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

5-0356A

1 IN THE SENATE

BY FAIKS AND KERTTULA

2 SENATE BILL NO. 67

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

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

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

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

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

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

22 (2) a total of 50 hours a year of outpatient treatment or
23 office visits for each covered individual, accumulated in any incre-
24 ments of time.

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

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

5 (d) In this section

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

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

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

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

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

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

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

20 (C) a hospital that is located in

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

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

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

1 (5) "mental or nervous condition" means a mental disorder
2 identified in

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

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

8 (6) "office visit" means treatment that is not inpatient
9 treatment or outpatient treatment and that is provided by

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

13 (B) a physician who is employed by the federal govern-
14 ment in the state and certified or eligible for certification in
15 psychiatry by the American Board of Psychiatry and Neurology; or

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

18 (7) "outpatient treatment" means treatment that is not
19 inpatient treatment and that is provided

20 (A) in the outpatient department of

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

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

27 (iii) an entity that is designated by the Depart-
28 ment of Health and Social Services as the organizational
29 unit in a geographical area to receive funds under

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

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

23 * Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to
24 disability insurance policies and to hospital or medical service subscriber
25 contracts entered into or renewed after January 1, 1938.
26
27
28
29

1 AS 47.30.520 - 47.30.620; and

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

7 (i) a psychiatrist who is licensed as a physician
8 in the state and certified, or eligible for certification,
9 in psychiatry by the American Board of Psychiatry and Neu-
10 rology;

11 (ii) a physician who is employed by the federal
12 government in the state and certified or eligible for certi-
13 fication in psychiatry by the American Board of Psychiatry
14 and Neurology; or

15 (iii) a psychologist licensed under AS 08.56.

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

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

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

27 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
28 provisions contained or referred to previously in this chapter, the
29 following chapters and provisions of this title also apply with

Now "Mandatory Offering"

5-0356B
Ford
3/27/87

Original sponsors: Faiks and Kerttula

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 67 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

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7 ment of a mental or nervous condition."

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11 CONDITION. (a) An insurer authorized under AS 21.09 to offer, issue
12 for delivery, deliver, or renew a group disability insurance policy
13 for major medical coverage on an expense-incurred basis in the state,
14 or a hospital or medical service corporation authorized under AS 21.87
15 to offer or renew a group contract for major medical coverage in the
16 state, shall offer the insured or subscriber an option to receive the
17 following coverage for treatment of a mental or nervous condition of
18 the insured, subscriber, or other person covered by the policy or
19 contract:

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

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

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

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

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

4 (d) In this section

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

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

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

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

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

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

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

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

21 (C) a hospital that is located in

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

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

27 (5) "major medical coverage" means a disability insurance
28 contract, or a subscriber contract, that provides benefits for hospi-
29 tal and medical care with potential lifetime maximum benefits for the

1 insured or subscriber of at least \$10,000;

2 (6) "mental or nervous condition" means a mental disorder,
3 *delete* except a disorder classified as alcoholic psychosis, drug psychosis,
4 alcoholic dependence syndrome, drug dependence or near dependent abuse
5 of drugs, identified in

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

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

11 (7) "office visit" means treatment that is not inpatient
12 treatment or outpatient treatment and that is provided in the profes-
13 sional offices of

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

17 (B) a physician who is employed by the federal govern-
18 ment in the state and certified or eligible for certification in
19 psychiatry by the American Board of Psychiatry and Neurology; or

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

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

24 (A) in the outpatient department of

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

28 (ii) a hospital that is located in another state
29 and that is either licensed or specifically exempt from the

1 licensing requirements of that state; or

2 (iii) an entity that is designated by the Depart-
3 ment of Health and Social Services as the organizational
4 unit in a geographical area to receive funds under AS 47.-
5 30.520 - 47.30.620; and

6 (B) by one or more of the following,

7 (i) a psychiatrist who is licensed as a physician
8 in the state and certified, or eligible for certification,
9 in psychiatry by the American Board of Psychiatry and Neu-
10 rology;

11 (ii) a physician who is employed by the federal
12 government in the state and certified or eligible for certi-
13 fication in psychiatry by the American Board of Psychiatry
14 and Neurology;

15 (iii) a psychologist licensed under AS 08.86; or

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

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

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

1 midwife.

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

3 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
4 provisions contained or referred to previously in this chapter, the
5 following chapters and provisions of this title also apply with re-
6 spect to service corporations to the extent applicable and not in
7 conflict with the express provisions of this chapter and the reason-
8 able implications of the express provisions, and for the purposes of
9 the application the corporations shall be considered to be mutual
10 "insurers":

11 (1) AS 21.03

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13 (3) AS 21.09, except AS 21.09.090

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

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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 1 **
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:

replace with CS SB 67 (HESS) same title
 attached amendment(s) and new title

do pass

do not pass

no recommendation

individual recommendations

further referral to _____

letter of intent adopted and attached

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

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

[Signature]
[Signature]
[Signature]

[Signature]

Paul [Signature] Do Pass
Chairman signature and recommendation

Committee Backup Attached

Original sponsors: Faiks and Kerttula

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25 this section may impose reasonable contract limitations but may not
26 require that the insured or subscriber pay a higher deductible or
27 co-payment for the cost of treating a mental or nervous condition than
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25 licensing requirements of the state;

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27 and that is either licensed or specifically exempt from the
28 licensing requirements of that state; or

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

4 (B) by one or more of the following,

5 (i) a psychiatrist who is licensed as a physician
6 in the state and certified, or eligible for certification,
7 in psychiatry by the American Board of Psychiatry and Neu-
8 rology;

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10 government in the state and certified or eligible for certi-
11 fication in psychiatry by the American Board of Psychiatry
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14 (iv) a person who works in conjunction with one or
15 more licensed mental health care providers and has a
16 master's or doctoral degree in psychology, nursing, or
17 social work, and is employed by the same health care facil-
18 ity providing treatment.

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22 a person who provides a service covered under a group disability
23 policy that extends coverage on an expense incurred basis, or under a
24 group service or indemnity type contract issued by a nonprofit corpo-
25 ration, if the service is within the scope of the provider's occupa-
26 tional license. In this subsection, "provider" means a state licensed
27 physician, dentist, osteopath, optometrist, chiropractor, or nurse
28 midwife.

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27 disability insurance policies and hospital or medical service subscriber
28 contracts entered into or renewed after January 1, 1988.

*Read by Deborah Smith
Div. of Mental Health*

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 Statistical 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
SB67-Page 2

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:

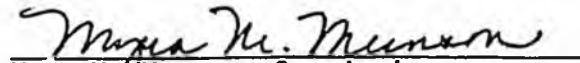


Dr. Mel Henry, Director
Division of Mental Health and
Developmental Disabilities

Date:

March 18, 1987

Approved by:


Myra M. Munson, Commissioner

Date:

March 18, 1987

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

SB 67

REQUEST: _____

Bill Version: _____
Publish Date: _____

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

Agency Affected: _____
BRU: Institutions and Administration
Components: Alaska Psychiatric
Institute

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
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 *DKM*
Division: _____

Phone: 465-3370
Date: 1/27/87

Approved by Commissioner: *James M. Hansen*
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

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.

TESTIMONY BY HEALTH INSURANCE ASSOCIATION OF AMERICA
BEFORE ALASKA SENATE HESS COMMITTEE
ON SENATE BILL 67

March 18, 1987

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

SB 67 would mandate or require insurers doing business in Alaska -- and that includes both those companies selling disability insurance policies and hospital or medical service corporations providing subscriber contracts -- to offer insurance coverage for the treatment of a mental or nervous condition. While the HIAA does not oppose insurance coverage for the treatment of a mental or nervous condition, the Association does oppose SB 67, and any similar legislation which requires insurers to provide or to make available particular benefits in their health insurance policies, for reasons which I will set out.

Historically, HIAA has opposed the enactment of any mandated health benefit laws for the following reasons:

- (1) Mandated health benefit laws erode the ability of insurance companies to tailor health benefit packages to meet the needs of particular plans and to market group health insurance policies to large plans on a national basis.
- (2) Mandated health benefit laws contribute to the rapidly escalating cost of health insurance.
- (3) Mandated health benefit laws promote self insurance. This legislation would not apply to self insurers or those with employee welfare benefit plans which are exempted under ERISA.

In summary, HIAA's opposition to SB 67 is based on the fact that HIAA favors the preservation of a system that allows the prospective purchaser of health insurance free choice of which risks he or she wishes to cover from among the various coverages offered by competing insurance carriers. The HIAA also believes that the choice of how the policyholder spends what funds are available for health insurance should be free of government decree.

Alaska State Legislature



PRESIDENT
907-465-3755

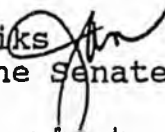
JAN FAIKS
POST OFFICE BOX V
JUNEAU, ALASKA 99811

Senate

March 17, 1987

MEMORANDUM

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

FROM: Senator Jan Faiks 
President of the Senate

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

SB 67 is currently before your committee. Since its introduction, further research has been conducted by my staff. I ask that the committee consider the following changes to the bill which are of concern.

#1
1. The language in proposed Section 1 creates a mandatory/option form of coverage for mental health insurance. This means that should an employer reject the minimum mental health coverage described by this bill, the insurer or service corporation may offer other coverage for treating a mental or nervous condition, but would not be required to do so.

My concern is that individuals would not be able to get the best coverage if their employers reject the basic package. The pure mandatory system offers no opt-out provision--the insurer or service corporation must offer other coverage if the insured or subscriber declines the coverage described by this bill.

This could be easily accomplished by deleting the words "an option to receive" which appear on page 1, line 16, and deleting section (c) which appears on lines 1 - 4 on page 2 of the bill.

