute care hospitals, acute psychiatric hospitals, and psychiatric health facilities.

___Indiana (p.l. 258) - Requires all insurance policies that provide coverage for inpatient mental illness or substance abuse treatment to include coverage for such services provided by a community mental health center or by any licensed psychiatric hospital.

___Kentucky (chap. 482) - Requires all health insurance policies to offer coverage for inpatient and outpatient treatment of mental illness to at least the same extent as physical illness coverage.

___Maryland (chap. 843) - Mandates that policies covering outpatient mental health benefits provide such coverage at 65% of the cost for the first 20 visits per calendar year or benefit period.

___Tennessee (SJR 310) - Creates a study committee on group insurance benefits for expenses arising from treatment for mental illness, alcoholism, and drug abuse.

___Texas (chap. 805) - Requires group health insurance policies to provide benefits for the necessary care and treatment of alcohol dependency that are not less favorable than for physical illness.

___Texas (SCR 62) - Authorized development of a plan for reimbursement of rehabilitative residential programs in lieu of more costly programs, as private insurers tend to favor hospitalization rather than community-based rehabilitative programs.

___Wyoming (chap. 45) - Provides for freedom of choice of practitioners in private health insurance policies.

MENTAL HEALTH PROJECT

National Conference of State Legislatures

SELECT ENACTED LEGISLATION RELATING TO MANDATED MENTAL HEALTH INSURANCE

May 1987

National Conference of State Legislatures
1050 17th Street • Suite 2100
Denver, Colorado 80265

MANDATED MENTAL HEALTH INSURANCE

SUMMARY OF LEGISLATION

During the past several years, a number of states have passed legislation relating to insurance coverage for mental health. At least two states, KENTUCKY (chap. 482) and TEXAS (chap. 805), passed legislation that requires mental health insurance coverage to be available under present law. Three states, INDIANA (p.l. 260), KENTUCKY (chap. 482), and MISSOURI (chap. 376), expanded the number of eligible service providers who could provide mental health services if an insurance policy offers mental health coverage. At least four states passed legislation to expand the minimum mental health benefits that are presently required by law, including ARKANSAS (act 236), MAINE (chap. 843 and chap. 633), MARYLAND (chap. 843) and WISCONSIN (chap. 29). CALIFORNIA (chap. 295), INDIANA (p.l. 258), MASSACHUSETTS (chap. 380), SOUTH DAKOTA (chap. 419), and WYOMING (chap. 45) expanded insurance mandates to include more mental health service providers or to include more insurance providers. Moreover, at least two states, ILLINOIS (p.a. 84-382) and TENNESSEE (SJR 310), are studying various aspects of mental health insurance during 1985 and 1986.

MANDATED MENTAL HEALTH INSURANCE
LEGISLATIVE SUMMARY

Arkansas

1985 Arkansas Acts, Act 236

Increases minimum coverage for psychiatric care under private health insurance group contracts of disability insurance from $4,000 to $7,000 per calendar year.

California

1985 California statutes, Chap. 295

Requires insurance policies that include coverage for inpatient care for nervous or mental conditions to provide coverage at general acute care hospitals, acute psychiatric hospitals, and psychiatric health facilities. This does not prohibit insurers from entering into alternate payment arrangements with providers or from restricting or modifying the choice of providers.

Illinois

1985 Illinois Laws, P.A. 84-382

Creates a Task Force for the study of Long-Term Care Insurance within the Department of Insurance to examine a private market approach to the provision of long-term care insurance. Findings and recommendations of the task force will be reported to the legislature and governor no later than December 31, 1986.

Indiana

1985 Indiana Acts, P.L. 258

Requires all insurance policies that provide coverage for inpatient mental illness or substance abuse treatment to include coverage for such services provided by a community mental health center or by any licensed psychiatric hospital.

1985 Indiana Acts, P.L. 260

Amends individual or group policy of accident and health insurance to entitle a health service provider in psychology for reimbursement of services.

Kansas

1986 Kansas Session Laws, Chap. 174

Amends the coinsurance and deductible provisions of previous mandated benefits. Limits payment to $1640 in any year and lifetime maximum of $7500 and makes HMO's subject to mandated benefits, while exempting medigap policies. Also redefines the conditions for which coverage must be provided.

Kentucky

1986 Kentucky Acts, Chap. 482

Requires all health insurance policies to offer coverage for inpatient and outpatient treatment of mental illness for at least the same extent and degree as coverage provided for the treatment of physical illness. Coverage provision also applies to health maintenance organizations.

Maine

1986 Maine Laws, Chap. 633

Requires nonprofit health service plans and health insurers to offer the option of providing benefits for the victims of Alzheimer's disease.

1986 Maine Laws, Chap. 843

Alters the rate at which certain health insurance policies are required to provide benefits for the treatment of acute mental illnesses.

Maryland

1986 Maryland Laws, Chap. 843

Amended mandated health insurance benefits for outpatient mental health care. Mandates that policies covering outpatient mental health benefits provide such coverage at 65% of the cost for the first 20 visits per calendar year or benefit period. Thereafter, coverage reverts back to the 50% of the cost of benefits which the policy provides for other types of illness.

Massachusetts

1986 Massachusetts Acts, Chap. 380

Provides for reimbursement by insurance companies and others for services performed by certified clinical specialists in psychiatric and mental health nursing if the specialist is licensed and is providing services within the scope of the license.

Missouri

1985 Missouri Laws, Chap. 376

Provides extensive regulatory provisions relative to group and individual insurance. In part, measure mandates that group health insurance policies which provide coverage for treatment of alcoholism shall provide coverage whether the insured is in a hospital or in a residential or nonresidential facility certified by the Department of Mental Health.

South Dakota

1986 South Dakota Session Laws, Chap. 419

Revises certain insurance reimbursement provisions and provides peer review for psychologists. Adds psychology to the listing of professions eligible for reimbursement under any insurance policies.

Tennessee

Tennessee SJR 310, passed 1986

Creates a special joint study committee on group insurance benefits for expenses arising from treatment for mental illness, alcoholism, and drug abuse. The findings of the committee will be submitted to the legislature by January 1987.

Texas

S.C.R. 62 - 1985 Legislative Session - passed

Directs the Texas Department of Mental Health and Mental Retardation and the state Board of Insurance to develop a plan for reimbursement of rehabilitative residential programs in lieu of more costly programs, as the lack of adequate funding is a severe barrier to the expansion of community-based services and private insurers tend to favor hospitalization rather than community-based rehabilitative programs.

1985 Texas General Laws, Chap. 805

Requires all group health insurance policies or contracts, including all self-funded or self-insured plans, to provide benefits for the necessary care and treatment of alcohol dependency that are not less favorable than for physical illness generally. Does not apply to those self-funded or self-insured plans with 250 or less employees or members.

Wisconsin

1985 Wisconsin Laws, Chap. 29

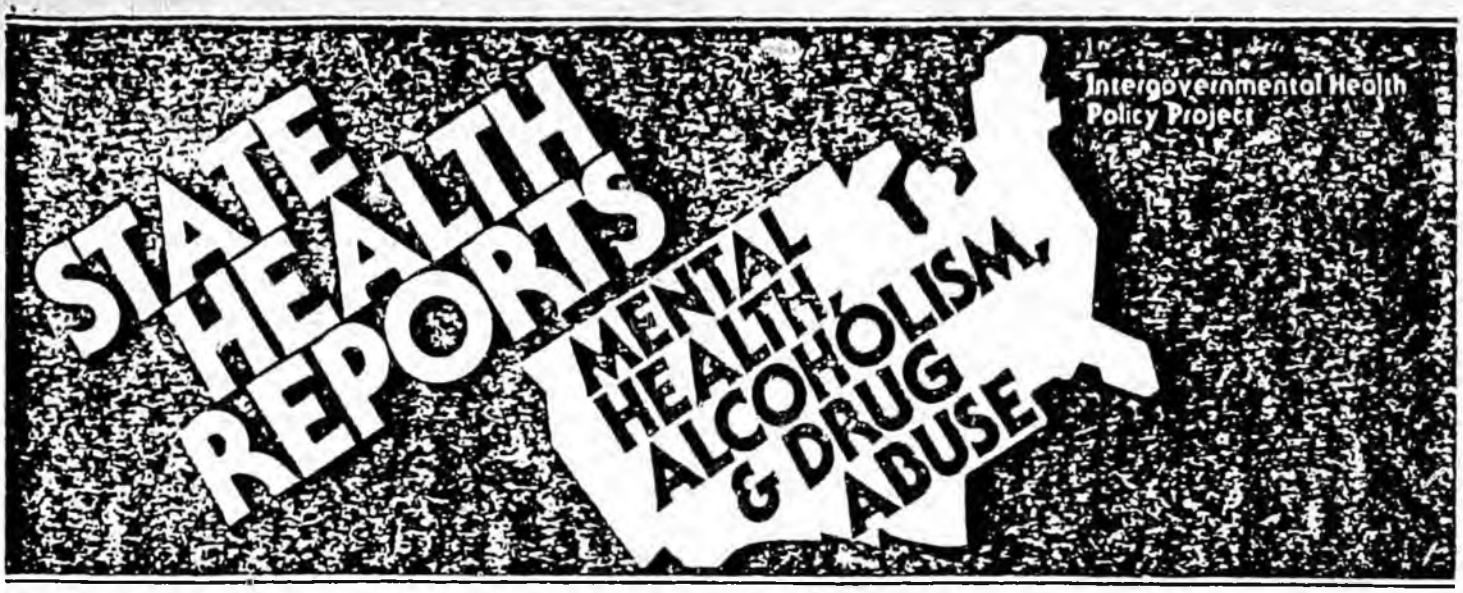
In part, changes the mandated coverage of group insurance policies for nervous and mental disorders, alcoholism, and other drug abuse problems. Group

policies must now include the following coverage: total inpatient and outpatient treatment coverage up to $7000; outpatient coverage up to $1000 minus a copayment of up to 10%; and inpatient coverage must provide not less than the lesser of either the expenses of the first 3 days as an inpatient in a hospital, or the first $7000 minus a copayment of up to 10%.

Wyoming

1985 Wyoming Session Laws, Chap. 45

Provides for freedom of choice of practitioners in private health insurance policies. Requires reimbursement for psychologists on the same basis as physicians.



No. 20 (Special Feature) *January 1986*

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

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

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

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

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

I. INTRODUCTION

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

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

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

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

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

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

II. BACKGROUND

A. Prevalence and Costs

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

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

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

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

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

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

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

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

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

B. Impact of the Federal Employee Retirement Income Security Act of 1974 on Mandated Benefit Statutes

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

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

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

C. Support for Mandated Benefits

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

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

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

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

D. Opposition to Mandated Benefits

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

necessary and appropriate care; and deny flexibility to employers.

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

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

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

III. PRIVATE HEALTH INSURANCE COVERAGE FOR MENTAL HEALTH CARE SERVICES

A. Overview

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

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

B. Existing Coverage

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

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

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

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

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

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

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

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

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

C. Model Benefits

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

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

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

determination of reasonable costs.[15]

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

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

D. Costs and Utilization

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

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

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

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

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

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

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

of total major medical benefit cost.

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

Blue Cross-Blue Shield, in testimony before the Maine legislature, said premium for mandated mental illness coverage increased by $5/month to the average family contract in Kansas, $2 to $3/month in Maryland, and $6/month in Massachusetts.[21]

Offset costs discussed in the introduction are an important component to consider when discussing the costs and utilization of mental illness benefits as are related costs, also discussed earlier. The National Institute of Occupational Safety and Health cites a "conservative" estimate of the costs of executive stress at more than $19 billion; even its "ultraconservative" figure is more than $11 billion.[22]

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

E. Current Status of State Laws Mandating Private Health Insurance Benefits for Mental Health Services

Of the twenty-six states regulating mental health benefits in private health insurance policies, fourteen have "mandatory coverage" statutes, which require insurers to pay for mental health care in certain types of insurance policies. "Mandatory coverage" laws exist in Arkansas, Colorado, Connecticut, Maryland, Maine, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia, and Wisconsin. The remaining thirteen states (California, Florida, Georgia, Illinois, Kansas, Louisiana, ~~Massachusetts,~~ Missouri, New York, Tennessee, Vermont, Washington, and West Virginia) require only that insurance policies "offer" such coverage at the policyholder's option. Connecticut, Maryland, and Virginia, have laws with both mandatory and optional provisions.

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

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

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

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

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

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

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

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

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

SUMMARY OF STATE MANDATES OF MENTAL HEALTH INSURANCE COVERAGE

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Arkansas	MA	1979	Psychological evaluation, counseling psychotherapy or related mental health services are entitled to payment or reimbursed on an equal basis.	Not specified	Reimbursed provided service is provided by facilities licensed as outpatient psychiatric center.	Group, Individual	Psychiatrist, psychologist, licensed outpatient psychiatric centers.
California	MA	1973	Terms of all coverage agreed upon between the group policy-holder and insurer.	Not specified	Terms of all coverage to be agreed upon between the group policy-holder and the insurer.	Group	Psychiatrist, psychologist, licensed marriage, family and counselor, registered registered nurse with a masters in psychiatric mental nursing and 2 years' experience in psychiatric mental health nursing, licensed clinical social worker.
Colorado	MBP	1976	Under basic coverage benefits, 45 days for full hospitalization in one 12 month benefit period. Each day of confinement as an inpatient shall reduce by 1 day the total days available for all other illnesses during the 12 month benefit period. Each day of inpatient care shall reduce by 2 days the 90 days available for partial hospitalization care.	90 days for partial hospitalization in one 12 month benefit period. Each 2 days of partial hospitalization shall reduce by 1 day the total days available for other illnesses during the 12 month period. Each 2 days of partial hospitalization care shall reduce by 1 day of the 45 days available.	Under major medical coverage benefits cover outpatient services furnished by a comprehensive health care service corporation, CMHCs. Copayment should not exceed 50%, up to $1,000. Deductibles shall not differ from the deductible amount for any other condition or illness.	Group	Psychiatrist, psychologist, hospital or psychiatric hospital; comprehensive health care service corporation, a community mental health center or other mental health clinics under the supervision of a licensed psychiatrist or psychologist.
Connecticut	MBP	1971	60 days per year in any hospital.	120 days. An exchange exists with inpatient benefits under the following (1) if the cost does not exceed 50% of the cost of 1 inpatient day at the average semi-private rate at the hospital, 2 sessions of partial equal 1 inpatient day; (2) if the cost/session exceed 50% of the cost of an inpatient day each session shall equal 1 inpatient day.	After major medical deductible, copayment of 50% up to $1,000. Additional benefits up to $2,000 shall be provided at the option of the group policy-holder.	Group, Individual	Psychiatrist, psychologist, MSW, (under the supervision of a licensed physician or psychologist) in a child guidance clinic, non-profit community mental health center, non-profit licensed adult psychiatric clinic operated by an accredited hospital.
Florida	MA	1976 Amended 1983	30 days per year.	If partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, total benefits paid should not exceed the cost of 30 days of inpatient hospitalization.	$1,000 per year	Group	Psychiatrist, psychologist, licensed mental health professional.

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MBP: Mandated Minimum Benefit Package

Produced for the APA National Education Program by GLS Associates, Inc., Philadelphia, PA, September 1985.

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Georgia	MA	1984	30 days per year under an individual policy and 60 days per year under a group policy.	Not specified	48 visits per year under an individual policy and 30 visits per year under a group policy.	Group, Individual	Not specified
Illinois	MA	1975 Effective 1977	Coverage for inpatient on par with physical benefits, but not more than 50% deductible for all expenses with an annual limit of the lesser of $10,000 or 25% of the lifetime policy.	Not specified	Cover for outpatient on par with physical benefits, but not more than 50% deductible for all expenses with an annual limit of the lesser of $10,000 or 25% of the lifetime policy.	Group, Individual	Psychiatrist, psychologist.
Kansas	MA	1978	30 days per calendar year.	Not specified	Coverage for the first $100 and 80% of the next $500 per year.	Group	Psychiatrist, psychologist, community mental health center or clinic, psychiatric hospital.
Louisana	MA	1975	Benefits on par with those offered for other illnesses.	Not specified	Benefits on par with those offered for other illnesses.	Group	Psychiatrist, psychologist, board certified social social worker in consultation with a physician.
Maine	MBP	1983	At least 30 days per year with a 20% co-payment and a lifetime limit of $25,000.	$100 deductible, 50% copayment with an annual limit of $1,000. Lifetime limit of $25,000.	$100 deductible, 50% copayment with an annual limit of $1,000. Lifetime limit of $25,000.	Group	Psychiatrist, licensed psychologist, an accredited public or psychiatric hospital and community agency under the supervision of a psychiatrist or licensed psychologist.
Maryland	MBP/MA	1974	MBP: 30 days per year in any hospital.	MA: 30 partial hospitalization treatment days per year.	MBP: after major medical deductible copayment can be no less than 50%.	Group (MBP & MA) Individual (MBP).	Psychiatrist, psychologist, social worker.
Massachusetts	MBP	1973	60 days in any hospital; on par with other illnesses.	Not specified	$500 per year	Group, Individual	Psychiatrist, psychologist, licensed clinical social social worker, comprehensive health service organization, licensed or accredited hospital, community mental health center or clinic.
Minnesota	MBP	1975	Not specified	Not specified	All group policies providing benefits for mental or nervous disorder treatment in a hospital shall also provide coverage to at least 80% of the first $750 per year while the insured person is not a bed patient in a hospital.	Group	Psychiatrist, psychologist, licensed or accredited hospital, community mental center or mental health clinic approved or licensed by authorized state agency.
Missouri	MA	1980	30 days per year; on par with other illnesses.	Not specified	Copayment no greater than 50% up to $1,500 or 20 sessions. Frequency of psychotherapy sessions may be limited but benefits shall be available for at least one session during any 7 consecutive days.	Group, Individual	Psychiatrist, psychologist.

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Montana	MBP	1983	Under basic inpatient expense policies, benefits are no less than 30 days per year. Under major medical policies, no less than 30 days per year and if inpatient benefits are provided beyond 30 days, the durational limits, dollar limits, deductibles and copayments need not be the same as applicable to physical illness generally.	Not specified	Copayment no greater than 50% or the coinsurance factor applicable for physical illness generally, whichever is greater and the maximum benefit for mental illness, alcoholism and drug addiction in the aggregate during the benefit period may be limited to not less than $1,000.	Group	Psychiatrist, psychologist, social worker, mental health treatment center.
New Hampshire	MBP	1973	Benefits on par with benefits for other illnesses for service in a licensed or general hospital. Major medical coverage may be limited to $3,000 per individual and a lifetime maximum of of $10,000, per individual. Allowable days not specified.	Partial hospitalization is covered under major medical expenses but the extent of coverage is not specified. Allowable days not specified.	Benefits should be at least as favorable as those which apply to the benefits for the treatment of other illnesses. Non-major medical policies must cover 15 hours of care after the first 2 visits. Allowable days not specified.	Group	Psychiatrist, psychologist, licensed pastoral counselor, mental hospitals, licensed licensed or general hospitals, community mental health center, psychiatric residential program.
New York	MA	1977	30 days per year in a general or mental hospital.		$700 per year deductibles and coinsurance on par with other benefits.	Group	Psychiatrist, psychologist, social worker.
North Dakota	MBP	1975	70 days per year for a licensed hospital. Each day of inpatient treatment shall be equivalent to 2 days of partial hospitalization.	140 days partial hospitalization per year. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment.	Not specified	Group (more than 50 persons with 70% of group participating).	Psychiatrist
Ohio	MBP	1978	Not specified	Not specified	$350 per year subject to reasonable deductibles and copays.	Group	Psychiatrist, psychologist, accredited hospital or community mental health facility.
Oregon	MBP	1984	No more than $7,500 in any 24 consecutive month period for inpatient care and treatment in hospitals. No more than $3,000 in any 24 consecutive month period in residential facilities. Within this $3,000 limit, payment shall be made for either full-day supervised residential or part-day treatment.	Part-day treatment on an organized, formal, regularly scheduled basis consisting of at least 4 hours of structured treatment per day, for at least 4 days each week. Shall be no more than $3,000 in any 24 consecutive period. Within this $3,000 limit, payments shall be made for either part-day or full-day residential treatment. Part-day treatment less than 4 hours of treatment per day for at least 4 days each week, is covered as outpatient treatment.	No more than $2,000 in any 24 consecutive month period.	Group	Psychiatrist, psychologist, nurse practitioner, clinical social worker, health facilities, residential facilities or inpatient services.

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Produced for the APA National Education Program by GLS Associates, Inc., Philadelphia, PA, September 1985.

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
North Dakota	MBP	1975	70 days per year for a licensed hospital. Each day of inpatient treatment shall be equivalent to 2 days of partial hospitalization.	140 days partial hospitalization per year. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment.	Not specified	Group (more than 50 persons with 70% of group participating).	Psychiatrist
Ohio	MBP	1978	Not specified	Not specified	$350 per year subject to reasonable deductibles and copays.	Group	Psychiatrist, psychologist, accredited hospital or community mental health facility.
Oregon	MBP	1984	No more than $7,500 in any 24 consecutive month period for inpatient care and treatment in hospitals. No more than $3,000 in any 24 consecutive month period in residential facilities. Within this $3,000 limit, payment shall be made for either full-day supervised residential or part-day treatment.	Part-day treatment on an organized, formal, regularly scheduled basis consisting of at least 4 hours of structured treatment per day, for at least 4 days each week. Shall be no more than $3,000 in any 24 consecutive period. Within this $3,000 limit, payments shall be made for either part-day or full-day residential treatment. Part-day treatment less than 4 hours of treatment per day for at least 4 days each week, is covered as outpatient treatment.	No more than $2,000 in any 24 consecutive month period.	Group	Psychiatrist, psychologist, nurse practitioner, clinical social worker, health facilities, residential facilities or inpatient services.
Tennessee	MA	1974	Not mandated	Not mandated	30 visits per year copays and deductibles on par with physical illnesses.	Group, Individual	Psychiatrist, psychologist, community health center with an approved plan for quality assurance, accredited hospitals.
Vermont	MA	1975	45 days per year in a general or mental hospital.	45 day equivalents of active care per year.	100% of the first 5 visits and 80% thereafter up to $500 per year.	Group	Psychiatrist, psychologist, licensed mental health professional, licensed general or mental hospital or community mental health centers.
Virginia	MBP/MA	1975	MBP: 30 days per year in a mental or general general hospital includes benefits for drug and alcohol rehabilitation and treatment with respect to drug and alcohol rehabilitation only. There is an $80 per day indemnity benefit and a lifetime coverage of 90 days.	Not specified	MA: $500 per year with reasonable deductibles and coinsurance that are not less favorable than physical illnesses, except that the copayment not exceed 50% up to $1,000 per benefit period.	Group, Individual	Psychiatrist, psychologist, licensed clinical social worker, mental health treatment center.
Washington	MA	1983					

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MBP: Mandated Minimum Benefit Package

Produced for the APA Division 39 Education Program by GLS Associates, Inc., Philadelphia, PA, September 1985.

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
West Virginia	MA	1977	45 days per year in a mental or general hospital; on par with illnesses in a general hospital.	Not specified	50% copayment up to $500 per year; sessions cannot exceed 50 per year.	Group, Individual	Psychiatrist, psychologist, licensed or accredited general mental hospital, comprehensive health service organization, community center or clinic.
Wisconsin	MBP	1975	Not less than the lesser of either the expenses of the first 30 days as an inpatient in a hospital, or the first $7000 minus a copayment of up to 10%.	Not specified	Up to $1000 minus a copayment of up to 10%.		Psychiatrist, psychologist, hospital, residential facility, outpatient treatment facility.

Total inpatient and outpatient treatment coverage up to $7000. The Department of Health and Human Services is required to review coverage amounts every three years and may recommend increases to the governor.

MA: Mandated Availability
MBP: Mandated Minimum Benefit Package

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MANDATED MENTAL HEALTH INSURANCE

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LEGISLATION INDEX DATA ENTRY FORM

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State MD Chapter/Bill ~~Chap.~~ HJR 29 Year 87 Available N

Summary: 1987 Md. Laws, H.J. Res. 29 establishes the Governor's Task Force on Mandated Health Insurance Benefits to investigate the impact of mandated benefits on the people of Maryland and to develop a coherent policy and statutory structure of mandated benefits. The task force is to report to the governor and the Legislative Policy ~~Task~~ Committee by November 1, 1987.

... should be mandated to offer the option of benefits for home health care.

PA 1986 Pa. Laws, Act 89 (SB 293) establishes the Health Care Cost Containment Council and authorizes it to contract with a Mandated Benefits Review Panel to review legislative proposals for mandated health insurance coverage or health benefits. The panel is to report to the council about the social and financial impact and medical efficacy of each proposal. The council must report its recommendations about the proposals to specified legislative and executive branch officials.

PA 1986 Pa. Laws, Act 64 (SB 935) requires that insurance policies, excluding Medigap policies, and HMOs provide coverage for alcohol abuse and dependency and specifies that deductibles or copayments for the first instance or course of treatment can be no more than those imposed for

Mandated Mental Health Benefits in Private Health Insurance

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Abstract. Eleven states mandate coverage of inpatient and outpatient mental health care in private health insurance. Health insurers have objected to these laws on the grounds that they interfere with consumer choice of health insurance benefits and are too costly. This paper analyzes the benefits and costs of mandates for psychotherapy. The potential benefits considered have to do with adverse selection in insurance markets and the offset effects of psychotherapy. Arguments based on economic efficiency are presented to justify the possible appropriateness of overriding individuals' choice of health insurance benefits. Mandates are estimated econometrically to increase the cost of psychotherapy in a state by about 10-20 percent. We conclude that mandates for mental health benefits in private health insurance may be reasonable state policy.

I. Introduction

Many states require insurers to include specified benefits in health insurance policies issued to their residents. Most common are mandated coverage for newborn care (37 states) and for physically handicapped and mentally retarded children (13 states).[1] Eleven states mandate coverage for inpatient and outpatient mental health care.[2] In general, state specification of the contents of health insurance policies has met some resistance

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from insurers, firms, and organized labor; but among the specific categories of benefits, mandates for mental health care have generated by far the most controversy.

Massachusetts is a case in point. Since January 1976, Massachusetts has required insurers: (1) to pay for 60 days of inpatient care per year in mental hospitals; (2) to cover inpatient care in a general hospital for mental conditions at the same level as physical illness; and (3) to pay for outpatient benefits of $500 per year when provided by a licensed facility, a licensed psychologist, or a physician who "devotes a substantial portion of his time to the practice of psychiatry."[3] In a campaign to change the law, Blue Cross and Blue Shield of Massachusetts issued a series of special reports on the cost of coverage under the mandates.[4] The Blues reported that their payments under group contracts for outpatient mental disorders rose from $.5 million per quarter in 1975 (before the mandate), to $7.0 million per quarter in 1979.[5] (This is a highly misleading estimate of the "cost" of the mandate, as we will discuss in more detail below). Other insurers in Massachusetts simply refused to offer the coverage. Metropolitan Life Insurance Company, and Travelers Insurance Company have only recently begun compliance with the statute under an injunction issued in a lawsuit filed by the Massachusetts Attorney General in June 1979.[6]

Mandates for mental health coverage have been subject to legal challenge in Maryland and New Hampshire. Other states are considering whether to implement or to remove mandates for mental health services. Given the emerging importance of state mandates in health policy, and special concerns about mandates for mental health care, it seems appropriate to consider whether mandates for mental health care represent good law and good policy.[7]

A state is constitutionally permitted to interfere with insurance contracts only if the regulation serves a legitimate state interest in the health and welfare of its citizens. (For a summary and evaluation of legal challenges to mandated mental health benefits, see Appendix A.) In the jargon of policy analysis, this might be cast as a question of the benefits—or perhaps of the relative costs and benefits—of the mandates. Courts are, of course, ill-equipped to make these comparisons; and indeed, in the absence of convincing evidence to the contrary, courts generally presume that legislative bodies have acted in the public interest. It is on the basis of this presumption that legal challenges to state mandates have failed.[8]

This paper discusses the benefits and costs of mandated mental health benefits independent of the presumption that the current policy in a state has special status. Section II presents the arguments why adverse selection in insurance markets, and external or offset effects of psychotherapy may justify mandates. Section III, based upon the experience of states

with mandates, estimates the cost of mandated coverage for psychotherapy. Conclusions are drawn in Section IV.

