

S B

6 7



# Alaska State Legislature

SENATE

*Office of the President*

P.O. Box V  
State Capitol  
Juneau, Alaska 99811  
(907) 465-3755

April 13, 1987

MEMORANDUM

TO: Representative John Sund, Chairman  
House Judiciary 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 House HESS Committee Substitute for Senate Bill 67 has been referred to your committee for consideration. This bill will require insurers to include minimum mental health coverage in all group 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 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.

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.

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 suicide.

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 include 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.

(b) The insurer or service corporation cannot charge a higher deductible for this coverage than for the treatment of any other condition or illness. Contract limitations must be reasonable.

(c) This subsection contains a definition of terms used in section 1.

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, 1989.

A similar bill was introduced in the 14th Legislature. It passed the Senate, and made it through the House, but died in the Rules Committee during the final hours of the 1986 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.

Thank you.

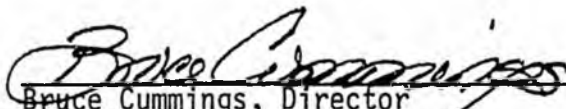
POSITION PAPER  
HCS CSSB 67 (HESS)

If enacted, this bill would require a minimum mandatory insurance coverage for treatment of mental and nervous conditions in all group major medical policies entered into or renewed after January 1, 1989.

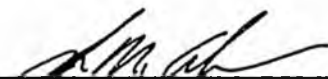
The coverage mandated by this bill exceeds coverage currently provided by the State policies for retirees. Enactment of this version will increase the State's contributions to Public Employees' Retirement System and Teachers' Retirement System. The coverage mandated by this bill is different than the coverage provided to employees. However, the differences would not require added costs.

Additionally, the effect of this bill is directly contrary to the State's efforts to reduce employer-paid premium costs for State employees via collective bargaining. This statutorily mandated benefit level would reduce the flexibility of the parties in negotiations to alter coverage/benefit levels in order to contain costs. Since the legislation would take effect for the next contract year, the agreements reached in health insurance negotiations would have to be rapidly revised to the new required coverage is provided.

The Department of Administration opposes this bill.

  
Bruce Cummings, Director  
Division of Labor Relations

Date 3/11/88

  
Commissioner John M. Andrews  
Department of Administration

Date 3/11/88

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, 1986 APT Children's Facility Study, and 1986 Banerjee 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:

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

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

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

Date: February 4, 1988

Approved by: Myra M. Munson  
Myra M. Munson, Commissioner

FISCAL NOTE

REQUEST:

Revision Date: \_\_\_\_\_ Agency Affected: Health & Social Services  
 Title: ...relating to insurance coverage for BRU: Community Mental Health Grants,  
the treatment of a mental or nervous cond. Institutions and Administration  
 Sponsor: \_\_\_\_\_ Components: Community Mental Health  
 Requestor: \_\_\_\_\_ 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-

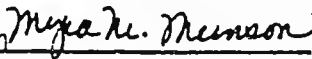
POSITIONS:

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.

IVAN H. FRASIER, M.A.

APR 8 1988

family counseling

P.O. Box 021850  
Juneau, Alaska 99802

Phone: 586-6810

April 8, 1988

Representative Sund  
Chairman, House Judiciary Committee  
Alaska State Capitol  
Juneau, Alaska

RE: House CS for CS for Senate Bill No. 67 (HESS)  
(Insurance coverage for the treatment of a  
mental or nervous condition.)

Hon. Chairman Sund,

This letter indicates support for the movement of the Bill toward passage and requests the addition of language to the Bill which recognizes the independent specialty of Marital and Family Therapy.

First, may I indicate my support for the passage of the Bill into law to provide insurance coverage for those seeking professional help for a mental or nervous condition. It has been well documented that services successfully addressing mental and emotional conditions most often lead to reduced need for more expensive medical treatment.

Secondly, may I suggest that there is valid reason to add the below suggested language to the Bill including Marital and Family Therapists as an independent specialty for treatment of mental or nervous conditions within the context of marital and family systems. Some of these reasons are as follows:

- 1) It appears clear that one of Alaska's highest priorities is professional, competent services to children and their families. (Reference the Governor's Interim Commission on Children and Youth Report.) Marital and Family Therapists meeting the standards suggested in the proposed additional language to the Bill are qualified to provide many of the needed services.
- 2) There is sufficient evidence that professional services that increase marital and family harmony and decrease family dysfunction decrease the use of more expensive medical services, usually paid for by insurance coverage.
- 3) The practice of Marital and Family Therapy is recognized nationally as a separately identifiable, credible profession. It is licensed or certified in seventeen states.
- 4) The additional of Marital and Family Therapists to the insurance bill provides an additional choice for the citizens of Alaska in selecting professional services.

May I request that the following language be added to the above referenced legislation:

add (9)(F) a marital and family therapist who is  
(i) licensed or certified as a marital and family therapist by a state; or  
(ii) is a Clinical Member of the American Association for Marriage and Family Therapy;

add (10)(A)(vi) a marital and family therapist who is licensed or certified by a state or is a Clinical Member of the American Association for Marriage and Family Therapy.

Delete or on page 5 line 1.

Replace the period with a semicolon after "workers" on page 5 line 5, and add or after the semicolon.

TO: Representative Sund  
FROM: Ivan Frasier  
RE: House CS for CS for Senate Bill No. 67 (HESS).

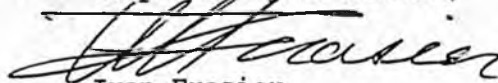
Page 2

The American Association for Marriage and Family Therapy (AAMFT) is the professional organization in the United States and Canada for Marital and Family Therapists, and its Commission on Accreditation has been designated by the U.S. Department of Education for setting standards for the education and training of marital and family therapists.

May I encourage you to consider that the addition of marital and family therapy to the insurance bill is in the public interest for Alaska's citizens, both from the view of increasing choices for professional services and from the view of cost effectiveness.

Thank you very much for your consideration of this request.

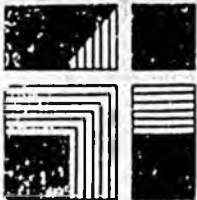
Respectfully Submitted,



Ivan Frasier

cc: Committee Members

Alaska Division of the American Association for  
Marriage and Family Therapy.



## Samaritan Counseling Center of Alaska

Expressing the love of God via counseling.

4502 Cassin Drive, Anchorage, Alaska 99507 • (907) 563-4325

Raymond Norman Fedje, Ph.D., D.D.  
Executive Director

February 26, 1988

Ref.: L-K-1008

Senator Jan Faiks  
P.O. Box V  
Juneau, Alaska 99811

Reference: CS FOR SENATE BILL NO. 67 (HESS)

Dear Senator Faiks:

On behalf of our Board of Directors and staff (please see the attached lists), I am writing to you regarding Senate Bill No. 67 (HESS) asking for inclusion of Pastoral/Christian Counseling Centers, such as the Samaritan Counseling Center of Alaska.

We are suggesting as an amendment to Sec. 8.B.IV, line 14 through 18 or as an additional paragraph V, the following be added:

A PASTORAL COUNSELING CENTER WHERE STAFF PROVIDERS HAVE AN ACCREDITED DEGREE IN COUNSELING OR PSYCHOLOGY AND WORK UNDER THE DIRECT SUPERVISION OF A LICENSED PSYCHOLOGIST OR PSYCHIATRIST (M.D.).

This past year we served 652 clients for a total of 6,071 therapy hours. Our staff is supervised by W.A. Cassell, M.D., F.A.P.A., License No. AA1533, with Dr. O. Matsutani, consulting psychiatrist, and Dr. Nancy E. Sydnam, M.D., as our consulting medical officer. Being included in the bill would make it less of a burden for our client to rely on their insurance for sessions given within the context of Pastoral Psychotherapy especially during our economically difficult times.


We do not receive state, federal or local funds for these services, so this would be most helpful to the Center in meeting the needs of the community.

Should you have particular questions, I would be happy to appear before your committee or answer questions for you.

Your consideration and support for this inclusion would be appreciated.

Sincerely yours,

SAMARITAN COUNSELING CENTER OF ALASKA

  
Raymond Norman Fedje, Ph.D.  
Executive Director

RNF:iw



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) the charge agreed to by contract between the provider and the third party payor;

# Richard M. Babyak & Associates

March 23, 1988

The Honorable John L. Sund  
Chairman  
House Judiciary Cmte.  
P.O. Box V  
Juneau, AK 99811

APR 5 1988

Dear Mr. Sund:

As you are aware, mental health problems are becoming one of the top issues demanding our immediate attention. The frequency and intensity of the problems are escalating, as are the attendant costs and burdens on state coffers.

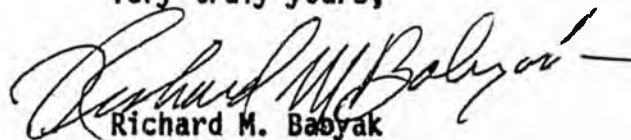
Upon review of the mental health problems, it becomes very apparent that the hospitalization of clients in need of services is an extremely expensive proposition. In my travels, I have seen a probable solution. There are many alternative residential rehabilitation programs that exist for treating people with mental health conditions. They are providing superior treatment environments in open community settings. Also, they are professionally staffed and ultimately more effective than inpatient hospitals. The cost is way below that of hospitalization.

In order to resolve these problems, I propose that you, as a state lawmaker, introduce a bill similar to Texas SCR #62, a copy of which is enclosed. A bill of this type will make a profound difference in providing a mandate for insurance companies to assume some of your state's burden of mental health costs. As a result of the mandate, the insurance companies would open up a new alternative in lieu of expensive inpatient hospital treatment.

A model program of alternative residential and day treatment care exists at Wiley House, which is located in Bethlehem, Pennsylvania. This comprehensive institution serves 1,500 clients on any given day and also serves as the base service case management unit for mental health in Lehigh County, Pennsylvania. If you should desire additional program materials similar to those enclosed, to serve your purposes when discussing alternative mental health systems and relative legislation, you are welcome to request such information from: Mr. Richard Biolsi, Assistant Executive Director, Wiley House Treatment Centers, 1650 Broadway, Bethlehem, PA 18015.

Should you wish to discuss the bill or other related issues, please give me a call.

Very truly yours,

  
Richard M. Babyak  
President

Enclosure

WHEREAS, Besides his overriding concern for the children of Texas, Senator Aikin was a devoted friend of the educators of this state and a strong proponent of increased pay for teachers and a strong teacher retirement system; and

WHEREAS, Beloved by his legislative colleagues and known as the conscience of the Senate, Senator Aikin served the legislature longer than any other individual in the state's history; and

WHEREAS, Through generous donations to the Aikin Fund by this esteemed gentleman's many friends and matching funds from the Permanent University Fund, the Aikin chairs became a concrete reality and an appropriate memorial to the life and service of the Honorable A. M. Aikin, Jr.; now, therefore, be it

RESOLVED, That the Legislature of the State of Texas hereby recognize the creation and establishment of the Aikin chairs as a permanent and lasting tribute to Senator A. M. Aikin, Jr.

Adopted by the Senate on March 14, 1985; adopted by the House on April 11, 1985.

Approved: April 23, 1985

Filed: April 24, 1985

---

S.C.R No. 62

WHEREAS, Recognizing that demands on the mental health delivery system continue to increase at a time when the state faces severe financial stress, it is imperative that all available sources of funds be utilized; and

WHEREAS, Current insurance regulations emphasize hospitalization programs rather than rehabilitative programs for those persons with mental disabilities; and

WHEREAS, Many persons with mental disabilities can receive more appropriate and beneficial treatment in less restrictive residential programs; and

WHEREAS, Apartment programs, foster care, and Fairweather lodges are significantly less expensive and more rehabilitative to those persons with long-term mental disabilities than hospitalization programs; now, therefore, be it

RESOLVED, That the 69th Legislature of the State of Texas hereby request the cooperation of the Texas Department of Mental Health and Mental Retardation and the State Board of Insurance in the implementation of the recommendation of the Legislative Oversight Committee on Mental Health and Mental Retardation to augment existing sources of funds for persons with mental disabilities; and, be it further

RESOLVED, That the Texas Department of Mental Health and Mental Retardation and the State Board of Insurance be directed to work with the insurance industry in developing a plan for reimbursement of the expenses for rehabilitative residential programs in lieu of more costly programs; and, be it further

RESOLVED, That an official copy of this resolution be prepared and forwarded to the commissioner of the Texas Department of Mental Health and Mental Retardation and the commissioner of the State Board of Insurance as an expression of the wishes of the Texas Legislature.

Adopted by the Senate on April 18, 1985; adopted by the House on May 17, 1985.

Approved: June 15, 1985

Filed: June 16, 1985

---

S.C.R No. 63

WHEREAS, Recognizing the availability of appropriate community residential services is a major factor in the development and implementation of a substantially communi'



## American Association for Marriage and Family Therapy

### MARITAL AND FAMILY THERAPY FACT SHEET

- o Marital and Family Therapy (MFT) means the diagnosis and treatment of mental and nervous disorders within the context of marital and family systems.
- o The provision of marriage and family therapy is already covered as a mental health benefit in many health benefit programs. It is not a new benefit. AAMFT believes in freedom of choice or direct recognition which allows the beneficiary to choose to have his/her health service provided by a range of qualified providers including marriage and family therapists. A sizeable research literature, together with a recent United States Office of Personnel Management (OPM) Study affirm that freedom of choice decreases the fees charged by mental health practitioners and does not lead to over-utilization of services. Many studies have shown a "cost-offset" when mental health coverage replaces traditional and expensive medical services. The "cost-offset" phenomenon is well recognized and accepted.
- o Marital and Family Therapy is recognized by the United States Government as a separate and distinct mental health discipline. Because of its uniqueness, in 1978 the United States Department of Health, Education and Welfare designated the Commission on Accreditation of the American Association for Marriage and Family Therapy as the sole national accrediting agency for graduate and post-degree educational and training programs in the field of marital and family therapy. The Government recognized that Marriage and Family Therapy is not simply a part of some other discipline like psychiatry, psychology, and social work. This recognition has been renewed three times, most recently in 1985.
- o Licensed marriage and family therapists (or in states where there is no licensure, MFT's who are clinical members of the American Association for Marriage and Family Therapy) are well trained. They have received extensive coursework and supervised clinical experience in marriage and family therapy. Clinical members of AAMFT have a minimum of a Master's Degree and two years of post-graduate experience.
- o Research shows that marriage and family therapy is the most effective treatment for many crucial problems facing America's families today--such as family violence, substance abuse, delinquency, and eating disorders. Since 50% of all marriages are projected to end in divorce, our nation's couples clearly need this help.



# American Association for Marriage and Family Therapy

## INFORMATION SHEET

The American Association for Marriage and Family Therapy, AAMFT, has long been established as the national professional association for marital and family therapists in the United States and Canada. Founded in 1942, AAMFT has nearly 13,000 members and divisions in almost every state. The members of AAMFT have met rigorous educational and training standards which have been established as entry criteria into the profession of marital and family therapy. The AAMFT clinical membership requirements help the public identify well educated, skilled and ethical practitioners in marital and family therapy which, in turn, helps to serve the growing public demand for marital and family therapy services.

Clinical members of AAMFT have completed specific post-graduate training in marital and family therapy as well as extensive supervised clinical practice with couples and families. In an effort to advance professional understanding of marital and family behavior and the treatment of marital and family dysfunction, the Association publishes the widely respected Journal of Marital and Family Therapy. This journal is viewed as a leading publication in the field of marital and family therapy. AAMFT also publishes a bi-monthly newspaper, entitled the Family Therapy News. In addition, the Association sponsors an annual conference, with an attendance of approximately 4,000 marital and family therapists who participate in over 250 workshops, training institutes, seminars and symposia emphasizing the most recent developments in marital and family therapy theory, technique and research.

As the leading national professional association in the field, AAMFT has been the forefront in promoting the education and training of marital and family therapists. In 1978, AAMFT's Commission on Accreditation for Marital and Family Therapy Education was officially recognized by the United States Department of Health, Education and Welfare as the sole national accrediting agency for graduate and post-degree educational programs in the field of marital and family therapy. The Commission's recognition has been renewed three times by the United States Department of Education, most recently in 1985.

For more information about the practice and profession of marital and family therapy, please contact the American Association for Marriage and Family Therapy.

## THE FOURTH MENTAL HEALTH DISCIPLINE

The field of marriage and family therapy is frequently referred to as the "Fourth Mental Health Discipline." The other three disciplines - psychiatry, psychology, and social work - are certainly older than the field of marriage and family therapy, but this new discipline has evolved rapidly to achieve its position of status in the mental health field. One reason for this occurrence is that it was initially populated by members of the other three disciplines and subsequently was able to advance based upon the collective experience of these contributors. Another reason of significance, is that these other disciplines all had historically acknowledged the role of the family in the development of human problems, as well as the treatment process. The profession of marriage and family therapy evolved as the profession wherein the collective body of knowledge regarding clinical implications of the family were gathered and developed, as well as the place where those who espoused this view gravitated to. From a review of the historical development of this field one quickly appreciates the important roles played by members of each of the other three mental health disciplines in its evolution. Because of the diversity of backgrounds of the pioneers in this field, there was a creative competition among them that also contributed to the rapidity of its growth. Psychoanalysis, like many other schools of thought, only had the creative benefit of Sigmund Freud as its one primary developer.

While marriage and family therapy has a short history, it does have a long past. The earliest traces of the family as a significant treatment factor can be found in Freud's early works. He was convinced that human conflicts were spawned in early interactions between children and their families. While he acknowledged the importance of the family in this regard, he attempted to isolate the family from treatment in order to "liberate" his patients from the problems of the family. It was as though he viewed the family as an infectious disease to be kept out of the "psychoanalytic operating room." Like Freud, most clinicians in the first half of this century acknowledged the family as an important variable in human problems and also continued to exclude the family from the treatment process.

It was not until the 1950's that the field of marriage and family therapy, as known today, began to become evident. About this time, early pioneers began to include family members in the process of helping to effect change. These practitioners were recognizing that it was every bit as important to understand and treat what was happening between people as it was to focus on what was happening inside of the individual. While clinical observation was demonstrating that it was productive to include family members in the change effort, a developing body of research findings were also substantiating this factor.

The decades of the sixties and seventies resulted in the firm acknowledgement of marriage and family therapy as the "fourth mental health discipline." The primary professional association which marriage and family therapists identify with is the American Association of Marriage and Family Therapy (AAMFT).

This Association is headquartered in Washington D.C. and has primary responsibility for the certification and endorsement of both training programs and individual practitioners. Individuals and training programs seeking the professional endorsement of this Association must first meet the professional standards established and then demonstrate their professionalism by meeting on-going continuing education requirements and review of their currency in the field. While the AAMFT has certain service functions it makes available to the professional membership, it continues to have as a primary function that of insuring that quality services are being made available to American families. Consequently, one means the American public has available to insure quality of the individual who might provide marriage and family therapy services is to determine if they are a clinical member of the AAMFT. The current membership of AAMFT is approximately 12,000.

While the AAMFT is responsible for National membership and monitoring of the development and maintenance of the profession at that level, most states also function with a separate division. Alaska is no different in this regard and recently formally organized the Alaska Association for Marriage and Family Therapy. Although our membership is smaller (25) than other states (such as Wisconsin, 200), we are very active in developing the field of Marital and Family Therapy in Alaska. While the AAMFT has their annual convention in different major cities across the nation, Alaska will also have a separate annual state convention. The purpose of this convention, as with the national convention, is to provide the membership with an opportunity to engage in continuing education and insure that individuals are current in their understanding of recent developments in the professional field. The State Association (Alaska Association for Marriage and Family Therapy), as with the national parent organization, is also concerned with monitoring legislation and other significant developments that have implications with regards to the American family. While the intent of both Associations is to insure high quality care to families by clinicians, it is also concerned with attempting to influence societal changes in a fashion that can foster even more optimal functioning by the families of the state and nation. While the American family has long been regarded as the most significant and enduring building block of our society, there is probably no professional association that has such a centralized focus on its care and preservation than the AAMFT and its state division, the Alaska Association for Marriage and Family Therapy.

## Family Therapy

# NEWS

Newspaper of the American Association for Marriage and Family Therapy

VOL. 19 NUMBER 1

1717 K Street, NW, #407, Washington, DC 20006

JANUARY-FEBRUARY 1988

*Action in All Parts of US*

## 1987 was Biggest Year Ever In State MFT Regulation

Passage of a marital and family therapy licensure act in Massachusetts late in 1987 topped off the busiest state MFT regulatory year in history. Four states had already enacted new legislation earlier in 1987 and four others had amended existing MFT regulatory statutes.

The American Association for Marriage and Family Therapy had recognized Minnesota and Washington laws as being consistent with AAMFT legislative policy and had given tentative approval to a new Wyoming act prior to the Bay State action. Legislation in the fifth new state, Rhode Island, was not recognized by the AAMFT. The intent of the AAMFT policy is to provide the public with qualified practitioners who have met adequate educational and training standards for the practice of marital and family therapy. Approval of a state's regulatory act by the organization also has the practical outcome of making licensed/certified individuals in the state immediately eligible for organizational membership.

Changes in existing laws were enacted in Connecticut, Florida, Nevada, and Utah. The Connecticut statute had mingled state recognition with prior membership in the AAMFT, a condition not sought or approved by the organization. That provision was struck from the law. Presence of a similar provision in the new Rhode Island statute is one of the reasons that legislation has not received AAMFT approval. In 1987, the state of Connecticut clarified the grandparenting provision within the law. As reported earlier in the *Family Therapy News*, Nevada changed its law from certification to licensure, enacted a freedom-of-choice law for reimbursement to consumers, and granted confidentiality

considerations to clients of MFTs. Utah's law was strengthened and extended through 1998 after a sunset review. Florida removed marital and family therapists from regulation by administrators in the state's Department of Professional Regulation by establishing a new board to regulate MFTs and other groups.

### The Massachusetts Story

Massachusetts' new law is similar to Georgia's regulation. MFTs will be licensed along with other "allied mental health and human services professions." A nine member board will consist of three public members and two members each from MFT, rehabilitation counseling, and mental health counseling.

The practice of "marriage and family therapy" is defined in the act as "the rendering of professional services to individuals, family groups, couples, or organizations, either public or private for compensation." It includes "applying principles, methods and therapeutic techniques for the purpose of resolving emotional conflicts, modifying perceptions and behavior, enhancing communication and understanding among all family members and the prevention of family and individual crisis" and permits the practice of "psychotherapy of a nonmedical nature with appropriate referrals to psychiatric resources."

Educational and experience requirements include as a minimum a master's degree in "a relevant field" with a "subsidiarization in marriage and family therapy" and two additional years of supervised clinical work. Reciprocity is required where the board determines that the requirements met in another state by an

applicant are equal to or exceed the Massachusetts requirements.

The Massachusetts legislature did not appropriate funds for the operation of the board. It was not clear at press time when operational funds would be made available.

Emily Mudd Mitchell, MA (Concord), has been the prime mover over a period of several years in the Massachusetts effort to secure regulation of MFTs.

### Recent Developments in Other States

Washington's heavy legislative and regulatory activity in 1987 included the appointment of an advisory council to assist the state's Department of Licensing in drafting regulations for implementation of the new statute. Among the council members are Ronald Lewis, MS (Puyallup), Bert Powell, MA (Spokane), and Charles York, PhD (Tacoma). The regulations are being written at the present time.

Important persons in seeing the legislation through to a successful conclusion

were Richard D. Fitzgerald, MSW (Spokane), president-elect of the Washington Association for Marriage and Family Therapy; Brenda Kerr, MA (Renton), WAMFT president; and Michael Nugent (Auburn), former WAMFT legislative chair.

The key players in securing passage of the Wyoming law were Ron Jeffrey, MA (Cheyenne), president of the Wyoming Association for Marriage and Family Therapy; and Edwina Waldrip, MSW (Cheyenne), a past-president of the Wyoming association. The new regulatory board was appointed last August. Work on drafting board regulations began during the fall and grandparenting of practitioners under the new act was scheduled to begin in January, 1988.

Minnesota's activities are covered elsewhere in this issue of the *Family Therapy News*. ■

*Michael Bowers, MA, Divisional Liaison for the American Association for Marriage and Family Therapy, contributed significantly to this report.*

### Off and Treating—

## CHAMPUS Demo Project For MFTs Underway

A demonstration project in which marital and family therapists are functioning as fully independent providers under CHAMPUS (the Civilian Health and Medical Program of the Uniformed Services) got underway December 1. The demonstration project, mandated in 1986 by the US House of Representatives Armed Services Committee, is intended to determine whether MFT services can be delivered in a more cost-effective manner without physician intervention. The committee questioned the need for physician

providers will be compared. Licensed/certified MFTs from Connecticut and New Jersey who are CHAMPUS authorized, meet the clinical membership requirements of the American Association for Marriage and Family Therapy—although not necessarily members, and agree in writing not to seek reimbursement from the beneficiary if their claim for services is denied by CHAMPUS will be compared with MFTs from New York and Massachusetts who meet similar criteria except for being state licensed/certified.