OUT OF SESSION

6060 YUKON DRIVE ANCHORAGE, ALASKA 99516 907-274-6611

2. The intent of proposed section 21.42.365(d)(3) which defines the class of eligible hospitals providing inpatient treatment is unclear as presently drafted. The literal interpretation of the language appearing on page 2, lines 13-25 of the bill excludes coverage for care received at hospitals, such as those found in the rural communities, which do not have specifically designated psychiatric units.

#2 I recommend that the language be amended to reflect the inclusion of community hospitals which do not have psychiatric units, but provide inpatient treatment by qualified health care professionals.

The committee's consideration of these changes will be appreciated. Should you need any further information, please let me know.



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Anchorage, Alaska 99510-2480
(907) 561-5065

MEMORANDUM

DATE: March 17, 1987

TO: Senator Paul Fischer
Senator Joe Josephson
Senator Lloyd Jones
Senator Jay Kerttula
Senator Rick Halford

FROM: M. E. Tirador *MET*

SUBJECT: Senate Bill #67, an act relating to insurance coverage
for the treatment of a mental or nervous condition

My name is Martin Tirador and I represent Blue Cross of Washington and Alaska. I appreciate the opportunity to present some of our concerns for your consideration of Senate Bill 67. This issue has been in the Legislature for the past two sessions. A listing of suggested amendments to the language of this bill is attached to and is part of my testimony today.

Blue Cross of Washington and Alaska suggests confining the offering of benefits for nervous and mental conditions to group contracts only. To open the offering to individual participants would increase administrative costs because of the need to obtain waivers, to rider individual contracts and to investigate health statements. This type of administrative cost is not necessary in the writing of group benefits.

I suggest that the 50 hours of out-patient care per year be replaced by 50 visits. Again, the cost of maintaining visit records by minutes could be an administrative headache for the provider and the insurer and could be a problem for the patient when their recollection of time differs from that of the provider.

The usual customary and reasonable definition needs to be expanded. Blue Cross of Washington and Alaska suggests the contract language be the determining factor. An open usual customary and reasonable rate could lead to increased costs in providing service.

March 17, 1987
Page Two

The definition of "in-patient" needs some expansion to permit partial hospitalization for patients in such a manner that out-patient benefits would not be reduced. Continuous treatment would not permit partial hospitalization thereby reducing the number of out-patient visits.

→ The defining of a mental and nervous condition on page 3 needs some expansion. As the language presently states, substance abuse would come under the definition of a nervous and mental condition. There are benefits for addictive diseases. Coverage for these conditions do not need to be included in defining nervous and mental conditions.

→ Lastly, we feel the definition of office visit needs expansion so as to differentiate it from in-patient and out-patient visits.

Thank you, again, for giving Blue Cross of Washington and Alaska an opportunity to present our concerns before this Committee.



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ADDENDUM
TO THE
TESTIMONY OF M. E. TIRADOR
TO THE
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
ON SENATE BILL 67

Page 1, Line 12 -- Insert group between a and disability;

Line 15 -- Delete subscriber and insert group;

Line 22 -- Delete hours and insert visits;

Lines 23/24 -- Delete the comma and insert a period. Delete accumulated in any increment of time.

Page 2, Line 12 -- Delete the semicolon and insert as determined by contract of coverage;

Lines 13/14 -- Delete all after treatment and insert a hospital registered bed patient for whom the hospital makes a daily room change in.

Page 3, Line 5² -- After association add except those conditions classified as alcoholic psychosis, drug psychosis, alcoholic dependence syndrome, drug dependence or near dependent abuse of drugs; or

Line 7 -- After activities add except those conditions classified as alcoholic psychosis, drug psychosis, alcoholic dependence syndrome, drug dependence or near dependent abuse of drugs;

Line 9 -- After provided add in the professional offices of and delete the word by.

Sen Fairs

March 21, 1987

CS for SB 67 (HESS)

Section 1

- NO* → 1. ~~Sec. 21.42.365(a) Page 1, Line 16 - delete "an option to receive"~~
- NO* → 2. ~~Sec. 21.42.365(c) Page 2, Lines 1-4 - Delete entire section~~
- O.K.* 3. Sec. 21.42.365(d)(3)(A) a general hospital that is either licensed under AS 18.20 or located and licensed in another state, which provides psychiatric care
4. ~~Sec. 21.42.365(d)(7)~~ Page 4, Line 1
Add after "and" on line 1 "is provided by"
- Yes* (B) by one or more of the following:
(i) a psychiatrist...
(ii) a physician...
(iii) a psychologist...
(iv) a person who works in conjunction with one or more of the licensed mental health care providers and has a master's or doctorate degree in psychology, nursing, or social work, and is employed by the same health care facility providing treatment.



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Line 9 -- After provided add in the professional offices of and delete the word by.

SB 67 An Act relating to insurance coverage for the treatment of mental or nervous condition

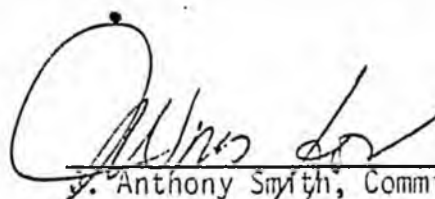
The Department of Commerce and Economic Development supports this bill. However, the department does wish to propose several technical amendments that will clarify the bill.

This act provides for a mandated offering of certain benefits for the treatment of a mental or nervous condition subject to the same deductible and co-payments as for any other covered condition or illness. The department supports this approach as opposed to a mandatory benefit inclusion.

The department recommends the following amendments:

- 1. The definition section, AS 21.42.365(d), ~~needs to have its subsections renumbered due to the addition of additional terms to be defined;~~
- 2. ~~The term "accumulation period" needs to be defined as the maximum length of time in which an insured or subscriber has to incur the amount of covered costs for treatment to satisfy any deductible required;~~
- 3. The term "deductible" needs to be defined as the amount of covered costs for treatment for which the insured or subscriber is responsible that must be incurred before benefits become payable under a disability insurance policy or subscriber contract in any accumulation period; and
- 4. The term "co-payment" needs to be amended to indicate the portion of the covered costs for treatment in excess of the deductible for which the insured or subscriber is responsible.

One further item is that the use of the term "cost" in this act would appear to require the benefits to be offered for the treatment of a mental or nervous condition on a usual, customary and reasonable basis. It needs to be recognized that some of the underlying contracts may provide benefits for all other types of illnesses and accidents on a preset, scheduled basis.


 J. Anthony Smith, Commissioner
 DATE: 3/18/87

TO: Senator Fischer, Hess, Cheri
FROM: Senator Kertula

File with
Mental Health Ins.
Bill

Raskolnikov Could Cop a Plea

INSANITY

The Idea and Its Consequences.

By Thomas Szasz.

414 pp. New York:

John Wiley & Sons. \$17.95.

By Dava Sobel

IN this, the latest battle of his Thirty Years War with organized psychiatry, Thomas Szasz argues that insanity is the 20th-century version of demonic possession, and that treatments for insanity are about as scientific as exorcism. In Dr. Szasz' view, the theories of insanity and demonic possession both arose from our need to explain away aberrant behavior. Because it is too horrible to think that a human being would want and choose to act in certain ways (murder innocents, for example, or live in a cardboard box on the street), society creates dark forces that are said to overpower such individuals and make them do the things they do. These dark forces, once called devils, are now known as mental disorders.

Dr. Szasz, a professor of psychiatry at the State University of New York Health Science Center in Syracuse, holds that mental illness and brain disease are wholly different entities. Brain disease, such as that caused by neurosyphilis, is easily documented and well described in pathology textbooks. Mental illness, on the other hand, is a myth, a metaphor, a legal fiction, a powerful, coercive tool for the incarceration of innocent

Dava Sobel, a former reporter for The New York Times, writes about science and medicine for several magazines.

people in mental hospitals and the exoneration of guilty ones by declaring them "not responsible" for their crimes.

Dr. Szasz is a brilliant debater, and the unpopularity of his position only serves to hone his formidable writing talent. He can turn a topic as somber as insanity and its social context into a book that is extraordinarily entertaining. He is as likely to quote Shakespeare or Molière as Freud and Jung, and when it suits him he quotes Ann Landers and Dear Abby, too. His irreverence and moral outrage fairly sizzle on the page. The worst thing I can say about him as a writer is that he sometimes sputters with too much passion.

A look at some of his earlier works ("The Myth of Mental Illness," "Schizophrenia: The Sacred Symbol of Psychiatry") will show that the central theme of "Insanity: The Idea and Its Consequences" is not new. But the author apparently justifies this fresh attack on an old enemy by the fact that the concept of mental illness continues to wreak havoc in society.

One of Dr. Szasz' favorite examples of this havoc is the insanity defense, which he views as psychiatry's destruction of "the old principle of moral agency and personal responsibility." Prize trophies from his vast collection of newspaper accounts of reprehensible crimes help him expose the insanity defense as a travesty of justice and a travesty of psychiatry. He cites a 1985 report in The New York Times in one such case: "The [U.S. Supreme] Court agreed to hear a prosecutor's appeal . . . suppressing the confession of a murder defendant as *involuntary because he was mentally ill.* [Dr. Szasz' emphasis.] . . . The man had approached a police officer on the street in Denver and said he wanted to confess a homicide. The policeman told him

of his rights to remain silent and to have a lawyer present. The man said he understood, and proceeded to confess the killing of a 14-year-old girl and to lead police to the scene and to other evidence."

"It would be difficult," Dr. Szasz continues, "to imagine what other evidence one would need to conclude that this man knew what he was doing: after all, it is not as if he had confessed to a murder and was unable to provide evidence of his guilt except his confession. How, then, did someone get the idea that this man was mad rather than a murderer? Obviously, the killer did not want to talk to a psychiatrist: had he wanted to, he could have sought one out, just as he had sought out a policeman. No doubt, as it is now customary in murder cases in the United States, the authorities arranged for him to 'be seen' by a psychiatrist. Sure enough, the killer told the psychiatrists exactly what they expected to hear in such a case: 'God's voice had told him to confess.' How psychiatrists, lawyers, and judges know that the defendant used the phrase *God's voice* literally, rather than as a metaphor for his conscience, the report in the *Times* does not say. So much for Raskolnikov. While it may be sad that Dostoevski has been rendered irrelevant by the march of psychiatric science, it is reassuring to realize that Raskolnikov was innocent after all."