II. The Benefits of Mandated Mental Health Insurance

The obvious effect of a mandate is to *force* people to buy insurance for mental health coverage. Why should the state force purchase of mental health coverage, when, without a mandate, an individual or group of individuals is free to negotiate its purchase with an insurer? If markets for mental health insurance coverage function well—in particular, if sellers of insurance price at cost, and if buyers of insurance are well-informed and accurately take into account the benefits to themselves and others in their decisions to purchase—then the policy of state interference with exercise of individual choice in insurance markets has little appeal. There are reasons to think, however, that markets for mental health insurance do not fully meet these exacting standards. Consideration of shortcomings in the market for mental health insurance, and how these relate to the case for mandated coverage, is the task of this section.

Two potential problems with markets for such insurance—both correctible by mandates—readily come to mind. The first is that individuals, or groups acting on behalf of individuals, may be ignorant of or unwilling to recognize the benefits of mental health services and insurance coverage. Prejudice against treatment for mental conditions has been widely noted.[9] Mandates counter any tendency to undervalue mental health services. In a state with a mandate, the health insurance plan automatically "subsidizes" an individual's purchase of mental health services. Second, many citizens may be concerned that everyone have access to mental health care. Mandates may reflect a general belief in a state that all should have the ability to pay for a minimum level of mental health services (whether or not they would choose to do so).

Although these two issues may be quite important for policy, little more can be said about them. Their importance is difficult to assess without evidence, first on the extent to which individuals are ignorant of or deny the benefits of mental health services, and second on the degree of concern for others' access to mental health care. For the rest of this section, therefore, we discuss in detail two additional arguments for mandates for which more evidence is available. These arguments are based on the problem of adverse selection in insurance markets, and on the offset effects of psychotherapy.[10]

Adverse selection

Insurance is priced according to the average behavior of groups. Prices or premiums will be the same for all members of a union, residents of a

state, or some other group in which an individual is classified. Often, the members of a large group will be sub-classified for pricing purposes into smaller groups by age, sex, and health at the time they select a policy. But the fact remains that among, say, all Massachusetts males aged 40-50 in good health, there will still exist significant differences in the degree of risk that the insurer incurs with each individual policy, even though the insurance premium for each member of this group must be identical.

The premium charged to the good risks in a pool is thus "too high" in the sense that it exceeds the premium the insurer must charge to cover costs, including administrative cost and return on investment. For the bad risks in the group, the premium is similarly "too low." Coverage at this premium, then, is a bad buy for the good risks, and a good buy for the bad risks. As a consequence, in a voluntary system the good risks will decline to buy coverage more frequently than the bad risks. This gives "adverse selection" its name: in a voluntary system, when premiums must be set according to the behavior of groups, an insurer draws not the typical or average range of group members, but an "adverse selection" of the risks.

Note that the good risks may not be declining coverage because they are unwilling to pay a premium equal to the expected costs an insurer would incur by covering them. They are declining coverage at a premium that is too high because of the insurer's inability to discriminate fully among degrees of risk. The preferences of the good risks are frustrated by a voluntary system that presents them with inappropriate prices.

Adverse selection can severely limit the amount of insurance coverage provided in a market. The insurer drawing an adverse selection of risks will be led to raise premiums to cover costs, a pricing strategy that is likely to be self-defeating. As premiums are raised in a voluntary system, some policyholders will drop their coverage. Those who do so will tend to be among the better risks of the group that chose coverage in the first place. Raising the premium thus leads to a further deterioration in the risk pool and to higher cost per insured. In the extreme, there may be no premium the insurer can set to cover costs for those who would choose coverage at that premium. This may be true even when all consumers are sufficiently risk-averse that they would buy coverage at expected cost, which equals actuarially fair premiums plus the usual industry loading charge.[11]

Competition among carriers can further darken the picture in the presence of adverse selection. Suppose a carrier has been able to sell insurance to some part of a population. A competitor may adopt the strategy of trying to attract the good risks from among those who chose the first carrier's policy. This can be done by offering slightly less coverage at a lower premium. The good risks are more likely to find this attractive, and as they desert the original carrier they undermine the viability of the original insurance package. The first carrier may be forced to react by cutting coverage in order to avoid being stuck with the poorest risks in the pool, starting a new cycle of coverage reductions.[12]

Adverse selection is present to some degree in all markets for insurance. It is more serious in some situations than in others. The essential ingredients for adverse selection are two. First, premiums must be set for a group, a condition which is virtually always met. Second, members of the group must differ in their degree of risk, they must *know* that they differ, and they must be prepared to act on their knowledge. This second ingredient is present in many of the categories of mandated coverage. Consider the most commonly mandated coverage, services to newborns. These expenses can be a significant financial risk, against which policyholders would presumably be willing to insure. The problem is that many people who are going to have children plan for it in time to select the most favorable coverage. Suppose one insurance company offers coverage for newborn care and a competitor does not. All those subscribers planning families (the "bad risks") will choose the first policy, while those who do not anticipate having children (the "good risks") will choose the competitor's policy. Any insurer venturing unilaterally into covering newborn care will attract a disproportionate share of the bad risks. The crucial second ingredient is present in coverage for mental health services as well: people differ widely in the likelihood that they will use mental health services, and many seem to have a good idea of the likelihood that they will use the benefit.

The problem of adverse selection presents itself in another way when the individual does not make a direct choice of health insurance coverage, but is included automatically in a group plan offered through employment. When employees know they differ in risk and pay the premium appropriate for the average group member, there is likely to be a substantial majority of members of the employee group opposed to mental health benefits, even if all employees would be in favor of coverage if the benefit were priced according to each individual's risk. Riders for mental health benefits may be rejected by representatives of the "good risk" majority asked to pay prices above their actuarial cost.

Evidence of adverse selection may appear when individuals are observed making choices among options for insurance coverage. Federal employees are served by the widest choice among health insurance options of any major group of employees in the U.S., and their behavior is one of the few sources of evidence for adverse selection. Federal employees choose among two Blue Cross/Blue Shield plans and an Aetna plan that are offered nationally, and, within any region, among local plans including health maintenance organizations. During the early 1970s both Aetna and Blue Cross/Blue Shield featured very generous coverage for outpatient psychotherapy, equal to coverage for ambulatory medical treatments. Aetna's plan, not confined to "usual, customary and reasonable" reimbursement levels, offered the most generous coverage. In a

review of its claims experience for mental and nervous conditions for 1973, Aetna attributed its high costs to drawing an adverse selection of federal employees.[13] Aetna's response to this was to impose a limit of twenty visits per year on its outpatient coverage for mental and nervous disorders. Many of the "bad risks" among federal employees apparently responded by leaving the Aetna plan and migrating to Blue Cross. In the year after Aetna's cut in benefits, Blue Cross saw the percentage of total benefits going for psychiatric care jump significantly for the first time in four years.[14] More recently, Blue Cross has reduced its coverage for outpatient psychotherapy by increasing the coinsurance rate for this benefit. There can be no doubt that adverse selection led to a reduction in the insurance coverage for psychotherapy for federal employees.

Adverse selection presents an opportunity for constructive intervention by the state. It may well be that everyone would buy reasonable insurance for the service in question—for example, mental health care—but cannot because no insurance company could offer such insurance without being victimized by adverse selection. The government can improve the situation by forcing all insurers to offer a minimum level of coverage, and thus preventing them from competing to attract only the good risks by reducing coverage below this amount. Adverse selection changes the perspective on a mandate. Far from violating consumer sovereignty, the state may be taking steps to implement it.[15] *The state mandate may more closely approximate the result that would have occurred in a market had insurers been able to price their product in accordance with the appropriate degree of risk of each enrollee.* Everyone may be "forced" to buy coverage more closely approximating that which they would have bought had markets been working well.

The mandate "solution" to the problem of adverse selection is not without its problems, however. First, how does one know, in the absence of a market test, that the state has mandated the correct level of benefits? Second, although mandated benefits may give people the coverage they would have purchased had markets been pricing efficiently, the mandated coverage must be financed by the usual system of pricing, where some people pay more than is justified by their likely costs and some pay less. Thus some people (the good risks) will feel imposed upon by this mandate: they would rather have the money than the coverage. This does not negate the fact that they are still getting the efficient coverage (that which they would have bought had prices been correctly set); but it does indicate that the mandate distributes the financing of that coverage in favor of the bad risks. This redistribution from the "healthy" to the "sick" cannot be judged on efficiency grounds, but only on political grounds: it is a redistribution that may not be objectionable. Finally, the intention of the mandates will be frustrated if people decline to buy health insurance after a rise

in premiums caused by mandates. Although it seems highly doubtful that the added cost imposed by a mandate would lead many individuals to forego insurance against health costs, mandates may be contributing to a trend toward self-insurance among large firms, since employer self-insurance plans are sheltered from direct state regulation by the Employee Retirement Income Security Act of 1974.

"Offset effects" of psychotherapy

For a market to work well, a consumer should take into account all of the benefits from purchase. If the consumer receives directly only part of the total benefits accruing to society, then he or she underestimates the social value of the purchase and may not buy "enough." In these circumstances, society may want to step in to encourage the individual to buy more, either by subsidizing purchase of the service or by requiring the individual to buy a certain amount.

There can be little doubt that the benefits and costs of treatment for mental illness extend beyond the individual "consumer" of mental health services—beyond the patient and his or her family. One obvious way in which some benefits of treatment for mental conditions are external to a patient is when others care about his or her well-being. But although compassion may play a large role in mental health policy, we will stress here another external benefit of mental treatment, the so-called "offset effect" resulting from mental health treatment and particularly from psychotherapy. Our society's system for funding medical and other social services means that every individual's decision about treatment has financial implications for many other people.

We pay collectively for treatment of mental illness. In 1975, 800,000 mentally ill were treated in mental hospitals, 900,000 in general hospitals, 350,000 in VA hospitals, 200,000 in nursing homes, and 13,000,000 by physicians other than psychiatrists, at a total cost of about $15 billion.[16] Mental illness is also dealt with by various social agents other than health personnel, including police and welfare agencies. Taxes support social services and VA hospitals; taxes and insurance premiums together pay for 90 percent of hospital expenses and 70 percent of physicians' charges. Even productivity lost due to mental illness is borne in part by all workers in the form of lower wages. It is simply incorrect to think that any individual can avoid paying part of the cost of mental illness. Our collective method of payment for most of health and social services builds in interdependencies. Each of us has a financial stake in treatment of others' mental illness.

An "offset effect" occurs when use of mental health services leads to a reduction in use of other health or social services. The existence of offset

effects can be anticipated based on the well-recognized interrelationships between mental health and general health, and between mental health and other social problems. Mechanic, for example, has observed: "[Mental health] problems are common and are often associated with physical symptoms and discomforts. . . . The distress associated with these patients' problems triggers a demand for medical services, and such patients are often recipients of intensive medical and surgical care that achieves little value."[17] Epidemiological data reported by the President's Commission on Mental Health (PCMH) show that at least 6 percent of the people who see a doctor other than a psychiatrist have a primarily psychological problem, and many more have psychological problems contributing to their feeling of ill health.[18] Sometimes these people are treated appropriately by their physicians, but sometimes the treatment is not appropriate. The PCMH concludes that most physicians are not adequately trained to be able to recognize and treat psychological problems. Direct treatment of the psychological problems and the psychological component of illness may lead to fewer demands on the rest of the health system. In discussion of mandates for coverage of $500–$1000 of services, it is the possible offset effects of short-term psychotherapy that are relevant.

Although offset effects seem highly plausible, their quantitative magnitudes have not been established. Indeed, in spite of the established clinical interrelation between health and mental health, the research literature has failed even to establish unambiguously the *existence* of an offset on other medical costs. In a thorough discussion of the literature, Jones and Vischi found evidence for offset effects in 24 of 25 studies of alcohol, drug-abuse, and mental health treatment, with magnitudes ranging from 5 to 80 percent reduction in medical utilization.[19] Virtually all of those studies were of short-term psychotherapy. Near unanimity is rare in a research literature. But for the deficiencies in the research designs of these studies,[20] the existence of an offset effect of short-term therapy would be regarded as well-established. In addition, the research investigating offsets has, primarily, been confined to health maintenance organizations, community mental health centers, or clinics in industry. The response of medical utilization to psychotherapy provided in the fee-for-service sector, where most treatment occurs, may be different.[21]

In interpreting this evidence for offsets, it is important to keep in mind the different perspectives the scientist and the policymaker or legislator must bring to the question of evidence. Science is very conservative. For evidence to provide convincing support for a new idea, such as the idea that treatment for mental conditions reduces other health costs, the researcher is required to exclude other possible explanations for the effect by the use of "controls" in the study, and to reduce the possibility that the effect could have been the result of chance variation in the sample to less

than 5 percent. If these criteria are not met, scientists remain skeptical of the hypothesis. This is appropriate when the activity in question is "hypothesis testing."

Legislatures, for their part, have less interest in hypothesis testing. They need to know if an idea is *likely* to be correct, rather than whether an hypothesis can be accepted within standards of scientific evidence. It would be a far too conservative approach to legislative action to require that all policies be demonstrated to be effective to the usual standards of scientific proof.

Adopting the perspective of the lawmaker, how likely is it that offset effects exist? First, before any explicit empirical tests of offset are considered, there are powerful reasons, related to the nature of physical and mental illness and the reasons people seek medical care, to expect offsets to exist. Second, although no one study fully meets scientific standards for research design, as a body of work the offset studies should probably be given considerable weight. Although design flaws generally had the effect of biasing findings in favor of finding an effect, other problems in these studies—notably problems associated with measurement error—tend to bias the results against a finding of offset.[22] Efforts to improve research methodology should certainly proceed; but, in the meantime, it is reasonable to expect that psychotherapy leads to some reduction on other medical costs.

To sum up the discussion in this section, adverse selection and offset effects of psychotherapy may mean that too little insurance for mental health services would be purchased when choice of insurance is voluntary. In the case of adverse selection, this is because insurers are incapable of pricing insurance for mental health to reflect an individual's true expected cost. Premiums are "too high" for many people, inappropriately discouraging purchase. In the case of offset effects, the mandate, by providing insurance, serves to subsidize an individual's purchase of a service which yields financial benefits to others.

III. Costs of Mandated Mental Health Benefits

The most frequent argument against mandates for mental health benefits is that they would be costly. Of particular concern is the cost for coverage of outpatient psychotherapy. Research on the influence of insurance on demand for psychotherapy supports the fear that introduction of insurance coverage would lead to large increases in use of psychotherapy. In a review of the limited literature on financing and demand for mental health services, McGuire concluded that the price-elasticity of demand for

psychotherapy is probably between one and two.[23] Research on the elasticity of demand for psychotherapy is of little direct help in estimating the costs of mandates, however, since a central feature of all mandates is a limit on the total coverage—usually $500. A study of the outpatient mental health utilization of enrollees in the Blue Cross and Blue Shield Plan for Federal Employees found that cutting off coverage at 10 visits (corresponding roughly to $500 of coverage) was a very effective check on demand, eliminating 74 percent of the covered visits.[24] Strict limits on coverage were probably made part of mandate legislation because of fear of large cost increases. In addition, strict limitations on coverage can be justified by reference to the literature on the effectiveness of psychotherapy, which provides stronger support for short-term therapy.[25]

Specific estimates of the cost of mandates for mental health have, to date, been derived from the experience of insurance carriers. In 1979, Blue Cross and Blue Shield of Massachusetts covered about 3,000,000 persons and paid out about $29,800,000 per year for outpatient psychotherapy. An estimate of the gross cost of the outpatient portion of the mandate to Blue Cross and Blue Shield, based on those figures, would be about $10 per person per year. It has been difficult to put together comparable estimates for costs to third-party payers in other states. GLS Associates have recently completed a study of mandates for the National Institute of Mental Health, but they were unsuccessful in attempts to extract data on costs from insurers.[26]

There are numerous reasons why it can be misleading to focus on costs to an insurer when evaluating the cost of a mandate. First, costs of psychotherapy are rising everywhere, with or without mandates, both because of increases in demand for psychotherapy and because of increases in the price of care. Some part of the cost increases seen in Massachusetts before and after the mandate would have occurred anyway, even if the mandate had not been imposed. General trends cannot be separated from impact of the mandate in data reported by a single insurer. Second, in addition to increasing costs, a mandate shifts the locus of the final payment for costs. There is a shift from out-of-pocket payments to payments by insurers, and a shift from the state (which may support mental health services in community agencies) to insurers. Although these shifts may be significant, they do not represent net increases in costs due to the mandates, only shifts in the way these costs are finally paid. Finally, focusing on a single insurer ignores any impact on cost of switches in contracts from one insurer to another after a mandate.

The true cost of the mandate is the *increase in resources being used in a state because of the mandate*. In the remainder of this section, we compare the experience of states with and without mandates in order to estimate the net increases in use of outpatient psychotherapy due to the

mandates. Our method takes advantage of the following relationship: if passage of a mandate has led to a large increase in the amount of psychotherapy *consumed* by a population, then there must have been a correspondingly large increase in the amount of psychotherapy *supplied* by mental health professionals, primarily psychiatrists and psychologists.

Table 1 compares the rates of growth in the numbers of psychiatrists and child psychiatrists in office-based practice between 1976 and 1978 in states that did and did not pass a mandate between 1974 and 1976. Although changes in the stock of providers will not be identical to changes in the flow of services, the two changes ought to be closely related. The purpose of the comparison is to see whether recent passage of a mandate is associated with unusually large increases in the number of psychiatrists. As the table shows, in states recently passing a mandate the rate of growth of psychiatrists was about 7 percent higher than in other states. This estimated difference is small, however, in relation to the general variance in growth rates, so it cannot be concluded with confidence that the passage of mandates had any effect on the growth in numbers of psychiatrists.

Table 1. Percentage Growth in Numbers of Psychiatrists and Child Psychiatrists in Office-Based Practice, 1976 to 1978

		Mean Percent Growth[b]	Standard Deviation
Group 1:	States (7) putting mandates into effect between 1974 and 1976[a]	31.1	38.5
Group 2:	Other states (43)	23.6	31.9
	All states	24.7	32.5

t-statistic testing difference of means between group 1 and group 2:
$t = .526$, insignificant at 10% level in a one-tailed test.

a. Colorado (1976), Maryland (1974), Massachusetts (1976), Minnesota (1975), New Hampshire (1975), North Dakota (1975) and Wisconsin (1975). Connecticut passed a mandate in 1971, and is included in Group 2.

b. Differences in growth were reduced when states in each group were weighted by 1978 population. The results for this comparison were:

	Mean Percent Growth	Standard Deviation
Group 1	20.0	19.9
Group 2	15.7	15.0
All states	16.1	15.7

Source: AMA, *Physician Distribution and Medical Licensure in the U.S.*

Table 2 makes a similar comparison for psychologists (actually, members of the American Psychological Association who identify themselves as health service providers).[27] Recent passage of a mandate is associated with a much higher growth in the number of psychologist health service providers—51 percent vs. 19 percent—and this difference is statistically significant. It is not surprising that supply of psychologists is more responsive to a mandate than supply of psychiatrists.[28] It is much more common for psychiatrists' services to be covered in health insurance policies in the absence of mandates; thus a mandate requiring coverage for services of both professionals will increase the amount of insurance coverage much more dramatically for the services of psychologists in the state. Also, the supply of psychologists as health service providers may be more responsive in the short run than is the supply of psychiatrists. Although

Table 2. Percentage Growth in Numbers of American Psychological Association Health Service Providers, 1976 to 1978, in States With Population 2,000,000 or Greater as of 1976

		Mean Percent Growth[b]	Standard Deviation
Group 1:	States (5) putting mandates into effect 1974 and 1976[a]	40.8	8.8
Group 2:	Other states (27)	19.4	25.5
	Groups 1 and 2	24.3	26.3

t-statistic testing difference of means between group 1 and group 2:
$t = 2.44$, significant at the 5% level in a one-tailed test.

a. Colorado (1976), Maryland (1974), Massachusetts (1976), Minnesota (1975), and Wisconsin (1975).

b. When states were weighted by 1978 population, the results changed little:

	Mean Percent Growth	Standard Deviation
Group 1	49.9	8.0
Group 2	20.5	18.1
All states	23.7	19.6

Source: American Psyc[illegible] Association, Human Resource Surveys for 1976 and 1978. The Human Resou[illegible] is a weighted sample of 10,000 psychologists. Weights and sample [illegible]sponse are [illegible]count of in our estimates of percent growth. Growth in small states cannot be reli[illegible]stimated from this information so they are dropped from the comparison. In addition, there is no data on psychologists in Florida for 1976 so this state was also not included.

most psychologists who provide health services have training in clinical or counseling psychology, such specialization is not required to obtain a license or certification. Psychologists with other backgrounds and experience may shift into clinical practice as the opportunities there are widened by increased insurance coverage.[29] Unfortunately, data are unavailable to make this comparison for other mental health professionals who may provide psychotherapy under supervision of a psychiatrist, especially psychiatric social workers.

Mandates, are, of course, only one of the factors that influence the utilization and cost of psychotherapy within a state. In principle, one would want to estimate a system of equations for the demand and supply of psychotherapy, with the presence of a mandate in a state being one of the variables affecting demand. Estimation of such a system is beyond the scope of this paper.[30] We have, however, estimated reduced form equations for services of psychiatrists and psychologists, reported in Table 3. The dependent variable is the logarithm of hours of fee-for-service practice by psychiatrists and psychologists per 1000 (non-HMO) population in 1978. The logarithm form was chosen so that independent variables would have the same estimated percentage effect in every state. The independent variables are expected to influence the demand for psychotherapy, or the attractiveness of a state to providers (or in some cases both). There is, of course, no price variable in the reduced form.

Regression equations (2) and (4) were estimated with data for the 38 states with 1,000,000 or more people in 1978 (to eliminate states with unreliable estimates of psychologists' services). We will be primarily concerned with equations (1) for psychiatrists and (4) for psychologists. Equations (2) and (3) are presented for purposes of comparison.

The first thing to notice about the results in Table 3 is the high explanatory power of the regression equations, one important indication that the relationship specified between the dependent and the explanatory variables is a reasonable one. Percentage of the population living in metropolitan areas, percentage of the population with at least four years of college, per capita income, and the log of the number of psychiatric beds per thousand population are intended to control for the demand characteristics of individuals in a state and for the attractiveness of the state to mental health professionals. No specific interpretation is attached to the estimated coefficients for these variables. Notable, however, are the powerful impacts of high levels of education and unemployment on use of psychiatrists' services.[31]

Three reimbursement and regulation variables were included in the equations. They are the percentage of state population in the Federal Employees Health Benefits Plan (FEHB) or in the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS), whether the state

had a freedom-of-choice (FOC) law in effect in 1978, and whether the state had a mandate in effect in 1978.

The FEHB and CHAMPUS plans together enrolled about 15 million individuals and featured (with the exception of some of the smaller carriers in the FEHB) generous coverage for outpatient psychotherapy in 1978. In the case of psychiatrists the estimated effect of this variable is near zero.

An FOC law requires an insurer offering coverage for mental health services to pay licensed or certified psychologists directly and independently of a physician for services psychologists are qualified to provide under state law. One might have predicted that an FOC law would lead to more psychologists' services in a state, and, because of potential competition between psychologists and psychiatrists, to fewer psychiatrists' services. This hypothesis is not borne out by the regression results shown in Table 3: the presence of an FOC law has a positive estimated effect on services of psychiatrists.[32]

Our major interest is in the estimated effect of mandates. According to equation (1) of Table 3, mandates are associated with a 12 percent higher use of services of psychiatrists in fee-for-service practice. The t-statistic of 1.33 on this estimate is, however, not statistically significant by the usual standards. In the smaller sample of 38 states, the estimated impact of mandates is about 10 percent.

All three regulation and reimbursement variables—percent of population in FEHB or CHAMPUS, the existence of FOC law, and mandates—are estimated to have a positive effect on the use of psychologists' services in fee-for-service practice. The t-statistics are largest for the mandate variable, but even these indicate inaccuracy in the point estimates and only justify low levels of confidence in the hypothesis of positive effect of mandates. According to the estimated coefficients, the presence of a mandate increases the use of psychologists' services by 18–25 percent.

These results suggest two generalizations about the effects of mandates on the use of psychotherapy in fee-for-service practice. First, the impact of the mandates is greater on the practice of psychologists than on the practice of psychiatrists. The point estimates of the effect of mandates in equations (3) and (4) are roughly twice the point estimates in equations (1) and (2). This is as we would expect, since a mandate typically changes insurance coverage for psychologists much more than for psychiatrists. (It should be kept in mind, however, that these coefficients are not estimated precisely; the difference between the two estimates would not pass standard tests of significance.) Second, the mandate appears to increase the use of psychotherapy in fee-for-service practice about 10–20 percent (although this estimate, too, is not precise).[33]

Table 3. Determinants of Use of Psychiatrists' and Psychologists' Services in Fee-for-Service Practice, 1978[a] (t-statistics in parentheses)

	Psychiatrists		Psychologists	
Independent Variables	50 States	38 States[b]	50 States	38 States[b]
	(1)	(2)	(3)	(4)
Percent of population in SMSAs, 1976	.00623 (4.24)	.0283 (1.21)	.00309 (0.92)	−.000165 (0.05)
Percent of adult population with 4 yrs. college, 1976	.110 (6.78)	.112 (5.31)	.0600 (1.61)	.0683 (2.37)
Log of per capita income (in thousands), 1978	−.423 (1.36)	.438 (0.89)	1.12 (1.56)	1.58 (2.36)
Percent unemployed, 1976	.0806 (4.13)	.0660 (3.06)	.0614 (1.37)	.060 (2.03)
Percent of population in FEHB or CHAMPUS, 1978	−.00516 (0.58)	−.00129 (0.14)	.0175 (0.85)	.0137 (0.78)
FOC law (0,1), 1978	.147 (2.08)	.0648 (0.77)	.174 (1.07)	.123 (1.07)
Mandate (0,1), 1978	.123 (1.33)	.0918 (0.88)	.249 (1.18)	.180 (1.26)
Log of psychiatric beds per thousand, 1976	.105 (1.44)	.154 (1.72)	.104 (0.62)	.171 (1.40)
Constant	1.54	.143	−1.11	−1.78
R^2	.853	.866	.500	.756
F	29.84	23.38	5.13	11.23

a. The dependent variables are log of fee-for-service hours of psychologists and psychiatrists per 1000 non-HMO population, 1978. Sources for dependent and regulatory variables are given in Appendix B. More states can be used here than in Table 2 since the regressions did not use data from 1976.

b. States with 1,000,000 or more people, 1978.

On average, Americans spent about $9-10 per person per year on fee-for-service psychotherapy. The Alcohol, Drug Abuse and Mental Health Administration estimates that about $1.8 billion was spent in 1980 for services of office-based psychiatrists and psychologists.[34] In addition, a small part of the $1.6 billion spent for services at Community Mental Health Centers and other outpatient clinics was purchased on a fee-for-service basis.[35] Taking total expenditures on fee-for-service psychotherapy at about $2.0 billion, and a U.S. population of about 220 million, we get roughly $9-10 per capita. In absolute terms, then, a 10–20 percent increase in cost of psychotherapy due to a mandate corresponds to about $1–2 per capita.

This $1–2 is an estimate of the total net increase in use of resources due to the mandate. A number of points can be made about this estimate to clarify its meaning. From the point of view of an insurer, it *overstates* the new cost due to a mandate to the extent that some of the new cost is borne by individuals in the form of deductibles, copayments, or payments after limits have been exceeded. But probably more importantly, it *understates* the new cost to insurers to the extent that old costs are shifted by the mandate—either from existing users of service newly covered or from state budgets. The $1–2 per person per year is thus not put forward as an estimate of the increase in premiums an insurer must charge.

It should also be noted that this estimate applies to the effect of a mandate on the resource use in a single state enacting a mandate. For this "marginal" calculation, the supply of services is properly regarded as being highly elastic. (This is confirmed by the estimation of a price equation reported in footnote 33.) If either many states simultaneously or the federal government enacted a mandate law, it could be expected that due to a somewhat inelastic national supply curve, the impact of a demand increase after a mandate would be divided between more services and a higher price.

IV. Conclusions

The benefits and costs of mandates for mental health services are relevant to both the legality and the general advisability of the regulations. Mandates for mental health services may be beneficial by (1) overcoming ignorance and prejudice against treatment for mental conditions, (2) ensuring that everyone has an ability to pay for at least a minimum amount of mental health care, (3) correcting inefficiencies in insurance markets due to adverse selection, and (4) promoting offset effects of psychotherapy. There is evidence, reviewed here, that adverse selection inhibits the marketability of mental health coverage. We have also reviewed evi-

dence that supports the existence of offset effects of psychotherapy. Our major finding with respect to costs is that mandates increase the net social cost of psychotherapy by about 10–20 percent, or about $1–2 per capita in absolute terms. Notable, however, is that this small change in net cost may be associated with large changes in the burden of payment of final costs.