*Good News and Bad News—*

## Kennedy Bill Includes Mental Health Benefit But Would Invalidate State Freedom-of-Choice

Legislation that would have a significant positive and negative impact on marital and family therapists and other qualified health care providers is before the 100th Congress. Perhaps the most important and far-reaching in consequences is the "Kennedy-Waxman" legislation that would affect 34 million uninsured Americans. It is regarded as a mixed package because although it seems likely that the one bill will mandate a minimum mental health benefit, as currently drafted the legislation still would invalidate all state laws pertaining to health insurance. The outcome would be the invalidation of all state freedom-of-choice laws that require the direct recognition and reimbursement of MFTs and other mental health professionals and the setting aside of state statutes requiring a minimum mental health benefit in health benefit programs.

The proposed legislation was introduced late in the 1987 Congressional session by Sen. Edward Kennedy (D-MA), Chair of the Senate Labor and Human Resources Committee, and Rep. Henry Waxman (D-CA), Chair of the Subcommittee on Health and Environment of the House Committee on Energy and Commerce. Given the title of Minimum Health Benefits for All Workers Act of 1987, the bills (S.1265 and HR 2508) would require employers to provide a minimum health benefits package for all workers who work more than 17 hours per week.

Sen. Kennedy's bill is expected to be considered early in 1988. Rep. Waxman and his subcommittee are not expected to take up the legislation in the House until after the Senate takes action. Thus, the



Sen. Edward Kennedy (D-MA)

immediate advocacy efforts by concerned groups are aimed primarily at Sen. Kennedy and his staff and at the Senate Labor and Human Resources Committee.

### AAMFT Active in Advocacy

The American Association for Marriage and Family Therapy (AAMFT) has worked since before the introduction of the legislation to lobby for the inclusion of both a required mental health benefit and freedom-of-choice language to require the direct reimbursement of MFTs and other qualified mental health professionals. A close advocacy coalition with social workers continues. Additionally, the California Association of Marriage and Family Therapists is working actively in concert with the AAMFT to secure inclusion of freedom-of-choice language for MFTs.

Calling the Kennedy-Waxman bills "one of the most significant pieces of health legislation of the last decade" and the AAMFT's "highest priority in this session of Congress," AAMFT Executive Director Mark R. Ginsberg, PhD, recently declared that "Although the outcome is unknown, it is clear that we are sitting at the appropriate table in our advocacy efforts and making every possible effort to secure inclusion in this legislation." Ginsberg, other members of the AAMFT staff, and Steven L. Engelberg, the organization's general counsel, have been meeting regularly with key Congressional staff.

### Legislative Alert Sent Out

A legislative alert requesting grassroots support has been sent out by Ginsberg and AAMFT Government Relations Representative Deborah Simmons, MA, to members of the organization living in key states represented on the Senate Labor and Human Resources Committee. The alert requests that members in those states write their Senator urging the inclusion of language in S.1265 requiring both a minimum mental health benefit and freedom-of-choice for consumers to select MFTs and other qualified mental health professionals. Members of the organization also have been urged to point out that health economics research consistently has shown that freedom-of-choice increases consumer access and availability of necessary health care services without increasing costs.

"With intensive lobbying, S.1265 could include federal freedom-of-choice language to require that *all* health insurance and other health benefit plans provide



Rep. Henry Waxman (D-CA)

direct reimbursement for marital and family therapists and other qualified health care professionals," Ginsberg and Simmons wrote in the legislative alert. "This is an important opportunity for AAMFT members," they declared.

The Senate Labor and Human Relations Committee includes Senators Edward Kennedy (D-MA), Chairman; Claiborne Pell (D-RI), Howard Metzenbaum (D-OH), Spark Matsunaga (D-HI), Christopher Dodd (D-CT), Paul Simon (D-IL), Tom Harkin (D-IA), Brock Adams (D-WA), Barbara Mikulski (D-MD), Orrin Hatch (R-UT), Robert Stafford (R-VT), Dan Quayle (R-IN), Strom Thurman (R-SC), Lowell Weicker (R-CT), Thad Cochran (R-MS), and Gordon Humphrey (R-NH). Senators Simon and Weicker are co-sponsors of the Senate bill. ■

TESTIMONY BY GORDON E. EVANS  
ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA  
BEFORE HOUSE HESS COMMITTEE  
ON CSSB 67 (HESS)

February 9, 1988

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a national trade association of the private health insurance industry. Its members include more than 330 companies writing over 85% of the health insurance policies written by private insurance companies in the United States. Blue Cross and Blue Shield plans are not HIAA members.

In its present form as CSSB67 (HESS), this legislation would require insurers doing business in Alaska -- and that includes both those companies selling disability (health) insurance policies and hospital or medical service corporations providing subscriber contracts -- to offer insurance coverage for the treatment of a mental or nervous condition. The proposed House Committee Substitute, which is identical to the version unsuccessfully proposed by Senator Faiks in the Senate Finance Committee last session, would mandate provision of such coverage.

While the HIAA does not oppose insurance coverage for the treatment of a mental or nervous condition, the Association does oppose any legislation which requires insurers to provide particular benefits in their health insurance policies, for

reasons which I will set out. Historically, HIAA has opposed the enactment of any mandated health benefit laws for the following reasons:

- (1) Mandated health benefit laws erode the ability of insurance companies to tailor health benefit packages to meet the needs of particular plans and to market group health insurance policies to large plans on a national basis.
- (2) Mandated health benefit laws contribute to the rapidly escalating cost of health insurance. The net effect of mandating the level of benefits coverage called for by the proposed House CS for CSSB67 would be to increase the cost of benefit coverage to insurers and to drive up the price of insurance premiums to the consumer. Mental health benefits are among the most costly, if not THE most costly, of benefit coverages. This could result in increasing the cost of doing business for employers who offer group coverage to their employees. It is even conceivable that affordable premium rates could not be established for individual policies to make coverage feasible.

- (3) Mandated health benefit laws promote self insurance. This legislation would not apply to self insurers or those with employee welfare benefit plans which are exempted under ERISA.

In summary, HIAA's opposition to CSSB67 is based on the fact that HIAA favors the preservation of a system that allows the prospective purchaser of health insurance free choice of which risks he or she wishes to cover from among the various coverages offered by competing insurance carriers. The HIAA also believes that the choice of how the policyholder spends what funds are available for health insurance should be free of governmental decree.

267

# Sitka Mental Health Clinic

P.O. Box 1763  
Sitka, Alaska 99835  
(907) 747-8994

Michael Boyd, Ph.D.  
Psychologist

12-9-87

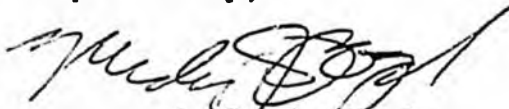
Honorable John Sund  
Chairman House Judiciary Committee  
Rm. 120  
Capital Building  
P.O. Box V  
Juneau, Alaska 99811

Dear Representative Sund:

I am writing concerning CSSB 67 which is scheduled to come before your committee during the upcoming session of the legislature. 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 companies will not pay for treatment provided by someone who is not a psychiatrist or licensed psychologist. While many clinics are directed by psychologists or psychiatrists, 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: Nilo Koponen  
Albert P. Adams  
Johnny Ellis

DIXIE A. HOOD, M.A.  
Marriage, Family & Child Counselor

April 17, 1988

Representative John Sund  
Chairman, House Judiciary Committee  
Alaska State Capitol  
Juneau, Alaska

Re: House CS for CS for Senate  
Bill No. 67 (HESS) (Insurance  
coverage for the treatment of a  
mental or nervous condition.)

Hon. Chairman Sund,

This letter is in support of insurance coverage for the treatment of a mental or nervous condition. I wish to address two issues.

First, psychological intervention has been demonstrated to be a means of decreasing the length of treatment and cutting medical and hospital costs. I am enclosing an article from Psychology Today (August, 1987) which discusses these benefits in more detail. Through physician referrals to me as a therapist I have personally been able to work with patients and see these gratifying results of decreased symptomology, first hand.

That leads me to the second issue. As a Marriage, Family and Child Counselor (trained and licensed in California), I have the professional competence to provide therapy for patients seeking treatment for a mental or nervous condition. I am requesting that language of the Bill be modified to include "a marital and family therapist who is licensed or certified as a marital and family therapist by a state or is a

Clinical member of the American Association for Marriage and Family Therapy."

I believe this insurance bill is an important step in increasing consumer choices for health care without increasing costs. I urge you to support the legislation with change suggested for inclusion of marriage and family therapists as qualified providers. Thank you for your consideration.

Respectfully,  
Dipe A. Hood

# Help for the Worried Well

PSYCHOLOGICAL INTERVENTION CUTS MEDICAL AND HOSPITAL COSTS AND HELPS PEOPLE FEEL BETTER.

BY CAROL TURKINGTON



Sadie has suffered with intractable headaches ever since her husband fatally shot himself in the head 15 years ago after she divorced him. But no physician could find anything physically wrong with her. Test after test uncovered nothing, bills piled up—yet the headaches continued. Physicians took to shaking their heads over her voluminous chart and began to tell Sadie bluntly: "There's nothing wrong with you. It's all in your head." But Sadie's pain was very real. When she finally arrived at the Biodyne Institute, a mental-health facility in Hawaii, she brought with her a grocery bag filled with 43 drugs she was taking for her headaches. Such desperate searching is not unusual.



The surprising fact is that as many as two-thirds of patient visits to the doctor are made by the "worried well," people psychologists call "somatizers." But because the patients and the physicians are unwilling or unable to see the problem's emotional component, patients trek from physician to hospital and back again, searching for a pill, a shot or an operation that will stop the hurting.

Psychologist Nicholas Cummings, who founded the Biodyne Institute, says, "Some patients spend as much as \$28,000 a year in a fruitless attempt to isolate a physical cause for what is basically an emotional problem. . . . On some days these patients saw four different physicians." Cummings says he never disputes the reality of patients' difficulties. "I can say with all honesty: I know you hurt. But as long as you're here, tell us a bit more about you." The psychological treatment often helps somatizers when others have failed. After only four sessions at Biodyne, for example, Sadie's headaches disappeared.

In dozens of studies over the last 30 years, researchers have found that providing psychological care to patients like these can cut medical costs anywhere from 5 to 80 percent by reducing expensive visits to physicians. These savings have been documented with a variety of patients in health maintenance organizations and with private patients. The psychological treatments range from traditional psychotherapy of various kinds to behavioral interventions such as biofeedback, visualization and other stress-reduction techniques.

One just completed study at Harvard University suggests that psychological treatment for patients may cut subsequent health-care visits almost in half. Researcher Caroline Hellman and colleagues studied 80 patients who belonged to the Harvard Community Health Plan (HCHP). They had two types of problems—physical symptoms with no known organic basis or physical illnesses with an organic cause that are influenced by psychological factors. These two categories account for an estimated 50 to 75 percent of the patients seen by general practitioners. Specific problems included hypertension, shortness of breath, indigestion, diarrhea, headaches, dizziness, sleep problems, eating or weight problems and anxiety, stress and ten-

---

## **I**N ALCOHOLISM TREATMENT PROGRAMS, PSYCHOTHERAPY REDUCED SICK DAYS AND MEDICAL COSTS DRASTICALLY.

---

sion. During the six months before the study, these patients visited the health plan more than twice as often on the average as other HCHP members.

The researchers divided the patients into three groups. One followed the "Ways to Wellness" program developed at HCHP; another took part in the "Mind-Body Group" program developed at Beth Israel Hospital in Boston. Both of these groups met for six weekly sessions during which they were taught visualization and ways of reframing attitudes; they also received relaxation and awareness training.

The third group met for two sessions, in which the patients learned about the relationship between stress and illness and were given stress-management exercises to do at home. The researchers used this group to compare the benefits of receiving only information, combined with the expectation of helpful treatment, against the benefits of more intensive group training and participation.

Immediately after the study ended, all patients felt better physically and psychologically. As time passed, however, only those in the first two groups maintained or increased their improvement. They also used health-plan services less frequently. Comparing six months before treatment and six months after, patients in the first two groups cut their visits to the HCHP by 47 percent. Patients in the third group increased their visits 28 percent.

The potential savings to the health plan during these six months, according to Hellman, ranged from \$171 to \$252 for each patient. In addition, Joan Borysenko, associate director of the behavioral medicine division at Beth Israel, reports that the Mind-Body pro-

gram also helped patients with insulin-dependent diabetes by lowering blood glucose and gave cancer patients a greater sense of control and reduced their stress.

One reason for doing studies like these at Harvard and in Hawaii is to see whether psychological care is cost-effective; that is, is the cost of providing mental-health care offset by savings in other medical services? Patrick DeLeon, a psychologist who is administrative assistant to Sen. Daniel Inouye of Hawaii, expresses the idea simply: "To prove that psychotherapy is cost-effective, you have to show what kinds of therapy work under what conditions and with what kinds of patients. The essence of being cost-effective is proving that what you are doing works."

The research findings are consistent, says Bryant Welch, an associate executive director of the American Psychological Association. "If you use prompt psychological interventions, you can make a substantial decrease in patient population needs to use more expensive treatment. All the data indicate that psychological services are cost-effective. There are some discrepancies as to how much."

One reason for the discrepancies is that different symptoms and problems respond differently to various kinds of therapy. Psychologist Robert Rosen of the Washington Business Group on Health (WBGH), an organization whose members include 200 large corporations, offers this example: "If someone is experiencing acute depression, a combination of drugs and psychotherapy is likely to produce greatest gains in reducing medical costs. But for phobias, behavioral or cognitive intervention may be the most cost-effective. It depends on what kind of problem you have and what kind of therapy you're offering."

Alcohol- and drug-abuse problems are major causes for absence and accidents in the workplace. Rosen, who is director of the Institute on Organizational Health at WBGH, points out, "If you treat someone for substance abuse, they are more likely to stay out of the hospital. In general, if the benefits and therapy are properly designed, and there is a good match between the type of therapy and the problem, you can [offset the cost of therapy by] reducing medical expenditures."



When Kenneth Jones and Thomas Vischi looked at 12 studies of alcoholism treatment programs for the Alcohol, Drug Abuse and Mental Health Administration, they found that therapy cut medical care 26 to 69 percent and reduced the number of sick days 38 to 47 percent. In one example, the Philadelphia Police Department estimated that it saved about \$1,000 in health-care costs for every inpatient who was treated for alcoholism.

Sociologist Emily Mumford and four colleagues analyzed 58 studies of how psychological treatment affected patients' later medical costs and reviewed claims files for a Blue Cross and Blue Shield Federal Employees Plan. They found that 85 percent of the studies "reported a decrease in medical utilization following psychotherapy." The researchers concluded that the evidence they found "argues specifically for the likelihood that mental-health treatment may improve patients' ability to stay healthy enough to avoid hospital admission for physical illness."

Sociologist Harold Holder and

---

**P**SYCHOLOGICAL  
INTERVENTION CUT  
HOSPITAL STAYS  
AFTER MAJOR SURGERY  
BY AN AVERAGE OF  
TWO DAYS.

---

James Blose completed a four-year study in 1985 for the National Institute of Mental Health in which they compared the health-care costs of people before and after receiving psychological treatment. Holder and Blose found that during the three years before the first treatment, there was a gradual rise in the frequency and expense of these patients' visits. Six months before the treatment started, the average medical cost per month

was \$493. Once treatment started, the cost decreased quickly and considerably to a monthly average of \$239 during the first six months and of \$137 three years later.

"The overall finding of a significant drop in total health-care costs following initiation of mental-health treatment," Holder and Blose concluded, "is consistent with much of the prior research."

Another study at the former United States Public Health Service Hospital in Baltimore demonstrated both the long-term effectiveness and potential cost-effectiveness of biofeedback treatment. According to Eileen Mager, one-time director of the Psychophysiology Clinic at the hospital, patients treated in the clinic made about 30 percent fewer visits to the clinic in the two years following treatment than they had before treatment.

Several studies also suggest that since older people generally use more medical care, of a more expensive kind, than young people do, the cost benefits of psychological intervention increase with age. In their research,

for example, Holder and Blose found that the most significant drop in health-care costs occurs for the treated people age 65 and over and the least for those under 45.

The benefits of therapy aren't re-

stricted to diseases with an obvious psychological component. Writing in the *American Journal of Public Health*, psychologist Herbert Schlesinger and four colleagues reported that a recent study of diabetes, isch-

emic heart disease, hypertensive heart disease, asthma and emphysema showed that the use of mental-health services reduced medical costs. Reviewing 13 other studies, Mumford, Schlesinger and psychologist Gene Glass also found that psychological intervention cut hospital stays after major surgery by an average of two days.

Why does counseling affect what seem to be purely physical problems? Psychologist George Everly Jr. suggests that we do not yet fully understand the link between mind and body. Everly, a visiting scholar at Harvard University, is studying why behavioral interventions seem to work with a host of seemingly disparate somatic and mental disorders. He believes a number of diseases (including hypertension, migraines, peptic ulcers, Reynaud's disease, irritable bowel, anxiety and adjustment problems) are "disorders of arousal" that originate in the limbic system of the brain and are thus helped by relaxation strategies. These disorders respond to behavioral interventions not only because they have a "common pathogenic thread," he believes, but because the treatment makes patients take an active part in their own health care.

Everly believes that applying one kind of therapy to a variety of disorders is more cost-effective than using different approaches for each. He has found, for example, that many patients do better no matter which stress-reduction technique he uses.

"You can't disallow the placebo effect," he admits, "but there is a common therapeutic thread among these disorders that responds to stress reduction. And it is clearly possible that certain behavioral techniques are cost-effective . . . by making the patient an active participant in his own care. Training patients to use behavioral techniques instead of visiting their doctor could greatly reduce costs.

"The best thing that could happen," Everly concludes, "is the hospital is there, and there is no need for anyone to come." □

*Carol Turkington is a science writer who lives in Reading, Pennsylvania. She was formerly a staff writer with The APA Monitor.*

*To order reprints of this article see the classified section.*

## HELP ON THE JOB

The operator working his sheet metal press that day was angry, upset and distracted. He was having trouble at home, caused in part by alcohol, and his supervisor had just blamed him for something that wasn't his fault. To make matters worse, he hadn't quite recovered from the effects of the drinking he had done last night and several nights before that.

Although he was an experienced operator, distraction and fatigue threw off his timing. Before he realized it, the three-ton press had clipped off part of his thumb. Physicians and physiotherapists finally restored use of his hand, but only after nine weeks of missed work and costly rehabilitation.

Accidents like this cost U.S. businesses more than \$32 billion each year in disability payments, workers' compensation, lost productivity and poor morale, according to the St. Paul Fire and Marine Insurance Company. Research confirms that most workplace accidents result from the inability of people to cope with stress.

In response to a growing understanding that how an employee feels affects performance on the job and, ultimately, company profits, businesses across the country have begun to offer counseling through Employee Assistance Programs (EAP's). While the first programs usually concentrated on alcoholism treatment, today's 5,000 or so EAP's address a wide range of problems from child-care to emotional distress.

Some companies provide little more than a desk and someone to refer employees to psychologists and other professionals in the community. Other companies provide counseling services on site or con-

tract for outside services. According to Willis Goldbeck, president of the Washington Business Group on Health, comprehensive programs include physical fitness, cardiovascular risk reduction, hypertension control, nutrition, smoking cessation and stress management. Many programs add CPR, life-style education, time management and other ways to manage one's life in a healthier fashion.

Although companies start programs for many reasons, the most important is usually to cut costs. Do they pay off? Goldbeck says that screening its employees for colon and rectal cancer costs the Campbell Soup Company about \$25,000 a year. But a single employee death from such cancer costs the company about \$64,000 in medical expenses and benefits. "They do not have to go too much further to know that for each life saved—a social good—there is a big corporate financial gain."

Numerous studies have shown that counseling and the other programs offered by EAP's help companies reduce absenteeism, decrease employee turnover and lessen health-care expenses. According to Goldbeck, a Kimberly-Clark EAP cut work accidents 70 percent. A five-year Dupont study found that the average annual benefit to the company from an alcoholism program was more than \$400,000. Smoking cessation programs in various companies produce immediate savings in janitorial costs and fire insurance.

"In short," Goldbeck concludes, "wellness programs, quite apart from the benefit to the individual and the broader 'social good,' are in the corporation's financial self-interest."



Alaska State Legislature  
House of Representatives  
COMMITTEE ON HEALTH, EDUCATION  
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCHV  
JUNEAU, AK 99811  
465-3759

February 26, 1988

Frederick Hillman  
2550 Denali St  
Anchorage, AK 99503

Dear Frederick,

Thank you for your Public Opinion Message regarding SB 67, health insurance for mental conditions. Senate Bill 67 passed from the House Health, Education and Social Services Committee this past week, and is now in the House Judiciary Committee.

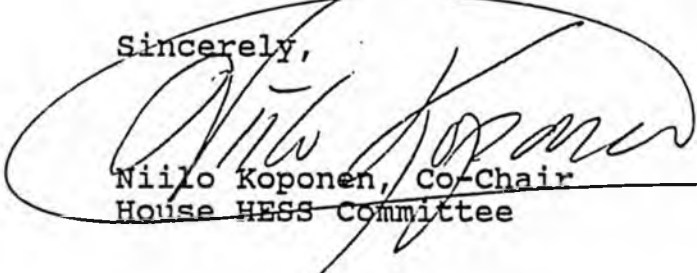
The providers included in House CSSB 67 (HESS) have very stringent educational and national certification requirements. No other state which we are aware of include marriage and family therapists as eligible providers for this type of coverage.

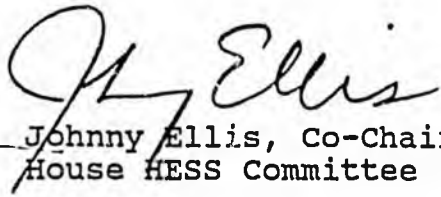
Furthermore, the mental and nervous conditions covered in SB 67 are only those listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Senate Bill 67 has the further committee referrals of House Judiciary and House Finance. We encourage you to express any further concerns you may have to members of those committees for their consideration.

Thank you again for sharing your views with us.

Sincerely,

  
Niilo Koponen, Co-Chair  
House HESS Committee

  
Johnny Ellis, Co-Chair  
House HESS Committee

FREDERICK J. HILLMAN, M.D.

DENALI NORTH THERAPY ASSOCIATES  
2550 DENALI STREET - SUITE 905  
ANCHORAGE, ALASKA 99503

(907) 258-1121

13 March 1988

Mr. Niilo Koponen  
Mr. Johnny Ellis  
Co-Chairs, House HESS Committee  
Alaska State Legislature  
Pouch V  
Juneau, AK 99811

Dear Mr. Koponen and Mr. Ellis,

Thank you for your reply to my Public Opinion Message regarding SB67, health insurance for mental conditions. I should like to enlarge my views a bit on various points that you touch on.

You mention that providers in SB 67 (viz. psychologists and psychiatrists) "have very stringent educational and national certification requirements". I am enclosing material from the American Association for Marriage and Family Therapy (AAMFT) giving requirements for membership, which would be comparable to requirements for licensure in most states. The AAMFT requires a masters degree in a course with content approved by the AAMFT, followed by 1000 hours of face to face contact and 200 hours of supervision, again by supervisors approved by them.

You add "No other state which we are aware of include marriage and family therapists as eligible providers for this type of coverage". So far fourteen states have either licensed or certified family therapists, separately or as part of composite Mental Health Boards. As you are probably aware already, the local chapter of the AAMFT has been trying for the past five or six years to get legislation passed that would license marriage and family therapists in this state, either by ourselves or with social workers and counselors in a Composite Board. I enclose a brochure that shows the situation nationally regarding the AAMFT. Actually, the U.S. Department of H.E.W. has recognized marriage and family therapy as a valid and important part of the field of mental health since 1978 and has designated the AAMFT as the sole national accrediting body for post-degree training in this field.

Regarding the Diagnostic and Statistical Manual of the American Psychiatric Association, marriage and family therapists (MFT's) do treat the same conditions as do psychiatrists and

psychologists and necessarily follow the terminology of the DSM. They are different in that MFT's treat from a 'systemic' or 'interactional' point of view. Disturbed individuals do not act in isolation: they interact with people around them, and conversely, the people in an individual's life affect that person. Family therapists have found that intervention is more effective when interactions are diagnosed and the system is changed, rather than when an attempt is made to diagnose whatever is going on intrapsychically and then to try to change the individual client in isolation. The 'systems' approach of family therapy has been especially effective in the treatment of alcoholism, delinquency, depression, eating disorders, obsessions and phobias (all DSM diagnoses). In other words, marriage and family therapy is not merely "marriage therapy".

Traditionally psychiatrists and psychologists have been trained to deal with individuals and few have been educated in a systems approach. Currently the thrust of psychiatric residencies and research has been toward reliance on drugs. Psychologists have been oriented toward 'behavior modification' or a 'Rogerian' type of verbal therapy in treating individuals. A few medical schools have recently added family therapists to their departments of psychiatry.

