SB67

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: HCS CSSB67(HESS)
Publish Date:

FISCAL NOTE

REQUEST:

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

Agency Affected: Department of Administration
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	0	0	0	0
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	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

CENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

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)

We do not anticipate a need for an increase in operation funding for the Division of Retirement and Benefits

Prepared By: Robert F. Stalnaker, Acting Director — Phone: 465-4470
Division: Retirement and Benefits — Date: 2-24-88

Approved by Commissioner: John M. Andrews — Date: 3/1/88
Agency: Department of Administration

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

MAR 3 1988

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 19, 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 90. The estimated FY 90 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 90 state PERS payroll ($479,549,872) equals:	$ 959.1
The increase in the TRS contribution rate (.15%) times the estimated FY 90 University of Alaska TRS payroll ($44,753,863) equals:	67.1
The increase in the TRS contribution rate (.15%) times the estimated FY 90 Department of Education TRS payroll ($5,613,930) equals:	8.4
	$1,034.6

02-P4LH

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

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

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

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

Sincerely,

Robert F. Stalnaker

Robert F. Stalnaker
Acting Director

RFS/bb/7

STATE OF ALASKA
1988 LEGISLATIVE SESSION

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

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

see attached sheet

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

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

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

FEB 0 1988
LEGISLATIVE FINANCE

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.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

Committee Substitute
for
Senate Bill 67 (HESS)

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

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

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

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

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

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

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

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

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

(3) works in conjunction with a licensed provider.

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

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

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

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

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

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

RECOMMENDED BY:

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

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

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

SENATE COMMITTEE REPORT

FURTHER:

3/31/87

DATE TURNED INTO OFFICE 5/1/87

Mr. President:

FINANCE Committee considered SB 67

insurance coverage for the treatment of a mental or nervous condition.

and recommended:

[ ] replace with CS FOR SB 67 (HESS)) [✓] same title
[✓] or adopt _____ CS FOR _____) [ ] new title

[ ] attached amendment(s) and

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

[ ] letter of intent adopted _____

Committee [✓] attached or [ ] adopted fiscal note(s)
[ ] new [ ] updated or [✓] previous
[✓] zero [ ] fiscal impact

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

Chairman signature and recommendation — DO PASS

[ ] Committee Backup Attached

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version : SB 67
Publish Date :

REQUEST:

Revision Date:
Title : "An Act Relating to Insurance Coverage 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						
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

Prepared by : Deborah K. Smith by FAM
Division :
Phone : 465-3370
Date : 1/27/87

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

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

RECEIVED
MAR 18 1987
LEGISLATIVE FINANCE

SB 67

SB 67

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.

Offered: 3/31/87
Referred: Finance

5-0356B

Original sponsors: Faiks and Kerttula

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 67 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

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

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

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

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

(c) If an insured or a subscriber declines the coverage offered

under this section, the insurer or service corporation may offer the insured or subscriber other coverage for treating a mental or nervous condition.

(d) In this section

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

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

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

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

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

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

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

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

(C) a hospital that is located in

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

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

(5) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits for the

insured or subscriber of at least $10,000;

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

(A) the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) published by the American Psychiatric Association; or

(B) the ICD-9-CM (First Edition) published by the Commission on Professional and Hospital Activities;

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

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

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

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

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

(A) in the outpatient department of

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

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

(iii) an entity that is designated by the

Department of Health and Social Services as the organizational unit in a geographical area to receive funds under AS 47.30.520 - 47.30.620; and

(B) by one or more of the following,

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

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

(iii) a psychologist licensed under AS 08.86; or

(iv) a person who works in conjunction with one or more licensed mental health care providers and has a master's or doctoral degree in psychology, nursing, or social work, and is employed by the same health care facility providing treatment.

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

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

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

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) <u>AS 21.42.345 - 21.42.365</u> [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed after January 1, 1988.

Mental Health Services:
The Case for Insurance Coverage

Samuel A. Mitchell

Charter North Hospital
3530 DeBarr Road
P.O. Box 143929
Anchorage, AK 99514 - 3929

Second Printing January 1986

Psychiatric Committee
Federation of American Hospitals

Richard L. Conte, *chairman*
Executive Vice President,
Outpatient Division
Community Psychiatric Centers

George Kossoy, *vice chairman*
General Counsel
Gracie Square Hospital

Stuart Ashman, M.D.
President and Medical Director
Tidewater Psychiatric Institute

Sy Banner
Administrator
Four Winds Hospital

Gary Bell
Director, Hospital Acquisitions
Charter Medical Corporation

Wesley Bilson
President
Delano Regional Medical Center

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Houston International Hospital

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Meadows Recovery Center

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American Healthcare Management

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Comprehensive Care Corporation

Tom Millea
Senior Vice President,
Chemical Dependency
Healthcare Services of America

Veronica Ojdana
Coordinating Administrator
Schick Shadel Hospitals

Robert Osburn
Director of Program Development
Charter Medical Corporation

James C. Ott
Director,
Quality Assurance Programs
Charter Medical Corporation

Michael S. Pinkert
President
Mental Health Management

Bruce A. Shear
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Jean P. Smith
Senior Vice President-
Psychiatric Group
Healthcare International, Inc.

Charles A. Speir
Chairman of the Board
and Chief Executive Officer
Healthcare Services of America

J. M. Stribling
Executive Director
Charter Broad Oaks Hospital

Kerry G. Teel
Senior Executive Vice President
and Chief Operating Officer
Healthcare Services of America

L. Stanton Tuttle
President
HCA Psychiatric Company

Sidney F. Tyler, Jr.
Senior Vice President-
Corporate Planning
National Medical Enterprises

Ralph J. Watts
Senior Vice President-
Southern Division
Community Psychiatric Centers

Norman A. Zober
President and Chief Executive Officer
Psychiatric Institutes of America

limited ambulatory use of mental health care. Only 8.8% of enrollees received annually any mental health care. Only 5% visited annually any formally trained mental health provider. The average ambulatory mental health expense was $24 per enrollee per year.