What further infuriates Dr. Szasz about his fellow psychiatrists is that they are not content to treat those who come to them for help, but choose instead to occupy "every nook and cranny of human behavior," and insist on searching "for the twisted molecule behind every twisted thought." Thus we have "tobacco dependence" and "pathological gambling" listed as bona fide entries in the official "Diagnostic and Statistical Manual of Mental Disorders." □

IMPACT ASSESSMENT
OF
PROPOSED LEGISLATION TO MANDATE
DIRECT REIMBURSEMENT TO
NON-PHYSICIAN PROVIDERS
UNDER FEHBP PLANS

JULY 1986

**CENTER FOR
HEALTH POLICY STUDIES**

IMPACT ASSESSMENT
OF
PROPOSED LEGISLATION TO MANDATE
DIRECT REIMBURSEMENT TO
NON-PHYSICIAN PROVIDERS
UNDER FEHBP PLANS

PREPARED FOR
BLUE CROSS AND BLUE SHIELD ASSOCIATION

JULY 1986

Prepared By: Zachary Dyckman, Ph.D
Center for Health Policy Studies
- 6310 Steven's Forest Road, Suite 100
Columbia, Maryland 21046

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SUMMARY OF MAJOR POINTS

Legislation has been proposed to mandate direct reimbursement under FEHBP plans to non-physician providers: chiropractors, clinical social workers, marriage and family therapists, nurse practitioners and all other nurses. Following is a summary of the major points that need to be considered by the Senate in considering this legislation:

- The FEHBP is a highly competitive health insurance market. Premiums, benefit structure and provider coverage are structured to provide what Federal employees want. The mandate approach runs counter to this competitive market orientation.
- Most FEHBP plans already offer direct payment to some non-physician providers, based on perception of consumer preference, impact on premium cost and other factors.

20 of 21 fee-for-service plans offer direct payment to certified nurse midwives.

18 of 21 fee-for-service plans offer direct payment to clinical social workers.

16 of 21 fee-for-service plans offer direct payment to chiropractors.

- Federal employees can choose plans which have the combination of benefits, covered providers and premiums which best meet their needs.
- Mandated direct payment to non-physician providers will result in higher charges, increased utilization and higher cost.
 - Charges of non-physician providers increase after mandates, sometimes to levels higher than charged by physicians (prevailing fees for clinical social workers were \$94 in Hawaii, higher than \$88 charged by psychiatrists).
 - Utilization of services increases; much of the services of newly covered providers are in addition to, rather than a substitute for, services provided by physicians.
 - Claims cost and premiums increase after mandated payment to additional providers.
 - Chiropractor cost per case increased from \$91 to \$294 between 1978 and 1984 for one major carrier, an increase of 225 percent. Physician cost per case increased by 70

percent to approximately \$75 during same period.

- Mental health services provided by clinical social workers and marriage and family therapists often increase sharply after mandate, due to broad range of counseling services available, increased peer group acceptance and aggressive marketing by providers. Studies have found that use of services is highly sensitive to availability of insurance coverage.
- Mandated payments to providers will cause increases in supply of providers, further exacerbating the cost increase problem. The size of the projected supply change is related to the potential for increased earnings and the availability of trained persons who can become licensed relatively quickly.
 - There are approximately 1.9 million registered nurses and .5 million licensed practical nurses. These nurses, with relatively limited additional training, can provide a wide array of health related services directly to patients. Over 10,000 nurses went into business for themselves within the past few years. Mandated direct payment to nurses will hasten this trend.
 - Marriage and family therapists are now licensed or certified in eleven states. Thirteen more states are considering licensure. Mandating payments to marriage and family therapists will stimulate efforts in all states for licensure and will result in rapid expansion in the supply of independent practicing marriage and family therapists.
- Short term effects of mandated direct payment to providers:
 - Will allow providers acting in their own self interest to determine coverage provisions under FEHBP plans, without regard to impact on premiums or whether Federal employees want the additional providers covered.
 - Will increase claims cost and premiums, particularly for chiropractors and in areas with substantial federal employment (providers will react to mandates by raising prices and by more aggressively marketing their services).

- Long-term effects of mandated direct payment to providers:
 - Will stimulate efforts to expand mandated benefits under FEHBP to acupuncturists, pastoral counselors and other providers.
 - Will set an important precedent at the Federal level and stimulate efforts of provider groups to obtain mandated benefits under private insurance and self-insurance programs. This is a major priority of mental health and other provider groups.
 - Will result in an expansion in the supply of non-physician independent practicing providers, which in turn will cause increased utilization and increased claims cost under FEHBP plans.
 - To the extent it serves as a precedent for mandates for private health benefit programs, will result in a significant increase in health care cost inflation.

The decision as to mandating direct payment to additional providers should be made only after careful consideration of its cost and benefit implications, both in the short and long run. Consideration should also be given to the precedent setting nature of passing Federal mandated benefits.

IMPACT ASSESSMENT OF PROPOSED LEGISLATION TO MANDATE DIRECT
REIMBURSEMENT TO NON-PHYSICIAN PROVIDERS UNDER FEHBP PLANS

Legislation is being considered in the Congress to mandate direct reimbursement under FEHBP health benefit plans for selected non-physician providers: chiropractors, clinical social workers, marriage and family therapists, nurse practitioners, nurse midwives and all other nurses who are licensed or certified by state or Federal government. This legislation, which is supported primarily by the provider groups seeking direct reimbursement, will have but a minimal effect of expanding choice of provider for FEHBP enrollees. However, it will have a substantial and long-lasting effect in raising provider charges, increasing utilization, and causing higher premiums for both the Government and Federal employees. Moreover, requiring all FEHBP programs to directly pay specific provider groups interferes with competition among plans to provide desired medical care benefits at the lowest possible cost. Finally, it sets a precedent for mandating specific benefits at the Federal level, which can have very major medical care inflation consequences for both Federal employees and all others covered under private health insurance programs.

Mandating of direct payment to non-physician providers benefits the affected providers at the expense of Federal employees and the general public who experience the cost consequences of the mandate. It is anti-competitive in terms of forcing benefit provisions on those who do not want them and who do not wish to pay for them.

The primary impact of mandated reimbursement for non-physician providers on provider accessibility, cost and other important factors are discussed briefly below.

Impact on choice of provider. The mandated reimbursement of non-physician providers will have only a minimal effect on enrollee choice of provider. Each of the services is already covered. At issue is whether non-physician providers can bill the plan directly without referral or supervision by a physician. Many FEHBP programs already provide direct payment to non-physician providers. For the non-physician providers considered in this legislation, the following are covered by FEHBP plans:

- Seven of 21 FEHBP fee-for-service plans offer direct reimbursement for nurse practitioners.
- Six of 21 FEHBP fee-for-service plans offer direct reimbursement for physician assistants.

- Twenty of 21 FEHBP fee-for-service plans offer direct reimbursement to certified nurse-midwives.
- Eighteen of 21 FEHBP fee-for-service plans offer direct reimbursement to clinical social workers.
- Sixteen of 21 FEHBP plans offer direct reimbursement for chiropractors.

In situations where plans do not pay providers directly without physician referral and/or supervision, it is generally because the plans believe that costs will increase, that for medical care reasons it is necessary to have physicians overseeing care, that few beneficiaries want to use these providers and/or that there are potential problems of excess utilization or fees with specific provider groups.

Impact on competition in FEHBP market. The FEHBP market has been heralded by health care competition proponents as a model for the private sector. Individual plans actively compete with each other on the basis of premiums, benefit structure and other plan characteristics. Most plans already offer direct reimbursement to several non-physician providers covered under this legislation based on enrollee preference, impact on premiums and on other factors which affect the competitive attractiveness of the program. Employees determine which plan best meets their needs, premiums, benefits, covered provider services and other factors considered. OPM and its predecessor, the Civil Service

Commission, have stated that expansion of direct access to providers is a matter best left to negotiation. Negotiation "would produce a desirable diversity of covered providers as well as covered benefits, as the needs and preferences of the Federal enrollee market would dictate."¹ It is anti-competitive to force plans to pay directly for specific provider services, especially when the primary beneficiaries of the mandated provider benefits are the providers themselves.

Impact on charges. Mandating direct payment for specific non-physician providers generally results in increased non-physician charges, in absolute terms and relative to physicians performing comparable services. This is predicted by economic theory and is borne out by actual health insurer experience.

Proponents of mandated benefits often point to lower charge rates of non-physician providers (prior to the mandate) as part of their argument that mandates will not raise claims cost. There is evidence from both public and private programs of increases in charges after provider mandates. Direct payment to clinical social workers was authorized under a 1980-82 CHAMPUS demonstration.² Prevailing fees for clinical social workers in Hawaii increased to \$94 per hour, which was in excess of the prevailing fee for psychiatrists of \$88. Similar increases in social worker allowances relative to physician allowances were documented in Massachusetts after mandates were implemented for

direct payments to social workers, although their fees did not usually exceed physician fees.³

Impact on utilization - mental health providers.

Proponents of mandates have argued that direct payment of non-physician providers will result in substitution of non-physician services for physician services, with no overall increase in utilization. In some cases, such as for nurse-midwives, this has occurred.⁴ Based on evidence of cost-effective provision of services, health insurers and their customers have included direct coverage for nurse-midwives as well as other providers in the benefit program.