The contrast is seen perhaps most clearly in the field of alcohol and substance abuse, where increasingly it is being recognized that treatment of an individual either by drugs or psychotherapy is usually futile unless the family is also involved in therapy (and sometimes friends and employer). One program in Yugoslavia actually hospitalizes entire families of alcoholic workers. Likewise, the most effective programs for the therapy of disturbed adolescents recognize the necessity of treating the families as well.

It is also true that the DSM was devised largely by psychiatrists having an individualistic and drug-oriented point of view, and it is sometimes difficult to fit 'systems' concepts into DSM terminology.

Historically the field of family therapy evolved over the past forty years from several roots. Pioneers in the field included men and women from the fields of psychiatry, psychology, psychoanalysis, anthropology, social work, library science, internal medicine, nursing, child guidance, and research biology. This historical pattern of diversity of origin among MFT's continues at the national level, and it also can be seen in Anchorage.

Let me add a personal note, as I think that I have a unique vantage point. My career was as a general surgeon until I changed fields in 1975 and joined the staff of the Alaska Psychiatric Institute, working there with traditional psychiatrists and psychologists for six years. I took training in family therapy, spent a year at the Anchorage Community Mental Health Center, have been in private practice for four years and have been part of the Adolescent Team at Charter North Hospital for the past year. I have worked closely with practitioners of all kinds of therapy in the field of mental illness, observed many styles and seen many degrees of competence. On the basis of my experience it is my opinion that the most competent therapists in Alaska have been family therapists, mostly at the masters level and coming from many different disciplines. Among the most effective ones in Anchorage currently, I think, are an MSW, a nurse, a clergyman, a psychologist, a psychiatrist, and a couple trained specifically in marriage and family therapy.

Thus the limitation of privileges in SB 67 to psychiatrists and psychologists represents to me an outmoded as well as an unrealistic point of view, one which might have been valid forty years ago but is no longer. You are doing a disservice to the consumers of mental health care in this state when your bill excludes the most competent practitioners in the field.

Sincerely yours,

*Frederick J. Hillman*

Frederick J. Hillman, M.D.

cc: House Judiciary Committee  
House Finance Committee

March 2, 1988

Senator Arless Sturgulewski  
Alaska State Legislature  
P.O. Box V (MS 3100)  
Juneau, AK 99811

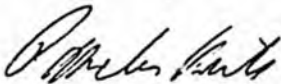
Dear Senator,

It has come to my attention that Senate Bill #67 Section 21.42.385 section B gives an operational definition of office visit. It should be noted that marriage and family counselors are excluding from providing treatment (through office visits) and receiving major medical reimbursement for marital counseling, family counseling and any other type of joint counseling, for instance, mother-son, father-daughter counseling, etc, etc.

As a profession that is recognized nationally by the Federal Government we believe that marriage and family therapists must be included in this bill. I am a marriage and family therapist in the state of Alaska. I have a Marriage, Family and Child Counseling license from the state of California that is not recognized in Alaska because there is no reciprocity ruling between Alaska and California. I find the exclusion of marriage and family therapists from this bill to be reprehensible. I am very much in support of marriage and family therapists being included for not only licensure but as recipients of major medical benefits for office visits for our clients.

Thank you for your consideration in this matter.

Sincerely



Pamela Kirk  
SR 9817 Hiland Drive  
Eagle River, AK 99577

# HOUSE COMMITTEE REPORT

(7)

Date referred: 2/26/88

FURTHER REFERRALS: Finance

DATE: May 5, 1988

The Judiciary Committee has considered CSSB 67 (HESS)

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

**RECOMMENDS:**

- replace with HCS CS SB67 (JUL)  the same title
- attached amendment(s)  a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the \_\_\_\_\_ Committee

**ADOPTS:**  \_\_\_\_\_ letter of intent

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

- fiscal impact  same as previous fiscal note published \_\_\_\_\_
- zero fiscal note  same as previous zero fiscal note published \_\_\_\_\_
- zero with analysis

**SIGNING DO PASS:**

[Signature]

[Signature]

[Signature]

[Signature]

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNING OTHER RECOMMENDATIONS:**

[Signature] no rec

[Signature] - no rec -

[Signature] (NO REC)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chairman's signature

Original sponsors: Faiks and Kerttula

1 IN THE SENATE

BY THE JUDICIARY COMMITTEE

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

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to insurance coverage for the treat-  
7 ment of a mental or nervous condition."

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

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

10 Sec. 21.42.365. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS  
11 CONDITION. (a) An insurer authorized under AS 21.09 to offer, issue  
12 for delivery, deliver, or renew a group disability insurance policy  
13 for major medical coverage on an expense-incurred basis in the state,  
14 or a hospital or medical service corporation authorized under AS 21.87  
15 to offer or renew a group contract for major medical coverage in the  
16 state, must provide the insured or subscriber the following coverage  
17 for treatment of a mental or nervous condition of the insured, sub-  
18 scriber, or other person covered by the policy or contract:

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

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

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

28 (c) Notwithstanding (a) of this section, if the insured or  
29 subscriber is an employer who employed fewer than 20 permanent, full-

1 time employees for each working day during each of at least 20 calen-  
2 dar workweeks in either the current calendar year or the preceding  
3 calendar year, the insurer, hospital, or medical service corporation  
4 is not required to provide the coverage specified in (a) of this  
5 section to the insured or subscriber but shall offer that coverage to  
6 the insured or subscriber as optional coverage.

7 (d) In this section

8 (1) "consulting relationship" means a relationship that  
9 involves review of treatment plans and goals and in-person patient  
10 contact on at least a quarterly basis;

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

13 (3) "cost" means the lowest of the following:

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

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

18 (C) the charge agreed to by contract between the  
19 provider and the insurer, hospital service corporation, or med-  
20 ical service corporation;

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

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

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

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

1 (C) a hospital that is located in

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

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

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

11 (7) "mental or nervous condition" means a mental disorder  
12 identified in

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

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

18 (8) "national professional organization" means the National  
19 Association of Social Workers; the National Registry of Health Care  
20 Providers; the American Association for Marriage and Family Therapy;  
21 the American Association of Pastoral Counselors; and the American  
22 Board of Examiners in Clinical Social Work;

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

26 (A) a psychiatrist who is licensed by a state as a  
27 physician and certified, or eligible for certification, in psy-  
28 chiatry by the American Board of Psychiatry and Neurology;

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

1 government in a state and certified or eligible for certification  
2 in psychiatry by the American Board of Psychiatry and Neurology;

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

5 (D) a person who works in a consulting relationship  
6 with a mental health care provider licensed by a state and has a  
7 master's or doctoral degree in psychology, nursing, or social  
8 work; or

9 (E) a clinical social worker who is

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

12 (ii) certified by a national professional orga-  
13 nization offering certification of clinical social workers;

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

16 (A) in the outpatient department of

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

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

23 (iii) an entity that is designated by the Depart-  
24 ment of Health and Social Services as an organizational unit  
25 in a geographical area to receive funds under AS 47.30.520 -  
26 47.30.620; and

27 (B) by one or more of the following:

28 (i) a psychiatrist who is licensed by a state as  
29 a physician and certified, or eligible for certification, in

1 psychiatry by the American Board of Psychiatry and Neu-  
2 rology;

3 (ii) a physician who is employed by the federal  
4 government in a state and certified or eligible for certi-  
5 fication in psychiatry by the American Board of Psychiatry  
6 and Neurology;

7 (iii) a psychologist licensed by a state;

8 (iv) a person who works in a consulting relation-  
9 ship with one or more licensed mental health care providers  
10 licensed by a state and has a masters or doctoral degree in  
11 psychology, nursing, or social work, and is employed by the  
12 same health care facility providing treatment; or

13 (v) a clinical social worker who is licensed or  
14 certified as a clinical social worker by a state or cer-  
15 tified by a national professional organization offering  
16 certification of clinical social workers.

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

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

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

28 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the  
29 provisions contained or referred to previously in this chapter, the

1 following chapters and provisions of this title also apply with re-  
2 spect to service corporations to the extent applicable and not in  
3 conflict with the express provisions of this chapter and the reason-  
4 able implications of the express provisions, and for the purposes of  
5 the application the corporations shall be considered to be mutual  
6 "insurers":

- 7 (1) AS 21.03
- 8 (2) AS 21.06
- 9 (3) AS 21.09, except AS 21.09.090
- 10 (4) AS 21.18.010
- 11 (5) AS 21.18.030
- 12 (6) AS 21.18.040
- 13 (7) AS 21.18.120
- 14 (8) AS 21.21.321
- 15 (9) AS 21.36
- 16 (10) AS 21.69.400
- 17 (11) AS 21.69.520
- 18 (12) AS 21.69.600, 21.69.620, and 21.69.630
- 19 (13) AS 21.78
- 20 (14) AS 21.90
- 21 (15) AS 21.42.345 - 21.42.365 [AS 21.42.345 AND 21.42.355]
- 22 (16) AS 21.89.040
- 23 (17) AS 21.89.060.

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

A M E N D M E N T

#1

Offered in the HOUSE

By Collins

TO: HCS CSSB 67(Judiciary)

HANLEY

Page 1, line 29:

Delete "20"

Insert "50"

A M E N D M E N T

TO: CSSB 67(HESS)

Page 1, line 16:

Delete "shall offer"

Insert "must provide"

Delete "an option to receive"

Page 1, line 22, after "50":

Insert "hours of"

Page 1, line 24:

Delete "offering"

Insert "providing"

Page 1, line 29 through page 2, line 3:

Delete all material.

Reletter the following subsection accordingly.

Page 3, line 10:

Delete "in"

Insert "through"

A M E N D M E N T

Offered in the HOUSE

By Gruenberg

TO: HCS CSSB 67(HESS)

Page 3, line 9, after "Providers;":

Insert "the American Association for Marriage and Family Therapy;"

A M E N D M E N T

Offered in the HOUSE

By Barnes

TO: HCS CSSB 67 (HESS)

Page 3, line 9, after "Providers;":

Insert "the American Association of Pastoral Counselors;"

A M E N D M E N T

Offered in the HOUSE

TO: HCS CSSB 67(HESS)

Page 1, after line 27:

Insert a new subsection to read:

"(c) Notwithstanding (a) of this section, if the insured or subscriber is an employer who employed fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, the insurer, hospital, or medical service corporation is not required to provide the coverage specified in (a) of this section to the insured or subscriber but shall offer that coverage to the insured or subscriber as optional coverage."

Reletter the following subsection accordingly.

**FISCAL NOTE**

**REQUEST:**

Revision Date: \_\_\_\_\_ Agency Affected: Health & Social Services  
 Title: ...relating to insurance coverage for BRU: Community Mental Health Grants,  
the treatment of a mental or nervous cond. Institutions and Administration  
 Sponsor: \_\_\_\_\_ Components: Community Mental Health  
 Requestor: \_\_\_\_\_ 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						
<b>TOTAL OPERATING</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
---------	-----	-----	-----	-----	-----	-----

REVENUE	-0-	-0-	-0-	-0-	-0-	-0-
---------	-----	-----	-----	-----	-----	-----

**FUNDING:** (Thousands of Dollars)


GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

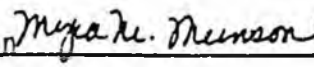
**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

**ANALYSIS :** (Attach a separate page if necessary)

see attached sheet

Prepared by: Mel Henry, Director  Phone: 465-3372  
 Division: Mental Health & Developmental Disabilities Date: \_\_\_\_\_

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

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

## FISCAL NOTE

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

**STATE OF ALASKA 1987 LEGISLATIVE SESSION  
FISCAL NOTE**

Bill Version: CS SB 67 HESS  
 Publish Date: 3-31

REQUEST: \_\_\_\_\_

Revision Date: \_\_\_\_\_  
 Title: "An Act Relating to Insurance Cover-  
 age of a Mental Health or Nervous Condi-  
 Sponsor: Faiks and Kertulla  
 Requestor: \_\_\_\_\_

Agency Affected: \_\_\_\_\_  
 BRU: Institutions and Administration  
 Components: Alaska Psychiatric  
 Institute

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

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>
<b>CAPITAL</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>
<b>REVENUE</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

**FUNDING: (Thousands of Dollars)**

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

**ANALYSIS : (Attach a separate page if necessary)**

See attached

Prepared by: Deborah K. Smith *DKS* Phone: 465-3370  
 Division: \_\_\_\_\_ Date: 1/27/87

Approved by Commissioner: *Thomas M. Munson* Date: 3/18/87  
 Agency: Dept. of Health & Social Services

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

CS SB 67 HESS

FISCAL NOTE

Payments to the Alaska Psychiatric Institute from 3rd party insurance are estimated to increase as a result of this bill. Community Mental Health Centers could expect additional revenue from 3rd party payors also. Data is not available from this Division to calculate the potential increase in revenue. Currently, 40% of our clients have some form of insurance.

# 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 12, 1988

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

Dear Representatives Koponen and Ellis:

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

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

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

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

The increase in the PERS contribution rate  
(.20%) times the estimated FY 89 state PERS  
payroll (\$479,549,872) equals: \$ 959.1

The increase in the TRS contribution  
rate (.15%) times the estimated FY 89  
University of Alaska TRS payroll  
(\$44,753,863) equals: 67.1

The increase in the TRS contribution rate  
(.15%) times the estimated FY 89 Department  
of Education TRS payroll (\$5,613,930) equals: 8.4

\$1,034.6

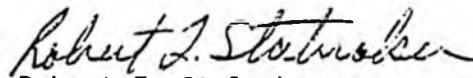
February 12, 1988

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

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

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

Sincerely,

  
Robert F. Stalnaker  
Acting Director

RFS/bb/7

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

**DRAFT**

Prepared By: Robert F. Stalnaker, Acting Director  
Division: Retirement and Benefits

Phone: 465-4470  
Date: 2-11-88

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

Date: \_\_\_\_\_

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

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

February 11, 1988

Analysis:

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

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

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

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

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

**DRAFT**

February 29, 1988

MAR 04 1988

Representative John Sund  
House Judiciary Committee  
Alaska State Legislature  
P.O. Box V, (MS 3100)  
Juneau, Ak. 99811

*I agree*

Dear Representative Sund:

Recently I sent a P.O.M. regarding SB 67 concerning mandatory insurance for mental health problems. The wording of the bill needs to be changed because it presently focuses on service providers with Master's degrees in Psychology, Social Work, or Nursing. Therefore, many other appropriate and qualified individuals are excluded from said insurance reimbursement. Ideally, there needs to be licensing for Master's level mental health therapists, so that the insurance bill could read that "any licensed provider" could be eligible for reimbursement. However, since there is no such licensing, the bill needs to include language such as "an equivalent degree" to assure that providers of services with Master's in Counseling, Marriage and Family Therapy, or similar degrees would be covered as well as those with Psychology, Social Work, and Nursing. It is not at all reasonable to focus on only three degrees as many other mental health providers are highly trained and appropriate therapists also.

I would appreciate your attention to this matter.

Sincerely,

*Vivian C. Finlay*

Vivian C. Finlay, M. Ed.,  
Marriage, Family and Child Therapist.

P.O. Box 872433, Wasilla, Ak. 99687

cc: Senator Kerttula  
Representatives: Fran Ulmer  
Sam Cotten  
Max F. Gruenberg, Jr.  
Mike Navarre  
Ramona L. Barnes  
Robin L. Taylor

AkAMFT

February 29, 1988

Senator Kerttula  
Alaska State Legislature  
P.O. Box V  
Juneau, Ak. 99811

Dear Senator Kerttula:

As a follow up to my phone conversation with Matt Fishel in your Wasilla office I would like to express my support for Senate Bill 423 which would provide for certification for Marital and Family Therapists. I believe that a hearing is needed on this subject so that the importance of certification and licensing may be discussed thoroughly.

I have been writing to members of the Alaska legislature since early 1984 on this subject of licensure for Marital and Family Therapists. I believe licensing is of critical importance to regulate the people who are "therapists" so as to assure adequate training and expertise, thereby giving consumers information to make informed judgements in seeking therapy services. Also if we presently had licensing the wording of legislative bills such as SB 67 would be less cumbersome; insurance reimbursement could be available to "licensed providers". However, since there is no licensing for Marital and Family therapists, we are excluded from the wording in such a bill.

As a Clinical member of the Alaska Association for Marriage and Family Therapists, and as a practicing therapist for the past 12 years (4 1/2 years in Alaska) I strongly support the need for licensing of Marital and Family Therapists. I have been licensed in the State of California as a Marriage, Family and Child Counselor since January 1980. I retain the license because I believe it helps the Alaskan public have confidence in my skills. I am required to obtain specific continuing education regularly in order to renew my license. I believe this is another valuable aspect of licensure.

I would appreciate your support of this bill and would like you to consider holding hearings on the subject.

Sincerely,

*Vivian C. Finlay*

Vivian C. Finlay, M.Ed.

Marriage, Family and Child Therapist, P.O.B. 872433, Wasilla, AK. 99687

cc: AkAMFT

Senator Paul Fischer

✓ Representative John Sund, House Judiciary Committee



Montreal, site of APA's 1988 annual meeting, calls St. Joseph's Oratory the world's most important shrine to St. Joseph, Canada's patron saint. The basilica was begun through the efforts of Brother André, who was beatified in 1982. APA members have until April 2 to preregister for the annual meeting and save on fees. More information about the meeting is available by calling (202) 682-6100.

## Court Holds Bipolar Disorder Is Physical

In a decision that could have wide-ranging ramifications for psychiatry and the insurance industry, an Arkansas appeals court recently ruled that bipolar disorder is a physical, not mental, illness and should be reimbursed at whatever payment rate an insurer has established for covering the treatment of physical illnesses.

After hearing testimony from several psychiatrists, the judge upheld a lower court ruling that ordered Blue Cross/Blue Shield to reimburse a policyholder for the treatment of bipolar disorder at the payment rate for coverage of physical disorders.

Under the insurance policy in question, as with most insurance policies, mental and nervous disorders were to be reimbursed at a lower rate than were physical illnesses and accidental injuries.

The father of a minor child, identified only as John Doe and Jane Doe respectively, filed suit against the insurance carrier after it refused to reimburse him to the extent he expected for the hospital treatment of his daughter's bipolar illness.

The Blues claimed that their definition of bipolar disorder as a mental illness was in line with similar classifications by Medicare, hospitals, and physicians throughout the country. Thus they were not remiss in refusing to reimburse Doe as they would have if the treatment was for a physical illness or an accidental injury.

One of the controversies in the case was whether the traditional classifica-  
*see "Bipolar," page 16*

## Emotionally Disturbed Students Status as 'Handicapped'

Emotionally disturbed students who are dangerous may not be so treated for an indefinite period unless school officials obtain approval from parents or a judge, the court ruled in late January.

A 6-2 majority in the case was written by Justice William Brennan Jr. in the Education of All Handicapped Children Act of 1975 (EHA) protects more than four million disaffected or "emotionally disturbed" children, approximately 10 percent of the total school population. The U.S. Department of Education estimates that approximately 10 million children are considered to be "emotionally disturbed." The Supreme Court's decision in *Brown vs. Board of Education* is cited as "perhaps the most important decision of the 20th century." Yet 21 years later, Congress has failed to enact the EHA. The Department of Education estimates that approximately 10 million children are considered to be "emotionally disturbed." The Supreme Court's decision in *Brown vs. Board of Education* is cited as "perhaps the most important decision of the 20th century." Yet 21 years later, Congress has failed to enact the EHA.

school until any disciplinary review proceedings have been completed, "unless the parents and state or local educational agencies otherwise agree."

By passing this legislation, Brennan asserted, "Congress very much meant to strip schools of the unilateral authority they had traditionally employed to exclude disabled students, particularly emotionally disturbed students, from school."

Concurring with Brennan's opinion were Chief Justice William Rehnquist and Justices Thurgood Marshall, By-  
*see "Students," page 11*

## AMA Launches Drive to Change States' Malpractice Laws

In the caucuses and reference committees of the AMA House of Delegates, South Florida has been termed "the Beirut of the professional liability crisis."

Some specialists in that part of the country have been staggering under colossal malpractice premiums. Neurosurgeons in Florida's Dade and Broward counties, for example, may be required to

pay as much as \$140,594—almost two and a half times the national average of \$56,739.

Last year St. Paul Fire and Marine Insurance Company, the largest medical malpractice carrier in the country, requested a nearly 30 percent increase in its malpractice premium rates for Florida. But when the state's insurance department granted only a 17

Psychiatry News  
3-4-88

# Ps

continued from page 1

VOL. XXIII No. 5 News

## In This Issue

<b>Foreign Medical Graduates</b>	<b>2</b>
<i>Through a series of meetings FMG residents have the opportunity to discuss problems with APA officials and experts in cross-cultural psychiatry.</i>	
<b>AIDS</b>	<b>3</b>
<i>APA Deputy Medical Director Carolyn Robinson, M.D., has urged the federal government to start an aggressive nationwide program of AIDS education in schools.</i>	
<b>Sterile Needles</b>	<b>5</b>
<i>A plan has been approved to provide clean needles to intravenous drug abusers in New York City to reduce the spread of AIDS.</i>	
<b>Shorter Hospital Stays</b>	<b>6</b>
<i>Early detection and treatment of psychiatric problems among hospital patients with both medical and psychiatric disorders should reduce hospital stays, according to a recent study.</i>	
<b>Nursing Home Reform Act</b>	<b>7</b>
<i>A new nursing home reform act will prevent mentally ill or retarded persons from being improperly placed in nursing homes, but leaves questions about their psychiatric treatment.</i>	
<b>Washington In Brief</b>	<b>7</b>
<b>Heinz Lehmann, M.D.</b>	<b>10</b>
<i>The psychiatrist who introduced chlorpromazine to North America for the treatment of schizophrenia recently celebrated 50 years of research, teaching, and clinical service at the Douglas Hospital in Verdun, Quebec.</i>	
<b>Victims of Trauma</b>	<b>13</b>
<i>Victims of extreme trauma are not doomed to lives of physical and mental suffering, according to a researcher who has identified five factors linked to surviving such ordeals.</i>	
<b>1987 MIAW Campaign</b>	<b>15</b>
<i>The APA Public Affairs Network experienced its most successful campaign ever for Mental Illness Awareness Week 1987.</i>	
<b>Econocast</b>	<b>18</b>
<b>Letters to the Editor</b>	<b>19</b>
<b>Type A Personality</b>	<b>27</b>
<i>A recent study has reaffirmed a link between Type A behavior and heart disease.</i>	



## Emotion Given

Emotionally disruptive are disruptive or be suspended for of time unless sel permission from the Supreme Court.

Writing for the decision, Justice Brennan argued that the Handicapped Act protects the more than a million disabled children receive services in from "unilateral" decisions. Of these approximately 385,000 be emotionally disruptive Department of Education.

During the landmark case, *Brock v. Board of Education*, the Supreme Court claimed education to most important function of local government.

Brennan observed it necessary to because thousands of children were still not receive educational services.

At that time, according to Brennan, many disabled children were 'warehoused' in special schools where they were neglectfully shepherded until they were dropped out.

Brennan pointed out that EHA safeguards guaranteed children the right appropriate public education "stay-put" clause. Title I states that if a disabled child is disruptive, he or she is

tion of bipolar (or manic-depressive) disorder as a mental illness was based on its symptoms or its causes and, if it was symptom based, did this reflect current thinking on how illnesses should be classified?

Several of the psychiatrists testifying as expert witnesses said that historically bipolar disorder has been labeled a mental or psychiatric illness, but that this is changing to reflect its causes rather than its manifestations.

At least five psychiatrists and psychologists testified about the nature and classification of bipolar disorder. All but one of them maintained that it is a biologically based illness.

### Classification Changing

Several witnesses testified that classification of illnesses by symptoms rather than etiology is outdated, and that psychiatry was shifting its classification focus to one that is based more on the causes than the behavioral and emotional manifestations of psychiatric disorders.

Thomas Harris, M.D., a Little Rock psychiatrist, told the court that there is a movement throughout medicine to reclassify bipolar disorder as a physical illness because of "overwhelming medical research" pointing to its biological roots as a chemical or hormonal imbalance in the brain. "I think most laymen and... most physicians and most people in psychiatry now classify illnesses by cause or origin," he said, and although people with this illness display serious behavioral and emotional disturbances, its causes are clearly physical rather than mental in nature.

Another witness pointed out that in 1986 the Arkansas Psychiatric Society said that "[b]ipolar affective disorder is an illness whose origin is biological." The judge took the district branch's statement into consideration in his ruling, the decision indicates.

The judge rejected an argument by Blue Cross/Blue Shield that since psychotherapy is an important component of treatment of bipolar disorder, it is in the realm of mental rather than physical disorders.

In upholding the trial court decision that Blue Cross/Blue Shield should have reimbursed the plaintiff at its treatment rate for physical illnesses, the appeals court judge noted that in addition to the evidence about the biological basis of bipolar illness, the insurer's case was weakened by the fact that although classification manuals still consider it primarily a mental disorder, such manuals were not adopted or even referred to by Blue Cross/Blue Shield in the insurance policy in question.

### Impact on Psychiatry

The impact on psychiatry of the Arkansas decision will be relatively minor unless courts in other states hand down similar rulings or extend the decision to illnesses such as schizophrenia and unipolar depression, for which there are biological components.