"Plans with small deductibles followed by free care, such as the $150 person per year individual deductible, do not significantly reduce expenditures below the free care level."[18]

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

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

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

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

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

18. Manning et al.

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

Mental Health Services:
The Case for Insurance Coverage

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

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

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

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

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

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

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

---

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

15. Mumford et al., p. 1156.

16. Mumford et al., p. 1154.

Acknowledgements

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

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

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

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

S.A.M.

8

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

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

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

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

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

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

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

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

substitution (methadone) to the therapeutic community approach.

Results

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

Comment

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

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

Study Description

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

Results

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

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

How cost beneficial is psychotherapy for people who are:

- not obviously self-destructive?
- not obviously potentially dangerous to others?
- not clearly unable to cope with the usual problems of everyday living without help?

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

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

Table of Contents

Major findings of the meta-analysis were:

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

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

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

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

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

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

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

5. People over 65 received proportionately less mental

13. Mumford et al., p. 1152.

Results

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

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

Study Description

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

Results

Benefits exceeded costs by a 2.5 to 1 margin.

Comment

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

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

Study Description

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

Results

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

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

Study Description

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

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

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

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

Study Description

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

Results

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

Comment

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

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

Study Description

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

1

Executive Summary

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

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

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

Myth #1:

The problems of behavior-related illnesses are not serious.

Reality

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

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

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

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

Myth #2:

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

Reality

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

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

Myth #3:

The costs of mental health care usually exceed the benefits.

7

The Benefits of Psychiatric Care Relative to Cost

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

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

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

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

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

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

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

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

Reality

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

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

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

Myth #4:

Mental health services are substantially overused and misused.

Reality

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

Summary

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

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

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

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

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

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

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

EXHIBIT NINE

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

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

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

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

2

Insurer Concerns

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

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

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

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

Finally, insurers are concerned that there is vast misuse

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

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

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

attributable only to C-group members.

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

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

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

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

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

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

[i]Interviewers' assessments.

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

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

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

*Significant at the .10 level.
**Significant at the .05 level.
†Signifcance not tested, as the number is a sum of means.
[a]These data were derived from agency or patient reports on the number of contacts, patient reports being used only when it was not possible (or was excessively costly) to obtain the relevant information from the agency. Estimates of the costs per contact were obtained from the agency.
[b]Data from the Department of Vocational Rehabilitation (DVR) were available only for the 28-month study period as a whole, which included the follow-up period after the experiment. The per patient costs presented in Exhibit Eight are 12/28, or 43 percent of the 28-month data, reflecting average cost for one year. The figures reflect double counting because much of the DVR expenditures go for payments to other agencies that are included in cost section 2 of the exhibit. We have been able to account for, and to exclude, DVR payments to the sheltered workshops but not, for example, to hospitals. The $24 difference is biased upward by the omission of counselling expenses

3

Prevalence and Cost of Mental Illness

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

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

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

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

★ ★ ★ ★

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

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

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

EXHIBIT ONE

PREVALENCE OF MENTAL ILLNESS WITHIN A SIX-MONTH PERIOD

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

*highest rate of treatment

Source: National Institute of Mental Health

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

EXHIBIT EIGHT

COSTS AND BENEFITS PER PATIENT, CONTROL (C) AND EXPERIMENTAL (E) GROUPS, FOR TWELVE MONTHS FOLLOWING ADMISSION TO EXPERIMENT

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

EXHIBIT SEVEN

ECONOMIC OUTCOMES OF REVIEWED RANDOMIZED CONTROL STUDIES[a]

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

a. Berk, p. 23.

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

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

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

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

EXHIBIT TWO

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

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

Totals may not add due to rounding.

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

b. Components are indicated in parentheses.

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

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

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

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

EXHIBIT SIX

ECONOMIC OUTCOMES OF REVIEWED SIMULTANEOUS CONTROL STUDIES[a]

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

a. Berk, p. 22.

EXHIBIT FIVE

CLINICAL OUTCOMES OF REVIEWED RANDOMIZED CONTROL TRIALS[a]

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

a. Berk, p. 2.

EXHIBIT THREE

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

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

Totals may not add due to rounding.

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

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

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

EXHIBIT FOUR

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

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

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

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

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

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

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

4

What is Mental Health Care?

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

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

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

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

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

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

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

4. OTA, p. 13.

6

Comparison of the Costs and Outcomes of Different Treatment Settings

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

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

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

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

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

Key findings from the 28-month study period were:

1. the cost per patient in the TCL program were slightly higher, *but*
2. the benefits, mainly in the form of patient earnings, also were higher;
3. the net result was that benefits valued in monetary terms for the TCL program were still less than valued costs, but the

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

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

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

10. Parloff, p. 43.

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

5

Is Mental Health Care Effective?

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

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

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

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

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

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

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

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

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

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

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

6. OTA, p. 44.

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

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

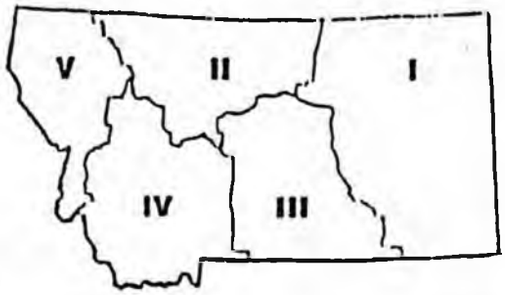
Smith et al. developed a standardized measure for the size of the effect of psychotherapy for each of the 475 studies selected for review. By standardizing the measure of effect, Smith et al. were able to compare results across studies. The findings of Smith, Glass and Miller offer impressive scientific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

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

When is mental health care effective?