Where direct reimbursement is initiated to non-physician mental health providers -- psychologists, clinical social workers, and family and marriage therapists -- an increase in utilization and costs almost always occurs. Use of psychotherapy and counseling services is to a high degree elective, and is responsive to provider marketing, and increased peer group acceptance. Increased accessibility to providers and improved benefits invariably results in increased utilization. The New York State employee group experienced an increase in outpatient mental health benefits of \$34 million, from \$26.85 to \$118.50 per enrollee -- an increase of 341 percent -- between 1982 and 1984 as a result of expansion of mental health benefits from approximately 50 to 80 percent.⁵ The FEHBP program experienced

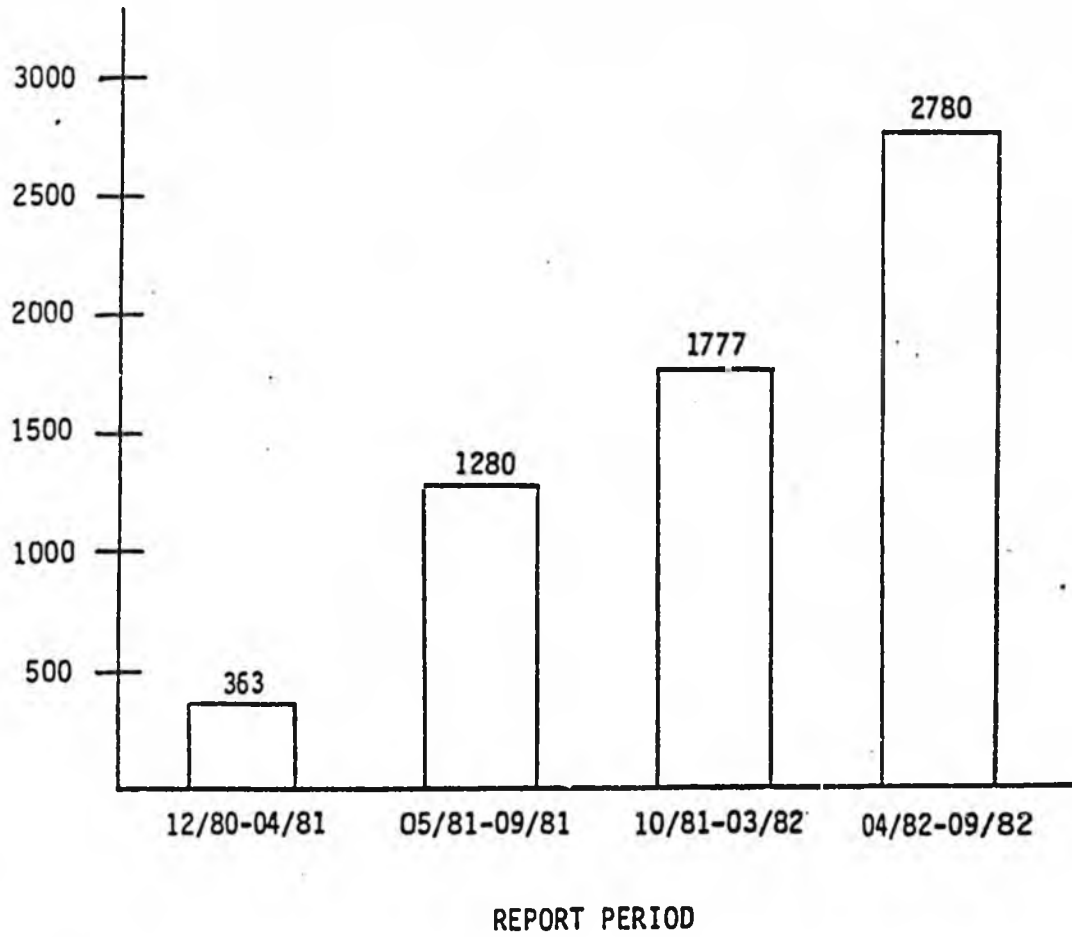
an increase in psychotherapy visits of from 521 visits to 813 visits per 1,000 enrollees between 1974 and 1978, most of which was accounted for by increased utilization of psychologists' services after direct reimbursement for their services was initiated in 1975.⁶

The increase in utilization is likely to be greater for social workers and therapists than for psychologists, as a result of mandating direct payment. This is expected because of the potentially great increases in provider supply and the broader range of counseling services that they provide. As noted earlier, CHAMPUS performed an experimental study on direct payment to independent certified clinical social workers from 1980 through 1982.⁷ The study examined charge levels, claims volume, type and volume of services utilization, and trends in these over the study period. A continuing increase in utilization occurred during the study. Over the final six months (April through September of 1982), 330 clinical social workers submitted 2,780 claims for services to 1,577 patients. This represented a cumulative increase of 667 percent in number of claims from the study's first period, when only 363 claims were filed. Exhibit 1 illustrates the steady rise in claims to the CHAMPUS program during the study period.

In Utah, clinical social workers became eligible for direct reimbursement in 1978. From 1979 to 1980 alone, the number of claims to Blue Shield of Utah for social worker

CLINICAL SOCIAL WORKER SERVICES CLAIMS,
CHAMPUS EXPERIMENTAL STUDY, 1980-1982

NUMBER OF
CLAIMS



services increased 69 percent, and cost increased 63 percent. The actual cost per person per year for the addition of these providers was estimated at \$7.84.⁸

Wisconsin observed a proliferation of treatment centers for alcoholism, drug abuse and mental and nervous disorders following a 1974 mandate for these benefits. The number of these state-approved treatment centers increased from 39 to 939 between 1974 and 1984.⁹

Utilization of marriage and family therapists has a potential for increase in utilization equal to or greater than that for clinical social workers and other mental health providers. According to the American Association of Marriage and Family Therapists, an average of 150 applications per month are submitted by persons wishing to become Association members. Only eleven states currently regulate these practitioners through licensure or certification. However, thirteen states are seriously considering licensure or certification of marriage and family therapists. If direct payment for their services is authorized, the field could be rapidly flooded with providers of variable qualifications.

Impact on utilization - chiropractors. Chiropractor services are considered by many health benefit programs as a major problem area for overcharges, excess utilization and

provider abuse. Health insurers report extensive litigation with chiropractors regarding amounts billed for services and whether services performed are within their approved scope of practice. Chiropractor visit fees are often low. However, because of the large number of X-rays, lab procedures and spine manipulations billed for, total per case costs are very high. Moreover, there is evidence that chiropractor costs are increasing more rapidly than other health care costs. The Hawaii Medical Service Association reports the following per case cost comparisons. Between 1978 and 1984, chiropractor cost per case increased by 225 percent. This compares to an increase of 70 percent for physician cases.

	AVERAGE COST PER CASE	
<u>Provider</u>	<u>1978</u>	<u>1984</u>
General Practitioner	\$ 23.30	\$ 41.90
Orthopedic Surgeon	52.30	88.77
Osteopath	56.70	92.51
Podiatrist	Not Available	60.20
Chiropractor	91.00	294.10

A problem in managing the chiropractor benefit and applying utilization review screens is the lack of comparability with other services. Managing the benefit is further complicated under national health insurance plans by state variation in

allowed scope of practice. In some states, the scope of practice is limited to conditions directly affecting the spinal and skeletal system; in others, chiropractors can treat all medical conditions, including cancer. Most (but not all) states prohibit chiropractors from performing surgery or administering drugs. Given the incidence of utilization and billing problems involving chiropractors, the variability in scope of practice presents particularly troublesome problems for a national FEHBP program and for their ability to control costs.

Impact on premium cost. The decision by individual FEHBP programs not to provide direct reimbursement for specific providers is not based on whim or on unreasonable bias against specific provider groups. It is based on an assessment that direct reimbursement would result in higher premium cost and that the additional coverage is not sufficiently attractive to Federal employees to overcome the competitive disadvantage of the higher premiums. An effort by plans to evaluate each benefit on its own merits is evident by the facts that:

- 1) Most FEHBP plans have voluntarily provided direct reimbursement for two or more of the provider types proposed for mandate; and
- 2) all but one of the provider types are offered direct reimbursement by at least 25 percent and as many as 95 percent of the FEHBP programs.

Reliable estimates of impact of direct reimbursement on premium costs are not available for some provider types. Projections are difficult to develop because some providers have long been covered by most health insurers (e.g., psychologists), insurer data systems generally do not retain separate claims data for some providers (e.g., nurse practitioners), and some providers are not generally covered under typical health insurance programs so little or no claims data exist.

Premium cost estimates are available for chiropractors. Current estimates by Blue Cross and Blue Shield Plans which already offer or are considering offering direct reimbursement to chiropractors range from \$2 to \$8 per contract month, or \$24 to \$96 per contract year. The wide variation in estimated premium cost reflects primarily differences in chiropractor supply by area. There is general agreement, however, that premiums for chiropractor services are increasing more rapidly than overall health care costs.

Impact on provider supply. Potential increases in prices or in opportunity to increase private patient business can result in expanded supply of providers. The magnitude of the expected change in supply is related to the attractiveness of the income opportunity and the ease with which providers can be trained or obtain required credentials to practice professionally. Econometric studies have shown a strong positive relationship between provider supply and mandated benefits. A study sponsored

by the National Institute of Mental Health estimated that implementation of state mandated benefits for psychologists results on average in a 19 percent increase in the state supply of psychologists.¹⁰ For social workers, the predicted increase is 24 percent.

After New Hampshire passed a bill in 1975 mandating specific mental health benefits and providers, the supply of psychologists and pastoral counselors billing for payment has increased nearly ten fold. Today, over 125 psychologists and pastoral counselors bill for services, compared to 13 prior to the mandate.¹¹

For most of the provider types included in the proposed legislation, a large supply of trained professionals exists who, with little or no additional formal training can become licensed providers with direct billing privileges. These would include salaried nurses, salaried social workers, and marriage and family therapists. Large numbers of persons are trained in these professions who are not currently employed or who are employed part time. A significant portion of these individuals could be induced to return to active self-employment if mandated direct reimbursement resulted in improved income opportunities. In areas of significant Federal employment, mandated direct reimbursement for social workers, therapists and chiropractors could result in sizeable increases in supply, which in turn would cause increased utilization and higher claims cost.