If this decision starts a judicial trend, however, the reaction of the insurance industry will in large part determine what the ramifications will be for psychiatrists and their patients.

If the Arkansas court's ruling becomes a precedent, or if the insurance industry is forced to reimburse for other psychiatric illnesses at the same rates as it does for other physical illnesses, the decision could raise significant issues "Bipolar," facing page

nificant and complex issues "for psychiatry as a whole, particularly in how we conceptualize the illnesses we deal with," said Paul Appelbaum, M.D., chair of the APA Commission on Judicial Action.

More immediate ramifications may be on reimbursement patterns and may differentially affect psychiatrists who treat the most severe illnesses compared with those who generally treat less severe psychiatric disorders, he suggested.

### APA Responds

To plan for how best to respond to the issues raised by this ruling, APA President-elect Paul Fink, M.D., announced at the January 29 meeting of the Joint Reference Committee that a work group to study the implications of the Arkansas decision will soon be appointed.

"The Arkansas case gives psychiatry an extraordinary window of opportunity," Fink told *Psychiatry News*. The task confronting psychiatry in light of the judge's ruling "is to use this decision in the best interest of all concerned, and we do this by helping people to understand that all major illnesses are physical, mental, and medical. All of these illnesses are biopsychosocial."

It is unfortunate, he added, that the judge chose to dichotomize psychiatric illnesses into separate categories of physical and mental disorders.

Fink emphasized that in light of its potential ramifications, psychiatrists must be "vigilant that insurance companies don't start to use [the Arkansas decision] to exclude psychiatric illnesses from coverage on a disease-by-disease basis." —K.H.

## Trauma

continued from page 13

previously committed, he said. One child among the children of Chowchilla who were kidnapped and buried underground for 24 hours continued to blame the kidnapping on "mean things" said to the mother the morning before the abduction.

"The final theme," Segal said, "sometimes ends up sounding more like a sermon than science, but it has to do with the capacity, even during great suffering, of victims to turn outward, or in psychiatric terms to practice dereflection, from self-involvement to a sense of compassion and involvement with others. Those who didn't make it, indeed many of those who died in captivity, by the testimony of physicians and others who were there, gave up the ghost and did not turn outward to their fellow captives in a sense of communication and concern."

### Implications

During a telephone interview Segal added, "I believe these findings have implications for the treatment of individuals who have undergone trauma and shattering crises of any sort. It may be important in treatment not only to help victims find sources of social support but to encourage attempts to find ways to reassert control and mastery over their existence, to rediscover meaning and purpose, to shed the mantle of self-blame and guilt, and to find vehicles for reaching outward to others rather than becoming ensnared in self-occupation and chronic victimhood."

Second-class postage paid at Washington, D.C. and at additional mailing offices.

Subscription rates: \$12.00 per year in advance. Single copies \$3.00. Payment in U.S. dollars only. Please allow 4-6 weeks for delivery of new subscriptions. Back issues \$4.00 each. Payment to: Psychiatric News, 1000 Pennsylvania Ave., N.W., Washington, D.C. 20004.

3-DIGIT 986  
PSYCH NEWS  
SERIALS ACQUISITION  
300 N ZEEB RD  
FARMERS BRANCH, GA 30204

## STUDENT MEMBER REQUIREMENTS

### Education

Current enrollment in a graduate program in marital and family therapy, or a course of study substantially equivalent, in a regionally accredited educational institution.

### Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

Student membership may be held until receipt of a qualifying graduate degree, or for a maximum of five years.

## APPLICATION PROCEDURES

Applicants must apply for the highest level of membership for which they qualify.

All applicants for membership and transfer of status must submit the following:

- AAMFT application for membership
- Non-refundable processing fee
- Official transcripts of graduate and professional education (Exception: Associate Members who have previously met all educational requirements.)
- Endorsements by two AAMFT Clinical Members

Please note additional specific materials required for these categories:

### Clinical membership

- Supervision reports completed by all supervisors, or
- Copy of a current state-issued MFT license or certificate recognized by the AAMFT Board of Directors

### Student members' p

- Current enrollment verification signed by the program coordinator/director at a regionally accredited educational institution.



For applications, please write:

AAMFT  
1717 K Street, N.W.  
Suite 407  
Washington, D.C. 20006

For more information, please call:  
AAMFT Membership Department  
(202) 429-1825

Effective 7-86

## MEMBERSHIP REQUIREMENTS

- CLINICAL MEMBER
- ASSOCIATE MEMBER
- STUDENT MEMBER

American Association  
for  
Marriage and Family  
Therapy



*The American Association for Marriage and Family Therapy (AAMFT), founded in 1942, is the professional association for the field of marital and family therapy. AAMFT offers professional contact and exchange of information, and serves the public interest through the advancement of the ethical practice of marital and family therapy. This brochure describes the requirements and procedures for becoming a Clinical, Associate, or Student Member of AAMFT.*

## CLINICAL MEMBER REQUIREMENTS

### Education

Completion of a master's or doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education, or a graduate degree from a regionally accredited educational institution and an equivalent course of study as defined by the AAMFT Board of Directors.

Applicants who have completed a program accredited by the Commission on Accreditation are considered to have completed all educational requirements. Coursework completed at institutions not accredited by the Commission is subject to review by the Membership Committee.

Meeting the educational qualifications consists of completion of a course of study substantially equivalent to the following curriculum. (Each course must be equivalent to a three-credit semester or four-credit quarter course.)

- Human Development (3 courses)  
Human development, personality theory, human sexuality, psychopathology, behavior-pathology.
- Marital and Family Studies (3 courses)  
Family development and family interactional patterns across the life cycle of the individual as well as the family. Courses may include the study of: family life cycle; theories of family development; marriage and/or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).

- Marital and Family Therapy (3 courses)  
Communications; family psychology; family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy such as: structural, strategic, transgenerational, experiential, object relations, contextual, systemic.
- Research (1 course)  
Research design, methods, statistics, research in marital and family studies and therapy.
- Professional Studies (1 course)  
Professional socialization and the role of the professional organization, legal responsibilities and liabilities, independent practice and interprofessional cooperation, ethics, and family law.
- Clinical Practicum (1 year, 300 hours)  
15 hours per week, approximately 8-10 hours in face-to-face contact with individuals, couples, and families for the purpose of assessment and intervention.

This course of study may be completed in a master's or doctoral degree program or subsequent to a graduate degree.

Applicants who have earned their first qualifying graduate degree prior to 1979 may establish coursework equivalency in the following manner:

- Workshops/Seminars—45 contact hours equals one three-credit semester or one four-credit quarter course
- Courses taught—one graduate level course taught equals one three-credit semester or one four-credit quarter course
- Extensive experience, publications, and educational qualifications in the field of MFT may be considered on a case-by-case basis.

### Clinical Experience

Completion of 2 years of post-graduate work experience in MFT and supervision in accordance with the following established membership standards:

- Supervised clinical experience must follow receipt of the first qualifying graduate degree and the practicum required as part of the course of study;
- Supervision must be provided by AAMFT Approved Supervisors or supervisors acceptable to the Membership Committee; and,

- Successful completion of at least 1000 hours of face-to-face contact with couples and families for the purpose of assessment and intervention, and 200 hours of supervision of MFT, at least 100 of which are individual supervision, is required.

Applicants without previous graduate degrees who have completed programs accredited by the Commission on Accreditation may be credited with 500 hours of face-to-face contact and 100 hours of supervision, of which not more than 50 hours may be group supervision.

### Licenses/Certificates

Applicants with a graduate degree and a state-issued MFT license or certificate recognized by the AAMFT Board of Directors are deemed to have complied with the educational and clinical experience qualifications for Clinical membership.

### Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

## ASSOCIATE MEMBER REQUIREMENTS

### Education

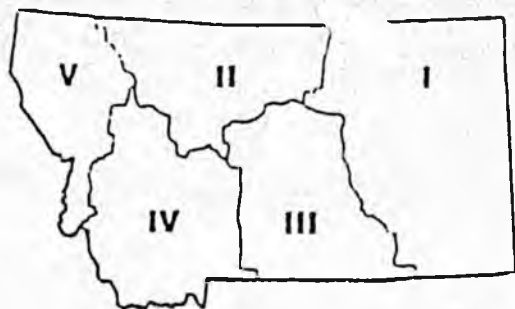
Completion of a master's or doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation, or a graduate degree from a regionally accredited educational institution and an equivalent course of study as defined by the AAMFT Board of Directors.

Meeting the educational qualifications for Associate membership consists of the completion of at least eight of the required courses and one year of clinical practicum as described under Clinical Member requirements.

### Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

Associate membership may be held until satisfactory completion of the requirements for Clinical membership, or for a maximum of five years.



## Montana Council of Regional Mental Health Boards, Inc.

2/21/86

Nancy Pease  
House Research Agency  
P.O. Box Y  
Juneau, Alaska 99811-3100

Dear Nancy:

In 1983 the Montana legislature passed a law requiring group insurance benefits for mental health treatment. The enclosed materials were presented to the legislative committees and used as justification for passage of the law mandating insurance benefits for the treatment of mental illness.

Testimony also indicated that too often people were being inappropriately hospitalized for psychological services since health insurance plans pay for hospital benefits but not for outpatient mental health treatment. Obviously the incentive was to place people in an expensive hospital because the costs were paid by the health insurance company. Less expensive outpatient services were not a paid benefit so a client's doctor would order hospitalization.

After our phone conversation, I checked the trend in inpatient hospital admissions as reported to our mental health authority, the Department of Institutions. The information was gathered from reports by the Community Mental Health Centers. In fiscal year (FY) 83 there were 6358 mental health inpatient hospitalization units reported. In FY 84 there were 5999 inpatient units. In FY 85 there were 5518 inpatient units. As reported by the Community Mental Health Centers the downward trend in inpatient hospitalization since the passage of the law in 1983 is clear.

**REGION I**  
EASTERN MONTANA COMMUNITY  
HEALTH CENTER  
1019 Main Street  
Missoula, Montana 59701  
(202) 92-141

**REGION II**  
GOLDEN TRIANGLE COMMUNITY  
MENTAL HEALTH CENTER II  
Monday Village Shopping Center  
P.O. Box 1046  
Great Falls, Montana 59403  
(701) 214-01

**REGION III**  
MENTAL HEALTH CENTER II  
1245 North 29th Street  
Billings, Montana 59102  
(252) 565-81

**REGION IV**  
MENTAL HEALTH  
SERVICES INC  
5121 1st Ave  
Great Falls, Montana 59403  
(407) 1116

**REGION V**  
WESTERN MONTANA COMMUNITY  
MENTAL HEALTH CENTER  
100 Montana 112  
Missoula, Montana 59701  
(202) 92-141

As you might guess the health insurance industry is philosophically opposed to any mandated benefits. However, in private conversations with insurance providers they have indicated that mental health benefits are a low cost item. They also were paying for it anyway through increased utilization of hospitalization and other physical illness benefits. In fact, I am not aware of any insurance company that raised their premiums any significant amount. Most insurance providers did not even adjust their premium rate after the passage of the law.

I hope this information is of use to you and the members of the House committee. If I can be of further assistance please feel free to call on me.

Best regards, .

A handwritten signature in cursive script, appearing to read "Steve", with a horizontal line above the name.

Steve Waldron  
Executive Director

# 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.*

**I**nsurance 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.

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 in-

## MENTAL HEALTH REPORT

formation 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-

*Steven S. Sharfstein is deputy medical director and Sam Muszynski is director of the Office of Economic Affairs with the American Psychiatric Association. Grace-Marie Arnett is former executive director of the Washington Psychiatric Society and a professional journalist.*

ment and 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 proven, 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.

*"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 false economy in insurance coverage."*

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.<sup>2</sup>

#### 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 ex-

perience 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.<sup>3</sup>

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.<sup>4</sup>

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.<sup>5</sup>

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.<sup>6</sup>

*"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-

appropriate 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.<sup>7</sup>

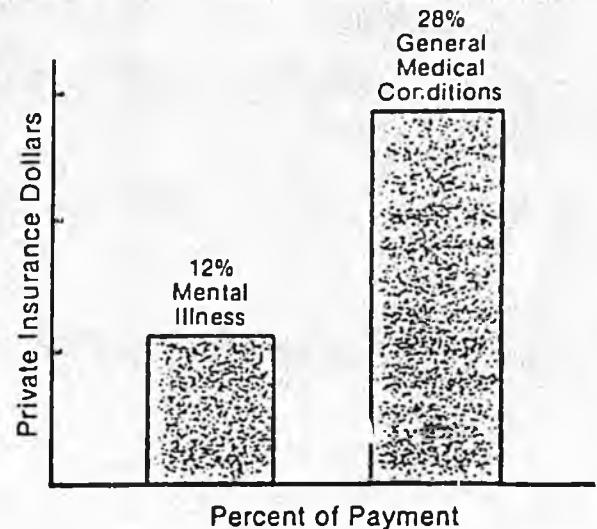
*"...As companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true where psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, 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.<sup>8</sup>

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 outpatient psychotherapy.<sup>9</sup>

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 is not concerned with utilization review, quality review, continuing education, advocacy with third party payers or 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 claim 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 peer review costs in 1981 were about \$20,000, and

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 responsibility 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

1. S. Muszynski, J. Brady and S.S. Sharfstein, "Coverage for Mental and Nervous Disorders: Summaries of 300 Private Sector Health Insurance Plans" (Washington, D.C.: American Psychiatric Press, Inc., 1983).
2. S.S. Sharfstein, S. Muszynski and E. Myers, "Health Insurance and Psychiatric Care: Update and Appraisal" (Washington, D.C.: American Psychiatric Press, Inc., 1984).
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.
5. S.S. Sharfstein et al, *op. cit.*
6. *Psychiatric Viewpoints Report: Health Insurance and the Practice of Psychiatry*, Roche Products, Inc. 1983.
7. L.L. Stein, M.A. Test and B.A. Weisbrod, "Alternative to Mental Hospital Treatment: I-Conceptual Model, Treatment Program, and Clinical Evaluation; II-Economic Benefit-Cost Analysis; III-Social Cost," *Archives of General Psychiatry* 37:392-397, 1980.
8. A. Reifman and R.J. Wyatt, "Lithium: A Brake in the Rising Cost of Mental Illness," *Archives of General Psychiatry* 37:385-388, 1980.
9. H.J. Schlesinger, E. Mumford, G.V. Glass, C. Patrick and S.S. Sharfstein, "Mental Health Treatment and Medical Care Utilization in a Fee-For-Service System," *American Journal of Public Health* 73(4):422-429, 1983.

FACT SHEET:  
EQUAL INSURANCE  
COVERAGE FOR MENTAL ILLNESS

Currently, ~~40~~<sup>14</sup> states regulate insurance coverage for treatment of mental and emotional problems by guaranteeing that benefits for mental illness are equal to benefits for physical illness. Most health insurance policies provide inadequate coverage for mental illness by limiting inpatient services and by providing no more than minimal outpatient services. Few, if any policies, cover partial hospitalization. Inadequate or untimely treatment of mental disorders is very costly in terms of the well-being of the individual, stability of the family and productivity in the work place. It may also result in costly and unnecessary hospitalization.

- FACT: Over 50% of the patients who go to physicians have symptoms due wholly or in part to mental or emotional factors.
- FACT: Some patients are forced to seek costly hospitalization because outpatient or partial hospitalization services are often not covered by their insurance.
- FACT: Most current insurance plans provide incentives for inpatient care by paying only for inpatient care rather than for outpatient or partial hospitalization care.
- FACT: Partial hospitalization is more effective than inpatient care in effecting client social adjustment and reducing family stress, and is comparable to inpatient care in preventing relapses.
- FACT: The cost of partial hospitalization is usually one half, to one third the cost of inpatient care.

Equal insurance coverage for mental illness will decrease medical utilization and result in a cost-offset which should save consumers money.

- FACT: Jones and Vischl reviewed 13 studies and found that decreased medical surgical utilization occurred in 12 of 13 <sup>STUDIES</sup> ~~patients~~ when mental health care was insured. Reduction in utilization ranged from 5% to 85% with a median reduction of 20%.
- FACT: Blue Cross of Western Pennsylvania instituted psychiatric benefits and found a significant reduction in medical utilization - the monthly cost per patient was reduced 50%.
- FACT: The University of Washington Health Services Center found a 41% reduction in the use of outpatient medical services by individuals receiving mental health services.
- FACT: The Group Health Association of Washington D.C. found that patients with mental health coverage reduced their medical-surgical utilization by 30.7%.

Equality of insurance coverage for mental illness has significant benefits for business and industry.

FACT: Equitable Life initiated an emotional health program for employees and increased productivity by \$3.00 for every \$1.00 spent.

FACT: Kimberly-Clark began an Employee Assistance Program and realized a 70% reduction in accidents.

FACT: Kennecott Copper started an Employee Assistance Program and found a 6 to 1 benefit to cost ratio; a 52% improvement in attendance; a 74.6% decrease in weekly indemnity costs; and a 52.4% decrease in medical costs.

Currently most insurance policies have higher co-payments, more restrictions and lower limits for mental health care than are placed on physical illness. As a result, the mentally ill, and in some cases, the taxpayer, must bear a far greater burden for the cost of mental illness than for physical illness. Equality of insurance coverage for mental illness will ensure that the private sector shares in the cost of providing mental health, thus freeing limited state dollars to fund services for the chronically mentally ill.

FACT: Nationwide, public funding sources provide 51% of the funds for mental health care, compared with 42% of the funds for general health care.

FACT: Insurance coverage accounts for only 15% of the total expenditures for mental health care compared with 25% of the expenditures for general health care.

FACT: In 1980, fee collections in mental health centers in New Hampshire increased 100% since insurance coverage for mental health care was mandated in 1977.

Equal insurance coverage for mental and nervous conditions prevents unnecessary and costly hospitalization, benefits employers, reduces medical costs by reducing utilization and saves tax dollars.

Federal  
Study

# Alcoholism Treatment and Total Health Care Utilization and Costs

## A Four-Year Longitudinal Analysis of Federal Employees

Harold D. Holder, PhD, James O. Blose, MPP

This study examines the effect of alcoholism treatment services on overall health care utilization and costs for health insurance enrollees under the Federal Employees Health Benefit Program with Aetna Insurance Company, 1980 through 1983. Claims filed by 1697 treated alcoholics (and their family members) continuously enrolled with Aetna during the study period were examined. In the years prior to initial alcoholism treatment, alcoholics incurred gradually increasing total health care costs on the average. These costs rose dramatically in the six months prior to treatment, began to decline after treatment initiation, and continued to fall during several follow-up years. For alcoholics less than 45 years of age, costs eventually declined to a point comparable with the lowest pretreatment levels.

(JAMA 1986;256:1456-1460)

EARLIER studies have established that alcoholics have lower life expectancies and thus higher mortality rates at younger ages than nonalcoholic populations.<sup>1,2</sup> Regular heavy ingestion of ethanol increases the chances of physical illness and early death.

On the average, alcoholics consume medical care resources at a much higher rate than nonalcoholic individuals.<sup>3</sup> There have been few studies, however, of the way that alcoholism treatment affects overall health care utilization and costs. This relationship has become an important issue during the past decade as more insurance carriers, self-insured companies, and health maintenance organizations (HMOs) have covered and/or provided alcoholism treatment. Several studies have examined

the impact of alcoholism treatment on medical care cost and utilization using data from prepaid plans or HMOs (H. Hunter, unpublished data, November 1978).<sup>4</sup> These have generally found a reduction in health care utilization or cost following alcoholism treatment. Holder and Hallan<sup>5</sup> report similar findings in a study of alcoholics in a fee-for-service population. Research in this area has been more thoroughly reviewed by Jones and Vischi<sup>6</sup> and Saxe et al.<sup>11</sup> While these studies consistently show decreases in overall health care utilization following alcoholism treatment, the generalizability of the findings can be questioned because of the possibility of self-selection in enrollment with HMOs.<sup>12,13</sup> Further, most of this research is based on relatively small numbers of cases concentrated in specific geographic areas.

The study reported herein provides further evidence regarding changes in general medical care utilization and

costs following initiation of alcoholism treatment. This research sought to avoid several limitations of many prior studies<sup>10</sup> by the use of several design features: (1) a large, continuously enrolled treated alcoholic population (about 1700 subjects), (2) a geographically diverse population including cases from all 50 states, (3) longer pretreatment and posttreatment time periods, (4) use of multiple cost and utilization measures to corroborate any observed effects, and (5) use of a comparison group.

In addition to providing an opportunity to corroborate the findings of previous small regional studies with a sizable national data base, this research has the capacity to extend our knowledge in two directions: (1) The large number of cases permits some exploratory analyses to be conducted on alcoholics of differing ages; and (2) the long time period examined provides a longer and more detailed picture of the pretreatment cost patterns of alcoholics than has been possible.

### RESEARCH APPROACH

The data for this study were derived from a review of all claims filed with the Aetna Life and Casualty Company during the calendar years 1980 through 1983 by all persons insured under the Federal Employees Health Benefit Program. As of September 1983, the Aetna plan covered 390 000 enrollees (federal employees and retirees) and about 980 000 beneficiaries in all. About half of all enrollees were aged 60 years or older. During the four-year

From The Human Ecology Institute, Chapel Hill, NC (Dr Holder and Mr. Blose), and the School of Public Health, University of North Carolina at Chapel Hill (Dr Holder).  
Reprint requests to The Human Ecology Institute, 211 N Columbia St, Suite B, Chapel Hill, NC 27514 (Dr Holder).

study period, 2934 individuals filed claims for alcoholism treatment.

An alcoholic was defined as any person who had received medical treatment under a primary diagnosis of alcoholism. Aetna utilized a limited classification system for coding types of illnesses but did identify alcoholism diagnoses as a single group. Aetna did not utilize International Classification of Diseases codes during the time period covered by the study.

Since the primary purpose of the study was to examine longitudinal patterns of medical care, only those families that had continuous health insurance coverage with Aetna during the study period were used for analysis. Of all families with at least one alcoholic member, 1645 (57%) were continuously enrolled. Those dropped from the longitudinal analysis were demographically similar to the continuously enrolled families, and no temporal patterns in enrollment discontinuity were evident.

A randomly selected group of continuously enrolled families that had filed no claims for alcoholism treatment during the study period was chosen. This random sample was stratified by age to ensure that the age distribution matched that of families with alcoholic members. The sample size ( $N=3598$ ) was twice that of the alcoholic family group. This group was used only to make comparisons with the alcoholic families regarding general medical care utilization patterns. It would be inappropriate to utilize such a comparison group for making inferences regarding the impact of alcoholism treatment.<sup>14</sup>

No statistically significant differences in demographic characteristics ( $P<.01$ ) were found between the two family groups. Both had a mean family age of approximately 50 years. This similarity in age was the result of selecting an age-stratified comparison group. Mean family size was  $2\frac{1}{2}$  persons. Family composition was similar as well.

All medical care claims for both groups for services rendered during the period from January 1980 through September 1983 were analyzed. Claims for medical services received during the final quarter of 1983 were incomplete because many such claims would not be filed until early 1984. Costs were defined as unique charges for services submitted to Aetna by medical care providers. Although the cost measures used here are limited to services for which claims were filed with Aetna, the Aetna plan is rather inclusive, and these measures thus serve as fairly comprehensive indicators of overall

health care utilization. Federal employees and annuitants can be insured under only one government-sponsored plan, including HMOs approved under the Federal Employees Health Benefit Program. While membership by Aetna enrollees or members of their families in other HMOs is possible, we consider it unlikely given the high average age of Aetna enrollees and the large number of retirees enrolled. All charges were adjusted to control for inflation during the study period using the Medical Care Index developed by the US Department of Labor as part of the Consumer Price Index. All cost figures cited herein are stated in January 1980 dollars.

Under the Federal Employees Health Benefit Program with Aetna, alcoholism treatment is explicitly covered under the surgical and medical expenses for mental disorders. There are two annual inpatient treatment benefit limits: \$20 000 (high-option coverage) and \$15 000 (low option). About 80% of the families in both the alcoholic and nonalcoholic study groups retained high-option coverage throughout the four-year period. Inpatient treatment is covered only if part of a program of therapy supervised by a physician who certifies that a follow-up program has been established. Inpatient care for detoxification alone without an associated therapy program is not covered by the plan. Outpatient treatment coverage includes the services of a physician or clinical psychologist. Services rendered by other providers are covered if they are supervised by a physician specializing in psychiatry. Annual outpatient treatment benefits are limited to \$1000 (high-option coverage) and \$750 (low option).

## RESULTS

The total medical care utilization and costs of the two family groups were examined by calendar year. This family-based comparison ensures the broadest frame of reference, ie, all insured individuals are included. No statistically significant differences were found across calendar years within either group. The four-year average per capita monthly health care costs for families with an alcoholic member were \$209.60, or almost 100% higher than comparable costs (\$106.54) for families with no apparent alcoholic members (statistically significant at  $P<.01$ ) (Fig 1). Most of this difference resulted from higher monthly inpatient costs (\$164.50 per person) for the families with an alcoholic member. These figures include both general

medical care and alcoholism treatment costs. When alcoholism treatment costs are omitted, the average per capita monthly health care cost of the alcoholic families was \$180.88.