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

8. OTA, p. 46.



Montana Council of Regional Mental Health Boards, Inc.

2/21/86

See P2

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 MENTAL HEALTH CENTER
1819 Main Street
Miles City, Montana 59301
(406) 232-1340

REGION II
GOLDEN TRIANGLE COMMUNITY MENTAL HEALTH CENTER
Holiday Village Shopping Center
P.O. Box 1048
Great Falls, Montana 59403
(406) 761-7000

REGION III
MENTAL HEALTH CENTER II
1245 North 29th Street
Billings, Montana 59101
(406) 252-5658

REGION IV
MENTAL HEALTH SERVICES, INC.
502 Fuller
Helena, Montana 59601
(406) 443-2830

REGION V
WESTERN MONTANA COMMUNITY MENTAL HEALTH CENTER II
[illegible]

Duncan
4/27/87

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,

Steve Waldron
Executive Director

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

February 24, 1986

MEMORANDUM

TO: Representative Mike Davis

ATTN: Marilyn Heiman

FROM: Nancy Pease *Nancy Pease*
Legislative Analyst

RE: Mental Health Insurance for State Employees
Research Request 86-111

At your request, we have attempted to assess the cost of mandated mental health insurance for state employees in other states.

We have surveyed nine of the fourteen states which currently provide mandated mental health coverage for their employees.[1] In general, spokespersons for the states were unable to estimate the cost of premiums for employee mental health coverage. In some instances, mental health was added simultaneously with other changes to the states' health care policies, so the rise in premiums attributable to mental health could not be determined. In other instances, existing mental health coverage was simply modified to meet state mandates for minimum coverage, and there was no change in health insurance premiums. Finally, a number of states instituted mental health coverage more than ten years ago, and the personnel benefits offices are unable to provide statistics on changes in premiums from that time.

While the states surveyed provided scant information on mental health premiums, they were generally able to provide information on mental health care claims and to comment upon the adequacy of coverage. The amount of mental health claims may not be strictly comparable among states; some states allow a major medical plan to cover mental patients' costs after the mental health benefits are exhausted.

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[1]Nine states responded: Massachusetts (mental health insurance mandated in 1973); Colorado (1975); Minnesota (1975); North Dakota (1975); Wisconsin (1975); Ohio (1982); Maine (1983); Montana (1983); and Oregon (1983).

Several states have adjusted the limits of coverage in recent years by: reimbursing only for treatment by licensed M.D.s; limiting coverage for alcohol abuse; or applying an annual or lifetime limit on benefits. At least one state, North Dakota, has recently expanded mental health benefits.

Costs of Mental Health Insurance in Other States

Massachusetts. Massachusetts was also unable to distinguish the cost of mental health premiums from general health premiums. The state pays 90 percent of the employee health premium and 80 percent of employee claims.[2] Spokespersons with Massachusetts's group insurance commission had no statistics on the amount of mental health claims or the adequacy of the $1,500 per year limit on claims.

Colorado. The State of Colorado pays all health insurance premiums for its employees and was unable to distinguish the cost of mental health premiums from general health premiums. Colorado's health policy covers 50 percent of its employees' mental health care costs.

Mental health claim payments accounted for 7 percent of all health claims paid by the State of Colorado from August 1984 to July 1985--an average of $172 per state employee.[3] Mental health claims were paid for the following types of care:

In-patient care	$ 806,230	
Out-patient hospital care	17,769	
Other out-patient care	762,492	
Total mental health care benefits paid by state (Colorado)	$ 1,586,491	FY 1984

According to Ruth Stambaugh of Colorado's Health Insurance Group, there were few claims for mental health coverage beyond the 45 days per year inpatient or the $2,000 per year outpatient benefit.

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[2]A Massachusetts employee can opt to purchase additional coverage, resulting in up to 96 percent reimbursement of health claims.

[3]Mental health benefits were available to 10,781 state employees, in addition to dependents and retirees not covered through medicare.

Minnesota. In Minnesota, the state pays 100 percent of employee health care premiums and at least 90 percent of family coverage premiums.

In Fiscal Year 1985, the State of Minnesota paid 52 percent of its employees' mental health care claims--an average of $110 per employee. At a cost of $5.3 million, the state's mental health care payments accounted for seven percent of the state's total health care costs.

Minnesota has recently reduced its outpatient benefit to 80 percent of the first $750 in outpatient care per year. According to Cornell Anderson, Minnesota's Employee Benefits Manager, the previous outpatient benefit of was too costly to the state.[4] Employees have filed numerous claims in excess of the current outpatient benefit, which is the state's minimum benefit; legislation has been introduced to raise this outpatient minimum.

North Dakota. North Dakota pays its employees' health premiums in full. A spokesperson for the public retirement system stated that mental health health coverage was expanded as of July 1, 1985. Previously, outpatient benefits were limited to $1,000 per year for care provided by a physician; outpatient benefits now provide for 60 percent copayment of the second $1,000 of claims and will reimburse for care provided by any licensed counselor. The costs to the state of the expanded coverage are not yet available.

Wisconsin. In Wisconsin, mental health coverage has been provided under the state's comprehensive health policy for over 10 years. Personnel in the benefits office were unable to prorate what portion of the premium covers mental health care. The state pays 100 percent of its employees' health premiums.[5]

Wisconsin offers employees their choice of ten health maintenance options through different health providers and has no state files on the total of mental health claims for state employees. Mental health

---

[4]Minnesota's previous outpatient mental health benefits provided for major medical coverage beyond the first $750 of claims. Under major medical coverage, 80 percent of a mental health patient's care was paid by the state until the patient had paid $1,000 out of pocket; whereupon, the state paid 100 percent of additional care costs.