While a definitive comparison of costs and benefits is impossible at this time, it is clear nevertheless that mandated mental health benefits should be immune from legal attack. Mandates are not preempted by federal law (see Appendix A). And consideration of the costs and benefits of the mandates leads to the conclusion that insurers can not bear the burden of proof necessary to establish that no legitimate state interest is served by the mandates, or that the social costs outweigh the social benefits.

As a matter of public policy, the question of the advisability of state mandates for mental health services can not be answered so easily. The costs of the mandates seem "small"; but are the benefits great enough to outweigh these costs? We do not propose a final answer to this question. But, in light of our research, mandating a minimum level of coverage for mental health services in private health insurance does appear to be reasonable state policy.

State regulation of health insurance will take on increased importance as federal influence is reduced. Policy research, in service to public decision-making, should seek to clarify the nature of the favorable and unfavorable effects of state policies and, where possible, measure the importance of these effects. Our detailed consideration of one type of state regulation, mandated coverage for mental health benefits, illustrates that although progress can be made on both fronts, further work is needed. Estimates of the net costs and benefits should obviously be refined. In addition, our work has made clear that mandates may powerfully influence the distribution of the cost of mental health services. The shift in cost from state budgets (taxpayers) to third-party payers (insurers) is only one of the several transfers resulting from mandates. Distributional issues are clearly worthy of further attention.

Notes

1. Diana Walsh, "The Health Insurance Industry: Structural Changes in an Uncertain Environment," *Health Care Management Review* 53 (Summer 1980): 71–85.
2. Mary Lou Cooper, *Private Health Insurance Benefits for Alcoholism, Drug Abuse, and Mental Illness* (Washington, D.C.: Intergovernmental Health Policy Project, The George Washington University, 1979). In addition, eleven states require insurers to offer coverage for mental health services, chosen at the option of the policy holder. The implementation of this so-called "mandatory availability" varies widely. This paper is concerned only with mandated coverage.
3. *General Laws of the Commonwealth* 175, §47B.

4. Blue Cross and Blue Shield of Massachusetts, "Special Report: Outpatient Psychiatric Payment Experience" (Boston: 1980). Blue Cross and Blue Shield are generally opposed to mandates for mental health care. See, for example, Group Hospitalization, Inc. "A Position Paper on Psychiatric Care Benefits" (Washington, D.C.: 1979). GLS Associates, Inc. "An Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance"—NIMH contract #278-78-0400 (MH), 29 June 1979—reports general industry resistance to mandates for mental conditions.
5. Blue Cross and Blue Shield of Massachusetts, "Special Report: Outpatient Psychiatric Payment Experience," pp. 1–2.
6. Superior Court Civil Action No. 35598, 22 October 1980, Suffolk County, Massachusetts.
7. See J. G. Larsen, "Mandated Health Insurance Coverage—A Study of Review Mechanisms" (Report to the Bureau of Insurance, State of Virginia, 1979), for a general discussion of some of the issues in mandated health insurance. The federal counterpart to state mandates is national health insurance, also a form of compulsory coverage. For discussion of many of the issues raised here in that context, see T. G. McGuire, *Financing Psychotherapy: Costs, Effects, and Public Policy* (Cambridge, Mass.: Ballinger Publishing, 1981).
8. See Appendix, note 10.
9. National Institute of Mental Health, "The Financing, Utilization and Quality of Mental Health Care in the U.S." (Washington, D.C.: 1976).
10. Another argument in support of mandates for mental health care is that private insurers, and especially Blue Cross and Blue Shield, are more responsive to established medical interests than to the desires of consumers. Mandates for mental health care generally increase insurance coverage for non-medical providers relatively more than for physicians (see Section III), and therefore might be opposed by medical interests. The line of thinking that health insurers are heavily influenced by medical interests is well established, though not universally accepted. See, for example, Federal Trade Commission, "Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans" (Washington, D.C.: 1979). That insurers must be forced to offer forms of coverage alternative to those most beneficial to physicians in private practice is the basis for Enthoven's influential analysis of health financing. See Alain Enthoven, *Health Plan* (Reading, Mass.: Addison-Wesley Publishing Co., 1980).
11. The result may not be to destroy the marketability of insurance altogether, but adverse selection reduces the amount of insurance purchased. See G. Akerlof, "The Market for 'Lemons': Qualitative Uncertainty and the Market Mechanism," *Quarterly Journal of Economics* 84 (August 1970): 488–500. For a useful survey, see J. Hirshleifer and J. Riley, "The Analytics of Uncertainty and Information—An Expository Survey," *Journal of Economic Literature* 17 (December 1979): 1375–1421.
12. This "comparative statics" discussion avoids the problem of existence and stability of equilibrium in insurance markets. For technical discussion, see M. Rothschild, "Models of Market Organization with Imperfect Information: A Survey," *Journal of Political Economy* 81 (November/December 1973): 1283–1308; M. Rothschild and J. Stiglitz, "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information," *Quarterly Journal of Economics* 90 (November 1976): 629–649; and C. Wilson, "A Model of Insurance Markets with Incomplete Information," *Journal of Economics Theory* 16 (December 1977): 167–207.
13. "Mental and nervous expenditures are seemingly quite easy to predict [by the insured] as evidenced by the fact that most such expenditures commence within a few days of the effective date of the individual's coverage. The Indemnity Benefit Plan [of Aetna] apparently has the most liberal mental and nervous benefit [of any plan offered to Federal employees], as evidenced by the fact that persons who joined the plan in 1972 constituted 14% of the total lives insured as of May 1973; yet they incurred 21% of the mental and nervous expenses. In view of this high degree of antiselection [our term is "adverse selection"] it would seem that some action should be taken to reduce the plan's mental and nervous benefits." Aetna Life and Casualty, "Study of 1973 Mental and Nervous Claims Under the Government-Wide Indemnity Benefit Plan" (Hartford, Conn.: 1974).

14. See Guillette, M., "Is Psychotherapy Insurable?" (Hartford, Conn.: Aetna Life and Casualty).
15. This presumes consumers are risk-averse and that the moral hazard associated with this coverage is not so severe as to make the coverage unattractive at actuarially-based premiums appropriate for each individual. The degree of moral hazard with this coverage is discussed in the next section.
16. For breakdown of costs by sector, see Alcohol, Drug Abuse and Mental Health Administration, Office of Program Planning and Evaluation, "Alcohol, Drug Abuse, and Mental Health Services Under National Health Insurance: Alternative Levels of Benefits and Estimated Costs" (Rockville, Md.: 1979).
17. D. Mechanic, "Considerations in the Design of Mental Health Benefits Under National Health Insurance," *American Journal of Public Health* 68 (May 1978): 486.
18. President's Commission on Mental Health, *Report* (Washington, D.C.: 1978).
19. K. R. Jones and T. R. Vischi, "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization," *Medical Care* 17 (December 1979): 1–82.
20. The most serious problem had to do with the nature of the control group, as Jones and Vischi emphasize (ibid.). Some studies used a "before-and-after" design, comparing medical utilization by the same people before and after psychotherapy. This design can be confounded by the "peaking" of all kinds of utilization in times of physical and emotional distress. Observed declines in medical utilization may well have occurred in the absence of psychotherapy. Other studies compared medical utilization of a group after psychotherapy with a matched population who did not choose psychotherapy. The problem with this design is that the groups are not really the same since the treatment group freely chose psychotherapy and the control group did not. Differences between the groups, rather than the psychotherapy itself, may account for differences in subsequent medical utilization.
21. Jones and Vischi (ibid.) do discuss one study in which treatment occurred in the fee-for-service sector, but this was done in West Germany more than thirty years ago. Armer's reports of the experience of The California Psychological Health Plan (not included in Jones and Vischi's review), in which groups of employees may receive psychotherapy from a "closed panel" of psychologists and psychiatrists in private practice, provides some evidence for offset effects. But the organization of this plan is again not fully representative of the general fee-for-service sector. See J. Armer, "Is Mental Wellness an Answer to the Runaway Cost of Health Care?" in *Mental Wellness Programs for Employees*, ed. Egdahl, Walsh, and Goldbeck (New York: Springer-Verlag, 1980).
22. The effects of "measurement error" on testing the effects of psychotherapy are discussed in McGuire, *Financing Psychotherapy: Costs, Effects and Public Policy*, pp. 63–71.
23. T. McGuire, "Financing and Demand for Mental Health Services," *Journal of Human Resources* 16 (Fall 1981): 501–522.
24. M. R. Van Korff and M. Kramer, "Mental and Nervous Disorders Utilization and Cost Study" (Washington, D.C.: National Institute of Mental Health and U.S. Office of Personnel Management, 1979), p. 28.
25. See McGuire, *Financing Psychotherapy*, esp. chapter 3, for discussion of the efficiency literature.
26. GLS Associates, "Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance."
27. In 1977, 84 percent of licensed or certified psychologists were members of the American Psychological Association. See D. Mills, A. Wellner, and G. VandenBos, "The National Register Survey: The First Comprehensive Study of All Licensed/Certified Psychologists," in *Psychology and National Health Insurance*, ed. C. Kiesler, N. Cummings, and G. VandenBos (Washington, D.C.: American Psychological Association, 1979), p. 126.
28. The rate of growth in psychiatrists for states in group 1 of Table 2 is 16.1, and 16.8 for group 2.
29. In a survey of licensed or certified psychologists in ten states in 1977, 20 percent of health service providers with a current specialty of clinical psychology were originally trained in some other specialty. H. Dorken and J. Webb, "Licensed Psychologists in Health

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30. For development of such a full model in the case of psychiatrists see Richard Frank, "Pricing and Location of Physician's Services in Mental Health" (Ph.D. dissertation, Boston University, 1981).
31. It is interesting that the coefficient on the unemployment rate is positive and significant, suggesting a kind of Brenner-effect on utilization—see Brenner, *Mental Illness and the Economy* (Cambridge, Mass.: Harvard University Press, 1975). A causal interpretation of an estimated partial correlation between unemployment and use of mental health services is much more plausible in a time-series analysis (as in Brenner's work) than in a cross-sectional analysis.
32. One explanation for a positive estimated effect of an FOC law is that the presence of the law is endogenous to a model of use of psychotherapy and is positively correlated with unmeasured influences on demand or supply for psychotherapy.
33. The effect of mandates on the price of psychologists' services was investigated using price as the dependent variable in equations similar to those reported in Table 3. The estimated impact of mandates was only about $.01 on hourly fees for psychologists.
34. See McGuire, "Financing and Demand for Mental Health Services," Table 3.
35. In 1976, Community Mental Health Centers received about 11 percent of their funds from patient fees or private insurance plans. See T. McGuire, "Markets for Psychotherapy," in *Psychotherapy: Practice, Research, Policy*, ed. G. VandenBos (Beverly Hills, Calif: Sage Publishing, 1980), pp. 187–246.

Appendix A: Legality of Mandated Mental Health Benefits

State legislation of mandated mental health benefits has been challenged on a number of constitutional grounds: (1) that enforcement of mandates violates the Commerce Clause of the U.S. Constitution; (2) that mandates violate the Due Process Clause of the Constitution; and (3) that mandates are preempted by federal legislation under the Supremacy Clause of the Constitution. This appendix will briefly outline the major underpinnings of these legal theories, and attempt to identify the policy considerations underlying the judicial treatment of the various constitutional arguments.[1]

Commerce clause

Where insurance policies have been issued outside a state, as is frequently the case with group contracts providing benefits to residents of a number of states, insurers have asserted that the application of mandated benefit statutes violates the Commerce Clause of the U.S. Constitution. The Commerce Clause establishes the primacy of the Congress in the regulation of interstate commerce. Thus, where Congress completely occupies the field of matter in interstate commerce, there is often no room for any parallel state regulation. However, as early as 1869, in *Paul v. Virginia*,[2] the Supreme Court held that the business of insurance was not interstate commerce subject to federal regulation. In the wake of *Paul* and subsequent cases, a diverse network of state regulation developed. But the Supreme Court reversed itself in 1944, holding in *United States v. South-Eastern Underwriters Association*[3] that the insurance business was subject to regulation by Congress under the Commerce Clause. In response to that decision, Congress enacted the McCarran-Ferguson Act in 1945,[4] which expressly provides that regulation and taxation of the business of insurance shall be subject to the laws of the several states.

Subsequent to the enactment of the McCarran-Ferguson Act, the Supreme Court made it clear that the statute effectively operates to "sustain [state insurance legislation] from any attack under the Commerce Clause."[5] The Court recognized that, as a result of the Congressional abdication in favor of the states, "uniformity of regulation . . . [is] not required in reference to the business of insurance."[6]

Despite the McCarran-Ferguson Act, insurance companies in recent cases challenging mandated-benefits legislation have sought to revitalize the Commerce Clause as a ground for attack on state insurance laws. In each of these cases, however, the courts have upheld the validity of the mandated-benefits statutes.[7]

Due process

Although the McCarran-Ferguson Act validated state regulation with respect to the Commerce Clause, it did not purport to define state authority in light of the Due Process Clause of the Fourteenth Amendment. The Due Process Clause is the touchstone of constitutional analysis of state insurance legislation which applies extraterritorially. Within the context of the due process considerations, it is well settled that a state may subject out-of-state insurance transactions to its laws *where the state has a legitimate interest in regulation*.[8]

With respect to state insurance statutes that apply extraterritorially to out-of-state insurance companies and policies, the Supreme Court has said:[9]

> A state has a legitimate interest in all insurance policies protecting its residents against risks, an interest which the state can protect even though the state action may have repercussion beyond state lines. . . . we [have] accorded great weight to the consequences of the contractual obligations in the state where the insured resided and the degree of interest that the state had in seeing that those obligations were faithfully carried out.

Under the due process principles enunciated by the Supreme Court, most state insurance legislation survives attack. Recent challenges to statutes mandating mental health coverage have not seriously pressed the due process argument. The courts in these cases have supported state mandates on the basis of the strong interest demonstrated by the states in providing treatment for mental and nervous conditions for their citizens.[10]

Federal preemption

The doctrine of federal preemption of state law under the Supremacy Clause of the U. S. Constitution has had a protracted history, marked by shifting attitudes toward the proper balance between state and federal authority.[11] Decisions of the United States Supreme Court in the last two decades suggest a narrow frame of reference. Federal law will preempt a state statute only where there is a clearly discernible Congressional intent to occupy the field for exclusive regulation by the federal government, or where the state act is in actual conflict with the applicable federal law;[12] preemption will also occur where Congress has expressly dictated that result.[13]

The first prong of the preemption test requires analysis of Congressional intent to occupy the field of regulation. Where the analysis involves an area of traditional state regulation, such as insurance, the courts are directed to "[assume] that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."[14] Local regulation is not to be "disturbed unintentionally by Congress or unnecessarily by the courts."[15]

If Congress has not occupied the field, the second step of the preemption analysis looks to a conflict with federal law. A conflict between state and federal law requires preemption where the state regulation is an "obstacle to the accomplishment and execution of the full purpose and objective of Congress."[16] A conflict will arise most clearly where state and federal laws require mutually exclusive conduct. However, there is no preemption where both statutes are enforceable without impairment of federal dominance of the field.[17] In fact, the Supreme Court has displayed a marked tendency in recent years to preserve local regulation in the face of a potential conflict with federal law.[18]

State mandates for health insurance have been alleged to be in conflict with two federal statutes: the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 101 *et seq.*; and the National Labor Relations Act (NLRA), 29 U.S.C. § 141 *et seq.* Virtually all employee health benefit plans are subject to ERISA, while the NLRA applies to plans that are the subject of collective bargaining.

The Employee Retirement Income Security Act. The Employee Retirement Income Security Act of 1974, was enacted to correct widespread abuses in administration of employee pension and welfare plans.[19] ERISA imposes on such plans minimum federal standards for reporting, disclosure, vesting, funding, and fiduciary duties.[20] Although all of the provisions of the act apply to pension plans, welfare plans are required only to observe the reporting, disclosure, and fiduciary standards.[21]

In establishing a new and detailed regulatory structure governing employee benefit plans, Congress decided to displace direct state regulation of such plans. The extent of federal preemption is delineated by Section 514 of ERISA, which creates a dichotomy between state laws that "relate to" an employee benefit plan and state laws that regulate insurance. Section 514(a) provides for general preemption of state law as follows:

> Except as provided in subsection (b) of this section, the provision of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

The broad preemption language of this section has generally led courts to preempt state laws that directly regulate employee benefit plans.[22]

ERISA, however, does not appear to preempt mandated insurance benefit statutes that do not apply directly to employee benefit plans, despite the indirect regulatory effect of the statutes on plans that purchase insurance coverage on behalf of their members. The "savings clause" of ERISA expressly provides that state "insurance, banking, and securities" laws are preserved from the broad preemptive effect of S. 514(a). In construing this section, federal and state courts have uniformly upheld the state statutes.[23]

In the leading decision on this issue, *Wadsworth v. Whaland*, the U. S. First Circuit Court of Appeals found that New Hampshire's mandated mental health benefit statute was not preempted by ERISA, even though the statute subjected plans that purchase insurance to indirect regulation. The court registered its strong support for the traditional national policy of state primacy in the regulation of insurance:[24]

> The plaintiff's interpretation would greatly diminish the state's primacy in regulating insurance. It would nullify all state insurance laws concerning group insurance when the group policy is issued to an employee benefit plan. We do not find, absent a clear statement of intent, that Congress meant to so restrict a state's authority to regulate insurance.

The *Wadsworth* Court directly acknowledged the anomaly created by ERISA, since the statute clearly preempts any state law that requires employers to provide mental health insurance or treatment services. However, the court correctly concluded that any policy conflict was best resolved by Congress. Indeed, some commentators believe a case such as *Wadsworth* demonstrates that Congress neither understood nor considered the broader implications of ERISA preemption.[25]

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The National Labor Relations Act. The NLRA requires employees, employers, and labor unions to discuss wages and conditions of employment, and provides a "protected" climate for the bargaining process. It is clear that states may not interfere with this "protected" climate.[26] The NLRA, however, does not regulate the substance of the contract, nor does it undertake to regulate wages, hours, working conditions, or employee benefits.[27] Moreover, the act neither contains an express preemption provision, nor does it expressly or by implication supersede the dictates of the McCarran-Ferguson Act.

Although the NLRA represents a comprehensive federal scheme, the Supreme Court has recognized numerous limitations to its preemptive effect, stating that "[we] cannot declare preempted all local regulation which touches or concerns in any way the complex interrelationships between employees, employers, and unions; obviously much of this is left to the states."[28] The larger context of state laws of general applicability takes precedence over the NLRA.[29]

Thus a number of specific exceptions to preemption by the NLRA have developed, including state action which is of peripheral concern to the NLRA[30] or which touches interests deeply rooted in local feeling and responsibility,[31] or local health and safety regulations which conflict with a collective bargaining agreement.[32] Mandated mental health statutes are of general applicability, and are not directed specifically at the collective-bargaining process. Therefore, the state and federal courts have rejected the claim that the NLRA preempts these state statutes.[33]

Appendix B: Sources of Data

Psychiatrists' hours were computed as the product of the number of psychiatrists and child psychiatrists in office-based practice in 1978 times the average number of hours worked by psychiatrists in 1978, reported on a regional basis. Source: *AMA Physician Distribution and Medical Licensure in the U.S., 1978.*

Psychologists' hours were defined as the sum of the number of psychologists in individual private practice times the mean hours per week providing health services for that group; plus the number of psychologists (not in individual private practice) providing fee-for-service psychotherapy less than 20 hours a week times 10 hours per week; plus the number of psychologists (not in individual private practice) providing fee-for-service psychotherapy more than 20 hours a week times 30. Number of psychologists in all categories are estimates. Source: *American Psychological Association Human Resource Survey, 1978.*

Percent of population in FEHB or CHAMPUS is estimated as follows. The distribution of FEHB coverage was assumed to be similar to the distribution of federal employment, taken from U.S. Bureau of the Census, *Employment and Earnings in States and Areas* (6744-5). Family size of federal employees was assumed to be the average for the state. The distribution of the total of 9,123,000 CHAMPUS eligible individuals was made according to the distribution of the number of claims received by CHAMPUS for November 1980. Source: American Psychological

Association, CHAMPUS project, directed by William L. Claiborn. We are grateful to Will Claiborn for information and advice for computing these estimates.

FOC laws were *not* in effect in the following states in January 1978: Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Missouri, Nevada, New Hampshire, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, West Virginia, Wisconsin, Wyoming. Source: Personal communication from Herbert Dorken.

Mandates were in effect in 1978 in the following states: Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, North Dakota, Ohio, Wisconsin. Source: Mary Lou Cooper, "Private Health Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness," (Washington, D.C.: Intergovernmental Health Policy Project, The George Washington University, July 1979), pp 25-27.

Notes to Appendices

1. It should be emphasized that these are the arguments that have been advanced in opposition to mandates. They do not necessarily represent our judgment about the best possible set of arguments to be made. It is not the intention of the authors to provide a comprehensive analysis of the constitutional issues implicated by mandated benefits legislation.
2. 8 Wall 168, 19L. Ed 357 (1869).
3. 322 U.S. 533 (1944).
4. 15. U.S.C. §10 *et seq.*
5. *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408 (1946); *Group Life & Health Insurance v. Royal Drug Co.* 435 U.S. 903 (1979).
6. Id. at 431
7. Contrast *Insurer's Action Council v. Markham*, 490 F. Supp 921 (D.C. Minn., 1980)—where the court correctly holds that the Minnesota Comprehensive Health Insurance Act is immune from Commerce Clause attack—with *Metropolitan Life Insurance Company v. Wayland*, New Hampshire Supreme Court, 28 December 1979, in which the court holds that New Hampshire's mandated mental health benefits statute does not impose an impermissible burden on interstate commerce. Even assuming, as the New Hampshire Court did, that the Commerce Clause is applicable to insurance regulation, it is clear that, absent conflicting federal legislation, the states may exercise their general police powers to regulate matters of local concern, even though interstate commerce is affected. Such legislation will be struck down only where the burden on commerce is clearly excessive in relation to the purported local benefits. *A & P Tea Co. v. Cottrell*, 424 U.S. 366 (1976). See also *Wadsworth v. Wayland*, 562 F.2d 70 (1st Cir 1977), *cert. denied*, 434 U.S. 1044 (1978).
8. *Osborn v. Ozlin*, 310 U.S. 53 (1940); *Hoopeston Canning Co. v. Cullen*, 318 U.S. 313 (1943); *Watson v. Employer's Liability Assurance Corporation*, 348 U.S. 66 (1954). In addition to a legitimate state interest, these cases require that the state must also have sufficient contacts with the transaction to justify state action.
9. *Travelers Health Association v. Virginia*, 339 U.S. 643, 647-48 (1950).
10. *Wadsworth v. Wayland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 434 U.S. 1044 (1978); *Metropolitan Life Insurance Company v. Wayland*, New Hampshire Supreme Court, 29 December 1979; *Commonwealth of Massachusetts v. Travelers Insurance Company and Metropolitan Life Insurance Company*, Suffolk Superior Court (No. 35598) 22 October 1980 (currently on appeal); *Insurer's Action Council v. Markham*, 490 F. supp. 921 (D.C. Minn., 1980).
11. See "The Preemption Doctrine: Shifting Perspectives on Federalism and the Burger Court," *Columbia Law Review* 75 (1975): 623.

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14. *Rice v. Santa*
15. *Jones v. Rail*
16. *Hines v. Dav*
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24. 562 F.2d at
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12. *Florida Lime and Avocado Growers v. Paul*, 373 U.S. 132 (1963).
13. Where Congress has explicitly indicated that a statute should have some preemptive effect, the Supreme Court has carefully examined the statutory scheme and required that the intent to preempt a particular concurrent state regulation be "clear and manifest." See *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977).
14. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).
15. *Jones v. Rath Packing Co.*
16. *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).
17. *Florida Lime and Avocado Growers, Inc. v. Paul.*
18. For example, in *Goldstein v. California*, 412 U.S. 546 (1973), the Court held that the states' right to regulate unauthorized phonographic reproduction was not preempted by federal copyright statutes which do not expressly regulate such reproduction. The Court found that exclusive federal power arose over matters "*necessarily* national in import," id. at 544, but that no preemption by federal copyright law would occur except where the statutes are absolutely contradictory and repugnant. See also *New York State Department of Social Services v. Dublino*, 413 U.S. 405 (1973); *Kargman v. Sullivan*, 552 F.2d 2, *reconsideration denied*, 558 F.2d 612 (1st Cir. 1977).
19. ERISA was the culmination of twelve years of investigation into pension and welfare plan abuses which had deprived many workers of their earned benefits. ERISA replaced the Welfare and Pension Plans Disclosure Act, 29 U.S.C. §1001 *et seq.* (1958). For a discussion of the history of federal legislation governing employee benefit plans, see Chadwick and Foster, "Federal Regulation of Retirement Plans: The Quest for Parity," *Vanderbilt Law Review* 28 (1975): 641; Snyder, "Employee Retirement Income Security Act of 1974," *Wake Forest Law Review* 11 (1975): 219.
20. ERISA is analogous to the Securities Act of 1933, 15 U.S.C. §77 (a) *et seq.*, since it relies, to a great extent, on disclosure requirements to police the activities it was designed to regulate. The Securities Act imposes no substantive regulation on the kind or quality of securities traded on the exchanges. ERISA likewise does not contain any regulation of the kind or quality of benefits.
21. An employee welfare benefit plan is defined as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship, or other training programs, or day care centers, scholarship funds, or prepaid legal services . . ." ERISA §3(1), 29 U.S.C. §1002(1).
22. E.g., *Hewlett Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal., 1977), *aff'd.* 527 F.2d 502 (9th Cir., 1978)—preempting the California Knox-Keene Health Care Service Plan Act which directly regulated the terms of employee benefit plans; *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695 (N.D. Calif, 1977), aff'd. 633 F.2d. 760 (9th Cir., 1980), *aff'd.* 50 U.S.L.W. 3212 (6 October 1981)—preempting the Hawaii Comprehensive Health Care Act requiring employers to provide employees with a prepaid health care plan. See also *St. Paul Electrical Workers Welfare Fund v. Markham*, 490 F. Supp. 931 (D.C. Minn., 1980). The statutes in these cases did not mandate the terms of *insurance policies*. Rather employers were required to provide enumerated benefits whether through the insurance mechanism or self-insured employee benefits.
23. See cases cited at note 10 supra. The *Wadsworth* Court recognized the anomaly of preempting direct regulation of employers and benefit plans while permitting the state to mandate the terms of insurance policies purchased by employers or benefit plans. The court concluded that this was a policy issue best addressed by Congress. 566 F.2d at 78.
24. 562 F.2d at 70.
25. "Note, ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws," *Columbia Law Review*, 78 (1978): 1536; Okin, "Preemption of State Insurance Regulation by ERISA," *Forum* 13 (1978): 652-679.

26. *Lodge 76, International Assoc. of Machinists and Aerospace Workers v. Wisconsin Employment Relations Comm.*, 427 U.S. 132 (1976).
27. *Terminal Railroad Association of St. Louis v. Brotherhood of Railroad Trainmen*, 318 U.S. 1, 6 (1942).
28. *Motor Coach Employee v. Lockridge*, 403 U.S. 274, 289 (1971).
29. This is so even if one part of a state's protective legislation might become "the subject of a demand" so affecting interstate commerce that federal agencies would have to be invoked to deal with it. *Terminal Railroad Association of St. Louis v. Brotherhood of Railroad Trainmen*, 318 U.S. 1, 7 (1942).
30. *Massachusetts Electric Company v. Massachusetts Commission Against Discrimination*, 375 Mass 160, 375 N.E. 2d 1192 (1978)—upholding a regulation requiring employers to provide benefits for pregnancy-related disabilities. The court recognized that these benefits were a mandatory subject of collective bargaining, but nevertheless concluded that the regulation was a peripheral concern of the NLRA.
31. *Farmer v. United Brotherhood of Carpenters*, 430 U.S. 290 (1977).
32. *Local 24, International Brotherhood of Teamsters v. Oliver*, 358 U.S. 283 (1958).
33. See note 10 supra.

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Dispelling Myths About Mental Health Benefits

BY STEVEN S. SHARFSTEIN, SAM MUSZYNSKI AND GRACE-MARIE ARNETT

The case is made that mental health coverage is cost-effective and controllable.