The mean age for the 1697 treated alcoholics was 51 years. The age distribution is shown in Fig 2, which shows that 85% were 35 and older and that more than 50% were more than 54 years old. About 65% were male. Treated alcoholics were located in all 50 states. Two thirds of those receiving alcoholism treatment were enrollees (employees or annuitants), 24% were spouses, and 11% were dependent children.

The primary form of alcoholism treatment was inpatient care, with an average length of stay of 21.7 days. Inpatient alcoholism care was received by 77% of the treated alcoholics and accounted for 95% of all alcoholism treatment costs. The utilization rate of the alcoholism benefit was low—less than 1% of covered individuals were treated for alcoholism in any given year. The estimated benefit cost for Aetna's alcoholism treatment coverage was \$1.34 per covered individual per year. About 65% of all charges were paid under the plan.

Most of the inpatient care was concentrated in general hospitals (82% of inpatient admissions). Other forms of inpatient or residential care, such as specialized alcoholism hospitals (9.2%) and hospital-affiliated inpatient or alcoholism care centers (6.3%), were used less frequently. Outpatient care was concentrated in physicians (66.4%) and general hospitals (13.7%). Other outpatient providers included clinical psychologists (5.7%), specialized alcoholism hospitals (2.8%), and psychiatric social workers (3.0%).

No individuals exceeded the annual benefit limits for inpatient alcoholism treatment and the outpatient benefit limits were exceeded only rarely—in less than 1% of the cases. Benefit limits thus did not result in any significant underestimation of alcoholism treatment cost or utilization.

The pattern of overall medical care for treated alcoholics was analyzed using the first known alcoholism treatment event as a reference point. The date of first alcoholism treatment was determined based on the available claims data. While it is possible that some individuals had previously received alcoholism treatment, this is unlikely to be a significant problem.

Since alcoholics began treatment during each month of the study period, individuals had varying amounts of pre- and post-alcoholism treatment initiation data available for analysis.

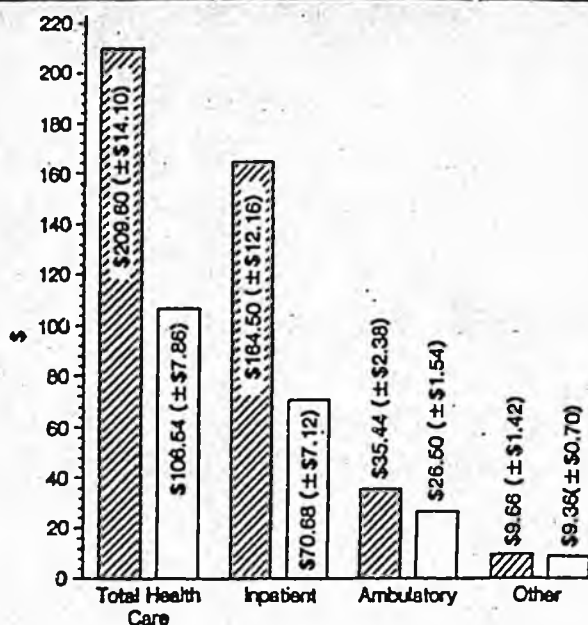


Fig 1.—Family health care costs (per capita monthly average), 1980 through 1983, for alcoholic (slashed bars) and nonalcoholic (solid bars) groups. Ninety-five percent confidence limits are given in parentheses.

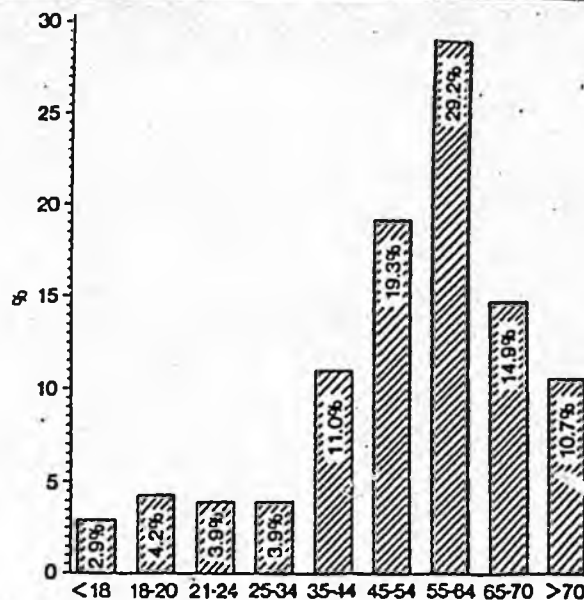


Fig 2.—Age of persons receiving alcoholism treatment.

Table 1.—Longitudinal Patterns in Total Health Care Cost and Utilization for Individuals With Available Data for 24-Month Pretreatment Period and 12-Month Posttreatment Period\*

Variable	13-24-mo Pretreatment Mean	1-12-mo Pretreatment Mean	1-12-mo Posttreatment Mean	F	P
Total cost	\$247	\$398	\$251	4.76	<.01
Inpatient cost	\$192	\$318	\$191	4.11	.01
Ambulatory cost	\$41	\$49	\$47	0.49	.61
No. of inpatient days	0.7	1.6	0.7	9.98	<.01
No. of inpatient treatment events	0.03	0.07	0.05	13.60	<.01

\*N=344. First alcoholism treatment claim and its associated cost and utilization have been excluded.

Table 2.—Longitudinal Patterns in Total Health Care Cost and Utilization for Individuals With Available Data for 12-Month Pretreatment Period and 24-Month Posttreatment Period\*

Variable	1-12-mo Pretreatment Mean	1-12-mo Posttreatment Mean	13-24-mo Posttreatment Mean	F	P
Total cost	\$290	\$242	\$192	3.85	.02
Inpatient cost	\$225	\$188	\$150	2.55	.07
Ambulatory cost	\$48	\$45	\$35	2.31	.09
No. of inpatient days	1.2	1.0	0.8	4.73	<.01
No. of inpatient treatment events	0.08	0.05	0.04	6.48	<.01

\*N=338. First alcoholism treatment claim and its associated cost and utilization have been excluded.

We tested for statistically significant changes in medical care cost and utilization using two groups of individuals having pretreatment and posttreatment periods of similar length: (1) persons for whom a full 24 months of

pretreatment data and 12 months of posttreatment data were available and (2) persons with 12 months of pretreatment and 24 months of posttreatment data. Mean monthly cost and utilization for specific 12-month intervals

were examined. Costs associated with the first alcoholism claim have been excluded from these and all subsequent analyses reported herein. Since initial alcoholism treatment usually involved an expensive inpatient stay, including these costs in the analysis tended to obscure the pattern of general medical care utilization. All subsequent costs for alcoholism treatment were included, however.

The total health care costs of group 1 (24 months of pretreatment and 12 months of posttreatment data, N=344) averaged \$247 per month during the period from 13 to 24 months prior to treatment initiation and rose to \$398 per month during the year immediately prior to treatment. This declined to an average of \$251 per month during the year following treatment initiation (Table 1). Those in group 2 (N=338) had an average monthly total health care cost of \$290 per month during the 12 months prior to treatment (Table 2). This declined to \$242 per month during the first year following treatment initiation and then declined further to a monthly average of \$192. Each of the mean comparisons was statistically significant at  $P < .02$ . These changes in overall monthly medical care are primarily the result of changes in inpatient utilization (Tables 1 and 2). While the longitudinal cost patterns of the two groups are similar, they appear to differ in average monthly costs for the 12-month pretreatment period. Some differences between groups should be expected due to stochastic variation.

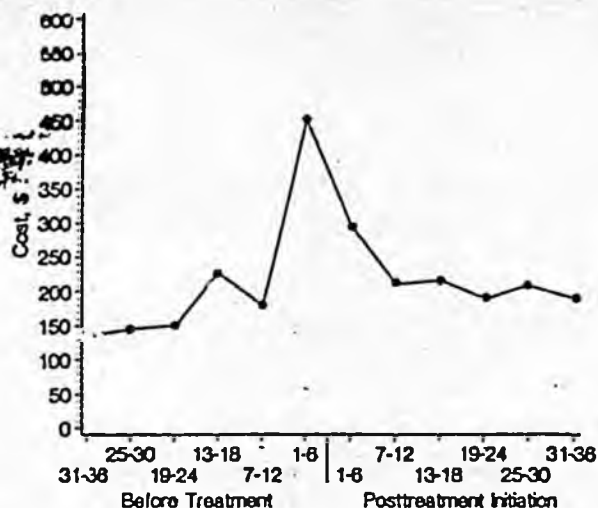


Fig 3.—Average monthly total health care costs for alcoholic individuals by six-month intervals (total population). Costs associated with first alcoholism treatment encounter were excluded.

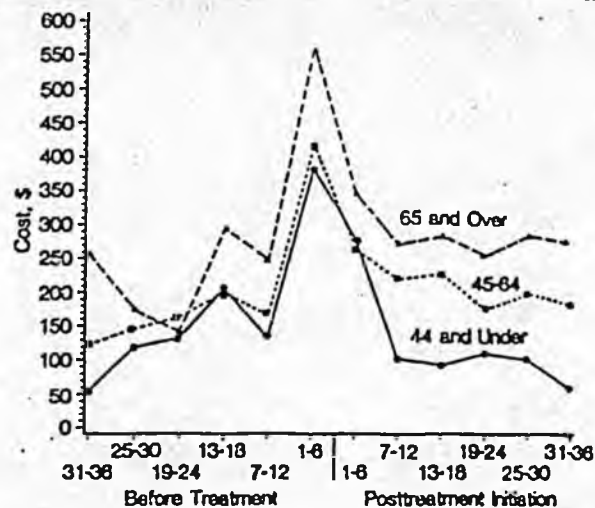


Fig 4.—Average total health care costs for alcoholic individuals by six-month intervals, by age group. Costs associated with first alcoholism treatment encounter were excluded.

Although the precise reasons for this particular difference are unclear, it is fairly certain that it is not due to a systematic discrepancy between individuals beginning treatment at different times. A comparison of the demographic characteristics of each of the four-year cohorts found no statistically significant differences. A cross-cohort comparison of average monthly costs also found no significant differences.

Taken as a whole, these results clearly indicate that mean monthly total medical care costs gradually increase before the initiation of alcoholism treatment, decline immediately following treatment initiation, and continue to decline at least into the second year.

These statistical analyses of specific subgroups were necessary to ensure that individuals were compared across similar time periods. However, overall patterns in monthly total medical care costs can also be examined by pooling the pretreatment and posttreatment data from all 1697 treated alcoholics to obtain a distribution of average monthly costs per individual during a six-year period (36 months before and after treatment initiation). A plot of this distribution is shown in Fig 3, using means for 12 different six-month intervals, where the midpoint on the horizontal axis is the start of alcoholism treatment. Monthly cell sizes always exceed 300 individuals.

This plot shows that, on the average, from 36 to 12 months before alcoholics begin alcoholism treatment their medical care costs gradually increase, with average monthly costs per person rising from approximately \$130 to \$179. During the year before treatment

begins, however, total medical care costs rise much faster. The average monthly medical care cost rose to \$452 in the six-month period before alcoholism treatment and to \$1370 in the final month.

After treatment begins, total medical care costs drop fairly rapidly for about 12 months. This drop continues, though more slowly, during the next two years. Total health care costs averaged \$294 per month during the six months following treatment initiation, but only \$190 per month by the third post-treatment initiation year.

While this pattern of overall medical care costs was almost identical for both men and women, alcoholics of different ages showed distinct medical care cost patterns. We examined three age groups: less than 45 years, 45 to 64 years, and 65 years and older. Alcoholics in each age group followed the general patterns of the total group (Fig 4). Yet there was a clear association between age and the extent of the drop in medical care costs following the start of alcoholism treatment. By 36 months after the start of treatment, the average monthly total costs of those less than 45 years ( $N=440$ ) had dropped to a level comparable with that experienced 36 months prior to treatment.

The middle age group (45 to 64 years old,  $N=823$ ) is most like the model age of groups typically represented in previous studies of treated alcoholics. The health care costs of this group also dropped significantly following the start of alcoholism treatment, although they did not reach levels as low as those existing several years prior to treatment. The oldest group ( $N=434$ ),

which consisted primarily of retirees, experienced the highest overall medical care costs and showed the least convergence to the levels that existed prior to initiation of alcoholism treatment.

#### COMMENT

The results presented herein provide important confirmation of the findings of previous studies showing a decline in the health care costs of alcoholics following the initiation of treatment. No study of a single enrolled population can be definitive, given both the diversity of the alcoholic population and the diversity of populations enrolled under employee health benefit plans, as well as variances in types of coverage and services available in different regions of the United States. Nonetheless, this research is probably more generalizable than many previous studies based on smaller regional samples. Additionally, the long time period available for analysis allowed us to examine the pretreatment medical care cost patterns of alcoholics more thoroughly than has been possible in prior research. This examination identified more clearly the nature of the rapid increase in costs that occurs in the year immediately preceding initial alcoholism treatment. It appears that within the six months prior to the start of alcoholism treatment, the emotional and physical problems of the average alcoholic escalate. These worsening problems manifest themselves in the use of additional health care services. This sharp upward ramp is not unique to alcoholism but also occurs for other chronic diseases.<sup>15</sup>

Further, the large sample size permitted for the first time an exploration

The earlier we get people to treatment the better the results

of the possibility that the effects of alcoholism treatment on health care could vary by age. Indeed, the findings indicate that this may be the case. Only for persons less than 45 years of age did posttreatment health care costs eventually decline to a level as low as that experienced several years prior to alcoholism treatment. While persons in older age groups also experienced declining costs after starting treatment, these costs did not decline to a point comparable with the lowest pre-treatment levels. This is likely a result of the increasing medical care costs that accompany aging,<sup>16</sup> as well as potentially more serious alcohol-related health problems due to a longer period of chronic abuse.<sup>17-19</sup>

It is possible that some of the post-treatment decline in total medical care costs resulted from factors other than the treatment itself, particularly statistical convergence to the mean. While

this factor may be operating for some individuals in the period immediately following treatment initiation, the longer-term decline in posttreatment costs is more likely the result of alcoholism treatment.

The effects of specific forms of treatment cannot be evaluated using these data. Rather, the findings are relevant to an actuarial concern for the extent of risk for increased benefit payments by a health insurance company, a self-insured employer, or an HMO. From this perspective, the aggregate reductions in total health care costs associated with alcoholism treatment in a situation where there is no direct control of the quality or type of alcoholism treatment are most relevant.

Random assignment to treatment and "no treatment" conditions to control for motivation to seek care is not possible in studies of this type. In any case, it is unlikely that a "no treat-

ment" alcoholic group randomly selected from the same enrolled population could be diagnosed and ethically denied care. Further, enrollees who are motivated to seek alcoholism treatment are the ones most likely to experience reductions in health care utilization and cost. The health policy question is not whether alcoholism treatment can bring about a reduction in total health care under controlled conditions but whether such treatment as actually rendered to a large population that is motivated to seek care can result in reduced overall health care costs. The results of this study provide further evidence that this question should be answered affirmatively.

This research was conducted under a contract from the National Institute on Alcohol Abuse and Alcoholism, US Department of Health and Human Services, contract ADM 281 83 0011.

References

1. Pell S, D'Alonso CA: A five-year mortality study of alcoholics. *J Occup Med* 1973;15:120-125.
2. Room R, Day N: *Alcohol and Mortality*, special report to National Institute on Alcohol Abuse and Alcoholism. US Dept of Health and Human Services, 1974.
3. Thaler H: Alcohol consumption and diseases of the liver. *Nutr Metab* 1977;21:186-193.
4. Hallan JR: Health insurance coverage for alcoholism: A review of costs and objectives. *Alcohol Health and Res World* 1981;4:16-21.
5. National Institute on Alcohol Abuse and Alcoholism: *Development of Cost Simulation Study of Alcoholism Insurance Benefit Packages Project Description and Recommendations*. Rockville, Md, US Dept of Health and Human Services, 1983.
6. Brock CB, Boyajy TG: *Group Health Association of America Study: Alcoholism Within Primary Group Practice HMOs*. Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 1978.
7. Sherman RM, Reiff S, Forsythe AB: Utilization of medical services by alcoholics participating in an outpatient treatment program. *Alcoholism Clin*

- Exp Res* 1979;3:115-120.
8. Hayami DE, Freeborn DK: Effect of coverage on use of an HMO alcoholism treatment program, outcome, and medical care utilization. *Am J Public Health* 1981;71:1113-1143.
9. Holder HD, Hallan JR: *Medical Care and Alcoholism Treatment Costs and Utilization: A Five-Year Analysis of the California Pilot Project to Provide Health Insurance Coverage for Alcoholism*. Chapel Hill, NC, H-2 Inc, 1981.
10. Jones KR, Vischi TR: Impact of alcohol, drug abuse and mental health treatment on medical care utilization. *Med Care* 1979;17:1-82.
11. Saxe L, Dougherty D, Eaty K, et al: *The Effectiveness and Costs of Alcoholism Treatment*. Congress of the US, 1983.
12. Berki SE, Ashcraft M, Penchanaky R, et al: Enrollment choice in a multi-HMO setting: The roles of health risk, financial vulnerability, and access to care. *Med Care* 1977;15:95-114.
13. Jackson-Beeck M, Kleinman JH: Evidence for self-selection among health maintenance organization enrollees. *JAMA* 1983;250:2826-2829.
14. Cook T, Campbell D: *Quasi-Experimentation: Design and Analysis Issues for Field Settings*. Boston, Houghton Mifflin Co, 1979.
15. Schlesinger HJ, Mumford E, Glass GV, et al: Mental health treatment and medical care utilization in a fee-for-service system: Outpatient mental health treatment following the onset of a chronic disease. *Am J Public Health* 1983;73:422-429.
16. National Center for Health Services Research: *National Health Care Expenditures Study—Household Data: United States, 1977*. US Dept of Health and Human Services, in press.
17. Maddox G, Robins LN, Rosenberg N (eds): *Nature and Extent of Alcohol Problems Among the Elderly*. Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 1984.
18. Schuckitt MA, Miller PL: Alcoholism in elderly men: A survey of a general medical ward. *Ann NY Acad Sci* 1976;237:558-571.
19. Blazer D, George L, Woodbury M, et al: The elderly alcoholic: A profile, in Maddox G, Robins LN, Rosenberg N (eds): *Nature and Extent of Alcohol Problems Among the Elderly*. Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 1984, pp 275-297.

# Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

AUG 20 1987

BARBARA BROWNE  
RAYMOND F. BROWNE, CLU, ChFC  
SUSAN T. McLAUGHLIN, MAT, MSUP, EdD  
CYNTHIA D. WAGNER, CLU

**T**here exists within the health care sector a considerable controversy over the issue of how to meet the costs of providing care for mental illness, alcoholism, and drug dependency. A major issue in this debate is the trend towards legislative mandates to include certain minimum benefits for mental illness, alcoholism, and drug dependency in insurance plans offered by insurers and health maintenance organizations. At this writing, over twenty states mandate some form of these benefits and such legislation is under consideration in a number of other states.

There is significant reluctance on the part of many insurers and health maintenance organizations to embrace any form of mandatory benefits. The insurers and health maintenance organizations have expressed the belief that provision of such benefits should be the choice of the individual or group purchaser.

The care providers for such illnesses, and other advocates of such care, contend that the social stigma and general denial systems of these illnesses prevent a groundswell of demand for such benefits by the public. They further contend that employers who are aware of this public perception do not feel meaningful pressures to voluntarily provide or expand benefits of this nature.

Against this background, a chorus of claims and counterclaims has

arisen from both camps. Central among these claims are four issues which this report attempts to explore. They are:

(1) A number of insurers and health maintenance organizations claim that mandating benefits for mental illness, alcoholism, and drug dependency will dramatically increase premium costs for health care protection and be disruptive to the health care delivery system.

(2) Some insurers and health maintenance organizations indicate that mandating these benefits will accelerate a trend by employers towards self-insurance as a means of avoiding the impact of the mandates, since at this time there is a legal question as to whether self-insured plans must comply with most existing legislation.

(3) Many insurers and health maintenance organizations also contend that individuals and employers faced with the increased costs of health coverages because of mandated benefits will severely curtail or terminate their existing group insurance programs.

(4) A number of providers of care for mental illness, alcoholism, and drug dependency claim that mandating such benefits will lead to significantly increased utilization of such benefits. While conceding that this increased usage may result in modest increases in costs for such protection, they contend that there will be an offset in savings through less general medical and hospital services utilization.

It is the purpose of this paper to explore these four issues by reviewing the actual health insurance experience in six states which have had mandated benefits in some form for a period of time. The six states reviewed in our report are Arkansas, Connecticut, Maryland, Massachusetts, Oregon, and Wisconsin. These states were selected for their many diverse characteristics to provide balance to the report. They differ in region, population, economy, and other important social measurements. Their mandated benefits were inception at different points in time and differ widely in structure.

## Methodology

The relatively short period of time since Wisconsin enacted the first mandated health insurance legislation in 1972 has made it difficult to obtain hard data on claim experience on mental health, alcohol, and drug claims in post-mandated benefit periods as contrasted to pre-mandated benefit periods. In the absence of such data, we conducted our study by contacting sources located in the six study states who had been actively involved in the pricing, administration, and marketing of large numbers of group health insurance plans during both pre-mandated and post-mandated periods. No individual coverage experience was studied.

A total of thirty-one sources were

# ... in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state.

contacted. All of the sources responded. These sources administered 84,500 plans in the study states covering a total of 8,822,100 participants. The sources have access to very significant data from both a quantitative and qualitative standpoint. The major carrier responded in each state. The largest national private carrier responded in each state. A national actuarial consulting firm responded for all states. A large national employer with locations in five of the six states responded for those five states. The balance of the responses were from major group insurers and independent agents located in the states studied. The respondents' answers were recorded exactly as given; however, it is obvious the respondents tended to round their numerical responses.

We have utilized data on mandated legislation that is aged for several years. This was done to present a mandated benefit structure for each state that would track as closely as possible with the period studied. The period studied was from the effective date of the mandates to a point thirty-six months after the mandates became effective. There may well be differences in the mandated benefits illustrated in the study and some legislation now in place.

Certain clarifications as to terminology are important. In questioning the experience of the respondents as to cost history, the respondents were asked not only if premiums increased but if premiums would have decreased in the absence of the mandated mental health, alcohol, and drug dependency benefits. This is important because respondents indicated some leveling of costs in recent years due to cost containment programs. We are also aware that it might not be desirable politically or from a marketing standpoint for an insurer to acknowledge cost increases for mandated benefits. It would not be difficult for the insurer to make internal rate adjustments to reach desirable pricing levels.

In regard to "mandated benefits," the term has a different meaning in different states. For example, in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state. In other states, the insurer or health maintenance organization must provide the benefit as an option for an employer to elect. In yet a third arrangement, an employer has the option, by written refusal, to waive the mandated benefits.

It should be noted as a point of interest, there are many other mandated benefits that do not deal with mental illness, alcohol, or drug abuse issues which are in place in the states we studied.

It should be noted that in accessing the move from insured to self-insured health plans by employers, we measured the movements that were solely attributable to mandated benefits or where mandated benefits were the major causative factor in the respondents' view. This is important because there are two points to consider in evaluating the movement of plans from insured to self-insured status. The first point relates to the size of the group involved. The respondents indicated that a group of less than 100 participants was not generally appropriate for self-insurance. This fact has particular significance in that the number of employers with less than 100 employees generally significantly outnumbered those employers with more than 100 employees. The second point is that mandated benefits are only one of the reasons, according to respondents, that such plans change status.

#### Table One Mandated Benefits in Place During Period Studied Arkansas

Drug—No benefits in legislation during period studied.

Alcohol—No benefits in legislation during period studied.

Mental Health—There are no mini-

mum benefits specified for inpatient treatment. Reimbursement for services in a licensed outpatient psychiatric center on a par with those for health care services in a hospital. Minimum for both inpatient and outpatient of \$4,000 per year. Employer must sign waiver to delete these benefits from coverage.

#### Connecticut

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans the benefits provide for 45 days inpatient coverage in a hospital or residential facility.

Mental Health—Inpatient benefits provide for at least 60 days full hospitalization or 120 sessions of partial hospitalization in a hospital (whether or not operated by the State) in any calendar year.

Outpatient benefits provide a deductible on a par with that for other illnesses. 50% copayment with mandated maximum benefit of up to \$1,000 in any calendar year. Availability of additional benefits, up to a maximum of \$1,000 at option of group policyholder with deductible or copayment provisions on a par with those for other illnesses.

#### Maryland

Drug—Inpatient benefits cover 21 days; there is a \$1,000 outpatient benefit with 80% copayment.

Alcohol—For Group plans only, the benefits provide 7 days detoxification; 30 days residential; 30 outpatient visits for at least \$1,000 with a lifetime limit of 120 inpatient days and outpatient visits combined.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year or benefit period. Mandates optional availability for partial hospitalization. Where a patient lives at home part of the time and spends some time in a treatment program.