[5]Wisconsin state employees' health premiums, which include mental health coverage, average $65 to $75 for single employees and $170 to $185 for employees and their families).

covers 30 days or $6,300 of inpatient care and 20 visits or $900 of outpatient care per year. Major medical coverage takes over after these limits are reached.

Ohio. The State of Ohio has long carried mental health insurance for its employees; thus, the state's health premiums did not increase with the passage of Ohio's law (effective in 1982) that all employers carry mental health insurance. The state pays 73 percent of health insurance premiums, which amounts to approximately $200 per month for a family of four.

Ohio's policy pays for 80 percent of outpatient costs and full costs for short-term, acute inpatient coverage of up to 31 days. Only the care of an M.D. is reimbursable and claims are limited to $15,000 per person per year. These limits are stricter than limits Ohio has had in the past; until 1973, Ohio would reimburse mental treatment provided by any licensed counselor and did not have a lifetime benefit limit. In 1979, Ohio decreased mental health and substance abuse coverage. Currently, state employees are reimbursed for 50 percent of usual customer/reasonable fee charges, up to a maximum of $500.

Maine. Maine has estimated that the cost of its newly enacted mental health and substance abuse coverage will increase the state's health insurance costs by 6 percent. The new mental health coverage will pay for claims for usual customers and reasonable fees for up to 60 days per year of inpatient care and 40 outpatient visits per year. Maine previously provided 50 percent copayment for mental health care under its major medical carrier. The new coverage took effect on May 1, 1985; annual costs to the state are not yet known.

Montana. According to Steve Waldron of the Montana State Mental Health Association, Montana did not experience an increase in premiums when mental health insurance was added to general health insurance in 1983. Mr. Waldron attributed the lack of increase to limits placed on coverage for alcohol abuse.

Blue Shield of Montana has not yet provided us information on the rate and cost of mental health claims. Concerning the terms of the coverage, Montana's policy currently reimburses most mental treatment prescribed by physicians, including prescriptions for treatment from unlicensed counselors. According to Mr. Waldron, a physician's prescription may encourage a patient to purchase mental treatment less discriminately than if the physician merely provides a referral. Thus, the practice of paying for most prescribed treatment may result in greater mental health claims.

I have attached a copy of a report received from Mr. Waldron entitled "Equal Insurance Coverage for Mental Illness", as well as a fact sheet concerning the same topic. According to Steve Waldron of the Montana State Mental Health Asscciation, this report references 11 studies to document that the cost of mental health coverage is slight and that mental health care diminishes claims for physical health care. forward a copy of the report upon receipt.[6]

Oregon. When Oregon enacted a mandatory minimum for mental health coverage in 1983, the state simply revised the terms of the mental health policy which it had carried since 1973. There was no increase in the premiums.

In Fiscal Year 1984, Oregon employees received an average of $27 per employee in inpatient mental health claims.[7] Outpatient mental care is limited to $2,000 in a 24-month period.

* * *

I hope this information is useful. Please let us know if you have further questions.

NP

Attachment

---

[6]The Montana Mental Health Association or the editor of the report may be contacted directly at the following numbers:

Montana State Mental Health Association (406) 442-7808
Mr. Steve Waldron
Mr. Harold Gerke (406) 245-5397
Chairman, Montana Council of Regional Mental Health Boards
1201 Clark Street
Billings, Montana 59102

[7]This average is calculated on information from the Oregon State Benefit Board which handles insurance to for approximately one half of Oregon's State workforce. Benefits for bargaining unit employees are handled by a seperate insurance board and may be different.

Equal Insurance Coverage
For
Mental Illness

The Surgeon General has called mental illness the number one health problem in America. Mental illness now costs America at least $40.3 billion per year and accounts for more days of hospital care than any other illness (Corrigan and Koyanagi, 1982 and the National Council of Community Mental Health Centers, 1982).

The National Council of Community Mental Health Centers (1982), has stated that:

> approximately 15% of the population need some type of mental health services
>
> approximately 25% of the population suffers from mild to moderate depression, anxiety, and other indicators of emotional disorders
>
> approximately 10 million Americans have alcohol-related problems
>
> approximately one half of all diseases have stress-related origins

Today, community-based care has replaced hospitalization as the primary treatment for mental illness. Almost three-quarters of the treatment for mentally ill people is provided on an outpatient basis or through partial hospitalization.

Nationwide, public funding sources provide 51% of the funds for mental health services, compared to only 42% of the funds for general health care. Insurance coverage accounts for only 15% of the total expenditure for mental illness, compared with 25% of expenditures for general health (Corrigan & Koyanagi, 1982).

At this time, approximately 63% of the civilian population has hospital coverage for mental illness; 54% have in-hospital provider coverage but only 37% have any outpatient coverage. Furthermore, this outpatient coverage is severely limited by higher co-payment requirements, more restrictions and lower limits than are placed on physical illness (Corrigan and Koyanagi, 1982).

Most health insurance policies provide inadequate coverage for mental illness. These policies limit mental health inpatient services to some extent, most have no more than minimal outpatient services, and few, if any, cover partial hospitalization (Corrigan and Koyanagi, 1982).

The effect of this inadequate coverage is two-fold. First, it acts as a powerful disincentive to seek treatment in less costly and often more effective, out-patient and partial hospitalization settings. Most policies cover only inpatient hospitalization which is more costly and more restrictive than is sometimes necessary. Second, the inadequate coverage destroys the basic principle of insurance: risk sharing. Higher co-payments and limits on benefits result in the mentally ill, and in some cases, the taxpayers, bearing a far greater burden of the costs of treatment for mental illness than for other illnesses (Corrigan and Koyanagi, 1982).

Recognizing the importance of adequate coverage for mental and emotional problems, ten state legislatures have passed laws that ensure equal benefits for the treatment of mental illness. These state legislatures have also recognized that legislation which guarantees equal coverage results in many other benefits.