The potential impact of the proposed legislation upon health services delivery is evident in the vast supply of nurses who could become eligible for direct payments. For example, there are 1.9 million registered nurses holding licenses in the nation.* Nearly 1.5 million of these are currently practicing in their field. Independent practice could be quite attractive to many currently either employed or not employed. The independent practice of nursing is becoming increasingly attractive to those who seek greater autonomy. More than 10,000 nurses have gone into private practice already, and rapid increases could occur if direct payment is mandated.¹²

The scope of practice of nursing is also increasing rapidly. A recent decision by the Missouri Supreme Court held that new functions for nursing practice can evolve without statutory constraint. Nurses in that state are authorized by definition to perform "nursing diagnosis." Use of this term indicates that diagnosis is not exclusively limited to physicians. In addition, functions of treatment and medication are liberalized by the court determination. In nineteen states, nurses are allowed to prescribe some types of drugs.

*U.S. DHHS, Health Resources and Services Administration, Bureau of Health Professions, "National Sample Survey of Registered Nurses, November 1984."

Conclusions of independent studies of mandated provider

reimbursement.

In response to efforts by provider groups to enact mandated direct payment and to arguments by employers and health insurers which generally are in opposition to mandates, studies have been conducted by various state government task forces, legislative task forces and other independent study groups of the public policy implication of provider mandates. In most cases, these task forces have concluded that additional mandated benefits and mandated payment to providers are not in the public interest, and have recommended against their adoption. The following observation was made in a study prepared for the Virginia Bureau of Insurance by Professor John Larson of Virginia Commonwealth University:

No one has demonstrated that there is any cost savings or stabilization in the increase of costs by reimbursing non-physician practitioners in addition to physicians under the same benefit package. Rather, research has clearly demonstrated that increased coverage of services result in increased utilization, thus total health care expenditures go up. A deceiving argument is that it must save insurance companies money when the subscriber is able to go to, for example, a clinical social worker, charging \$25, rather than a psychiatrist, charging \$50 for psychotherapy. The flaw in the argument is that in a system where the provider (either psychiatrists or clinical social workers) is able to influence the price and the level of utilization, each is able to encourage enough utilization to assure an adequate income. The outcome is that total expenditures increase for three possible reasons: 1) the utilization of psychiatrists does not significantly decrease nor does [sic] their fees; 2) in time clinical social workers' fees begin to approach the fee levels of psychiatrists; and 3) the utilization of clinical social workers' services increases.

A study conducted by the Hawaii Legislative Reference Bureau in 1985 for the Hawaii Senate reached the following conclusion:

The experience of HMSA (largest private health consumer in Hawaii), Hawaii's Medicaid program, and other health insurers has demonstrated that expansion of coverage to new groups of providers results in increased utilization of services, escalation of fees, and therefore, increased total expenditures by insurers. Mental health benefits under various HMSA plans have annual ceilings ranging from \$500 to \$1,000. Most of the HMSA's members who utilize mental health benefits do not now reach the annual ceilings. Expanding mental health coverage to clinical social worker services would, in all likelihood, result in increased costs and create the probability of increases in premiums.¹⁴

The National Association of Insurance Commissioners (NAIC) recommended that state legislatures consider fully the demonstrated public need, impact on costs and other factors before enacting mandated benefit legislation.

The State of Washington enacted legislation in 1984 which put the burden on those that sponsor specific mandated benefits to provide answers to a list of critical questions. All sponsors of mandated benefit legislation in Washington State are required to prepare a report which investigates the following issues:

(1) The Social impact: (a) To what extent is the treatment or service generally utilized by a significant portion of the population? (b) To what extent is the insurance coverage already generally available? (c) If coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care

treatments? (d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship? (e) What is the level of public demand for the treatment or service? (f) What is the level of public demand for insurance coverage of treatment or service? (g) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?

(2) The Financial impact: (a) To what extent will the coverage increase or decrease the cost of treatment or service? (b) To what extent will the coverage increase the appropriate use of the treatment or service? (c) To what extent will the mandated treatment or service be a substitute for more expensive treatment or service? (d) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders? (e) What will be the impact of this coverage on the total cost of health care?¹⁵

These issues have not been satisfactorily addressed by the proponents of the FEHBP mandate proposal.

Policy Decision: Should direct reimbursement for non-physician providers be mandated under the FEHBP program? The passage of a mandated direct reimbursement bill will not immediately result in sharply higher FEHBP premiums. Most of the FEHBP programs already provide direct reimbursement for several of the providers covered under the proposed legislation, and direct reimbursement for providers not usually covered may not result in immediate substantial increases in charges and utilization. But the legislation is not necessary and would be harmful over the longer run, for the following reasons:

- The FEHBP program is highly competitive, with benefit structures and covered providers highly attuned to enrollee preference and impact on premiums. Interference in this process by forcing unwanted coverage is neither necessary nor desired by Federal employees.

- Over the long run, FEHBP costs will increase substantially if the mandates are enacted, as a result of:
 - encouragement of states to license or certify additional provider groups;
 - expansion of supply of licensed providers as direct billing opportunities increase;
 - increase in charges of non-physician providers; and
 - increase in utilization of non-physician providers, particularly for chiropractors, social workers, and marriage and family therapists.

- The passage of mandated direct reimbursement for FEHBP plans sets a bad precedent. It may result in an increasing number of state mandates and possibly Federal mandates for benefits and providers under private health benefit plans. Given the highly

elective nature of mental health counseling and therapy services, and difficulty in controlling chiropractor claims cost, an expansion of mandated benefits for these services under private insurance will result in substantial health care cost inflation.

Forcing FEHBP programs to directly reimburse specific provider groups benefits almost exclusively the specific provider groups, is anti-competitive, and has potential consequences for a major increase in health care cost. It serves neither Federal employees nor the overall public interest.

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QUESTION #2:
Why Are Mental Health Benefits
So Troublesome For Health Insurers?

MENTAL HEALTH
SERVICES - EAST

QUESTIONS

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g Their Regulation of
Benefits, Eligibility

THE MILWAUKEE JOURNAL
Mental health
benefits: Not enough?
Too much?

By Neil D. Rosenberg

Journal Medical Reporter

The State Department of Health and Social Services wants to increase — in one instance triple — the required minimum benefits insurance companies must offer for mental health services. The possibility sparks anew a 10-year old controversy over whether such benefits are actually inadequate or necessary at all.

There are a variety of conflicting con- siderations

needed by thousands of people who he- vely want mental health services and

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

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

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

Wisconsin State Rep. John Merkt questions "when is enough, enough?" in mandated mental health coverage, citing usage of the benefit by the 4,200 students on the Madison campus of the University of Wisconsin, one-third of whom used the benefit last year, enough

to more than double the student health insurance premium. Of the claims for psychiatric, alcoholism and drug abuse services, 90% were psychiatric, a pattern that he labels "abuse." He explains: "This benefit is subject to overuse and abuse by both users of the service *and providers* of the service." Merkt launched a study that found students using the full benefit in the first semester, then using the full benefit again in the second semester. This was corrected by changing the student health policy from a calendar-year basis to a policy-year basis.

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

CONGRESS FEARFUL

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

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

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

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

But insurers find it nearly impossible to identify displaced costs.

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



Rep. Merkt



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

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

That's 22 states in the 1970's.

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

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

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

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

*not counting mentally handicapped (32 states)

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

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

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

California, Maryland and Oregon were in that maiden group.

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

"Prior to the mandated \$500 mental health benefit, the Plan paid \$1.9 million for outpatient mental health benefits. Payments have increased by 2,400% ... exceeding \$48 million in 1985.

"Moreover, there are now more than 6,600 psychiatrists, and licensed clinical independent social workers participating in the benefit ... a ratio of one mental health provider for every 666 citizens ... the

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

WISCONSIN CARE BOOMING

Wisconsin's experience matches Massachusetts':

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

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

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

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

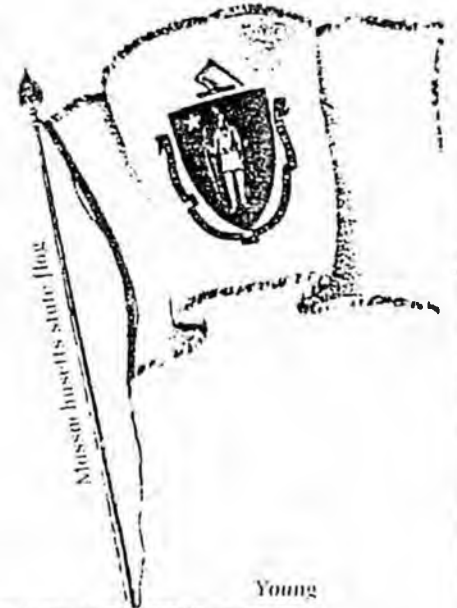
- \$6 extra family fees per month in Massachusetts,
- "nearly \$5" in Kansas, and
- "between \$2 and \$3" in Maryland.

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

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

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

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



Young



PREVALENCE AND CHARACTERISTICS

- Over 600 state mandated health benefits exist. Approximately 50 of these are mandated offerings, and the rest are mandated benefits.

Mandated health benefit laws require insurers to provide or to make available particular benefits in their health insurance policies. Mandate laws come in two general forms: a mandated benefit is one which must be included in all policies written by the insurer; a mandated offering need not be included in all policies, but must be made available to groups requesting it.*

The Blue Cross and Blue Shield Association differentiates between four types of mandated benefit laws, those concerned with:

1. providers -- payment for services by a type of practitioner;
2. services -- coverage of specific illnesses or treatment methods;
3. beneficiaries -- coverage for particular dependents under plan;
4. continuation -- continuation or conversion of coverage.