Outpatient benefits provide copayment of up to 50% of the benefits provided for other types of illness.

# Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

## Massachusetts

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans and Health Maintenance Organizations the benefits provide for 30 days inpatient and \$500 outpatient coverage.

Mental Health—Inpatient benefits provide at least 60 days full hospitalization in a licensed/accredited public/private mental hospital in any calendar year. Benefits and limitations on a par with those for other illnesses.

Outpatient benefits provide up to \$500 per year for services furnished by a comprehensive health service organization, a licensed/accredited hospital, an approved mental health center, and other mental clinics or day care centers with furnished mental health services or services provided by a licensed psychotherapist, psychologist, or clinical social worker.

## Oregon

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group plans only, the benefits provide for \$6,000 per 24-month treatment period with mix of inpatient, residential, and outpatient and with usual copayments and deductibles.

Mental Health—General: Maximum overall benefit of up to \$9,000 in any 24-consecutive month period (unless payments are for both chemical dependency, including alcoholism, in which case an overall benefit cap of \$6,000 may be applied.) Deductibles and copayments on a par with those for other illnesses.

Except as noted above, inpatient benefits provide for not less than \$7,500 in any 24 consecutive month period for full hospital or other health

States and Plans Surveyed	Increase in Premium	Insured-Self-Insured	Plans Terminating	Offsetting Cost Reductions
Arkansas	None - 0	None	None	None - 33%
Groups—6,420	1-5% - 0			Significant - 0
Participants 619,700	5-10% - 100%			Too early to determine - 67%
	10-15% - 0			
Connecticut	None - 75%	None	None	None - 40%
Groups—16,400	1-5% - 25%			Significant - 20%
Participants 1,565,000	5-10% - 0			Too early to determine - 40%
	10-15% - 0			
Maryland	None - 42%	None	None	None - 29%
Groups—13,750	1-5% - 0			Significant - 0
Participants 1,295,600	5-10% - 58%			Too early to determine - 71%
	10-15% - 0			
Massachusetts	None - 40%	None	None	None - 75%
Groups—1,060	1-5% - 40%			Significant - 0
Participants 822,400	5-10% - 0			Too early to determine - 25%
	10-15% - 20%			
	None - 33%	None	None	None - 33%
Groups—1,060	1-5% - 0			Significant - 33%
Participants 822,400	5-10% - 67%			Too early to determine - 34%
	10-15% - 0			
Wisconsin	None - 25%		None	None - 50%
Groups—5,830	1-5% - 0	None-88%		Significant - 28%
Participants 755,000	5-10% - 75%	Modest-12%		Too early to determine - 22%
	10-15% - 0			

facility within the dollar limit for inpatient.

Except as noted above, outpatient benefits provide not less than \$2,000 in any 24 consecutive month period.

## Wisconsin

Drug—For Group plans only, the benefits provide 30 days inpatient coverage and the first \$500 of outpatient treatment.

Alcohol—For Group plans only, the benefits provide 30 days of inpatient coverage; and the first \$500 of outpatient coverage.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year in approved public or private hospitals. Benefits on a par with those for other

illnesses. Partial hospitalization included under outpatient coverage.

Outpatient coverage provides not less than \$500 in any calendar year, including partial hospitalization. (State may adjust the dollar limit every two years.) Benefits on a par with those for other illnesses.

## Summary

### Composite Results for All Sources

(1) 35% of the sources indicated there was no measurable premium increase in the plans they covered attributable to the inception of mandated benefits.

11% of the sources indicated that

(1) Some 22 sources provided both statistical data and background information. A number of organizations had sources reporting in more than one state. One source omitted a question due to premium tracking difficulty. Further details regarding this study are available to interested readers from the authors.

Without exception the respondents indicated there had been no plan terminations due to mandated mental health, alcohol, and drug benefits.

they had experienced premium increases in the 1-5% range in the plans they covered attributable to the inception of mandated benefits.

50% of the sources indicated that they had experienced premium increases in the 5-10% range in the plans they covered attributable to the inception of mandated benefits.

3% of the sources indicated that they had experienced premium increases in the 10-15% range in the plans they covered attributable to the inception of mandated benefits.

(2) 98% of the sources indicated there had been no change from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

2% of the sources indicated changes from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

(3) None of the sources in our study states indicated that there had been any plans terminated due to the implementation of mandated benefits.

(4) 14% of the sources indicated they had experienced measurable cost reductions in other areas since the implementation of mandated benefits in plans which previously did not offer coverage in the mandated benefit areas or offered limited coverage in those areas.

43% of the sources indicated there had been no offsetting cost reductions in other coverage areas since the inception of mandated benefits.

43% of the sources indicated that it was too early to determine if there had been savings in other coverage areas since the inception of mandated benefits.

### Observations

The composite figures indicate a consistency of response throughout the six states studied despite their aforementioned differences.

### Premium Increases

We found no dramatic premium increases in the states studied due to mandated mental health, alcohol, and

drug benefits. Some respondents indicated that a reason for this was that although individual claims for the mandated benefits may be significant, the number of claims for these benefits as a percentage of the total claim exposure was not significant in their experience. Another reason given for the moderate premium increases is that many plans already had benefits in place for mental health, alcohol, and drug abuse which approached, equaled, or exceeded the mandated benefits. The major carrier reported premium decreases in two states after mandated benefits were enacted. We believe it fair to assume that in many cases the premium increases indicated were the result of prospective rate increases by the insurers as opposed to rate adjustments based on actual experience. The respondents, in large numbers, indicated they simply had no hard claims figures on the mandated benefits being studied. It is interesting to note that a major carrier estimated claims made for substance abuse (not including mental health) were less than one-half of one percent of total claims. Another area not dealt with in our study but of considerable interest is the effect of costs occasioned by the involvement of family members in the treatment of substance abuse patients. It has been indicated that health care providers seeking reimbursement for family services are assigning nervous or mental health diagnosis such as "adolescent adjustment disorder" or "stress" to the family members (Science Management Technology Study 1981.)

### Trend to Self-insurance

The two percent of the respondents reporting plans changed solely due to mandated benefits indicated only five plans were actually changed. The respondents reported a modest trend to self-insurance in plans of over one hundred lives; however, reported that mandated benefits were a minor consideration in that trend. Cash flow, plan design flexibility, and elimina-

tion of premium taxes in states where they exist, were cited as the main reasons for the movement to self-insurance. Future legislative efforts at the federal level could impact on this area if "qualified plans" were dealt with in regard to mandated benefits as contrasted to the current state approach which deals primarily with insurers and health maintenance organizations.

### Plan Terminations

Without exception the respondents indicated there had been no plan terminations due to mandated mental health, alcohol, and drug benefits.

### Offset Savings

No conclusion as to whether meaningful offset savings had been experienced could be reasonably determined from the sources' responses. The respondents differed more on this question than any other. It was interesting to note that those sources reporting offset savings were associated with the administration of plans with large numbers of participants. These respondents note that outpatient costs had increased with utilization after mandates, however, inpatient costs had decreased and the total of outpatient and inpatient costs had decreased. A reason cited for this result was that many participants no longer had to enter a hospital in order to receive benefits for mental health, alcohol, or drug abuse. Another factor to be reckoned with over time is the shift in costs resulting from previous misdiagnosis of drug, alcohol, and mental health claims. It is not uncommon for the family physician to label these claims differently in order to allow the patient to avoid stigma and discrimination, and to obtain reimbursement where none is provided under drug, alcohol, or mental health.

(I/R Code No. 3250.00)J

Barbara Browne is an officer in The Browne Company, a Washington-based national insurance and tax planning firm. Prior to her association with the firm, Ms. Browne was

# Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

Office Manager for Aetna Life and Casualty in Cleveland, OH.

Raymond F. Browne is an officer in The Browne Company. He attended the University of Maryland. Mr. Browne's articles have appeared previously in this Journal and other publications. Enrolled to practice before the Internal Revenue Service, he has lectured before professional groups throughout the country on tax planning.

Susan T. McLaughlin received her BA at the University of Toronto, MAT at Reed College, MSUP at Columbia University, and EdD at Harvard. Dr. McLaughlin is a healthcare consultant in Washington, DC.

Cynthia D. Wagner received her BA in Economics from Chatham College in 1975. Ms. Wagner is Vice-President for Comprehensive

Benefits Service Co., Inc. Prior to this affiliation she was Vice-President, Sales in the group division of United States Life Insurance Co.

## References:

"Private Health Insurance Coverage for Alcoholism and Drug Dependency Treatment Services: State Legislation That Mandates Benefits Or the Offering of Benefits for Purchase," National Association of State Alcohol and Drug Abuse Directors. Special Report, July 1983.

"Private Health Insurance Benefits for Alcoholism, Drug Abuse, and Mental Illness," Intergovernmental Health Policy Project, The George Washington University, July, 1979.

"Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health

Insurance," Final Report to the National Institute of Mental Health, Susan Sargent, GLS Associates, Philadelphia, June 1979.

"Oregon's Experience with Remodeling Insurance Benefits for Mental Health and Chemical Dependency," Report to the 63rd Oregon Legislative Assembly on Implementation of Chapter 601, Oregon Laws 1983.

"Mandated Mental Health Benefits Under Private Insurance: A Review of State Laws," Center for Health Policy Studies, 5865 Robert Oliver Place, Columbia, MD 21045.

"Formal Policy Statement on Youth Alcohol and Drug Problems Adopted By The American Bar Association On July 10, 1985."

"A Study of Effectiveness of the Texas Legislation for the Coverage of Alcoholism and Drug Abuse," prepared by Rudd and Wisdom—1985.

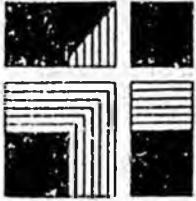
## U.S. POSTAL SERVICE STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Required by 39 U.S.C. 3685)

1. Title of Publication: Journal of the American Society of CLU & ChFC
  - 1a. Publication No.: 119120
2. Date of filing: September 10, 1986
3. Frequency of issue: Bimonthly
  - 3A. No. of issues published annually: 6
  - 3B. Annual Subscription Price: \$24.00
4. Complete mailing address of known office of publication: 270 Bryn Mawr Avenue, Bryn Mawr, PA 19010
5. Complete mailing address of the headquarters of general business offices of the Publisher: 270 Bryn Mawr Avenue, Bryn Mawr, PA 19010
6. Names and complete addresses of publisher, editor, and managing editor: Publisher: American Society of CLU & ChFC, 270 Bryn Mawr Ave., Bryn Mawr 19010, Editor: Kenneth Black, Jr., CLU, Georgia State University, Univ. Plaza, Atlanta, GA 30303, Managing Editor: Edward H. Armsby, American Society of CLU & ChFC, 270 Bryn Mawr Ave., Bryn Mawr, PA 19010
7. Owner: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Items must be completed.) American Society of CLU & ChFC, 270 Bryn Mawr Avenue, Bryn Mawr, PA 19010
8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state) None
9. For completion by nonprofit organizations authorized to mail at special rates (Section 423, 12 DMH only) The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes has not changed during preceding 12 months.

	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
10. Extent and nature of circulation		
A. Total No. Copies Printed (Net Press Run)	42,265	42,582
B. Paid Circulation		
1. Sales through Dealers and Carriers, Street Vendors and counter sales	None	None
2. Mail Subscription	39,751	41,220
C. Total Paid Circulation (Sum of 10B1 and 10B2)	39,751	41,220
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	248	205
E. Total Distribution (Sum of C and D)	39,999	41,425
F. Copies Not Distributed		
1. Office Use, Left Over Unaccounted, Spoiled after Printing	2,266	1,157
2. Returns from News Agents	None	None
G. Total (Sum of E, F1 and 2—should equal net press run shown in A)	42,265	42,582

I certify that statements made by me above are correct and complete.  
F. Robert Titus, Mgr. Support Svcs.

Honorable John Sand - Please let me know when the hearing will be on SB. # 67. I will testify if it is by teleconference in Anch. Thank you so much for your interest -



**Samaritan Counseling Center of Alaska**

Expressing the love of God via counseling.

4502 Cassin Drive, Anchorage, Alaska 99507 • (907) 563-4325

*Allen Price*

February 26, 1988

Raymond Norman Fedje, Ph.D., D.D.  
Executive Director

Ref.: L-K-1008

3661 Hazen Dr.  
Anch AK 99515  
(907) 344-6278

Senator Jan Faiks  
P.O. Box V  
Juneau, Alaska 99811

Reference: CS FOR SENATE BILL NO. 67 (HESS)

Allen & Nancy Price  
3661 Hazen Circle  
Anchorage, AK 99515

Dear Senator Faiks:

On behalf of our Board of Directors and staff (please see the attached list), I am writing to you regarding Senate Bill No. 67 (HESS) asking for inclusion of Pastoral/Christian Counseling Centers, such as the Samaritan Counseling Center of Alaska.

We are suggesting as an amendment to Sec. 8.B.IV, line 14 through 18 or as an additional paragraph (v), the following be added:

A PASTORAL COUNSELING CENTER WHERE STAFF PROVIDERS HAVE AN ACCREDITED DEGREE IN COUNSELING OR PSYCHOLOGY AND WORK UNDER THE DIRECT SUPERVISION OF A LICENSED PSYCHOLOGIST OR PSYCHIATRIST (M.D.).

This past year we served 652 clients for a total of 6,071 therapy hours. Our staff is supervised by W.A. Cassell, M.D., F.A.P.A., License No. AA1533, with Dr. O. Matsutani, consulting psychiatrist, and Dr. Nancy E. Sydnam, M.D., as our consulting medical officer. Being included in the bill would make it less of a burden for our clients' to rely on their insurance for sessions given within the context of Pastoral Psychotherapy especially during our economically difficult times.

We do not receive state, federal or local funds for these services, so this would be most helpful to the Center in meeting the needs of the community.

Should you have particular questions, I would be happy to appear before your committee or answer questions for you.

Your consideration and support for this inclusion would be appreciated.

Sincerely yours,

SAMARITAN COUNSELING CENTER OF ALASKA

Raymond Norman Fedje, Ph.D.  
Executive Director

RNF:iw

Enclosures

# Alaska State Legislature

## Committees:

Chair-State Affairs  
V. Chair-Judiciary  
Telecommunications  
Special Ethics  
Legislative Council  
Finance Subcommittee  
for the University of Alaska  
Joint Committee  
on Economic Recovery



P.O. Box V  
Juneau, Alaska 99811  
(907) 465-4947

**REPRESENTATIVE FRAN ULMER**

March 1, 1988

Allen Price  
3661 Hazen Circle  
Anchorage, AK 99515

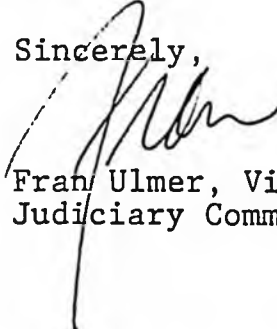
Dear Mr. Price:

Thank you for your note regarding Senate Bill 67 and requesting amended language to include a pastoral counseling center.

I have shared a copy of your letter with the Committee and have requested that you be notified by committee staff when the bill will be heard.

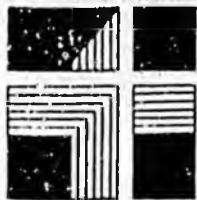
Thank you for sharing your concerns.

Sincerely,

  
Fran Ulmer, Vice Chair  
Judiciary Committee

cc: Representative John Sund, Chair  
w/attachment

2-26-88 Vics Chair Program - Please let me know when hearing is on SB #67. I feel addition of this material important to Alaska



Thank you so much

Allen Price

**Samaritan Counseling Center of Alaska**

Expressing the love of God via counseling.  
4502 Cassin Drive, Anchorage, Alaska 99507 • (907) 563-4325

3661 Hazen Circle  
Anchorage, AK 99515  
(907) 344-6078

February 26, 1988

Raymond Norman Fedje, Ph.D., D.D.  
Executive Director

Ref.: L-K-1008

Senator Jan Faiks  
P.O. Box V  
Juneau, Alaska 99811

Reference: CS FOR SENATE BILL NO. 67 (HESS)

Allen & Nancy Price  
3661 Hazen Circle  
Anchorage, AK 99515

Dear Senator Faiks:

On behalf of our Board of Directors and staff (please see the attached list), I am writing to you regarding Senate Bill No. 67 (HESS) asking for inclusion of Pastoral/Christian Counseling Centers, such as the Samaritan Counseling Center of Alaska.

We are suggesting as an amendment to Sec. 8.B.IV, line 14 through 18 or as an additional paragraph (v), the following be added:

A PASTORAL COUNSELING CENTER WHERE STAFF PROVIDERS HAVE AN ACCREDITED DEGREE IN COUNSELING OR PSYCHOLOGY AND WORK UNDER THE DIRECT SUPERVISION OF A LICENSED PSYCHOLOGIST OR PSYCHIATRIST (M.D.).

This past year we served 652 clients for a total of 6,071 therapy hours. Our staff is supervised by W.A. Cassell, M.D., F.A.P.A., License No. AA1533, with Dr. O. Matsutani, consulting psychiatrist, and Dr. Nancy E. Sydnam, M.D., as our consulting medical officer. Being included in the bill would make it less of a burden for our client to rely on their insurance for sessions given within the context of Pastoral Psychotherapy especially during our economically difficult times.

We do not receive state, federal or local funds for these services, so this would be most helpful to the Center in meeting the needs of the community.

Should you have particular questions, I would be happy to appear before your committee or answer questions for you.

Your consideration and support for this inclusion would be appreciated.

Sincerely yours,

SAMARITAN COUNSELING CENTER OF ALASKA

Raymond Norman Fedje, Ph.D.  
Executive Director

RNF:iw

Enclosures

## PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE SUND

NAME: BEATRICE ROSE

TITLE:

ADDRESS: 2263 KISSEE COURT

CITY: ANCHORAGE

ZIP: 99517

PHONE: 243-4806

BILL NO: SB 67

SUBJECT: HEALTH INSURANCE FOR MENTAL CONDITIONS

MESSAGE: MENTALLY ILL PEOPLE DO HAVE A DISEASE AND DESERVE TREATMENT.

INSURANCE COMPANIES INFLATE THE COST BY NOT REIMBURSING THERAPY GIVEN BY  
 CLINICAL SOCIAL WORKERS WHO CHARGE LESS THE PSYCHIATRIST. I URGE YOU TO VOTE  
 FOR SB 67 AMENDED TO INCLUDE SERVICES OF CLINICAL SOCIAL WORKERS.

POMID: 03081526

DATE: 02/23/88

TIME: 08:15:26

LIONAME: ANCHORAGE LIO

COPIES: REPRESENTATIVES

BARNES  
 COTTEN  
 GRUENBERG  
 NAVARRE  
 TAYLOR  
 ULMER  
 ADAMS  
 BOYER  
 BROWN  
 DAVIS  
 FRANK  
 GOLL  
 LARSON  
 POURCHOT  
 RIEGER  
 SWACKHAMMER  
 WALLIS

## PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE SUND

NAME: JERRY MCCUTCHEON

TITLE:

ADDRESS: 121 W 11TH AVE

CITY: ANCHORAGE

ZIP: 99501

PHONE: N/R-

BILL NO:

SUBJECT: STATE BAILOUTS

MESSAGE: FINANCE THOSE WHO USED POOR JUDGEMENT AGAINST THOSE WHO USED PRUDENT  
 JUDGEMENT. BAILOUTS ABSORB THE AVAILABLE MIONNEY FOR PUBLIC PROJECTS WHICH  
 COULD HAVE PRODUCED JOBS AND, IN TURN, KEPT MORE PEOPLE IN THEIR HOMES WHICH  
 WOULD PRODUCE MORE JOBS. BAIL OUT MONEY ENDS UP IN FEDERAL HANDS AND LEAVES  
 THE STATE OF ALASKA.

POMID: 03092405

DATE: 02/23/88

TIME: 09:24:05

LIONAME: ANCHORAGE LIO

COPIES: REPRESENTATIVES REPRESENTATIVES SENATORS

ADAMS	BARNES	ABOOD
BOUCHER	BOYER	BINKLEY
BROWN	CATO	COGHILL
COLLINS	COTTEN	DUNCAN
DAVIDSON	DAVIS	ELIASON
DONLEY	ELLIS	FAHRENKAMP
FRANK	FURNACE	FAIKS
GOLL	GRUENBERG	FANNING
GRUSSENDORF	HANLEY	FISCHER
HERRMANN	HOFFMAN	HALFORD
HUDSON	KOPONEN	HENSLEY
LARSON	MARTIN	JONES
MENARD	MILLER	JOSEPHSON
NAVARRE	PEARCE	KELLY
PETTYJOHN	PHILLIPS	KERTTULA
POURCHOT	RIEGER	RODEY
SHULTZ	SPRINGER	STURGULEWSKI
SWACKHAMMER	TAYLOR	SZYMANSKI
ULMER	WALLIS	UEHLING
ZAWACKI		ZHAROFF



*OK Lumber Company, Inc.*  
*Building Supply Center & Hardware*

March 14, 1988

P. O. BOX 10449  
FAIRBANKS, ALASKA 99710  
(907) 457-8270  
FAX (907) 457-3122

Senator John Binkley  
Representative Mark Boyer  
Senator Faiks  
Representative Menard,

Ref: SB363 and HB 403 (the same)  
Ref: SB67 and HB 440

Sirs and Ms. ;  
75% of the small business in this state of Alaska in 1986 have voted against this type of insurance! Do you not pay attention to what we have to say via the NFIB (National Federation of Small Business)

If we have a drug and alcohol problem, then it's our personal responsibility to take care of it.. IT IS NOT THE RESPONSIBILITY OF THE TAXPAYERS to take care of our vices! If one plays with fire..he or she had better be prepared to be burned! Vote against this program. Senator Binkley and Representative Boyer, I urge you to listen to the taxpayers and those small business's that keep the taxpayers and you employed. Vote against this type of insurance.

Senator Faiks. I urge you to vote against this bill you have your name tagged to. This is still a free country, but with the legislation you people are trying to put into being..it soon won't be!

Rep. Menard, So now you all got your way with pregnancy coverage; letting the government stick its nose into peoples private affairs, Now you have to cover the other side that can't get pregnant! What next? Insurance to cover the mongrel stray dog that made your dog pregnant? And of course, then an insurance to cover the cat that can't have a litter of kittens?

To all of you, are we in a free country? Are we to be subjected and liable for everyones vices and personal affairs? I urge you to take responsible action, and cool down your desires to become A SOCIALIST GOVERNMENT! Read your history books..Socialism does not make a strong country!

Sincerely yours,

Angie Kruckenberg

Copies to all who represent me in Alaska



*OK Lumber Company, Inc.*  
*Building Supply Center & Hardware*

March 11, 1988

P O BOX 10449  
FAIRBANKS, ALASKA 99710  
(907) 457-6270  
FAX (907) 457-3122

Ref: Workmans Comp article, as in todays Newsminer, inclosed.

To my representatives, legislators, senators, and to all those who represent me in my Government.

Sirs/Ms.;

In reference to paragraph 1 and 2. This is the main problem of the high costs of insurance. Is there any paper trace by the state, upon the insurance carriers, of the employers claim costs that are in reserves? And is there any paper trace of the insurance carriers ever returning these amounts back to the employer? \*\*\*see exhibit 1\*\*\*

In my case, and I am inclosing my total history of claims in this letter. I can show you where the reserve amounts have sat dormant, as a cost to me, while the insurance company collected interest, and charged me higher costs in the high risk pool, while these funds were not used. \*\*exhibit 2\*\*\*

I am complainly highly because this one case, (JUNE 13. 1985) of an employee who broke an ankle when he said he fell off the trailer bed, with no witnesses. The Coastal people told me he stepped out of the truck and broke his leg. Flippo tells me he stepped off the end corner of the trailer between it and the truck. When Coastal called me about it, I immediately called Humana Hospital where they took him, to request a blood test, as he seemed very "funny acting" when he left my office. I was told that they could not do that. This was the man's third trip to Anchorage for us and he knew that this was just a temporary situation.

We all know that 1985 in Alaska took a nose dive as far as the economy goes, and MANY employees used workmans compensation for their means of support in this declining era. If each case was thoughtly investigated during this time period, you would see MASSIVE FRAUD by employees, the medical association and the legal professions. They all wanted to live in the manner that they became accustomed to during the BOOM years! (And we have only 3 fraud investigators in the entire State!)

Page 2

It was later, upon getting back all the references and the inquiries into his history that I found out that he had lied on his application with me. He wrote that he had NEVER been in an accident. (when in fact he had three with his past employer, "Wickland Oil Transport" 1st one not chargable to him. 2nd one could have been avoided by himself. In the 3rd one he killed several people! And in this one he collected workmans compensation from the state of California! YET ON HIS APPLICATION FORM HE TELLS ME HE HAD NEVER EVER COLLECTED COMPENSATION! AND HE SAYS HE NEVER HAD AN ACCIDENT! (This was told to me by telephone by his ex-boss Gerry Heifner for whom he worked from 6/78 to 3/85) I have his payroll files in my office and will send you all pages if you request.