For example, responsible legislation that guarantees coverage for mental health services will cut down on unnecessary, and costly hospitalization. Many patients are forced to seek hospitalization because outpatient or partial hospitalization services are not paid for covered by their insurance. When mental health benefits are available, medical utilization is often reduced.

Blue Cross of Western Pennsylvania instituted psychiatric benefits and found a significant reduction in the use of medical-surgical services. In fact, the monthly cost per patient was reduced by 50%. The University of Washington Health Services Center reports that individuals receiving mental health services have reduced their use of outpatient medical services by 41% and the Group Health Association of Washington, D.C. reports that patients with mental health coverage have reduced their medical-surgical utilization rate by 30.7% (National Council of Community Mental Health Centers, 1982).

Jones and Vischi reviewed 13 studies and found decreased utilization of medical services occurred in 12 of the 13. Reductions ranged from 5% to 85% with a median reduction of 20%. Furthermore, Jones and Vischi hypothesized that the reduction in medical care utilization would continue to be reduced as the time after psychotherapy increased.

Jones and Vischi found only one study in which medical utilization was not reduced. This study involved a neighborhood health clinic in a medically underserved Mexican-American community. The natural expectation in such a situation is that utilization of all services would increase in response to previously unmet needs (Jones and Vischi, 1979).

The Kaiser Permanente study found a 62% reduction in outpatient medical visits and a 68% reduction in hospital days by the fifth year after psychotherapy. In a West German study, an 85% reduction in average hospital days per year occurred for a five year period after mental health treatment. The West German study concluded that the large decline in hospital utilization was caused by the psychotherapy provided because as many as 80% of the neurotic, psychosomatic and other symptoms reported had been of at least two years duration (Jones and Vischi, 1979)

The strong interrelationship between physical and mental illness is becoming increasingly apparent. There are many studies on the subject, "but the common belief among physicians is that well over half of the patients who come to them have symptoms that are due wholly or in part to mental or emotional factors" (Reibel and McMillan, 1977). Northern California Kaiser Permanente found "68% of its doctor visits are for complaints for which no organic basis can be found" (Personnel Journal, 1981).

Mental health care has not only reduced medical utilization and costs, it has had significant benefits for business and industry. Kennecott Copper instituted an Employee Assistance Program which resulted in a six to one benefit to cost ratio. Kennecott Copper experienced a 52% improvement in attendance, a 74.6% decrease in weekly indemnity costs and a 55.4% decrease in medical surgical costs. The Equitable Life Assurrance Society inlated an employee emotional health program and increased productivity by $3.00 for every $1.00 spent on the program. The Kimberly-Clark Corporation began an Employee Assistance Program, and reduced on-the-job accidents by 70% in one year (Corrigan and Koyanagi, 1982).

Bertram S. Brown reports that 80-90% of all industrial accidents are related to personal problems; 15-30% of the work force are seriously handicapped by emotional problems; and 65-80% of people fired by industry are terminated because of personal problems (Brown, 1973).

Barrie, found support for Brown's report when he conducted a three year study of absenteeism at Weirton Steel Company. Barrie's study demonstrated that psychiatric illness was the principal reason for the absence of 61% of those examined (Barrie, 1980).

Since 1975, there has been a significant growth in employee wellness programs among major industrial employers. However, among smaller companies, little evidence of investment in wellness programs has been shown (Goldbeck and Kelfhaber, 1981).

Insurance companies may oppose guaranteed equal insurance coverage for mental and nervous conditions on the premise that insurors will have to charge high premiums; however, this is not necessarily the case. Two insurance carriers who underwrite health benefits, Crown Life and Massachusetts Mutual, incorporated a pre-paid mental health plan into their total benefits package at no additional cost to the policy holders.

> One carrier included the plan in a multi-employer trust. During the first year, (1975) their paid loss ratio dropped from 92% to 67%. Despite inflation in health care costs, there was no rate change under this policy until the fourth year after the change. It is interesting that the rate increase, which took effect in late 1978, followed a period in which publicity, employee meetings and distribution of educational materials on the mental health plan were discontinued. Experience with other groups also shows that an ongoing educational effort is essential to the success of this plan (PERSONNEL JOURNAL, 1981).

The experience of many major insurance plans suggests that:

> only a small proportion of the insured population uses outpatient mental health benefits;
>
> the number of visits is generally low, particularly when controlled by a combination of co-payments, deductibles or visit limits;
>
> expenditures for mental health services are not a disproportionate part of health benefit packages (Corrigan and Koyanagi, 1982).

Van Korff and Kramer(1979), examined utilization data from 12 large insurance plans that provided coverage for outpatient mental health services. In the group that had the highest percentage of claims for outpatient treatment, only 2.2% of the people made claims. The highest average number of visits was 18.8, in a plan that had no upper limit on the number of outpatient sessions. The weighted average for all 12 plans was 9.5 visits per 100 covered members. With this rate of utilization, and using a cost of $45 per visit, each covered member would pay $4.26 per year, or 8 cents per week to cover the <u>full cost</u> of treatment. With 80% co-insurance, each covered member would pay $3.40 per year or 6.5 cents per week (Van Korff and Kramer, 1979).

Several studies of the Federal Employees Health Benefits Program (FEHBP) high option plan have been conducted. The plan covers 365 days of inpatient mental health care and reimburses 80% of the costs of out-patient treatment after a $100 deductible.

During the period from 1966 to 1973, when all medical costs were increasing rapidly, Blue Cross/Blue Shield experienced an annual increase of 25% in the cost of claims for treating mental disorders under the FEHBP high option. Because the FEHBP in Washington, D.C. combines comprehensive benefits, a population with abundant providers and an insured population that is willing to use mental health services, some of its experience probably describes the <u>upper limit</u> of mental health utilization (Corrigan and Koyanagi, 1982).