MENTAL HEALTH REPORT

Insurance coverage for mental health care always has lagged behind that of coverage for other medical care, and today, private insurance coverage for psychiatric illness is only half as available as coverage for other medical problems.

The American Psychiatric Association, in 1983, surveyed health insurance benefits provided by a cross section of major private sector employers. The 300 plans in the study sample covered 33 million workers and dependents employed in such corporations as IBM, General Motors and Exxon plus numerous mid-sized and smaller companies. The survey showed all of the plans provided some level of inpatient coverage for mental illness, but only 49 percent of the insured were protected for mental illness expenses on the same basis as any other illness. The remaining 51 percent of insured individuals were covered at a reduced level. Ninety-eight percent of the plans had some coverage for outpatient expenses for mental illness treatment. But, again, only 10 percent of the plans provided these benefits on the same basis as outpatient coverage for other medical conditions.[1]

An earlier study of 455 major insurance programs, conducted in 1980 by Hewitt Associates, a benefits consulting firm, also found equal outpatient coverage for mental disorders in only 10 percent of the plans.

This discrimination is bad for patients, for business, for mental health providers and, ultimately, for the community and taxpayers. Unequal coverage of psychiatric treatment has evolved primarily because of several prevalent myths about mental health benefits and care. In business' role as a formulator of health care policy, accurate information is essential to assure that employers make wise economic decisions about health care coverage for employees while providing for quality health care.

The 1960s and 1970s were decades of tremendous growth for mental health services, fueled by ever expanding public and private third party financial resources. From 1955 to 1977, the number of patients treated in inpatient and outpatient mental health facilities almost quadrupled, from 1.7 million to 6.4 million.

There also was a major shift in the type of care delivered, with inpatient care declining sharply while outpatient care increased tenfold, primarily because of federal funding of community mental health centers.

The emergence of an accessible mental health treatment system in the U.S. depended upon joint private and public financing. Through these investments, the private and the public sectors have demonstrated over the last two decades the importance of mental health care. But concerns over the costs of this care have arisen in tandem with alarm over the nation's soaring total health care bill. As a result, a last in-first out policy is being adopted by health insurers with regard to psychiatric coverage, whose growth traditionally has lagged behind that of other medical coverage.

Restricting Benefits

Today, psychiatrists have approximately twice the number of patients with no health insurance as other physicians, and those patients with insurance have greater limits on their psychiatric benefits than for medical care. Mental health coverage has been curtailed in a number of plans, including those under the Federal Employees Health Benefits Program (FEHBP). Some carriers, beginning in 1981, imposed strict limitations on the amount of mental health care federal employees and their dependents may receive under the plans. The Blue Cross-Blue Shield federal employees plan, for example, in 1982 imposed a 50-visit limit on outpatient mental health treat-

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[illegible] a 60-day limit on inpatient care annually, whereas in the past treatment was limited only by medical necessity.

Decades of clinical experience and research have shown, however, that mental and physical illness cannot be separated without impeding effective treatment. Psychiatric problems often are presented as physical complaints while somatic diseases initially may be experienced as emotional symptoms. Restrictions on mental care coverage cannot prevent individuals from obtaining some kind of care, although that care may not be the most appropriate for their illness. There is good evidence that attempting to establish a false dichotomy between mental and physical illness leads to a false economy in insurance coverage.

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For example, an executive under great stress may experience headaches, abdominal pain, fatigue and depression. Unless accessible psychiatric diagnosis and care are available, this executive might have to undergo costly medical and diagnostic testing and specialty consultations. It is cost-effective to treat this person with psychiatric interventions.

In addition, because of the essentially cognitive nature of psychiatry, especially as it involves psychotherapy, because psychiatrists can treat only a limited number of patients each day, and because fewer of their patients are insured, psychiatrists' earnings are near the bottom of the income scale compared with other physicians. So while psychiatrists contribute little to soaring health care costs, insurance coverage for their patients, nonetheless, is often the first to be cut.[2]

The Uncontrollable Costs Myth

Psychiatric care will not be reimbursed equally along with other medical treatments, however, until some of the myths considered unique to psychiatry are addressed. There are four commonly held myths that may account for discriminatory treatment of psychiatric coverage.

The first such myth is that costs of psychiatric treatment are uncontrollable and unpredictable. Opponents of comprehensive psychiatric coverage suggest that providing benefits with no limits on the number of days for inpatient treatment or the number of visits for outpatient care would bankrupt an insurance carrier because of the influx of new patients who would seek these services. Actual experience shows these concerns to be invalid.

Data from the Blue Cross-Blue Shield federal employee health plan, for example, which had no artificial limits on mental health coverage from 1967 to 1981, aside from the same deductibles and copayments for general medical care, indicate that mental health costs are stable over time. After an initial jump in costs immediately following the introduction of broader psychiatric benefits between 1967 and 1969, mental health care accounted for 7.2 percent to 7.7 percent of the total benefits paid from 1970 to 1981.

In 1971, the Rand Corporation began a health insurance study that enrolled 7,500 persons at six sites across the country in 14 different insurance plans having patient copayments ranging up to 95 percent, with a maximum dollar expenditure of $1,000 per family. The Rand study found that expenditures for mental health care constituted only about 5 percent of the total health care costs for all insurance plan enrollees.

It was further determined that when insurance pays more of the bill and the patient less, people use extra psychiatric care at about the same rate as they use extra care from other medical specialists. The researchers found that between 7.1 and 9.6 percent of the population studied used mental benefits; this calculation embraces visits to general practitioners and internists whenever a psychotropic medication or a mental health reason was involved in the visit. Only a small percentage of the individuals (0.4) saw clinicians more than 40 times a year. The Rand study underscores the stability over time of costs for mental health care under insurance.[3]

Health economist John Krizay has done studies that also suggest that costs level out over time or show a plateau effect. In a 1982 study, for instance, he analyzed the experiences of the two insurers participating in the FEHBP — Blue Cross-Blue Shield and Aetna — on a state-by-state basis and translated these data into per capita utilization rates and costs in constant dollars. He noted that in almost all states the total percentage of enrollees who received psychiatric benefits under these plans was around 1.5 percent of total enrollment, indicating that the availability of insurance financing does not cause excessive utilization.[4]

Many of the restrictions on insurance coverage for psychiatric care appear to stem largely from concern about the costs of long-term custodial care or intensive psychotherapy. The standard treatment regimen for intensive psychotherapies involves a minimum of three therapy sessions a week. Experience with the FEHBP, which placed no annual restrictions on the number of outpatient visits for more than a decade, has shown that the number of persons receiving intensive psychotherapeutic treatment ranged from 0.9 percent of all psychiatric outpatients treated in 1971 to 1.1 percent in 1973. The cost for treatment for this population during the same time period ranged from 8.7 percent to 10.3 percent of the total cost of physicians' treatment of mental disorders.[5]

The availability of coverage limited only by medical necessity for intensive psychotherapy during the early

1970s did not seem to cause any appreciable increase in the number of people using this form of treatment. It is clear that in this system, which offered a comprehensive benefit — the full range of mental health services — that the number of people utilizing intensive psychotherapy remained consistently low. This seems a self-stabilizing factor mitigating against threats of exorbitant overutilization of the benefit.

Still, misconceptions about the excessive duration and costs for all psychiatric care have prevailed, and unwarranted discriminations against both inpatient and outpatient psychiatric care in general have persisted. The growing body of data and coverage experience suggests that these concerns and resultant discriminations need to be reviewed. A look at the larger picture of utilization of mental health benefits in comparison to use of other medical services indicates, too, that even with unlimited access to psychiatric care, use is predictable and the portion of the total health dollar consumed is modest.

The "Moral Hazard" Myth

Another myth is that mental health care costs are unstable because of the "moral hazard" which is especially applicable to psychiatric coverage. "Moral hazard" describes the case in which the services demanded for treatment of an illness depend, in part, on the price of these services. Since insurance lowers the price to consumers, more services may be used than if the consumer were required to pay the entire medical bill.

Arguments for restricting mental health benefits focus on the assumption that liberal coverage encourages unnecessary and excessive use. Supporters of this view cite data such as this: Among outpatient users of mental health care in the federal employees Blue Cross-Blue Shield plan, 9 percent accounted for 45 percent of the total cost. Likewise, in the Michigan Blue Cross plans, the highest utilization group of persons, consisting of 10 percent of the users with mental disorders, accounted for over 60 percent of the charges.

But that someone with insurance may be more likely to initiate medical care, and once under care, be likelier to opt for more extensive treatment is not a phenomenon exclusively found in the mental health area. General medical literature also has documented the fact that insurance encourages utilization of physician services. The 1981 Rand study, for example, reported that 1 percent of utilizers of medical care in the 7,500 sample accounted for 28 percent of the total expenditures.

Another study, "Insurance Effects on Employer Group Dental Expenditures," published in the June 1984 issue of *Medical Care*, further illustrates this point. The study found consumers spend more on dental care when they have dental insurance, and 81 million Americans have this type of coverage. Specifically, the study's findings indicate that total outlays for covered dental service are 36 percent higher for employees whose group insurance requires no cost sharing than for workers whose group insurance covers only 80 percent of the costs of basic dental services.

There is no established consensus about the extent of the impact of insurance on use of psychiatric services. Nonetheless, it is unwarranted to assume that this is a phenomenon unique to mental health care and, therefore, that specific benefit limitations to control for moral hazard are justified. The distribution of higher users of mental health benefits seems, if anything, to be less extreme.

According to a National Center for Health Statistics survey of ambulatory care conducted between May 1973 and April 1974, less than 20 percent of all physician visits are for problems considered "serious" or "very serious" by physicians. Nonetheless, 61 percent of all visits concerned problems for which the same patient had been seen by the same physician before, and, in roughly the same percentage of cases, the patient was instructed to return for yet another visit.

The demand for medical services, in other words, has little to do with "seriousness" in terms of clinical judgment. Relief from discomfort or anxiety is the most common motive for seeking medical advice. Thus it is both impossible to design a health insurance program around a concept of "seriousness," and illogical to apply a "seriousness" doctrine to coverage of psychiatric services alone. In that same vein, it is inappropriate for carriers to provide open-ended coverage for various nonpsychiatric conditions while restricting coverage for mental disorders. Yet, a recent study by Roche Products, Inc. showed more than 90 percent of psychiatrists stated they seldom or never see patients who primarily are seeking self-improvement.[6]

"There is no established consensus about the extent of the impact of insurance on the use of psychiatric services. Nonetheless, it is unwarranted to assume that this is a phenomenon unique to mental health care....The distribution of higher users of mental health benefits seems, if anything, to be less extreme."

Lengthy inpatient care and intensive outpatient treatments are important and valid approaches in psychiatric care, just as open heart surgery is an important and valid method of treatment for cardiac patients.

The Cost-Effectiveness Debate

A third myth is that mental health care is not cost-effective. When benefits for mental health care are expanded and the stigma associated with receiving treatment for mental conditions decreases, an initial increase in insurers' costs attributable to psychiatric care is likely to occur. However, with psychiatric problems no longer masked under other diagnoses, and with early detection and ap-

propriate treatment of these conditions. It also is probable that such costs will be offset partly by reduced expenditures for care of other illnesses.

Over the past few years there has emerged a body of evidence that spending for psychotherapy produces savings elsewhere through increased employee productivity, reduced absenteeism and lower costs for other medical care. There is wide and growing acceptance in private industry that it is worthwhile to invest in providing mental health services to employees as corporations can recoup some of the costs of this coverage in other areas.

Increasing medical care expenditures has made evidence of cost-effectiveness essential. In psychiatric treatment, however, results are not as quantifiable as in other medical disciplines. What is the dollar value of relief from incapacitating depression or anxiety, for instance? How can one measure the benefits to a child who is no longer beaten by an alcoholic father or calculate the advantages of a patient's increased capacity for intimate relationships?

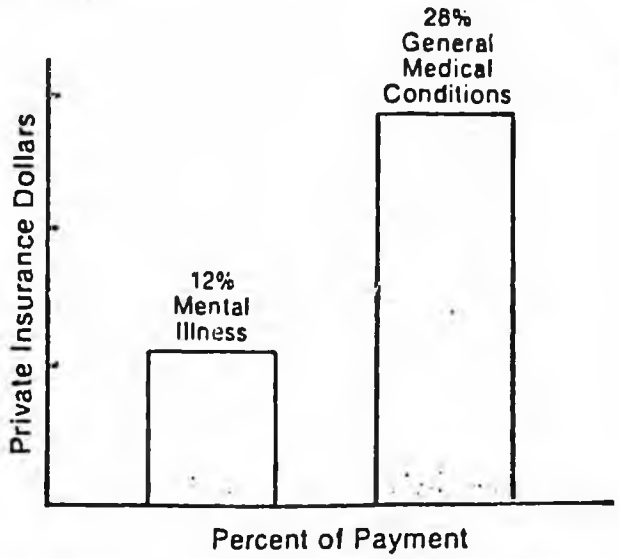
Yet some notable studies have been done which document the cost-effectiveness of psychiatric care in quantifiable terms. Among these was an extensive, three-part study reported in 1980 which found that the use of community based programs for the chronically disabled psychiatric patients greatly reduced the need for hospitalization, lengthened community tenure and enhanced community adjustment. A rigorous cost-benefit analysis determined that benefits outweighed costs by about $400 per individual.[7]

"...As companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true where psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, for example."

A 1980 study looked at the issue of costs and benefits from a broad societal perspective. The focus was on the impact of the psychoactive medication lithium on the costs generated by manic depressive psychoses. Their conservative estimate of the 10-year savings was $4.2 billion, that is, $2.9 billion in unexpended treatment costs plus $1.3 billion in productivity gains.[8]

Further, a 1983 study involving the Blue Cross-Blue Shield federal employees health plan showed a group of patients who began outpatient psychotherapy following diagnosis of chronic medical disease used 56 percent fewer medical services during the third year after diagnosis than a group with the same diseases who received no psychotherapy.[9]

These studies clearly show that treatment for mental illness is cost-effective and can be measured directly in terms of savings from nonutilization of other medical services.



The Accountability Issue

A final myth is that psychiatric treatment is not accountable to insurance carriers. Utilization review in the form of peer review has become the cornerstone of organized psychiatry's accountability to payers and consumers. The goal of utilization review is to monitor the necessity and appropriateness of care, while peer review is intended to improve the quality of care. Psychiatric peer review is carried out by psychiatrists and it is concerned with utilization review, quality review, continuing education, advocacy with third party payers for improved care and cost control.

Unfortunately, many insurance carriers have chosen to put strict limits on psychiatric care rather than implement peer review procedures.

The American Psychiatric Association has developed peer review services to give employers the option of providing psychiatric care limited only by medical necessity, thereby enhancing their opportunity to achieve savings through cost avoidance in other areas of medical care. The APA's peer review program was established in the early 1970s and expanded in 1976 at the behest of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health insurance program for military families. Panels of psychiatrists are organized in each of the APA's district branches or chapters.

More than 400 psychiatrists nationwide now review mental health benefits claims for a total of 24 national and local insurers. Three psychiatrists review each case, basing their evaluations on guidelines in the *Manual of Psychiatric Peer Review*, which is regularly revised by the APA. In 1982, the APA conducted 5,000 reviews for CHAMPUS and 965 reviews for other third party payers.

The reported cost savings resulting from use of the APA program are impressive. Aetna Life and Casualty's peer review costs in 1981 were about $20,000, and its

estimated savings were $2.4 million. Mutual of Omaha Insurance Company estimated a savings of about $300,000 during its first year of participation in the program. CHAMPUS reports that peer review has led to "outright savings" of $5 million a year since it began participating three years ago. In addition, savings in costs of medical care avoided as a result of peer review may be three to four times greater than the direct savings. Peer review has been effective in assuring that necessary and appropriate care is delivered.

The APA program is recognized by many third party payers as a responsible effort by the psychiatric community to deal with significant issues of accountability. Mental health benefits require special attention by claims reviewers because of the essential task of protecting patient confidentiality in order for the treatment process to work. The APA's peer review program makes this service available by utilizing careful, professional reviewers in a system that assures accountability and confidentiality.

Business Leadership Needed

It has been predicted that 90 percent of health care services in 1990 will be delivered through contract arrangements between providers and third party payers and their intermediaries. Already systems are evolving to change the economics of health care delivery. There is increased cost sharing to heighten consumers' awareness of cost, and there is more competition between plans for premium dollars. Diagnosis related groups (DRGs) are altering dramatically medical services paid through Medicare and are being adopted rapidly by numerous other all-payer systems.

The extent to which business takes the lead in making choices and helping the medical and other health professions to set the course for health care delivery may well determine the success or failure of the evolving systems to provide quality care at reasonable prices to employers and employees. Some crucial issues must be addressed in this process. One is that as more and more people are covered by insurance the original definition of insurance is weakening. Increasing limits on psychiatric coverage mean that employees are less likely to be protected against the onset of a catastrophic mental illness. Also, as companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true when psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, for example.

A second issue is that because of prevalent myths about mental health benefits, access to private psychiatric insurance coverage is limited and, consequently, more of the burden for this care falls to the public sector, especially state mental health programs. Only 12 percent of the payment for treatment of mental illness comes from private insurance dollars, compared with 28 percent of the payment for treatment of general medical conditions. States pay almost 50 percent of the cost of mental health care while paying less than 15 percent of the cost of other medical treatments.

This shift in the financial burden of mental health care to the public sector creates especially serious problems for the mentally ill in times of budget cutbacks by all levels of government. Patients receive less care and sometimes no care at all. The untreated show up on the streets as the homeless and in the jails and courts.

The public sector has a responsiblity to care for the 28 million Americans who reported in a 1982 Robert Wood Johnson Foundation survey that they had serious trouble obtaining medical treatment. An estimated one million of these people were refused treatment for financial reasons and had no where else to turn but to public facilities. If these facilities are crowded with employees and their dependents whose employers have eliminated catastrophic psychiatric care from their health insurance packages, then the poor and near-poor are left with no place to go for mental health care.

It is imperative that business stand up to this challenge to provide insurance coverage in its truest sense for its employees to obtain private psychiatric treatment so that the state can provide adequate care to those with no other alternatives.

With accurate information to dispel myths about whether psychiatric costs are controllable, the need for psychiatric treatment, the cost-effectiveness of such care and accountability to carriers, business should be prepared to lead the revolution into the next century to assure employees receive full, affordable and high quality health care. ■

The opinions expressed in this article are those of the authors and do not reflect the official position of the American Psychiatric Association.

Notes

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3. K.B. Wells, W.G. Manning, N. Duan and J.P. Newhouse, "Cost Sharing and the Demand for Ambulatory Mental Health Services," R-2960-HHS (Santa Monica, Calif.: Rand Corporation, 1982).
4. J. Krizay, "Federal Employees' Experience as a Guide to the Cost of Insuring Psychiatric Services in the Various States." *American Journal of Psychiatry* 139:866-871, 1982.
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State Mandates for Mental Health Insurance: What Is Their Cost?

Bette Runck

Reductions in public financing of mental health services have forced policy makers at all levels of government to turn their attention to private insurance plans. Of particular interest are state mandates requiring minimal inpatient and outpatient mental health benefits in private health insurance policies.

Connecticut was the first state to pass such a law, in 1971 (1). Since then, ten other states have followed suit, and several more are considering similar mandates. Insurance companies, citing large cost increases, have vigorously opposed such measures. Some even refused to offer the coverage until court orders forced their compliance.

Now a Boston economist has demonstrated that such mandates cost society little. Other evidence suggests that the mandates may provide indirect benefits to offset their cost.

In a study comparing the experience of states with and without mandates, Thomas G. McGuire (2) of Boston University found a 10 to 20 percent increase in the use and cost of outpatient mental health services as a result of the mandates. McGuire's findings contrast sharply with insurance company reports of the cost of coverage under the mandates. In Massachusetts, Blue Cross and Blue Shield reported that they paid out 14 times more for outpatient mental health care in 1979 than they did in 1975, before the state's mandate went into effect—a 1,300 percent increase.

While not refuting the insurers' claims of greater cost, McGuire provides a different perspective on them. Insurers consider only the increased cost to them, but McGuire looks at the cost to society as a whole. The insurance company figures reflect the fact that, with mental health benefits, insurers pick up the tab that was once paid by the public and users themselves.

Figuring the costs

Although legislated benefit packages differ from state to state, most cover at least 30 days of inpatient care in a private mental hospital, a general hospital, or a state hospital (1). Outpatient benefits in most states have deductibles comparable to those for other major medical benefits, copayments no greater than 50 percent, and a minimum coverage of $500 worth of expenses per year after deductibles and copayments.

The argument over the cost of mandates focuses on the provision of outpatient benefits because most private health insurance plans already have at least limited inpatient mental health coverage (2). Before the McGuire study, the only available data on the additional cost of such benefits came from insurers, but even that was sparse.

In a recent article in the *Journal of Health Politics, Policy, and Law*, McGuire and John T. Montgomery, an attorney formerly with the Massachusetts Department of the Attorney General, argue that it is misleading to focus on the cost to insurers when evaluating the cost of a mandate (2). First, they point out, the cost of outpatient care has risen with or without a mandate. When looking at costs before and after a mandate, it is difficult to separate out that inflationary trend. Second, a mandate shifts some out-of-pocket and state costs to insurers. "Although these shifts may be significant," note McGuire and Montgomery, "they do not represent net increases in costs due to the mandates, only shifts in the way these costs are finally paid." A further reason why the cost reported by one insurer may be misleading is that it does not account for the possibility that contracts may have been shifted from one insurer to another.

To arrive at what he believes to be a truer cost of a mandate for mental health benefits, McGuire compared the rates of growth in numbers of mental health practitioners in states with and without mandates. He assumed that if the passage of a mandate leads to an increase in the amount of psychotherapy consumed, then there must be a corresponding increase in the amount supplied. McGuire further assumed that the flow of services would be closely related to the number of service providers.

He found that while the growth in the number of psychiatrists was about 7 percent higher in states with mandates than in those without, the corresponding figure for psychologists was much higher—32 percent. McGuire does not find this difference surprising. In the absence of mandates, psychiatrists' services are more commonly covered in health insurance policies than are psychologists'; under the mandates, psychologists' services are typically covered.

After calculating the growth rates of mental health practition-

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ers, McGuire factored out the proportion of growth that could be attributed to the mandates. The use of the services of psychiatrists in fee-for-service practice increased by about 10 to 12 percent. For psychologists identified as health service providers, the increase was 18 to 25 percent. For all fee-for-service practice, the increase was about 10 to 20 percent. Translated into dollars, the increase comes to $1 to $2 a person in the general population.

The mandates' advantages

Providing affordable mental health care to a large number of people is, of course, the principal benefit of the mandates. But why is it necessary for the state to step in and force people to buy such coverage? McGuire and Montgomery present four answers to that question.

First, they note that there is widespread prejudice against treatment for mental disorders, which causes mental health benefits to be undervalued. Second, states may choose to use the mandate mechanism to assure that most state residents have the ability to pay for at least a minimum amount of mental health care.

Third, and perhaps most important, mandates do away with the problem of so-called adverse selection. This term refers to the tendency of high-risk policyholders to choose insurance plans with coverage they are likely to use. As the cost of those plans goes up, low-risk policyholders often choose other plans. Then the plan that offered the coverage may drop it to remain competitive.

"Adverse selection changes the perspective on a mandate," write McGuire and Montgomery. "Far from violating consumer sovereignty, the state may be taking steps to implement it." Nevertheless, they note, the effect of mandates is to distribute the cost of mental health care to all policyholders, with good risks paying too much and poor risks paying too little. "This redistribution from the 'healthy' to the 'sick' cannot be judged on efficiency grounds, but only on political grounds; it is a redistribution that may not be objectionable," according to McGuire and Montgomery.

The intention of the mandates may still be frustrated, however, if they contribute to a trend toward large firms offering their own insurance; employer self-insurance plans are not subject to direct state regulation.

Offset effects

"Offset effects" of mental health care are the fourth argument McGuire and Montgomery offer in favor of mandates. The use of mental health services may reduce the costs to society of health and social services, police, and reduced productivity.

McGuire and Montgomery cite an analysis by Jones and Vischi (4), who found evidence for offset effects in 24 of 25 studies of alcohol, drug abuse, and mental health treatment; in these 24, reductions in medical use ranged from 5 to 80 percent.

As Jones and Vischi caution, problems in the design of these studies make the evidence tenuous. However, McGuire and Montgomery point out that legislators often cannot wait for impeccable scientific proof but must act on available evidence. The existence of offset effects is intuitively sound and also supported by the evidence at hand.

McGuire and Montgomery's analysis of the mandates, which includes a discussion of unsuccessful challenges to their legality, falls short of definitive conclusions about whether the mandates are good social policy in the long run. Their research does lead them to conclude, however, that mandating a minimum level of coverage for mental health services in private health insurance appears to be "reasonable state policy."

Not the perfect solution

Steven Sharfstein, M.D. (3), deputy medical director/assistant to the medical director of the American Psychiatric Association and a longtime student of insurance trends, believes that although mandates offer important public health and economic advantages, they have their limitations. Most serious is that minimum levels of coverage tend to become the maximum coverage available—"floors become ceilings."

Fifteen states have chosen to encourage mental health coverage without actually requiring it. They have passed laws mandating insurance companies to at least offer such coverage; the decision to buy it is left up to policyholders or their group representatives. In those states, actual purchase of benefits has been low. According to the Philadelphia firm of GLS Associates, Inc., which did a study of all the mandates for NIMH in 1979, there are several reasons for this low number of purchases (1). Among them are that mental health benefits are expensive, decisions are often made by group purchasers who opt for more popular benefits (such as dental care), and insurers do not actively sell this coverage.

Research such as McGuire's may help to change public perceptions about the ultimate cost of buying mental health coverage. "It is important to have creative economists like McGuire look at the objective facts in controversial issues such as the cost of psychiatric care under insurance," says Sharfstein. "We no longer have to rely on the statements of the insurance companies themselves."

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Paying for Mental Health Care in the Private Sector

BY FREDERICK C. LEE AND GAIL SCHWARTZ

Employers are looking to cut costs through benefit redesign and alternative providers.

MENTAL HEALTH REPORT

Mental health benefit, service, and delivery issues have become increasingly important to benefit managers of large corporations. Although few employers have developed a sophisticated data system that allows them to fully comprehend the nuances of this field, many have identified real concerns through increased scrutiny of benefit payments. This new sensitivity to costs is matched by heightened awareness of the need for benefit redesign which also is responsive to the expanding emotional support requirements of today's workers.

The Washington Business Group on Health (WBGH), in a recent survey, documented current corporate thinking on the use of alternative providers and settings as a strategy for containing costs and improving mental health care delivery. The survey also looked at what limits are being placed on mental health coverage and why.

There are a number of reasons why employers have become concerned about mental health issues. The federal government as overseer of Medicare has focused attention on mental health benefits with its emphasis on financing this care in a cost-effective fashion. Likewise, the Federal Employees Health Benefit Program (FEHBP), in concentrating on use of psychiatric benefits, has alerted private sector companies to economic problems created by mental health care coverage. States also have stirred attention with limitations imposed on Medicaid and state employee mental health benefits. Company benefit managers have extended considerable time analyzing the value of providing incentives for outpatient care, including mental health treatment, in lieu of inpatient care. In examining ways of reducing employer health costs, benefit managers also have become conscious of the merit of promoting mental wellness. A cultural change has occurred whereby employees are not nearly as covert about their need for and use of mental health services. This trend, in turn, has prompted expansion of worksite mental health programs including counseling, employee assistance programs (EAPs) and stress reduction classes.

Lastly, as employers have become better watchdogs of their benefit programs through the collection of utilization and charge data, they realize that considerable resources are being consumed by mental health episodes of care or inattention to psychiatric problems. In analyzing annual claims, benefit managers often discover that incidents of inpatient psychiatric care represent several of their top 10 most costly benefit payments.

Surveying the Trend Setters

For all these reasons, employers have increased their concern about the use of mental health services by employees. Through its survey, WBGH has tracked the efforts of member companies which have changed or contemplate revising their mental health benefits and in-house services. The survey of 64 large, mostly Fortune 500 corporations, asked about their overall approach to mental health coverage, including trends in services provided, benefits offered, changes implemented and costs accrued for a beneficiary population of 19 million.

The survey results depict the moves made by the employers who are trend setters in health care cost management and who, in the years ahead, are likely to be emulated by thousands of other large and small companies.