I have talked to each of my insurance agents and NO ONE WOULD INVESTIGATE THIS CASE! In 1987 I had someone investigate where he lives and what he does. He lives in a high income area, a very elaborate home, with swimming pool and emmensities that many people would desire. He manages a condominium or apartment complex, and it would not surprise me if he isn't a partner in it.

With a figure of almost half a million dollars on this case, I was told 1st by Dorothy Ronning, of Dawson Insurance (1985 agent), and then by Kathy, 1986 and 1987 agent at James and Associates, in Seattle, Ws. that the amount is TOO LITTLE FOR THE INSURANCE COMPANY TO INVESTIGATE!

Sure, why should they investigate? It will only cost them money...when in fact all they have to do is "set aside a reserve" for this account..against my account, add it to the many other employer "reserve" accounts in the same situation, CALL A MEETING WITH THE STATE OF ALASKA GOVERNMENT, tell our state people that they (THE INSURANCE COMPANYS) have to have MORE MONEY! SO UP GOES THE INSURANCE RATES FOR WHATEVER % THEY ASK FOR; And all the time all these reserves (listed as additional claim costs) are sitting in their bank accounts drawing more interest!

OF COURSE THE MORE THEY CAN SHOW AS TO HOW HEAVY THE CLAIMS ARE, THE MORE PREMIUM THAT THEY CAN CHARGE US!!

Have you people who are representing us looked at this side of the coin? Please do, if you haven't! I don't know how long we employers will last at the rate it is going now!

TRUSS FABRICATION PLANT • DOORS • WINDOWS • CABINETS

FACILITIES LOCATED AT 649 ROHLOFF STREET, JUST OFF OF 4 MILE OLD STEESE HWY., ACROSS FROM CURRY'S CORNER

Why isn't it possible for employers to get a history of employees on the following:

1. Driving records, every state.
2. Proof of medical certificates, and Doctors address on same. see attached. \*\*\*exhibit 3\*\*\*The doctor's name is not signed as an "MD!" And no address to check it out for my protection as an employer!
3. Workmans compensation records, every state.
4. The permission to request another physician's examination if something seems to appear fraudulent. And when it is shown as fraudulent (my case, 4/1/78 John Balsh. another Doctor wrote me that this injury was not due to his work at our place, but a prior problem he had.) see #5 below.
5. Cooperation from the state and/or insurance company for investigation, if an employer finds there are abuses here.
6. Every employer to receive from his carrier, a loss claim record of injured employees without the hassel of going through his agent, who sometimes does not want to bother. It's almost like they want to keep it a secret!  
Plus, many self employed people have no knowledge of what to ask for to protect themselves, to be aware of what is going on in their workmans comp account.

If these above items were possible, these types of people would not go from state to state, taking advantage of their employers with accidents coverage by workmans compensation. Nor would it be allowable for doctors to dig up 30 and 40 year old childhood injuries, and add it to a simple scratch, protect it by a band-aid, and expand a \$100. workmans comp visit, into over \$100,000. of costs. Inclosed is a picture of this injured employee, 7 hours after the accident, at a company picnic on July 22, '986. \*\*exhibit (4)\*\* This band aid injury tacked on a clai ost of \$112,000. to my account!

With only 3 fraud investigators in the state, how do I as an employer protect myself from this kind of problem?

There should be limits set to the costs charged by the medical profession and the legal profession. Present method makes it easy and lucrative for them, because it is a workmans compensation injury. See copy of different cost scales for this chiropratic clinic attached. \*\*\*exhibit 5\*\*\* I am sure if medical clinics were checked, you would see similar differences as I show you here, but with only 3 fraud investigators in Alaska, its very easy to "get away with it".

Again, how can employers protect themselves of this? We are not ever told or given reports of what is going on with the injured employee! It is our premiums that pay for this, we employers of all people should be allowed to know!

In the past 15 years, we have had over 700 employees on our payroll. Per my OSHA records. I had 42 accidents: 27 with No Days Lost. 9 with a total of 13 days lost. 1 with 2 weeks lost. 1 with 42 days lost. 1 with 3 months lost. 1 fraud that was caught. 2 still outstanding, both fraudulent, but still collecting.

1973 42 accidents.	1974 4 accidents.	1975 1 accident.
1976 1 accident	1977 1 accident	1978 2 accident
1979 NO ACCIDENTS.	1980 2 accidents.	1981 1 accident.
1982 8 accidents.	1983 4 accidents.	1984 NO ACCIDENTS
1985 6 accidents	1986 11 accidents	1987 3 accidents.

*Mass of these all are individual bills a long list on 2.*

If I had cooperation of suspicious cases, the entire cost of workmans compensation claims for this firm for 15 years, would be less than the premium that I paid in this 1 year for 1987. See attached 1987 total premium cost. *exhibit 6*

If we cannot get proper audit controls of the insurance companys showing the ACTUAL claims paid, instead of the fictitious reserve\* accounts being added to the claim costs, thus throwing an inflated amount of claim costs upon the employers, of which they base the employers premiums costs; I'd like to suggest the following:

Is it possible to drop all insurance carriers, let the state start from scratch, and underwrite the workmans compensation insurance, with adequate investigators, and set limits on each and every injury what ever it may be, (example; a finger worth 1000., an arm 50,000. etc.) If this method were used, it would not be, as lucrative to sacrifice the finger or arm for Workmans compensation funds. Doctors on the other hand would only receive a set amount for that finger or arm. And the legal profession would not be so "sue happy" if there was a maximum amount in place.

And then perhaps, by the employers track and safety records, the state would allow them to have certain limits by which they could self-insure. In addition, have a state fund, (collected from all employers to cover certain catastrophic injuries that are reviewed by a board and thoroughly investigated.)

Also, make it mandatory that every employer would get at least a quarterly report of all costs that occur in that employers claim record.

Thank you for hearing me out. Please advise if anything in these areas can be corrected.

Sincerely yours,

*Angie Kruckenberg*  
Angie Kruckenberg

begin arriving late Saturday even-

(See GAMES, Page 5)

Games corporation.

most recent recession... and the gains of the boom that

# Legislator problem: to cut worker comp rates or revise state law

By LARRY PERSILY  
Associated Press Writer

JUNEAU—Legislators disagree on whether the state should force insurance companies to lower worker's compensation rates or just revise the compensation law and hope for a rate decrease.

Opposition to mandatory rate reductions also is coming from insurance companies and the state insurance director.

The Senate last month passed a major rewrite of worker's compensation laws, but the House Labor and Commerce Committee chair in said Thursday the bill is inadequate and he wants to change it.

The Senate bill (SB322) does not require insurance companies to lower their rates. The bill was drafted with help from a statewide labor and management task force.

A proposed House substitute would require companies to decrease their rates by 6 percent for 18 months.

"We're asking worker's to agree to some compromises . . . and in that process one of our primary goals is to reduce rates," said Rep. Dave Donley, Labor and Commerce chairman.

The Anchorage Democrat said,

"The Senate bill fails to address many legitimate public concerns and is a mediocre product that does not adequately or fairly address the issues hundreds of Alaskans have asked us to address."

Senate Labor and Commerce Committee Tim Kelly said he is nervous about a mandated rate decrease.

"You might see insurance companies decide not to offer coverage up here," Kelly said, noting that although the state can require rate cuts it cannot require companies to do business in Alaska.

The Anchorage Republican said employers could find it difficult to obtain coverage if an excessive mandatory rate reduction forces companies to stop writing policies in Alaska. That would defeat the bill's purpose to bring about affordable worker's compensation coverage.

"You've got to have some control over the insurance industry," Kelly said, because the state requires employers to carry the insurance. But too much state control of rates could lead to problems, he said.

"At first blush it would appear that mandated rate decreases are attractive," said Paul Roller, acting director of the Division of In-

urance. But the state cannot force a company to write insurance at a loss, he said.

"We are opposed to mandatory rate decreases because they are unworkable," Roller said.

Alaska employers spent about \$180 million on worker's compensation insurance in 1987. Recent rate increases and fears of another major increase prompted legislators, labor and management representatives to join forces in an attempt to rewrite state laws setting out benefits for injured worker's.

The bill would restrict claims for stress-related injuries, reduce benefits to people living out of state, limit rehabilitation services and change several other aspects of the program, with the intent of lowering costs to insurance companies and rates to employers.

A letter of intent accompanying the Senate bill said the measure is expected to result in at least a 2 percent drop in rates, but letters of intent do not carry the force of law.

Fewer cases going to litigation, lower rehabilitation costs and fewer stress-related claims are the major money-savers of the bill.

Roller said Maine tried manda-

(See WORKERS, Page 5)

Shultz said, underscoring the seriousness with which the United States views the situation there.

He accused Noriega of trying to impose a military coup in Panama by deposing President Eric Arturo Delvalle, whom the United States regards as the legitimate constitutional authority.

Under the Caribbean Basin Initiative, Panama and about 20 other countries are eligible to sell most products duty-free to U.S. markets.

But this measure will have mostly symbolic impact because the bulk of Panama's exports to the Un-

## WORKERS

(Continued from page 1)

tory rate cuts in 1985 and the state has suffered through tremendous problems since then, including massive rate increases to return insurance companies to financial stability.

Donley expects to move the bill out of his committee next week, sending it to House Judiciary for further review.

Labor and Commerce members are scheduled to vote Tuesday on the substitute version and other proposed amendments to the Senate bill. If the House changes the bill, it would have to return to the Senate for concurrence with the amendments.

Donley wants to amend the bill to provide a "direct cash incentive for businesses to develop and maintain workplace safety programs." His proposed amendments would require insurance companies to pay a 5 percent to 10 percent rebate of premiums to employers that have an approved safety program and have not been cited for serious safety violations in the past year.

"The total failure of the other body (the Senate) to act on work place safety legislation . . . requires that we try to incorporate some protection for worker's health and safety in the measure before us," Donley said.

Safety incentives are the best way to save lives and save money on insurance, he said.

Fairbanks Daily News-Miner, Fairbanks, Alaska, Friday, March 11, 1988



## Weather helps cut into Redington's lead

News-Miner and AP reports  
RIPPLE—Strong winds and unusually warm temperatures have whittled Joe Redington's lead in the 1,150-mile Iditarod Trail Sled



By the time he decided to move, Herbie Nayokpuk decided his team rested enough to push on. Nayokpuk, known as the Shishmaref Cannonball, had arrived in

ACCOUNT NUMBER 36C411425 ACCOUNT ID 00070435 CURRENT DATE 01/30/87

\*\*\*\*\* A C C O U N T I N F O R M A T I O N R E P O R T \*\*\*\*\* PANEL ID 0509

ACCOUNT SUMMARY: O.K. LUMBER CO., INC.

NAME: SO. K. LUMBER COMPANY, INC.

ADDRESS: P.O. BOX 10449

CITY: FAIRBANKS STATE: AK ZIP: 99701

\*\*\*\*\* ACCOUNT INFORMATION REPORT \*\*\*\*\*

CA195038P IF YOU WISH TO SEE A CLAIM LISTING LINE BY LINE - DEPRESS PFKEY3,  
CLAIM TOTALS - DEPRESS PFKEY4, NO CLAIM LISTING - DEPRESS PFKEY5.

PF KEY: F X F

ACCOUNT NUMBER 36C411425 ACCOUNT ID 00070435 CURRENT DATE 01/30/87

\*\*\*\*\* A C C O U N T I N F O R M A T I O N R E P O R T \*\*\*\*\* PANEL ID 0442

POLICY CLAIM LISTING

ITEM NO.	CLAIM NUMBER	CLAIM DATE	DIR INDEMT AMT	DIR EXP AMT	DIR D/S	DIR INCURRED AMT	R/I INCURRED AMT	RG LINE
01	914G05622700	06/13/85	125401	2470	329417	457288	0	COMP
02	914G05626901	04/24/85	124	26	0	150	0	COMP
03	914G05626902	04/24/85	197	52	0	188	0	COMP
04	914G05626903	04/24/85	152	36	0	188	0	COMP
05	914G05626904	04/24/85	0	90	0	0	0	COMP
06	914G05628500	06/01/85	20520	565	0	21085	0	COMP
***TOTALS***			146394	3239	329417	479050	0	

08

CL573.2  
10J

ALASKA NATIONAL INSURANCE  
LOSS EXPERIENCE

ALL POLICIES AND ASSOCIATED CLAIMS SINCE 1984

PAGE 1  
REPORT DATE: 12/31/87  
RUN DATE: 01/05/88  
EFFECTIVE DATE: 01/31/87

INSURED	ACCIDENT DATE	LINE	CLAIM NUMBER	LOC CAT	LOC CD	PAID LOSSES	PAID MED. LOSSES	ALLOCATED LOSS EXPENSE	NET OUTSTAND LOSS RESERVE	INCURRED LOSS AND EXPENSE
O.K. LUMBER CO., INC.	04/29/85	150	06438	03	000 C5	670.00	462.13	450.62	0.00	1,402.20 CLOS
LARRABEE, ALDEN D.	06/14/85	150	93303	03	030 C6	0.00	61.00	0.00	0.00	61.00 CLOS
LUM JAC. INJURY/CAUSE UNKNOWN	07/14/85	150	06573	00	030 C5	110.07	0.00	0.00	0.00	110.07 CLOS
HARDEN/RJOK, DEAN J.	07/14/85	150	83418	00	000 C6	0.00	311.41	0.00	0.00	311.41 CLOS
FELL OFF TRUCK/CONTUSION	07/22/85	150	06363	00	030 C5	16,006.53	45,046.12	3,360.41	45,586.94	112,000.00
MATTFIELD, PAUL H.	09/26/85	150	83831	00	030 C6	0.00	125.00	0.00	0.00	125.00 CLOS
MOVING TRUSS CART/INJURED LEFT WRIST	09/29/85	160	06765	03	000 C6	0.00	60.00	0.00	0.00	60.00 CLOS
MATTFIELD, PAUL H.	09/29/85	160	83632	00	000 C6	0.00	332.00	0.00	0.00	332.00 CLOS
MOVING TRUSS CART/INJURED LEFT WRIST	10/13/85	160	83992	00	000 C6	0.00	131.00	0.00	0.00	131.00 CLOS
LAHLER, ELWIN J.	11/12/85	150	83391	00	030 C6	0.00	121.00	0.00	0.00	121.00 CLOS
FELL INTO PILE OF LUMBER	12/26/85	150	84181	03	000 C6	0.00	362.00	0.00	0.00	362.00 CLOS
LAHRE, DELANE SCOT										
BOARD FELL & HIT CLMT'S RIGHT HAND										
LILLIE, JOHN V.										
MANUALLY ADJUSTING EQUIPMENT ON TRUCK/BACK										
PARDY, JEFF										
CUT RIGHT HAND ON SKILL SAW										
ADAMSON, ERIC W.										
CLMT'S LEFT HAND STRUCK BY PIECE OF WOOD										
TCOMEX, BILL F.										
INJURED LEFT MIDDLE FINGER WITH HAMMER										
SERRA, JOSEPH P.										
SLIVER FROM BOARD IN RT HAND/INFECTION										
LOCATION TOTALS						16,836.60	47,011.71	3,811.03	45,586.94	115,216.28
INSURED TOTALS						16,836.60	47,011.71	3,811.03	45,586.94	115,216.28

Out of Pool claim experience

If you are in a pool -  
you get a different report.  
Talk us separately

Exhibit



NAME: \_\_\_\_\_

OFFICE CALLS: \_\_\_\_\_ 40

97260-52 Spinal Manipulation	35
97260 LMT Spinal Manipulation	40
97260-14 Spinal Manip. (Sun/Hol)	60
97260 Spinal Manipulation	N/C
A2000 (Medicare) Spinal Manip.	40
00590 (Medicaid) Spinal Manip.	40
97261 Manual Manip Extended	55

X-RAYS WITH ANALYSIS:

72010 Full Spine	*160
72010 Full Spine Re-Check	160
72040 Cerv Pre Pettibon	60
72040 Cerv Obliques (2)	90
72040 Cerv Flex/Ext. (2)	80
72100 Lumbar-AP/Lateral	80
72100 Lumbar-Obliques	80

EXAMS-NEW PATIENTS:

9900 Initial Hist/Exam	N/C
99000 Brief Hist/Exam	45
99010 Limited Hist/Exam	55
99020 Comprehensive Hist/Exam	*155

MEDICAID X-RAYS:

00510 Radiologic exam, spina.cerv	65
00570 Lumbosacral: anteroposterior and lateral	65

SUPPLIES

97700 SPS/PS Checkout	20
99007 SPS/PS Exam/Casting	40
99070 Foot Levelers	**
99070 CryoGel Packs (2)	15
99070 Ortho Cervical-Collar	29
99070 Lumbar Support Belt	45
99070 Cervical SP/Support Block	25
99070 Ortho Lo-Back Spinal Support	28
99070 Exercise Fulcrums	45

EXAMS-ESTABLISHED PATIENTS:

99040 Brief Re-Exam/Evaluation	35
99050 MT. Re-Exam/Evaluation	45
99080 Comprehensive Re-Exam	*120

SERVICES:

97741 Kinesiotherapy: Brief Nimm	20
97740 Ext/Nimm Kinesiotherapy	35
99030 Thermo-Cryotherapy	20
97122 Traction	20
97014 Electric Stimulus	35
97110 Rehabilitation Exercises	15

Week \_\_\_\_\_ Month \_\_\_\_\_

Mon Tues Wed Thurs Fri Sat

( ) RCF ( ) RE ( ) REX

Comments: \_\_\_\_\_

SPECIAL SERVICES:

99010 NSF Charges	25
99010 NSF	40
99010 Consultation	N/C
99060 Chart Notes/Records	25
99080 Narrative Report (page)	40

CHARGE: \_\_\_\_\_ FEE: \_\_\_\_\_

\*\* See Price Lists

40 o/c  
40

all items marked  
- are work in progress  
Comp costs.

W/W.C.  
1st fee  
\$505

If you are  
an individual  
w/ no  
insurance  
the cost is  
35<sup>00</sup> visit  
+ 160<sup>00</sup> exam

Dist Visit W/W.C. Comp.  
W/W.C. insurance  
40<sup>00</sup> visit cost  
+ 120<sup>00</sup> Exam cost  
total w/ work/comp 160<sup>00</sup>

personal visit 35<sup>00</sup> gets exact same service  
By one who has had both!

# PROVIDENCE WASHINGTON INSURANCE GROUP

- PROVIDENCE WASHINGTON INSURANCE CO.      PROVIDENCE WASHINGTON INSURANCE COMPANY OF ALASKA  
 MOTOR VEHICLE CASUALTY CO.      WESTERN ALLIANCE INSURANCE COMPANY  
 YORK INSURANCE COMPANY

- EASTERN REGIONAL OFFICE — 20 Washington Place · Providence, RI 02901  
 MIDWESTERN REGIONAL OFFICE — 209 North York Street · Elmhurst, IL 60126  
 ALASKAN REGIONAL OFFICE — 301 W. Northern Lights, Suite 501, Anchorage, AK 99503  
 SOUTHWESTERN REGIONAL OFFICE — 7715 Chevy Chase Drive · Austin, TX 78761

DATE	2/12/88
CANCELLED	<input type="checkbox"/> P/R <input type="checkbox"/> S/R
POLICY NUMBER	WC 760628

INSURED O.K. LUMBER COMPANY, INC.	LOCATION	POLICY PERIOD 1/19/87 to 1/19/88
AGENT # NAME 469 FRED S. JAMES (ASSIG NED RISK)	LOCATION	AUDIT PERIOD SAME to

CLASS	DESCRIPTION	BASIS OF PREMIUM	RATE	PREMIUM	RATE	PREMIUM	RATE	PREMIUM
AK								
8232	to 1/1/88	40,886	16.22	6,632.00	} 19968	} 3994 - high risk cost added		
758		120,708	3.54	4,273.00				
.02		80,164	10.06	8,064.00				
8810		95,822	.82	786.00				
8742		20,439	1.04	213.00				
9898	Experience Mod <u>1.20</u>			23,962.00				
0900	Expense Constant	<u>358019</u>		114.00				
8232	from 1/1/88	1,249	15.44	193.00	} 538 perm. + H risk added			
8058		4,036	5.05	204.00				
2802		952	12.59	120.00				
8810		<u>2,606</u>	.82	21.00				
9898	Experience Mod <u>1.20</u>	<u>8843</u>		646.00				
0900	Expense Constant	<u>366.862</u>		15.00				

COLUMN  
TOTALS

NOTE: All premiums shown have been fully earned. Payment is therefore due immediately on presentation of this bill.

*My cost to insurance Company →*  
24,747.00  
  
*My claims including 200% Reuse for 1987*  
76160

EARNED PREMIUMS (DETAIL ABOVE)	24,737.00
LESS PREMIUMS PREVIOUSLY CHARGED	16,189.00
ADDITIONAL <del>XXXX</del> PREMIUMS	8,548.00

STATEMENT

INSURED'S COPY



# Alaska Association for Marriage and Family Therapy

A DIVISION OF THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

President  
JOHN A. PAGAN, M. S.

President Elect  
RANDALL JONES, M. A.

Past President  
MERCY DENNIS, M. A.

Secretary  
PAMELA E. KIRK, M. S.

Treasurer  
KATHLEEN A. HOLMES, M. S.

Board Members  
LEON T. WEBBER, D. Min.  
ROBERT NELSON, Rel. D.  
SARA GRIFFITH, M. Ed.  
FREDERICK HILLMAN, M. D.

April 5, 1988

*Smith color for  
electronic - DRAB*

To: Representative Sund

From: Mercy Dennis

RE: SENATE BILL NO. 67

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

I wish to bring to your attention that this bill does not allow for consumer freedom of choice for mental health care providers. By requiring that the mental health care provider have "a masters or doctoral degree in psychology, nursing, or social work" the bill excludes several areas of nationally recognized and accredited training and educational programs that produce competent professionals in the mental health field. I have two suggestions that would allow for this bill to better serve the people in Alaska seeking mental health services.

1. Sec. 21.42.365 (c) (9) (D) to read "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, social work, or **equivalent related field:** or "

Another solution to this problem would be:

2. ADD under Sec. 21.42.365 (c) (9) (F)

(F) a Marriage and Family Therapist who is

(i) licensed or certified as a marriage and family therapist by a state: or

(ii) a clinical member of The American Association for Marriage and Family Therapists;

Thank you for your consideration on this important matter.

cc Members of House Judiciary Committee

# ALASKA STATE SENATE

JOE P. JOSEPHSON  
DISTRICT H ANCHORAGE  
3111 C STREET, SUITE 550  
ANCHORAGE, ALASKA 99503  
(907) 561-7611



WHILE IN JUNEAU  
P.O. BOX V  
JUNEAU, ALASKA 99811  
(907) 465-4525

March 8, 1988

Raymond Norman Fedje, Ph.D.  
Executive Director  
Samaritan Counseling  
Center of Alaska  
4502 Cassin Drive  
Anchorage, Alaska 99507

Dear Ray:

Thanks for your note of February 26. I supported SB 67, which has passed the Senate.

I am forwarding a copy of your note to my House colleague, Representative John Sund, who chairs the House Judiciary Committee, so that he can be aware of your recommendation for a possible amendment.

I will await House action with interest. Truth to tell, I strongly support the objectives of SB 67, but I think we need to be assured, especially in these difficult times for employers, that the passage of the bill will not accelerate a flight from group insurance for health in general.

I have also enclosed copy of the latest version of this measure, as it passed out of the House Health, Education and Social Services Committee.

With best personal regards, I am

Sincerely,

A handwritten signature in cursive script, appearing to read "Joe P. Josephson".

Joe P. Josephson  
State Senator

JPJ:rak  
Enclosure

✓ cc: Representative John Sund

# Alaska State Legislature

MAR 28 1988

SENATOR  
ARLISS STURGULEWSKI

Chairman, Senate Community and Regional Affairs Committee  
Vice-Chairman, Senate Judiciary Committee  
Member, Senate Resources Committee



2957 SHELDON JACKSON STREET  
ANCHORAGE, ALASKA 99508

While in Juneau  
P. O. BOX V  
JUNEAU, ALASKA 99811  
(907) 465-3818

Senate

A handwritten signature, likely of Arliss Sturgulewski, written in dark ink.

March 25, 1988

Pamela Kirk  
SR 9817 Hiland Drive  
Eagle River, AK 99577

Dear Pamela:

Thank you for your recent letter regarding SB 67 "An Act relating to insurance coverage for the treatment of a mental or nervous condition." This bill passed the Senate with my support on May 8, 1987.

Senate Bill 67 is currently in the House Judiciary Committee. I will send a copy of your letter to Representative John Sund who is chairman of that committee so he is aware of your concerns with the bill.

Kindest regards,

Arliss Sturgulewski  
Alaska State Senator

cc: Representative Sund

FREDERICK J. HILLMAN, M.D.

DENALI NORTH THERAPY ASSOCIATES  
2550 DENALI STREET - SUITE 905  
ANCHORAGE, ALASKA 99503

(907) 258-1121

15 March 1988

Mr. John Sund  
Chairman, House Judiciary Committee  
Alaska State Legislature  
Pouch V  
Juneau, AK 99811

*Shove*

Dear Mr. Sund,

Recently I sent a Public Opinion Message to  
Senator Ellis and Senator Koponen regarding SB 67  
(health insurance for mental conditions) and received  
a response which then led me to write to them to enlarge  
my previous brief remarks. Since SB 67 is now in your  
committee, I am enclosing a copy of my letter to them  
and hope that you will find it of interest.