For example, Towery, Sharfstein and Goldberg (1980) examined the FEHBP for the six month period from January to June, 1977 and found that:

> two percent of the population used supplemental benefits for outpatient mental health services;
>
> those who used outpatient services made an average of 32.7 visits during the year;
>
> fifty percent of people using outpatient services had 20 visits or less; 63 percent had 30 visits or less and only six percent had more than 100 visits.
>
> for 506,451 outpatient contacts, the cost was about $26.50 per insured person and the average cost for an outpatient visit was $39.72 (Towery, Sharfstein and Goldberg, 1980).

An earlier study of FEHBP showed that mental health care was a small part of total health care costs. In 1974 there were only 5 inpatient admissions for mental disorders per 1000 covered people and the cost of inpatient care for mental illness was $75 per day compared with $108 per day. While the average length of stay for people with mental disorders was 17 days, compared with 7.3 days for all other disorders, the cost of inpatient mental health care was only $6.50 annually per person covered under the FEHBP Blue Cross/Blue Shield plan (Corrigan and Koyanagi, 1982).

In "For Ayes Only," Corrigan and Koyanagi (1982) state:

> The potential for cost savings by averting inpatient psychiatric care was the major impetus behind the "Effective Care '81" program initiated by Blue Cross and Blue Shield of Minnesota. In 1980, inpatient psychiatric charges averaged $2,800, while the outpatient average was $90 - a 30 to 1 differential. For all claims related to mental and emotional disorders, 75% were for inpatient treatment. The Effective Care '81 program was designed to reduce total inpatient days 10% by diverting appropriate cases to outpatient treatment. James O. Regnelr, President of Blue Cross and Blue Shield of Minnesota, noted that 'besides the quality and cost considerations, outpatient care often is much less disruptive to the person's family, job and normal routine' (Corrigan and Koyanagi, 1982).

Partial hospitalization is also less expensive and often more effective alternative to inpatient psychiatric hospitalization. The cost of a day of partial hospitalization is usually one half to one third the cost of a day of inpatient care.

Greene and De La Cruz (1981), compared partial hospitalization with inpatient treatment in a review of eleven research studies. They concluded that, overall, partial hospitalization is unequivocally more cost-efficient than inpatient treatment and that partial hospitalization, or day treatment, is superior to inpatient treatment in effecting client social adjustment. The two treatment modes are comparable in alleviating psychopathological symptoms and day treatment is at least comparable to inpatient care in preventing subsequent relapses. Furthermore, day treatment reduces family stress as compared to inpatient care (Greene and De La Cruz, 1981).

If projected savings based on cost offsets and different treatment modes are so significant, legislators may ask why insurers and employers need to be required to provide mental health coverage equal to coverage for physical health. A major obstacle remains - - insurance companies do not routinely collect and analyze their data in a way that allows them to assess cost offsets. The studies which have been cited have been specifically designed to examine the impact of mental health benefits.

It has been demonstrated that equal insurance coverage for mental and nervous conditions should result in reduced medical utilization and lower overall health costs. In addition employers should benefit by having a healthier, happier work force that will have fewer accidents, better attendance and will produce more.

Mentally ill people will benefit from such legislation because they will be able to choose appropriate treatment that may be delivered in time to prevent problems from becoming so severe that hospitalization is necessary. Montana taxpayers should also benefit from mental health coverage that is equal to physical health coverage. The private sector will be required to share the costs of providing mental health care, freeing limited state dollars to fund services for the chronically mentally ill.

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STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REFLY TO:

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

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

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

STEVE COWPER, GOVERNOR

April 27, 1987

Ms. Roxanne Stewart
Senator Duncan's Office
P.O. Box V
Juneau, AK 99811

Dear Roxanne:

I am writing in response to your request for a fiscal note for the work draft of the proposed CSSB 67 that you provided me last Friday. While there has not been sufficient time to prepare a formal fiscal note, following is the Division of Retirement and Benefits' estimate of the fiscal impact on the state's health plans.

Should this higher level of coverage described in the bill be incorporated, FY 89 costs to the state are estimates to increase by at least $1,009,426. This figure does not include any estimate for medical cost inflation through July 1, 1988.

This cost is calculated as follows:

The increase of $3.30 per month for health cost times the number of covered state employees (12,100) times 12 months equals:	$ 39,930
The change in the PERS employer contribution rate (.17%) times the estimated FY 89 state PERS salaries ($419,656,104) equals	713,415
The change in the TRS employer contribution rate (.06) times the estimated FY89 state TRS salaries ($2,576,265) equals	31,545
The change in the TRS State Match contribution rate (.06) times the estimated FY 89 TRS system salaries ($374,226,795) equals	224,536

The Department of Administration has been opposed to legislation that has mandated benefits in the health coverage. The level of coverage is

4/27/87

subject to collective bargaining and adjust itself to the interests and needs of the parties. This level of coverage would serve to increase health costs at a time when they are already increasing due to heavy usage of the plan.

Sincerely,

Michael B. Coughlin
Deputy Director

MBC/cam/6

Alaska State Legislature

Senate

Finance Committee

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

April 6, 1987

TO: Senator Jim Duncan

FROM: Senator Johne Binkley, Co-Chairman
Senator Don Bennett, Co-Chairman

RE: Subcommittee Assignment - Senate Bill 67

We are assigning Senate Bill 67, "An Act relating to insurance coverage for the treatment of a mental or nervous condition," to you for subcommittee work. This bill was received in Finance on March 31. We would like to schedule the bill before the Finance Committee as soon as possible so your expeditious consideration will be appreciated.

As noted in our previous memorandum on subcommittee assignments, we request that you notify the sponsor that the bill is in your subcommittee. You may request other members of the Finance Committee to participate in your consideration of the bill. Please notify all Finance Committee members of any public hearings you may schedule so they can participate if they wish.