Data collected on these companies' general health care expenditures for 1982 and 1983 revealed that respondents spent an average of $1,312 per capita in 1982 vs. $1,422 in 1983, reflecting an average per capita increase of 12 percent. Fifty-seven percent of the companies experienced an increase of between 10 and 20 percent.

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Companies that reported per capita cost increases of more than 15 percent do not necessarily differ from those which have experienced smaller increases.

All the companies sampled are major employers in various types of industry including heavy manufacturing, pharmaceuticals, insurance, automobile, energy, hotels, financial services, computers and retail operations. These companies employ a variety of cost management strategies that include efforts to moderate mental health costs. It is clear from analysis of the survey data that the escalating costs of health care are not typical of just one or a few industries.

Wide Spectrum of Modifications

Companies selected for this survey have adopted an interesting range of changes in mental health coverage that reflects their efforts to cope with use of services. Some of the changes represent nothing more than an effort to stay even with cost of living and inflation factors. For example, 19 percent of the companies, including Boeing and Warner Lambert, increased either their annual or lifetime dollar maximum for mental health benefits. Eight percent of the corporations cut their lifetime maximum, however, on the premise that their responsibility of providing for care of an employee or dependent who may be chronically ill should only go so far. Twenty-one percent of the companies have increased employee cost sharing, requiring greater deductibles or coinsurance. But 6 percent of those surveyed reduced the cost sharing burden on employees and, more importantly, 22 percent of the companies enhanced their reimbursement for outpatient mental health services.

Some of the more innovative changes reported included the expansion of mental health benefits by 3 percent of the companies to cover day treatment hospitals, the offering of EAP services to employees who enrolled in a health maintenance organization (HMO), the extension of coverage by 3 percent of the companies for outpatient alcohol and drug programs (like Proctor & Gamble and ALCOA), and the use of flexible benefit programs to isolate employees requiring more extensive mental health coverage.

Three percent of the companies resorted to a defined compensation policy for outpatient care, setting an annual dollar limit with no restriction on the charge per visit or selection of provider. Five percent of the employers limited the number of visits per year on an outpatient basis and 5 percent required preadmission certification before inpatient psychiatric admission. Sixteen percent limited the number of inpatient days covered. For example, 3 percent of the employers set an inpatient limit of 120 days, 8 percent had a 60-day limit, 2 percent, a 45-day limit and 3 percent, a 30-day limit. One company, Chevron, altered both the number of outpatient visits and the rate of coinsurance at the same time. Now this company's employees will receive an 80 percent copayment (up from 50 percent), but the limit on outpatient mental health care visits annually has been reduced from 40 to 20.

Employers and other purchasers of health care are exploring the use of alternative health care providers who may provide care more cost-effectively. This is especially true in mental health because of the diversity and sheer numbers of alternative providers. Corporations have begun to directly reimburse a variety of mental health professionals. The majority of employers sampled have always reimbursed psychiatrists and psychologists. Currently, 92 percent of employers reimburse for psychologists. In addition, 41 percent reimburse for social workers. Furthermore, corporations have almost doubled (to 34 percent) their use of psychiatric nurses since surveyed by WBGH in 1982.

Corporations employ psychologists more often than psychiatrists, although the tasks these providers perform are comparable regardless of their training. Twenty percent of the companies surveyed have full-time psychologists and 10 percent employ psychologists as part-time consultants.

"Many companies have begun to restructure benefit plans to incorporate alternatives to inpatient psychiatric coverage. Despite this trend, there is little available data to substantiate associated cost savings. Twenty percent of the survey respondents...said they have begun reimbursing for day treatment centers and 14 percent are reimbursing for night [hospitalization]...."

The WBGH survey also examined whether companies use specific individuals as "gatekeepers" to steer employees into appropriate mental health treatment settings. Twenty-seven percent of the respondents reported having a staff person responsible for identifying individuals in need of mental health treatment, 39 percent had someone referring patients to other providers, 25 percent had an employee monitoring ongoing treatment, and 27 percent had an individual overseeing psychiatric long-term disability cases. In most cases, these various tasks are being performed by the same individual. Triage duties were shared by the following: nurse, medical or counseling department staff member, physician, psychiatrist, EAP coordinator, plant personnel director, benefit manager, administrator or psychologist. In two cases, these functions were filled by a manager of disability services and a long-term disability coordinator.

Many companies have begun to restructure benefit plans to incorporate alternatives to inpatient psychiatric coverage. Despite this trend, there is little available data to substantiate associated cost savings. Twenty percent of the survey respondents, such as Aetna, said they have

begun reimbursing for day treatment centers and 14 percent are reimbursing for night hospitals which allow patients to work during regular employment hours. A few companies have also added extended care facilities to their plans.

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Coverage for inpatient psychiatric care remains, however, the most generous mental health benefit offered by employers. There has been some benefit redesign in this area, with 33 percent of companies reporting that they have set a lifetime maximum on dollar outlays for psychiatric inpatient care. Of these companies, 29 percent have set the level at $20,000 to $25,000. Otherwise, no real trend in redesign of inpatient psychiatric coverage has become apparent. No company yet has introduced a maximum dollar limit per episode of care, and only 8 percent of the surveyed corporations imposes a maximum daily reimbursement for inpatient care. None of the companies with a daily cap has established dollar limits. Instead, the employers stipulate reasonable and customary or semiprivate room restrictions. One employer, The Continental Group, Inc., did introduce a limit for inpatient days in excess of 60, committing to a reimbursement rate of $100 per day or 50 percent of the hospital charge, whichever is less.

Seventy percent of the companies have stop-loss coverage built into their plans. More than two-thirds of employers with a stop-loss provision have a specific inpatient psychiatric clause. The average recorded inpatient psychiatric stop-loss was $1,590. But limits ranged from $500 to $5,000.

"A number of medium and large sized companies have developed EAPs. The impetus for this movement has been employer recognition of the costs, absenteeism and loss of productivity associated with emotional problems, alcoholism, drug abuse and mental illness.... Some employers are finding EAPs to be a viable, cost-effective option."

Employers also relied on coinsurance as a cost management strategy to control inpatient psychiatric benefits use. Fifty-five percent of the employers had an 80-20 cost sharing provision; one-fourth still had first dollar coverage.

Outpatient coverage, as noted earlier, remains an area of concern for employers. Respondents to the WBGH survey have implemented some conventional limitations to protect against induced demand. Although research has yet to indicate the most appropriate benefit design for checking unnecessary outpatient use, the three most commonly employed strategies have been: placing a maximum limit on annual payment per employee for outpatient services; restricting the number of reimbursable outpatient visits per year; and imposing a dollar limit on reimbursement per visit. Fifty-six percent of the companies surveyed limit yearly reimbursement for outpatient mental health services to between $1,500 and $2,000 per employee, with the average limit being $1,723.

Eight percent of the companies rely on a separate deductible for mental health services, but the bulk of the respondents choose to offer coinsurance restraints. Thirty-two percent of the employers pay less than 50 percent coinsurance, another 51 percent pay exactly half of the copayment, and 6 percent pay more than half of the provider's charge. The remaining 11 percent have adopted a graduated cost sharing strategy in which employee coinsurance requirements increase with the number of outpatient visits. For example, at Ford Motor Company the employee pays 20 percent of the cost of the first five visits, on up to 100 percent for more than 15 visits per year. One company even has adopted a graduated copayment level based on the diagnosis, an intervention many other companies may view as too controversial to attempt, because it interjects benefits managers into medical practice decisions. Only 21 percent of the employers have limited the number of annual outpatient visits. Of this group, five percent have set restrictions of 100 and 140 days per year, 5 percent have constrained use to an average of 23 days, and 11 percent selected either 50 or 52 days as the maximum reimbursable limit.

Utilization Review Limited

Many of the companies surveyed have adopted utilization review programs for general medical care, but the provision of separate mental health care review is less common. Thirty-seven percent of employers polled said they carry out concurrent inpatient psychiatric review. The first program of this kind among respondents was established in 1982. Only 11 percent of the corporations, including Armco, Goodyear and IBM, perform concurrent review of outpatient mental health care utilization. The same number of employers, among them LTV and Digital, reported implementing preadmission review as a gatekeeping function for potential inpatient psychiatric episodes.

One example from the survey demonstrates how the business community has collaborated with providers to make needed mental health care available while maintaining control over costly, inappropriate use of resources. The St. Louis Area Business Health Coalition has joined with a local, federally sponsored peer review group and the Eastern Missouri Psychiatric Society to create a concurrent inpatient psychiatric review program which begins this month. The program took 16 months to develop and relies on certain established criteria in determining appropriateness of care.

Reviews of care will be charted and the aggregate data analyzed. The program will charge $2.50 per admission. A conservative estimate by the business coalition

is that the program will reduce inpatient psychiatric care by 5.38 days per stay which could result in a $1,614 savings per admission. Despite the importance of this effort, the time spent developing this program underscores the fact that such proposals cannot be drawn up and implemented overnight.

Variations in EAPs

A number of medium and large sized companies have developed EAPs. The impetus for this movement has been employer recognition of the costs, absenteeism and loss of productivity associated with emotional problems, alcoholism, drug abuse and mental illness. More recently, corporations have realized that long-term psychotherapy is not the only option for employees with mental health problems. Some employers are finding EAPs to be a viable, cost-effective option.

Seventy-three percent of the companies surveyed by WBGH have EAPs, most of which were developed in the last eight years. The majority of EAPs employ a combination of health care professionals, and other types of staff. There were no significant patterns to these combinations. The following table gives a breakdown of the different professionals and paraprofessionals used in the EAPs of the survey respondents.

Type of professional/paraprofessional	Percent of EAPs in which professional/ paraprofessional is represented.
Counselors	21%
Volunteers	2
Licensed Clinical Social Workers	26
Nurse	14
Master of Counseling	5
Psychologist	14
Pyschiatrist	7
Master of Social Work	4
Physician (other than Psychiatrist)	4
Lawyer	2
Management Representative	5
Others	20

Over the past several years, EAPs have broadened their focus beyond their initial emphasis on alcohol and drug abuse. A number of EAPs have incorporated assistance in coping skills, family counseling and financial planning. Of the EAPs surveyed, 68 percent have comprehensive missions, while 30 percent are oriented solely around alcohol and drug abuse intervention and treatment.

The majority (67 percent) of employers house EAPs in their corporate medical departments, 24 percent put EAPs under their personnel departments, and the remaining 9 percent of employers have established independent EAPs or put that responsibility under the health and safety divisions.

Companies have dealt differently with the issue of who on an EAP's staff should initially identify employees to determine appropriateness of care. WBGH's analysis shows that psychiatrists are rarely involved in making this determination; they do so in only 4 percent of the EAPs reviewed. Psychologists make this judgment in over one-fifth of the EAPs (22 percent). Licensed certified social workers do the initial screening in almost a third (29 percent) of EAPs, while counselors screen EAP clients in 18 percent of the programs. In the remaining companies, the designation is made by some member of the medical department, a registered nurse, or the EAP manager.

"Employers...[also] pay for mental health problems through...psychiatric disabilities....For 30 percent of the companies surveyed, psychiatric disabilities comprised more than 11 percent of their caseload. These employees frequently have severe mental health problems which make it difficult for them to work full-time."

In establishing EAPs, employers make an investment in their work force and assume new responsibility for their employees' mental health. But critical policy questions have to be resolved prior to implementation: Which employees should be eligible? What types of problems should be considered? Should EAP resources be limited to employees? Should they be broadened to include employees, dependents and retirees? Fifty-two percent of the companies surveyed offer their EAP services to their employees, dependents and retirees; 32 percent of the companies exclude retirees from EAPs, but make their programs available to employees and dependents; and 16 percent of employers make their EAP programs available only to employees. Where an EAP is restricted to employees, the company clearly views its responsibility as limited to cases where job performance is affected by mental health problems.

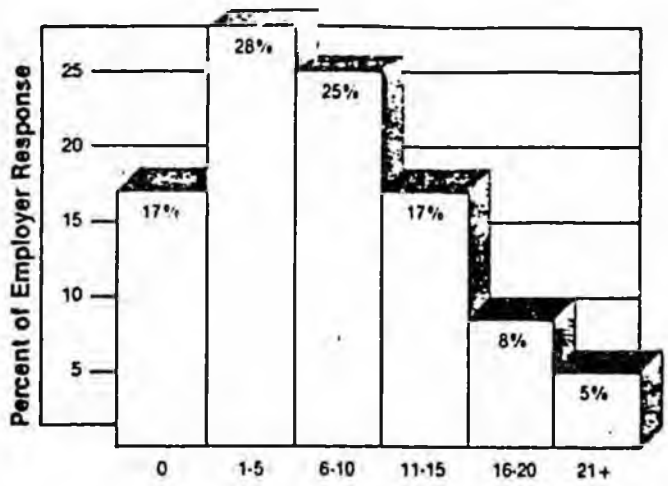
Of the total number of persons seen by EAPs, the majority (58 percent) were seen for screening and referral only, while the remainder actually were treated by EAP staff. The overwhelming majority (over 90 percent) of cases were self-referred, while the remainder were referred by supervisors or management, union representatives, fellow employees, or the medical department. Once an employee visited an EAP he or she most often was referred to in-house staff. Alcohol treatment centers and drug abuse programs were the other common referral sites.

Forty-one percent of the companies surveyed have a stress management program. Sixty-five percent of these employers house their stress management program within the EAP and the remaining 35 percent have put stress management under the corporate medical department, health and safety division, or employee services. Sixty-two percent of respondents stated their EAPs also work with disabled employees.

Handling Psychiatric Disability

Employers not only pay for mental health problems through increased absenteeism and health care costs, but also through psychiatric disabilities that require provision of short- and long-term disability and workers compensation benefits. The added financial burden of these income maintenance payments can be enormous.

The following chart shows the percentage of long-term disability (LTD) claims due to psychiatric conditions among survey respondents.



LTD Cases
(Percent with Psychiatric Causes)

For 30 percent of the companies surveyed, psychiatric disabilities comprised more than 11 percent of their caseload. These employees frequently have severe mental health problems which make it difficult for them to work full-time.

One-third of the survey respondents said they have a program to bring psychologically disabled workers back to work. Often times, these programs are also open to physically disabled workers. The most common employer sponsored return-to-work program is an incentive arrangement whereby the disabled individual can work part-time and continue to receive disability benefits while he or she readjusts to employment. During this trial work period, the disabled employee does not run the risk of losing his or her disability benefits and Medicare coverage until he or she is fairly certain about being able to remain on the job. In most instances, individuals are selected on a case-by-case basis for such a program.

In addition, two companies surveyed have identified an individual who is solely responsible for disability benefits. One company, Owens-Illinois, employs a "long-term disability coordinator," while Xerox has a physician "disability manager."

Independent medical examiners frequently are called upon to assess the status of disabled workers. Internal rehabilitation committees comprised of representatives from company benefits and corporate medical departments also have merged as oversight groups that deliberate on the potential for rehabilitation of specific employees.

As corporations become more aware of the high cost of disability, cost management techniques will be advanced that echo the efforts employed by business over the last decade to reduce overall health care costs.

Shape of Changes to Come

The benefit changes recorded by participants in this survey give some indication of what revisions can be expected from employers who have yet to act. A number of these companies, however, are waiting until there are more data available on the impact of changes in mental health coverage. The most common alteration planned for 1985 will deal with outpatient care: 8 percent of the companies surveyed intend to enhance incentives for outpatient use by decreasing employee coinsurance levels from the usual 50 percent to 20 percent.

Concerns about excessive use of mental health benefits have motivated 4 percent of the companies to reduce the lifetime maximum, and another 4 percent to propose a limitation on the number of outpatient visits. Goodyear, Deere and Company, and Bethlehem Steel are examples of companies surveyed that are working on development of a preferred provider organization, HMO or other type of prepaid, risk sharing program with mental health providers.

Such interest indicates corporate leaders are scrutinizing closely mental health costs. Many employers now realize that they are paying dearly for expenses associated with mental illness, and yet they have little understanding of what they have been purchasing. The recent employer movement towards collecting, analyzing and monitoring data has made this more apparent. In addition, corporations are recognizing that mental health services can be provided through a wide range of alternatives and are beginning to reflect these options in the design of employee benefits.

The WBGH mental health survey reveals several trends in mental health care coverage including:

- That corporations are becoming extremely concerned about high health care costs, absenteeism, disability costs, and lost productivity associated with mental health;
- That benefit managers are grappling with how to redesign reimbursement for mental health coverage to reflect new options in service delivery and alternative providers;
- That employers also have recognized utilization review is an imperative component of benefit design;
- That employers are continuing to broaden their EAPs to include more areas such as counseling for disabled employees and that EAPs will become more diffused as the movement gains momentum;
- That as companies invest more in their employees as human resources, they will continue to develop new mental wellness programs.

In short, corporate awareness of mental health costs is likely to culminate in the restructuring of reimbursement and the delivery of mental health services. ■

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

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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.

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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 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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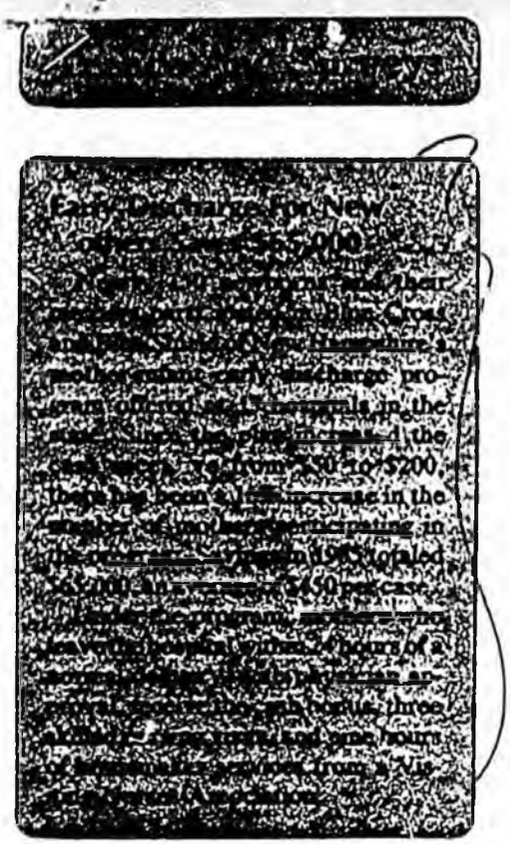

care, the report said, adding:

"With women accounting for two-thirds of the expected labor force growth, a more concerted effort by industry and the public sector is needed to assure quality child care.

"Child care is important for worker morale and productivity. It is also essential for the employment of welfare recipients. Child care facilities can provide a stimulating environment for younger children. This can be particularly beneficial for children from more disadvantaged surroundings."

Mr. Ong, who also is chairman and CEO of B. F. Goodrich Company, said the study was designed only to suggest what problems would arise in the next 15 years, "not to spell out our silver bullets to take care of the problems."

However, in a section on guidance for action toward the future challenge in labor market policy, the report did call for a national policy on child care "to identify the most appropriate responsibilities for the different levels of government."

No One Can Do All

It said that care of children during work hours has become a national issue, important to both men and women workers, with increases in single heads of households and two-wage-earner families.

The Alliance report said:

"No one sector can assume full responsibility and costs. Because many businesses already realize that worker attendance and productivity can be affected, they are providing information on available child care or assisting in expenses through benefit packages."

Businesses also need increasingly to consider flexible work schedules or greater part-time opportunities to meet needs of parents, stated the report.

"Since many needing child care, such as single heads of families, have lower incomes, governments must also respond. Options include tax incentives for business investment and income-based voucher programs for parents." □

Dropping Mental Health Coverage Can Be Costly

The cost of mental health benefits is high but the cost of not providing them may be even higher, according to the Washington Business Group on Health.

Speakers at the spring meeting of the National Association of Private Psychiatric Hospitals quoted the statistics on costs to employers of mental illnesses of employees and noted that those treating mental illness are responding to employer's cost concerns

associated with mental health benefits.

Dr. Howard Hoffman, of the Psychiatric Institute of Washington, D.C., referred to the study by the Washington Business Group on Health which reported that:

- Weirton Steel reports that 61% of its absenteeism is due to psychiatric problems.
- Kennecott Copper Company's "Insight" counseling program reports a 53% reduction in absenteeism and 55% hospital/surgical/medical reduction.
- The California Psychological Health Plan, a benefit plan added to some insurance policies, reports that users have a 20%-24% reduction in hospital/surgical/medical utilization.
- Blue Cross of Western Pennsylvania reports that for 136 persons who used insured outpatient psychiatric benefits, medical costs dropped from $16.47 to $7.06 per month.
- Group Health Association reports that users of mental health counseling benefits reduced their nonpsychiatric physician visits by 30.7% and lab/X-ray services by 29.8%.
- General Motors' alcoholism program reports a 49% reduction in lost work hours and a 29% reduction in disability costs.
- Bethlehem Steel has a 60% rehabilitation rate in its alcoholism program.
- Kimberly Clark's employee assistance program showed a 70% reduction in accidents for the year after participation compared with the year before.

Alternative Treatments

Speakers described psychiatric hospital responses to health care cost containment measures currently being taken by employers, insurers and other providers. Hospitals are developing alternative treatments such as outpatient treatment, day treatment and partial hospitalization as well as inpatient treatment. In addition, some hospitals work with local business health care coalitions and provide professional consultation, education programs and EAP resource services.

Flexibility Is Key

Dr. Hoffman said hospitals are developing flexible and creative approaches to meeting the needs and concerns of payors and employers shopping for services should be prudent buyers. When reviewing mental health benefits packages, employers should keep four points in mind:

- Substance abuse is not a single entity but encompasses many different problems and diagnoses.
- Caps on services are not all bad if there is an outlier appeal method.
- A creative exchange of benefits for less intensive services provides for flexibility.
- Child and adolescent illness is different from adult mental illness and needs different services. □

Stress Affects All Workers

The results of a recent nationwide survey shows that executives are not the only group of employees who are adversely affected by stress. The Panasonic Industrial Company and the Professional Secretaries International (PSI) polled 1,000 members and found that the stress faced by secretaries can contribute to absenteeism, diminished productivity, and any number of health problems.

The survey evaluated the impact of environmental conditions, such as job functions, work atmosphere, professional relationships, executive work habits, and office equipment.

Lack of communication is a major cause of secretarial stress. Of the 70% who reported too little communication with their

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Parity for Mental Health

Should there be "parity" or equality in coverage for mental illness in health insurance? Clear divisions have existed on this issue for some time. To providers and patient advocates, parity has symbolic as well as practical significance. In addition to enhancing patients' ability to pay for care and providers' ability to collect revenue for care, parity symbolizes acceptance by the medical profession and society at large of the legitimacy of mental illness and the value of mental health treatment. The American Psychiatric Association, for example, has drawn an analogy between stigmatizing the mentally ill and what they refer to as the "historical discrimination against the mentally ill in insurance plans."

Policy makers and most researchers, however, have rejected the call for parity on the grounds that equal insurance coverage would encourage excessive utilization. The research evidence has consistently shown, where health and mental health are compared, that the demand response for mental health care is greater than for most other health care. Principles of insurance design justify less coverage for services for which the "moral hazard" problem is more severe.

Parity: The Retreating Goal

Virtually all private and public insurance plans place special limits on coverage for mental health care. Less than ten percent of individuals covered by employment-related group health insurance have identical coverage for outpatient mental and physical health care. Medicare presently places strict limits on outpatient care and has special inpatient day limits in psychiatric facilities. Medicaid programs vary state to state; in many states mental health care is not a covered service or is subject to special restrictions.

In the past decade, the disparity between coverage for physical and mental illness has increased. Health cost inflation has eroded the real value of coverage denominated in dollars. Medicare pays $250 in total for outpatient mental health benefits (with 50 percent coinsurance). This can buy only about one-quarter of the care it could buy in 1965. Many states have mandated $500 or $1000 of insurance coverage. In 1976, Massachusetts mandated coverage of $500, which could purchase more than 14 visits to an office-based psychiatrist. Today the coverage is worth less than seven visits. Furthermore, cost-control efforts have led to benefit reductions specific to mental health in prominent health plans, including the nationally available plans for federal employees available from Blue Cross and Aetna.

Time of Reconsideration

Although the trend may appear to be moving away from parity in coverage, other changes in health care payment systems are giving cause for serious reconsideration of the perceived wisdom on the parity issue. Effective alternatives to patient cost sharing are being implemented and evaluated. As these innovative cost-control mechanisms become more effective, the need to impose cost sharing on patients to restrain utilization is diminished, and the case for using insurance primarily to protect patients against the financial risk of illness is strengthened.

Opportunities for significant restructuring of insurance coverage are greatest in the area of hospital care, because of recent changes in methods of reimbursement. Powerful supply-side incentives to limit utilization obviate the need for patient cost-sharing. In Medicare, *all* psychiatric discharges are paid by some form of prospective payment, fully prospectively in the case of nonexempt facilities on the basis of DRGs, and partially (roughly half) prospectively for exempt facilities paid under TEFRA. All but a handful of states use some form of prospective payment for psychiatric discharges in Medicaid. Contracting by private insurers is becoming the rule rather than the exception. In this environment, special limits on psychiatric discharges in these plans should be reconsidered.

Should Parity be the Goal?

Is it parity that should be sought? It is interesting that the mental health community has generally opposed parity on the reimbursement side in Medicare. The argument that mental health care should be treated like the rest of medical care was not persuasive when the rest of medical care was being paid prospectively on the basis of DRGs.

Health maintenance organizations (HMOs) are an example of near-parity for mental health. Although most HMOs explicity limit mental health visits to 20 per year, in fact, the real limit on use is what the clinicians at the plan decide the patient needs—very few patients reach 20 visits. In this sense, the limit on mental health care is the same as it is for other areas of health care. It is not at all clear that this instance of full parity is what we should want. When the provider is paid prospectively, mental health services seem to be one of the areas of heaviest management pressure to limit use.

In the case of payment system rules, equality with other medical care should not be the goal *per se*. The goal should be coverage that appropriately balances access to care and cost. We must ask, therefore, parity with what?

Health service researchers are likely to continue to argue that on the basis of distinct patterns of demand (and now supply) behavior, the reimbursement and financing system for mental health care should be different than for other medical care. Introduction of supply-side cost control policies makes the case for parity in payment systems stronger, to be sure. But leaving aside the question of parity, it is certainly true that changes in reimbursement methods put us in danger of cost overkill. It is time to lighten up on the demand-side controls on mental health care—particularly for hospital care—to provide more financial protection for the catastrophic expenses due to mental illness.

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FINAL REPORT

MANDATED HEALTH BENEFITS IN MARYLAND: A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

Prepared for

Blue Cross and Blue Shield of Maryland

Blue Cross and Blue Shield of the National Capital Area

November 1985

Excerpts (marked *)

(let me know if you want any other sections)

CENTER FOR HEALTH POLICY STUDIES

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MANDATED HEALTH BENEFITS IN MARYLAND: A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

Prepared for

Blue Cross and Blue Shield of Maryland

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November 1985

Prepared by: Zachary Dyckman, Ph.D.
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MANDATED HEALTH BENEFITS IN MARYLAND:
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Introduction

The issue of the appropriateness and need for specific mandated health insurance benefits is a critical one in Maryland. It is likely that the Maryland legislature will be confronted with mandated benefit issues this year. It is the express desire of the Maryland General Assembly that decisions as to whether to expand, contract or change the structure of mandated benefits be made on the basis of reliable, accurate information on cost and benefit implications of specific mandate decisions. To this end, the House Economic Matters Committee has requested that Blue Cross and Blue Shield of Maryland, and Blue Cross and Blue Shield of the National Capital Area address a number of important questions concerning mandated health insurance benefits. This report is in response to those questions.

This report has been prepared by the Center for Health Policy Studies under the direction of Zachary Dyckman, Ph.D., for Blue Cross and Blue Shield of Maryland and Blue Cross and Blue Shield of the National Capital Area. The methodologies used to respond to the issues raised by the Committee include analyses based on existing published and unpublished research studies, computer runs of Blue Cross and Blue Shield claims cost files, information obtained from the Maryland Division of Insurance and other insurance industry sources and a special mandated benefit survey of Blue Cross and Blue Shield plans.

The report focuses on those benefits specifically mandated to be included in health insurance policies. Excluded from consideration in this report are benefits which are mandated to be offered to health insurance purchasers. Also excluded are mandated benefits for maternity coverage (mandated for larger groups by Federal statute), mandates for conversion rights and recently mandated benefits for in-vitro fertilization (no claims cost experience available).