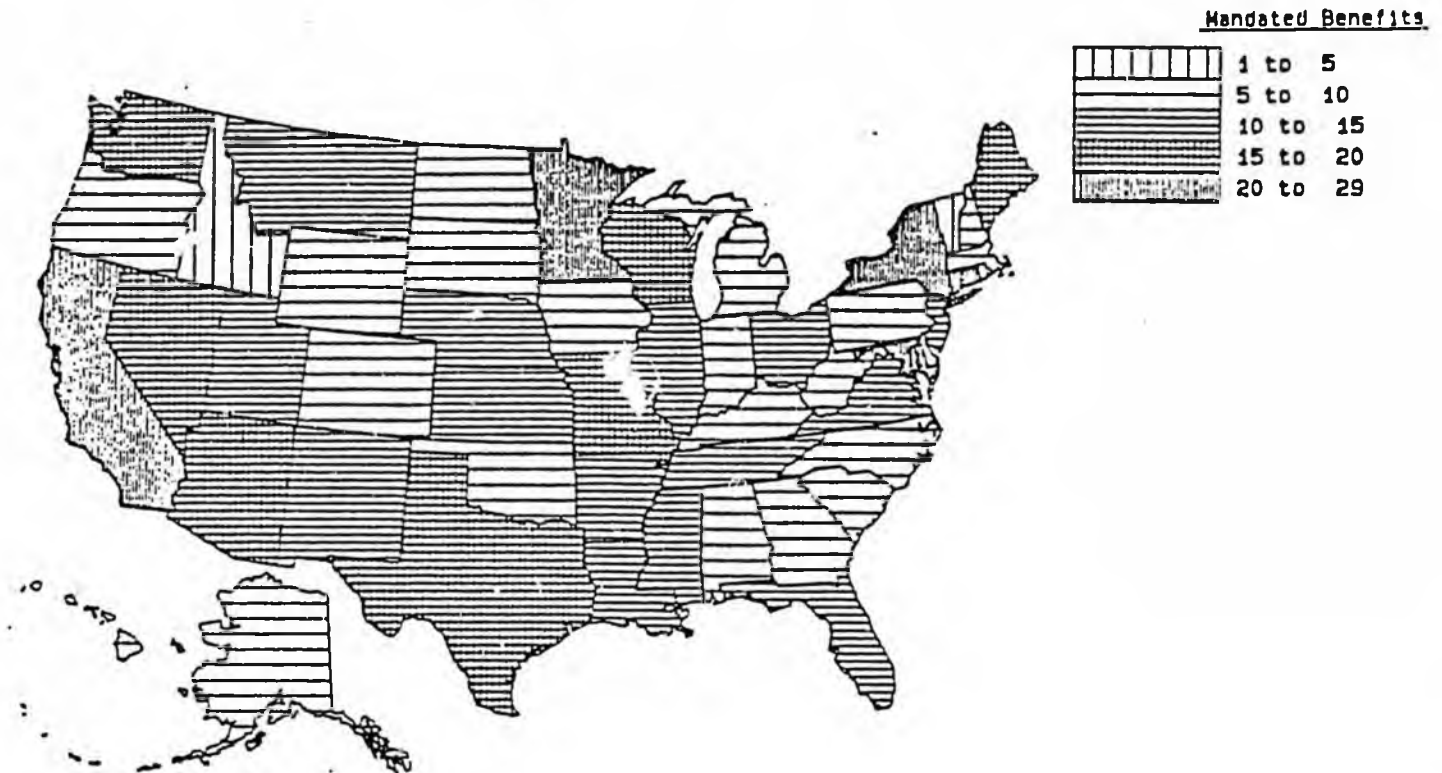
The emphasis of mandated benefits and offerings has changed over time. The first "generation" of laws expanded coverage to professionals previously excluded (e.g., dentists, chiropractors, psychologists). The next groups provided an expanded range of services (e.g., maternity coverage, newborn care) and benefits oriented to both providers and services (e.g., Alzheimer's disease, substance abuse treatment). Federal and state budget cuts prompted mandates to support community health centers, state institutions, and other publicly oriented health services. Benefits now may enter a new generation, as more states pass laws restricting new mandated health benefits.

- All states mandate at least some benefits, although there is wide variation in numbers and types of laws.

Delaware, Idaho, and Vermont each provide fewer than six mandated benefits. California, Connecticut, Maryland, Minnesota, and New York offer more than 21 mandated benefits or offerings. The largest number of states offer between six and ten mandates or offerings.

* The vast majority of these laws mandate benefits rather than offerings. Throughout this paper the term "mandated benefit" will be used in reference to both mandated benefits and offerings, unless otherwise specified.

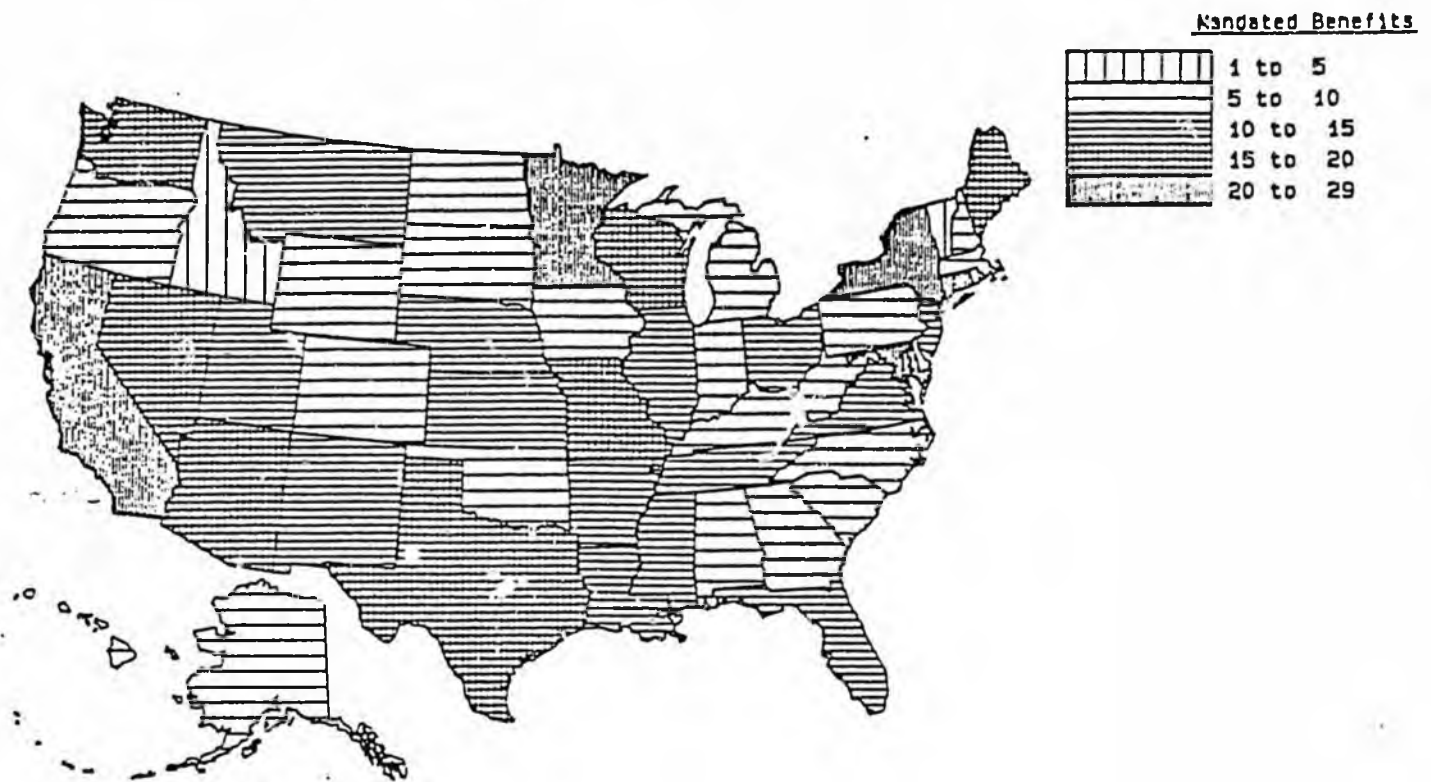
NUMBER OF STATE MANDATED BENEFITS 1986



The most common mandates (those occurring in 30 or more states) are coverage for psychologists, optometrists, chiropractors, alcoholism treatment, newborn coverage, coverage for the mentally and physically handicapped, and conversion privileges.

Most of the benefits are mandated in only a handful of states. Among the least common are: maternity benefits for the natural mother of an adopted child under the adoptive parents' policy (AZ), acupuncture (CA), naturopathic medicine (CT), liver transplants (IL), denturists (MT and OR), in vitro fertilization (MD), insulin infusion pumps (WI), and pastoral counselors (NH).