When you are ready to report the bill back to committee, please notify Senator Binkley's office so that it can be scheduled for hearing before the full committee.

cc: Senator Jan Faiks

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

Senate Bill 67

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

The purpose of this bill is to expand health insurance coverage in the state to include an option that provides 45 days a year of in-patient treatment for each covered individual and a total of 50 hours per year of out-patient treatment or office visits for each covered individual. This coverage would provide treatment for any disorder identified in the Diagnostic and Statical Manual-Version 3 (DSM III) or the ICD-9-CM classification of disorders.

This proposed legislation would provide treatment services in either an in-patient or out-patient setting, or through office visits.

In-patient treatment is defined to include "continuous treatment during a 24-hour period" in 1) a psychiatric unit of an in-state or out-of-state licensed general hospital, 2) an in-state or out-of-state licensed psychiatric hospital, or 3) an in-state or out-of-state hospital that is specifically exempted from licensure.

Out-patient treatment is defined to include treatment through 1) the out-patient department of the various types of hospitals listed above, 2) the state's system of community mental health centers, 3) a state licensed and certified or certified-eligible psychiatrist, 4) a physician employed by the federal government in this state who is a certified or certified-eligible psychiatrist, or 5) a state licensed psychologist or psychological associate. Out-patient treatment services could also be provided by persons who have masters or doctorate degrees in psychology, nursing or social work, so long as those persons are supervised by licensed and certified or certified-eligible psychiatrists, physicians, or psychologists and employed by the same health care facility as their supervisors.

The Department's concern with this legislation lies solely with our belief that at least half of the community mental health centers in the state will not be eligible to receive these third party (i.e., insurance) payments because the centers are not headed up or supervised by the required level of professional staff. Many of the rural community mental health centers across Alaska are headed by individuals with masters degrees in social work and are not directly supervised by either a licensed and certified or certified-eligible physician, psychiatrist, or licensed psychologist; consequently, the treatment services provided by employees of these centers could not be billed to the insurance carrier.

These centers provide effective treatment programs and we believe their lack of ability to entice physicians and psychologists to their communities should not be a deterrent to the receipt of third party payments for the quality care they provide.

POSITION PAPER/Department of Health & Social Services

The Department of Health and Social Services endorses the concept of reimbursing the providers of mental health services for the provision of services which are within the scope of their practice and supervision and when properly licensed by the state. Mental Health care is an integral part of the general health care system and, as such, should be reimbursable under insurance coverage. However, we would encourage an amendment that would allow reimbursable insurance coverage be available to all persons who utilize the services of Alaska's 27 community mental health centers. We understand that such an amendment is currently under consideration and we wholeheartedly endorse such a change to this progressive legislation.

Recommended by: _____
Dr. Mel Henry, Director
Division of Mental Health and
Developmental Disabilities

Date: March 18, 1987

Approved by: _____
Myra M. Munson, Commissioner

Date: March 18, 1987

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 3/11/87 5-DAY NOTICE
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER: FINANCE

**FISCAL NOTE(S) ATTACHED / **
IN ACCORDANCE WITH AS 24.08.035
(see below)

1.189/87

DATE TURNED INTO OFFICE 3/31/87

Mr. President:

HESS Committee considered SB 67

~~relating to~~ insurance coverage for the treatment of a mental or nervous condition.

and recommended:

[X] replace with CS SB 67 (HESS) [X] same title [ ] new title

[ ] attached amendment(s) and

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

[ ] letter of intent adopted and attached

** Committee [X] attached or [ ] adopted fiscal note(s)
[X] zero [ ] fiscal impact

MEMBERS SIGNING DO PASS

Rick Halford

OTHER RECOMMENDATIONS

Tom Green No Rec

Dave Donley Do Pass
Chairman signature and recommendation

[ ] Committee Backup Attached

5-0356L
Ford
4/24/87

Original sponsors: Faiks and Kerttula

IN THE SENATE BY THE FINANCE COMMITTEE

CS FOR SENATE BILL NO. 67 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

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

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

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

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

(c) In this section

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

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

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

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

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

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

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

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

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

(C) a hospital that is located in

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

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

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

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

(A) the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) published by the American Psychiatric

Association; or

(B) the ICD-9-CM (First Edition) published by the Commission on Professional and Hospital Activities;

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

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

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

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

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

(A) in the outpatient department of

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

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

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

(B) by one or more of the following,

(i) a psychiatrist who is licensed as a physician

in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

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

(iii) a psychologist licensed under AS 08.86; or

(iv) a person who works in conjunction with one or more licensed mental health care providers and has a master's or doctoral degree in psychology, nursing, or social work, and is employed by the same health care facility providing treatment.

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

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

* Sec. 3. AS 21.87 340 is amended to read:

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the

reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) <u>AS 21.42.345 - 21.42.365</u> [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed after January 1, 1988.

APR 1 3 1987

Alaska State Legislature

PRESIDENT
907-465-3755

JAN FAIKS
POST OFFICE BOX V
JUNEAU, ALASKA 99811

Senate

April 7, 1987

MEMORANDUM

TO: Senator Johne Binkley, Co-Chairman
Senate Finance Committee

FROM: Senator Jan Faiks
President of the Senate

SUBJECT: Committee Hearings on Senate Bill 67
Relating to insurance coverage for the
treatment of a mental or nervous condition

Senate Bill 67 has been referred to your committee for consideration. I would appreciate your scheduling hearings on this legislation at your earliest convenience.

The purpose of this bill is to require insurers to offer their customers the opportunity to purchase minimum mental health coverage in all health insurance policies sold in Alaska, and to eliminate the discrimination which currently exists between mental health and other medical insurance benefits.