Mandated Benefit Research Issues

Selected issues are discussed briefly here:

Issue: • What is the cost of health benefits mandated in Maryland?

1984 claims expenditure data (claims cost and administrative expenses combined) for Maryland Blue Cross and Blue Shield and National Capital Area Blue Cross and Blue Shield (Maryland contracts) were extracted from claims files and combined to

develop data for all Blue Cross and Blue Shield members in Maryland, excluding Federal Employee Benefit Plan and Medicare supplemental enrollees. The mandated benefit cost data are summarized below.

BLUE CROSS AND BLUE SHIELD MANDATED BENEFIT COST IN MARYLAND, 1984

	Amount Per Member Contract Month	Amount Per Family Contract* Year	Percent of Total Benefit Costs
Mandated Benefits			
All Mandated Benefits	$ 5.61	$ 222.16	11.5%
Mental and Alcohol Rehabilitation	4.25	168.30	8.7
Outpatient Mental	2.19	86.74	4.5
Total Benefit Cost	$48.67	$1,927.33	100.0

*Assumes statistically average family of 3.3 persons.

The cost of Maryland mandated benefits, excluding maternity benefits and other selected mandates identified in the report, is 11.5 percent of total benefit cost. The aggregate cost of mandated benefits for 1,317,000 Blue Cross and Blue Shield members in Maryland is approximately $89 million, out of total benefit cost of $769 million.

Issue: • Which benefits mandated in Maryland are offered in states in which these benefits are not mandated?

The Center for Health Policy Studies conducted a survey of other Blue Cross and Blue Shield Plans. The primary purpose of the survey was to determine what benefits are commonly provided by Blue Cross and Blue Shield Plans for the benefits which are not mandated in their states but which are mandated in Maryland. Because the survey attempts to measure benefit levels which are determined by purchaser preferences rather than by state regulatory decisions, i.e., state mandates, Plans were surveyed in states which have relatively few (or no) mandated health insurance benefits.

Forty-two Blue Cross and/or Blue Shield Plans were selected for the survey from 34 states which were known to have few mandated benefits, based upon prior studies. A total of 34 Plans in 29 states responded to the survey questionnaire, for a response rate of 81 percent. Most surveyed Plans routinely

provide inpatient mental health, alcoholism and drug abuse benefits, with 30 days coverage the most common level of benefits. Similarly, most Plans routinely provide benefits for hospice care, prosthetic devices and home health care. These benefits are comparable to Maryland mandated benefits for these services. Few Plans provide benefits for in-vitro fertilization, a recently mandated service in Maryland.

Most of the Plans which routinely provide outpatient mental health benefits require 50 percent patient coinsurance, which is comparable to the Maryland mandate. However, most Plans had dollar limits on outpatient mental health benefits and/or limits on number of visits per year covered in addition to coinsurance requirements. The Maryland mandate precludes use of an annual limit on dollar benefits or number of visits unless comparable annual limits are used for other major medical benefits.

Issue: • Are mandated benefits hastening the trend toward self-insurance?

State mandated benefit laws regulate benefits provided under health insurance programs. HMO programs and employer self-insured health benefit programs are exempt from state mandated benefit laws. In 1982, more than one-third of all persons in the United States covered under health benefit programs were covered under programs exempt from mandates. This has increased to about 50 percent in 1985. It is estimated that health benefit programs covering 35 to 50 percent of Maryland residents are exempt from mandated benefits. Interviews with employers and administrators of self-insured programs indicate that the desire to avoid some or all Maryland mandated benefits is one of several primary factors inducing employers to move to self-insurance.

Issue: • What is the cost of health insurance in Maryland relative to other states?

Data are not available which would allow meaningful health insurance cost comparisons across states. Also, differences among states in health insurance costs are related primarily to factors other than mandated benefits. These include:

- historical utilization patterns
- historical provider prices
- existence of state rate regulatory programs
- competitiveness of the medical care market, possibly related to HMO market penetration

- number of persons covered under union agreements and specific benefits provided under these agreements

- relative number of large (costly) teaching hospitals in states.

As a result of these considerations, health insurance cost comparisons are not made across states.

It is useful, however, to compare provider supply across states, for those providers primarily affected by mandated benefits. Relative supply of mental health providers has been found to be highly correlated with mental health utilization and costs. Comparisons are made for practicing psychiatrists, psychologists and registered clinical social workers. Maryland ranks 4th, 3rd and 5th among all 50 states, in number of psychiatrists, psychologists and clinical social workers per 100,000 population, respectively. Maryland has between 52 percent and 120 percent more mental health providers, adjusted for population, than the United States as a whole.

These data indicate Maryland has a relatively abundant and possibly excess supply of mental health providers. The data also suggest that mental health care utilization and costs are higher in Maryland than in most other states.

Issue: • What are the estimated premium costs of selected benefits recently considered but not mandated in Maryland - Alzheimer's disease and increased benefit for outpatient mental health from 50 to 80 percent?

Alzheimer's Disease

Alzheimer's disease is a type of dementia primarily affecting the elderly which results in progressive loss of memory and other cognitive functions. There is no known method to halt or reverse the process. It is estimated that five percent of those over age 65 have Alzheimer's disease or related conditions, or approximately 20,000 persons in Maryland. Treatment often requires a mix of medical care and long-term care services.

Several important factors need to be evaluated, if mandated benefits are to be considered for Alzheimer's disease.

- Alzheimer's is diagnosed by an analysis of patient symptoms and through a process of elimination. It can be diagnosed definitively only after death.

- There are other chronic mental and physical debilitating conditions that require institutional care or extensive home care. Should Alzheimer's disease be singled out for mandated insurance coverage?

- Long-term custodial care is not covered under private health insurance programs. There has been, as of yet, no demonstration as to the feasibility of providing benefits for long-term care under private health insurance.

It is estimated that it would cost about $270 million to provide for the long-term care needs of Alzheimer's patients, assuming one-third require institutionalization and two-thirds require varying degrees of home care. This figure includes funds already being spent by Medicaid, self-pay and other sources for long-term care for Alzheimer's patients.

Increase in Outpatient Mental Health Benefits from 50 to 80 Percent

Outpatient mental health care, defined as mental health services provided in a non-inpatient setting by psychiatrists, psychologists, clinical social workers and others who may be licensed to perform such services in Maryland, is by far the largest expenditure category among all mandated benefits. It accounts for 4.5 percent of total benefit cost in Maryland, or approximately $35 million of total Blue Cross and Blue Shield benefit cost.

A number of factors are considered in developing a cost estimate for increased mandated benefits.

- Econometric studies indicate an elasticity of demand for mental health services of between one and two; i.e., a more than proportionate increase in utilization for a given decrease in effective price due to an increase in insurance benefits.

- It is well established in the research literature that claims cost and utilization experience under managed care HMO settings are irrelevant for projections of claims cost for mandated benefits in a fee-for-service environment. An offset factor, observed for selected types of patients in managed care settings, such as for patients recovering from heart attacks, has no relevance for projecting claims cost in a primarily fee-for-service setting.

- Maryland has a relatively abundant and possibly excess supply of mental health providers.

- Mental health and substance abuse treatment providers of all types are actively marketing in the electronic and print media. Utilization of services will be greater where providers have excess capacity than where supply-demand imbalances do not exist.

- Mental health claims cost can increase because: (1) a greater proportion of claims for services being used now will be covered under expanded benefits; (2) existing users will receive a greater quantity of services because of expanded benefits, due partly to provider induced demand; and (3) expanded benefits combined with increased provider marketing efforts will cause additional persons to use mental health services. Each of these is expected to occur as a result of an expansion of benefits from 50 to 80 percent, with factors (2) and (3) assuming greater importance after the initial year.

The following increases in claims cost are projected within two years after implementation of a change in mandated benefits from 50 to 80 percent:

- Existing claims will increase 60 percent from $2.19 to $3.50, simply as a result of greater benefits being paid for the same volume of claims.

- Substantial increases in utilization will occur for both existing and new users of mental health benefits. The projected combined effect is an increase in visits by approximately 100 percent within two years. As a result the $3.50 per member month will increase to $7.00, in addition to general inflation.

- For a typical family contract of 3.3 persons, annual premiums for outpatient mental health care are projected to increase from $86.74 to $277.20 in approximately two years, an increase of 320 percent.

In considering these projections, it is important to understand that the proposed increase in mandated benefits for outpatient mental health care is fundamentally different from previous mandated benefits. It substantially increases coverage for an already costly benefit, for which utilization is known to be highly responsive to reduced cost sharing. It could also serve as a major impetus to move to self-insurance and thus be exempt from all mandates.

MANDATED HEALTH BENEFITS IN MARYLAND:
A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

INTRODUCTION

The issue of the appropriateness and need for specific mandated health benefits (mandated benefits) is a critical one in Maryland. It is likely that the Maryland legislature will be confronted with mandated benefit issues this year. It is the express desire of the Maryland General Assembly that decisions as to whether to expand, contract or change the structure of mandated benefits be made on the basis of reliable, accurate information as to cost and benefit implications of specific mandate decisions. To this end, the House Economic Matters Committee of the Maryland General Assembly has requested that Blue Cross and Blue Shield of Maryland, Blue Cross and Blue Shield of the National Capital Area and health insurance companies operating in Maryland address a number of important questions concerning mandated health insurance benefits. These questions, restated and simplified somewhat from those expressed verbally at the Committee meeting on May 7, 1985, are listed in Exhibit 1 on the following page.

This report has been prepared by the Center for Health Policy Studies, under the direction of Zachary Dyckman, Ph.D., for Blue Cross and Blue Shield of Maryland and Blue Cross and

EXHIBIT 1

MARYLAND MANDATED BENEFITS RESEARCH ISSUES

- Are mandated benefits necessary? Are mandated benefits desirable from a public policy perspective?
- What is the cost of Maryland mandated benefits?
- Are mandated benefits hastening the trend toward self-insurance?
- What is the cost of health insurance in Maryland relative to other states?
- Which benefits mandated in Maryland are offered in states in which these benefits are not mandated?
- What would be the impact on individual purchasers and on individual members of groups of changing from mandated benefits to mandated offerings?
- How are employer health benefit decisions made? What is the process used by companies to determine which benefits to offer?
- What are the estimated benefit costs of selected benefits recently considered but not mandated in Maryland - Alzheimer's disease and increased benefit for outpatient mental health from 50 to 80 percent?
- How are decisions made concerning Blue Cross and Blue Shield coverage of new services and for determining whether a procedure is no longer "experimental"?
- What is the impact of mandated benefits on the availability of health insurance in Maryland?

Blue Shield of the National Capital Area. The commercial health insurance companies, in cooperation with the Health Insurance Association of America, have produced an independent report. The Center is a health policy research firm that conducts studies relating to health finance for the Health Care Financing Administration (administers Medicare), other Federal and state agencies, private health insurers and other purchasers of health care services. Dr. Dyckman served as project director for a recently completed study by the Center for the National Institute of Mental Health on the impact of mandated mental health benefits on the cost and utilization of health care services.

The methodologies used to prepare this report include analyses based on existing published and unpublished research studies, computer runs of Blue Cross and Blue Shield claims cost files, information obtained from the Maryland Division of Insurance and other insurance industry sources and a special mandated benefit survey of Blue Cross and Blue Shield plans. The specific research sources are identified in the discussion of each of the research issues.

Specific Mandated Benefits Examined

This report considers a wide range of health services for which benefits have been mandated in Maryland over the past decade. It focuses on those benefits specifically mandated to be

included in health insurance policies. Excluded from consideration in this report are existing benefits which are mandated to be offered to health insurance purchasers. Also excluded are mandated benefits for maternity coverage (mandated for larger groups by Federal statute); mandates for conversion rights; and the mandated benefit for in-vitro fertilization services (legislation was enacted earlier this year and no actual claims cost experience is available). The mandated benefits considered in this report are listed below.

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354D & 470E	Nervous & Mental Mandates at least 30 days of inpatient care per calendar year or benefit period under all group and direct-billing contracts. Mandates a rate of payment for nervous and mental disorders under major medical of not less than 50% of the rate provided for other types of illnesses. Amended with the intent of adding extraterritorial applications for these benefits.	Before 1978 Amended 1981
Article 48A §490F	Alcoholism Rehabilitation Mandates that all group contracts include benefits for alcoholism rehabilitation (7 days emergency care or detoxification, 30 days inpatient care (Type C or D facility) and 30 outpatient	1980 Amended 1981

STATUTE	BENEFIT	EFFECTIVE
	Alcoholism Rehabilitation (Cont.) visits that can be limited to not less than $1,000 during any calendar year). Basic benefits may be limited to 120 days and visits combined in a covered person's lifetime.	
Article 48A §354L, 470K and 4770	Social Worker Mandates coverage for services provided by a licensed, certified social worker. Applies to group and direct-billing subscribers who reside or work in Maryland.	1978
Article 48A §354Q	Prosthetic Devices/Orthopedic Braces Requires payment of benefits under both group and direct-billing contracts for prosthetic devices and orthopedic braces.	1978
Article 48A §354E & 470G	Blood Products Prohibits the practice of excluding payment for blood products which would otherwise be covered under the group or non-group contract (does not apply to whole blood or concentrated red blood cells).	Before 1978
Article 48A §470J	Home Health Care Mandates benefits for at least 40 home care visits per calendar year or twelve month period. Home care providers include registered nurses, physical therapists, dieticians, etc. Applies to group and direct-billing contracts.	Before 1978 Amended 1982

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354 & 489	Chiropractors Mandates that benefits for contractually included services be provided when rendered by a chiropractor licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354 & 490	Podiatrists Mandates that benefits for contractually included services be provided when rendered by a podiatrist licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354 & 477F	Optometrists Mandates that benefits for contractually included services be provided when rendered by an optometrist licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354 & 490A	Psychologists Mandates that benefits for contractually included services be provided when rendered by a psychologist licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354Y, 470T, 477Z	Coverage for Nurse Anesthetists Requires that insurers and nonprofit health service plans provide benefits whenever a covered service is rendered by a certified nurse anesthetist acting within the scope of a nurse anesthetist's license. Payment cannot be contingent on a nurse anesthetist's being employed by a physician. Defines a nurse anesthetist within the Health Occupation Article.	1984

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354Z, 470U, 477AA, 490A-1	Coverage of Licensed Health Care Providers Requires that group and non-group contracts of a non-profit health service plan or commercial insurer provide benefits for covered services regardless of which provider renders the service, so long as the provider is licensed under the Health Occupation Article.	1979
Article 48A §354X, 470R and 477X	Cleft Lip and Cleft Palate Mandates benefits for in-patient and outpatient expenses arising from the management of cleft lip and cleft palate. Applies to group and direct-billing contracts.	1982

Outline Of The Report

The report is structured to be both relatively brief, yet comprehensive. Each issue forms a separate section of the report. Background material, technical discussions and supporting data are provided as appendixes to the report.

Research Issue: Are mandated benefits necessary? Are mandated benefits desirable from a public policy perspective?

This is a critical issue discussed briefly here to provide an appropriate framework for consideration of the specific issues discussed in this report.

As with most public policy issues confronting state governments, there are legitimate pros and cons to specific mandated health benefit proposals. By definition, mandated benefit laws force at least some health insurance purchasers to buy certain benefits that they would prefer to decline if this option were available. The market for health insurance has grown increasingly competitive, with Blue Cross and Blue Shield Plans, commercial health insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and third-party administrators offering a wide variety of health plans. A competitive economic market is an efficient mechanism to allocate resources: it works well to provide the products that purchasers want at a reasonable cost. Competitive forces will, within a short period, force out of the market those sellers which provide services that are not wanted or are inferior, or which sell their products at higher than competitive prices. Interference in the health insurance market should be considered only if there are overwhelming public policy arguments supported by objective, reliable data to support mandating specific benefits.

Some of the most important issues raised by both sides of the policy debate on mandated benefits are summarized below. Many of these issues are considered more fully later in this report.

Primary arguments raised by providers and other proponents of specific mandated benefits are:

- Specific health care services are needed by the public and are not covered, or are inadequately covered, under existing health insurance programs.
- Employers (and insurers) have biases against certain types of benefits (e.g., mental health services), because they are uninformed or for other reasons.
- Benefits for specific services (defined by types of service or provider) not now generally provided would result in reduced use of other health care services and would reduce overall health care costs.
- Some employers may not wish to purchase certain benefits, but the benefits are desirable from an overall public policy perspective.

Primary arguments often made by employers, unions, Blue Cross and Blue Shield Plans and commercial health insurers against specific mandated benefits are:

- Employers, unions, and insurers are informed and sophisticated buyers and sellers of health benefits; they have access to the most reliable information on the cost and performance of benefits for specific services.
- Employers can and to an increasing extent do exempt themselves from mandated benefits by using "self-insurance" programs. Costly mandates hasten this process.

- The primary forces behind specific mandated benefits are often providers who will economically benefit from mandates, rather than the public. Arguments as to cost effectiveness are often self serving and are not based on reliable, objective data.

- Health care benefits included in employer and union-employer sponsored benefit programs reflect the preference of those covered under the program. It is unfair to force groups to purchase unwanted benefits instead of benefits preferred by group members.

- Employer sponsored health benefit programs cannot cover all services. Some services are best financed through consumer self-pay, government sponsored programs, or other mechanisms.

- Multi-state employers and/or employers with union contracts face substantial administrative and employee relations problems in complying with state mandates. Sometimes, benefits are reduced in order to comply with specific provisions of state mandated benefit laws.

- Mandated benefits add to the cost of health benefit programs. The increased cost often results in reduced coverage for other, preferred medical care benefits. In extreme cases, increased cost results in higher labor costs which provide incentives to reduce the size of the work force, or to locate plants in other states, particularly for low-wage, high labor cost industries.

The relevance and importance of specific arguments for or against mandates varies with the nature of the mandated benefit under consideration. In general, mandated benefits have greater effects on cost to the extent that they affect costly or potentially widely used services, and they differ substantially from health care benefits currently offered by most employers.

Research Issue: What is the Cost of Maryland Mandated Benefits?

This is a basic but important question regarding mandated benefits in Maryland. While conceptually simple, the measurement of the cost to Blue Cross and Blue Shield of mandated benefits (claims cost and administrative expenses) is a complex undertaking, primarily because data are not easily retrievable by mandate categories. This is particularly true for outpatient mental health benefits and other benefits provided under major medical portions of health benefit programs, for which claims are often submitted directly by Blue Cross and Blue Shield members, rather than providers. The terminology included in many major medical claims for procedure descriptions, diagnoses and coding are often imprecise, causing difficulties in accurately classifying diagnostic and type of service information.

Blue Cross and Blue Shield Plans serving Maryland were able to develop 1984 claims expenditure data (includes claims cost plus administrative expense) for the following categories of mandated benefits:

Mental illness, inpatient

Mental illness, outpatient (home & office)

Prosthetic Devices

Alcohol Rehabilitation

Cleft Lip and Palate

Podiatrist

Social Worker

Chiropractor

Psychologist

Optometrist

Licensed Practitioner

Home Health Care

Nurse Anesthetist

Not included in the data are mandated benefits for maternity, for which Federal statutes in effect mandate benefits under most group contracts; for benefits which are mandated to be offered rather than provided; and mandated conversion type benefits. Claims expenditure data for each Plan include administrative costs, sometimes called retention, of approximately 10 percent, with administrative costs being higher relative to claims cost for medical-surgical and major medical benefits than hospital benefits (larger dollar cost per claim). Administrative costs are computed at a common rate for both group and individual coverage accounts. The study focuses on claims expenditures, sometimes referred to as benefit cost in this report, because subscription charges are set each year so that they are approximately equal to projected claims expenditures.

Approximately 1,317,000 persons are covered under Blue Cross and Blue Shield contracts in Maryland, excluding those covered under Federal Employee Benefit Programs and Medicare supplemental programs. Of these, 85 percent are covered by Maryland Blue Cross and Blue Shield and 15 percent by Blue

Cross and Blue Shield of the National Capital Area. Federal Employee Benefit Programs and Medicare supplemental health insurance programs are exempt from mandated benefit legislation.

Maryland Blue Cross and Blue Shield claims expenditures (not including National Capital Area Blue Cross and Blue Shield data for Maryland -- shown in Appendix A) are shown on a per member month basis in Exhibit 2. Most Blue Cross and Blue Shield health benefit programs include three interrelated benefit programs: hospital benefits, which cover primarily inpatient hospital expenses; medical/surgical benefits, which cover primarily surgical expenses and physician medical services provided in the hospital; and major medical benefits, which cover primarily medical services provided in the home and office setting and medical services not completely reimbursed under the hospital and medical/surgical benefit programs. Expenditures are shown for each mandated benefit category separately for hospital, medical/surgical and for major medical benefits, and for all benefits combined. In computing total claims expenditures, it is assumed, as is most often the case, that Blue Cross and Blue Shield accounts have all three benefits: hospital, medical/surgical and major medical benefits. Some accounts have hospital benefits from Blue Cross and Blue Shield and medical/surgical and/or major medical benefits from another carrier. In addition to claims expenditures for each mandate category, expenditure data are also shown for three summary categories of mandated benefits: mental health and alcohol rehabilitation, outpatient mental health, and

EXHIBIT 2

MARYLAND BLUE CROSS AND BLUE SHIELD
EXPENDITURES PER MEMBER MONTH,
COMBINED GROUP AND INDIVIDUAL CONTRACTS,
1984

EXPENDITURE CATEGORY	HOSPITAL	MED/SURG	MAJOR MED	TOTAL
Mental*	$ 1.47	$ 0.21	$ 1.53	$ 3.21
Prosthetic Device	0.04	0.01	0.35	0.41
Alcohol Rehab	0.34	0.00	0.00	0.34
Cleft Lip/Palate	0.01	0.00	0.00	0.01
Podiatrist	0.00	0.44	0.04	0.48
Social Worker	0.00	0.00	0.16	0.16
Chiropractor	0.00	0.00	0.17	0.18
Psychologist	0.00	0.01	0.40	0.42
Optometrist	0.00	0.00	0.00	0.00**
Licensed Practitioner	0.00	0.01	0.00	0.01
Home Health	0.13	0.00	0.01	0.14
Nurse Anesthetist	0.00	0.00	0.00	0.00**
Summary Categories				
Total Mandated Benefits***	1.99	0.69	2.67	5.35
Mental & Alcohol Rehab	1.81	0.23	2.09	4.12
Outpatient Mental****	0.00	0.00	2.09	2.09
TOTAL ALL CLAIMS (Mandated and Non-Mandated)	$26.99	$13.29	$ 7.68	$ 47.96

*Includes both inpatient and outpatient mental health benefits.

**Less than $.01 per member month.

***Maternity benefits excluded. If maternity benefits were included, total mandated benefit cost would be $6.33 per member month.

****Includes outpatient benefits for services provided by psychologists and social workers.

all mandated benefits combined. Mental health benefits include benefits for services provided by psychologists and social workers. Excluded from mandated benefit expenditures are maternity benefits and the other mandate categories excluded from our analysis, which were noted above. Exhibit 3 shows the same claims expenditure data, as a percentage of all claims.

The following are the primary findings regarding 1984 mandated benefit costs for Maryland Blue Cross and Blue Shield:

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

The data shown in Exhibits 2 and 3 are for group and individual contracts combined. Approximately 10 percent of Maryland Blue Cross and Blue Shield members, excluding those covered under Federal government and Medicare supplemental contracts, are covered under individual (non-group) contracts. Mandated benefit claims expenditures for group and individual contracts are shown separately for group and individual contracts in Appendix A. Mandated benefit costs as a percentage of total

EXHIBIT 3

MARYLAND BLUE CROSS AND BLUE SHIELD
EXPENDITURES AS A PERCENTAGE OF ALL CLAIMS,
COMBINED GROUP AND INDIVIDUAL CONTRACTS,
1984

EXPENDITURE CATEGORY	HOSPITAL	MED/SURG	MAJOR MED	TOTAL
Mental*	5.45 %	1.56 %	19.87 %	6.68 %
Prosthetic Device	0.17	0.07	4.64	0.85
Alcohol Rehab	1.25	0.00	0.00	0.70
Cleft Lip/Palate	0.03	0.02	0.00	0.02
Podiatrist	0.00	3.31	0.57	1.01
Social Worker	0.00	0.04	2.02	0.33
Chiropractor	0.00	0.01	2.26	0.37
Psychologist	0.00	0.09	5.26	0.87
Optometrist	0.00	0.00	0.00	0.00**
Licensed Practitioner	0.00	0.05	0.02	0.02
Home Health	0.48	0.00	0.12	0.29
Nurse Anesthetist	0.00	0.00	0.00	0.00**
Summary Categories				
Total Mandated Benefits***	7.38	5.16	34.75	11.15
Mental & Alcohol Rehab	6.70	1.70	27.16	8.59
Outpatient Mental****	0.00	0.00	27.16	4.35

*Includes both inpatient and outpatient mental health benefits.

**Less than .001 percent of total benefit costs.

***Maternity benefits excluded. If maternity benefits were included, total mandated benefit cost would be 13.1% of all claims.

****Includes outpatient benefits for services provided by psychologists and social workers.

benefit costs are higher for individual contracts than for group contracts. However, data for individual contracts are not strictly comparable to data for group contracts, as benefit designs, levels of coverage, and proportions of members covered under all three benefit programs (hospital, medical/surgical and major medical) differ between group and individual contracts.

As noted above, approximately 15 percent of Blue Cross and Blue Shield enrollees in Maryland are covered by Blue Cross and Blue Shield of the National Capital Area. Mandated benefit cost data for Maryland group accounts of National Capital Area Blue Cross and Blue Shield, comparable to data shown in Exhibits 2 and 3 for Maryland Blue Cross and Blue Shield, are shown in Appendix A. Data for National Capital Area Plan's individual Maryland contracts are not available. Summary mandated benefit cost data for the National Capital Area Plan are shown in Exhibit 4, along with Maryland Plan data and combined Plans serving Maryland data.

Mandated benefit costs for the National Capital Area Plan's Maryland enrollees are higher than for the Maryland Plan enrollees, both in terms of dollars and as a percentage of total benefit cost. Mandated benefit cost per member month for Blue Cross and Blue Shield of the National Capital Area is $6.83, or 13.0 percent of total benefit cost. Mental and alcohol rehabilitation benefits, and outpatient mental health, respectively, are 9.4 percent and 5.2 percent of total claims cost.

The last two columns of Exhibit 4 show the combined Maryland mandated benefit cost experience for Blue Cross and Blue Shield Plans serving Maryland. The cost of mandated benefits represents 11.5 percent of the total benefit cost of Blue Cross and Blue Shield enrollees in Maryland. For the total estimated 1,317,000 Blue Cross and Blue Shield enrollees in Maryland, excluding those enrolled under Federal government and Medicare supplemental contracts, total cost of mandated benefits in 1984 is estimated at $88.7 million out of total benefit cost of $769.2 million. Mental and alcohol rehabilitation mandated benefits represent 8.7 percent of total benefit cost, while outpatient mental benefits represent 4.5 percent of total benefit cost.

An additional cost often overlooked in the discussion of cost of mandated benefits is implementation cost. Discussions with administrative staff of the Blue Cross and Blue Shield Plans serving Maryland indicate that the process of implementing a mandated benefit is a complex, costly task, involving many different operations. Attached as Appendix C is a description of the various tasks and associated costs required to implement the most recent mandate enacted in Maryland, benefits for in-vitro fertilization. Thirty-two discrete tasks are identified with a combined first year implementation cost of $108,000. This is the direct cost to a single carrier of implementing a single mandated benefit. There are additional indirect costs that are not included in this estimate, such as cost of responding to

EXHIBIT 4

BLUE CROSS AND BLUE SHIELD PLANS SERVING MARYLAND
CLAIMS EXPENDITURES PER MEMBER MONTH,
COMBINED GROUP AND INDIVIDUAL CONTRACTS
1984

	Maryland BC-BS*		Nat. Cap. Area BC-CS* Maryland Experience		Combined** BC-BS Maryland Experience	
	Amount	Percent	Amount	Percent	Amount	Percent
All Mandated Benefits	$ 5.35	11.2%	$ 6.83	13.0%	$ 5.61	11.5%
Mental and Alcohol Rehab.	4.12	8.6	4.97	9.4	4.25	8.7
Outpatient Mental	2.09	4.4	2.74	5.2	2.19	4.5
Total Benefit Cost	$47.96	100.0	$52.66	100.0	$48.67	100.0

*Maryland Blue Cross & Blue Shield data includes group and individual cost experience.
Blue Cross and Blue Shield of the National Capital Area data includes only Maryland group experience.