Sincerely yours,

*Frederick J. Hillman*

Frederick J. Hillman, M.D.

STATE OF ALASKA  
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY  
LEGISLATIVE REFERENCE LIBRARY

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

Mary Van Nimwegen

H. Jud      May 5, 1988      1:30pm



ALASKA STATE LEGISLATURE  
HOUSE OF REPRESENTATIVES  
RESEARCH AGENCY

Pouch Y, State Capitol  
Juneau, Alaska 99811  
(907) 465-3991

April 29, 1985

TO:

FROM: Nathan Sherwood  
Legislative Analyst

RE: Mental Health Insurance  
Research Request 85-314

You requested that we respond to the following questions:

- What types of health insurance coverage does the State now mandate?
- Does the State require an employer to pay a portion of the premium for health insurance or can entire premiums be passed through to the employee?
- What would be the cost of optional mental health insurance benefits providing the same copayments, deductibles, and length of coverage as physical health insurance?
- Could the State require that optional mental health insurance be offered to individuals on group policies?
- What is the Hill-Burton Act and how does it relate to the funding of mental health services?

State Requirements for Health Insurance

Under current Alaska law, employers are not required to provide health insurance coverage for employees. Alaska Statute 21.51 and AS 21.54, the chapters addressing disability and group disability policies respectively, contain requirements that health insurance policies must meet; however, there is no provision which requires an employer to offer, provide, or pay for any employee health insurance. This circumstance has been used to argue against mandating specific kinds of health coverage; critics argue that if the cost of procuring insurance for employees becomes too high, employers may exercise their option not to provide any health coverage.

April 29, 1985  
Page Two

### Cost of Optional Mental Health Coverage

The potential cost of optional mental health insurance depends on a number of factors. The types of services covered, the dollar limits on coverage, and provisions for copayments and deductibles affect the cost of an insurance policy. Furthermore, it makes a significant difference whether the State permits the choice of purchasing mental health insurance to be made for a group as a whole or requires that each individual within the group be given the option of purchasing mental health insurance.

If the choice is made at the group level, then costs should be comparable to the costs of mandated group mental health coverage. Martin Tirador, with Blue Cross of Washington and Alaska, noted that the costs for group coverage under a mandated offering would be somewhat higher than under mandated coverage because not every group would elect coverage, thus, there would be fewer people across which to spread the risks and administrative costs of the mental health coverage. According to Mr. Tirador, Blue Cross estimates that under SB 295, which mandates a mental health coverage offering, the rate for employee-only coverage under a group basic and major medical plan with a \$100 deductible would increase an average of 6.8 percent for all group sizes. For a group of 5-10 persons, the increase comes to about \$7.45 per month per employee.

This estimate is considerably higher than the estimate of \$3.54 per month for each family covered that Blue Cross made for coverage mandated under HB 313; however, Mr. Tirador stated that Blue Cross is in the process of revising its estimate for HB 313, and the company anticipates that it will be much closer to the estimates for SB 295.<sup>1</sup>

If mental health insurance were offered at the individual level, with the person choosing between coverage and some other alternative, then the cost of the insurance will probably be higher. When individuals are given the option of buying insurance or not, adverse selection usually occurs--the people who choose insurance are those most likely to make claims against the policy. Individuals who perceive little likelihood of using the covered services will not elect to buy coverage, preferring to use their money for some other purpose. This concentration of high risk individuals in the pool of insured individuals leads to higher per person costs of insurance than when the risk is spread across a group that includes lower risk individuals as well.

In the extreme case, adverse selection can price all but a few out of a market for insurance. As the price increases, individuals who do not

---

<sup>1</sup>I will provide you with the revised estimates for Blue Cross insurance costs under HB 313 as soon as I receive them.

April 29, 1985  
Page Three

anticipate heavy usage of the covered service will be even less likely to purchase insurance. In turn, prices must rise to reflect the increasing concentration of high risks in the pool of insured individuals and even more people will opt out of insurance coverage.

Of course, not everyone has an accurate perception of the probability of their needing mental health services. Some individuals may overestimate the risk. In addition, some individuals may place a high value on security even if they perceive only a small chance that they will need services. These people might purchase mental health insurance even at a higher price than the probability of their needing the coverage would otherwise justify. To the extent that people with below average utilization of mental health services elect to purchase insurance, the effects of adverse selection will be moderated.

#### State Requirement for Individual Choice of Mental Health Option

A requirement for each individual covered under a group health plan to be offered mental health coverage could work in many different ways. The cost of the coverage could be borne by whoever pays for the group health plan or the premiums could be separate, paid for by the individual selecting mental health coverage. Rates could be the same for all members or could differ according to the risk associated with various classes of individuals.

J.P. Tangen, who represents the American Council of Life Insurance, stated that he did not see any legal problem with simply requiring insurers to make a mental health insurance plan available to individuals, assuming they bore the cost of the coverage themselves. John George, Director of Insurance for the Department of Commerce and Economic Development, mentioned that there are questions as to the extent to which the federal Employee Retirement Income Security Act (ERISA) preempts state regulation of employer-provided health insurance, the major form of group health insurance in Alaska.

John Ambrose, with the National Mental Health Association, was not aware of any state with a mandated offering of mental health coverage which required that the individual be offered the choice of whether to purchase mental health coverage. The decision is usually made for the group.

There may be some practical problems with offering the mental health coverage on an individual basis. As noted earlier, there is the question of who is to pay for the coverage. If an employer pays for the coverage, employees presumably would be offered some alternative benefit. For individuals to have a meaningful choice, they must be given an alternative; if there is no cost to the insurance or no alternative

April 29, 1985

Page Four

benefit is foregone, then virtually everyone would choose mental health insurance.

Some employers, such as the State of Alaska, offer their employees supplemental benefit packages from which employees are permitted to choose options. Mental health insurance could be offered as an option in such a package.

If employees were required to purchase insurance out of their own pocket, they would be using money for which they may have incurred some tax liability. By shifting the cost of the insurance from pretax to posttax dollars, the cost of mental health coverage may be increased, as deductions for health care do not cover all health care expenses.

Another potential problem is the rate structure for mental health coverage. Some of the individuals whom we contacted noted that because of the problems of adverse selection, a single rate for all members of a group selecting mental health coverage could be very expensive. However, individual rates based on risk could prove cost prohibitive to the individuals most in need of coverage.

#### The Hill-Burton Act

The Hill-Burton Act generally refers to the Hospital Survey and Construction Act of 1946 and its subsequent amendments. One of the features of the act was that state, municipal, and nonprofit health care facilities were eligible to receive capital project grants. In return, the facilities were required to provide a level of uncompensated care to needy patients.

Under the formula established by the Hill-Burton Act, the facilities were required to provide each year for twenty years the lesser of:

- 1) uncompensated care equal to 10 percent of the Hill-Burton grant, indexed to the Consumer Price Index for inflation; or
- 2) uncompensated care equal to 3 percent of the facility's operating costs.<sup>2</sup>

Every facility with a Hill-Burton obligation must offer uncompensated care to individuals with incomes that fall below the federal poverty

---

<sup>2</sup>Facilities receiving grants under Title XVI of the Public Health Act must also meet the annual uncompensated care requirements shown; however, there is no limit to the duration of that obligation. It continues indefinitely.

standards set for the program. There are no limitations on assets other than income. The current annual income limits under the Poverty Income Guidelines for Alaska are shown below:

<u>Size of Family Unit</u>	<u>Poverty Guideline</u>
1	\$6,560
2	8,810
3	11,060
4	13,310
5	15,560
6	17,810
7	20,060
8	22,310
Each Additional Member	2,250

\* \* \* \*

Facilities are also given the option of providing care to patients with up to twice the income of the federal poverty guidelines. Within this range, facilities can set their own income limits and institute a reduced rate schedule for covered services. For example, a facility might charge a patient with an income one and one-half times the federal poverty standard 25 percent of the normal charge for services. The difference would then be charged against the facility's Hill-Burton obligation.

The health care facility must bill other sources of coverage before applying the cost of a patient's treatment to its Hill-Burton obligation. Anything above and beyond what is met by that third-party coverage may be charged to Hill-Burton. Eligibility for Hill-Burton coverage is not considered a source of coverage for other government health programs; Medicaid, Medicare, and catastrophic illness programs do not require individuals to seek coverage from Hill-Burton before paying for the cost of care.

The Hill-Burton Act does not distinguish between mental and other types of health services. Any health care service provided by the facility may be paid for with Hill-Burton funds. However, the facility determines which services will be covered under its Hill-Burton obligation. At the beginning of each fiscal year, the facility must publish an allocation plan stating how much uncompensated care it intends to provide during that year and what kinds of services are included. It should be noted that even if a hospital received federal funds to construct an outpatient facility, it would not have to cover the services of that facility under Hill-Burton. It could limit Hill-Burton coverage to inpatient services.

April 29, 1985  
Page Six

Each year, a facility that has received Hill-Burton funds must publish a public notice of its allocation plan in its community; notices must also be posted in the facility and provided to each patient entering the facility. Patients can apply for Hill-Burton eligibility at any time during their stay; the facility has two working days to make an eligibility determination. A tentative approval may be made pending verification of income information.

We have provided only a brief synopsis of the Hill-Burton program; if you would like additional information on the mechanics of the program, or if you have any other questions concerning this memorandum, please do not hesitate to contact us.

JS



ALASKA STATE LEGISLATURE  
HOUSE OF REPRESENTATIVES  
RESEARCH AGENCY

Pouch Y, State Capitol  
Juneau, Alaska 99811  
(907) 465-3991

May 2, 1985

MEMORANDUM

TO:

FROM: Jonathan Sherwood  
Legislative Analyst

RE: Cost of Mental Health Insurance under HB 313 and SB 295  
Research Request 85-314 (Additional Information)

Martin Tirador, with Blue Cross of Washington and Alaska, has provided me with the most current estimates of the cost of mental health coverage under HB 313 and SB 295. This information is presented on the following page. Mr. Tirador emphasized that although these estimates are more accurate than earlier numbers, they still represent Blue Cross's best guess.

Blue Cross gives coverage groups one of several possible risk ratings, depending on its characteristics. According to Mr. Tirador, Risk Level 3 is a moderately low risk group.

If you have any questions, please do not hesitate to call me.

JS

Attachment

ESTIMATED INCREASED MONTHLY COSTS FOR MENTAL HEALTH COVERAGE

Group Plans

Basic Hospitalization and Major Medical  
 \$100 Deductible  
 Risk Level 3  
 (for rate effective April 1, 1985)

<u>Group Size</u>	<u>HB 313</u>	<u>SB 295</u>
5-10	\$8.20	\$7.45
11-24	7.50	7.20
25-99	7.25	6.60

Comprehensive Health  
 \$100 Deductible  
 Risk Level 3  
 (for rate effective April 1, 1985)

<u>Group Size</u>	<u>HB 313</u>	<u>SB 295</u>
5-10	\$9.70	\$8.80
11-24	9.45	8.60
25-99	8.60	7.80

Nongroup Plans

Individual Only  
 Age 40-44

<u>Deductible</u>	<u>HB 313<sup>a</sup></u>	<u>SB 295</u>
\$200	\$8.30	\$7.55
\$500	6.40	5.80
\$1,000	5.20	4.70

<sup>a</sup>HB 313 does not mandate coverage for individual plans; this column represents the cost of including coverage mandated under HB 313 in nongroup plans.

Source: Martin Tirador, Blue Cross of Washington and Alaska.

Table Prepared by the House Research Agency, May 1985.



ALASKA STATE LEGISLATURE  
HOUSE OF REPRESENTATIVES  
RESEARCH AGENCY

P.O. Box Y, State Capitol  
Juneau, Alaska 99811-3100  
Mail Stop 3100  
(907) 465-3991

February 15, 1988

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Karen Oakley *ko*  
Legislative Analyst

RE: Mental Health Insurance: Cost of Mandatory Availability  
Research Request 88.167 (Preliminary Information)

Senate Bill 67 mandates that insurers offering major medical insurance include mental health coverage as an option, and you asked how much the addition of such coverage would add to the cost of a major medical premium. In this memorandum, we provide preliminary information on this topic.

Background

Twenty-six states have statutes addressing the provision of mental health benefits under private health insurance policies. These statutes are of two general types: 1) mandated coverage statutes which require that mental health coverage be provided under major medical policies and which specify the benefits that must be provided; and 2) mandated availability statutes which require only that mental health coverage be offered at the policy holder's option and which may or may not specify the benefits that must be offered. Mandated coverage is found in 13 states.<sup>1</sup> Mandated availability is found in 13 other states (see Table 1).

-----

<sup>1</sup>States with mandated coverage statutes are Colorado, Connecticut, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia, and Wisconsin.

Alaska is one of 24 states that does not currently have a statute addressing the provision of mental health benefits. Senate Bill 67 would require that insurers in Alaska offer mental health benefits as an option under major medical insurance policies; Alaska would then become a mandated availability state. During the 1985 session, the legislature considered two bills which mandated availability, House Bill 313 and Senate Bill 295. House Research Memoranda 85.263 and 85.314 discuss these bills, including cost estimates, and are attached.

In Table 1 (attached), the laws of states mandating availability of mental health insurance are compared. The laws differ with respect to the following criteria:

- the type of providers eligible to be reimbursed;
- whether group or individual policies must be covered; and
- whether minimum inpatient, outpatient and partial hospitalization benefits are specified;

Summarizing the features of the current mandatory availability laws:

- Most of the laws were enacted 10 to 15 years ago. Ten of the 13 states enacted mandatory availability of mental health coverage during the 1970s; three states enacted their legislation during the 1980s.
- Six states mandate that coverage be offered to groups only; the remaining seven states mandate that coverage be offered to groups and individuals.
- All states consider psychiatrists and psychologists to be eligible providers; otherwise, states vary considerably in their definition of eligible providers.
- Only two states specify a minimum benefit for partial hospitalization.
- States differ in specification of the inpatient and outpatient benefits which must be offered. Washington and California have not specified required benefits. The other states typically require the offering to include coverage for 30 to 45 days per year for inpatient benefits or require the coverage to be the same as that provided for other illnesses. For outpatient benefits, the other states typically specify an upper dollar limit, ranging from \$500 to \$1,500 per year, or specify the maximum number of visits, ranging from 20 to 50 visits per year.

### Cost of Optional Mental Health Coverage: General Considerations

Adding mental health coverage to a major medical insurance policy increases the cost of the premium because additional benefits are provided. How much the added coverage will cost depends on a number of factors, including several factors within the control of the legislature. The provisions of a mandatory availability statute that will most affect the cost of the insurance include:

- the types of services covered;
- the dollar limits to the coverage;
- any provisions for copayments or deductibles; or
- whether the choice of purchasing mental health insurance must be made for groups as a whole or whether each individual within a group has the option to select the mental health benefit.

In general, the more services that are required to be covered, the higher the dollar limits to the coverage, and the lower any copayments or deductibles, the higher the premium will be. Because treatment of mental conditions most often occurs on an outpatient basis, the cost of mental health insurance is largely dependent on the required outpatient benefit offering and on the amounts of any copayments or deductibles for the outpatient benefit.

The costs of mental health insurance under a mandatory availability statute are also dependent in large part on whether the decision to elect mental health coverage is required to be made at the group level. Under a mandatory coverage statute, the insured population is large; this reduces the per capita cost. Under a mandatory availability statute, the insured population will undoubtedly be smaller, and premiums will be higher. If the statute requires that the decision to elect mental health coverage be made at the group level, the costs should be comparable to but slightly higher than costs of mandated mental health coverage.

If the decision to elect mental health coverage resides with the individual, the costs will be even higher. When individuals have the option to select coverage, the people who are most likely to make claims are the ones most likely to select the coverage. Thus, high risk individuals predominate in the pool of insured individuals; this increases the cost.

### Estimates of the Cost of Mandated Availability in Alaska

Estimates of the additional cost to a major medical or comprehensive health insurance policy from selection of a mental health benefit under proposed mandatory availability statutes considered during the 1985 session, SB 295

and HB 313 were made by Blue Cross. These estimates are presented in Table 2. Estimates for mandated availability were in the range of \$7 to \$9 per month for group policies.

I contacted Blue Cross for an estimate of the costs under SB 67, but they were still in the process of analyzing the cost. Presumably Blue Cross will provide this information during their testimony on the bill.

#### Costs of Mental Health Coverage in Other States

In the time available, I was able to obtain information on mental health insurance costs in only three states: Florida, California and Washington.

In Florida, the mandatory availability statute was passed originally in 1976 and then amended in 1983. The statute applies only to group policies; inpatient coverage is limited to 30 days per year, and outpatient coverage is limited to \$1,000 per year. According to Charlie Gray, of the Florida Insurance Commissioner's Office, major medical premiums for groups that include the mental health coverage are about 5 percent higher than for policies without the coverage.

In California, the mandatory availability statute was passed in 1973. Milo Pearson, of the Department of Insurance, said that at the time of passage, the increased cost was minimal and not a major issue.

Washington has had a mandatory availability statute for five years. Their statute is somewhat unique in that the benefits that must be offered are not specified. Beth Stecher, a rate analyst with the Office of Insurance, provided a sampling of rates charged by various insurers for mental health coverage. The typical benefit provided is \$2,000 for inpatient and \$500 for outpatient services.<sup>2</sup> Typical rates for low risk groups ranged from \$1 to \$2 per employee with the cost doubling if the coverage applied to the employee's spouse as well.

I hope you find this information useful. Additional information on costs of mental health coverage in other states will be provided. Please let me know if you need any additional information.

Attachments

-----  
<sup>2</sup>Ms. Stecher noted that the \$2,000 benefit for inpatient services is illusory since few people required inpatient treatment. She also said that the outpatient limit of \$500 is almost too low to have any value and that the Washington legislature is considering specifying the benefits that must be offered.

TABLE 1

## COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Alaska Senate Bill 67	not applicable	Group	licensed general or psychiatric hospitals;  community mental health centers;  person with a master's or doctoral degree in psychology, nursing or social work and works in conjunction with a licensed mental health care provider	45 days per year	50 outpatient treatments or office visits per year	Not specified
Arkansas	1979	Group, Individual	licensed outpatient psychiatric centers	Psychological evaluation, counseling psychotherapy or related mental health services are entitled to payment or reimbursed on an equal basis	Reimbursed provided service is provided by facilities licensed as outpatient psychiatric center	Not specified
California	1973	Group	licensed marriage or family counselor;  registered nurse with masters in psychiatric mental nursing and 2 years experience;  licensed clinical social worker	Terms of all coverage agreed upon between the group policy-holder and the insurer	Terms of all coverage agreed upon between the group policy-holder and the insurer	Not specified

TABLE 1 (Continued)

## COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Florida	1976 Amended 1983	Group	licensed mental health professional	30 days per year	\$1,000 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
Georgia	1984	Group, Individual	not specified	30 days per year under an individual policy and 60 days per year under a group policy	48 visits per year under an individual policy and 50 visits per year under a group policy	Not specified
Illinois	1975	Group, Individual		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	Coverage 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	Not specified
Kansas	1978	Group	community mental health center or clinic;  psychiatric hospital	30 days per year	Coverage for the first \$100 and 80% of the next \$500 per year	Not specified
Louisiana	1975	Group	board certified social worker in consultation with a physician	Benefits on par with those offered for other illnesses	Benefits on par with those offered for other illnesses	Not specified

TABLE 1 (Continued)

## COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Missouri	1980	Group, Individual		30 days per year; on par with other illnesses	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	Not specified
New York	1977	Group	social worker	30 days per year in a general or mental hospital	\$700 per year deductibles and coinsurance on par with other benefits	Not specified
Tennessee	1974	Group, Individual	community mental health center with an approved plan for quality assurance;  accredited hospitals	Not specified	30 visits per year copays and deductibles on par with physical illnesses	Not specified
Vermont	1975	Group	licensed mental health professional;	45 days per year in a general or mental	100% of the first 5 visits and 80% thereafter up to	45 day equivalents of active care per year

TABLE 1 (Continued)

## COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Washington	1983					
West Virginia	1977	Group, Individual	licensed or accredited general mental hospital;  comprehensive health service organization;  community center or clinic	45 days per year in a mental or general hospital; on par with illnesses in a general hospital	30% copayment up to \$500 per year, sessions cannot exceed 50 per year	Not specified

SOURCE: Intergovernmental Health Policy Project

NOTES: 1. All of the states specify psychiatrists and psychologists as eligible providers. "Other eligible providers" are those other types of mental providers eligible to be reimbursed for provision of mental health services to covered individuals.

Prepared by the House Research Agency, February 1988 (88.167).

Table 2

ESTIMATED INCREASED MONTHLY COSTS FOR MENTAL HEALTH COVERAGE

Group Plans

Basic Hospitalization and Major Medical  
 \$100 Deductible  
 Risk Level 3  
 (for rate effective April 1, 1985)

<u>Group Size</u>	<u>HB 313</u>	<u>SB 295</u>
5-10	\$8.20	\$7.45
11-24	7.50	7.20
25-99	7.25	6.60

Comprehensive Health  
 \$100 Deductible  
 Risk Level 3  
 (for rate effective April 1, 1985)

<u>Group Size</u>	<u>HB 313</u>	<u>SB 295</u>
5-10	\$9.70	\$8.80
11-24	9.45	8.60
25-99	8.60	7.80

Nongroup Plans

Individual Only  
 Age 40-44

<u>Deductible</u>	<u>HB 313<sup>a</sup></u>	<u>SB 295</u>
\$200	\$8.30	\$7.55
\$500	6.40	5.80
\$1,000	5.20	4.70

<sup>a</sup> HB 313 does not mandate coverage for individual plans; this column represents the cost of including coverage mandated under HB 313 in nongroup plans.

Source: Martin Tirador, Blue Cross of Washington and Alaska.

Table Prepared by the House Research Agency, May 1985. (85-263)

# STATE OF ALASKA

## DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 24, 1988

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

Dear Representatives Koponen and Ellis:

Re: House CS CSSB 67 (HESS)

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

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

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

The increase of \$3.70 per month	
times the number of state employees	
(12,000) x 12 months	\$532,800

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

February 24, 1988

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

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

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

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

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

Sincerely,

*Robert F. Stalnaker*  
Robert F. Stalnaker  
Acting Director

RFS/MBC/cam/6

**STATE OF ALASKA 1987 LEGISLATIVE SESSION  
FISCAL NOTE**

Bill Version: CS SB 67 HESS  
Publish Date: 3-31

REQUEST: \_\_\_\_\_

Revision Date: \_\_\_\_\_  
Title: "An Act Relating to Insurance Cover-  
age of a Mental Health or Nervous Condi.  
Sponsor: Faiks and Kertulla  
Requestor: \_\_\_\_\_

Agency Affected: \_\_\_\_\_  
BRU: Institutions and Administration  
Components: Alaska Psychiatric  
Institute

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

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>
<b>CAPITAL</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>
<b>REVENUE</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

**FUNDING: (Thousands of Dollars)**

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>	<b>-0-</b>

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

**ANALYSIS : (Attach a separate page if necessary)**

See attached

Prepared by: Deborah K. Smith *DKS* Phone: 465-3370  
Division: \_\_\_\_\_ Date: 1/27/87

Approved by Commissioner: *John M. Munson* Date: 3/18/87  
Agency: Dept. of Health & Social Services

**Distribution (by preparer):**

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)
- Senate Secretary

CS SB 67 HESS

FISCAL NOTE

Payments to the Alaska Psychiatric Institute from 3rd party insurance are estimated to increase as a result of this bill. Community Mental Health Centers could expect additional revenue from 3rd party payors also. Data is not available from this Division to calculate the potential increase in revenue. Currently, 40% of our clients have some form of insurance.

# HOUSE COMMITTEE REPORT

5/9/87

Judiciary  
Finance

Date referred:

FURTHER REFERRALS:

Health, Education and  
Social Services

DATE: 2-24-88  
CSSB 67 (HESS)

The \_\_\_\_\_ Committee has considered  
"An Act relating to insurance coverage for the treatment of a mental or  
nervous condition."

**RECOMMENDS:**

- replace with HCS SB 67 (HESS)  the same title
- attached amendment(s)  a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the \_\_\_\_\_ Committee

**ADOPTS:**  \_\_\_\_\_ letter of intent

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

- fiscal impact  same as previous fiscal note published \_\_\_\_\_
- zero fiscal note  same as previous zero fiscal note published \_\_\_\_\_
- zero with anal.

**SIGNING DO PASS:**

John Ellis

Vito Kopona

Max Thurnberg

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNING OTHER RECOMMENDATIONS:**

Bill Hanson - No Rec.

David Juley - No Rec.

ROD E. JESS - No Rec.

Clare Stanley - No Rec.

\_\_\_\_\_

\_\_\_\_\_

Vito Kopona  
CO-Chairman's signature

John Ellis