This legislation was passed out of the Senate Health, Education and Social Services Committee, its first committee of referral, on March 30, 1987.

Enclosed are memos which gives background information on this legislation. Should you or the committee members need additional information, please let me know.

Your prompt consideration of my request will be appreciated.

Thank you.

cc: Senator Jim Duncan

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

Alaska State Legislature

PRESIDENT
907-465-3755

JAN FAIKS
POST OFFICE BOX V
JUNEAU, ALASKA 99811

Senate

April 7, 1987

MEMORANDUM

TO: Senator Johne Binkley, Co-Chairman
Senate Finance Committee

FROM: Senator Jan Faiks
President of the Senate

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

Senate Bill 67 has been referred to your committee for consideration. This bill will require insurers to offer their customers the opportunity to purchase minimum mental health coverage in all health insurance policies sold in Alaska.

Specifically, this bill proposes the following:

Section 1. AS 21.42 is amended to add a new section (21.42.365) which will require coverage for treatment of a mental or nervous condition.

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

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

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

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

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

(C) As originally drafted, the bills provides that if an insured or a subscriber does not opt for the coverage under this section, the insurer or service corporation may offer other coverage for treating a mental or nervous condition.

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

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

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

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

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

Alaska State Legislature

PRESIDENT
907-465-3755

JAN FAIKS
POST OFFICE BOX V
JUNEAU, ALASKA 99811

Senate

April 7, 1987

MEMORANDUM

TO: Senator Johne Binkley, Co-Chairman
Senate Finance 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

Senate Bill 67 has been referred to your committee for consideration. This bill will require insurers to offer their customers the opportunity to purchase minimum mental health coverage in all health insurance policies sold in Alaska, and will eliminate the discrimination which currently exists between mental health and other medical insurance benefits.

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

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

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

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

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

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

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

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

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

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

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

In 1984, mental illness was estimated to have cost our nation 67.6 billion dollars. This figure includes not only the direct cost of treating mental illness ($12 billion), but also the greater cost of lost productivity and employment ($44.6 billion) and of mental health related crimes, vehicle accidents, and other social burdens ($11 billion).

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

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

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

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

On the other hand, psychotherapy produces savings in the form of increased employee productivity and reduced absenteeism. As mental health treatment becomes more affordable and available to employees, employers report a significant increase in job attendance and productivity and a significant reduction in on-the-job accidents. The Equitable Life Assurance Society has verified that every dollar invested in mental health treatment results in a three dollar increase in productivity. Mental health treatment also reduces drug and alcohol-related crime.

Medical science has long recognized the correlation between physical disease and mental health. Physicians have estimated that up to one-half of all ailments which they treat have symptoms of mental or emotional disorder. Many dollars that are now paid for other medical services are actually paid for the indirect treatment of mental impairments. In addition, studies have proven that direct treatment of mental problems results in lower costs for other medical care.

In a 1983 study, a moderate amount of psychotherapy was shown to significantly reduce hospital costs for persons suffering

from four different types of chronic disease. Another study that same year showed that patients who received outpatient psychotherapy treatment used 56% fewer medical services than those who had not been treated.

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

Senate Bill 67 may indirectly reduce the dependency of the community mental health centers in Alaska on State funds. These facilities currently receive matching grants from the State and charge their patients a sliding fee base upon their ability to pay. After the grant is matched, all additional fees are devoted to enhance the programs and expand their facilities. Division of Mental Health personnel report that because of a lack of funds, these centers can only provide 25-30% of the communities' mental health needs. They predict that the passage of a mental health insurance bill will allow them to serve up to one-half of this need.

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

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

I would appreciate the committee's consideration of the legislation at its earliest convenience. Should you need any additional information, please let me know.

Thank you.

5-0356L
Ford
4/17/87

Original sponsors: Faiks and Kerttula

IN THE SENATE BY THE FINANCE COMMITTEE

CS FOR SENATE BILL NO. 67 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

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

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

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

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

(c) In this section

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

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

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

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

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

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

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

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

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

(C) a hospital that is located in

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

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

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

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

(A) the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) published by the American Psychiatric

Association; or

(B) the ICD-9-CM (First Edition) published by the Commission on Professional and Hospital Activities;

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

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

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

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

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

(A) in the outpatient department of

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

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

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

(B) by one or more of the following,

(i) a psychiatrist who is licensed as a physician

in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

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

(iii) a psychologist licensed under AS 08.86; or

(iv) a person who works in conjunction with one or more licensed mental health care providers and has a master's or doctoral degree in psychology, nursing, or social work, and is employed by the same health care facility providing treatment.

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

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

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

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the

reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

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

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed after January 1, 1988.

5-0356L
Ford
4/17/87

Original sponsors: Faiks and Kerttula

IN THE SENATE BY THE FINANCE COMMITTEE

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

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

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

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

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

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

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

(C) a hospital that is located in

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

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

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

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

(B) by one or more of the following,

(i) a psychiatrist who is licensed as a physician

in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

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

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* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed after January 1, 1988.

Introduced: 1/19/97
Referred: Health, Education and Social Services and Finance

5-0356A

IN THE SENATE BY FAIKS AND KERTTULA

SENATE BILL NO. 67

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

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

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

(c) If an insured or a subscriber declines the coverage offered under this section, the insurer or service corporation may offer the insured or subscriber other coverage for treating a mental or nervous condition.

(d) In this section

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

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

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

(B) the usual, customary and reasonable charge for the treatment;

(3) "inpatient treatment" means continuous treatment during a 24-hour period in

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

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

(C) a hospital that is located in

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

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

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

AS 47.30.520 - 47.30.620; and

(B) by one or more of the following, or by a person who is under the direct supervision of one or more of the following, has a master's or doctorate degree in psychology, nursing, or social work, and is employed by the same health care facility as the person or persons providing the direct supervision,

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

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