**Combined experience computed by using .85 and .15 weights, respectively for Maryland and National Capital Area Plan claims expenditures.

subscriber and provider inquiries related to benefit provisions and restrictions. In addition to implementation costs experienced by Blue Cross and Blue Shield, large employers operating in multiple states may experience additional costs and administrative and provider relations problems. These relate to required preparation of revised benefit brochures, and problems relating to lack of uniformity of benefits for employees in different states and of confusion about the new benefit provisions and limitations.

APPENDIX D

ANALYSIS OF MENTAL HEALTH PROVIDERS BY STATE

ANALYSIS OF MENTAL HEALTH PROVIDERS BY STATE

This section compares the supply of mental health providers in Maryland with all other states and with geographically adjacent states. The information provided is relevant to the question about the cost of health insurance in Maryland relative to other comparable states. A comparison of health insurance costs among states would be more dependent upon factors such as the competitiveness of the medical care market (including HMO market penetration), the existence of state rate regulatory programs, and the relative number of large, costly teaching hospitals in the state than upon the effects of mandated benefits, however. Consequently, the impact of mandated benefits is more appropriately addressed in terms of mandated provider supply and effects upon actual cost of mandates.

The impact of mandated benefits in relation to provider supply is examined here for several reasons. First, existence of an adequate supply of providers assures accessibility of mental health services to those in need of treatment. If no shortage of providers exists, the importance of mandates for assuring accessibility to services is decreased. Second, the impact of a mandate increasing coverage levels for mental health services will be more dramatic if the state has relatively more numerous providers. If an excess supply of providers exists, the impact of a mandate for 80 percent coverage of outpatient services will lead to greatly increased utilization and costs. Finally, the

existence of mandates for mental health insurance can affect the growth of provider supply in states. Knesper et al. (1984) found that the distribution of psychiatrists, psychologists, and social workers across U.S. counties was significantly and positively associated with the availability of liberal mental health insurance benefits (including insurance laws). It was estimated that the elasticity of psychiatrists with respect to insurance availability was 0.42, or a 10 percent increase in insurance availability was associated with a 4.2 percent increase in psychiatrists per 100,000 population. Continued growth in provider supply in areas with existing adequate supply would be less desirable from a policy perspective than encouraging providers to locate in less well-served areas.

Exhibit 1 illustrates the numbers of patient care psychiatrists by state and per 100,000 population in 1983. Maryland was found to have 18.6 patient care psychiatrists per 100,000 residents, a level 72 percent higher than the national average of 10.8 per 100,000. Only Connecticut, Massachusetts and New York had higher psychiatrist/population ratios than Maryland. These data were obtained from the American Medical Association's annual publication Physician Characteristics and Distribution in the U.S., 1983 Edition, a source widely used by the Federal government and others in research projects.

Numbers of doctoral psychologists providing health/mental health services by state and per 100,000 population in 1983 are

EXHIBIT 1

NUMBERS OF PSYCHIATRISTS PROVIDING
PATIENT CARE BY STATE AND
PER 100,000 POPULATION
1983

STATE	PSYCHIATRISTS*	PSYCHIATRISTS/ 100,000 POPULATION	STATE RANK
Alabama	140	3.5	46
Alaska	25	5.2	38
Arizona	234	7.9	23
Arkansas	111	4.8	41
California	3,762	14.9	5
Colorado	425	13.5	7
Connecticut	724	23.0	3
Delaware	70	11.6	9
Florida	833	8.0	22
Georgia	411	7.2	27
Hawaii	129	12.7	8
Idaho	25	0.3	50
Illinois	1,087	9.5	16
Indiana	265	4.8	42
Iowa	158	5.4	37
Kansas	236	9.7	15
Kentucky	227	6.1	32
Louisiana	308	6.9	29
Maine	101	8.8	20
Maryland	801	18.6	4
Massachusetts	1,332	23.1	2
Michigan	850	9.4	17
Minnesota	296	7.1	28
Mississippi	92	3.6	45
Missouri	374	7.5	26
Montana	30	3.7	44
Nebraska	87	5.5	36
Nevada	47	5.2	39
New Hampshire	98	10.2	14

EXHIBIT 1 (Cont.)

STATE	PSYCHIATRISTS*	PSYCHIATRISTS/ 100,000 POPULATION	STATE RANK
New Jersey	845	11.3	10
New Mexico	121	8.6	21
New York	4,158	23.5	1
North Carolina	107	1.8	49
North Dakota	33	4.8	43
Ohio	827	7.7	25
Oklahoma	172	5.2	40
Oregon	243	9.1	18
Pennsylvania	1,325	11.1	11
Rhode Island	98	10.3	13
South Carolina	194	6.0	33
South Dakota	19	2.7	47
Tennessee	266	5.7	34
Texas	1,068	6.8	30
Utah	103	6.4	31
Vermont	75	14.3	6
Virginia	571	10.3	12
Washington	384	8.9	19
West Virginia	111	5.7	35
Wisconsin	376	7.9	24
Wyoming	12	2.4	48
ALL U.S.	25,287	10.8	

*Psychiatrists engaged primarily in patient care

Source: American Medical Association, Physician Characteristics and Distribution in the U.S., 1983 Edition, Chicago.

presented in Exhibit 2. Maryland had 28.9 doctoral psychologists per 100,000 population, compared to the national average of 19.0 per 100,000. Maryland ranked third among all 50 states in psychologist supply, after Massachusetts and New York. Psychologists providing health/mental health services deliver physical and mental health care, or provide services adjunct to educational, rehabilitation, and vocational services, as opposed to those whose primary activity consists of education or research. The relatively high number in Maryland may be partially due to the large number of psychologists employed in federal agencies, such as the National Institute of Mental Health. Data are based on the 1983 American Psychological Association Census of Psychological Personnel, the most extensive attempt in over a decade to enumerate psychologists.

Exhibit 3 presents information on numbers of registered clinical social workers for 1985. Maryland has a level of 7.7 clinical social workers per 100,000, which is 120 percent higher than the national average of 3.5 per 100,000. Connecticut, Massachusetts, New Hampshire, and New York had higher social worker/population ratios than Maryland. Clinical social workers provide assessment, diagnosis, treatment (including psychotherapy and counseling), client-centered advocacy, consultation and evaluation. Registered clinical social workers must be members of the Academy of Certified Social Workers (ACSW), or be licensed

EXHIBIT 2

DOCTORAL PSYCHOLOGISTS PROVIDING
L HEALTH SERVICES BY STATE
PER 100,000 POPULATION
1983

DOCTORAL PSYCHOLOGISTS*	PSYCHOLOGISTS/ 100,000 POPULATION	STATE RANK
404	10.2	44
103	21.4	12
664	22.3	10
216	9.3	48
6,371	25.3	7
852	27.1	6
864	27.5	4
90	14.9	34
1,478	14.1	36
807	14.1	37
214	21.0	14
137	13.9	39
1,892	16.5	26
673	12.3	42
289	10.0	45
478	19.7	19
331	8.9	49
397	8.9	50
228	19.9	18
1,243	28.9	3
876	44.6	1
1,358	15.0	32
881	21.3	13
291	11.3	41
746	15.0	33
133	16.6	25
258	16.1	28
165	18.4	22
231	24.1	9

EXHIBIT 2 (Cont.)

YCHOLOGISTS/ 100,000 POPULATION	STATE RANK
20.1	17
17.8	24
30.7	2
14.4	35
11.2	43
15.9	29
14.0	38
20.9	15
18.8	20
20.7	16
9.6	46
15.9	30
16.3	27
13.8	40
21.9	11
27.2	5
17.9	23
18.7	21
9.1	47
15.1	31
24.2	8
9.0	

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Association.

EXHIBIT 3

NUMBERS OF REGISTERED CLINICAL SOCIAL WORKERS BY STATE AND PER 100,000 POPULATION
1985

STATE	CLINICAL SOCIAL WORKERS*	SOCIAL WORKERS 100,000 POPULATION	STATE RANK
Alabama	23	0.6	48
Alaska	29	6.0	8
Arizona	66	2.2	26
Arkansas	23	1.0	44
California	704	2.8	18
Colorado	72	2.3	21
Connecticut	244	7.8	4
Delaware	11	1.8	31
Florida	236	2.3	22
Georgia	85	1.5	34
Hawaii	22	2.2	27
Idaho	9	0.9	47
Illinois	749	6.5	6
Indiana	122	2.2	28
Iowa	85	2.9	16
Kansas	82	3.4	14
Kentucky	37	1.0	45
Louisiana	181	4.1	11
Maine	18	1.6	33
Maryland	333	7.7	5
Massachusetts	483	8.4	3
Michigan	340	3.8	12
Minnesota	137	3.3	15
Mississippi	12	0.5	49
Missouri	86	1.7	32
Montana	12	1.5	35
Nebraska	37	2.3	23
Nevada	11	1.2	40
New Hampshire	82	8.6	2

EXHIBIT 3 (Cont.)

STATE	CLINICAL SOCIAL WORKERS*	SOCIAL WORKERS 100,000 POPULATION	STATE RANK
New Jersey	430	5.8	9
New Mexico	20	1.4	36
New York	1,525	8.6	1
North Carolina	88	1.4	37
North Dakota	8	1.2	41
Ohio	275	2.6	20
Oklahoma	75	2.3	24
Oregon	77	2.9	17
Pennsylvania	239	2.0	29
Rhode Island	53	5.6	10
South Carolina	37	1.2	42
South Dakota	9	1.3	39
Tennessee	56	1.2	43
Texas	316	2.0	30
Utah	22	1.4	38
Vermont	32	6.1	7
Virginia	155	2.8	19
Washington	100	2.3	25
West Virginia	19	1.0	46
Wisconsin	178	3.8	13
Wyoming	2	0.4	50
ALL U.S.	8,201	3.5	

*Clinical Social Workers registered with National Association of Social Workers (NASW). Membership in NASW is a prerequisite to becoming a certified social worker.

Source: NASW Register of Clinical Social Workers, 1985, and unpublished summaries of NASW statistics.

or certified in a state at a level at least equivalent to ACSW standards. Data presented were obtained from the National Association of Social Workers, based on those who apply for listing in their register.

Numbers of mental health providers (including psychiatrists, psychologists, and social workers) are summarized in Exhibit 4 for Maryland, adjacent states and all U.S. Maryland ranks in the top five states for numbers of psychiatrists, psychologists, and social workers per 100,000 population, while only one adjacent state, Delaware, ranks in the top ten for any of these providers (ninth in psychiatrists). The District of Columbia was excluded from all tables in this section, because its small size and central city environment make its provider supply incomparable to other states. It should be noted, however, that some Maryland residents in the Washington metropolitan area are likely to use providers within the District of Columbia, further increasing the effective supply of providers accessible to Maryland residents.

The primary conclusions supported by this information include the following:

- Maryland ranks very high in mental health provider supply, among the top five states in psychiatrists, psychologists, and clinical social workers.

EXHIBIT 4

SUMMARY OF MENTAL HEALTH PROVIDERS IN MARYLAND,
ADJACENT STATES AND ALL UNITED STATES

STATE	PSYCHIATRISTS		PSYCHOLOGISTS		SOCIAL WORKERS	
	Per 100,000 Population	U.S. Rank*	Per 100,000 Population	U.S. Rank*	Per 100,000 Population	U.S. Rank*
Maryland	18.6	4	28.9	3	7.7	5
Virginia	10.3	12	17.9	23	2.8	19
Pennsylvania	11.1	11	18.8	20	2.0	29
Delaware	11.6	9	14.9	34	1.8	31
West Virginia	5.7	35	9.1	47	1.0	46
ALL U.S.	10.8		19.0		3.5	
Ratio of Maryland to All U.S.	1.72		1.52		2.20	

*Ranking of state in number of providers per 100,000 population in comparison to all 50 states.

Sources: American Medical Association, Physician Characteristics and Distribution in the U.S., 1983 Edition, Chicago;

J. Stapp, A. M. Tucker, G. R. VandenBos, Census of Psychological Personnel: 1983, Draft 1985, American Psychological Association:

NASW Register of Clinical Social Workers, 1985, and unpublished summaries of NASW statistics.

- Accessibility to mental health providers is substantially greater for residents of Maryland relative to adjoining states and to the U.S. as a whole. It is likely that geographic accessibility problems are relatively minor too, given the relatively small s. and urban nature of the state.

- An increase in mandated mental health benefits would cause the already adequate provider supply to grow further, by a factor of about 3 to 5 percent for each 10 percent increase in benefits.

- From a policy-making perspective, encouragement of continued growth in mental health provider supply in Maryland is a less than desirable goal, given that the state already has among the highest levels of these providers in the nation.

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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.

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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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SEATTLE P-I, WED. 2/10/88

Health care costs of employers soar

The Associated Press

NEW YORK — The cost of providing health care benefits to employees jumped to an average of $1,985 per worker last year as employers hunted for ways to curb costs, a survey said yesterday.

A poll of 2,016 corporate and government employers found that their costs rose 7.9 percent last year, or an average $128 per employee, said A. Foster Higgins & Co., which conducted the survey. The average cost had risen 7.7 percent in 1986.

Nearly one-fifth of the employers surveyed said their health costs soared 20 percent or more, according to Higgins, a New York-based benefits consultant. Six percent of the employers said they were hit with cost jumps exceeding 30 percent.

"Increases in the actual price of medical care supplied by doctors, hospitals and other providers is the fundamental reason for the plan cost hikes," said David Rahill, who directed the study, which looked at employers with a total of 13 million employees.

Higgins, a subsidiary of Johnson & Higgins, surveyed employers ranging from American Telephone & Telegraph Co. to the village government of Winnetka, Ill.

For public sector employers, health care benefit costs averaged $2,071 per worker, while the cost averaged $2,364 per worker for benefits in work places that are at least 50 percent unionized.

The economy-of-scale theory seemed not to apply. For employers with 5,000 or more workers, benefits averaged $2,100 per worker last year, compared with $1,962 for employers with fewer than 5,000 workers.

Overall, health benefit costs made up 9.7 percent of the payroll pie, up from 8.9 percent in 1986, an increase that Rahill called "disturbing."

"Continued increase could hamper the ability of American business to compete with lower-cost labor markets," he said, adding that higher costs could even spur companies to consider moving their operations.

Rahill said the study underscored the need for more stringent cost-control efforts. Only 30 percent of employers surveyed managed either to hold costs constant or reduce them last year, the survey found.

Higgins' survey found that 61 percent of the employers did not require employees to help foot the bill on individual coverage. But 88 percent did require their employees to pay a deductible. A third of the employers said they raised deductibles in the last two years.

Source: A. Foster Higgins & Co.

The Associated Press

Compilation by HIAA staff

AVERAGE LENGTH OF STAY
FOR PHYSICAL CONDITIONS AND
FOR PSYCHIATRIC CONDITIONS OR DIAGNOSES

Average length of stay for physical conditions, obtained from the American Hospital Association for 1984, is 7.3 days.

I have two sources for average length of stay for psychiatric diagnoses. The first source is from the Commission on Professional and Hospital Activities. This is data which is received from general, non-Federal, short-term hospitals. This is defined as a medium stay less than 30 days. This excludes data from psychiatric hospitals.

The length of stay for these diagnoses are:

paranoid schizophrenia - 15.1 days
acute schizophrenic episode - 15.4 days
childhood psychoses - 24.2 days
major depressive psychoses - 17.2 days
other effective psychoses - 16.4 days
miscellaneous psychoses - 11.6 days
anxiety states - 6.9 days
neurotic depression - 12.6 days
miscellaneous neuroses - 10.3 days

miscellaneous mental disorders - 13.6 days

The next figures I am going to quote were given to me over the phone by Bertie Firestone from the National Institute of Mental Health. These are average length of stay figures obtained from private psychiatric hospitals. These again are given by certain diagnoses.

Average length of stay for:

any alcohol related admission - 20 days
any drug related admission - 19 days
organic disease - 17 days
effective disorders - 20 days
schizophrenia - 18 days
other psychoses - 20 days
anxiety disassociative - 14 days
personality disorder - 17 days

This concludes the information that I was able to obtain about average length of stay. I did attempt to get data from the American Psychiatric Association, but they declined to give me any information about length of stay figures.

Company Practices In Mental Health Coverage; Plan Design Limits Reflect Increases In Cost, Use

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Employees are using mental health benefits more often, according to "Company Practices In Mental Health Coverage," a study by Hewitt Associates. About half of the 293 companies surveyed experienced an increase in mental health claims since 1983, while only 8% experienced a decrease. Although the number of companies that were able to track claims costs was small (28), costs increased each year from $118 in 1984 to a projected costs of $169 in 1987 per employee.

The complete study includes company practices in mental health and employee assistance programs and may be purchased from Hewitt Associates, 100 Half Day Road, Lincolnshire IL 60015. Attn: Cathy Schmidt.

Health care benefits have been subject to dramatic changes during the past five years. An increasing number of employers are concerned with one area of benefits that has been considered uncontrollable--mental health coverage.

Hewitt Associates surveyed 293 companies of various sizes and industry types to find specific prevalence patterns for mental health benefits and company-sponsored employee assistance programs. This report highlights the survey findings for the mental health benefits.

Surveyed companies were almost evenly distributed between manufacturing (49%) and nonmanufacturing (51%) industry classifications. In terms of the number of employees, 15% employed less than 1,000, 46% covered from 1,000 up to 5,000, 16% covered between 5,000 and 10,000, 19% between 10,000 and 50,000, and only 4% employed more than 50,000 employees.

Companies were almost evenly divided also in their reasons for offering mental health coverage. Moral obligation and competitive practice were the two most common responses as cited by 37% and 35%, respectively. Cost management for overall medical plan (15%), employee demand (6%), part of medical plan (4%), employee productivity (1%), and all others (2%).

Design And Usage

More than three-fourths of the companies have made no major design changes to inpatient or outpatient limits within the past two years. For the 288 companies surveyed, 80% did not change inpatient limits and 76% made no changes in the outpatient limits. However, 11% reported that they are planning changes within the next 12 months. Anticipated changes include limiting the number of inpatient days, adding or limiting annual and/or lifetime dollar limits, and overall evaluation of mental health coverage due to increasing claims costs.

In terms of utilization, 33% of the 197 companies said they have not been able to track use of the mental health benefit. Of those able to compare changes in use since 1983, just over half have seen an increase.

Design Features

Employers have ranked use of mental health benefits high on the list of health plan services that are difficult to control. The most common method used to control use places some type of special limit on plan benefits. Ninety-three percent of companies combined inpatient and outpatient limits (lifetime and/or annual) for mental health and substance abuse coverage. Of those plans, 71% had specific coverage limits for both mental health and substance abuse under the medical plan.

Specific limits for outpatient mental health benefits only was reported by 19% of the surveyed plans, and inpatient benefits were treated as any other illness under the medical plan. Seven percent reported specific limits for inpatient substance abuse only and inpatient mental health was covered as any other illness. Specific limits for inpatient mental health was reported by 3% of the companies surveyed and inpatient substance abuse is covered as any other illness.

More than half (54%) of the companies combined inpatient/outpatient limits expressed either as an annual or lifetime maximum; some companies had both. Annual dollar maximums were included in the plans of 22% of those companies with limits that ranged from

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
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June 3, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Jay Livey
Legislative Analyst

RE: Mental Health Insurance Laws in Other States
Research Request 87.307

You asked that we: 1) determine the extent to which other states regulate the coverage of mental health services under health insurance policies sold within the state; 2) identify the types of mental health providers that are eligible to be reimbursed under the mental health coverage in other states; and 3) discuss the impact to mental health services in Alaska associated with designating specific mental health providers to be eligible for reimbursement from insurance claims.

Mental Health Insurance in Other States

The attached chart identifies the states which regulate mental health benefits in private health insurance policies. Thirteen states (Colorado, Connecticut, Maryland, Maine, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia and Wisconsin) have laws which require insurers to include mental health services as part of certain insurance policies sold in the state. Thirteen states (Arkansas, California, Florida, Georgia, Illinois, Kansas, Louisiana, Missouri, New York, Tennessee, Vermont, Washington and West Virginia) require only that insurance policies "offer" mental health coverage at the policy holder's option.

Mandated Coverage. Of the states which mandate mental health coverage, four states (Connecticut, Maryland, Massachusetts and Virginia) require coverage for individual as well as group policies. The type of mandated coverage specified in state insurance laws varies considerably. Colorado, Connecticut, Maine, Maryland, New Hampshire and Oregon specify coverage of inpatient services, partial hospitalization and outpatient services. Massachusetts, Montana, Virginia and Wisconsin specify inpatient and outpatient coverage only while Ohio and Minnesota specify only outpatient coverage. North Dakota specifies coverage for inpatient services and partial hospitalization but not for outpatient services.

Mental health providers eligible to receive insurance reimbursement under mandated coverage include psychiatrists in all thirteen states, psychologists in 12 states and social workers in six states. It should be noted, however, that the licensing requirements vary among states with regard to the qualifications required of these mental health providers. In virtually all of these states, mental health services offered in a licensed hospital or community mental health center are covered under mandated insurance policies.

Mandated Availability. Of the thirteen states which mandate availability of mental health coverage as a policy option, nine states specify that only inpatient and outpatient coverage be offered. Two states, Florida and Vermont, specify that in addition to inpatient and outpatient coverage, partial hospitalization should also be offered. Tennessee offers only outpatient coverage while Washington statutes do not specify services to be offered.

In twelve of these thirteen states--Georgia does not specify the types of providers eligible for insurance reimbursement--psychiatrists and psychologists are designated as professionals eligible for insurance reimbursement. In addition, five states specify social workers or other counseling professionals as eligible providers.

Provision of Mental Health Services in Alaska

Under Alaska law, three types of mental health professionals are licensed by the State: psychiatrists (AS 08.64), psychologists and psychological associates (AS 08.86). It is unlawful for an individual who is not so licensed to practice psychiatry or psychology or to generally advertise his or her services as relating to psychiatry or psychology. However, this does not preclude other types of health professionals from providing counseling services, e.g., drug and alcohol counsellors and family counselors.

Any hospital other than federal hospitals must be licensed by the State. A hospital is defined as any "institution or establishment, public or private, devoted primarily to providing diagnosis, treatment, or care over a continuous period of 24 hours each day for two or more unrelated individuals suffering from illness, physical or mental disease, injury or deformity, or any other condition for which medical or surgical services would be appropriate." Alaska has two hospitals licensed as psychiatric hospitals, Alaska Psychiatric Institute (API) and Charter North. In addition, Fairbanks Memorial, Providence and Mt. Edgecumbe are licensed to provide psychiatric services.

Community mental health centers established under AS 47.30 do not require a State license, but their operations must conform to State law and department regulations. Currently, there are 27 community mental health centers in Alaska. (See Table 1 for a summary of the community mental health centers in the state.)

Table 1 also includes the staffing characteristics of the community mental health centers as of October 1986. As the table indicates, eight mental health centers have medical doctors on staff. Of the centers without an M.D., eight have a PhD psychologist on staff (although two of these individuals were not licensed by the State) and 11 centers were staffed by an individual with a Masters degree. Within this latter group, one individual with a Masters degree was licensed as a psychological associate.

TABLE 1
COMMUNITY MENTAL HEALTH CENTERS IN ALASKA

		---------STAFFING INFORMATION---------		
LOCATION	NUMBER OF COMMUNITIES SERVED	MEDICAL DOCTOR	PSYCHOLOGIST	PSYCHOLOGICAL ASSOCIATE
Anchorage	3	yes	yes	yes
Fairbanks	8	yes	no	no
Wasilla	6	yes	yes	yes
Juneau	7	no	yes	yes
Kenai	4	yes	yes	no
Ketchikan	6	no	yes	no
Bethel	35	yes	no	no
Kodiak	6	no	yes	yes
Nome	16	no	no	no
Homer	8	yes	yes	yes
Sitka	2	no	yes	no
Barrow	7	no	no	no
Dillingham	26	yes	no	no
Kotzebue	12	no	no	no
Dutch Harbor	11	no	yes	no
Valdez	1	no	no	yes
Seward	5	yes	yes	yes
Prince of Wales	4	no	no	no
Galena	7	no	yes	no
Cordova	2	no	yes	no
Tok	7	no	no	no
Haines	3	no	no	no
Copper Center	10	no	no	no
McGrath	3	no	yes	no
Aniak	9	no	no	no
Fort Yukon	7	no	no	no
Tanana	8	no	no	no

Notes: Staff information provided as of October 1986.
Source: Alaska Department of Health and Social Services, Division of Mental Health.

Prepared by the House Research Agency, June 1987.

Table 2 provides a geographical distribution of licensed mental health providers in the state. As the table indicates, the licensed mental health providers are located predominantly in the larger communities in the state although Homer, Dutch Harbor, Seward, Petersburg and Glenallen all have a licensed provider.

TABLE 2
GEOGRAPHIC DISTRIBUTION OF LICENSED MENTAL HEALTH PROVIDERS IN ALASKA

COMMUNITY	PSYCHIATRISTS	PSYCHOLOGISTS	PSYCHOLOGICAL ASSOCIATES
Anchorage	30	44	7
Fairbanks	4	19	1
Wasilla	0	2	2
Homer	0	2	0
Cordova	0	1	0
Kodiak	0	1	0
Juneau	2	5	1
Ketchikan	0	4	0
Kenai/Soldotna	0	4	0
Sitka	0	3	0
Dutch Harbor	0	1	0
Seward	0	1	0
Kodiak	0	2	1
Petersburg	0	0	1
Glenallen	0	0	1
Out of State		13	0
Total	36	102	14

Source: Psychiatrist information from personal communication with the Alaska State Medical Association. Other data from Department of Commerce and Economic Development, Division of Occupational Licensing.

Prepared by the House Research Agency, June 1987.

Mental Health Insurance in Alaska

As Tables 1 and 2 indicate, there are areas of the state in which no providers could be reimbursed by insurance companies if reimbursement were restricted to licensed psychiatrists and psychologists. (Although psychological associates are licensed by the State, they must work under the direct supervision of a psychologist or psychiatrist.) Based on staffing patterns present in October of 1986, nine community mental health centers serving 84 rural communities do not have a licensed mental health provider on staff. As Table 2 indicates, these same communities have no private practitioners who could provide reimbursable services.

Expanding the definition of reimbursable providers to include master level practitioners would allow all community mental health centers to provide reimbursable services. According to the Division of Mental Health, as of October of 1986, all community mental health centers were staffed by an individual with at least a Master in Social Work (MSW) degree or Master of Arts (MA) degree in psychology.

One suggestion that has been made with regard to expanding the scope of reimbursable services in the state is to license mental health programs rather than mental health providers. Under this licensing format, community mental health centers which provide the required standards of service would be licensed by the State and be eligible for insurance reimbursement. Depending upon the licensing standards adopted, a community mental health center could be eligible for reimbursement even if the staff did not include a provider eligible to offer reimbursable services. The Division of Mental Health is currently investigating this approach.

It has also been suggested that although many rural areas do not currently have eligible providers, the market incentives created by mental health insurance legislation would cause providers to move into the underserved areas. This scenario assumes that there are a significant number of individuals in the underserved areas who would be covered by insurance policies and who would seek mental health services. Steve Caverly, acting director of the mental program at the Yukon-Kuskokwim Health Corporation (YKHC), noted that in the Bethel area, this assumption was not necessarily accurate.

Mr. Caverly noted that, in Bethel, there are a significant number of individuals who are covered under group insurance plans. However, this is not true in the villages that are within the YKHC service unit. He doubts that the YKHC program could collect sufficient revenue from insurance companies to offset the expense of hiring a psychiatrist or psychologist if the employment of these providers were necessary to bill insurance companies. However, he did note that the program currently bills for medicaid and some private insurance so that a billing procedure already exists.

Mr. Caverly identified two technical problems with regard to the types of practitioners eligible for insurance company reimbursement. First, he noted that it is very difficult for the mental health programs in the rural areas to attract and retain psychiatrists and psychologists, even if sufficient funds are available to pay them. Turnover of these professionals is high in the rural areas and recruitment is a time-consuming process. Consequently, it is likely that for significant periods of time a community mental health center may not have either a psychiatrist or psychologist on staff even if this were the desired staffing level. If insurance coverage is discontinued during the time that one of these providers is not on staff, clients may choose to discontinue services rather than make higher out-of-pocket payments.