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Number of States Mandating Specific Benefits or Offerings

<u>Benefit or Offering</u>	<u>Number of States</u>
<u>Providers</u>	
nurse midwives	19
nurse practitioners	9
nurse anesthetists	5
physical therapists	3
occupational therapists	2
speech/hearing therapists	4
psychologists	36
psychiatric nurses	5
social workers	12
dentists	26
oral surgeons	2
optometrists	30
podiatrists	24
chiropractors	36
osteopaths	9
other providers	10
<u>Benefits</u>	
alcoholism	37
drug abuse	17
mental health	28
breast reconstruction	10
maternity	18
prescription drugs	2
orthotic/prosthetic devices	3
cleft palate	4
diabetic education	3
diabetic outpatient care	2
second opinion	4
home health	15
hospice	7
longterm care	2
ambulatory surgery	10
antiabortion provisions	6
public institutions	8
ambulance/transportation for newborns	3
pediatric preventive care	3
other health centers	6
<u>Dependents</u>	
dependent students	5
adopted children	18
newborns	38
mentally/physically handicapped	34
noncustodial children	1

Benefit or Offering

Number of States

Continuation

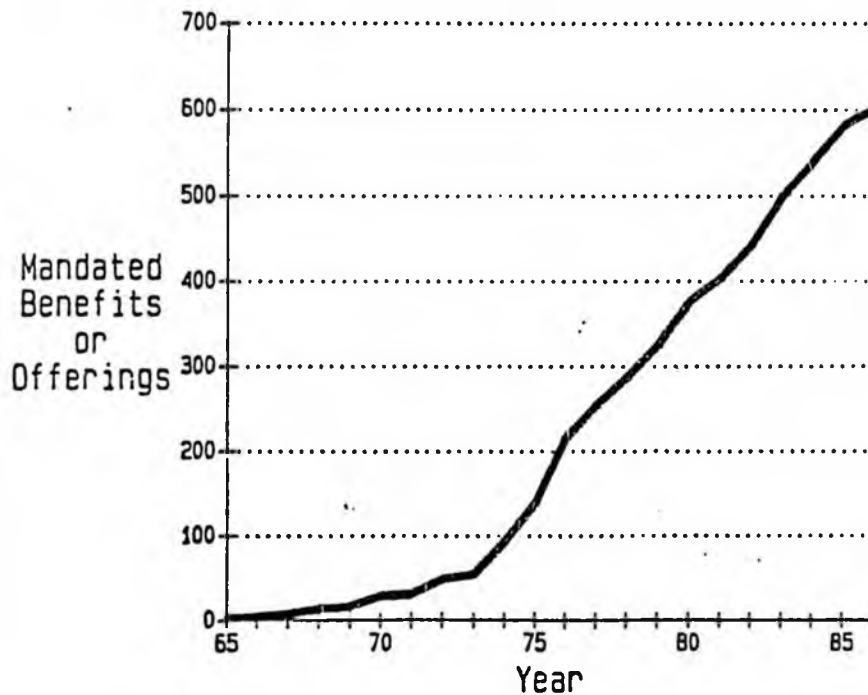
conversion privilege	32
continuation for dependents	27
continuation for employees	21

Other

catastrophic coverage	3
mandate evaluation	5

SOURCE: Blue Cross & Blue Shield Association, 1986

CUMULATIVE TOTAL OF STATE HEALTH BENEFIT
MANDATES
1965-85



SOURCE: Blue Cross Blue Shield Association, 1986

- Hawaii and Minnesota offer innovative approaches to health benefits. Hawaii mandates coverage and minimum benefit levels for all employers under an exception to ERISA. Minnesota requires minimum benefit levels for employers providing benefits.

Hawaii's mandated health benefit policy is unique in the nation. The Hawaii Prepaid Health Care Act requires all employers to provide health insurance coverage to any employee who has worked four consecutive weeks for 20 or more hours each week. Coverage may be provided through an insurance company or HMO, or the employer may self insure. Regardless of the type of coverage chosen, Hawaii establishes a minimum level of coverage to be provided.

Passage of the Hawaii Prepaid Health Care Act preceded ERISA by only a few months. In 1983 ERISA was amended to allow continuation of the Hawaii plan, after the Supreme Court ruled that it violated ERISA's preemption provisions.

Minnesota's law follows ERISA restrictions -- it does not require employers to provide health insurance to employees. The law does, however, require an employer who provides a health plan to adhere to certain standards. The insurance commissioner rates all insurance plans offered in the state "qualified" or "unqualified," according to state core coverage guidelines; qualified plans must be ranked further as "1" "2" or "3," based on the deductible amount.

Employers offering coverage to their employees must provide a number 2 qualified plan or better. The law, as originally written, covered both fully insured and self-insured plans. As a result of a lawsuit brought under ERISA's pre-emption provisions, however, the state is enjoined from forcing self-insured plans to comply.

ISSUES

A. THE CONTROVERSY -- VIEWS OF ORGANIZATIONS

- The battle lines are clearly drawn on the issue of mandated benefits.

Those in favor of mandates include several types of organizations:

Provider Groups (professional associations of social workers, psychologists, chiropractors, etc.) -- Providers fear that consumers will not use what they consider to be valuable services in the absence of insurance coverage. In some cases insurance coverage also is seen as conferring legitimacy on a practice.

Advocates for the mentally ill, the disabled, people with particular illnesses, children, and other populations -- These people often require scarce and/or costly medical care. Insurance coverage enables them to obtain it at reasonable cost.

State Lawmakers -- Members of many state legislatures pursue mandated benefits as a response to inadequate coverage among their constituents and/or intense lobbying by advocates and providers.

Those opposed to further mandated benefit legislation include:

Business Owners and Managers -- Business people fear increased premium costs and administrative complications;

Business Organizations Such as Chambers of Commerce and Manufacturers Associations; and

The Insurance Industry -- Insurers believe that continued mandated benefit activity encourages employers to drop traditional insurance packages in favor of self insurance.

The AFL-CIO opposes the concept of mandated benefits, as do most member unions. These groups perceive mandates as short-circuiting the collective bargaining process. Some unions representing low-wage workers, however, take a more ambivalent stance. Those in weak collective bargaining positions see state mandates as the only way their members will receive certain health coverages.

B. PROS AND CONS OF STATE MANDATED HEALTH BENEFITS

As noted above, there are various types of mandated benefits: those relating to providers, illnesses or treatments, dependent coverage, and continuation of coverage. The type of benefit often plays a major role in determining an individual or an organization's support or opposition. Provider-oriented benefits, for example, tend to receive the least support, except among the provider groups which propose them.

• Arguments for mandated benefits.

Improving access to services and providers. Mandates are necessary because existing coverage patterns discriminate against those with mental health problems, special needs, or rare conditions, and leave many who need this care with inadequate coverage. The health insurance system has a strong "medical model" bias -- nontraditional health services or providers are excluded from the system.

Overall cost savings. Mandated benefits offer the opportunity for substantial reductions in health care costs through substitution of the mandated service (e.g., home health care, social workers) for expensive traditional services and providers (e.g., hospital care, psychiatrists). Other savings are indirect -- states requiring coverage for substance abuse, for example, should experience lower levels of absenteeism, productivity problems, and traffic accidents due to alcoholism and drug abuse.

Pooling of costs and risk. Expensive or longterm treatments can financially devastate an individual or family bearing the total cost of care. Spreading the risk and cost throughout a larger population adds little to individual premium costs while enabling those in need of care to obtain it.

Overcoming information gaps. Health care consumers find it difficult to obtain adequate information necessary for making informed insurance coverage decisions -- doctors do not advertise, environmental changes affect an individual's chances of developing health problems, etc. Those not bargaining collectively for health benefits may not participate in coverage decisions and, where bargaining occurs, negotiators may not adequately represent all members' interests. In this age of employee givebacks and cafeteria plans, mandates limit the occurrence of inadequate insurance coverage due to information gaps.

- **Arguments Against State Mandated Benefits**

Cost increases. Mandated benefits generally result in higher cost and utilization levels because, as a rule, the statutes contain no cost containment mechanisms. Mandation lowers the cost of a given service to the health care consumer -- instead of full price, he or she now pays only for deductions and coinsurance -- enabling more people to obtain it. Savings resulting from substitution of services are offset by overall growth in utilization, and often by higher charges as insurance coverage makes demand less sensitive to cost increases.

State legislatures as an inappropriate arena. Benefits mandated by state legislatures are more likely to reflect lobbying skills on the part of interested groups than actual public concerns. And mandation removes a benefit from both the collective bargaining process and individual insurance choices. While advocates of mandates intend to provide greater choice to health care consumers, the result may be to limit that choice -- mandated benefits may replace others more appropriate to individuals or bargaining groups.

Incentives to self insure or drop coverage. Mandated benefits provide a cost advantage to self insured plans, which ERISA exempts from state mandate laws. An additional inducement exists for companies operating in more than one state -- self insurance eliminates the administrative burdens associated with operating a different plan in each state. Self insured plans may provide less comprehensive coverage than fully insured plans, leading to higher levels of inadequate coverage. Smaller firms and those otherwise unable to self insure may simply eliminate insurance coverage for their employees.

C. THE EVIDENCE ON COST

- Opponents of mandated benefits argue that they increase the cost of health care and insurance. Proponents counter that increases in some areas are offset by lower costs in others. Current evidence is not definitive, in fact there is no national data and very little state data with which to evaluate state mandates.

A Virginia study found that mandated benefits increase price and utilization of covered services. A 1979 study for the Virginia state insurance department provided a comprehensive overview of literature addressing mandated benefits. The report considered mandated benefits in general rather than specific Virginia laws and concluded that:

"The general effects of expanding benefits/coverage by whatever means are threefold: (a) it usually lowers the out-of-pocket costs to the consumer for use of covered services; (b) when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services; and (c) it assures a flow of

revenue to providers. The more direct results are an increase in the price and level of utilization of covered health care services."

The report suggests that future mandated benefit legislation be evaluated on the basis of "unmet need, cost impact, provisions for controlling utilization and cost/fees, and mechanisms for assuring quality." Another option would be the establishment of minimum benefit levels to protect consumer interests. The report rejects reversion to the open market, arguing that the insurance market does not lend itself to the flow of necessary information to consumers.

HIAA study found mandated benefits accounted for 12-17% of premium costs, but may be offset by other factors. A study done for the Maryland House of Delegates in 1985 is often cited in cost arguments. The study was done by the Health Insurance Association of America (HIAA), a vocal opponent of mandated benefits. Unlike the Virginia study, this report evaluated the effects of benefits specific to the state. HIAA found that state mandated benefits accounted for 12-17% of total premium costs in Maryland with nervous and mental health care and maternity and newborn care accounting for the greatest portions.

Premium cost components in Maryland

<u>Benefit category</u>	<u>Employee premium</u>	<u>Family premium</u>
Mandated	\$11.05	\$ 46.10
Non-mandated	<u>83.95</u>	<u>223.90</u>
Total	\$95.00	\$270.00
Mandates as proportion of total	12%	17%

SOURCE: HIAA, 1985

There may be offsetting cost reductions, however. The report notes that, due to measurement difficulties, these values do not include cost reductions in some areas (e.g., hospital stays) resulting from mandates in other areas (e.g., hospice and home care). Further, the proportion of premiums comprised of mandated benefits does not actually represent the cost of mandated benefits. Many insurers provided particular benefits prior to mandation -- thus, the cost would exist with or without a mandate.