A second problem is associated with determining the appropriate level of service for the client. Mr. Caverly noted that, in some cases, clients are better served within their home communities. Many community services can be most efficiently provided by practitioners other than psychiatrists and psychologists. However, if these services are not reimbursable because they are not offered by an eligible provider, a client may choose an inappropriate level of service (such as inpatient treatment in Anchorage) because it is covered by his or her insurance policy.

If you have any questions or want additional information, please contact this agency.

Attachments

SUMMARY OF STATE MANDATES OF MENTAL HEALTH INSURANCE COVERAGE

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Arkansas	MA	1979	Psychological evaluation, counseling psychotherapy or related mental health services are entitled to payment or reimbursed on an equal basis.	Not specified	Reimbursed provided service is provided by facilities licensed as outpatient psychiatric center.	Group, Individual	Psychiatrist, psychologist, licensed outpatient psychiatric centers.
California	MA	1973	Terms of all coverage agreed upon between the group policy-holder and insurer.	Not specified	Terms of all coverage to be agreed upon between the group policy-holder and the insurer.	Group	Psychiatrist, psychologist, licensed marriage, family and counselor, registered registered nurse with a masters in psychiatric mental nursing and 2 years' experience in psychiatric mental health nursing, licensed clinical social worker.
Colorado	MBP	1976	Under basic coverage benefits, 45 days for full hospitalization in one 12 month benefit period. Each day of confinement as an inpatient shall reduce by 1 day the total days available for all other illnesses during the 12 month benefit period. Each day of inpatient care shall reduce by 2 days the 90 days available for partial hospitalization care.	90 days for partial hospitalization in one 12 month benefit period. Each 2 days of partial hospitalization shall reduce by 1 day the total days available for other illnesses during the 12 month period. Each 2 days of partial hospitalization care shall reduce by 1 day of the 45 days available.	Under major medical coverage benefits cover outpatient services furnished by a comprehensive health care service corporation, CMHCs. Copayment should not exceed 50%, up to $1,000. Deductibles shall not differ from the deductible amount for any other condition or illness.	Group	Psychiatrist, psychologist, hospital or psychiatric hospital; comprehensive health care service corporation, a community mental health center or other mental health clinics under the supervision of a licensed psychiatrist or psychologist.
Connecticut	MBP	1971	60 days per year in any hospital.	120 days. An exchange exists with inpatient benefits under the following (1) if the cost does not exceed 50% of the cost of 1 inpatient day at the average semi-private rate at the hospital, 2 sessions of partial equal 1 inpatient day; (2) if the cost/session exceed 50% of the cost of an inpatient day each session shall equal 1 inpatient day.	After major medical deductible, copayment of 50% up to $1,000. Additional benefits up to $2,000 shall be provided at the option of the group policy-holder.	Group, Individual	Psychiatrist, psychologist, MSW, (under the supervision of a licensed physician or psychologist) in a child guidance clinic, non-profit community mental health center, non-profit licensed adult psychiatric clinic operated by an accredited hospital.
Florida	MA	1976 Amended 1983	30 days per year.	If partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, total benefits paid should not exceed the cost of 30 days of inpatient hospitalization.	$1,000 per year	Group	Psychiatrist, psychologist, licensed mental health professional.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Georgia	MA	1984	30 days per year under an individual policy and 60 days per year under a group policy.	Not specified	45 visits per year under an individual policy and 50 visits per year under a group policy.	Group, Individual	Not specified
Illinois	MA	1975 Effective 1977	Coverage for inpatient on par with physical benefits, but not more than 50% deductible for all expenses with an annual limit of the lesser of $10,000 or 25% of the lifetime policy.	Not specified	Cover for outpatient on par with physical benefits, but not more than 50% deductible for all expenses with an annual limit of the lesser of $10,000 or 25% of the lifetime policy.	Group, Individual	Psychiatrist, psychologist.
Kansas	MA	1978	30 days per calendar year.	Not specified	Coverage for the first $100 and 80% of the next $500 per year.	Group	Psychiatrist, psychologist, community mental health center or clinic, psychiatric hospital.
Louisana	MA	1975	Benefits on par with those offered for other illnesses.	Not specified	Benefits on par with those offered for other illnesses.	Group	Psychiatrist, psychologist, board certified social social worker in consultation with a physician.
Maine	MBP	1983	At least 30 days per year with a 20% co-payment and a lifetime limit of $25,000.	$100 deductible, 50% copayment with an annual limit of $1,000. Lifetime limit of $25,000.	$100 deductible, 50% copayment with an annual limit of $1,000. Lifetime limit of $25,000.	Group	Psychiatrist, licensed psychologist, an accredited public or psychiatric hospital and community agency under the supervision of a psychiatrist or licensed psychologist.
Maryland	MBP/MA	1974	MBP: 30 days per year in any hospital.	MA: 30 partial hospitalization treatment days per year.	MBP: after major medical deductible copayment can be no less than 50%.	Group (MBP & MA) Individual (MBP).	Psychiatrist, psychologist, social worker.
Massachusetts	MBP	1973	60 days in any hospital; on par with other illnesses.	Not specified	$500 per year	Group, Individual	Psychiatrist, psychologist, licensed clinical social social worker, comprehensive health service organization, licensed or accredited hospital, community mental health center or clinic.
Minnesota	MBP	1975	Not specified	Not specified	All group policies providing benefits for mental or nervous disorder treatment in a hospital shall also provide coverage to at least 80% of the first $750 per year while the insured person is not a bed patient in a hospital.	Group	Psychiatrist, psychologist, licensed or accredited hospital, community mental center or mental health clinic approved or licensed by authorized state agency.
Missouri	MA	1980	30 days per year; on par with other illnesses.	Not specified	Copayment no greater than 50% up to $1,500 or 20 sessions. Frequency of psychotherapy sessions may be limited but benefits shall be available for at least one session during any 7 consecutive days.	Group, Individual	Psychiatrist, psychologist.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Montana	MBP	1983	Under basic inpatient expense policies, benefits are no less than 30 days per year. Under major medical policies, no less than 30 days per year and if inpatient benefits are provided beyond 30 days, the durational limits, dollar limits, deductibles and copayments need not be the same as applicable to physical illness generally.	Not specified	Copayment no greater than 50% or the coinsurance factor applicable for physical illness generally, whichever is greater and the maximum benefit for mental illness, alcoholism and drug addiction in the aggregate during the benefit period may be limited to not less than $1,000.	Group	Psychiatrist, psychologist, social worker, mental health treatment center.
New Hampshire	MBP	1975	Benefits on par with benefits for other illnesses for service in a licensed or general hospital. Major medical coverage may be limited to $3,000 per individual and a lifetime maximum of of $10,000, per individual. Allowable days not specified.	Partial hospitalization is covered under major medical expenses but the extent of coverage is not specified. Allowable days not specified.	Benefits should be at least as favorable as those which apply to the benefits for the treatment of other illnesses. Non-major medical policies must cover 15 hours of care after the first 2 visits. Allowable days not specified.	Group	Psychiatrist, psychologist, licensed pastoral counselor, mental hospitals, licensed licensed or general hospitals, community mental health center, psychiatric residential program.
New York	MA	1977	30 days per year in a general or mental hospital.		$700 per year deductibles and coinsurance on par with other benefits.	Group	Psychiatrist, psychologist, social worker.
North Dakota	MBP	1975	70 days per year for a licensed hospital. Each day of inpatient treatment shall be equivalent to 2 days of partial hospitalization.	140 days partial hospitalization per year. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment.	Not specified	Group (more than 50 persons with 70% of group participating).	Psychiatrist
Ohio	MBP	1978	Not specified	Not specified	$550 per year subject to reasonable deductibles and copays.	Group	Psychiatrist, psychologist, accredited hospital or community mental health facility.
Oregon	MBP	1984	No more than $7,500 in any 24 consecutive month period for inpatient care and treatment in hospitals. No more than $3,000 in any 24 consecutive month period in residential facilities. Within this $3,000 limit, payment shall be made for either full-day supervised residential or part-day treatment.	Part-day treatment on an organized, formal, regularly scheduled basis consisting of at least 4 hours of structured treatment per day, for at least 4 days each week. Shall be no more than $3,000 in any 24 consecutive period. Within this $3,000 limit, payments shall be made for either part-day or full-day residential treatment. Part-day treatment less than 4 hours of treatment per day for at least 4 days each week, is covered as outpatient treatment.	No more than $2,000 in any 24 consecutive month period.	Group	Psychiatrist, psychologist, nurse practitioner, clinical social worker, health facilities, residential facilities or inpatient services.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Tennessee	MA	1974	Not mandated	Not mandated	30 visits per year copays and deductibles on par with physical illnesses.	Group, Individual	Psychiatrist, psychologist, community health center with an approved plan for quality assurance, accredited hospitals.
Vermont	MA	1975	45 days per year in a general or mental hospital.	45 day equivalents of active care per year.	100% of the first 5 visits and 80% thereafter up to $500 per year.	Group	Psychiatrist, psychologist, licensed mental health professional, licensed general or mental hospital or community mental health centers.
Virginia	MBP/MA	1975	MBP: 30 days per year in a mental or general general hospital includes benefits for drug and alcohol rehabilitation and treatment with respect to drug and alcohol rehabilitation only. There is an $80 per day indemnity benefit and a lifetime coverage of 90 days.	Not specified	MA: $500 per year with reasonable deductibles and coinsurance that are not less favorable than physical illnesses, except that the copayment not exceed 50% up to $1,000 per benefit period.	Group, Individual	Psychiatrist, psychologist, licensed clinical social worker, mental health treatment center.
Washington	MA	1983					
West Virginia	MA	1977	45 days per year in a mental or general hospital; on par with illnesses in a general hospital.	Not specified	50% copayment up to $500 per year, sessions cannot exceed 50 per year.	Group, Individual	Psychiatrist, psychologist, licensed or accredited general mental hospital, comprehensive health service organization, community center or clinic.
Wisconsin	MBP	1979	Not less than the lesser of either the expenses of the first 30 days as an inpatient in a hospital, or the first $7000 minus a copayment of up to 10%.	Not specified	Up to $1000 minus a copayment of up to 10%.		Psychiatrist, psychologist, hospital, residential facility, outpatient treatment facility.

Total inpatient and outpatient treatment coverage up to $7000. The Department of Health and Human Services is required to review coverage amounts every three years and may recommend increases to the governor.

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Source: State Health Reports, Intergovernmental Health Policy Project, No. 20 (Special Feature), January 1986.

JAN. 1988

ITEM II-A-4

STATE MANDATES OF PSYCHIATRIC INSURANCE COVERAGE

Mental health benefits are required in insurance mandates in 27 states. Mandated benefit packages (MBP) are required in 14 states; mandated availability (MA) is required in 13 states. Details of the insurance mandates are presented in the following tables.

SUMMARY OF STATE MANDATES OF MENTAL HEALTH INSURANCE COVERAGE

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Arkansas	MA	1979	Psychological evaluation, counseling psychotherapy or related mental health services are entitled to payment or reimbursed on an equal basis.	Not specified	Reimbursed provided service is provided by facilities licensed as outpatient psychiatric center.	Group, Individual	Psychiatrist, psychologist, licensed outpatient psychiatric centers.
California	MA	1973	Terms of all coverage agreed upon between the group policy-holder and insurer.	Not specified	Terms of all coverage to be agreed upon between the group policy-holder and the insurer.	Group	Psychiatrist, psychologist, licensed marriage, family and counselor, registered registered nurse with a masters in psychiatric mental nursing and 2 years' experience in psychiatric mental health nursing, licensed clinical social worker.
Colorado	MBP	1976	Under basic coverage benefits, 45 days for full hospitalization in one 12 month benefit period. Each day of confinement as an inpatient shall reduce by 1 day the total days available for all other illnesses during the 12 month benefit period. Each day of inpatient care shall reduce by 2 days the 90 days available for partial hospitalization care.	90 days for partial hospitalization in one 12 month benefit period. Each 2 days of partial hospitalization shall reduce by 1 day the total days available for other illnesses during the 12 month period. Each 2 days of partial hospitalization care shall reduce by 1 day of the 45 days available.	Under major medical coverage benefits cover outpatient services furnished by a comprehensive health care service corporation, CMHCs. Copayment should not exceed 50%, up to $1,000. Deductibles shall not differ from the deductible amount for any other condition or illness.	Group	Psychiatrist, psychologist, hospital or psychiatric hospital; comprehensive health care service corporation, a community mental health center or other mental health clinics under the supervision of a licensed psychiatrist or psychologist.
Connecticut	MBP	1971	60 days per year in any hospital.	120 days. An exchange exists with inpatient benefits under the following (1) if the cost does not exceed 50% of the cost of 1 inpatient day at the average semi-private rate at the hospital, 2 sessions of partial equal 1 inpatient day; (2) if the cost/session exceed 50% of the cost of an inpatient day each session shall equal 1 inpatient day.	After major medical deductible, copayment of 50% up to $1,000. Additional benefits up to $2,000 shall be provided at the option of the group policy-holder.	Group, Individual	Psychiatrist, psychologist, MSW, (under the supervision of a licensed physician or psychologist) in a child guidance clinic, non-profit community mental health center, non-profit licensed adult psychiatric clinic operated by an accredited hospital.
Florida	MA	1976 Amended 1983	30 days per year.	If partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, total benefits paid should not exceed the cost of 30 days of inpatient hospitalization.	$1,000 per year	Group	Psychiatrist, psychologist, licensed mental health professional.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Georgia	MA	1984	30 days per year under an individual policy and 60 days per year under a group policy.	Not specified	48 visits per year under an individual policy and 50 visits per year under a group policy.	Group, Individual	Not specified
Illinois	MA	1975 Effective 1977	Coverage for inpatient on par with physical benefits, but not more than 50% deductible for all expenses with an annual limit of the lesser of $10,000 or 25% of the lifetime policy.	Not specified	Cover for outpatient on par with physical benefits, but not more than 50% deductible for all expenses with an annual limit of the lesser of $10,000 or 25% of the lifetime policy.	Group, Individual	Psychiatrist, psychologist.
Kansas	MA	1978	30 days per calendar year.	Not specified	Coverage for the first $100 and 80% of the next $500 per year.	Group	Psychiatrist, psychologist, community mental health center or clinic, psychiatric hospital.
Louisana	MA	1975	Benefits on par with those offered for other illnesses.	Not specified	Benefits on par with those offered for other illnesses.	Group	Psychiatrist, psychologist, board certified social social worker in consultation with a physician.
Maine	MBP	1983	At least 30 days per year with a 20% co-payment and a lifetime limit of $25,000.	$100 deductible, 50% copayment with an annual limit of $1,000. Lifetime limit of $25,000.	$100 deductible, 50% copayment with an annual limit of $1,000. Lifetime limit of $25,000.	Group	Psychiatrist, licensed psychologist, an accredited public or psychiatric hospital and community agency under the supervision of a psychiatrist or licensed psychologist.
Maryland	MBP/MA	1974	MBP: 30 days per year in any hospital.	MA: 30 partial hospitalization treatment days per year.	MBP: after major medical deductible copayment can be no less than 50%.	Group (MBP & MA) Individual (MBP).	Psychiatrist, psychologist, social worker.
Massachusetts	MBP	1973	60 days in any hospital; on par with other illnesses.	Not specified	$500 per year	Group, Individual	Psychiatrist, psychologist, licensed clinical social social worker, comprehensive health service organization, licensed or accredited hospital, community mental health center or clinic.
Minnesota	MBP	1975	Not specified	Not specified	All group policies providing benefits for mental or nervous disorder treatment in a hospital shall also provide coverage to at least 80% of the first $750 per year while the insured person is not a bed patient in a hospital.	Group	Psychiatrist, psychologist, licensed or accredited hospital, community mental center or mental health clinic approved or licensed by authorized state agency.
Missouri	MA	1980	30 days per year; on par with other illnesses.	Not specified	Copayment no greater than 50% up to $1,500 or 20 sessions. Frequency of psychotherapy sessions may be limited but benefits shall be available for at least one session during any 7 consecutive days.	Group, Individual	Psychiatrist, psychologist.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Montana	MBP	1983	Under basic inpatient expense policies, benefits are no less than 30 days per year. Under major medical policies, no less than 30 days per year and if inpatient benefits are provided beyond 30 days, the durational limits, dollar limits, deductibles and copayments need not be the same as applicable to physical illness generally.	Not specified	Copayment no greater than 50% or the coinsurance factor applicable for physical illness generally, whichever is greater and the maximum benefit for mental illness, alcoholism and drug addiction in the aggregate during the benefit period may be limited to not less than $1,000.	Group	Psychiatrist, psychologist, social worker, mental health treatment center.
New Hampshire	MBP	1975	Benefits on par with benefits for other illnesses for service in a licensed or general hospital. Major medical coverage may be limited to $3,000 per individual and a lifetime maximum of of $10,000, per individual. Allowable days not specified.	Partial hospitalization is covered under major medical expenses but the extent of coverage is not specified. Allowable days not specified.	Benefits should be at least as favorable as those which apply to the benefits for the treatment of other illnesses. Non-major medical policies must cover 15 hours of care after the first 2 visits. Allowable days not specified.	Group	Psychiatrist, psychologist, licensed pastoral counselor, mental hospitals, licensed licensed or general hospitals, community mental health center, psychiatric residential program.
New York	MA	1977	30 days per year in a general or mental hospital.		$700 per year deductibles and coinsurance on par with other benefits.	Group	Psychiatrist, psychologist, social worker.
North Dakota	MBP	1975	70 days per year for a licensed hospital. Each day of inpatient treatment shall be equivalent to 2 days of partial hospitalization.	140 days partial hospitalization per year. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment.	Not specified	Group (more than 50 persons with 70% of group participating).	Psychiatrist
Ohio	MBP	1978	Not specified	Not specified	$550 per year subject to reasonable deductibles and copays.	Group	Psychiatrist, psychologist, accredited hospital or community mental health facility.
Oregon	MBP	1984	No more than $7,500 in any 24 consecutive month period for inpatient care and treatment in hospitals. No more than $3,000 in any 24 consecutive month period in residential facilities. Within this $3,000 limit, payment shall be made for either full-day supervised residential or part-day treatment.	Part-day treatment on an organized, formal, regularly scheduled basis consisting of at least 4 hours of structured treatment per day, for at least 4 days each week. Shall be no more than $3,000 in any 24 consecutive period. Within this $3,000 limit, payments shall be made for either part-day or full-day residential treatment. Part-day treatment less than 4 hours of treatment per day for at least 4 days each week, is covered as outpatient treatment.	No more than $2,000 in any 24 consecutive month period.	Group	Psychiatrist, psychologist, nurse practitioner, clinical social worker, health facilities, residential facilities or inpatient services.

MAs Mandated Availability
MBPs Mandated Minimum Benefit Package

Produced for the APA National Education Program by GLS Associates, Inc., Philadelphia, PA, September 1985.

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Tennessee	MA	1974	Not mandated	Not mandated	30 visits per year copays and deductibles on par with physical illnesses.	Group, Individual	Psychiatrist, psychologist, community health center - with an approved plan for quality assurance, accredited hospitals.
Vermont	MA	1975	45 days per year in a general or mental hospital.	45 day equivalents of active care per year.	100% of the first 5 visits and 80% thereafter up to $500 per year.	Group	Psychiatrist, psychologist, licensed mental health professional, licensed general or mental hospital or community mental health centers.
Virginia	MBP/MA	1975	MBP: 30 days per year in a mental or general general hospital includes benefits for drug and alcohol rehabilitation and treatment with respect to drug and alcohol rehabilitation only. There is an $80 per day indemnity benefit and a lifetime coverage of 90 days.	Not specified	MA: $500 per year with reasonable deductibles and coinsurance that are not less favorable than physical illnesses, except that the copayment not exceed 50% up to $1,000 per benefit period.	Group, Individual	Psychiatrist, psychologist, licensed clinical social worker, mental health treatment center.
Washington	MA	1983					
West Virginia	MA	1977	45 days per year in a mental or general hospital; on par with illnesses in a general hospital.	Not specified	50% copayment up to $500 per year, sessions cannot exceed 50 per year.	Group, Individual	Psychiatrist, psychologist, licensed or accredited general mental hospital, comprehensive health service organization, community center or clinic.
Wisconsin	MBP	1975	Not less than the lesser of either the expenses of the first 30 days as an inpatient in a hospital, or the first $7000 minus a copayment of up to 10%.	Not specified	Up to $1000 minus a copayment of up to 10%.		Psychiatrist, psychologist, hospital, residential facility, outpatient treatment facility.

Total inpatient and outpatient treatment coverage up to $7000. The Department of Health and Human Services is required to review coverage amounts every three years and may recommend increases to the governor.

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Source: State Health Reports, Intergovernmental Health Policy Project, No. 20 (Special Feature), January 1986.

(2)

Memo: Rep. Niilo Koponen - House HESS
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 ~~es~~ 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 smaller. 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 ~~was~~ 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 Clinical Social Work Practice (SIC) in Alaska, there are internal grievance committees that can handle ethics complaints.

We can not recommend that ACSW be used as an alternative ~~the~~ 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)

WATKINS, SALLIE A., DR* PIP/AL ACSW
Private Practice
PO Box 2167, University of Alabama, Tuscaloosa AL 35486
PH: (205) 752-4377H
REGNO: 024904 *CERT:* LCSW, AL
PRAC: FAM; I; GR; CP
EDUC: DSW 81 U Alabama University AL ; MSW 72 U Alabama, University AL
SPEC: AD; C; GER; Gen Prac
EXPER: 73- Asst Prof University of Alabama Birmingham; 80-83 Bryce Hospital Social Work Supervisor; 74-77 Brewer-Porch Childrens Center Social Worker

Tuskegee Institute

SMITH, ELSIE M.* LCSW/AL ACSW
Tuskegee University
808 Neal St, Tuskegee Institute AL 36088 *PH:* (205) 727-0214
REGNO: 006181
PRAC: GR; I
EDUC: MSW 57 Atlanta U, Atlanta GA
SPEC: AD; A; MIN
EXPER: 74- Dir Spec Prgm Tuskegee University; 72-74 Dir Campus Individual Development Ctr; 61-72 Outpt Soc Wkr Tuskegee Mtl Hlth Ctr

Waterloo

CRAVEN, DOROTHY S.* LCSW/AL ACSW
Veterans Admin Med Ctr
Rt 1 Box 110, Waterloo AL 35677 *PH:* (205) 766-5683
REGNO: 024870
PRAC: I; FAM; CP; GR
EDUC: MSW 70 U Alabama, University AL
SPEC: AD; Gen Prac
EXPER: 82- Veterans Admin Med Ctr

ALASKA (Total 20)

Anchorage

ANDERSEN, ELLEN M.* ACSW
US Public Health Service
2955 Drake Dr, Anchorage AK 99508 *PH:* (907) 265-9557B
REGNO: 001201
PRAC: FAM; GR
EDUC: MSW 72 U Michigan, Ann Arbor MI
SPEC: C
EXPER: 78- Sr Soc Wkr US Public Health Service; 77-78 Soc Wkr Bureau of Indian Affairs; 75-77 Pottawattamie Child Guidance Ctr

ANDREINI, MILDRED J. ACSW
Ctr for Chdn & Parents
3524 Stanford Drive, Anchorage AK 99508 *PH:* (907) 276-4994B
Counseling Ctr
101 E Ninth Avenue #7A, Anchorage AK 99501
PH: (907) 279-5441B
REGNO: 024144 *CERT:* RN, AK; RN, CA
PRAC: I; FAM; CP; GR
EDUC: MSW 82 U Houston, Houston TX
SPEC: AD; Eat Dis; Mar/Dvc; Med Con; Gen Prac
EXPER: 84- Executive Director Ctr for Chdn & Parents; 82- Clinical Social Worker Private Practice

BLAKE, DANIEL A.* ACSW
Private Practice
1709 Bragan Suite B, Anchorage AK 99508 *PH:* (907) 279-3822B
REGNO: 012861
PRAC: FAM; I; GR
EDUC: MSW 75 Washgtn U/GW Brown, St Louis MO
EXPER: 78- Private Practice; 76-78 Ped SW Yale-NH Hosp Yale Sch of Med

CARRAHER, BARBARA SHARP* ACSW
Humana Hospital
7231 Kiska Circle, Anchorage AK 99504 *PH:* (907) 338-1167
Social Services Dept, 2801 DeBarr, Anchorage AK 99508
PH: (907) 276-1131
REGNO: 001202
PRAC: I; GR; FAM
EDUC: MSW 69 U North Carolina, Chapel Hill NC
SPEC: AD; Med Con; Dth/Dyg; Sub Ab
EXPER: 82- Soc Svc Director Humana Hosp; 73-80 Clinical Soc Wkr NC Mem Hosp; 71-72 Sr Soc Wkr Queen Ellz II Hosp

CRAIG, HELEN S. ACSW
Langdon Psychiatric Clinic
2503 Sprucewood, Anchorage AK 99504 *PH:* (907) 561-1361B
REGNO: 017326
PRAC: FAM; I
EDUC: MSW 74 U Illinois, Urbana IL
SPEC: A
EXPER: 77- Langdon Psychiatric Clinic; 74-77 Involvement Centers of Wisconsin; 74-74 Mattoon Community Mental Health Center

DOHRMAN, MARGIE M.* ACSW
DHEW-PHS-IHS
PO Box 6377, Anchorage AK 99502 *PH:* (907) 694-2207
REGNO: 011872
PRAC: I
EDUC: MSW 68 U Denver, Denver CO
SPEC: AD
EXPER: 68- Clinical Social Worker Alaska Native Med Ctr

DUKE, VERONICA M.* ACSW
State of Alaska
State of Alaska, 2900 Providence Drive, Anchorage AK 99508
PH: (907) 561-1633
REGNO: 000842
PRAC: I
EDUC: MS 59 U Missouri, Columbia MO
EXPER: 72- Chf Soc Wkr Alaska Psych Inst Program Manager; 70-72 Psych Soc Wkr Alaska Psych Inst; 56-60 Psych Soc Wkr State of MO

ECKRICH, SHERRY* ACSW
Div of Fam & Youth Svc
6501-A Donna Drive, Anchorage AK 99504 *PH:* (907) 337-0879
REGNO: 027288
PRAC: I; CP; GR; FAM
EDUC: MSW 76 Washgtn U/GW Brown, St Louis MO
SPEC: AD; Fam Vio; Gen Prac; Mar/Dvc; Med Con
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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EDUC: PhD 76 U Pittsburgh, Pittsburgh PA; MPH 73 U Pittsburgh, Pittsburgh PA; MSW 71 U Pittsburgh, Pittsburgh PA
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EXPER: 86- Director Good News Counseling of Alaska; 84-86 Director Samaritan Counseling of Alaska; 75-84 Director Alaska Childrens Services Executive

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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 Wk, Alaska Chdns Svc Ctr for Chdn & Parents; 66-70 Dir Therapeutic Svc Jesse Lee Home

Eagle River

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Star Rt Box 5203, Eagle River AK 99577 *PH:* (907) 694-2055H
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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
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Box 5020, Loveland Circle, Eagle River AK 99577
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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
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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

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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

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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

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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

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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

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REGNO: 019399
PRAC: I; CP; FAM; GR
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SPEC: A; C; Mar/Dvc; Gen Prac; Chd/ Sex Ab
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PO Box 73411, Fairbanks AK 99707 *PH:* (907) 488-3948B
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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; 82-83 Clinician Fairbanks Community Mental Health; 82-82 Lecturer Dept of Psych Univ of Alaska

Kodiak

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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
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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

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EDUC: MSW 64 U Kansas, Lawrence KS
EXPER: 81- Clinician Norton Sound Family Svcs; 75- Private Practice with Psychiatric Cnslt; 72-76 Private Practice Shawnee Mission KS

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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

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EDUC: MSSW 57 Columbia U, New York NY
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EXPER: 83- Clinician III Norton Sound CMHC Nome AK; 82- Private Practice Overview Clinic Nome AK; 82-83 Director Extended Care SE CO Fam/MHC

PROFESSIONAL SOCIAL WORK RECOGNITION

Vendorship Report

June 1987

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.
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(301) 565-0333

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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 $30 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 more 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.

			REQUIREMENTS	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 [illegible] physician or surgeon
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. $1000	Not specifically but may be	Not required
Kansas	April 1982	Specialist Clinical Social Worker	None	LCSW 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 CSWs	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 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

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(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 - 220... 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 professional 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 $40.00 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

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

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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.

- 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.

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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-

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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 [illegible]

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 the 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 fees 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 appointments; 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 questionable

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 organization.

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.

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.

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

Kim Busch 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 (HESS)
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.

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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(907) 747-8994

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