In other HIAA findings:

-- Mandated offerings, if available to individuals, are subject to adverse selection. Those selecting optional coverages will be those most likely to require them, limiting the pooling of risk.

- The number of mandated benefits in a state has little if any effect on the cost of insurance relative to other states. Practice styles of local physicians have a much greater effect.
- Mandated benefit costs include indirect costs resulting from increased utilization, administrative expenses, reductions in other coverage, and increased employee contributions to premiums.

In Wisconsin, mental health and chiropractic facilities ballooned after passage of mandated benefit laws. A 1975 Wisconsin law requires that all insureds receive \$500 of mental health benefits with first-dollar coverage. Between 1975 and 1984, the number of outpatient mental health facilities in Wisconsin ballooned from 39 to 939. In the ten years following enactment of optional chiropractic coverage, membership in the Wisconsin Chiropractic Association more than doubled.

Other studies call for closer scrutiny of proposed mandated benefits. Studies in Florida, New York, Connecticut, and Minnesota, stress the diversity among mandated benefits. Several of the reports argue that this makes them impossible to assess on other than a case by case basis. All noted the need for closer scrutiny of proposed mandated benefit laws, in some cases suggesting establishment of minimum benefit standards in lieu of further mandates.

STATE RESPONSES

- Repeal of previously mandated benefits is extremely rare. States, however, are beginning to require advocates of new mandates to justify their position.

In 1984 Washington became the first state to require advocates of new mandated benefits to provide legislators with a report on the social and financial impact of the proposed benefit. Oregon and Arizona passed similar laws in 1985, and Pennsylvania followed in 1986. Washington's legislature passed six mandated benefit laws in 1983, the year before the new requirements; two laws passed in 1984 and one in 1985. The reporting statutes require advocates to present an analysis of:

The social impact:

- current utilization of treatment or service;
- availability of insurance;
- avoidance of treatment or financial hardship due to absence of coverage;
- public demand for the treatment or service; and
- union interest in collectively bargained coverage.

The financial impact:

- effect of coverage on cost and use of the treatment or service;
- expected substitution of the proposed treatment or service for more expensive alternatives; and
- impact of mandation on administrative expenses and overall costs of health care.

Nebraska's state government chose a different approach to mandated benefits. Last year the governor signed into law LB895, which states that "No legislative proposal to mandate or require the offering of health care coverages or services shall apply to any insurer unless the proposal applies equally to employee welfare benefit plans described in (ERISA)." This new law effectively bans new benefits or offerings, since the Supreme Court has ruled that ERISA plans are not subject to state mandated benefit legislation.

OPTIONS FOR FEDERAL ACTION

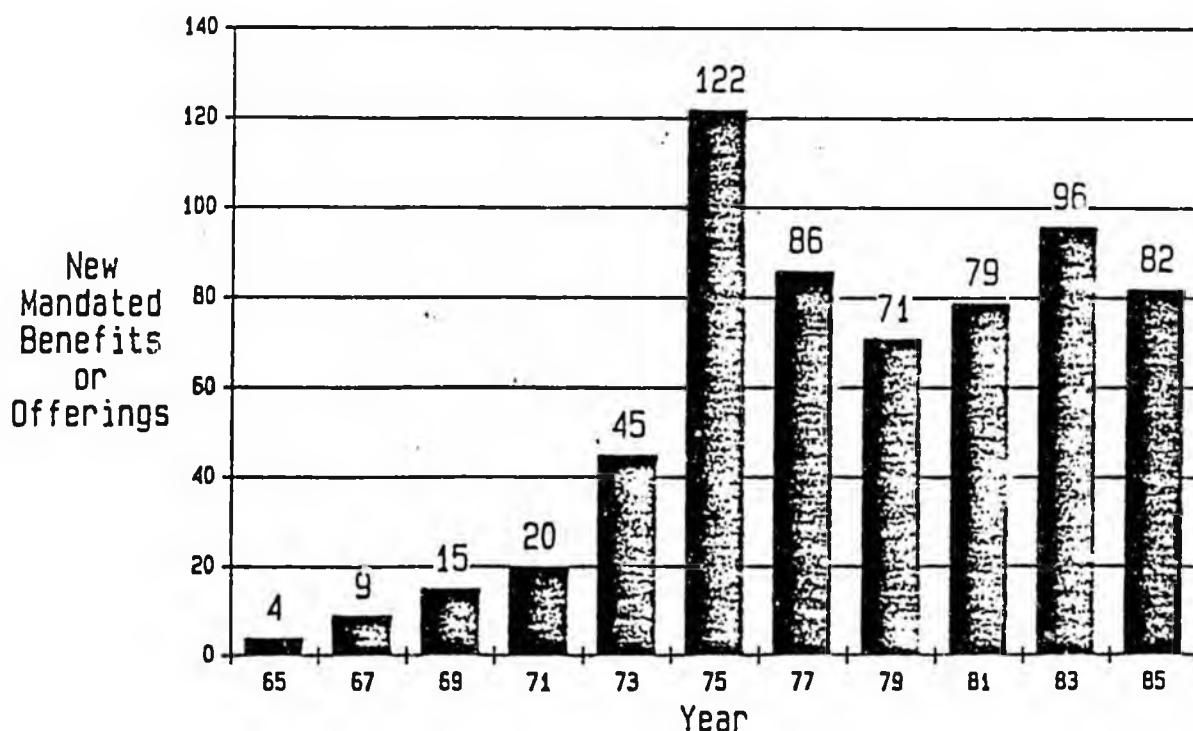
• What federal level policy options exist in the area of state mandated coverage?

1. Do nothing. In the past several years, states have enacted fewer new mandated benefit laws and expressed more interest in limiting mandate activity. Escalating health care costs and growing dissatisfaction with mandated benefits may drive states to abandon mandates without federal intervention.

Issues and questions:

- The current mandated benefit "system" includes great diversity among states, both in terms of number and type of benefits. Leaving all further action to the states virtually ensures a continuation of this patchwork of benefits.
- A previous drop in mandate laws began in 1975 and lasted until 1979, when a new round of mandate activity began. There is no way to be sure the current dropoff is permanent.

NUMBER OF NEW STATE BENEFIT MANDATES
BIENNIAL TOTALS, 1965-85



SOURCE: Blue Cross Blue Shield Association, 1986

2. Encourage limits on new mandated benefit laws. Five states have enacted laws restricting new mandates, with others expressing interest. Federal activity could focus on mechanisms to encourage and/or coerce states to limit mandate activity.

Issues and questions:

- Would such activity target all states or just those with large numbers of mandated benefit laws?
- Should incentives encourage repeal of existing mandates and/or restrictions on new legislation?

3. Establish minimum benefit standards. Minnesota and Hawaii both set minimum standards for health insurance policies offered in those states. Such standards would greatly minimize the risk of inadequate coverage while eliminating underinsurance as a justification for mandated benefits.

Issues and questions:

- Given the wide variation in mandated benefit levels, such legislation would have to establish a middle ground -- comprehensive enough to discourage further mandates but not so broad as to discourage compliance in states with few mandates.
- Should states be required to follow federal standards or be allowed to establish their own?
- Would such legislation cause significant shifts to self insurance or no insurance?

4. Require employers to provide health insurance to their employees. Hawaii is the only state with such a requirement at the present time, due at least in part to ERISA. Federal legislation could require employer-provided insurance or enable states to pass their own laws in this area.

Issues and questions:

- This approach would require changes in ERISA, a law which Congress is reluctant to amend.
- The business community would undoubtedly oppose any shift toward benefit requirements.
- Would significant worker dislocation result from such legislation?

5. Enact national health insurance. A national health system could conceivably address the access and adequacy issues which state mandated benefits attempt to consider. Such an approach would remove coverage decisions from the states, employers, and individuals.

Issues and questions:

- National health insurance has many enemies, including business, medical associations, and insurers.
- Are national health insurance proposals politically realistic in these days of massive budget and program cuts?

SB 67 An Act relating to insurance coverage for the treatment of mental or nervous condition

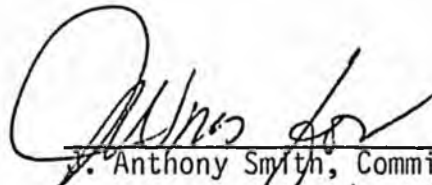
The Department of Commerce and Economic Development supports this bill. However, the department does wish to propose several technical amendments that will clarify the bill.

This act provides for a mandated offering of certain benefits for the treatment of a mental or nervous condition subject to the same deductible and co-payments as for any other covered condition or illness. The department supports this approach as opposed to a mandatory benefit inclusion.

The department recommends the following amendments:

1. The definition section, AS 21.42.365(d), needs to have its subsections renumbered due to the addition of additional terms to be defined;
2. The term "accumulation period" needs to be defined as the maximum length of time in which an insured or subscriber has to incur the amount of covered costs for treatment to satisfy any deductible required;
3. The term "deductible" needs to be defined as the amount of covered costs for treatment for which the insured or subscriber is responsible that must be incurred before benefits become payable under a disability insurance policy or subscriber contract in any accumulation period; and
4. The term "co-payment" needs to be amended to indicate the portion of the covered costs for treatment in excess of the deductible for which the insured or subscriber is responsible.

One further item is that the use of the term "cost" in this act would appear to require the benefits to be offered for the treatment of a mental or nervous condition on a usual, customary and reasonable basis. It needs to be recognized that some of the underlying contracts may provide benefits for all other types of illnesses and accidents on a preset, scheduled basis.



J. Anthony Smith, Commissioner
DATE: 3/18/87